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The phenomenon of dual diagnosis in the light of attachment theory – a case study

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Summary

A key precept of Bowlby's attachment theory is that every human being has a biologically and genetically imprinted need to develop relationships with other people. The relationship, which develops between a child and mother, constitutes the starting point for the development of ensuing emotional ties with people ever more distant than the mother – both within the family, as well as outside of it. Emotional disorders in adulthood are due to disturbed early development of attachment. Fulfilment of the need for successful relationships in later life is the key for building and sustaining one's mental health. M. Ainsworth has assessed the quality of attachment styles from infanthood onward. In the course of her research, she defined three categories of attachment styles: secure, avoidant, fearful-ambivalent. Regardless of attachment style, it is of utmost importance that the adult person's need for relationships during the whole life comes to fruition on various levels of social interaction. The patient's psychological representation of the object of attachment may also influence his/her compliance in treatment. The therapeutic relationship in the psychiatric setting can thus be viewed in the light of Attachment Theory. This point of view seems particularly relevant, when one considers the problems encountered in the treatment of dual diagnosis patients. Clinical experience shows that dual diagnosis (psychiatric disorder with concomitant substance dependency) patients are particularly difficult in terms of compliance. This case report describes a 32-old man suffering from schizophrenia, addicted to alcohol, with incident abuse of amphetamines, coming from a dysfunctional family background. Close scrutiny of the patient's life from the perspective of Attachment Theory reveals a thorough lack of secure relationships from early childhood, through to his adult life, including failed marriage and parenthood. Every addiction therapy, he has hitherto undertaken, has failed, concurrent with psychotic relapse. For the therapist, he is a constant source of frustration.

dual diagnosis / attachment theory / compliance

INTRODUCTION

The concept of dual diagnosis is applicable to a fact of the coexistence of alcohol or drug addiction and other mental disorder e.g. schizophrenia in one person. In this concept it is important to emphasize simultaneous occurrence of two or more kinds of mental illnesses, of which one concerns the problematic abuse of psychoactive substance (WHO 1995, UN 2000).

The motivation for taking psychoactive substance by persons with schizophrenia is connected with the subjective feeling of benefits from alcohol or drugs abuse. Research shows, that schizophrenia patients choose the substance to cope with the consequences of illness, especially with depression, a need to feel different emotions more intensively and to reduce side effects of taking pills [1, 2].

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Therapeutic difficulties in the treatment of persons with a dual diagnosis stem, not only from two illnesses coexisting in one person, but mainly from the problem of combining two totally different methods of treatment for people with schizophrenia and addicts. With schizophrenia patients, the most important issue is to build the therapeutic relationship slowly, which ensures sense of stability, close distance, tolerance for rejection, non directive treatment. In the case of addiction, it is important to put forward clear borders, and to apply confrontative therapy [3]. In this situation a question arises as to the model of understanding of these kinds of disorders, as well as therapeutic recommendations for therapists.

A means to address the issue may be J. Bowlby`s attachment theory. Its main assumption is the thesis that in each person there exists a biologically and genetically conditioned, passing tendency to create strong emotional bonds with others [4]. The connection which is created between a mother and a child, is the background for developing emotional relationships with others. If this earliest process of bond formation is disturbed or even does not occur, with some probability various emotional disorders might be developed in the adulthood. Despite that, the need to form bonds with other people remains [5, 6].

Through lifetime, a bond system whose aim it is to integrate the experience of an individual thinking and behaviour models is being created. A specific model of attachment is being formed, I - model, and model of relation between I and others. These are interaction models created from the earliest life moments in agreement with certain rules, e.g. availability. During an optimal attachment process the following concepts about the self become integrated, the self becomes seen as love-worthy, important, accepted, and the world is viewed as full of friendly people who care for others' needs. Otherwise, when the earliest experiences lack important people, who may accompany and give help and care, a belief is being formed, that people are unworthy of trust and unpredictable. In the same way negative self-evaluation is created, as unimportant and not worth of love [7].

M. Ainsworth observed children behaving in context of availability and separation with the mother and three behaviour styles were determined, specifying types of bonds, which are created between a mother and a child. Ainsworth marked off the following styles: secure attachment, dismissive-avoidant and anxious-preoccupied. Secure relationship is optimal for a child's development; it gives safety and trust to people and future life situation. This secure relation allows the developing individual to build a model of self and others. The foundation to build these models are the interactions between an individual and the attachment object. These models are individual cognitive structures and, simultaneously; are a kind of cognitive frame, thanks to which processes of reality, events, people and interpersonal relations perception occurs.

Basing on the developed schemata of beliefs other cognitive schemes are created. Dismissive-avoidance attachment style, does not ensure the feeling of security and the experience of intimacy in adulthood, causes feelings of discomfort and threat. Anxious-preoccupied attachment style, makes people feel uncertain in relationships in which the need of being very close with the partner is not satisfied. This need is connected with a belief that one is not as desired as one pleases and the desire might deter from contact with other people. There is no agreement as to how the attachment style which developed in childhood is in force, while creating relations in adulthood [8].

The attachment relation is especially fulfilled through searching for closure even more intensively in the situation of threat and usage of the attachment person as a provider of the feeling of security. Consequently the attachment behaviour helps to stay in homeostasis by fear intensifying and anxiety regulation. The subjective feeling of fear, anxiety and vegetative arousal intensify the tendency of attached behaviour. Those behaviours may be treated as one of the many ways of coping with the consequences of difficult situations. Existence and availability of the attachment object to which a person can appeal plays a homeostatic role.

Researchers do not say any more if it is an exceptional relation wanted only under special conditions or generally fulfilling a person's need. It is important to ask how the experiences from early childhood influence intimate bonds building and how it looks in adulthood. In literature there are two opposite hypothesis concerning this re-

lation: suitability and compensation. The first of these assumes that behaviour in adulthood is repeated after the one created in childhood, and is a consequence of the attachment style. This behaviour and bond types are modified slightly and potential life partners might experienced them. The second one, the compensation hypothesis, is related to M. Ainsworth statement, that children who have not experienced secure attachment with parents, can try to attach to other meaningful persons, e.g. collateral relative, teacher, tutor, doctor, therapist, priest etc. [8]. It is not clear if in adulthood we prefer the attachment style created in childhood, or if we have a chance to change it under favourable circumstances.

At that stage it is not clear which hypothesis is better. The relation between a patient and the psychiatric institution staff might be understood in context of the attachment theory. This point of view is especially useful in therapy with dual diagnosis patients. Clinical practice shows that the most difficult treatment is with a mentally ill person who is also addicted to a psychoactive substance. Experience shows that those patients have problems with trust and cooperation and they put the therapist's patience on a trial, break therapy or are removed from it, because of breaking the rules. Applying the attachment theory to understand the patients' problems and the therapeutic relation can help in solving the problems appearing within the treatment.

In context of the attachment theory a very interesting dual diagnosis patient case study is presented below. A patient with schizophrenia and an addiction from a psychoactive substance. The same as in Bowlby's and Ainsworth's model, it can be observed how the patient's attachment style has been created in childhood and how the efforts to change it look in adulthood. The patient's history had an influence on the therapeutic relation and treatment.

CASE STUDY

A 32 year old patient came to the Daily Psychiatry Rehabilitation Ward with dual diagnosis of paranoiac schizophrenia and alcohol addiction. The patient had problems with accommodation to the ward conditions. He simply sworn to participate in therapeutic classes and group psychotherapy for dual diagnosis patients. It was difficult for him to follow the rules, in reality he kept breaking them and was checking how far he can move. In spite of an individual therapeutic program and nondirective conduct, the patient was still breaking prior arrangements and acted on his disadvantage. In retrospect, it turned out that the difficulty was based in going into secure and trusting therapeutic relations, whose functioning was the same as in the subject's home. His family environment from the very beginning of his life did not encourage the creation of secure attachment style. The patient was a son from his mother's second marriage. He had been brought up with four siblings, born from different relationships of their mother. First years of the patient's life lacked stability and a distinctive attachment object. His parents divorced when he was a small child and his grandmother took over partial custody. In his house, his mother's boyfriends used to turn up and he treated them as fathers, which in turn made him undertake unrealistic and unsuccessful attempts to become close with them. There were often arguments with the step-fathers. In his early years he did not exactly know who his biological father was. It has always been an important subject for him who his father is and if he could love him. He only met him when he was a teenager. However, the father was neither interested in him nor have they managed to get closer together. The feeling of rejection and alienation within his own family, was intensified by frequent illnesses since his first months of life, which was connected with staying in hospitals. When he was three years old he was in a hospital because of pneumonia. While being there, he did not talk to anyone, so he was considered to be deaf-mute. Since that time he has been often suffering from respiratory system infections and stays in hospitals and sanatoriums. He spent a lot of time away from home and family. He could not remember people who would make him feel cared for, needed and loved. From that time he remembered he was punished for crying with injections. At the end of primary school he had surgery. His mother did not want to take him back from the hospital so without any reason he spent one-and-a-half month in the hospital in the atmosphere of fear, threat, and incomprehension of the situation. He returned home after the doctor threatened his mother to send him to an orphanage. He recalls the time of his childhood as uneasy,

sad and full of criticism from his mother. He felt worthless, not loved and rejected. The patient's mother was absorbed by her job; foretelling, clairvoyance which had become a career, out of a hobby. He did not know anyone who loved him and whom he would be attached to. At home he was treated as redundant and disturbing. He started to treat himself the same way. School did not help in this lonely and sad childhood. He finished his school education at the primary school level. Throughout the first years of education he played truant, came into conflict with teachers and colleagues. He was scared till he became stronger and nobody attacked him anymore. When he was twelve he run away from home and was caught by border guards. When he was seventeen he started to work. At this time he started to drink alcohol as a way of getting along with colleagues. It gave him a kind of closeness and relation with others. It was the first time he did not feel lonely. But he was still unable to build permanent relationships. The patient did not believe in others. Anxious-preoccupied attachment style was not enough for satisfactory functioning within the family and with friends. An ineffective attempt to overcome the anxious-preoccupied attachment was an effort to find his biological father and build a father-son relation with his mother's friends. Another such effort was his marriage from which he has a daughter. After around 3 years he got divorced. The patient does not keep in touch with his ex-wife and child. He feels he is not prepared for such meetings. There is a question what is he not ready for? To give love, care and interest to people who are dependent on him? Or, also is he not ready to take love, interest and any other emotions from parenthood? This experience showed that he is not just doomed to be rejected, not loved or unwanted. For the first time in his life he was loved. After the separation with his wife, he came back to his mother. He also had been living at different women's apartments and finally, because of alcohol his mother threw him out and he stayed in a homeless hostel. Now he is living with his mother, brother and brothers` family again. They will all have to leave this flat because of eviction. The whole family is now in a very difficult social situation. The patient was also in conflict with the law, which ended in court as criminal cases.

Around his 30's he begun alcohol abuse treatment. His first alcohol addiction therapy attempts were undertaken after long years of drinking. When he was 13 years old, he got drunk for the first time and since he was seventeen he started to get drunk with colleagues regularly. From time to time he took marijuana, methamphetamine and drunk not portable alcohol. The alcohol problem concerns his whole family – his father and brothers whereas his sister is a co-addicted wife of an alcoholic.

From the beginning of his drying out until now he broke his abstinence many times. He had to drink alcohol to feel good and comfortable. Thanks to this he was able to tell jokes, feel bonds with people and stopped feeling fear and uncertainty. If he did not drink, he was angry with people and could not understand them. Already, for a long time alcohol does not give him the sensations described above. Now he is drinking because he wants to brighten his mind, to relax muscle tension as a side effect of pharmacotherapy and to feel emotions more intensively. The patient is drinking because sober life is to difficult as he feels worthless. Alcohol stimulates emergence of psychosis which gives his life a new value and sense. The atmosphere before drinking is also important; he drinks with his whole family sitting together and talking. It is not important what happens next. They start drinking in the atmosphere of closure and unison which disappears when they become drunk.

It is difficult to determine the beginning of his mental condition. Probably everything started many years before his first hospitalization, even around adolescence. The diagnosis claimed the illness to be paranoid schizophrenia. In its sharp phase, there appeared delusions of reference, remote control, poison, genealogical, religious mission, content suggesting visual, cenesthetic hallucination and auditory pseudo-hallucination. Formal thinking disorders and suicidal thoughts were asserted. The patients statements were dominated by unproductive, ambiguous considerations with single neologisms. The patient was certain he could communicate with others by thoughts. He was convinced, that some creature or other creation has become a part of his body and is intoxicating his nervous system. During his first hospitalization there came longing for times before he was born. The patient al-

ways had doubts about his biological father. He created different hypothesis suspected not to be his mother's son, that perhaps his grandfather conceived him or he come to the family from an orphanage. It was connected with strong tension, sense of distinctiveness and alienation but also a feeling of being someone unusual. In some way it compensated for and explained the suffering which his life was full of. For some time in the patient's symptomatology religious experiences were dominating. Sentences resembling Bible's verse came to his mind, so he felt that has to pass the message on. He often read the Holy Scripture and considered issues like "who God is, are people created to His resemblance?" He also experienced a feeling that in his body, there is some unutterable force or he is Jesus Christ. For him these beliefs were a source of strong positive feelings which he did not get in the everyday life. None of real life activities could be compared with that. At this time he split from earlier, uncertain attachment objects; that means: his mother, unknown and idolized father, wife, child, and turned to God as a substitute attachment object. The patient had a personalized relation with God who loved and accepted him. Such an understanding of religion made sense of his life and could make him securely bound with an ideal object and one controlled by the psychosis. According to Kirkpatrick`s idea, such an attachment model has a compensating role for the earlier lack and appears in people without a formed secure attachment style, who are children of low-religious mothers.

The patient has declared acceptance of neuroleptic treatment from the beginning. However, he often felt uncomfortable because of the suppressed emotions. He then thought about taking smaller dozes or even stopping taking the pills. He regularly stopped pharmacological treatment in order to drink a beer. He drunk a little of alcohol to abate the drug effect and returned to a psychotic state thanks to which he felt his life as satisfactory, as someone important and had close and secure relation with God. He used to say that being with people and trusting is difficult for him because people usually tell different things from what they think. That was the way his mother behaved, as well as his brothers and sister in law and many other people. That is why he is very careful in relations, as they bring about tension and fear. The first addiction treatment was a turning point as he experienced he can trust people. During therapy he escaped from relation, did not come to the ward and did not pick up the phone when symptoms intensified. He often broke the agreement and left classes. After one year of therapy the patient started to ask for help when he had a crisis and had some problems. He believed that with hospital staff he can feel safe and it was a very important experience for him, second one after the positive religious experience. Basing on this belief he begun to build a relation with the therapist. His therapist became the second object, besides God, who the patient made a relation with. His expectations about the relation were unrealistic. The key was the relation supposed to be marked with so great closeness to communicate without words, as it was with God. The therapist, as the second attachment object, was the sign he is getting better and trying to integrate his self after the psychosis. This relation was controlled by the patient just in some part, which was the difference between the relation with God and the therapeutic one. Through making impossible demands and excessively self-concentrating and concentrating on his own needs and not taking into consideration the whole treatment context, the patient was confronted with the real and not controlled world. He would not be able to predict everything and subordinate it to his needs. In consequence there were problems to enforce contract with the patient, he often refused cooperation and following the therapist's recommendations, broke abstinence and discontinued pharmacotherapy. In spite of this difficulty the patient remained in treatment which was fit to needs and possibilities of dual diagnosis patient with anxious-preoccupied attachment style. The treatment atmosphere helped him to change his relation with people and in the compensation processes, benefiting rebuilding a secure relation with others.

There emerges a question as to the functioning of the so defined attachment object. It appears that the basic principle is a regulatory function which is created by accepting the patient's emotions, giving information, explaining and the therapist's behaviour cohesion in relation that is a clear, predictable object behaviour. Such an affective containing in an attachment relation depends on accepting, keeping, approving anxiety

and difficulty by the attachment object. Thanks to that, the patient is able to inspect his own situation, tolerate uncertainty and psychic tension through using own psychic apparatus that is the emotional and cognitive process [5].

Special type of relations are built by therapists and the mentally ill patients in crises. Undoubtedly this relation can be named an attachment relation. In building a relation, the therapist contains the patient's emotions. Consequences of such an experience are absorbing a significant person and creating an inner cognitive representation of the therapist. Such an image helps to alleviate the patient's own fear. Containing psychic states of a mentally ill person takes place by listening with empathy to what the patient wants to say. Giving an information about illness, its dynamic, its cause, treatment and side effects of pharmacotherapy can be soothing and relieving. It can also concern emotional processes and how they function, what happens to the patient and how others can take his behave. During interaction it is building mutual trust, feeling of stability of the relation which as a result reduce fear. Controlling fear takes time and is connected with listening, taking information, making and checking hypothesis about the patient's self. These things help to cope consciously with fear, for which the basis is attachment relation [9].

Difficulties in treatment and rehabilitation of patients with dual diagnosis come mainly from difficulties with making the decision who and when should treat which of the co-existing illnesses. It seems that the only successful way of conduct is simultaneous, integrated treatment of both disorders. Integrated means that through multitude influences, treatment of schizophrenia and addiction we try also to give the patient stability and unity of these different influences. Can it be achieved? Perhaps the key is not the therapeutic programme but a therapist who can be an expert in addiction, schizophrenia and social problems. Such a therapist can build a secure bond with the patient where there will be place for directive conduct, which will show his life situation and his possibilities and there also will be place for not threatening, close therapeutic relation bonds.

Through slowly and non-confrontational building of closeness and secure closeness, conditions for secure attachment will be created [10]. Such conditions are designed to execute security, affiliation and adopted attachment model. It seems that such a therapy effect can be reduction of stress and inner tension which indirectly protects the patient from losing abstinence and going back to non adaptive styles of coping. The model of a therapist who takes care of many aspects of a patient's life helps to build a therapeutic relationship but it is not perfect, because it can bring about a feeling of being too close, which may cause non-adaptive attachment patterns from the past, breaks in abstinence and psychotic relapses. Also, the therapist may feel overloaded with his/her role in the patient's life and an excess of different functions and often extremely different therapeutic requirements during the treatment, which in turn can cause burn out. This should also be acknowledged and taken into account.

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