

Approaches to Substance Abuse in Cuba: Ricardo A. González MD PhD DrSc

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For over 40 years, he has done one of the most difficult jobs in medicine; 4000 of his patients are among those many might write off as “lost causes.” Yet he radiates optimism, his stories and experience reflecting a belief in the human potential to change and grow and a vocation to help his patients do so.

Now an internationally recognized expert on addictions, in 1976 Dr González founded Cuba’s first patient service for substance abuse at the Eduardo B. Ordaz Psychiatric Hospital in Havana, a program he directed until last year. It is now the national reference center for another 17 such programs, two more in Havana and one in every other Cuban province. In addition, it serves as a model for treatment centers catering to international patients (undoubtedly the most well known among them Diego Maradona, the Argentine soccer star): two in Holguin Province and one in Santiago Province, with another being developed at Las Praderas International Health Center in Havana.

Dr González’s 25 books on psychiatry, medical ethics and addictions attest to a prolific career in research and practice.



Today, he continues to work “from retirement” as consulting professor and psychiatrist in the addiction service he founded, and also chairs Cuba’s National Medical Ethics Commission. In this interview, Dr González shares insights from his years of experience addressing substance abuse, as well as on repercussions and management of such conditions in Cuba.

MEDICC Review: How do you define substance abuse?

Ricardo González: It’s a complex concept covering any inappropriate use of psychoactive substances, whether prescription drugs, such as sedatives and stimulants; or substances—such as solvents—that are legal for other purposes; or illegal drugs, in Cuba’s case including marijuana and opiates. It also includes smoking and harmful use of alcohol. You’re probably familiar with the terms *hard* and *soft* drugs, based on their mechanisms of action and—to some extent—their effects. Hard drugs act on the prefrontal supraorbital region, effectively performing a temporary prefrontal lobotomy, with consequences for consciousness, personality and behavior. So-called soft drugs act on the reticular system and the frontal and dorsolateral regions, and have a moderate cognitive effect. Both also act on the gratification cycle and the limbic system.

To me, it’s more useful to think of *hard* and *soft* in terms of their consequences, not just mechanisms of action. Thus, I believe alcohol, marijuana and nonmedical use of prescription drugs should also be considered hard drugs, because they too affect personality and behavior: in Freudian terms, they weaken the ego and superego, giving the id free rein. Ironically, given its devastating impact on individual and population health, tobacco is considered a soft drug; I suppose you could say it’s a soft drug with hard consequences. And of course there is vast social and medical

harm from drinking by individuals who are not alcohol-dependent; motor vehicle crashes, fires and personal injury, intentional and unintentional, are just a few examples. WHO states that alcohol use by individuals who are not alcohol dependent results in higher social costs than alcoholism per se. Additionally, alcohol is the “model drug” and gateway to many others.

MEDICC Review: How big a problem is substance abuse in Cuba?

Ricardo González: Well, starting with substances that are thus far socially acceptable, about 5% of Cuba’s adult population aged ≥16 years fulfill WHO criteria for alcohol dependency. This is a relatively low proportion for the Americas, but a further 10% meet criteria for hazardous or medically harmful use. In an anonymous nationwide survey we did in 2008, 0.4% of adults reported having used illegal drugs at least once; of course under-reporting is inevitable for such a sensitive question, but it’s consistent with what we’ve observed in demand for non-alcohol addiction services. A discussion of tobacco would take another whole interview!

The picture is not static. With increased tourism over the past 20 years, Cuba has gradually attracted more attention from international drug traffickers; our customs officials have detected shipments via “mules,” most destined for the USA or Europe, but a few for Cuba. Cuba’s geographic position along sea and air

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transportation routes puts it at risk; the traffickers drop drug packages offshore to be picked up by small craft. It's hard to police our 4100 km of coastline—plus hundreds of small keys and islets—thus, when some packages make it to the black market and are sold at low prices, that increases access to drugs here. Nevertheless, enforcement against such activities has become more effective, so as imported options decrease, we have had to better control nonmedical use of prescription drugs. The good news is that we are seeing a noticeable and steady decline in new cases of drug dependency other than alcohol.

MEDICC Review: And what about alcohol?

Ricardo González: It's one of the two most frequently used of the legal substances: that is, alcohol and tobacco. That's where the bulk of our problems lie. Among the illegal ones, marijuana and cocaine are most frequent, although in much lower proportions, as I've indicated.

Culturally, Cuba shares with its Caribbean and South American neighbors a certain permissiveness regarding alcohol use, and both tobacco and rum continue to be important culturally and economically. Yet, despite our limitations of resources and the US blockade, we have made advances with strong policies supportive of population health and education. For example, all forms of conventional alcohol advertising, printed or electronic, are prohibited. This doesn't mean we are making all the progress we would like; when it comes to alcohol use, our epidemiologic profile is similar to that of the rest of the Americas.

MEDICC Review: The service at the Eduardo B. Ordaz Psychiatric Hospital in Havana is Cuba's national reference center for treatment of substance abuse. Tell us about the approach you use there.

Ricardo González: Our substance abuse program is a specialized comprehensive one, guided by the principles, criteria and protocols of Cuba's National Substance Abuse Program, applied to people addicted to alcohol or other drugs. We start by understanding that substance abuse is a complex system, with potential for reinforcement across types of substance use, as well as the gateway effect I mentioned previously. The implication is that we have to work on all fronts simultaneously; prevention of illegal drug use has to start with prevention of misuse of legal substances, whose impact tends to be underestimated globally.

We weigh the enormous social impact of people acting under the influence of substances that substantially modify personality and behavior—whether alcohol, a prescription drug or illegal drugs—the repercussions of which begin long before addiction. We also consider the bystander who suffers the stress of living with an addict, and for whom that stress becomes a risk factor for both psychological and physical maladies, up to and including suicide.

Because there are so many important influences on substance-related behavior beyond the sphere of the health system, multi-sectoral involvement is key. We promote community rejection of substance abuse. We try to raise awareness that even the most

“virtuous” person can be at risk of substance abuse in one form or another. We emphasize the importance of the home environment as a protective factor and active participant rehabilitation. And we think good relationships among the health team, patient, family and community are fundamental.

On another front, research is essential to debunk myths about substance abuse and find ways to address them. The treatment team must have the professional and personal maturity to recognize that our predecessors have made discoveries that can't be dismissed, rather they should be assessed scientifically and updated to respond to patient needs. So, we shy away from sectarian and dogmatic positions and don't rule out approaches that could be helpful to our patients' rehabilitation and their families just because they don't fit our own theories or school of thought.

Besides treatment, teaching and research, the program publishes scientific works and material for patients and the general public, aimed at education, persuasion and inspiration.

MEDICC Review: What are the aims of rehabilitation?

Ricardo González: The main objective is to attain lifelong abstinence from all drugs with significant effects on consciousness, personality and behavior. We seek to help the patient make a substantial lifestyle change in all aspects that incur risk (for example, to avoid places and activities that are cues to drug use), and to identify and resolve personal issues, both those caused by substance use as well as pre-existing ones.

MEDICC Review: How do you work towards these aims?

Ricardo González: Our approach is both integrated and eclectic. We use group and individual psychotherapy, therapeutic community principles, mutual support groups, medications if necessary...basically whatever is useful for the individual in need. We use Prochaska's transtheoretical model of the stages of change to help identify what might work best at different stages: precontemplation, contemplation, preparation, action and maintenance, or relapse prevention.

We don't snub any tool that could help a patient. For instance, we acknowledge the valuable contributions of Alcoholics Anonymous (AA) and Narcotics Anonymous (NA)—we would be foolish to ignore the accumulated experience of millions of people around the world. We freely borrow from the 12-step approach, incorporating some of its elements into our own. For example, we distilled the 12 steps into 4: recognition by the addict that they can't beat the drug on their own; changing lifestyle to avoid situations that would cue relapse; working to build character and personal resources; and reparation to those they have harmed. And we appreciate the value of the cohesion and social influence provided by therapy groups, and the role that mutual support groups play to help recovering people integrate into new social circles away from those where they became involved in substance abuse.

AA emphasizes spiritual growth as part of the abstinence process, independent of particular theistic belief structures. We see spirituality as the constellation of virtues that enable people to view another's needs as their own, and that promote their human sensitivity and solidarity. Every morning our patients recite a 24-hour pledge modeled on AA's and adapted to our sociocultural context,

AA PLEDGE ADAPTED TO CUBA

Just for Today...

I swear by the lives of those I love most dearly, that during the next 24 hours, I will abstain from the toxic substances that enslave me, and I will avoid situations and conversations that might tempt me to use. I will hold in my mind the thought that the artificial pleasure they give me creates great suffering for those who love me and keeps me from reaching my life goals. My parents' suffering is enormous; when they brought me into the world they had other aspirations for me than drug addiction. I too have other dreams, and suffer from my addiction. For the sake of my loved ones as well as for my own, I must recover from my addiction.

to enhance moral commitment and cognitive reinforcement of the person's ability to confront their addiction. In addition, we have found that daily reflection on José Martí's writings provides an important source of inspiration. [Martí: 19th Century Cuban poet, journalist, leader of the country's independence struggle against Spain.—Eds.]

In ambulatory and hospital treatment, group sessions without professional participation have been useful to motivate people to join a mutual support group after the professional followup period.

We also apply therapeutic community principles to create an environment in which, along with active participation of patients and families, available human and material resources are mobilized to create a sensitive, engaged and supportive micro environment.

Because alcohol is a gateway drug, on principle we treat both alcoholics and persons addicted to other drugs in the same program. Treating the different types of addiction together has two purposes: it helps alcoholics see themselves and the dangers lying ahead, and it helps develop a sense of solidarity. There is also a practical issue: we just don't have enough drug addicts to run a separate program for them; for the vast majority of our patients, alcohol is the problem. Similarly, unlike many programs internationally, we don't have enough female patients to set up gender-specific groups, although clearly that would be desirable in some cases. For example, a history of sexual or physical abuse may make a woman afraid to participate in a group with men. Thus far, there is one addiction rehab program for women at the Enrique Cabrera General Teaching Hospital in Havana.

MEDICC Review: How could someone join your program?

Ricardo González: Except in emergency cases, patients needing rehabilitation from substance abuse will be seen first by their family doctor who does the initial assessment and refers them to a community mental health center or polyclinic. There a team with expertise in psychiatry, psychology, social work, nursing and occupational therapy does a comprehensive assessment. Ideally, the patient would be treated in ambulatory care in their community, with backup as needed from crisis intervention units, day hospitals or hospital psychiatric services. Complicated cases needing hospitalization would be referred to centers such as ours, for adolescents or adults. In the relapse prevention stage, there

are several options for ongoing support; AA and NA, and mutual support groups run by the Ministry of Public Health. Clinics that cater to international travelers also have significant experience in this area; they are not part of the Cuban health system as such, but follow the same working principles.

From the start, we established that Cubans who came to our program for help battling addiction would not be subject to police or judicial action; this continues to be the case. Patients may enter at their own request or that of their families, with patient consent. Exceptionally, on rare occasions, we concede to compulsory admission in cases of multiple addictions, when the family considers the situation highly dangerous and, on failing to gain patient consent, seeks a court order. We have also admitted opiate-addicted international travelers who go into withdrawal when they can't get their drugs in Cuba.

MEDICC Review: What happens when someone is hospitalized in the program?

Ricardo González: First, we have them read a description of the program and its conditions and then sign a therapeutic contract. In the contract they state their intention to become and remain drug free and to observe the norms of the therapeutic community, to remain in the center for the four-week detox phase, to attend all program activities, etc. (also acknowledging that if they change their minds, they can sign themselves out). We ask them to write an autobiography with a self assessment, to gather insights into their history and self perceptions. Unless they require intensive medical support because of withdrawal symptoms, they will immediately be incorporated into the life of the therapeutic community.

MEDICC Review: What therapeutic methods do you use most often?

Ricardo González: Our most common psychotherapeutic approaches are cognitive behavioral, didactic, rational emotive, humanistic and systemic. We also use dynamic psychotherapy when there appear to be unconscious motivations at work; we've used narrative psychotherapy to good effect in such cases, chiefly in the daily group sessions, where patients take turns reading consciousness-raising cards aloud (cards where they have written reflections on specific issues, questions, or aphorisms related to addiction).

Individual psychotherapy is an element in the program, but not the most important one. We would never use it as the only therapeutic modality.

Regardless of the psychotherapeutic tool used, and whether it involves individuals or groups, we try to create an atmosphere that is understanding and inspiring, and totally nonjudgmental. That's why we select the health team members for their sensitivity, compassion, altruism and demonstrated potential to engage fully with patients in their family and community environments. The aim is to make our facilities true oases of respect, love, humane sensibility and engagement.

We try to eliminate the slang and attire of the using subculture, not only because they affect the addict's image in his or her family and community, but because they can trigger the urge to resume use. In talking with patients and families we use figurative language,

based on similes, metaphors, aphorisms and sayings, to facilitate communication. In the past five years, at the suggestion of a Chilean professional team that visited our service, we have incorporated humor into our morning meetings with excellent results: we simply ask one of the patients or staff to tell a joke. They're usually well told, and always well received. So humor becomes a social lubricant...much more effective than alcohol or other psychoactive substances.

At the end of the group sessions we have what we call a solidarity chain, in which everyone joins their raised hands and choruses: *Together we can beat drugs*. It's a variant of cohesion techniques used in other Caribbean countries.

MEDICC Review: What about medications and other tools?

Ricardo González: We use some biological therapies, in the acute phase if needed, or when progress is particularly slow or there are other problems such as depression.

We have used acupuncture for withdrawal symptoms, but not systematically. We could make more use of it, and also make greater use of relaxation techniques and meditation, which now are used at a fairly basic level, mainly in the first phase of the Schultz autogenic training (a relaxation technique developed by a German psychiatrist). Once the person is in a relaxed state, we ask them to visualize the future. For example, we ask them to imagine going home at night and seeing a joyful welcome and serenity instead of a family fearful of what they've been up to or how they're going to behave. Visualizing their drug-free future reinforces their expectation of being able to win the battle and motivates them to stay in the rehab program.

Oral vitamin therapy is important for almost everyone, since all these drugs are highly nutrient depleting. Vitamins are given orally, unless polyneuritis is present, in which case we use injectable vitamins.

As for medications, we use chlormethiazol only in cases of severe withdrawal, especially when there is confusion and delirium; because of its addictive potential, we never use it for more than seven days. We use carbamazepine or clonazepam only if the patient has a history of convulsions in withdrawal; this is particularly common in meprobamate addicts, more than 95% of whom convulse in the withdrawal stage. If progress is sluggish we use acamprosate or naltrexone daily. And if withdrawal is accompanied by anxiety, we use chlordiazepoxide, clorazepate, diazepam or levomepromacin, as long as there is no severe psycho-organic dysfunction or serious liver problem.

The antidepressants used most often are amitriptyline, which is very well tolerated during withdrawal, and sertraline, also very effective.

In patients under 50 we use disulfiram, after assessing their cardiovascular, renal and hepatic function, and with patient consent; we won't give it with just family consent. Its function is persuasive, not aversive (as was the case 30 years ago when it was standard for behavioral conditioning, to create alcohol rejection). We've used calcium carbamide when health limitations or schizophrenia are present, because it selectively affects hydroxylase acetaldehyde without blocking the dopamine breakdown enzyme. We've

had excellent results with calcium carbamide and metronidazole in some cases, despite their shorter half-life.

In opiate withdrawal with total suppression, we use clonidine, a presynaptic alpha-2 receptor agonist, together with high doses of chlorazepate or chlordiazepoxide. Since these reactions are limited to a few international travelers who can't get their drugs in Cuba, we don't have a methadone program.

MEDICC Review: Is the program unique in Cuba?

Ricardo González: As a national reference center we offer training and consultation, and we publish from our experience and research; we provide a model for other programs, but the model is not imposed. Different programs may emphasize different tools in the therapeutic arsenal. For example, not everyone employs reflections on the writings of José Martí.

MEDICC Review: What do you see as the program's most important strengths and achievements over time?

Our basic frame of reference is as health providers committed to helping patients and their families, based on three principles: humanism, ethics and service. By humanism I mean respect for the patient by the entire health team and constant concern for their wellbeing and personal development. Our ethical framework includes the precepts of patient autonomy, beneficence, non-maleficence and fairness, as well as absolute confidentiality and practicing the golden rule of treating people the way we ourselves would like to be treated. A strong vocation to serve leads us to take on patients' and families' needs as our own—to me, a form of spirituality.

These principles are critically important to address relapses without feeling hostile, or to keep from dismissing as "lost causes" patients whose recovery is slow. There's a saying, "Love me when I least deserve it." To be able to do that in practice requires internalizing our principles. And the vocation I speak of is not just medical; it needs to be there in every single member of the health



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Interview

team, regardless of their role, from the housekeeping staff to the hospital director. That commitment is felt by the patients, and they respond in kind. We treat them as people, not criminals or perverts. Respect engenders respect.

As for achievements, I think the fact that we have not had a single patient suicide in over 35 years in our 50-bed service speaks volumes.

MEDICC Review: What lessons have you learned that you would share with other centers having similar aims?

Ricardo González: One of the most important is the critical role of the health team's attitude; it needs to be nonjudgmental, respectful, kind, helpful, and optimistic about the chances of recovery even in the toughest cases. That's why, when recruiting members of the health team, we focus on the personal qualities I mentioned, which helps us develop and maintain the vitally important and deep connections with patients and family members.

We emphasize psychotherapy and group techniques, without ruling out biological therapies if needed. We avoid dogmatism and rigid adherence to a particular theoretical framework or school of thought and use whatever psychotherapeutic resources best meet the patients' and their families' needs. Then there's the importance of matching the approach to the patient's stage in the recovery process; for example, linking him or her with a self-help group once abstinence is established to prevent relapse.

MEDICC Review: And the program's biggest challenges?

Ricardo González: In clinical terms, a dual diagnosis of addiction and schizophrenia is one of the hardest to manage; marijuana use is particularly problematic and can trigger decompensation.

I support decriminalizing the addict, but not legalizing the trade At a broader societal level, the tendency to increased tolerance of drugs worldwide. Well-meaning advocates of harm reduction have argued that legalization would bring prices down and prevent people from having to turn to prostitution or crime to pay for their habits. What they don't factor into the equation is the issue of price sensitivity. One of the most effective policy interventions in reducing tobacco use has been increased prices through taxation. An historical example, a sort of natural

experiment in the other direction, happened in 18th century England: the devastating "Gin Epidemic" that occurred when a glut of cereal production brought the price of gin down to 10% of its original price.

I support decriminalizing the addict, but not legalizing the trade. To get me in that camp, you would have to convince me that there wouldn't be an upsurge of use with lower prices.

MEDICC Review: What should society and the health system be doing to more effectively address issues of substance abuse and addiction?

Ricardo González: Well, besides the multisectoral efforts I noted earlier, we need intergovernmental action, because the phenomenon is international.

The public has to be made aware of the issue in all its dimensions: medical, social, economic, ethical and humanitarian.

It's crucially important to raise public awareness of the relationship between drugs that affect behavior (including alcohol and psychotropic medications) and re-emerging diseases such as tuberculosis, as well as sexually transmitted infections. For example, under the influence of drugs, people may choose their partners unwisely and are unlikely to use condoms.

MEDICC Review: Do you have advice for patients (and their loved ones) about preventing addiction to psychoactive substances? Or about avoiding relapse?

Ricardo González: Well, the most important factor for prevention is easier said than done: a stable and loving home throughout childhood, right up through adolescence. When people lose their parents prematurely through death or divorce—sadly, the child sometimes gets "divorced" too—they are at higher risk for self-medicating their pain through drugs.

Decreasing adult role modeling of tobacco, alcohol and other drug use will also benefit the next generation.

As for avoiding relapses, it's important to identify situations that create temptation, and stay away from them. Another strong recommendation would be to take advantage of mutual support groups, powerful communities for remaining abstinent. 