

**TREATMENT FOR SUBSTANCE
ABUSE IN RESIDENTIAL CENTRES
IN THE 21st CENTURY**

BY

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DECLARATION

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Dear Sir

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TREATMENT FOR SUBSTANCE ABUSE IN RESIDENTIAL CENTRES IN THE 21st CENTURY

Is the result of my own investigation and research and that it has not been submitted in part or in full for any other degree or to any other University.

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ABSTRACT

The aim of this exploratory study was to examine and compare three traditional models of substance abuse treatment interventions at various rehabilitation treatment centres in South Africa. Three treatment centers were chosen each representing a particular treatment model, namely the Disease/Minnesota Model at Careline Crisis Centre (Hillcrest, Durban), the Therapeutic Community Model at Horizon Halfway House (Cape Town) and the Narconon Model at Narconon Rehab (Johannesburg).

Data was obtained by means of two research instruments, namely structured interview schedules and focus group. The study was qualitative entailing critical analysis of data yielded by the research instruments. In the structured interview, the researcher asked the staff members at each centre questions and recorded their answers while the focus group methodology was used with the clients or patients (referred to as “students” in the Narconon Model) at each of the centres. The groups were comprised of three or four members. The study was conducted in two phases where phase one comprised 13 themes and phase two comprised three themes.

Based on the structured interviews with the staff members at the three treatment centres and the data yielded from the focus groups of the clients, strengths, weaknesses, differing conceptualizations of chemical addiction and the foci of intervention to treat the addictions of clients were evaluated with the purpose of integrating the best from each of these models of treatment to propose the development of what the researcher has chosen to call The Empowerment Model. Drawing from the conception of human consciousness in the philosophical tradition of existentialism where human consciousness is viewed as Nothingness, a void that is filled or engaged with Being-in-the-World, Being-with-Others and being-with-Oneself. Failure in the engagement of consciousness leads to a frustrating painful void. Given the existence of addictive chemicals, the human in the course of the history of humankind developed the ingestion of such chemicals to seek to fill the void with pleasurable sense experiences. The Empowerment Model aims to create an awareness of this human weakness and advocates filling or engaging this void with purpose in life comprising most notably Spirituality, Sociability, Vocation and Recreation to grow and evolve to a point of going beyond being human.

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CHAPTER 1

1.1 INTRODUCTION

This research is an examination of whether the current residential treatment model at various substance abuse treatment centres is successful or not and to find out what can be changed to achieve success in the treatment of substance abuse.

The web of illusion and disillusionment that weaves the substance abuser's body, mind and spirit together catches almost everyone in its sphere and makes it one of the most challenging and complicated issues facing today's clinician. Just as a web may be at once inviting, invisible and deadly for the unsuspecting, a lack of knowledge regarding addiction can be time consuming, frustrating and ultimately destructive in the therapeutic setting. Due to the interwoven symptoms throughout the body, mind and spirit of the substance abuser, treatment must also be multidimensional and interconnected. There is currently much debate over whether chemical dependency is genetic or environmental, nature or nurture. Addiction creates its own constellation of symptoms, and treatment initially must focus on the psychological aspect of addiction ([www.psychceu.com/Reweaving the web](http://www.psychceu.com/Reweaving%20the%20web)).

The analysis of individual emotional sensitivity and psychological convictions reveal a deeply personal viewpoint that provides insight into the "world beyond" the symptoms of addiction. This method of inquiry probes into the root cause of addictions and allows clinicians to customize treatment to specific patients.

Social science research, which is a study of innate individual biases that shape individual perspectives, applies observational methods to examine and understand human social affairs (Babbie 1999). It provides points of view and technical procedures that uncover experiences that otherwise escape human perception.

To reduce the influence of bias, a researcher must understand two individual realities: agreement reality and experiential reality. Agreement reality applies socially accepted beliefs and values to day-to-day interactions. Experiential reality is learned behavior that results from firsthand experience (Babbie 1999). In other words, the latter is a product of our own experience whereas the former is a product of what people have told you. The problem is that both seem very real. Science may offer a solution: "Science is as a method of inquiry – a way of learning and knowing things about the world around us. Science offers an approach to both realities, agreement as well as experiential.

Scientists have certain criteria that must be met before they will accept the reality of something they haven't personally experienced. In general, an assertion must have both, logical and empirical support: it must make sense and it must align with both observations in the world" (Babbie 1999: 6). In other words, science offers a method to examine and rationalize individual experiences. Whereas epistemology is the science of knowing, methodology might be called the science of finding out.

Only part of what people "know" comes through direct experience. Another much larger part comes from the agreed upon knowledge that others give us. Although the researcher has personal experience of substance abuse, only part of the knowledge of what he knows will assist, but a much larger part will come from agreed upon knowledge in the form of research material.

The study is introductory for social research both at a local and international level since there is documented literature available on current treatment models rather than a on future model that incorporates aspects of alternative therapies into best practice.

1.2 RATIONALE

I am presently employed as Director of a non-profit drug and alcohol rehabilitation centre situated in Westville, Durban, South Africa known as Minds Alive. As an ex-substance dependent individual involved in assisting families and other dependent individuals in counselling and facilitating support groups, drug awareness programs

throughout the country for the past nine years and the founder and director of Minds Alive for the past three and half years, I have found it becoming increasingly more difficult to assist an individual into maintaining long term recovery. The majority of those addicted to various types of drugs be it legal or illegal, prescription or over-the-counter drugs relapse is inevitable. Irrespective of which treatment centre the individual had been to, none guarantees a successful recovery.

It has become frustrating to the individuals, their families and also to the staff employed in these treatment centres. The reason for this trend is not absolutely clear. The question that arises is whether the treatment program used in the residential centre is effective or not. Many treatment centres are fixed in their own programs and depend on aftercare to improve the recovery rates. In my experience over the years, interacting at grassroots level with families, addicted individuals and many treatment centres and being a patient of one of the treatment centres nine years ago, there is a need to explore the gaps in residential treatment centres.

The focus of this study will be on the different models/programs used in different residential treatment centres in South Africa and to explore the gaps, if any, in each treatment model and to recommend suggestions.

1.3 MOTIVATION

From a very early age, we were repeatedly being told about the “facts” of life and how the world works. These “facts” became undisputed “truths” and we accepted them because everybody knows them. We did not question this because it spares us the task of having to research from scratch. Knowledge is cumulative and we are constantly looking for information and understanding it. This becomes a platform and leads to the thirst for more knowledge (Babbie 1999).

Likewise, the need to explore the treatment model for substance abusers in residential treatment centres is the motivation for this research, as there is debate and arguments on treatment for addiction in South Africa and throughout the world.

Whilst there has been a significant amount of research done on the disease concept of treatment, the socio-emotional aspects for recovery in persons addicted to substances in the form of empowering the individual to make an informed choice about drugs, has not been researched extensively. We need to explore if addiction can be treated not as a disease, but instead as a choice.

Everyone claims addiction is a major problem in this country and throughout the world. Addiction, either directly or indirectly, costs billions of rands in every area of life: poor health, lost productivity, crime, accidents, etc (National Drug Master Plan 2004). Current treatment is helpful but limited. It appears to work well in the short term but is ineffective in maintaining recovery over time (Otto 2001).

For example, residential treatment centres provide a multidisciplinary approach to facilitate recovery from addiction. They offer a structured therapeutic environment that begins with the withdrawal or detoxification process and extends through aftercare planning following residential treatment. The treatment often includes both individual and group counselling, structured physical activities, nutritional counselling, stress reduction, holistic approaches such as yoga, saunas, acupuncture and neuro-feedback, vocational training, relapse prevention support, social skills training, educational services and 12-step substance abuse programs.

These programs generally offer supervised detoxification that may involve medication in a hospital setting or social detoxification (i.e. no medication) in a non-hospital setting. Residential treatment settings have the advantages of 24-hour supervision and reduced likelihood of clients using alcohol or drugs while in treatment. The patients experience highly structured days, and a total immersion in treatment with removal from the everyday stressors and pressures (http://alcohol-drug-treatment.net/residential_treatment.html).

The Disease Concept of addiction is a controversial and debated topic in the field of substance abuse and addiction. One would have to be well informed on the subject to even attempt to understand the controversy intelligently.

This research will not claim to know for sure whether drug abuse is or is not a disease but will present a little of both sides of the ongoing debate within professional circles. First, we must accurately define disease, since when the word disease is mentioned most think of something like cancer, AIDS or diabetes. These diseases can be isolated in part and extracted from the body and visibly viewed and observed by the eye under a microscope or other apparatus (http://alcohol-drug-treatment.net/disease_concept.html.)

This is not the case with the Disease Concept of alcoholism and addiction. According to Webster's Dictionary disease is defined as follows: "Disease: Any departure from health presenting marked symptoms; malady; illness; disorder." The word concept is also defined by Webster's Dictionary as: "Concept: A notion, thought, or idea." This popular model of addiction is accredited to Jellinek 1960 that presented a comprehensive disease model of alcoholism.

The World Health Organization acknowledged alcoholism as a serious medical problem in 1951, and the American Medical Association declared alcoholism as a treatable illness in 1956. Following Jellinek's work, the American Psychiatric Association began to use the term disease to describe alcoholism in 1965, and the American Medical Association followed in 1966 (Royce 1989). As with many concepts and theoretical models in the addiction field, the disease concept was originally applied to alcoholism and had been generalized to addiction to other drugs as well. The "disease of addiction" is viewed as a primary disease. That is, it exists in and of itself and is not secondary to some other condition. This is in contrast to the psychological model of Dual Diagnosis where addictive behavior is seen as secondary to some psychological condition (http://alcohol-drug-treatment.net/dual_diagnosis.html).

Arguments Against the Validity of the Disease Concept:

As earlier stated, the disease concept is controversial and not without critics. Two well-known critics are Stanton Peele and Herbert Fingarette, both of whom have written books, as well as articles disputing the disease concept of addiction for the following reasons.

Since the Disease Concept was attributed to Jellinek, much criticism had been directed at his research, which was the basis for his conclusions about the disease concept. Jellinek's data were gathered from questionnaires that were distributed to Alcoholics Anonymous (AA) members through its newsletter, "The Grapevine". Of 158 questionnaires returned, 60 were discarded because members had pooled and averaged their responses, and no questionnaires from women were used. Jellinek himself acknowledged that his data was limited. Therefore, one might wonder why Jellinek's concept of the disease of alcoholism received such widespread acceptance (http://alcohol-drug-treatment.net/disease_concept.html).

One criticism is that the disease concept is consistent with the philosophy of AA, which is by far the largest organized group dedicated to help alcoholics. Secondly, as Peele (1989) noted: "The disease model has been so profitable and politically successful that it has spread to include problems of eating, child abuse, gambling, shopping, premenstrual tension, compulsive love affairs, and almost every other form of self-destructive behavior... From this perspective, nearly every American can be said to have a disease of addiction".

Fingarette (1988) goes on to state that the alcohol industry itself contributes to forming a public perception of alcoholism as a disease, as a marketing ploy:

"By acknowledging that a small minority of the drinking population is susceptible to the disease of alcoholism, the industry can implicitly assure consumers that the vast majority of people who drink are not at risk".

There are many other criticisms of the Disease Concept, however the researcher will not go into them at this time. Instead the researcher will review some of the evidence to support the Disease Concept.

Arguments Endorsing the Disease Concept:

Since the introduction of the Disease Concept research studies have examined a possible genetic link in alcoholism/addiction.

There was a popular theory of alcohol addiction expressed by Ohlms (1983) in his book "The Disease Concept of Alcoholism" that proposed that alcoholics produced a highly addictive substance called THIQ during the metabolism of alcohol.

THIQ is normally produced when the body metabolizes heroin and is supposedly not metabolized by non-alcoholics when they drink. According to Ohlms (1983), animal studies have shown that a small amount of THIQ injected into the brains of rats will produce alcoholic rats and that THIQ remains in the brain long after an animal has been injected. Therefore, the theory is that alcoholics are genetically predisposed to produce THIQ in response to alcohol, that the THIQ creates a craving for alcohol, and that the THIQ remains in the brain of the alcoholic for a long period after the use of alcohol is discontinued. This would provide a physiological explanation for recovering alcoholics, who relapse quickly and return to their previous use patterns. More recent research on genetic causes of alcoholism has focused on some abnormality in a dopamine receptor gene and deficiencies in the neurotransmitter serotonin or in serotonin receptors (Coleman 1990).

As noted from the above information, there is room for debate and controversial arguments. Almost every treatment centre has their treatment model based on the disease concept and if relapse is inevitable, then what hope is there once an individual is labeled as an alcoholic or an addict? The main purpose of this research is to explore another route or road to reach the final destination of ultimate success.

1.4 TREATMENT OPTIONS - LITERATURE REVIEW

The ultimate goal of all drug abuse treatment is to enable the dependent to achieve lasting abstinence. Among the different types of treatment programs are:
(<http://www.helpuide.org/mental>)

- Outpatient drug-free treatment programs, which do not include medications and encompass a wide variety of programs for substance dependent individuals who visit a clinic at regular intervals. Most of the programs involve individual or group counselling.

- Therapeutic communities (TCs), which are highly, structured programs in which patients stay at a residence, typically for 6 to 12 months. Patients in TCs include those with relatively long histories of drug dependence, involvement in serious criminal activities, and seriously impaired social functioning.
- Short-term residential programs, often referred to as chemical dependency units, involves a 3- to 6-week inpatient treatment phase followed by extended outpatient therapy or participation in the 12-step self-help groups, such as Narcotics Anonymous or Alcohol Anonymous.
- Long-term residential programs involve a stay for detoxification, short-term (a few days to a few weeks), or longer-term treatment (a few months to a year or more). These facilities provide a structured environment, often based on the 12-step approach, and include drug education and different types of therapy (group, individual, and sometimes family or couples therapy).
- Methadone maintenance programs for heroin addicts, which are usually more successful at retaining clients with opiate dependence than are therapeutic communities – which in turn are more successful than outpatient programs that provide only psychotherapy and counselling.

There are a number of self-help programs that help the individual deal with the addiction, as a form of aftercare to those who attended residential centres or to those who go for treatment in the form of outpatient (<http://www.helpuide.org/mental>).

These programs are as follows:

- I. Narcotics Anonymous (NA) is the largest self-help organization for drug abusers: is an offshoot of Alcoholics Anonymous with a group meeting format, group intervention and the 12-Step Program: (<http://na.org/basic.htm>)

- Group meetings facilitated by members,
- Meetings take place daily on a regular basis, at various times, and in many different locations around the world,
- Attendance is voluntary, and membership is free,
- Members are free to attend any of the many meetings held each week,
- Includes support from fellow members who either are struggling or have struggled with the same problem,
- Uses a buddy system ("sponsor") and group intervention to help members when they are tempted to relapse or do relapse,
- Uses the 12-Step Program as guiding principles, (developed by the earliest members of Alcoholics Anonymous; adopted and adapted to many other self-help programs)
- Abstinence-based personal recovery program from the substance or addictive behaviour,
- Person admits his or her powerlessness over the substance or behaviour,
- Turns his or her fate over to a higher power "as you understand it",
- Follows steps to examine the effects the behaviour has had on his or her life, to accept responsibility for damage caused to others, and to make amends.

There are also several non-12-Step programs available, for those who have other interests, special needs, or who object to the "higher power" or "powerlessness" basis of NA and AA:

II. Secular Organizations for Sobriety (SOS) a network of independent meetings with an alternative recovery method (<http://secularsobriety.org.htm>.)

- Promotes abstinence and provides support from others struggling with the same issues,
- Encourages self-empowerment approaches to recovery for those who are uncomfortable with the spiritual content of the AA/NA model,

- Takes the approach that staying clean is a separate issue from religion or spirituality,
- Credits the individual for achieving and maintaining his or her own sobriety, without reliance on any Higher Power.

III. SMART Recovery (Self-Management And Recovery Training) is a program that aims toward abstinence from drugs and alcohol through self-empowerment and self-directed change (<http://smartrecovery.org/>).

- Based on principles of Cognitive-Behavioral Therapy (CBT),
- Teaches specific tools and techniques within a 4-point program,
- Enhancing and maintaining motivation to abstain,
- Coping with urges,
- Problem solving (Managing thoughts, feelings and behaviors),
- Lifestyle Balance (Balancing momentary and enduring satisfactions),



IV. Women for Sobriety (WFS) Founded in 1976, this is the only national organization focusing specifically on the needs of alcoholic women, whose recovery in AA was found to be less successful than for men. Women with drug addiction are also participants in WFS (<http://wwwwomenforsobriety.org>).

Premises and structure are:

- The psychological needs are different for women than for men,
- Weekly meetings in small groups of 6-10 women, with a structured format for confidential discussion,
- Based on thirteen positive statements to encourage emotional and spiritual growth.

V. NARCONON: L. Ron Hubbard, founder of Scientology, developed Drug Rehabilitation Technology.

- Founded in 1966,
- Program conducted at centre in San Diego,

- Deter program relies on exercise, sweating in a sauna, and nutritional supplements,
- Program features courses of study to achieve personal stability,
- 78% success rate claimed.

1.5 STATEMENT OF THE PROBLEM

“Tradition and authority play an important role in the search for knowledge. It simply provides us with a starting point for our own inquiry, but sometimes may lead us to start at the wrong point. This then pushes us off in the wrong direction. Sometimes you cannot ignore the events that contradict your general conclusions about the way things are” (Babbie 1999).

Many people receive treatment for drug addiction each day. Eliminating drug use is necessary for successful recovery. However, even individuals who are determined to stay clean often suffer one or more slips before achieving long-term sobriety. While this is a setback, it does not mean that a person cannot recover from addiction. That person may have to restart treatment to enable him or her to again get on the road to long-term and secure sobriety. It is the reason for the 12-Step expression "One Day at a Time."

In the 90's, television advertisements were well structured using celebrities or professionals acknowledging a substance-abuse problem and assuring the viewer that their favorite rehabilitation program would guarantee a cure for alcoholism and/or drug dependency. If recovering alcoholics or drug addicts are questioned on how they stopped their use of alcohol or drugs; their answers vary although each of them is convincing and emotional. They will cite such diverse approaches such as hospitalization, diet, exercise, counselling, sauna's, religion, hypnosis, amino acids and self-help groups.

When it comes to successful treatment, only one thing is certain: practically any approach will, at times work for some of the people. Successful treatment, in other words is like a good suit of clothes which have do be tailor-made for each individual (http://alcohol-drug-treatment.net/treatment_approaches.html).

Most drug treatment professionals do not recommend one "best" treatment approach; they know there are too many variations among abusers. In general, the levels of treatment range from simple and behavioral to complex and medical. The person dependent upon drugs or alcohol may have used the chosen substance for so long that he or she has literally forgotten how to cope with life stresses; how to have a meaningful, drug-free life-style; or how to solve the social or psychological problems that prompted the substance abuse in the first place, in these instances a very comprehensive approach must be prescribed if one is to expect any degree of successful recovery.

Again, different treatment approaches are required. Regardless of treatment, some drug and alcohol dependent persons repeatedly relapse after treatment. Relapse should not necessarily be viewed as a failure of either the treatment program or the individual.

In general, the more varied treatment approaches an individual attempts, the closer he or she becomes to finding the one that will work for them. Once abstinence is achieved, the "clean" or sober individual can take several steps to enhance recovery and avoid relapse. Among the general recommendations are belonging to a group as a support system, having religious involvement, practicing good health habits; including proper diet, sleep, and exercise, as well as goal planning and self enhancement projects (http://alcohol_drug_treatment.net/treatment_approaches.html).

Deciding on a treatment approach is often a very confusing, difficult and an important endeavor to undertake. This study focuses on strengths and gaps in models and makes it easier to select best practices from treatment models.

1.6 AIMS AND OBJECTIVES

1.6.1 THE AIM OF THE STUDY IS:

To analyse the effectiveness of current traditional treatment models that are being used in Residential Drug and Alcohol Rehabilitation Centres in South Africa.

1.6.2 THE OBJECTIVES OF THIS STUDY ARE AS FOLLOWS:

- a) To critically analyze the traditional rehabilitation model that are popular in the treatment of substance abuse in South Africa.
- b) To identify strengths of current strategies used in the traditional approaches in Residential centres.
- c) To identify gaps/weaknesses of current strategies used in the traditional approaches in residential centres.
- d) To obtain recommendations for the use of alternative strategies/approaches that could complement the traditional model.

1.7 KEY QUESTIONS TO BE ANSWERED IN THE RESEARCH

- a) Are the traditional methods that are being used in treatment centres for substance abuse meeting the needs for recovery?
- b) What are the identified strengths/weakness of the traditional approaches/models?
- c) What alternative strategies or therapies are recommended to complement traditional methods?
- d) What mindset and paradigm will best serve service providers to accommodate alternate therapies?

1.8 VALUE OF THE STUDY

This study will ensure a holistic approach to understanding and treating substance abuse. Currently, the disease model dominates treatment in South Africa and the world over. Both the strengths and weakness of the disease model will be analysed, together with recommendations for changes. The study will yield valuable data towards meeting the challenges of treating substance abuse holistically.

1.9 THEORETICAL FRAMEWORK

A systems perspective will adequately provide a theoretical backdrop for appreciating the various treatment modalities that could serve the dependent. Dysfunction in any one-treatment program will also affect the treatment product as a whole. This will facilitate a multi-dimensional approach that suggests that these modalities offer more than the cumulative sum of their independent treatments.

1.10 RESEARCH APPROACH & METHODS

“Science is an enterprise dedicated to ‘finding out’. No matter what you want to find out, though, there will be a great many ways of doing it”(Babbie 1999:71).

1.10.1 RESEARCH DESIGN

This study involves a qualitative research design that will focus on traditional treatment models for substance abuse, their successes and failures and identifying the need for complementing alternative therapies that can assist an individual in recovery.

Qualitative methods allow for flexibility in the research process. “Thus, the responsiveness to the individuals’s conceptualization of themselves is also related to a willingness to formulate new hypothesis and alter old ones as the research progresses, in the light of emerging insights” (Massen 2000:6).

The specific research design will be exploratory in nature. “This purpose is typical when a new interest is being examined when the subject of study is relatively new and unstudied, or when a researcher seeks to test the feasibility of undertaking a more careful study” (Rubin and Babbie 1997: 108).

In this research, the purpose is to explore the current traditional models used in residential treatment centres for substance abuse that are unstudied and the feasibility of improving the models will be tested.

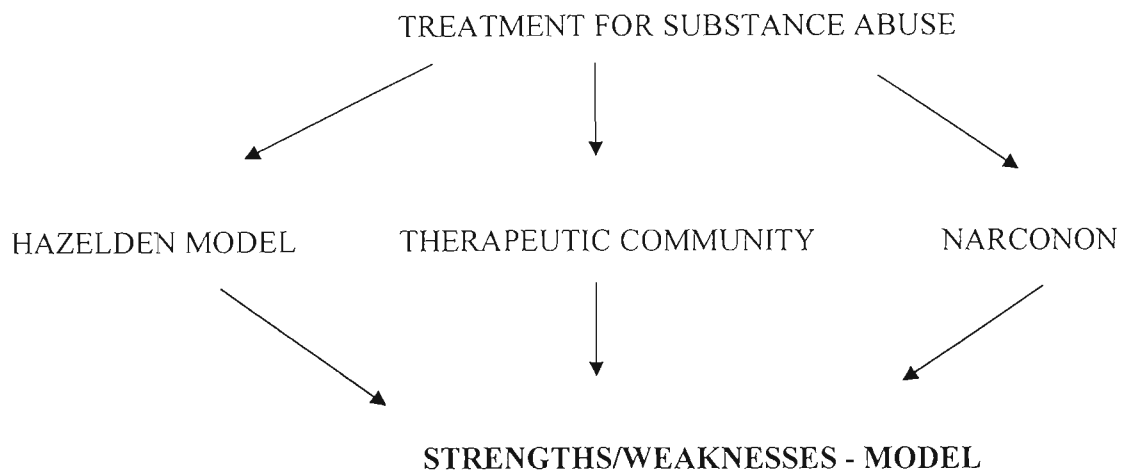
“Exploratory studies are quite valuable in social scientific research. They are essential whenever a researcher is breaking new ground, and they can almost always yield new insights into a topic for research” (Babbie 1999:73). Since the success rate of recovery using the traditional models is not significant, the researcher will be breaking new ground in identifying specific strengths and weaknesses of these models. The researcher will have two sources of data, one from the professional staff and the other from individuals undergoing treatment at the same residential treatment centre.

1.10.2 SAMPLING

The sample is derived from residential treatment programs because the recovery process starts here. Once the dependent has developed a strong foundation for recovery, abstinence from substances is easier. Sampling is the process of selecting observations. There are two types of sampling methods namely:

- a) Probability sampling – “The ultimate purpose is to select a set of elements from a population in such a way that descriptions of those elements accurately portray the parameters of the total population from which the elements are selected. Probability sampling enhances the likelihood of accomplishing this aim and also provides methods for estimating the degree of probable success” (Babbie 1999:181). Major forms are simple random samples, stratified random samples, and various types of cluster samples.
- b) Non-probability sampling – “Social research is of few, conducted in situations where you cannot select the kinds of probability sample used in large scale social surveys” (Babbie 1999:173). Major forms are accidental samples, quota samples and purposive samples.

In stratified random sampling, “the treatment model is divided into three strata. Again, the strata may be based on a single criterion or a combination of two or more criteria. A simple random sample is taken from each stratum, and the subsamples are then joined to form the total sample” (Selltitz, Wrightsman & Cooks 1981:432).



In this study, the researcher used stratified random sampling as a method for obtaining a greater degree of representativeness, thereby decreasing the probable sampling error. Rather than selecting the sample from the total population at large, the researcher would ensure that appropriate numbers of elements are drawn from homogenous subsets of that population (Babbie 1999). A proportionate number of respondents involved in treatment would be selected from the different centres thus representing all the treatment centres in South Africa implementing different models.

“In the case of purposive sampling, sometimes it is appropriate to select the sample on the basis of the researchers own knowledge of the treatment centres, its elements, and the nature of the aims” (Babbie 1999:174). The choice of the different treatment centres was selected with good judgment so as to get cooperation and to ensure confidentiality because of the mindset that their model used was the best. “The basic assumption is that with good judgment and an appropriate strategy one can handpick the cases to be included in the sample and thus develop samples that are satisfactory in relation to one’s needs” (Selltitz, Wrightsman & Cooks 1981:427).

The combining of probability and non-probability sampling involved the opposite strategy. In the case of using probability sampling a list of selected treatment centres using different models was used representing all the centres in South Africa and in the case of using nonprobability sampling, the sample was selected on the researcher’s own knowledge of the treatment centres. The researcher took a probability sample of elements within a nonprobability sample of areas.

The sample for the study was obtained from different rehabilitation centres throughout South Africa. The treatment centres were chosen on the basis of the different treatment models that were being used. There were two samples used namely:

The first sample for the study was obtained from the population of therapists/social workers and counsellors employed currently in residential treatment centres. Treatment centres from different parts of South Africa were selected. One treatment centre per traditional models was selected namely:

- A. Hazelden Model – Careline Crises Centre (Hillcrest – Durban)
- B. Therapeutic Community Model – Horizon (Cape Town)
- C. Narconon Model – Narconon (Johannesburg)

Sample 1

Approximately five subjects per centre were selected from therapists/social workers/counsellors.

Sample 2

The second sample was obtained from the patients in the same treatment centres. These patients were selected from the final phase of their treatment program in order to effectively analyse strategies used in their recovery. Groups of four were interviewed collectively from the above selected treatment centres. Service providers selected members who were willing to participate in the study and available for the discussion/interview. Thus this sample was a purposive sample.

1.10.3 RESEARCH TOOL

The research tools used were:

- A) Individual Interview:

In Phase One of the study, the basic individual interview was used in data gathering within the qualitative approach. “The interview was a method used in collected survey data, rather than asking respondents to read questionnaires and enter their own answers, the researcher would ask the questions orally and record respondent’s answers” (Babbie 1999:242).

There are several advantages to having a questionnaire administered by an interviewer rather than the respondent completing a written format.

- a) Attain higher response rates than mail surveys. A properly designed and executed interview survey ought to achieve a completion rate of at least 85%.
- b) Respondents seem more reluctant to turn down an interviewer standing on their doorstep than to throw away a mailed questionnaire.
- c) The presence of an interview also generally decreases the number of “don’t knows” and “no answers”- since minimizing such responses is important to the study.
- d) It can also serve as a guard against confusing questionnaire items. If the respondent clearly misunderstands the intent of a question or indicates that he or she does not understand, the interviewer can clarify matters thereby obtaining relative responses.
- e) Finally, the interviewer can observe respondents as well as ask further questions to clarify vague responses.

These advantages were evident in the conduct of this study. Data collection in the form of an unstructured interview schedule was the integral part of the research. The purpose was to assess the current methods of intervention used in the treatment of addiction and the target population was those involved in therapy and counselling. Open-ended questions were also used to allow for rich descriptions

“A qualitative interview is an interaction between an interviewer and the respondent, in which the interviewer has a general plan of inquiry but not a specific set of questions that must be asked in particular words and in a particular order.

It is essentially a conversation in which the interviewer establishes a general direction for the conversation and pursues specific topics used by the respondents. Ideally, the respondent does most of the talking” (Babbie 1999).

Kvale (1996) offers two metaphors for interviewing: the interviewer as a miner or a traveler. The first model assumes that the subject possesses specific information and that the interviewer’s job is to dig it out. By contrast, in the second model, the interviewer “wanders through the landscape and enters into conversation with the people encountered. The traveler explores the many domains of the country, as unknown territory or with maps, roaming freely around the territory. The interviewer wanders along with the local inhabitants, asks questions that leads the subjects to tell their own stories of their lived worlds.”

The goal of the study was therefore, to see the research topic from the perspective of the interviewee, and to understand how and why he or she had that particular perspective.

B) Focus Group:

In Phase Two of the study, the researcher chose the qualitative method of data collection, focus group interviews. Babbie & Mouton (2001) claim that the effective way of using focus groups is to use the group to find information you would not otherwise be able to access collectively. The focus group was useful because it gave space to patients to get together and create meaning regarding their treatment and to share experiences among themselves, about their present needs, problems and frustrations.

Focus groups are useful when multiple viewpoints or responses are needed on a specific topic. The researcher used the focus group interviews in order to gain multiple insights into and viewpoints about the needs, strengths and weaknesses of the treatment experienced by the individual addicted, and group discussions were facilitated around the similarities and differences of these experiences.

Before planning the content of the interview, the researcher defined the concepts to be discussed into selected themes. The interview therefore focused on identified themes and critical questions that captured the intent of the study: the strengths, weakness, needs and experiences of the individuals undergoing treatment for a substance abuse problem.

1.10.4 METHODS OF DATA ANALYSIS

Observations and analysis are interwoven processes in field research. The aim of data analysis is about interviewing and group discussion. Field research is where mode of reasoning is especially evident and important (Babbie 1999:275). Qualitative data analysis was expected because of the rich range of questions used in the two research tools (see Annexure 2 A and B).

The most general guide is to look for similarities and dissimilarities. In sociological terms, look for norms of behavior. On the other hand, the field researcher is constantly alert to differences. The researcher was able to effectively understand differences across the various treatment centres through the interview and focus group discussion. Responses were categorized according to similarities and differences during analysis.

Data analysis and data collection were developed together in the interactive process (Strause and Corbu 1990). Data analysis marks the stage in the process where you begin to draw back from the field and concentrate on making sense of what has been discovered.

1.11 ETHICAL ISSUES

Webster's New World Dictionary defines ethical as "conforming to the standards of conduct of a given confession or group".

- A copy of the research proposal was submitted to the university ethics committee and approval granted.
- Consent was obtained from all the participants before taking part in the study.

- The researcher respected the respondent's privacy and assured them of confidentiality and anonymity.

Science progresses through honesty and openness: Ego – defenses and deception retard it. In order for the researcher to serve other researchers – he identified the scientific discoveries by telling the truth about all the pitfalls and problems experienced in the study.

De Vos (1998) highlights that researchers are ethically obliged to ensure that they are competent and adequately skilled to undertake the proposed investigation. The researcher received adequate supervision, to ensure that the ethical standards were upheld at all times.

1.12 LIMITATIONS

1. The sample size limits generalisability. This does not invalidate the research, as this was an exploratory study.
2. It was originally intended to examine 2 treatment centres per Disease and Therapeutic Model. Due to difficulties in administering the research in terms of lack of co-operation from management at the number of treatment centres, only 1 centre was targeted from each model.
3. In researching the TC model (Horizon) in Cape Town only 1 staff member was on duty and interviewed. Unavailability of staff and non co-operation made this study positively challenging and in one case, the TC model, the researcher had minimal data from which to draw conclusions.
4. The results reflect the perceptions of staff who may or may not have expert training in the model they practice or claim to support.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

This chapter defines the treatment process of the various treatment models used by residential treatments centres and an evaluation of the treatment modalities before presenting a literature review.

Drug abuse treatment aims at bringing about independence from illicit drugs (such as heroin and cocaine) or licit drugs (such as alcohol and prescription medications). "Drug abuse treatment" per se is a complex and variable network of services designed to meet both, the multiple and individual needs of the abuser.

Drug dependence is a chronic, relapsing disorder requiring intensive reparation. Thus, breaking the recurring behaviour is effortful and difficult. Frequent drug users often suffer economic loss and extreme physical, psychological, emotional and social pain. Stigmatization, disapproval and isolation from society are also difficulties that drug users are confronted with. Furthermore, loved ones, as well as the larger community are adversely affected by the condition of substance abuse. (Office of National Drug Control Policy [ONDCP], 1994).

Rehabilitation Centres and Treatment Research Communities have reached consensus that positive outcomes can be reached through drug abuse treatment. However, the challenge sets in, when the most effective type of treatment for each individual, needs to be identified. During this period, determining apt treatment for each patient is vital and hence rigorous evaluation of treatment programs and patient outcomes is required which is striven to be achieved by the current research.

Drug abuse treatment can take place in hospitals; long-term residential treatment centres; outpatient clinics, counselling centres, psychotherapists' offices, or religious places.

The choice of treatment recommended for an individual depends on various factors such as the drug of choice, history of drug use and previous drug treatment, social needs, criminal record, financial situation, and personality characteristics.

In this chapter the literature review will be laid out under the following sections:

- Structured Treatments
- Residential Treatment Centres
- Traditional Models
- Alternative Strategies

2.2 DEFINITION/S

The term "substance abuse treatment" can generally be defined as providing structured action required to manage health and other associated problems due to the abuse of drugs and to amend personal and social functioning. According to the World Health Organization Expert Committee on Drug Dependence, the term "treatment" refers to "the process that begins when psychoactive substance abusers come into contact with a health provider or any other community service, and may continue through a succession of specific interventions until the highest attainable level of health and well-being is reached" (WHO Expert Committee on Drug Dependence 1998, p3).

The definition given by The United Nations Office on Drugs and Crime of the Secretariat state that 'treatment' is "providing persons, who are experiencing problems caused by their use of psychoactive substances, with a choice of treatment services and opportunities which maximize their physical, mental and social abilities, thereby assisting them in attaining the ultimate goal of freedom from drug dependence and social reintegration" (The United Nations Office on Drugs and Crime of the Secretariat 2003).

Treatment basically includes the usage of alternate methods and interventions. The nature of treatment interventions, including medical, psychosocial, traditional healing and other rehab services, can vary in different countries. Interventions are therefore decided upon based on a country's influential political, cultural, religious, social and economic factors.

2.3 STRUCTURED TREATMENTS

This includes services like a formal assessment; development; monitoring and review of individual plans for client care; and programs of medical treatment and/or counselling services. Some therapy programs, which are hosted in mainly residential settings, are formally structured. They include an intensive schedule of single and group-based educational sessions and therapy and training sessions to assist rehabilitation and recovery (United Nations Office on Drugs and Crime 2003).

Summaries of the main types offered are as follows:

2.3.1 Detoxification/ Stabilization Phase

This is the initial stage of drug treatment. It provides medically supervised detoxification to drug dependents. Consistent abusers of certain drugs (opioids, sedative and hypnotic drugs) require detoxification to overcome withdrawal symptoms. This varies according to the type of drug that was being utilized. Common *general* symptoms include craving, anxiety, restlessness, irritability, insomnia and impaired attention (United Nations Office on Drugs and Crime 2003).

Whilst psycho-stimulant dependents (amphetamines and cocaine), might not experience direct physical withdrawal effects, and therefore not require a prescribed agonist to ease discomfort, severe psychological problems (induced psychosis) and sleep disturbance may be suffered, which may necessitate administration of prescribed medication.

Detoxification programs aim to achieve withdrawal in a harmless and secure manner. Different medications have been effective in opioid detoxification, including true analogues or agonists such as methadone, partial agonists such as buprenorphine and other non-opioid drugs that are called adrenergic agonists (lofexidine or clonidine). Some in-patient programs use opioid antagonists under sedation or general anaesthesia (ultra-rapid detoxification) (Ling, W., Rawson, R. A., and Compton, M. A. 1994).

In some countries, opiate products (including tincture of opium) are used as a detoxification agent. Withdrawal from benzodiazepines is usually achieved through use of a long-acting benzodiazepine (example, diazepam).

Detoxification alone, is not a rehab treatment for drug dependence, and is therefore not solely effective in helping clients achieve permanent abstinence

Detoxification can be done either as:

Outpatient detoxification: is usually carried out at the outpatient facilities or at the client's home, with a period of stabilization using substitution agents. After stabilization, the client is gradually withdrawn. The client is also encouraged to receive counselling, medical treatment and other support services. The entire process can range from a few weeks to several months.

Short-term residential detoxification: Chemically dependent individuals need a medically supervised and controlled environment. This should be placed appropriately at short-term residential centres. These programs proceed through a detoxification stage to brief, relapse prevention, counselling and an education phase. This provides an opportunity for screening or managing any physical or psychological problem that could hinder rehabilitation progress.

2.3.2. Rehabilitation/ Relapse Prevention Phase

This phase is designed to change the behaviour of clients to allow them to regain control of their urge to use substances, which include psychosocial, pharmacological interventions and aftercare and are discussed as follows:

A. Psychosocial interventions

Can be implemented in two settings namely:

a) Community or Outpatients Programs

Developed to meet the needs of the individual using a case management approach, this program is based on an ongoing assessment of existing problems, personal resources,

social supports and stressors done by an addiction specialist or social worker. After an assessment, a set of personal treatment goals is formulated. Progress towards these goals is monitored and regularly reviewed (United Nations Office on Drugs and Crime 2003).

A client-centred, cognitive behavioural and motivational framework is mostly used. Treatment duration varies from brief intervention sessions to months-long structured programs. The goals of treatment are to help the client increase understanding of their drug-abuse behaviour and awareness of drug-intake consequences. This is achieved through individual and group counselling.

b) Residential rehabilitation programs

Two types of residential programs are available:

- Short-term programs usually include a 3, 4 or 6 week period. This type of program is usually based on the “Minnesota Model.”
- Long-term programs generally do not provide medically supervised withdrawal and can last between one to two years. This program is based on the Therapeutic Community Model.

Residential rehabilitation services include: living with other drug users in a communal setting during recovery; group and individual counselling; individual case management; improved life skills; vocational training and aftercare support.

They are usually closely aligned with mutual-help groups like Narcotics Anonymous and Alcoholic Anonymous (United Nations Office on Drugs and Crime 2003).

Some residential programs include a second stage, often referred to as “halfway houses.” This is a semi-independent group-living environment, usually located near the area of the main residential programs. This allows recovering clients to prepare for their return to the community, with continued formal support.

B. Pharmacological Interventions.

There are two types namely:

a) Substitution and maintenance programs

Abstinence is the primary goal in most rehabilitation programs. However, substitution agents (methadone and buprenorphine) may be prescribed for people with opioid dependence, for maintenance purposes. The substitute substance is administered at a suitable and stable level for a period of several months and sometimes years. Clients needing such treatment may present a history of failure in abstinence-oriented programs.

b) Antagonist pharmacotherapy

An opioid-dependent person, who has been fully detoxified, can be prescribed an antagonist medication, naltrexone, as part of preventing a relapse. This medication prevents any effects from heroin or other opiates should the individual consume them.

Naltrexone, which provides no addictive risk, can be used as continuing outpatient treatment combined with family therapy. Medication taken on a continuous lengthy period, blocks the effects of opiates, and thereby assists in long-term recovery of maintaining a drug-free state.

Although substantial efforts have been made to develop cocaine antagonists, no cocaine blocking agents have yet been scientifically proven to be effective.

C. Aftercare Arrangements

“**Aftercare**”, is a structured treatment program, which includes a period of less intensive treatment, once the main programs have been completed. This can last for a month or longer, even indefinitely. It is a form of providing continuous support required by clients. Regular telephonic contact, scheduled appointments and unscheduled or drop-in visits may all be available.

Clients may also be encouraged to access self-help groups and other general community support and advice services in their vicinity as required.

2.4 RESIDENTIAL TREATMENT CENTRES

Residential treatment centres (RTCs) offer continuous supervision in a staff-secure environment and various mental health treatment programs for substance abuse. Certain psychiatric or substance abuse cases, who have proven too ill or unruly to be housed in either foster care, day treatment programs, and other non-secure environments and who do not qualify to be admitted in a psychiatric hospital or a secure correction facility, are housed here.

Psychoanalytic therapy, psycho-educational counselling, behavioural management, group counselling, and medication management may be offered. As with most treatment options, the type and quality of services offered, range from hospital-like environments to group homes and halfway houses.

There are different methods used in Residential Treatment Centres namely:

a) Drug Rehabilitation Treatment Centres Using 12 Step

The 12 Step Recovery Model is based on the method originated from Alcoholics Anonymous. These steps usually last for 3 to 4 weeks. This method of treatment has been around the longest and there has been evidence of moderate success. When hard drugs first appeared, the 12 Step-method was utilized to combat these addictions, in the absence of other treatment models.

Today the success rate is approximately 10%-25%. This depends on the facility administering the treatment. With private facilities, the success rate is slightly higher (www.drug-rehab-locator.net June 3 2005).

b) Drug Rehabilitation Treatment Centres using Behavioral Modification

Behaviour Modification was developed to work on the self-centred or asocial personality. This method relies on 'boot camp style' tactics, where the individual is belittled by peer-groups. The aim is to rebuild the individual into a social person. However, the success rate is marginal (about 10%), and other methods are therefore recommended. Consequently, very few centres use this method (www.drug-rehab-locator.net June 3 2005).

c) Drug Rehabilitation Treatment Centres using Long Term Religious Modality

The long-term religious based model requires the individual to relocate for a year or two and work in a camp, engaging in activities like farming. This method also strictly combines activities with prayer and religious study.

About 20% of the individuals who complete this modal will abstain from hard drugs. However, due to the long-term commitment required, this model is usually not accessible to most addicts, and waiting lists are long.

d) Drug Rehabilitation Treatment Centres using Biophysical Modality

This method utilizes a purification sauna to detoxify the body. Dr. Forrest Tennant found that the human body stores a residue called 'metabolite' in the fat tissue for up to seven years following drug abuse. Metabolite causes cravings and anxiety. Furthermore, drugs like **heroin**, **oxycontin**, **cocaine**, and **crystal meth** are more powerful than the chemicals that the brain produces, which allows one to feel happy, hence, they also bring about depression. It takes a year for this chemical balance to be restored (www.drug-rehab-locator.net June 3 2005).

The purification sauna and vitamins expel residues stored in fat tissue. This then eliminates cravings, anxiety and depression. The chemical balance is effectively restored with exercise and vitamins.

This model also utilises a social-educational component to restore or build skills encouraging the individual to be a drug-free and a productive member of society. **Treatments based on this model experience a success rate of over 70%** and biophysical drug treatment centres are usually recommended (www.drug-rehablocator.net June 3 2005).

2.5 MODELS USED IN RESIDENTIAL TREATMENT CENTRES

The traditional models are now discussed to provide the reader and the researcher with a theoretical and conceptual basis for understanding the topic under investigation.

2.5.1 DISEASE OR MINNESOTA MODEL

The theory of the disease model is that alcoholism and drug dependence are physical illnesses, and not a matter of willpower or the habit of recurrent excessive consumption. Diseases are thus considered a primary, progressive, chronic illness and not the end result nor the symptom of another disorder.

Alcohol and drug dependence results in the individual's entire personality impacting on every aspect of one's life. As a result, the disease model represents a comprehensive explanatory concept, encompassing the social, psychological, spiritual, and biological dimensions of alcohol and drug dependence.

Historically, the *Minnesota model* treatment was developed to address the disease of alcohol and drug dependence, incorporating some of the major components of Alcoholics Anonymous (Spicer 1993). This model was initially conceptualized at a small state hospital in Willmar, Minnesota, and was fully developed as private non-profit residential programs in Minnesota called Hazelden.

From there, this model became prevalent in treatment programs across the United States, and in other countries (Fuller 1989; Spicer 1993). Project MATCH (Project MATCH Research Group, 1997), worked with staff at Hazelden to develop a manualized version

of the Minnesota model called the '12-step facilitation model'. This provided the vehicle by which individuals initiate pervasive, ongoing lifestyle changes focusing on continuous abstinence (Nowinski, Baker, & Carroll 1992).

2.5.1.1 History and Origin

The disease model was originally developed in relation to alcoholics; however, researchers have found a similarity between this model and drug dependence. Benjamin Rush, founder of modern psychiatry, described alcoholism, in the 18th century, as an illness that "resembles certain hereditary, family, and contagious diseases" (Keller 1986).

Disease may be defined as an imbalance, resulting in a list of disabling symptoms. The causes of disease are often unknown and are therefore best understood in terms of its biological basis and symptom indications. Engels (1977) expanded the biomedical concept of disease to include psychological, cultural, and social implications affecting the individual's susceptibility and treatment response.

Lewis (1994) compared alcoholism to hypertension and coronary disease, being closely linked to environmental risks and factors in terms of onset and progression. Like alcoholism, both of these medical conditions are affected by personality and lifestyle and also have genetic contributions in terms of the causes. The exact biological cause for most chronic diseases, are unknown.

A bio-psychosocial model of disease has greater potential for explaining and understanding disease entities. It also provides a broader base for effective intervention, including behavioural or lifestyle changes.

Pioneers of the disease model (Jellinek 1946; Silkworth 1939) provided a theory based on traditional biological concepts of disease. They stressed upon the psychological, spiritual, and social impacts of the illness and the process of recovery.

Silkworth (1939) described alcohol dependence as an illness characterized by an atypical physiological reaction to alcohol that triggers a mental obsession. The mental obsession of the individual leads to a physical need for alcohol intake despite the person

being aware of the consequences and might have strong intentions to reduce or quit alcohol consumption. Silkworth claimed that alcoholics could not resume normal drinking since the root cause of the disease involved a physical allergy to alcohol.

Silkworth also described the psychological aspects of craving: restlessness, irritability, and tension, mental strain of the individual's inability to reduce or stop drinking. He contended that only a drastic personality change would reduce the emotional turmoil of the alcoholic. This transformation, described by William James as quoted in *Alcoholics Anonymous* (1955), involved a gradual change in consciousness, or a spiritual awakening.

Jellinek (1946, 1960) elaborated on the disease model by addressing its physiological dimensions, progression of the disease, and a classification of disease typologies. Like Silkworth (1939), Jellinek (1946) contended that the alcoholic experienced an atypical response to alcohol involving an internal tension and craving that eventually led to an involuntary loss of control over drinking behaviour. Using a survey of about 2 000 alcoholics, Jellinek also drew a distinction between heavy drinkers and alcoholics by hypothesizing an X factor that caused individuals to consume liquor uncontrollably.

Jellinek (1946) described the symptomatic and prodromal phase of alcoholism, the crucial and the chronic phase respectively. The initial pre-alcoholic symptomatic phase is experienced in the form of a rewarding consequence (i.e. reduction in tension). Alcoholism then progresses from occasional to frequent relief drinking. This phase is also characterized by an increased tolerance-level, as more alcohol is needed for the perceived sedative effect.

As continuous consumption progresses, excessive amount of alcohol is ingested. However, the signs of intoxication are few:

One sign is the loss of memory of selected time frames or certain behaviour patterns or events. These limited periods of amnesia occur during the prodromal phase.

Other progressive symptoms include drinking to attain a feeling of normality, a preoccupation with alcohol, rapid consumption for relief, and lingering feelings of guilt.

In the crucial phase, alcohol-intake starts a chain reaction involving a physical demand for consumption, which is accompanied by an involuntary loss of control over drinking behaviour. It becomes increasingly difficult to predict periods of abstinence or intoxication. The crucial phase involves hyper-vigilance, rationalization, and periods of remorse. The individual is likely to make concerted efforts to control drinking behaviour by temporary abstaining or by pattern-change and times of drinking or by changing the alcohol-brand or type.

The symptoms of the first four stages, are all present during the chronic phase, in addition to prolonged periods of intoxication that result in ethical deterioration, severe memory dysfunction, physical traumas, and irrational fears. The chronic phase is associated with occupational and social deterioration. Also, interpersonal relationships or vocational productivity may be difficult to maintain. The chronic stage can result in severe irreversible disability or death, if not treated timeously.

Jellinek's (1946) description of the progressive nature of the disease provides both a rationale for clinical intervention and an impetus for further research and theoretical expansion.

2.5.1.2 Current Status of the Model

Advances in explaining the pathophysiology of alcoholism, have focussed the link between biological dysfunction and drinking behaviour. Neurobiological and neurobehavioral explanations of addiction, in particular, have been proposed in accordance with the disease model. Several researchers have further explored the progression of symptoms, as outlined by Jellinek (1946, 1960).

Schuckit, Smith, Anthenelli, and Irwin (1993 Pg 790, 791) found a commonality of symptoms and concluded, "The evidence of a general development of alcohol-related life problems is consistent with the prior research by Jellinek as well as the several additional attempts to replicate his earlier findings".

The authors, however, were not sure as to whether the predictable progression of symptoms actually signalled a disease, and instead referred to it as a "diagnosable clinical syndrome."

More recent neurology-field studies have shown that alcohol and drug dependence are aptly described as diseases. In his study of molecular and cellular changes in neural function produced by chronic drug use, Hyman (1996) found that brain cells adapt to the introduction of chemicals. He suggested that the excessive bombardment of the brain by drugs, leads to long-line molecular adaptations that mars the functioning of the part of the brain that controls motivated behaviour. Hyman (1995) concluded, "alcoholism is a brain disease that markedly damages self-control over drug-seeking behaviour" (pg. 841).

Leshner (1997), proposed that because of drug-induced cellular adaptation, a metaphorical molecular "switch" signals a change from 'use' to 'addiction', at which point, the brain is significantly altered, producing drug effects and behaviour that vary from the "pre-disease" state. Leshner's article is particularly important because he stressed the importance of getting rid of the stigma and moral overtones linked to the concept of addiction.

In treatment, the disease model is used to make the patient know that the illness is treatable and that he/she cannot be blamed for the disease. However, the patient has the responsibility of self-recovery similar to a patient with any other disease.

2.5.1.3 Maintenance of the Disease

In addition to the reinforcing qualities of alcohol that result from its use (Koob & Bloom 1988), defence mechanisms which deny the severity of drinking and its consequences also contribute to the maintenance of the disease.

This defence system is characterized by an effort to minimize alcohol or drugs consumption, rationalize problems it has bred, and blame others for the use behaviour. Intimidation, angry defensiveness, manipulation, and oppositional behaviour may also arise as a defensive mechanism against interventions that prevent continued use of alcohol or other drugs (Levy 1993; Metzger 1988).

Thus, the defence mechanisms contribute to a state of denial. The individual rarely initiates self-improvement and lacks motivation in seeking assistance.

The assumption may be made that an individual will be shocked from denial into a state of reality as the disease progresses to a more chronic level. However three main factors contribute to the maintenance of the disease and the defence system namely:

- Physiologically one may continue in an attempt to avoid withdrawal symptoms and to quell cravings (Beck, Wright, Newman, & Liese 1993). However, some drugs like marijuana, do not instantly cause extreme cravings or withdrawals, whilst other drugs produce immediate withdrawal symptoms, which are short-lived and which can be reduced by medication. However, it is rare that detoxification alone will end addiction. It is more important that the brain be fundamentally altered, as proposed by current neuroscientists (Hyman 1996; Leshner 1997). The individual may no longer be able to experience normal reward states without chemicals.
- Behavioural theorists believe that dependence is maintained by reinforcement caused either by the chemical itself or by environmental-stimuli justifying alcohol/drug use (Froelich & Li 1991; Miller & Brown 1997). Sometimes, the catalyst may be a combination of external and internal (cognitive) stimuli. For example addicts who return to their using environment after a long period of abstinence usually experience strong cravings, which make relapse likely.
- Another maintenance factor is the attitude and behaviour of family and friends. Family members themselves often develop defence systems around the disease, thereby normalizing the dependent's behaviour. Thus part of the treatment includes helping significant others identify their own issues and behaviours surrounding the alcoholic and addict, and to make changes. In some disease models, this is termed *co-dependency* (Morgenstern & McCrady 1992).

An important aspect of Minnesota model treatment is teaching recognition of the above-mentioned factors and to make personal and lifestyle changes to address them. An important component of the disease model is that a patient is never fully cured. Due to the result of the brain's fundamental change in how the abused substances are processed, the individual may never safely use again. This can be understood as the maintenance phase in "stages of change" theory (Prochaska, DiClementi, & Norcross 1992), during

which time the individual deters from behaviour likely to cause relapse into active addiction.

2.5.1.4 Rationale for how the disease model of treatment follows from the theory

Due to the complex and multifaceted nature of alcohol and drug dependence, treatment needs to be comprehensive. The full-blown dependency stage is likely to be consequential and complicated in the biological, intrapersonal, psychosocial, and mental health spheres of the individual's life (Sheehan, Owen).

Failure to consider the social need, environmental support for recovery, and ignoring negative contributing factors, results in an incomplete approach to the complexity of the disease process. Treatment methods are based on ones capacity to learn skills and practice newly acquired behaviour. A multidisciplinary team is therefore required.

Roles of the multidisciplinary team are listed below:

- **Physical Health Care**

Physicians and nurses ensure that the road to abstinence is a smooth one, by monitoring symptoms, and establishing protocols to reduce seizure risk, promote physical comfort, and prevent related complications (Sheehan & Garretson 1994). They also diagnose and treat medical conditions. In the disease model of treatment, the goal is to stabilize ones physical state so that one can be more available for the treatment process.

- **Mental Health Care**

Psychological assessment identifies intellectual functioning, personality characteristics, and mental disorder. Objective personality tests also aid in identifying traits and characteristics relevant to treatment response. Psychiatrists and psychologists work as a team in assessing, diagnosing, and treating concurrent mental health complications. Psychotherapy and non-addictive psychotropic medications may be used.

The disease model helps patients understand what aspects of their personalities or actual disorders may cause them to relapse, as well as to identify and build on personal strengths.

- **Spiritual Care**

Spiritual care helps individuals to examine their values and standards for behaviour. The basis for ethical living and behaviour change is provided, while addressing life's difficult questions. Chaplains undertake individual pastoral counselling and group sessions and frequently provide intensive grief work for those individuals experiencing losses related to addiction. From the disease model perspective, dependents have often abandoned values and connections that were once important to them. Finding meaning and strength beyond willpower may perhaps help the person learn new ways of living.

- **Chemical Dependency Counselling**

The main component of treatment services are provided by counsellors through ongoing assessment, treatment planning, and individual and group counselling tasks, which entail data collection, diagnosis and the development of behaviour-changing treatment strategies based on counselling methods used. The counsellor takes an active role as an agent of change (Sheehan, Owen).

2.5.1.5 Therapeutic change: Assumptions about how people change

Therapeutic change is based on education, therapy and fellowship – these being the three modes of intervention, which build on the methodology of the 12 steps of Alcoholics Anonymous:

- Education provides the informational basis for self-understanding, skill training, and attitude-changes.
- Individual and group therapy address the emotional conflicts, which serve as obstacles in the path of behaviour change.

- Fellowship is the interpersonal value of self-help, which contributes to building a common motivational effort to modify self-defeating behaviour, gain support for ongoing change, and establish resources for continuous learning.

2.5.1.6 Key interventions

The chemical dependence counsellor co-ordinates a plan of care that is developed by a multidisciplinary team. Counselling services use the methodology of the 12 steps of Alcoholics Anonymous to assist the individual. Personal application is measured by the standards created in the treatment plan. It is evaluated on overt observations of change in affect, attitude, and behaviour. Treatment strategies are modified according to needs and response.

At Hazelden, the Minnesota model involves five key clinical processes namely:

- Pre-entry services provide educational information, emotional support and referral for the good of those attempting change or clinical-services involvement.
- Intake, the initial stage, involves one realising that one has a problem, and the will to progress. Intake focuses on barriers towards improvement; provides intervention for urgent clinical needs; and eases the treatment- transition.
- During assessment and care planning, an alcohol and drug assessment, a social history, a psychological evaluation, a spiritual care consultation, and a physical examination are undertaken to evaluate the bio-psychosocial elements of the disease. A clinical formulation is then formed as an outcome, which provides an in-depth description of the clinical issues that will serve as a basis for ongoing treatment planning.
- Care processes encourage active attitude and behaviour change by use of treatment plan. The treatment plan is designed for intervention, based on the developmental approach of increasing self-awareness, new learning, emotional stability, and behaviour change.

- Continuing care involves services necessary to aid adjustment to post-treatment sober-living. Less intensive intervention continues, involving referral to Alcoholics Anonymous, individual counselling, and in some cases to be placed in a halfway house.

2.5.1.7 Treatment ingredients, structure, goals, and approaches

The clinical process of care, deals with the application of the 12 steps through a treatment strategy. Counselling techniques such as person-centred, cognitive behavioural, or existential approaches are made use of to:

- Heighten comprehension of each step and reasoning;
- Reduce obstacles to continued progress;
- Resolve risk factors for relapse; and
- Mobilize potential strengths.

Progress is evaluated by observing attitude changes, and/or behavioural change related to accepted outcomes from each treatment plan.

- **Self-Discovery**

Initial treatment goals encourage problem-recognition and acceptance. These realisations allow the individual to understand and apply Step 1 from *Alcoholics Anonymous* (1955), which reads, "We admitted we were powerless over alcohol-that our lives had become unmanageable". Due to defence mechanisms of denial, educational interventions help to promote self-discovery.

These interventions may be via psycho-educational services, such as group instruction and lectures that explain the dynamics of alcohol and drug dependence. Alcohol and drug assessment data are used to identify self-defeating problems related to relationships, career and health.

The first step has two parts. The first phase refers to the involuntary loss of control over alcohol and provides the rationale for continuous abstinence. The second component refers to the devastating consequences of the disease.

- **Self-Efficacy**

The second stage in the process of care focuses on self-efficacy. Step 2 counselling deals with hope for change. During this stage, emphasis is placed on the individual's ability to recover by accessing resources beyond the limits of one. For example, treatment methods may include a daily journal of positive events, daily meditation, or reading selections from *Alcoholics Anonymous* (1955).

During this stage, the concept of a Higher Power is introduced which is a positive factor that may impact on the quality of one's life. Spirituality is a self-defined, personal experience. For many, a Higher Power may be a therapeutic support group, a counsellor, or AA itself. For most, it is a combination of spirituality that helps provide a reason to life with the support of other recovering peers.

- **Taking Action**

With the development of trust, individual and group counselling helps progression from Step 2 to Step 3. During this stage, behaviour may focus on social skills tasks that involve self-disclosures and risk-taking behaviours in the practice of newly learned behavioural skills. Step 3 deals with taking action in response to reaffirmed beliefs, expectations, and values. Step 3 of *Alcoholics Anonymous* reads, "Made a decision to turn our will and our lives over to the care of God *as we understood Him*."

This step signifies various changes. First, a conscious decision is made, to trust emerging values, which will help shape decisions and actions. Next, a willingness to trust this evolving spirituality, to the extent of willingness to abandon one's unsatisfactory functioning in exchange for suggested methods of recovery.

- **Self-Inventory**

Improvement that comes about due to each of the steps treatment method is self-renewing and incremental. Step 4 treatment method builds upon the changes, attitudes, and behavioural skills from Steps 1, 2, and 3. Input from people in varying circles of the individuals life, is used to help understand problems or behaviour patterns, existing strengths, and potential blocks to continue growth and change.

Step 4 is about making a fearless moral inventory of one-self. Treatment methods applied to Step 4 include support and education. The inventory is totally confidential. This allows one to realize past problems and mistakes, while considering strengths and personal resources. Step 4 processes often provoke negative feelings.

People have difficulty on Step 4, perhaps due to either continued blaming of others, being preoccupied with anger and resentment, or anxiety from painful memories. Single treatment strategies are then planned, to treat and reduce the emotional behavioural obstacles, to participation in a fourth-step treatment process.

Any personality changes linked to Step 4 treatment frequently involve a willingness to consider one's shortcomings, which act as risk factors for relapse, a balanced self-perception of strengths and limitations, and resolution of shame and self-reproach.

- **Letting Go**

Step 5 treatment methods provide reasons for surrendering, by sharing the contents of the Step 4 inventory with another. Step 5 of Alcoholics Anonymous reads, "Admitted to God, to ourselves, and to another human being the exact nature of our wrongs." Treatment methods include consulting a trusted spiritual adviser to lay a foundation for self-disclosure. An accepting environment facilitates step 5 where personal information is shared without judgment.

The process of honest disclosure is the essential therapeutic value in this treatment process. At the conclusion, the participant is free to request feedback or engage in a dialogue regarding the inventory with the fifth-step listener.

- **Continuing Care**

The initial phase of recovery is usually associated with Steps 1-5. The first steps are closely linked to a spiritual awakening. Awareness of the reality of one's situation is reached and acceptance of the guidance from others for sober-living skills is acquired. This is further strengthened by Steps 6-12, the relapse prevention steps which deal with continued elaboration of skills learned in Steps 1-5 (Sheehan, Owen 1998).

For the purpose of this study, steps 6 – 12 involving aftercare are not relevant and therefore not discussed in detail. Post-treatment services, assists recovery process by helping to prevent future relapse. Based on the extent of severity, care options are individually prescribed. Recommendations of one-on-one counselling and referral to a 12-step self-help support group are frequently suggested to those who have a supportive family and social environments, employment, and a successful response to treatment.

Many are referred to mental health professionals for the treatment of mental health complications such as unresolved childhood trauma, serious relationship dysfunction, or poorly controlled depression and anxiety. For those individuals with unstable family and social environments, prior unsuccessful treatment attempts, unresolved mental disorder, and limited vocational options, halfway house placement is recommended.

2.5.1.8 Role of the therapist

A key treatment modality of the disease model is the mentoring relationship, between a primary therapist (chemical dependence counsellor) and the client. The relationship provides the means by which counselling helps the individual move towards incremental behaviour changes.

Change is promoted through planned intervention that builds on different counselling approaches consistent with 12-step methodology. Counsellors assess the extent and severity of addiction, integrate diverse information from the multidisciplinary team, develop treatment plans, facilitate group and individual counselling, conduct family conferences, develop continuing-care plans, and coordinate related case management activities.

2.5.1.9 Common obstacles to successful treatment

One obstacle, that can impede the successful use of the Minnesota model form of treatment, is the comprehensiveness of the resources, needed to implement the model effectively. However, if they are not available or fundable within an agency itself, the resources, can be gathered from the surrounding community.

2.5.1.10 Client characteristics

Studies have examined the extent to which client characteristics may counter-indicate the Minnesota model treatment. Variability of the client population is an important factor in the study of treatment response. There are limited studies that focus exclusively on predictive factors for treatment response to the disease model. Early efforts attempted to evaluate demographic or descriptive variables as predictors of treatment response. Depression and anxiety have been associated with post-treatment drinking (Hatsukami & Pickens, 1980; Pickens, Hatsukami, Spicer, & Svikis, 1985).

However, more recent endeavours have failed to identify predictive demographic or other standard background variables in the study of treatment response to the disease model. For example, in a study of over 1000, men and women admitted to a disease model residential facility, Stinchfield and Owen (1998) found that variability was evenly distributed in terms of treatment outcome. Variables such as co-morbid conditions, age, gender, employment, and relational support did not have predictive value for treatment outcome.

In a study of individual client types and response to different models of treatment, Project MATCH (1997) did not identify variables for treatment outcomes, relevant to the disease model in terms of individual client variability. It was found that people with lower levels of psychopathology did better in the 12step facilitation model than in the other two treatment models; the converse, however, was not true. No other demographic, mental health, alcohol severity, or other background characteristics predicted a better outcome in any of the models tested.

Morgenstern, Frey, McCrady, Labouvie, and Neighbors (1996) examined specific disease model processes and their effects. Patients with a greater commitment to abstinence and stronger intentions to avoid high-risk situations achieved higher success rates. Among those who did relapse, those with a greater commitment to Alcoholics Anonymous and a stronger belief in a Higher Power had less severe relapses than those who did not.

Particular subgroups of alcoholic or drug-dependent individuals may be likely to have a less than favourable treatment response. Mental disorders such as schizophrenia and related conditions or severe personality disorders such as borderline or antisocial individuals are likely to have difficulty with the relational qualities of the treatment model and its spiritual dimension. The cognitive nature of the treatment approach rules out individuals with severe cognitive dysfunction.

Because of the bio-psychosocial nature of the disease model, application of select treatment modalities within or outside the Minnesota model may be indicated to address the special needs of youth, individuals with co-morbid conditions, and those suffering from social instability and economic disadvantage.

2.5.1.11 Strengths and weaknesses

There are three main strengths of the disease model approach that directly affect clients:

- Clients benefit from their counsellors' input and interactions, and also from peers;
- Those who are ahead in the recovery process, even if by just a few days, provide credible and hopeful role models for the client; and
- Clients become part of a support group to those recovering which extends beyond confines of the treatment program.

By belonging to Alcoholics Anonymous groups, clients have access to continuous support at any time of the day, world -wide. The disease model thus provides a free system of lifelong support through referral to a 12-step self-help group (Sheehan, Owen).

A major strength of the 12-step model is its holistic approach to recovery. This model is capable of integrating innovation as knowledge is gained regarding the nature of the illness and the recovery process. The disease model serves as a conceptual umbrella, which covers diverse treatment approaches, thus maximizing opportunities for effective treatment.

The model's greatest strength is also potentially its greatest limitation. Since the model relies on a multidisciplinary team, services can be time-consuming and costly. The model demands time, attention, and effort for the principles and practices to work.

Other limitations pertain to potential problems in implementing. If the disease model of treatment, is too rigidly interpreted, it becomes distorted and presented in a confrontational, religious, or generic fashion rather than suiting the individuals needs. The core therapeutic principles and methods of the model are then obscured, and many clients are naturally resistant and unable to benefit from it.

2.5.1.12 CONCLUDING STATEMENT

The disease model of alcoholism has developed from theoretical innovations, clinical observations, and research. Jellinek's early work serves as an overview under which new view points or scientific findings may be added to explain the multidimensional nature of the illness. Abstinence is the prime factor of the disease model. The 12-step facilitation model, or Minnesota model, is a natural outgrowth of the disease model utilising a strong spiritual dimension. Post-treatment recommendations routinely involve referral to a 12step self-help support group for relapse-prevention and continuous care in addition to counselling, mental health services, and where needed, extended care such as halfway house placement.

2.5.2 Therapeutic Community Treatment Model

The Therapeutic Community (TC's) is a drug-free modality that utilizes a social psychological approach to the treatment of drug abuse. TC's programs are used in residential and non-residential settings (hospitals, jails, schools, halfway houses, day treatment clinics, and ambulatory clinics). Its model and methods are based in a theoretical framework that has evolved from both clinical and research experience (De Leon, 1995).

2.5.2.1 Early Development of the TC Model

Therapeutic community (TC's) programs for substance abuse appeared a decade after TC's in psychiatric hospitals pioneered by Jones (1953) and others in the United Kingdom (Kennard, 1983; Rapoport, 1960). There are some limited surveys of TC program's evolution. Contemporary TC's for addictions derive from Synanon, founded in 1958 by Charles Dederich, with other recovering alcoholics and drug addicts. Evolution of the modern addiction TC following Synanon can be readily traced in the history of programs that grew during the 1960 and the 1970's in North America, and eventually spread to Europe (Brook & Whitehead 1980; De Leon & Ziegenfuss 1986; Glaser 1974; Kooyman 1992).

Status of the Model and its Applications

The TC modality consists of a wide range of programs. It serves a diversity of clients who use various drugs, and who present complex social and psychological problems in addition to their chemical abuse. Client differences as well as clinical requirements and funding realities have encouraged the development of modified residential TC's with shorter durations of stay (3,6 and 12 months), as well as TC-oriented day treatment and outpatient ambulatory models.

It can be distinguished from other major drug treatment modalities in two ways:

Firstly, it offers a systematic approach guided by perspective on the drug use disorder, the person, recovery, and right living.

Secondly, the primary 'therapist' and influence, is the community itself, consisting of the social environment, peers, and staff who, as role models of successful personal change, serve as guides during recovery.

The community is the focal point in which change occurs, and the method for allowing transition. The TC, views substance abuse as a disorder of the whole person. Regardless of social standing or primary drug differences, substance abusers share important similarities.

Most reveal problems in socializing, cognitive-emotional skills, and overall psychological development process of incremental learning toward a stability in behaviour, attitudes, and values of 'right living' associated with maintaining abstinence.

In the TC view, addiction is a symptom of the disorder. Thus, the problem is the person, not the drug. The sources of the addiction disorder are social and psychological. The emphasis is individuals' contribution to problems in the past and to their solutions in the present.

Thus, accepting responsibility for one's conduct and attitudes is the key to personal change. The distinguishing approach of the TC is the deliberate use of the peer community to aid social and psychological changes.

Due to social differences, residents have lost or never acquired values to live healthy, productive lifestyles. In a nutshell, substance abuse is viewed as a complex socio-psychological disorder of the individual, consisting of recurrent negative patterns of behaving and thinking, and poor emotional management.

2.5.2.2 The TC Traditional Model

They are similar in planned duration of stay (15-24 months), structure, staffing pattern, perspective, and rehab regiment, although they differ in size (30-600 beds) and client demography. Most incorporate the basics of the program model, which can be outlined in the TC structure and its process, based on the individual's transition, within the community life context.

A) TC Structure: Basic Components

The social organization of the TC is composed of junior, intermediate, and senior resident peers, or family. This structure strengthens the individual's identity with a perceived, ordered network of others. It also arranges relationships of mutual responsibilities, vital to others recovering at various treatment-levels.

The daily operation of the community itself is the task of the residents, working together under staff supervision. The broad range of resident job assignments illustrates the extent of the self-help process. These include conducting all house services (e.g., cooking, cleaning, kitchen service, minor repair), serving as apprentices, running all departments, and conducting house meetings, certain seminars, and peer encounter groups (De Leon & Rosenthal, 1989).

The staff is made up of TC-trained clinicians and other human service professionals. Primary clinical staff is usually former substance abusers, which were rehabilitated in TC programs. The staff monitors and evaluates clients' status, supervise resident groups, assign and supervise resident job functions, and oversee house operations. Clinically, staff conduct therapeutic groups, provide individual counselling, organize social and recreational projects, and liase with significant others. They decide matters of resident status, discipline, promotions, transfers, discharges and treatment planning.

The new client enters a progressive setting. Resident job functions are arranged in a hierarchy according to seniority, clinical progress, and productivity. Job assignments begin with the most menial chores and lead to coordination and management levels. Indeed, clients come in as patients and can leave as staff.

This social organization of the TC reflects the basic aspects of its rehab approach (De Leon & Rosenthal 1989)

1. ***Work as Education and Therapy:*** Work and job changes have clinical relevance for substance abusers, most of whom have not successfully adapted to the social and occupational world of the larger society. Job promotions therefore carry the obvious rewards of the status and privilege. However, lateral job changes are more frequent, providing exposure to all aspects of the community. This involvement heightens the sense of belonging and strengthens commitment to the community.

2. ***Mutual Self-Help:*** The essential dynamic in the TC is mutual self-help. The residents themselves conduct the day-to-day activities. In their jobs, groups, meetings, recreation, and personal and social time, it is the residents who continually exchange vital messages and expectations to the community.
3. ***Peers as Role Models:*** Peers, including staff, act as role models and rational authorities become the primary mediators of the recovery process. Role models are those who demonstrate the expected behaviours and reflect the values and teachings of the community. In the TC view, it is not just an exercise in conformity, but also an essential mechanism for complete psychological change.

Role models display responsibilities such as: willingness to confront others whose behaviour is not in keeping with the rules of the therapeutic community, the spirit of the community, or the knowledge that is consistent with growth and rehabilitation. Role models are obligated to be aware of the appearance, attitudes, moods, and performance of their peers, and to confront negative signs immediately.

4. ***Staff as Rational Authorities:*** Staff foster the learning process through their managerial and clinical functions, and in their psychological relationship with the residents act as role models, parental surrogates, and rational authorities. TC clients often have had difficulties with authorities, which have either not been trusted, or perceived as guides and teachers. Thus, they need a successful experience with an authority figure that is viewed as credible (recovered), supportive, corrective, and protective in order to gain authority over themselves (personal autonomy). Staff exercises their powers to teach, guide, facilitate and correct, rather than punish, control, or exploit.

B. THERAPEUTIC COMMUNITY PROCESS: BASIC PROGRAMS ELEMENTS

The recovery process may be defined as interaction between treatment interventions and client improvement. The daily regiment consists of structured and unstructured activities, which may be grouped into the main elements:

1. Therapeutic Educative Activities

These consist of various group and individual counselling. They promote expression of emotions, divert negative acting out, permit ventilation of feeling, and resolve personal and social issues.

There are four main forms of group activities:

- a) Encounters - Its approach is confrontation, and its objective is to modify negative behaviour and attitudes directly.
- b) Probes and c) Marathons: These have as their primary objective significant emotional change and psychological insight.
- d) Tutorial groups stress learning of skills.

All of the above attempt to foster trust, personal disclosure, intimacy, and peer solidarity to facilitate therapeutic change, in varying ways.

With the exception of the encounter, which is peer led, the groups are conducted by staff, assisted by senior peers. One-on-one counselling balances the individual-needs and community-needs. Peer exchange is ongoing and constitutes the most consistent form of informal counselling. Staff counselling sessions are both formal and informal and usually conducted when needed.

2. Community Enhancement Activities

Community Enhancement Activities include four main facility-wide meetings (De Leon, 1995).

- 1) Morning meetings are convened with all residents and staff on the premises, to initiate the day's activity. This creates a positive, motivated and united attitude amongst all.

Peers conduct planned programs of recitation of the TC. Philosophy, songs, readings and skits. This meeting is particularly important in that most residents of the TC's have not followed the routine of the ordinary day.

2) A seminar is convened every afternoon, usually for one hour. Most seminars are conducted by residents, and sometimes led by staff and guest speakers. The seminar emphasises listening, speaking, and conceptual behaviour.

3) House meetings are convened after dinner, usually coordinated by a senior resident. In this forum, social pressure is employed to ease individual change through public acknowledgment of positive or negative behaviour of those concerned.

4) General meetings are called as and when needed, usually to address negative behaviour, attitudes, or incidents in the facility. These meetings, conducted by staff, are designed to identify problem- people or conditions or to reaffirm motivation and reinforce positive behaviour and attitudes in the community.

3. Community and Clinical Management

These activities maintain the physical and psychological safety of the environment. It also ensures that resident-life is orderly and productive. The community is protected and strengthened as a context for social learning. The main activities, privileges, disciplinary sanctions, and surveillance, have both management and clinical relevance in the model.

In the TC, privileges are handsome rewards, which reinforce achievement value. Job promotions, room privacy, and peer leadership roles are decided upon by overall progress in the programs. Inappropriate behaviour, or negative attitude can result in loss of privileges, which can be regained by demonstrated improvement. Loss of even small privileges is regarded as a status setback that is particularly painful for individuals who have struggled to raise their low self-esteem.

In the TC, social and physical safety is prerequisites for psychological trust. Thus, disciplinary sanctions are implemented against behaviour that threatens the safety of the TC. For example, breaking of cardinal rules, such as violence or threat of violence can bring immediate expulsion. Even threat as minor as theft of a toothbrush or a book must

be addressed. The punishment must fit the crime and therefore suitable punishment will depend on varying factors.

Although often perceived as punitive, the basic purpose of contracts is to provide a learning experience by compelling residents to attend to their own conduct, reflect on their own motivation, feel some consequence of the behaviour, and to consider alternate forms of acting under similar situations.

Contracts also have important community functions. The faculty is made aware of all disciplinary actions. Consequently, contracts deter violations. They provide vicarious learning experience for others. As symbols of safety and integrity, they strengthen community togetherness.

The 'house-run' is very effective in assessing the physical and psychological status of the residential community. Several times daily, staff and senior residents walk through the entire facility, inspecting its overall condition.

This procedure has clinical implications as well as management goals which provide observable, physical indicators of self-management skills, attitude toward self and the program, mood and emotional status, level of self-awareness and the physical and social environment for residents and staff (De Leon 1995).

Most TC's utilize spot random urine testing or incidents-related urine testing procedures. Residents, who deny the use of drugs or refuse testing on request, are rejecting a fundamental expectation in the TC, which is to trust staff and peers enough to disclose undesirable behaviour.

The voluntary admission of drug use initiates a learning experience, which includes exploration of conditions precipitating the infraction. Denial of actual drug use, either before or after urine testing, can block the learning process or may lead to termination or dropout. When positive urine is detected, the action taken depends on the drug use, time and status in the program, previous history of drug and other infractions, and condition of use. Actions may involve expulsion, loss of time, job demotion, or loss of privileges for specific periods. Review of the 'triggers' or reasons for drug use is also an essential part of the action taken.

2.5.2.3 ACTIVE INGREDIENTS OF THE TREATMENT

All activities/interventions of the social environment are designed to produce therapeutic and educational change in individuals, and all participants are mediators of these changes. The efficacy of this global intervention, however, depends on individual's participation in programs. Participation means that the individual engages in and learns to use all the elements of the community as tools for self-improvement. Therefore, an individual's full participation in the community is the aim of the treatment, in order to achieve one's goals of lifestyle and identity change.

The TC approach is contained in the relationship between the individual and the community. These ingredients are defined in terms of four interrelated components of the community (De Leon 1995).

- The community context, which consist of peer and staff relationships and daily regimen of planned activities;
- The community's expectations, which consist of a high standard and implicit demands for individual participation in;
- The use of community assessment, which consist of peers and staff's formal and informal observation of the individual's progress in meeting community expectation;
- Community responses to assessment, consisting of various forms of feedback, instruction, positive and negative sanctions, and consequences.

It is in striving to meet community expectations and standards for participation that the individuals achieve their social and psychological goals.

2.5.2.4 ROLE OF THE THERAPIST

The staffs is responsible for sustaining an environment that enhances the self-help learning process for single residents and/or the entire community. Staff composition consists of a mix of traditional and non-traditional professionals in a variety of clinical, management, administrative and supportive service positions.

Treatment program personnel are directly responsible for the daily, clinical and operational activities of the residential facility (De Leon 1995).

Non-traditional professionals generally have recovery experience and formal training in human services. Traditional professional staff consists of social workers, psychologists, psychiatrists and nurses, some with recovery experience. Regardless of background, all staff must be integrated through cross- training in the basic concepts of the perspective, community approach, program model, and methods of the TC, in order to ensure effective program implementation.

Although emotional breakthroughs and powerful insights occur, staff is discouraged from using conventional therapeutic language or methods that conceptualize them as therapists.

Counselling sessions may be conducted, with the resident, in planned private conversations. The goal is resolution of issues that threaten the resident's commitment or ability to remain in the peer community. Staffs primarily advise, support and instruct, and in some cases refer the resident to a mental health therapist or other service professionals.

2.5.2.5 COMMON OBSTACLES TO SUCCESSFUL TREATMENT

Majority of whom fail to complete the full course of treatment. Although research shows that many of these non-completers show benefits, the global social and psychological goals of the TC are not fully realized (De Leon 1995). Thus, the obstacles to successful treatment are the factors that contribute to premature dropout. Some of these factors associated with characteristics of the client and implementation of the treatment protocol, are briefly listed:

- a) Client suitability: Many substance abusers that enter the TC's cannot tolerate the structured regimen and demands of these programs.
- b) Client Motivation: continually fluctuates during the course of the residential stay. Therefore, there is constant emphasis on sustaining motivation, particularly in the early phases of treatment.

c) Conflicts: the intensity of community life fosters conflicts between the residents, and between residents and staff.

d) External Pressures: residents often experience pressures from family or employers to leave treatment prematurely.

e) Flight into Health: most admissions show improvement within the first three months of treatment, which may paradoxically stimulate many to leave prematurely.

f) Environmental Risk: recent research indicates that TC programs vary in their adherence to essential elements of the model. In particular, differences in the internal and surrounding environment of the program, may contribute to dropout (Jainchill, Messina, & Yagelka 1997).

g) Staff Training: staff requires an understanding of the theory and rationale for the treatment protocol. Recovered staff is often inflexible in their response to individual differences. Their narrow experience and training rather than conceptual understanding of the TC approach may limit their clinical skills and knowledge. Conversely, traditionally trained human services professionals in the TCs lack experience with personal recovery and are limited by concepts, language, and perspective of their professional training.

h) Funding Policy: recent changes in health care policy have resulted in shorter planned duration of treatment. These changes impose limits in implementing the TC treatment protocol based upon its perspective.

2.5.2.6 CHARACTERISTICS OF CLIENTS MOST LIKELY TO RESPOND TO THE MODEL

a) Social and Psychological Profiles.

Residents in traditional programs are usually men [70 - 75%], but admissions of women have recently increased. Most community-based TC's are integrated across gender, race/ethnicity and age, though the demographic proportion differs by geographic regions and in certain programs.

About half of all admissions are from broken homes or dysfunctional families. The majority have poor work histories and have occasionally engaged in criminal activities. Among adult admissions, less than one third have been employed full-time during the year before treatment, more than two thirds have been arrested, and 30 - 40% have had prior drug treatment histories (De Leon 1984; Hubbard, Simpson & Sells 1982).

Approximately 30% of adult admissions and 50-70 percent of adolescent admissions to residential TC's are criminal justice referrals, although some TC programs exclusively serve criminal justice referrals (De Leon 1993; Jainchill 1997; Tims, De Leon, & Jainchill 1994).

The majority of TC admissions have multiple drug use histories. Most report cocaine or crack as the primary drug of abuse. Research shows that those admitted to TC's reveal a considerable degree of psychosocial dysfunction in addition to their substance abuse. (Brook & Whitehead 1980; De Leon 1976, 1980, 1984, 1989; Holland 1986; Kennard & Wilson 1979).

Studies indicate that over 70% of those admitted, disclose a lifetime non-drug psychiatric disorder, in addition to substance abuse or dependence. One third have a current or continuing history of mental disorder in addition to their drug abuse. The most frequent non-drug diagnoses are phobias, generalized anxiety, psychosexual dysfunction, and antisocial personality. There are only a few cases of schizophrenia, but lifetime affective disorders occurred in over one third of those studied (De Leon, 1993).

b) Clients Who Are Best Candidates for Long-term Residential TC's

There are no typical profiles of dependents that succeed in residential therapeutic communities. However, the need for long-term treatment in TC's is based on clinical and research experience. The clinical indicators of long-term residents in TC's can be briefly summarized across five main domains:

1. Health and social risk status: Most abusers who seek treatment in the TC experience acute stress. They may be in a crisis or harmful to themselves or others, so that a period of residential stay is indicated. However, clients suitable for long term residential

treatment require longer periods of residential treatment because they are a constant risk or threat and they must move beyond relief, seeking genuine recovery.

2. *Abstinence Potential:* According to the TC's view, abstinence is a prerequisite for recovery. Thus, the residential TC is needed to interrupt drug use and to stabilize an extended period of abstinence, to facilitate a long-term recovery process.

3. *Social and Interpersonal Function:* Drug use results in inadequate social and interpersonal function and often reveals a more general picture of immaturity or an impeded history development. Thus, a setting such as the TC is needed as it focuses upon the broad socialization and/or rehabilitation of the individual.

4. *Antisocial Involvement:* In the TC view, the term antisocial includes behaviours such as exploitation, abuse and violence, attitudes of mainstream disaffiliation, and rejection or absence of pro-social values. Modification of these characteristics requires the intensive re-socialization approach of the TC setting.

5. *Suitability for the TC:* A number of those seeking admission to the TC, may not be ready for treatment or suitable for long-term residential regimen demands. Assessment of these factors at the time of admission provides a basis for treatment planning in the TC, and sometimes for appropriate referral. Some indicators of motivation, readiness, and suitability for TC treatment are acceptance of the severity of the drug problem; acceptance of the need for treatment; willingness to sever ties with the family, friends, and current lifestyle while in treatment; and willingness to surrender a private life and to meet expectations of structured community. Although motivation, readiness, and suitability are not criteria for admission to the TC, the importance of these factors often emerge after the start of treatment. If they are not identified and addressed, this can lead to an early dropout (De Leon, 1993; De Leon & Jainchill, 1986; De Leon, Melnick, Kressel, & Jainchill, 1994).

2.5.2.7 CONTRAINDICATIONS FOR RESIDENTIAL TC TREATMENT

Traditional TC's maintain an open-door policy, with respect to admission to residential treatment. This understandably results in a wide range of treatment candidates, not all of whom are equally motivated, ready, or suitable for the demands of the residential

regimen. Relatively few are excluded because the TC policy is to accept individuals who elect residential treatment regardless of the reasons influencing the choice. However, there are two major guidelines for excluding clients:

a) Suitability: refers to the degree to which the client can meet the demands of the TC regimen and integrate with others. This includes group participation, fulfilling work assignments, and living with minimal privacy in an open community, usually under dormitory conditions.

b) Community Risk: refers to the extent to which clients present a management burden to the staff or pose a threat to the security and health of the community or others. Histories of arson, suicide, and serious psychiatric conditions, warrant expulsion. Psychiatric exclusion is usually based on a documented history of psychiatric hospitalizations or first impressions from the interview [example frank delusions, thought disorder, hallucinations, confused orientation, or signs of serious affect disorder]. Clients on a regular psychotropic regimens are generally excluded, because use of these usually correlates with clinically severe psychiatric disorder.

Clients requiring medication are acceptable in the TC's, as are handicapped clients or those with prosthetics, providing they can meet the demands of the program. Because of the concern about communicable disease in a residential setting, tests are required for tuberculosis and hepatitis prior to entry into the facility or at least within the first weeks of admission.

Most TC's has recently implemented policy and practices concerning testing for HIV status and management of AIDS or AIDS-related complex. These emphasize voluntary testing, with counselling, special education seminars on health management and sexual practices, and special support groups for residents who are HIV-positive or have a clinical diagnosis of AIDS or AIDS-related complex (De Leon, 1997; McKuster & Sorensen, 1994).

2.5.2.8 AFTERCARE SERVICES

Currently, most long-term TC's have links with other service providers, and 12-step program groups for their graduates. However, the TC's with shorter-term residential components have instituted well -defined aftercare programs.

Special workshops on relapse prevention training, using curriculum, expert trainers, and formats have been developed outside of the TC area (e.g., Marlatt & Gordon, 1985). These workshops are offered as formal additions to the existing TC protocol, usually in the re-entry stage of treatment.

2.5.2.9 STRENGTHS AND WEAKNESS OF THE TC MODEL

Although successful TC treatment has been around for some 30 years, a detailed theoretical framework model and method has been recently developed. The strength and weaknesses of the TC approach are based on clinical experience supported by developing research. Not unexpectedly, some of the strengths of the TC are also weaknesses.

- *Strengths*

The TC remains the treatment of choice for the severe antisocial, or socially disaffiliated substance abuser. The goals of lifestyle and identity change, for these individuals, remain paramount, but require long-term treatment, regardless of health care policy change. Current studies confirm the effectiveness of modified TC's for those with occurring mental illnesses (Sacks et al.1997), adolescents (Jainchill, Bhattacharya, & Yagelka 1995), and inmates in state correctional facilities (Lipton 1995).

Contrasted with conventional medical and mental health-oriented approaches, the TC model elaborates on empowering the individual in the change process, the use of peer communities as a method of facilitating change, and the reality of achieving long-term, sustained changes. The TC model is therefore, the best example of effective self-help, recovery-orientated approach to the individual's treatment.

- *Weaknesses*

Although the individual is the constant focus of the TC, the structure and process elements of a peer community as method approach are relatively inflexible in meeting the individual's needs.

Thus, in TC programs, there is a constant tension between the needs of individual and those of the community, which must ultimately favour the individual (De Leon 1995). The TC model appears most appropriate only for the most serious users, and those who are socially deviant. In the past, the traditional addiction TC was not suited for well-socialized addicts, or for those with serious psychiatric illness.

The TC is generally a high-demand treatment that appears appropriate for highly motivated clients who are ready to change, and who perceive the TC environment as suitable.

Aftercare issues are adequately addressed in the re-entry stage of the residential program. Thus the model now provides for well-developed aftercare networks to maintain treatment gains. The pressure of cost-containment has further challenged the relevancy of the long-term residential model and has underscored distinctions between primary treatment and aftercare.

The TC illustrates the complexity of a community as method model of treatment. Multiple interventions, address multiple dimensions of the individual in the change process, defined as a dynamic interaction between individual and the community. Empirical research on such a complex model is difficult to implement and abstracting the "active treatment elements" of the TC process poses challenges similar to those in researching villages or family systems (De Leon 1995).

2.5.2.10 CONCLUDING STATEMENT

The TC is a powerful social psychological alternative to pharmacological treatments of substance abuse and related problems. The TC is oriented to recovery. It stresses on the need for a change of lifestyle and identities. It remains the treatment of choice for severe drug abuse in a systematic and structured way.

It also integrates various effective elements of other approaches, such as family therapy, relapse prevention, and mental health.

2.5.3 NARCONON MODEL

There is not much information available on the literature review except the web sites that is promoting the Narconon treatment centres that is available throughout the world. There is a manual available describing in detail the treatment programs used at these centres but are not available to the public.

2.5.3.1 Origins

William Benitez, who founded the Narconon program in 1966, was a heroin-addicted inmate of Arizona State Prison. In the prison library he came across a book by L. Ron Hubbard, "The fundamentals of thought" which outlined an entirely new approach towards solving the problems of life. After reflecting on what he had read, his intention was the following: "Decision to set up Narcotic Foundation" which was noted on his wall calendar. He also circled the 18th of the same month as his target date to approach officials to request permission to set up a drug rehabilitation program inside prison walls. Permission was initially denied due to security concerns.

Benitez persevered in winning the support of the prison administration and started to pilot a program with 20 other inmates. "What impressed me the most about Mr. Hubbard's works," Benitez later wrote, "was that they concentrated not only on identifying abilities, but also on methods (practical exercises) by which to develop them. I realized that drug addiction was nothing more than a 'disability,' that begins when a person ceases to use his abilities essential to constructive survival." From these works, with the help of volunteers and later contributions from Mr. Hubbard, Benitez developed a comprehensive program. He named it 'Narconon' meaning "no-drugs" (Hubbard 1996).

Benitez credited this program to saving his life and the lives of his fellow inmates who participated in the Narconon initiation.

Benitez even turned down an early parole, as he did not want to leave the prison until the program was successfully completed. His intention was clear, he knew that he had discovered an effective method and wanted to make sure that it was made available to others in need. "I demonstrated to officials that any person, inmate or otherwise, could benefit from Narconon because its attention was on increasing abilities, and we had an ethics mechanism built into the program, and that the responsibility and involvement required of a member could soon dissuade anyone not serious about improvement". The program met its expectations brilliantly, such that seven months into Narconon, he was asked to initiate another program for young offenders housed in the annex outside the prison walls" (Hubbard 1996).

Upon his release, Benitez moved to California and after incorporating Narconon as a non-profit organization, opened the first Narconon residential treatment facility in Los Angeles in 1971 as a halfway house for inmates who had started the program in prison. As demand increased, Narconon Los Angeles began accepting substance abusers directly from the community and this gradually developed into a full residential program. This centre is currently successfully in operation.

Over 35 years later, the Narconon programs worldwide retain the essential character – a drug-free, educational, life-skills program. The network of Narconon programs has expanded from the one program in Arizona State Prison to now include residential, outpatient, adult and juvenile centres across the United States as well as the rest of the Americas, Europe, Africa, Australia and Asia.

As this network grew, Narconon International was formed to direct and assist the much-needed expansion of drug rehabilitation as well as worldwide prevention programs. Narconon International provided technical assistance, training and the needed materials to increase capacity and sustainability.

The need for effective drug rehabilitation is currently greater as the scope of the problem is vast. To further increase our efforts, Narconon International has built alliances and partnerships with community leaders, health professional and government agencies.

2.5.3.2 The Narconon Program components

a) Narconon new life detoxification program

Detoxification is only the first step on the road of addiction treatment. Exercise, nutrition, and sweating in dry, low-heat saunas with plenty of water and replacement minerals helps the body eliminate the burden of toxins.

The programs has a very unique and effective detox procedure that actually rids the body of the old drug residues, which in turn eliminates physical cravings for the drugs and allows a person to feel much healthier mentally and physically. This is called the Narconon New Life Detoxification Program and is part of Narconon long-term residential treatment (Hubbard 1996).

b) Life Improvement courses (Hubbard 1996)

- 1) Narconon Learning Improvement Course enables students to overcome barriers to study and improve comprehension towards the result of a real world ability to apply learnt information, in their lives.
- 2) Narconon perception and communication Course helps a person to remove himself from past upsets and other chaos associated with past drug use through specific exercises in communication with the environment.
- 3) Narconon Ups and Downs in Life course evaluates the characteristics of constructive and destructive personality types, so that one can select associates with care and establish a more stable, secure personal environment.
- 4) Narconon Personal Values and Integrity Course provides the data and exercises through which confronting past destructive actions, the student regains his personal integrity, accepting personal responsibility.
- 5) Narconon Changing Conditions in Life Course enables one to evaluate the state of different parts of one's life and how to improve these, step by step, until one achieves a more desirable condition for each.

6) Narconon “The Way to Happiness” Course is a study of a non-religious code of moral guidance by L. Ron Hubbard to help one follow a personal path of future conduct that will lead to greater good of all concerned.

c) Program completion discharge plans & follows up

Developing a personalized plan for life after graduation, one works out the specific steps to take with family, friends, etc., in order to reconstruct a healthy, ethical, constructive life. Narconon staff maintains close contact to help monitor stability (Hubbard 1996).

Recovery, involves an extended process that usually utilises professionals in the addiction treatment field. Narconon staff are certified and trained and comprise of a Medical Director, nurses on site 24 hours a day as well as an average of 30 Certified Chemical Dependency Counsellors.

To ensure successful recovery, addicts require skills and tools to deal with daily situations and problems. Factors such as coming across addict associates, returning to the same environment and places, or even small things such as smells and objects, trigger memories that can create a desire to use drugs again. This can hinder the goal of complete recovery and can permanently prevent one from regaining control of life. Narconon provides the life skills necessary to overcome these barriers and have permanent recovery so that former addicts can lead a healthy, successful and drug-free life.

2.5.3.3 CONCLUDING STATEMENT

This model focuses on using Bio-Physical Modality. This method utilizes a purification sauna to detoxify the body. The human body stores a residue called 'metabolite' in the fat tissue following drug abuse. Metabolite causes cravings and anxiety.

The purification sauna and vitamins expel residues stored in fat tissue. This then eliminates cravings, anxiety and depression. This model also utilises a social-educational component to restore or build skills encouraging the individual to be a drug-free and a productive member of society.

2.5.4 ALTERNATIVE STRATEGIES

2.5.4.1 Introduction

We are often unaware of the nature of the perceptual shifts necessary to make a satisfactory change in life. Some change is needed, but we often remain unable to state aptly, the changes needed. Rather than focusing on an external formula, the study of addictions must focus on how we move to a higher logical level that provides proper insight to personal growth free from addictive substances.

The recovery process is tied to the restructuring of meaning in the addict's life. The process is linked to a series of personal redefinitions. Manipulation of meaning can have a powerful impact on the substance abuser's life and is looked at below. The necessary repertoire of tools to foster those shifts must also be developed. Apart from the need for a clear sense of the cognitive tasks for growth, beyond active addiction, identification of the kinds of cognitive tasks assumed by each remedy is needed.

There are underlying assumptions in the 12 step programs no less than in rational recovery, cognitive-behavioral, or stages of change formulations. Whatever program is used, the clear cognitive goals, which are assumed within the system, must be understood

Finally, our effectiveness is partly a function of our own flexibility. As long as we refuse to reconceptualize our tools to fit the patient we will fight a losing battle. We all know conceptual rigidity as a symptom of addictive thought. The capacity to reach individuals depends on our capacity to meet them within their own worldview. If we cannot understand their view, and respect it as such, we cannot expect them to understand ours (Washton and Stone-Washton 1993; Grinder and Bandler 1982).

Recovery from addiction may be understood as a redefinition of the meaning of the addict's life. Just as entry in to the addictive process redefined who and what they were, so their emergence from that world of addictive definitions and meanings is an important

part of recovery. We might say that the addict's life was reframed or redefined by addiction. The task of recovery itself is reconstituted as redefining the life of the substance abuser so that reframed, or recontextualized, his life can proceed without addictive substances.

Meaning impacts on the individual on multiple levels. Prochaska, Norcross, and DiClementi (1994), authors of the transtheoretical stages of change model have shown that one of the crucial predictors of failure in recovery is the identification of the self with the addictive process. One who accepts the identity of "addict" is far more likely to fail in treatment than someone who identifies himself or herself as a "recovering addict." The difference is crucial. Here, the life of the substance abuser is given new and destructive meaning when it is reframed or contextualized in terms of our cultural definition of an addict.

The cultural definition of the word "addict" would make him a criminal and a degenerate. For many people, their belief about the nature of their problem is crucial in the determining the course of their treatment. People who believe that they are addicts often respond less well to treatment than people who do not (Peele 1996).

Prochaska, et al. has also shown that the largest number of negative outcomes in addictions treatment correlates with a failure to accomplish a crucial series of redefinitions. Among them is a move from a negative, past oriented, self-loathing orientation to a positive future orientation. This is the specific task involved in movement from pre-contemplative denial into readiness to change--the development of positive futurity. Their information suggests that 80 percent of all clients coming into recovery programs have not made the decisions necessary to make change a possibility. Most of the programs, however, assume that they have (Prochaska, et al. 1994).

Stanton Peele (1991), the iconoclastic addictions researcher from Rutgers University, essentially makes the same argument when he points to treatment readiness as a crucial element in recovery.

The 85% of substance abusers, who needed no external treatment, were all individuals who succeeded in a crucial piece of cognitive reframing (Peele and Brodsky 1991).

The first step of AA/NA and every other 12-step recovery program is a reframe, a change of meaning, understanding and belief. "*We admitted we were powerless over our addiction and that our lives had become unmanageable.*"

This admission of powerlessness and lack of control is a vital passage. According to the disease model doctrine, it marks the transition between delusional complacency and the possibility of change. It is a redefinition of self and of the meaning of one's actions. Unfortunately, in light of the research cited above, it may be altogether stated incorrectly.

Jungian theory suggests that addiction fills the purpose of initiation -- the transition from childhood to adult status through symbolic death and rebirth -- in an over rationalized, secularized world. Unfortunately the initiation stops short of the rebirth to selfhood or adulthood.

This leaves the addict trapped in the death phase of initiated process with no hope of rebirth. As a failed initiation, addiction dooms its victim to an eternal cycle of immature dependence and consumerism (Henderson 1984; Zoja 1989).

In the world of secular recovery, *Rational Recovery* reframes addictions by personifying them and teaching the addict to listen for and recognize the addictive voice. In their perspective the addiction is a normal expression of a well-functioning organism (Trimpey 1992).

Even when one begins to look at religious conversions of whatever variety, it becomes immediately apparent that one of the crucial elements in recovery is a transformation of meanings. Without discounting the power of religion, similar reframes appear in cases of finding one's self and changes of environment.

Wherever one turns, meaning, beliefs, and personal definitions seem to lie at the heart of change. Following, will be the brief exploration of the idea of reframing, its application to addiction and some specific examples for its application.

2.5.4.2 Reframes Defined

Neuro Linguistic Programming is a discipline, which arose in the 70s at the University of California, Santa Cruz under the influence of John Grinder, Richard Bandler, Robert Dilts and Judith Delozier. It is essentially an integrative discipline drawing successful strategies for communication and change.

Both often see change work, in terms of changes in meaning. In these perspectives a central tool is represented by the idea of reframing. A reframe is a change of the meaning of a specific stimulus event by manipulation of its context or content.

To reframe ... means to change the conceptual and/or emotional setting or viewpoint in relation to which a situation is experienced and to place it in another frame, which fits the “facts” of the same concrete situation equally well or even better and thereby changes its entire meaning (Watzlawick et al 1974 p. 95).

A) Reframes and the analysis of the addictive process

On a general, behavioural level, the goal of recovery is a set of behavioural changes whose central aim is the end of addictive behaviour. The chemical dependent needs to stop using and to regain choice when the urges arise. The alcoholic likewise is seeking to re-establish a level of control in his or her life.

Accordingly there has arisen a culture of change that is centered on the addictive process. At one end the culture is characterized by spiritual and religious practices aimed at personal transformation and spiritual growth. These include religious awakenings, 12-step programs, and other spiritual and pseudo-spiritual belief systems and paths.

On the other hand are arrayed various cognitive and behavioral interventions, which seek to deal scientifically with the problem. These include cognitive-behavioral interventions, behavioral therapy, and certain hypnotic and metaphorical interventions. In the wide range between, there is an unimaginable jumble of promises, aids, programs, and intervention strategies.

B) Crucial shifts in meaning: Reframes

In the 12 step model

The 12 steps are so often framed in terms of a religious/spiritual process. Where spirituality is lacking, understanding the steps as providing specific perceptual changes may be useful. In the spiritual context the same reframes will help the recovering addict, in his or her search for stability.

In the disease model

The 12-step program begins with the idea that there are substances, practices or ideas of which the addict has lost control. Indulgence in them, inevitably leads to a downward spiral of abuse and loss of control. This perspective gives rise to the *disease concept* of addiction.

The disease concept holds that, addiction is a progressive and fatal disease. Indulgence in the addictive substance, whether sugar, abusive behaviour, co-dependency, or drugs and alcohol, leads to the reassertion of diseased patterns of thought and physiological craving. From this perspective, absolute abstinence is the only answer.

In so far as it is only used as a means of impressing upon the individual that there is a physiological and/or psychological tendency to lose control over the abused substance, the disease model is quite useful. Some of the older materials from the Hazelden Foundation, Laundergan (1982) rightly referred to the "disease metaphor."

Operationally, the disease metaphor represents an initial awareness that 'there are places, persons, attitudes, behaviors, and substances which I cannot handle and would do well to avoid'.

It also implies that, just as life has become unmanageable through the addictive substance or behavior, so it might also be restored to sanity through the avoidance of that substance or behavior. The crucial idea here is this: *I can't handle it. I shouldn't try and I should also learn to keep my distance.* This is a simple and useful message.

So long as the emphasis remains on avoiding the substance the idea retains its utility. Unfortunately there is a tendency to emphasize the disease in such a way that it diverts from the real utility of the model. If we posit an addictive mindset that includes a manipulative tendency, there are fewer excuses that are more accessible than those of self-pity.

Among the consistent problems with the disease model of addiction is the temptation for some people to reject the concept and for others to attempt to use it in their manipulative strategies. In either case, the individual focuses upon the idea of disease as weakness.

On the one hand it is destructive to self esteem "I am diseased" on the other it creates a ready excuse-- "I can't help it, I have a disease." The concept, however, is easily restated in terms of biological leaning, which provides neither the excuse to abuse nor a diseased image.

Both alcohol and other drugs represent a change in the body's chemical environment. Once a crucial threshold of interaction is passed, the body begins to adapt to the new environment. Each return is characterized by a streamlining of the adaptation until the time comes where the change is nearly instantaneous. This is not disease. It is the body rising to protect itself and adapt to a new facet of the environment.

As such, it is evidence of the individual's capacity to adapt, change and grow (Bateson 1972; Delozier and Grinder 1987)

In this light, the addictive process becomes evidence of the capacity to change. While the change that has been learned, the addictive behavior is unhealthy in its consequences, it is living proof of the organism's own vitality and capacity to learn. Generalizing from this example, the addictions counselor and the client or offender can now derive hope for future change from the problem itself. If I can learn to be addicted, I can learn to be unaddicted, or at least to change. The successful reframe of the addictive process becomes a tool for future change.

Conclusions

Addictions may be conceived in terms of meaning structures. As meaning structures, addictions and their subcomponents are subject to redefinition. These reframe or changes in the structure of meaning are some of the crucial tasks in guiding an individual through recovery. Through the use of personal flexibility and imagination, the treatment professional can reframe the meaning of events and perceptions in such a way as to enhance the process of recovery.

2.5.4.3. HOLISTIC APPROACH

In years past, treatment centres have focused primarily on treating the psychological aspects of addiction, while neglecting to address the delicate inter-connective balance of the body, mind and spirit. Most individuals who enter into a 28-day treatment program receive education about their addiction, the traditional programs scratch the surface of the issues that underlie their addictive behavior, and are introduced to the program of AA (Alcoholics Anonymous).

After treatment, clients are encouraged to live in a supportive environment such as a half way house. However, most return to their homes and are unprepared to live life without drugs. In some cases, this traditional approach to treatment may be effective.

Usually, the success rate of traditional addiction treatment is very low.

The Holistic approach to medicine and treatment holds that human beings have a body, mind and spirit. These elements of the human being are intertwined and exist in a delicate balance that determines positive or negative physical/mental health.

The holistic method respects this balance and approaches treatment with the understanding that in order to achieve positive results this equilibrium must be restored.

A) Body

The 21st century holistic approach begins with the body. What we ingest creates the foundation for the proper functioning of our mind and body. Stimulants and toxins such as caffeine, refined sugars, processed foods, food additives, and a poor overall diet contribute immensely to an imbalance in brain chemistry. It is crucial that these foods be eliminated or significantly reduced in the diet in order to restore healthy brain functioning. Chemical dependency along with an insufficient diet can wreak havoc on an individual's delicate immune system. These complications can contribute to depression, agitation, and decreased energy stores and eventually to relapse.

Along with a proper diet, a good vitamin supplement regiment is also necessary because much of the vitamin, mineral, and amino acid stores, which are the building blocks of neurotransmitters in the brain, are depleted from drug and alcohol abuse. Also, exercise, meditation, neuro-feedback, and stress reduction techniques are essential in keeping our mind and body stable. Some excellent disciplines for achieving mind/body congruency are: yoga, tai chi, and karate.

Acupuncture is a modality that can often assist the body in the rebalancing process. This treatment allows energy to flow into the body to stimulate the production of neurotransmitters and calm some of the cravings for drugs and alcohol. Also, nurturing the body with hot baths and steams, to rid the body of toxins, good music, and gentle relaxation will help to restore peace of mind.

B) Mind

Current research has suggested that certain chemical imbalances in the brain appear to play an important role in contributing to addiction. The abuse of drugs and alcohol causes brain chemistry to deviate even further from the normal range.

With chronic abuse, a vicious cycle is formed that grows exponential over time. This causes a lack of concentration, emotional instability, feelings of depression, and a total absence of a moral and spiritual balance. It is important to change the root causes of the addictive behavior in order for treatment to be successful. Some effective new therapies that can produce changes in behaviour are EMDR, NLP, and neuro-feedback, Journey Process.

Eye Movement Desensitization and Reprocessing (EMDR) is an approach to psychotherapy that uses eye movements to stimulate the information processing in the brain. This therapy provides much faster results than traditional therapy. It is often used for treating trauma such as: sexual abuse, domestic violence, war, crime, depression, addiction, phobias, and self-esteem issues. A recent study performed by Kaiser-Permanente found that EMDR was twice as effective and in about half the amount of care than typical therapy. Overall, EMDR allows the brain to heal its own wounds at the same rate that the rest of the body is able to heal its physical ailments, making a long and tedious recovery a thing of the past.

Another interesting modality that is very effective is Neuro Linguistic Programming (N.L.P.). NLP is the study of the structure of subjective experience. It is a therapeutic tool, which can reprogram a client's belief systems and behaviors. NLP incorporates a set of models on how communication can be affected by subjective experience. It utilizes a change in language and thought processes to understand behaviors.

Neuro-feedback is a cutting-edge technique that trains the brain in order to help it improve body function regulation and overall brain health. When there is poor brain functioning, it is recognized through the EEG (Electroencephalogram). By challenging the brain, much like muscles are challenged in physical exercise to improve their strength, normal brain functionality can be restored. The benefits of neuro-feedback include healthier sleep patterns, relief from anxiety and depression, and attention and emotional management. Emotional management is very important in how an individual reacts to a particular situation (Kaiser, Othmer and Scott).

Brandon Bays founded journeywork in the early 1990's when she developed ovarian cancer. She focuses on a forgiveness process, which aids in healing at cellular level. All the hurts of the past must be removed by forgiving yourself and those you hurt in order to release the emotional pain that is carried throughout life. She also teaches ways to move from a negative and disruptive feeling by moving through the layers of different emotions until an individual reaches the source which can be unconditional love, peace and so on.

C) Spirit

One of the most important steps in addiction recovery is psychological awareness. Becoming aware of personal speech, thoughts, body language, and actions is crucial in maintaining a life free from chemical dependency. It is important to learn how to avoid the pitfalls of negative thoughts and negative people. An individual must learn that it is more important to be kind than to be right, and to develop values and integrity and finally, to learn to be good to one's self and others by trusting in a higher power.

By believing in a higher power, it is easier to submit oneself to recovery and treatment. The relationship that is developed through spirituality enriches life and gives hope and inspiration. Recovering individuals discover that a life free from drugs and alcohol is possible, and is a life well worth living. Spirituality is the foundation for the development of a positive living philosophy.

The twelve-step programs are a spiritual way of life. They are non-denominational, anonymous and non-controversial. The success of these programs is based upon "the therapeutic value of one addict helping another". Many atheist and agnostic individuals have been able to embrace the twelve steps with their own personal concept of a higher power.

The role of a higher power in their life becomes G.O.D. (Good Orderly Direction). Every addict that is serious about recovery is able to attain serenity and fullness of life by applying these steps and these principles to their daily life.

Concluding Statement

Addiction treatment has come a long way through the years and still has a long way to go. In the 21st century, it appears that the most effective approach to treating addictive disorders is the Empowerment Model using the holistic approach. There are many different holistic approaches available for the treatment for substances to treat the body, mind and soul and only a few have been mentioned in this chapter.

In this approach, individuals suffering from the disease of addiction are treated with respect, dignity, and as a whole person with a body, mind and spirit. It takes time to heal and to restore the proper functioning of these three elements, and they are fundamental to a successful recovery. It is very important to increase public awareness of addiction by changing the concept of labeling in order to decrease the stigma that surrounds it, which is preventing some of the afflicted, from accessing necessary treatment.

If our communities embraced a more holistic attitude toward recovery, perhaps there would be an improved success rate in treatment and more resources would become available to the population suffering from addiction. Knowledge of addiction is a powerful tool that will assist our planet in defending itself against this moral, physical, and spiritual decay.

CHAPTER 3

RESULTS AND DISCUSSION

3.1 INTRODUCTION

This chapter presents the results of the study by describing, discussing, and analysing data obtained in the study. The analysis comes from two sources of data, one from the professional or trained staff and the other from the individuals undergoing treatment at the same residential treatment centre.

In this study, the researcher used stratified random sampling as a method for obtaining a greater degree of representativeness. A proportionate number of respondents involved in treatment were selected from the different centres thus representing all the treatment centres in South Africa implementing three major models of treatment.

The first sample for the study was obtained from the population of therapists/social workers and trained counsellors employed currently in residential treatment centres. Approximately five subjects per centre were selected.

The second sample was obtained from the patients in the same treatment centres. These patients were selected from the final phase of their treatment program in order to effectively analyse strategies used in their recovery. Two groups of four were interviewed collectively from the selected treatment centres. Members were selected by service providers who met the requirement that they need to be in the final stage of the treatment programs and who volunteered to participate in the study. Thus this sample was a purposive sample.

The research tool used in phase one of the study was individual interview for the staff where the researcher asked questions orally and recorded the respondent's answers.

In Phase Two of the study, the researcher chose focus group interviews for the clients in treatment. The interview therefore focused on identified themes and critical questions that captured the intent of the study, the strengths, weaknesses, needs and experiences of the individuals undergoing treatment for a substance abuse problem.

The sample for the study was obtained from different rehabilitation centres throughout South Africa. The treatment centres were chosen on the basis of the different treatment models that were used. The following treatment centres were selected:

- a) Disease/Minnesota Model - Careline Crises Centre (Hillcrest, Durban),
- b) Therapeutic Community Model – Horizon Halfway House (Cape Town),
- c) Narconon Model – Narconon (Johannesburg).

3.2 DATA PRESENTATION

The rest of this chapter follows a systematic format of data presentation (2 data sources) as per the models, following an analysis and discussion against literature review. The data is presented first, as per the theme order. In the analysis and discussion, some themes are discussed using two data sources. Responses were summarized, but where possible, the respondents' language is maintained.

3.2.1 DISEASE/MINNESOTA MODEL

PHASE 1

This first phase involved interview schedules from the professional staff at the Careline Crises Centre at Hillcrest, Durban. Five staff members were interviewed as follows: Director, Manager, Social Worker, Counsellor and Life Skills Facilitator.

THEME 1: Sample Profile

The sample consisted of the following personnel:

- The Director who has 10 years experience and was qualified as a crisis worker;
- The General Manager who has 5 years experience and employed as the General Manager;
- The Social Worker who has 5 months experience at this centre and has a BA (SW) qualification;
- The Counsellor who has been employed for the last 1 year and has a BA (Psych) qualification;
- Life Skills Facilitator who has been employed for the last 9 months at the centre.

THEME 2: Model, Description and Aims

The treatment model was identified by the following points derived from the professional staff interviewed:

- Addiction is conceptualized and hence identified as a disease;
- Since it is a disease, the organ affected is the midbrain;
- The drugs hijack the normal functioning of the midbrain through the release of dopamine;
- It has also been reported that there is a genetic predisposition;
- Due to an addictive personality, the substance abuse problem is triggered by traumatic events in life;
- It is a group based treatment using the client-centred approach;
- It is a structured program of 29 sessions;
- The aims of this model assist clients in understanding where addiction comes from and aids them to move through various stages of changing behaviours and to challenge the flight or fight response.

THEME 3: Conceptualization

Addiction, according to this model, was conceptualized as follows by the professional staff:

- Addiction is a chronic disease which has a predisposition to genetic influence;
- Addiction is a visible expression of an underlying problem;
- Addiction acts as a behaviour which can respond to a variety of interventions;
- Due to stress or trauma in childhood it causes a defect in the midbrain;
- The client uses drugs to survive.

THEME 4: Success Rate, Factors Facilitating Recovery, Strengths

The following points were noted with respect to success rate, factors facilitating recovery and strengths of this model from responses from the professional staff:

There was no idea of success rate across all respondents, which according to two respondents is due to there being no research done to establish statistics.

Factors that facilitate recovery were identified as:

- The client needs to overcome denial as a first step towards recovery;
- Needs to be honest about his/her addiction;
- Client and others supporting the recovery process must be motivated and positive;
- Complete abstinence from any addictive substance;
- Strong support system;
- Strong boundaries;
- Development of leadership qualities;
- Accountability;
- Staff must develop a good rapport with clients to understand their addiction and the recovery process;

- Staff building trust with clients – taking them for outings during their treatment;
- After treatment, clients need to stay in a conducive environment and implement their life/coping skills, attend support groups;
- Cognitive and behavioural interventions;
- Long-term rehabilitation or halfway houses before being integrated into society.

The advantages and strengths of this model were identified as follows:

- Understanding, on the part of the client, the disease concept of addiction;
- Allowing the client to realize that like any other disease their addiction/behaviour needs to be managed and they take responsibility for this;
- Program is not confrontational;
- Client can enter the treatment program at any point in the cycle;
- The program works in such a way as to reduce resistance to treatment and enhance motivation;
- Clients know what boundaries are in place and are being taught to have good leadership qualities;

THEME 5: Failure, Disadvantages and Factors Preventing Recovery

The following points were noted from the professional staff with respect to failure, disadvantages of this model and factors preventing recovery:

- It gives the client an excuse to use drugs by labelling it as a disease because a level of complacency may develop and a sense of hopelessness prevails: “no cure for the disease”;
- Confrontation between family and clients can be a disadvantage because they need to be stronger to encounter realities of life;
- Many want a quick fix solution but clients need to understand that recovery is a long-term process.

- Because their belief systems overpower them, some clients are not willing to change and relapse becomes common;
- Association with high risk situations like familiar places, people and things too soon in recovery;
- Stressful situations causes them to relapse as an excuse when things go wrong;
- Minimal or no support structures;
- No short-term or long-term goals planned;
- False belief systems and attitude;
- Have not experienced the hardships of the streets – was not allowed to suffer the consequences for his/her actions due to enabling by the family;
- Clients have been forced to go for treatment by family members or employers;
- Not wanting to deal with issues and do not want to let go of the past;
- Not being honest with oneself and blaming everybody else.

THEME 6: Aftercare

The following responses by the professional staff were indicated with respect to aftercare:

- It is a support system that allows members to discuss their concerns with each other with no judgement and complete acceptance and understanding;
- Aftercare has become a vital part of recovery because clients feel part of a family in which they listen to each other's recovering stories and derive strength from people who have been through similar circumstances;
- Regular drug testing;
- Clients can telephone for support once they have left the centre.

THEME 7: Linguistics

Respondents suggested that the following linguistic associations be incorporated into their program, with reference to each of the words/phrases listed below:

- **Disease:** Inevitable, manage the problem over lifetime, reduces client guilt, genetic predisposition to drugs and problems in the midbrain;
- **Incurable:** sustainable with/without medication, must be qualified with the knowledge that it can be controlled, it is a brain disease and life can be prolonged by stopping substance abuse, fight and avoid relapse;
- **Once an addict, always an addict:** choice, awareness that an individual will always be at risk in high-risk situations, it is not a helpful language but always true, unless if you have not been given the tools to recover and stay clean, although been labelled with the statement you can cope and manage;
- **Lifelong-recovery:** defect to the midbrain is permanent so recovery is lifelong, client is always a potential addict, maintenance during recovery, support and management along with a level of accountability is required for the individual, not realistic – fosters overconfidence and complacency;
- **Relapse is acceptable:** not an option, can be acceptable if only to learn from it to continue the fight, relapse is part of recovery patients – need to relapse to see the severity and difficulty of staying clean, clients are told that they can try again;
- **Powerlessness:** it's the first step in acknowledging the problem of your addiction, not acceptable without God in the recovery process, it is a lot more difficult to find true strength, the feeling of hopelessness is misunderstood and the client becomes desperate.

THEME 8: Holistic Model

The professional staff suggested that the following features characterize a holistic outlook:

- A model that incorporates treatment with equal emphasis on body, mind and soul;
- Professional counselling using a holistic approach by a psychologist who understands addiction and group therapy;
- Family should also understand addiction means treating body, mind and soul;
- Long-term rehabilitation, approximately two years coupled with life skills program, exercise and healthy eating.

THEME 9: Spirituality

Implementation of spiritual concepts in this model yielded the following responses from professional staff:

- AA/NA 12 step work which addresses spiritual aspects of the individual;
- Church attendance and prayer;
- Pastor/church minister visits weekly;
- Submission to a Higher Power;
- Facilitates inner healing and fills the void in the soul.

THEME 10: Motivation

According to the professional staff interviewed, their view of intrinsic and extrinsic motivation in aiding recovery was as follows:

- Intrinsic motivation has to be primary and extrinsic, secondary in aiding recovery;
- The respondent emphasizes the importance of motivation in aiding recovery;
- The importance of the involvement of professional staff in order to motivate the client so that they continue with aftercare.

THEME 11: Alternative Therapies

The professional staffs was asked if any alternative therapies were used to supplement/complement their treatment program and the following were their responses:

- Encouraging more outdoor activities such as swimming, camping, braais and hiking;
- Showing of videos and DVDs for education and relaxation;
- Implementing group and individual courses dealing with contributing factors for substance abuse, e. g. trauma debriefing, anger management;
- Games and exercises with an interactive component to encourage team building;
- Exposure to substances during treatment to desensitise oneself from cravings;

- Family systems approach;
- When working on a holistic level combining different treatment models is necessary from a medical approach to a family systems approach and to a person-centred approach.

THEME 12: Administrative Staff

Professional respondents mentioned the following supports that management and professional staff improve, empower and create easier facilitation in order to ensure adequate treatment to the smooth running of the centre:

- Teamwork and in-service training;
- Supervision for staff;
- Case studies/discussions;
- Assessing and identifying problems/issues between professional staff and management;
- Management should identify problems and implement solutions – quick response time;
- Adequate staff complements require a comprehensive multidisciplinary team.

THEME 13: Recommendations

The following recommendations for professional staff to be included in their program mentioned alternative therapies were as follows:

- Incorporating sauna and vitamin therapy to improve detoxification;
- More physical activities in the form of exercise, gym, jogging and swimming;
- More facilities to create new mind sets, e.g. occupational therapy.

PHASE 2

In this phase of the study, the researcher chose focus group interviews for the clients in treatment. The interview focussed on identified themes and critical questions that captured the intent of the study: the strengths, weaknesses, needs and experiences of the individual undergoing treatment for a substance abuse problem. Two groups were interviewed, Group A and Group B with four clients per group.

Theme 1: Current Treatment Program/Model

The following treatment program table depicts responses in relation to the beneficial aspects of treatment at the centre.

Table 1. Beneficial Aspects

Group A	Group B
Respected as individual with dignity	Accepted with Trust and Honesty
Continuous support base after treatment	You Came Here Wanting to Change – You Can Leave When You Like
Trusted with Responsibilities	Learning to be honest with yourself and God
Honesty and Sincerity	Learning the Twelve Step Recovery Program - then go to advanced life skills where we can learn independently
Spiritual Guidance	Spiritual Guidance to find a sense of purpose
Physical Exercise to keep fit	Not Treated like Drug Addict – bad actions but not bad people
Trusted with weekend outings which builds our integrity	Learn Communication and Relationship Skills
Medical Treatment/Assistance whenever needed	

Those that are staying in treatment for a year or two are assisted in finding jobs	
Emotional support from counsellors	

Weaknesses were discussed in less depth and are tabulated below.

Table 2. Weaknesses of Program

Group A	Group B
None	Being Forced to do things Against Your Will
	No psychiatrist on the property

Theme 2: Responses to the Terminology

The response from the client sample to the words/terms/labels used in the above mentioned model is as follows:

Table 3. Responses to the Terminology

<u>Group A:</u>	<u>Group B:</u>
<u>Addict:</u> We are recovering addicts – understandable	Recovering addicts – accept it
<u>Recovery for Life:</u> Acceptable no cure but manageable.	Know it's a lifelong road; we know it's a disease.
<u>Chronic Illness:</u> Yes, it is a primary disease – progressive.	Can only get better not worse.
<u>Disease:</u> Yes, life goes on.	Yes, it is a disease.
<u>Incurable:</u> Manageable when symptoms are arrested.	Not true – manageable.

<u>Relapse:</u> Now we know that it is not an option because we have too much to loose and nothing to gain by using drugs.	Fearful – depends on choices.
<u>Powerlessness:</u> Powerless of the drug – yes but not powerless to manage.	We are not powerless.
<u>Addiction:</u> Behavioural patterns that need to be understood and managed in 3 areas: spiritual, psychological and mental.	Disease – compulsive addictive behaviour.

Theme 3: Recommendations

Table 4 below tabulates responses from client samples concerning recommendations for future improvements of the current treatment model.

Table 4. Recommendations

Group A	Group B
Obstacle Courses as extracurricular activities	None
Art and Crafts - Occupational Therapy	Program is adequate for those serious about it

3.2.2 THERAPEUTIC COMMUNITY MODEL (T.C.)

PHASE 1

The analysis of the T.C. Model is presented hereunder-using interview schedules on staff at Horizon Halfway House, Cape Town. The five full time staff complement was not available for the individual interviews, except one.

This was unfortunate given the painstaking attempts to secure appointments, and may be indicative of work pressure, responding to crises and/or reluctance to be researched because of reasons unknown.

THEME 1: Sample Profile

The sample consisted of the following personnel:

Four of the staff members were not available for interview, only one namely Assistant Counsellor, The paraprofessional who facilitated at the centre had been working at Horizon for approximately one year, and his age was 34 years.

THEME 2: Model, Description and Aims

The treatment model was described as follows:

The model used is the Therapeutic Community Model, which is described as the clients concentrating on their own behaviour using work as education, therapy, and mutual self-help programs that inculcate morals and values. Peers, including staff act as role models.

THEME 3: Conceptualization

Addiction was conceptualized as follows:

In the Therapeutic Community Model addiction is a symptom, not the essence of the disorder, thus the problem is the person not the drug. The purpose of the peer community is to facilitate social and psychological change in that individual, in other words to break down the behaviour that comes with addiction. The sources of the addiction are psychosocial in nature.

THEME 4: Success Rate, Factors facilitating recovery, Strengths

The following points were noted with respect to success rate, factors facilitating recovery and strengths of this model:

According to the respondent, success rate was very low and the factors to facilitate recovery are for the client to believe in himself, come in for treatment voluntarily, balanced diet and exercise. The strength of this model was identified as using resources such as spirituality, family, vocational survival skills, positive peer pressure, role modelling, emotional and psychological intervention.

THEME 5: Failure, Disadvantages and Factors Preventing Recovery

The respondent with respect to failure, disadvantages of this model and factors preventing recovery identified the following points:

There is a gap in the chain in command during an emergency. Clients find it difficult to use tools such as acceptance and communication during recovery.

THEME 6: Aftercare

The following was indicated with respect to aftercare:

Aftercare in the form of attending AA/NA meetings is crucial in sustaining recovery. Talk therapy is important because it relieves stress.

THEME 7: Linguistics

Responses showed regarding the incorporation of the following language in this program:

- **Disease:** Should call it DIS-EASE – should not use the label disease;
- **Incurable:** Not curable and incurable, disease can be arrested;
- **Once an addict, always an addict:** this phrase is a psychological setback for the clients;
- **Lifelong-recovery:** client is in recovery for the rest of his/her life;

- **Relapse is acceptable:** it is not acceptable especially if you use the tools and coping skills;
- **Powerlessness:** when you are an active user you are powerless but not in recovery.

THEME 8: Holistic Model

The respondent stated that a holistic approach is characterized by working with the body, mind and soul.

THEME 9: Spirituality

The respondent emphasized that spirituality is important by having a purpose in life in order to fill the void.

THEME 10: Motivation

The respondent viewed motivation in aiding recovery in the form of intrinsic factors when individuals allow change to come from within and extrinsic factors when clients help others in recovery by becoming good role models.

THEME 11: Alternative Therapies

The alternative therapies to supplement or complement treatment suggested by the respondent were massages to help with the pain and sauna to help detoxify. He also stressed that it is important to combine different treatment models.

THEME 12: Administrative Staff

The respondent stated that the following supports needed from management in order to ensure adequate treatment were communication and debriefing between management and staff as well as effective in-training service.

THEME 13: Recommendations

The recommendations reported by the respondent were as follows:

- Regular exercise program;
- Language and interpersonal skills;
- Improved dietary requirements;
- Treatment would be easier if parents and community were not in denial.

PHASE 2

Two groups of clients were interviewed, Group A and Group B with three clients per group. Only six clients were resident at the time of interviewing at Horizon Centre.

Theme 1: Current Treatment Program/Model

The following treatment program table depicts responses in relation to understanding the benefits of the T.C. Model.

Table 5. Beneficial Aspects

Group A:	Group B:
The foundation of the program depends on the pillar and structure of the system	Helps emotionally
Allows you to be psychologically stable and to deal with your emotions	Helps to open up and let go of things with the help of others
Family concept, behaviour shaping, psychological and emotional treatment, spirituality	Become more spiritually inclined
Group Therapy as a form of therapeutic session	Tools to prepare me for the outside world

	Behaviour Shaping – emotional/psychological
	Peer pressure
	Therapeutic Sessions
	Religious Sessions
	Role Modelling
	Vocational Concept
	Family Concept

The group did not identify weaknesses.

Theme 2: Responses to the Terminology

The response from the client sample to the words/terms/labels used in the T.C. Model is as follows:

Table 6: Responses to the Terminology

Group A:	Group B:
<u>Addict:</u> <ul style="list-style-type: none"> Somewhat degrading, but ultimately is brought on myself. Don't really feel anything – come to terms that I am an addict. 	<ul style="list-style-type: none"> Someone who suffers from compulsive and excessive impulsive behaviour. Makes you realize that you are not prone. Labelled or lesser than normal people.
<u>Recovery for Life:</u> <ul style="list-style-type: none"> Absolutely true. Inspiration to go on and to do what I have to do. 	<ul style="list-style-type: none"> Accept that recovery is a lifelong process. Take each day at a time.
<u>Chronic Illness:</u> Feel bad/labelled when addressed.	Seriously suffering and feeling bad

<p><u>Disease:</u></p> <p>Ok – but treatable or curable.</p>	<ul style="list-style-type: none"> • An illness that brings about death, jail, mental institutions • Incurable but can be tamed • Can be arrested.
<p><u>Incurable:</u></p> <p>Person who said this has a problem.</p>	<p>Something that I have to live with for the rest of my life.</p>
<p><u>Relapse:</u></p> <ul style="list-style-type: none"> • It happens, its common, doesn't mean the end of the world, recovery just gets harder. • Hate the world. • Doesn't have to happen and there be no excuse for relapse. 	<p>When us addicts fall or when we are unable to work through a problem causes us to return to usage.</p>
<p><u>Powerlessness:</u></p> <ul style="list-style-type: none"> • Can go either way, but it will not allow it subconsciously. • Makes me feel more powerful to fight my addiction. • An object doesn't have power over me and it doesn't control my life anymore. 	<ul style="list-style-type: none"> • Cannot live with drugs because it is going to kill me in the end. • When I was an active user, but not in recovery because I am getting stronger.
<p><u>Addiction:</u></p> <ul style="list-style-type: none"> • Everyone has addictive qualities. • It is the lifestyle not the drug. 	<p>We develop a passion in our addiction and become more and more compulsive in our behaviour.</p>

Theme 3: Recommendations

Table 7 below tabulates responses from client samples concerning recommendations for improvements to the T.C. Model.

Table 7:Recommendations

Group A	Group B
More interaction with other rehabs and recovering addicts to understand addiction more clearly	Allow to study, learn skills, prepare for work industry
Occupational Therapy	Get a skill or a diploma or course during our stay
Exercise	Better Food/Diet
	Regular Exercise
	Occupational Therapy – language and interpersonal skills

3.2.3 NARCONON MODEL

PHASE 1

The analysis of data on the Narconon model is presented hereunder, using the interview schedules on staff at Narconon Rehabilitation, Johannesburg. Five staff members were interviewed made up of the following: Executive Director, Senior Director for Production, Coursework Supervisor, Purification Supervisor, and Personal and Communication Supervisor. Within the Narconon context of treatment the client is referred to as “student”.

THEME 1: Sample Profile

The sample comprised of the following personnel and their qualifications are derived from the training they received from the Narconon Centres:

- The Executive Director who has 13 years experience, aged 40 years with qualifications in Advanced Diploma in Eastern Medicine and Honours in Physiological Assessment;
- “Personal & Communications Systems and Successful Narconon” personnel who has 4 years of experience, aged 29, dealing with Engineering/Training withdrawals;
- The Senior Director for Production has 3 years experience at this centre and has a BA (LLB), aged 29 years. Deals with Withdrawals/Detox/Case Supervisor Arrowhead Narconon;
- Case Work Supervisor qualified as Case Work Supervisor aged 25 years and has 8 months to 1 year experience in Criminon;
- Purification Supervisor aged 56 years with two and half years experience and trained in dealing with withdrawals and detoxification.

THEME 2: Model, Descriptions and Aims

This treatment model was described in terms of the following:

Narconon model is divided into three phases, namely 1: Drug Free Withdrawals, 2: Detoxification – Purification Process and 3: Therapeutic Routine – Life Skills Training. It aims is to put the student back into society as a normal person to assist the student to become drug free persons who are valuable and contributing members of society.

THEME 3: Conceptualization

Addiction was defined as follows according to the respondents:

- Addiction is not a disease;

- Can be cured;
- Person is not an addict for the rest of his life;
- It is based on lack of life skills, confrontation and communication.

THEME 4: Success Rate, Factors facilitating recovery, Strengths

The following points were noted with respect to success rate, factors facilitating recovery and strengths of the Narconon Model by the professional respondents:

Success rate is around 70% if stay is completed.

Factors facilitating recovery were:

- To help them find out about issues that might cause them to use drugs and how to deal with them;
- The ability to confront and communicate;
- To have the determination, honesty and sincerity;
- To have a sense of purpose;
- Must be willing to come voluntarily for the treatment;
- Family support is important.

The strengths of the model were:

- To give the student the necessary skills to lead a productive life in society;
- To free the body from toxins so that they can think clearly;
- To treat withdrawals drug free;
- To be open to confrontation and not live in the past;
- To enhance communication skills;
- To deal with the reality of life and not get stuck in one's thinking;
- To be a successful and productive individual in the community;
- To learn improvement courses and encourage the use of a dictionary to understand the meaning of words;
- To learn about oneself;

- To change in order not to become lifeless in the program;
- To help businessmen who come for treatment to learn skills to be more successful;
- To look at physiological and physical aspects of addiction.

THEME 5: Failure, Disadvantages and Factors Preventing Recovery

The professional respondents with respect to failure, disadvantages of this model and factors preventing recovery noted the following points:

The disadvantages of this model were:

- Those using psychotropic drugs in psychiatry cannot be helped;
- People who have been to other rehabilitations and stuck into the disease model find it difficult to change their mindsets;
- If the individual is not willing to come for treatment voluntarily or comes for the wrong reasons it will not work;
- Since the program is four and half months long, some do not complete the full course;
- The fees are expensive.

Factors preventing recovery were:

- Socializing with the same company;
- Living in the environment which is people suppressive;
- Not accepting his problem – still in denial;
- Unable to confront;
- People around him are against the Narconon program;
- Individuals should not take on something that is too much for them;
- Change for the wrong reasons;
- Be more aware of the environment;
- Visitors are not controlled during treatment.

THEME 6: Aftercare

The following responses by the staff were indicated with respect to aftercare:

- The students who do the full program do not need the aftercare;
- Need to improve communication between the student and the family;
- Empowered to cope with life;
- If there is any problem need to review the cause and refresh;
- Ex - students can come visit and refresh when they feel.

THEME 7: Linguistics

Responses showed the incorporation of the following language in this program:

Disease:

- Do not consider it as a disease;
- Do not support this label because there are no physical impediments;
- It's a jail of the mind and this label is hurting – rather tell people we got a problem.

Incurable:

- Definitely not, if the right process for recovery is followed;
- You will get a good result, if the student is determined he can stop using substances;
- Using the word incurable is criminal.

Once an addict, always an addict:

- It does not exist, there is no ground to support this statement;
- Using this statement is like a rumour – no one has been born an addict.

Lifelong recovery:

- Keeps you dependent on a support structure which is not helping the recovery;

- Each one of us has our own task to complete;
- If you have the life skills there is no need to be in lifelong recovery.

Relapse is acceptable:

- If a person relapses, then he is afraid to confront his problem;
- Do not support the statement because it means you did not use the life skills;
- When you relapse you delay yourself.

Powerlessness:

- It does not exist – we have full control;
- Each one of has the strength to achieve its ability.

THEME 8: Holistic Model

The staff described a holistic approach as follows:

- It's a drug free treatment – no substitute involved;
- It is inclusive of giving the person the necessary eight life dynamics, i.e. treating the mind, body and soul;
- Treats the person physically to detox the body then mentally to empower the person with communication, training routine and learning improvement courses.

THEME 9: Spirituality

The staff described the role of spiritual concepts in treatment as follows:

- It is an orthodox point of view;
- Spiritual component is of vital importance and it gives you a sense of purpose/direction;
- Spirituality is within the person, the person believes in his or her own religion.

THEME 10: Motivation

The staff's view on intrinsic and extrinsic motivation in aiding recovery was described as follows:

Intrinsic:

- Willingness to change and get a new life;
- Having the right tools when given the choice;
- To motivate someone – be honest and open.

Extrinsic:

- Strong family support.

THEME 11: Alternative Therapies

The alternative therapies to supplement/complement treatment were identified as follows:

In this program different alternatives are already incorporated. Assist therapy is an alternative used when a person is going through withdrawals to assist the pain and relax the body; a purification process is used to detoxify the body.

There is space for combining different models since each rehabilitation has its own method and the treatment centres need to use what is working for them. Some felt that combining different models is going to be difficult and might be costly. They suggested that the different treatment modalities might be combined as long as no medication is prescribed.

THEME 12: Administrative Staff

The staff recommended in-service training to be incorporated as a refresher course from the management to ensure adequate treatment in the rehabilitation centre.

THEME 13: Recommendations

The following were recommended by the staff for alternative therapies to be incorporated into their program:

- Physical activities such as walks and exercise need to be incorporated;
- People need to understand that we are losing the battle of drug abuse and one needs to put ones differences aside between professionals and religious leaders and concentrate on what is best for the community;
- In the treatment of substance abuse we must stop the labelling “once an addict, always an addict” since it is discouraging the person;
- Community should get more involved in treatment centres because drugs are destroying our society;
- The way of raising a child to become responsible in order to be more confident so that they can refuse drugs.

PHASE 2

In this phase of the study, the researcher used focus group interviews with clients in treatment. Two groups of clients were interviewed, Group A and Group B with four clients per group.

Theme 1: Current Treatment Program/Model

The following treatment program tables depict responses in describing the benefits of the Narconon Model.

Table 8: Beneficial Aspects

Group A	Group B
Natural Detox with vitamins (no medication), then spending +/- 5hrs a day in a sauna, for up to +/- 30 days.	The Sauna, it helps release all the old toxins out of your system.
Training routines on “confronting”, “control” and “communication” and handling and objectives exercises.	This program also helps us to figure out our own problems and it helps us to find out our own solutions to our problems.
	This program brings us into present time and it helps us by being able to communicate easier and it teaches us to control.
	The program never defines who you are nor tells you who you must be – it only helps you do that for yourself and demonstrates the benefits of making good choices.
	They don’t use us to get us off drugs; it’s the vitamins that benefit us greatly.

No weaknesses were identified.

Theme 2: Responses to the Terminology

The response from the student sample to the words/terms/labels used in the above-mentioned model is as follows:

Table 9: Responses to the Terminology

Group A:	Group B:
<u>Addict:</u> No problem when used constructively.	Addict means you are still using, so wed rather say you are a recovering addict.

<u>Recovery for Life:</u> Yes – you always need to be aware.	No problem.
<u>Chronic Illness:</u> No – self-induced.	Don't agree with it.
<u>Disease:</u> No – it can be treated without medication.	Disease of addiction rather.
<u>Incurable:</u> No – it can be cured.	No it's curable.
<u>Relapse:</u> Yes – can occur at any time.	No problem.
<u>Powerlessness:</u> Not good phrase, anything you put your mind to gives you the power.	In active addiction we are powerless, but in recovery we do have the power.
<u>Addiction:</u> Yes – many people have different not just drugs.	No problem.

Theme 3: Recommendations

Table 10 below tabulates responses from client samples concerning recommendations for improvements of the current treatment model for the future.

Table 10:Recommendations

Group A	Group B
We would add a compulsory physical activity, or exercise	Compulsory physical exercise, e.g. sports and gym.
A more scientifically worked out nutritional eating program	More interaction with outside world, e.g. outings to help prepare when you leave.
Group Sessions	

3.3 DISCUSSION

Results reported are hereafter discussed separately as per the models, namely the Minnesota Model, the Therapeutic Community Model and the Narconon Model in the light of the literature review contained in chapter two of this report. Both data sources were together analysed where available in order to present a comprehensive picture.

3.3.1 DISEASE/MINNESOTA MODEL

THEME 1: SAMPLE PROFILE

Professional staff comprised of the Director and the General Manager who had substantial experience working at the centre while the professional staff had relatively lesser experience. Generally at centres following the Minnesota Model, it was found that there is a full complement of professional staff, namely clinical/counselling psychologists, psychiatrists, nurses, occupational therapists.

This is due to the fact that a single approach or discipline is not adequate or appropriate; rather a multidisciplinary team composed of counsellors, physicians, nurses, psychologists, and religious teachers is required (Sheehan, Owen 1998). At the centre researched, it was found that a full complement of professional staff was not incorporated in this centre due to financial constraints. It was also noted in the focus group that this is mentioned as a disadvantage where there was no psychiatrist on the property. Similarly under recommendations, it was indicated that occupational therapy be offered.

THEME 2: Model, Discussion and Aims

Professional respondents said that the mid-brain is the organ affected by chemical dependency and one respondent alluded to this by reference to a genetic predisposition to substance abuse. Another respondent spoke of the model and its description more in terms of the nature of the counselling, namely group and client-centred therapy – this is erroneous as the model is identified by the conceptualization of addiction as a chronic disease rather than by the treatment modalities used such as psychotherapy.

Common across three of the five professional respondents was that stress such as traumatic events triggers addiction while two spoke of chemical dependency as a flight-fight response to stress. This is so because addiction and its consequences constitute a flight away from the pain of stressful situations due to the pleasure enhancing nature of becoming and being “high”.

Alternatively, an addict could be said to be fighting stress in the sense of coping with and going through – fighting with – the stressful situations but at the expense of chemical addiction which is required to experience the pleasures of addiction (being “high”). The latter offsets the discomforts of stress in the same way that the pleasure of playing music while spending sleepless nights working on the data analysis may enable the task to be accomplished with relative ease.

While originally the chemical use was due to a flight or fight response, once used, the substance demands usage again for dependency reasons as Beck, Wright, Newman, & Liese (1993) point out. Physiologically an individual may continue unwittingly in an attempt to avoid withdrawal symptoms and to quell cravings.

THEME 3: Conceptualization

Responses were generally consistent with conceptualization of addiction as a disease. Also responses were consistent with previous themes due to reference to mid-brain damage and genetic predisposition.

Lewis (1994) compared alcoholism to other diseases such as hypertension and coronary disease, which are not solely biological in nature, being closely linked to an environment of risk and factors in terms of onset and progression. Like alcoholism, both of these medical conditions are affected by personality and lifestyle and also have genetic contributions in terms of aetiology.

The disease model conceptualizes addiction as bio-psychosocial in nature and it has a greater potential for explaining and understanding disease entities. Respondents in this study also identified addiction as bio-psychosocial in nature.

Pioneers of the disease model (Jellinek, 1946; Silkworth, 1939) provided a theory based on traditional biological concepts of disease. It is described as an illness characterized by a very atypical physiological reaction that triggers in mental obsession.

THEME 4: Success Rate, Factors facilitating recovery, Strengths

Overall it comes across that there is a need for research to establish the success rate of the disease model. The client needs to get out and stay out of denial, which requires the client to understand addiction and be well motivated to complete recovery. Staffs at the treatment centre as well as family and other members of the client's environment need to be available when he/she gets back to that environment. Knowing that one is addicted and being motivated to be in recovery would require that there should be complete abstinence from any addictive substance within a strong social support system.

An overall healthy lifestyle based on good leadership and total accountability from the client with long-term rehabilitation in an environment where coping skills learnt during life skills training at the centre are implemented. The environment should not be high-risk. Staying in recovery requires constant cognitive interventions learnt from positive cognitive styles taught at the treatment centre during life skills training.

The strength of the disease model is that it does justice to the mysterious nature of addiction by likening it to the mysteries of chronic medical disease. While it may seem that the disease conceptualization is not empowering in that it renders the addict a powerless victim before the disease, the disease model is ironically empowering in that it enables addiction to share in the insight of chronic medical disease albeit a self-defeating and limiting insight – better to know that I cannot do something than not to know at all.

The disease model helps the client understand that like other diseases, addictive behaviour and beliefs need to be managed and that he/she should take full responsibility for this by becoming accountable for all actions.

The focus group clients spoke about being respected as individuals with free will, learning to be honest with yourself and God, trusted with responsibilities and taught communication and relationship skills. They also spoke of being treated with dignity and came to realize that they were not bad people but only their actions were bad.

In the literature review, a major strength of the program is the 12-step facilitation, which implements a holistic approach to recovery. It was also noted in the focus groups that the 12-step recovery program was very beneficial.

The focus groups spoke about the continuous support base after treatment in which the disease model provides a free system of lifelong support through referral to the AA/NA groups.

THEME 5: Failure, Disadvantages and Factors Preventing Recovery

Regarding labelling addiction as a disease, the disease model carries the risk that it may lead to the view that nothing can be done about addiction and provides an excuse for continuing use of drugs. It was said that clients need to understand that addiction needs to be managed over the long-term as there is no quick fix solution. Poor or no support structures, bad goal planning, false belief systems and dishonesty to one by not wanting to deal with issues were all factors identified in preventing recovery.

It was suggested that clients should rather be in recovery forever than to be destroyed by the ravages of addiction for it is better to have a hallowed recovery than a harrowing addiction. If one does live with addiction rather than being in recovery, it is a life of emotional, psychological, social and spiritual death which is far worse than physical death.

While addiction is repeated substance abuse, it should be noted that it is *an increasing* repeated usage over life due to the phenomenon of *tolerance*. Tolerance of a drug is reached when a certain dosage does not bring about the desired result but begs the dosage to be increased for the same desired result to be achieved. According to the literature review, there are potential problems in implementing the disease model. If adhered to too strictly, treatment for the disease model becomes distorted and presented in a confrontive, religious manner (Sheehan, Owen 1998), as it was evident from the clients interviewed in the focus groups.

THEME 6: Aftercare

Once having left a rehabilitation centre, it is aftercare that makes recovery successful. The rehabilitation centre provides a place of acceptance and understanding which makes the possibility of remaining in touch with it and being able to return to, feasible for future well being.

In being faced with imminent relapse, the addict has the choice of contacting the staff at the rehabilitation centre to overcome emotional conflict with the possibility of being able to return to it for a brief period – this constitutes aftercare. Respondents said that in offering acceptance and understanding with guidance in making crucial addiction choices, the centre also offers a sense of belongingness – belonging to a loving and concerned society of people as opposed to belonging to the drug of choice and to a society that is preoccupied with labelling, stigmatization and concerns that have nothing to do with humanitarianism. Aftercare entails regular drug testing.

Continuing care involving ongoing care planning includes services necessary to facilitate adjustment to sober living after treatment. This is followed by less intensive intervention involving referral to Alcoholics/Narcotics Anonymous, individual counselling, and in some cases to place next in a halfway house. Crucial to aftercare is the AA/NA support groups.

According to the literature review, aftercare assists the quality of recovery by helping to prevent future relapse (Project MATCH Research Group 1997) with respondents too indicating that a proper support structure after treatment is crucial in maintaining recovery.

THEME 7: Linguistics

The response of staff members to the “trigger words” showed that addiction is a relapsing chronic disease due to a genetic predisposition to addiction that manifests as problems in the midbrain of the addict.

Defect to the midbrain is permanent, so recovery is life long and addiction is incurable. However, controlling and avoiding relapse and stopping substance abuse can prolong life. Unless you have been given the tools to recover and stay clean, addiction and relapse will thrive. The client is always a potential addict.

The disease model is not realistic and fosters overconfidence as well as complacency – “there is no cure”. Thus relapse is acceptable if only to learn from it to continue the fight. Relapse is part of recovery – clients need to relapse to see the severity and difficulty of staying clean; clients are told that they can try again. Addicts feel powerless in the face of the power of addiction, which equals the power of God. Therefore they need God in the recovery process – without God in the recovery process, it is much more difficult to find true strength (Kasiram, 2005).

According to the focus groups, all the clients agreed that they are recovering addicts and they accepted it, since it is a disease defined as a chronic relapsing illness, which is incurable, and they are powerless over their addiction. They also understood that the road to recovery is a lifelong road but manageable. According to the literature review (Engels 1977), the disease is neither the end result nor the symptom of another disorder but a primary, progressive, chronic illness as was evident from responses from both the clients and staff.

An important component of the disease model is that a patient is never fully cured; as a result of how alcohol or other drugs are processed, the individual may never safely use again. This can be understood as the maintenance phase in “stages of change” theory (Prochaska, DiClementi, & Norcross 1992), during which time the individual actively practices certain behaviours to decrease the likelihood of relapse into active addiction.

THEME 8: Holistic Model

Both staff and clients spoke about healthy diet and physical fitness through exercise being important in a holistic program. The holistic model looks not only at the addiction, which needs to be managed or cured, but also at various aspects of an overall healthy lifestyle, which works hand in hand to generate health in the course of living so that addictive behaviour, which is unhealthy, becomes incongruous with the rest of a healthy lifestyle.

In not choosing addiction, i.e. in choosing recovery, the recovering addict is making a healthy choice as in opting to eat whole wheat bread instead of refined white bread. Such healthy choices need to be made in conjunction with each other, synchronously. It does not make sense to choose recovery while other lifestyle choices are unhealthy as choices feed into each other. This is what a holistic outlook entails.

THEME 9: Spirituality

Both staffs’ and clients’ responses made reference to spirituality which came across as playing a strong role in recovery and in overcoming addiction. Given the nature and power of addiction, any addict, who is intimate with the nature and power of addiction would not hesitate that there is something dark, negative, devilish and evil about addiction. Such qualities render addiction into something, which cannot subsist with spirituality. The idea is to choose Spirituality to be incompatible with choices and decisions that lead to addiction or remaining an addict.

One path to spirituality is organized religion such as Christianity, Islam or Hinduism that involves church attendance and prayer as well as belief in and submission to a Higher

Power, which is also one of the twelve steps in Narcotics Anonymous (NA). Of great importance is that Spirituality facilitates inner healing, which is something prior to, and necessary for external healing. It is possible to follow a spiritual path without following an organized religion –philosophical and spiritual growth can be conflated.

THEME 10: Motivation

According to staff and clients both intrinsic and extrinsic motivation are needed, i.e. motivated both from the inside and the outside – the former self-driven, the latter other driven where the other is non-me, i.e. other people or other things in the outside or external world. Things are not done arbitrarily but due to motivation that is done for some reason or the other. The more motivated you are, the more basis you have for doing something.

An important aspect of the Minnesota Model is teaching the individual to recognize the physiological changes in the individual, behavioural conditioning and the attitude and behaviour of family and friends as the internal and external factors as well as to make personal and lifestyle changes to address them. These learning's are expected to serve as motivators in the journey to recovery.

THEME 11: Alternative Therapies

Respondents indicated that therapy at rehabilitation centres comprises indoor lectures imparting knowledge as well as group and individual psychotherapy. Massages for pain and sauna for detoxification can be regarded as indoor alternative therapies. Alternative indoor therapies include games, videos, DVD and courses. However, alternative outdoor activities such as camping, walking and swimming are also important. This accordance of importance to alternative indoor and outdoor activities was consistent across staff and client responses.

THEME 12: Administrative Staff

Staff responses indicated the importance of supports such as management support, in-service training for thorough treatment of the substance abuser. Staff at drug

rehabilitation centres comprises professionals, such as therapists and counsellors as well as administrative staff. In-service training, supervision of staff, adequate staff compliments as well as committed and dedicated staff is important for any model.

THEME 13: Recommendations

Improvements on the physical aspects such as sauna & vitamin therapy, exercises and other activities were mentioned. According to the focus groups, group A recommended more creative activities although group B felt that the program was quite adequate for those that are serious about recovery.

This indicates that while there was room for improvement in terms of physical and creative activities, there was sufficient content in the treatment program for it to be beneficial.

3.3.2 THERAPEUTIC COMMUNITY MODEL (T.C.)

The Therapeutic Community Model is a type of drug rehabilitation centre using behavioural modification, which was developed to work on an anti-social personality disorder. This method relies on boot camp style tactics where the individual is belittled by groups of peers, the goal being to rebuild the addict into a more social person.

THEME 1: Sample Profile

Only one staff member who was a previous patient of the same centre was in charge at the time of the interview. According to the literature review the T. C. Model can be distinguished from other major drug treatment modalities as the primary therapists and teachers being the community itself. Staff act as role models and serve as guides in the recovery process. Staffs are made up of T. C. trained clinicians and other human service professionals.

One of the staff members not available at the time of the interviews was trained in Indonesia in the T.C. Model. Primary clinical staff is usually former substance abusers that have they been rehabilitated in the T.C. program.

THEME 2: Model, Description and Aims

Not much could be critically analysed from the findings as only one staff member was available for the interview and focus groups did not shed much light on this theme.

According to the staff member's response in the interview, the model involves a purposive use of the peer community to facilitate social and psychological change in individuals undergoing treatment at a rehabilitation centre. A substance abuser is viewed as a complex, social, psychological whole person, consisting of recurrent negative patterns of behaving and thinking, poor emotional management or has lost or never acquired values to live a healthy productive life.

The social organization is composed of relatively few staff and the residents are composed of junior, intermediate and senior peers who constitute the community. The residents, working together under staff supervision, undertake the daily operation of the community itself. This broad range of resident job assignments, illustrates the extent of the self-help process.

The new client will be given job assignments such as mopping the floor and then moving up in the hierarchy according to seniority, clinical progress and productivity. The clients can come in as patients and can leave as staff as we have seen with the staff member interviewed (De Leon 1995).

This social organization of the T. C. Model reflects the fundamental aspects of its rehab approach

THEME 3: Conceptualization

The respondent viewed substance abuse as the disorder of the whole person. Addiction is a symptom, not the essence of the disorder – thus the problem is the person not the drug. The sources of the addiction disorder are social and psychological.

THEME 4: Success Rate, Factors Facilitating Recovery, Strengths

According to staff response, success rate is very low and factors identified as facilitating recovery were for the client to come in voluntarily as well as to have determination and commitment to change.

The focus groups stated that the beneficial aspects were in the structure of the program. This allows the individual to become psychologically and emotionally stable so that he/she can deal with emotions. Behaviour shaping in the form of role modelling, communication skills and peer pressure gave clients a strong foundation to succeed in the outside world. Spirituality was also emphasized in the structured interview and focus groups, as to be an important factor for recovery and is evident with literature by Kasiram (2005).

THEME 5: Failure, Disadvantages and Factors Preventing Recovery

The staff member interviewed indicated that there is a gap in the chain of command during an emergency – staff occupying a particular station finds it difficult to reach those higher in the staff hierarchy. Peers generally found it difficult to use tools such as acceptance and communication during recovery because they still felt conflict between own doom and the power of addiction.

The researcher notes that the model underscores the importance of empowering the individual in the change process. It is relatively inflexible in meeting the unique needs of individuals, thus there is a constant tension between the needs of the individual and the needs of the community. The T.C. Model is a high demand treatment that appears appropriate for clients who are highly motivated and ready to change.

THEME 6: Aftercare

Aftercare takes the form of attending AA/NA meetings, which is crucial to sustain recovery. Generally the ideal T. C. Models have programs over a year, i.e. between 1 to 2 year programs, so aftercare is not so crucial as in other treatment centres. In this study, having a three months program instead of an original T.C. program, which is 1 to 2 years, suggested that aftercare at least in the form of AA/NA meetings was required.

According to the literature review, the T.C. Model had assumed that the issues of aftercare are adequately adjusted in the re-entry stage of the residential program (De Leon 1995).

THEME 7: Linguistics

When the staff member was interviewed and asked about the incorporation of the following language used in the program, his response was that the word disease should be separated and identified as DIS-EASE. It was also noted that these statements are a psychological setback.

Likewise the Focus groups, felt that these labels were degrading, and made them feel as lesser than normal people but they agreed that recovery is a lifelong process. They also felt that they are powerless over their addiction only when they are an active user but in recovery they feel strong to fight the addiction.

In the T.C. view, according to the literature review, the problem is the person not the drug and the same sentiment was shared by the focus group which said that it is the lifestyle, not the drug that is problematic.

THEME 8: Holistic Model

Judging from the interview with the staff member, it would seem that holistic treatment – working with the mind, body and soul – is very important for effective treatment.

THEME 9: Spirituality

Only one staff member response was available and the response was vague giving a personal opinion of spirituality: “it is very important because you must love what you do every day”.

THEME 10: Motivation

The client has to be motivated and determined to accept this form of treatment and this has to come both from within the individual and from external factors. It has also been noted that the staff members and senior residents are supportive in order to be good role models and foster positive peer pressure.

THEME 11: Alternative Therapies

This staff member to be important alternative therapies to complement the program indicated massages and sauna. This is a similar response to the responses on this theme in the disease model.

THEME 12: Administrative Staff

According to the staff member the lack of management support in the form of communication and debriefing was real. According to the literature review, the recovered staffs is often inflexible in their response to individual differences because their clinical skills and knowledge may be limited – they require more in-service training.

THEME 13: Recommendations

It was noted after interviewing the staff member that more physical activities were required; language and interpersonal skills and improved dietary requirements were also necessary. The same sentiment was noted the by focus groups in that they would like more interaction with other recovering addicts to understand addiction and maybe empower themselves with a skill or diploma during their stay in the centre.

3.3.3 NARCONON MODEL

It was clear from responses by staff and focus groups that this is a type of drug rehabilitation treatment centre using the bio-physical modality which focuses on purification sauna and vitamins to release residues stored in fat tissue in order to eliminate cravings, anxiety and depression caused by drug abuse. This model also utilizes a social educational component to empower the individual.

THEME 1: Sample Profile

Staff comprised mostly managerial staff, i.e. directors, a Case Work Supervisor and a Purification Supervisor. Positions such as the latter two, amongst others, are based on training and qualifications obtained within the Narconon centres. The executive director had as much as 13 years experience. There were no professional staffs such as therapists, psychologists, psychiatrists or social workers, consistent with literature on this model.

THEME 2: Model, Description and Aims

The model is made up of the New Life Detoxification Program, which eliminates the drug residues through exercise, saunas and nutrition. There are also Life Improvement Courses in the form of Learning Improvement Course, Perception and Communication Course, Ups and Downs in Life Courses, Personal Values and Integrity Course, Change in Conditions in Life Course and the Way to Happiness Course. The aim is to assist a person to live a complete drug free life.

THEME 3: Conceptualization

Responses indicated that addiction is nothing more than a disability that begins when a person ceases to use his abilities essential to constructive survival. Therefore this model empowers an individual to rid him/herself of all the toxins, which causes cravings in the

form of mental pictures and teaches life improvement skills so that they are no longer addicted.

THEME 4: Success Rate, Factors Facilitating Recovery, Strengths

According to the professional sample staff success rate was 70% if clients stayed the full duration, which is about four and half months. Factors facilitating recovery involve dealing with issues that led to drug taking in the first place, the ability to confront and communicate, to have determination, honesty, sincerity and a sense of purpose, to be willing to come for treatment, continuous family support – before, during and after treatment.

Strengths of the Narconon Model were identified as: training in skills to cope with life while abstaining, the release of toxins in mind and body, disengaging from the past, – can confront dozen times, improvement of communication, dealing with reality without getting stuck or losing out, learning self-understanding, self-improvement, learning to become more successful and learning about physiological and physical aspects of addiction.

According to the focus groups, it was noted that the beneficial aspects of this program was sauna therapy as well as the life improvement courses which assisted them to find solutions to their own problems, and also to communicate better and to be stronger so that they can control their desire to use drugs (Hubbard).

THEME 5: Failure, Disadvantages and Factors Preventing Recovery

Staff attributed difficulty in treating to: addiction to psychotropic, psychoactive drugs in psychiatry, addicts who have been to other rehabilitations following the disease model of addiction, those who do not voluntarily come for treatment, those who are not willing to spend the full four and half months of treatment and those who cannot afford the treatment program since the fees are expensive.

Factors preventing recovery were: socializing with the same people in whose company drugs were taken, living in a people suppressive environment, being in denial or unable to confront, being in contact with people against the Narconon treatment program, taking on something with which the student cannot cope, changing for the wrong reasons, visitors being uncontrolled during treatment. These factors clearly are important in that they overlap with the factors preventing recovery given in other models as well.

THEME 6: Aftercare

The researcher is of the opinion that in this model those that are completely detoxified by the purification process and complete all life improvement courses/training do not require aftercare. Those that are finding difficult to cope on the outside are allowed to come and assist so that they can refresh on the recovery and point to difficulties in the outside world when returning to it after treatment.

THEME 7: Linguistics

From the responses, it was clear that addiction is not considered a disease since there is no physical basis or physical impediments – it is a problem, which needs to be solved. Addiction is not considered incurable – with determination, the student can stop using substances. According to this model there is no ground or basis for the statement that once an addict, forever an addict. This was evident from the responses.

Recovery was not regarded as lifelong. Equipped with life skills, the recovering addict can leave a life of addiction behind without relapse. Powerlessness does not exist – after treatment and recovery; the former addict is in full control.

The focus group respondents did not have any problem with the labels, the terms “addict” and “recovery for life” which may be understandable because they may have been to other treatment centres using the disease model. However, they did not agree with their addiction being a chronic illness or disease.

They felt that the term powerlessness is not a good phrase because if you put your mind to anything “you can have the power”. This is similar to the sentiments indicated in the literature review.

THEME 8: Holistic Model

The Narconon model treats an individual in physical and mental terms, i.e. with respect to body and mind without necessarily any referring to soul or spirit.

THEME 9: Spirituality

According to findings, spirituality is not in its own right given any place where religion may if so chosen by the student, provide spiritual growth and evolution. Respondents did mention that spiritual component is important by way of giving a sense of purpose or direction to the client.

THEME 10: Motivation

The respondents from both the staff and student sample indicate that intrinsic motivation entails having an inner drive and willingness to change and start a new life. Extrinsic motivation entails strong support from significant others, e.g. family support.

THEME 11: Alternative Therapies

According to responses in the Narconon Model, many different alternatives are already incorporated. Assist therapy helps with going through withdrawals to assist the pain and relax the body while purification is used to detoxify the body. There is place for combining different models – different rehabilitations have different ways of combining models provided that no medication is used.

THEME 12: Administrative Staff

It was mentioned that there should be more in-service training for the staff members.

THEME 13: Recommendations

It was noted from most responses that more physical activities in the form of walks and exercise be incorporated and both staff and students shared this sentiment. In the focus group discussions it was proposed that a more nutritionally balanced eating program be incorporated and since the individuals are instituted in a rehabilitation environment for a long time, they feel that there should be more interaction with the outside world in order to prepare them when they leave.

According to the response from the staff sample, they felt that since they were losing the war against drugs, the community and other role players involved in treating substance abuse should stand united. The sentiment in regard to the label “addict” should also be discontinued so that the problem can be destigmatized.

3.4 OVERALL DISCUSSION

On the whole then it would seem that addiction is a medical and/or behavioural condition that is of great concern considering that it is so difficult to treat and heal. Either a long time has to be spent in rehabilitation as in the Narconon Model, or in the ideal Therapeutic Community (T.C.) Model, namely 1 to 2 years or recovery is seen as long-term or for that matter lifelong or indefinite as in the Minnesota Model where addiction is conceptualized as a chronic medical disease requiring regular aftercare. In the T.C. Model, the period is long, due to the fact that the intent is to change not only the addiction but also the person him/herself.

Since it is difficult to find any rehabilitation centre that offers a minimum of 1 year of treatment in terms of T.C. Model based intervention entailing behaviour modification and since the success rate is so poor with respect to the Disease/Minnesota Model, it would seem that the Narconon Model provides with the best program.

However good a program it might be, the Narconon Model treatment centres are very costly since the stay at the centre is four and a half months minimum and for the treatment to be successful, a complete stay is required to live up to the statistic of an

over 70% success rate. Even if costs or fees are not a consideration, to complete four and half months would require great patience, perseverance and persistence and on the part of the student.

The Narconon Model also has strength in that it does not rely on any belief in the spiritual realm or Higher Power, which the 12 steps NA entails – this is a consideration since there is a special Secular Organization for Sobriety (SOS) to cater for addicts who are atheistic or agnostic.

Even though staff at Narconon Model treatment centres is well trained within a theoretical structure, it is necessary for a greater complement of staff to ensure that a multidisciplinary team including psychiatrists, psychologists, social workers, social scientists and religious leaders is employed to offer holistic and comprehensive services.

It seems that the limitation of the Minnesota Model is its conceptualization of addiction as a disease, while the limitation of the T.C. Model is that treatment exists largely in theory with only a few treatment centres implementing it in practice such as the rehabilitation centre in George, Knysna that offers a program, which is 1 year long. Most current T.C. treatment centres implement changes to the person and his/her behaviour in line with the tenet that the person (addict) is the problem and not the drug/s but do not provide for a treatment program between 1 to 2 years long.

Clearly a place exists for a new model to be proposed where the above discussed differences between the existing three models can be resolved into a theoretically sound and practically implementable treatment program.

CHAPTER 4

CONCLUSIONS AND RECOMMENDATIONS

4.1 INTRODUCTION

The aim of this exploratory study was to examine and compare three traditional models of substance abuse treatment interventions at various rehabilitation treatment centres in South Africa. Three treatment centres were chosen each representing a particular treatment model, namely the Disease/Minnesota Model at Careline Crisis Centre (Hillcrest, Durban), the Therapeutic Community Model at Horizon Halfway House (Cape Town) and the Narconon Model at Narconon Rehab (Johannesburg).

Data was obtained by means of two research tools, namely structured interview and focus groups. The study was qualitative entailing critical analysis of data yielded by the two research tools. In the structured interview, the researcher asked the staff members of each centre questions and recorded their answers whilst the focus group methodology was used with the clients or patients (referred to as “students” in the Narconon Model) at each of the centres. The groups were comprised of three or four members. The study was conducted in two phases where phase one comprised 13 themes and phase two comprised three themes. These phases correspond with the research tools mentioned above, namely phase 1 was conducted with staff members using the structured interview and phase 2 was conducted with the clients using the focus group.

In this chapter the results obtained for this study are summarized according to the 13 themes derived from the questionnaire given in Annexure 2. for phase one. Thereafter, recommendations are made for each centre, for a future model and for future research.

4.2 SUMMARY - MOST SIGNIFICANT FINDINGS

4.2.3 PHASE ONE

4.2.3.1 THEME 1: Sample Profile

The treatment centre for the Disease/Minnesota Model had administrative staff and professional staff. The latter comprised one undergraduate with a BA in Psychology and one undergraduate with a BA in Social Work. Also there was a paraprofessional who was the life skills facilitator.

In comparison, the treatment centre for the Therapeutic Community Model (T.C.) had only one staff member available, a paraprofessional.

The treatment centre for the Narconon Model had staff members that were trained and qualified within its own structures, this being a self-contained model.

4.2.3.2 THEME 2: Model, Description and Aims

The Disease/Minnesota Model characterizes addiction by its likeness to a chronic medical disease and aims to achieve lifelong recovery from a hereditary disease that implicates problems in the midbrain.

In contrast, the T.C. Model characterizes addiction by behavioral problems. Behavior modification is offered to the client through peer pressure. The client is kept for a long period, i.e. 1 to 2 years in residence for treatment and later sent to a halfway house until resistance to overcoming addiction is absent or minimal. The person rather than the drug is regarded as the problem.

The Narconon Model characterizes addiction as a hurdle to be overcome and tailors a treatment program over four and a half months for curing addiction. It is essential that the stay be completed. Coping skills in life are achieved during the stay.

4.2.3.3 THEME 3: Conceptualization

The Disease/Minnesota Model conceptualizes addiction as a chronic medical disease with a genetically predisposed biological source triggered by traumatic events in childhood.

In comparison, the T.C. Model conceptualizes addiction as psychosocial in nature and etiology.

The Narconon Model regards addiction as a problem that can be fought and overcome through education. It refers to clients as students and teaches life coping skills over a four and a half month period. The skills are claimed to be used as a shield against relapse after a satisfactory period of active abstinence from addictive substances during the full treatment.

4.2.3.4 THEME 4: Success Rate, Factors Facilitating Recovery, Strengths

The Disease/Minnesota Model emphasized the following factors facilitating recovery: overcoming denial; being honest to oneself about addiction; intrinsic and extrinsic motivation; abstinence from addictive substances; strong-support system; and accountability.

The T.C. Model interviews identified the following factors facilitating recovery: client's belief in himself/herself; coming into treatment voluntarily; balanced diet and exercise; spirituality; family and vocational values; role modeling; emotional and psychological intervention.

The Narconon Model emphasized the following factors facilitating recovery: addressing underlying issues leading to drug usage; ability to confront and communicate; have determination, honesty and sincerity; have a sense of purpose; and have family support.

4.2.3.5 THEME 5: Failure, Disadvantages and Factors Preventing Recovery

The Disease/Minnesota Model emphasized the following factors as retarding recovery:

- Excuse to use drugs because “no cure for the disease”;
- Confrontation between family and clients because they need to be stronger to encounter realities of life;
- Want quick fix do not understand that recovery is lifelong;
- Overpowering belief systems that need change where relapse becomes common;
- Association with high-risk situations;
- Minimal or no support structures; no short-term or long-term goals;
- Not wanting to deal with issues;
- Not wanting to let go of the past; and not being honest with oneself and blaming everybody else.

The T.C. Model identified the following factors as preventing recovery:

- Being in denial – not using the tools of acceptance and communication to foster recovery;
- Not using and implementing life skills;
- Not being responsible and disciplined.

The Narconon Model emphasized the following factors as preventing recovery:

- Socializing with same company;
- Not accepting, still in denial;

- Unable to confront;
- People around client have bad view of Narconon Model;
- Taking on something too great for them;
- Changing for the wrong reasons; returning to same environment;
- And visitors not being controlled during treatment.

4.2.3.6 THEME 6: Aftercare

The Disease Model - data on aftercare was the following: need to improve communication between the client and the family; empowered with life skills to cope with life; if there is any problem need to review the cause and refresh; and the person can come visit and refresh when necessary.

The T. C. Model – aftercare takes the form of attending AA/NA meetings, which is crucial to sustain recovery. Generally the ideal T. C. Models have programs over a year, i.e. between 1 to 2 year programs, so aftercare is not so crucial as in other treatment centres. Due to the centre that had been interviewed in this study having a three months program instead of the original T.C. program, which is 1 to 2 years, aftercare at least in the form of AA/NA meetings was required. According to the literature review, the T.C. Model had assumed that the issues of aftercare are adequately adjusted in the re-entry stage of the residential program.

The Narconon Model - in this model, those that are completely detoxified by the purification process and complete all life improvement courses/training do not require aftercare. Those that are finding it difficult to cope on the outside are allowed to come and assist so that they can refresh on the recovery and point to difficulties in the outside world when returning to it after treatment.

4.2.3.7 THEME 7: Linguistics

The Disease Model - an important component of the disease model is that a patient is never fully cured; addiction is a relapsing chronic disease due to a genetic predisposition

to addiction that manifests as problems in the midbrain of the addict. Defect to the midbrain is permanent, so recovery is life long and addiction is incurable. However, controlling and avoiding relapse and stopping substance abuse can prolong life. Unless you have been given the tools to recover and stay clean, addiction and relapse will thrive. The client is always a potential addict. The disease model is not realistic and fosters overconfidence as well as complacency – “there is no cure”. Thus relapse is acceptable if only to learn from it to continue the fight. Relapse is part of recovery – clients need to relapse to see the severity and difficulty of staying clean; clients are told that they can try again. Addicts feel powerless in the face of the power of addiction, which equals the power of God. Therefore they need God in the recovery process – without God in the recovery process, it is much more difficult to be thoroughly motivated.

The T.C. Model - The staff member was interviewed, his response was that the word disease should be separated and identified as DIS-EASE. It was also noted that the statements presented in the interview are a psychological setback.

According to the patients/clients, labels were degrading and made them feel as lesser than normal; but they agreed that recovery is a lifelong process. They also felt that they are powerless over their addiction only when they are actively using drugs but during recovery they feel adequately strong to fight the addiction.

In the T.C. model, according to the literature review, the problem is the person not the drug and the same sentiment was shared by the focus group which said that it is the lifestyle, not the drug that is problematic.

The Narconon Model - addiction is not considered a disease since there is no physical basis or physical impediments – it is a problem, which needs to be solved. Addiction is not considered incurable. With determination, the student can stop using substances. According to this model, there is no ground or basis for the statement that once an addict, forever an addict.

Recovery is not regarded as lifelong. Equipped with life skills, the recovering addict is able to overcome addiction without relapse – relapse is not acceptable. Powerlessness does not exist – after treatment and recovery; the former addict is in full command of him/herself.

According to the focus group, the individuals do not have any problem with the terms or labels “addict” and “recovery for life” which may be understandable because such clients have been to other treatment centres using the disease model but within this model it is not agreed that addiction is a chronic illness or disease. They felt that the term powerlessness is not a good phrase since it is possible to have the power to fight addiction, as it is possible to have power over anything that one chooses to fight.

4.2.3.8 THEME 8: Holistic Model

The Disease Model – staff and clients spoke about healthy diet and physical fitness through exercise as important to a holistic program. The holistic model looks not only at the addiction, which needs to be managed or cured, but also at various aspects of an overall healthy lifestyle, which work hand in hand to generate health in the course of living so that addictive behaviour, which is unhealthy, becomes incongruous with the rest of a healthy lifestyle. In not choosing addiction, i.e. in choosing recovery, the recovering addict is making a healthy choice as in opting to eat whole wheat bread instead of refined white bread; such healthy choices need to be made in conjunction with each other, synchronously. It does not make sense to choose recovery while other lifestyle choices are unhealthy as choices feed into each other. This is what a holistic outlook entails.

The T.C. Model - judging from the interview with the staff member, it comes across that holistic treatment, i.e. working with the mind, body and soul is very important for effective treatment. The Narconon Model - The Narconon model treats an individual in physical and mental terms, i.e. with respect to body and mind without necessarily any reference to soul or spirit.

4.2.3.9 THEME 9: Spirituality

The Disease Model - both staff and client responses made reference to spirituality, which came across as playing a strong role in recovery and in overcoming addiction. The dark, evil qualities of addiction render it into something, which cannot subsist with spirituality. The idea is to choose spirituality to be incompatible with choices and decisions that lead to addiction or remaining an addict. Belief in and submission to a Higher Power is also one of the twelve steps in Narcotics Anonymous (NA) and is generally very beneficial in recovery. Of great importance is that spirituality facilitates inner healing, which occurs before external healing.

The T.C. Model – the response of the single staff member was vague giving a personal opinion of spirituality: “it is very important because you must love what you do every day.”

The Narconon Model - spirituality was not given any prominence; if chosen by the student, it may provide for spiritual growth and evolution. Respondents mentioned that the spiritual component is important to give a sense of purpose or direction in life.

4.2.3.10 THEME 10: Motivation

The Disease Model – according to staff and clients, both intrinsic and extrinsic motivation are needed – the former is self-driven (me) and the latter other driven where the other is non-me, i.e. other people or other things in the outside or external world; things are not done arbitrarily but due to motivation, that is done for some reason or the other; the more motivated you are, the more basis do you have for doing something. An important aspect of the Disease/Minnesota Model is teaching the individual to recognize the physiological changes in the individual, behavioural conditioning and the attitude and behaviour of family and friends as the internal and external factors as well as to make personal and lifestyle changes to address them.

The T.C. Model – the client has to be motivated and determined to accept this form of treatment and this has to come from within the individual and from external factors; it has also been noted that the staff members and senior residents are supportive in order to be good role models and foster positive peer pressure.

The Narconon Model – intrinsic motivation entails having an inner drive and willingness to change and start a new life while extrinsic motivation entails strong support from significant others, e.g. family support.

4.2.3.11 THEME 11: Alternative Therapies

The Disease Model – therapy at rehabilitation centres comprises indoor lectures imparting knowledge as well as group and individual psychotherapy. Massages for pain and Sauna for detoxification can be regarded as indoor alternative therapies. Alternative indoor therapies include games, videos, DVD and courses. However, alternative outdoor activities such as camping, walking and swimming are also important. Giving of importance to alternative indoor and outdoor activities was consistent across staff and client responses.

The T.C. Model – Massages and sauna were indicted by the staff member to be important alternative therapies.

Narconon Model – in the Narconon Model, many different alternatives are already incorporated. Assist therapy helps with going through withdrawals to assist the pain and relax the body while purification is used to detoxify the body. There is place for combining different models. Different rehabs have different ways of combining models provided that no medication is used.

4.2.3.12 THEME 12: Administrative Staff

The Disease Model – staff responses indicated the importance of supports such as management support and in-service training for thorough treatment of the substance abuser. Staff at drug rehabilitation centres comprises professionals, such as therapists and counsellors as well as administrative staff. In-service training, supervision of staff, adequate staff compliments as well as committed and dedicated staff are all important for treatment success in any model. Moreover, a multidisciplinary team would be ideal comprising a multifaceted approach to the client's addiction problem.

The T.C. Model – according to the staff member, the lack of management support in the form of communication and debriefing was serious. According to the literature review, the recovered staffs is often inflexible in their response to individual differences because their clinical skills and knowledge may be limited – they require more in-service training. Paraprofessionals, as they are called are the recovered staff who might have the addiction experience and the experience with working with addicts lack the knowledge which has to be applied in treating addicts – this knowledge comes through rigorous training at institutes at which professionals graduate.

The Narconon Model –there should be more in-service training for the staff members. Training of staff members is in terms of the principles of Scientology developed by Hubbard. However, chemical addiction is a very complex condition and each individual being addicted to different chemicals has very different physiological and psychological reactions.

Professional people who are trained would either be aware of such a variety of reactions and be equipped to deal with them or be in a position to act swiftly to enlist the services of professionals who have specialized in addiction studies – how, for example, would a person not versed in severe withdrawal be able to deal with an addict who is prone to seizures?

4.2.3.13 THEME 13: Recommendations

The Disease Model – recommendations were made for improvements on the physical aspects such as sauna & vitamin therapy, exercises and other activities. According to the focus groups, group A recommended more creative activities although group B felt that the program was quite adequate for those that are serious about recovery.

The T.C. Model – it was noted after interviewing the staff member that clients require more physical activities, language and interpersonal skills and improved dietary requirements to be implemented; the same sentiment was voiced by focus groups in that they wanted more interaction with other recovering addicts to understand addiction and empower themselves with skills or diplomas during their stay in the centre.

The Narconon Model – It was noted from most responses that more physical activities in the form of walks and exercise were to be incorporated and both staff and students shared this sentiment. In the focus group discussions, it was proposed that a more nutritionally balanced eating program be incorporated. Also since individuals are in a rehab environment for a long time, they felt that there should be more interaction with the outside world in order to prepare them when they leave. According to the response from the staff members, they felt that since we are losing the war against drugs, the community and other role players involved in treating substance abuse should stand united.

4.3 OVERALL RECOMMENDATIONS

Further recommendations are made in terms of answers to key questions that were posed in Chapter 1 of this report:

Are the traditional methods that are being used in treatment centres for substance abuse meeting the needs for recovery?

In the final analysis the answer to this question would be in the negative. In the Disease/Minnesota Model not enough research has been done to provide an idea of success rates. In the Narconon Model where the success rate was said to be over 70% for people who completed their treatment at the centre. Also some of the prominent tenets of the Model remain researchable areas, namely genetic predisposition and defects in the midbrain.

The Therapeutic Community Model falls short when it is noted that six-week programs in the name of the Therapeutic Community Model are implemented when the theory behind Therapeutic Community states that such programs have to be between 1 and 2 years long. Also, although this model is based on behavior modification, none of the responses to questions to staff and clients is systematic desensitization to drug of choice mentioned.

The Narconon Model treatment programs are probably the best of all programs for substance abuse to meet the needs for recovery. However there is only one Narconon rehabilitation centre in South Africa located in Johannesburg. Drug abuse is a problem that is multiplying day by day in current society and demand for rehab centres is great. Furthermore the fee for treatment at Narconon Treatment Centre is very expensive.

What alternative strategies or therapies are available, that can compliment traditional methods?

Sauna and vitamin therapy could be recommended to be used with the Disease Model and Therapeutic Community Model treatment centres. Occupational therapy could be used at all the treatment centres. Acupuncture is very useful at helping addiction problem as well as helping pain during withdrawal from opiates. Reflexology and aromatherapy (massage) therapy are useful for a number of health problems as well as to enhance detoxification. Nutritional therapy by a dietician both traditional and alternative would be a useful adjunct to tailor eating preferences to an individual's body type.

From the foregoing discussion of the three traditional models, it is clear that there are weaknesses in each of them, which creates a place for the formulation of an alternative model that transcends these deficiencies.

What mindsets and paradigm will best serve service providers to accommodate alternative therapies?

Open-mindedness would be the best mindset to adopt when it comes to treating people for health problems of which addiction is one. For an individual with undiagnosed pain, a physician would seek causes in the body of the client; a clinical psychologist would seek causes in the mind of the client; and a neurolinguistic program would seek answers in the emotional life of the client. The best paradigm would be one that acknowledges all as possible explanations and one of them valid for a particular individual.

Thus it may be that for one individual pain may be due to physical abnormalities in the body while for another it may be due to underlying emotional pain of the individual, which is blocked, and manifesting as physical pain. To rigidly state that all pain is fundamentally physical or fundamentally emotional irrespective of individual differences is to be single-minded and biased or prejudiced. Service providers with an absence of such prejudice will be able to implement treatment programs that accommodate a multidisciplinary team including both traditional and alternative (or complementary) approaches.

Additional recommendations regarding a more encompassing model of addiction treatment would include the following:

1. A Global Conceptualisation /Model of Addiction treatment: It is recommended that the advantages/strengths and disadvantages/weaknesses of each treatment model should be teased out in this research study, future studies should focus on the formulation of a new model that would incorporate the best of each of the traditional models of rehabilitation studied in the course of the research reported here. Seeing as the Narconon mode has the greatest success rate and

the most comprehensive list of benefits as documented by the staff interviewed as well as the focus groups, much wealth of information regarding a new model can be drawn from here.

As mentioned in section 2.5.4 under Alternative strategies, the new model should encompass more empowerment of the recovering substance abuser. This would include more understanding of the self through intensive lecturing, seminar sessions, discussion groups and practical applications through role-play.

2. The sentiment in regard to the label “addict” should also be discontinued so that we can destigmatize the problem. This would allow the self-worth of addicted persons to improve preventing further addictive behaviour due to poor self-worth that deepens the addiction problem.

Alternatives to the label ‘addict’ have already been implemented in the Narconon program with much success. The model in question uses the term ‘student’ as opposed to ‘addict’. Terms such as ‘peer’, ‘client’, and ‘friends’ may be effective alternatives to the label ‘Addict’.

3. Recommendations regarding the structure of the therapeutic environment at, and after discharge from the treatment centre, as mentioned by the various interviewees:

- a) One to one psychotherapy - This should be implemented by a trained professional including a psychiatrist or a psychologists. The frequency of the individual psychotherapy sessions would be unique to the individual’s needs as well as the resources available to the centre in question. However, a frequency of 1 therapy session per week is desirable.

- b) Structured family involvement** – The family/ caregivers form a vital pillar in the recovery of the substance abuser. The support given by family is known to aid, or dissolve, the efforts made by the recovering substance abuser to abstain. Thus they form a vital pillar of therapy. Many a time family confrontations have been the cause of the emotional distress, leading ultimately to the experimenting with substances, or relapse. Family /Caregivers should therefore be included in therapy. Confrontation with family can be aggressive and distressing. However, techniques to diffuse confrontation and improve communication in such situations should be exercised. These include empathy, advice, encouragement and moral support. One to one counselling, as well as family therapy, and structured aftercare. An infrastructure for counselling on a needs basis should also be developed.
- c) Stress management** - Stress is an inevitable occurrence in daily life. Its management can be fulfilling or distressing. It has been identified as the most potent factor in reactively relapsing. Thus its management forms a primary component of the program offered to substance abusers. This would include the perception of a stressor, relaxation techniques and stress avoidance techniques.
- d) Occupational Therapy** - The profession seeks to analyse dysfunctional lifestyles, and rehabilitate using constructive activity. The realm of activities used as a medium of therapy would include leisure time activities, discussion groups, work related activity and personal management skill. The objectives of this form of therapy would also include building cognitive skill such as judgement and decision-making, problem solving and concentration. It is known that one physiological effect of excessive substance is the deterioration of cognitive skills. Hence the need to actively and consciously improve that faculty. Occupational Therapy does so in a non-evasive manner and the substance abusers find it stimulating and fun. Another primary benefit of occupational therapy is the improvement of self-esteem, the lack of which has also been identified as a factor, which could dictate the recurrence of the substance abuse.

Group therapy sessions can be carried out, and an occupational therapy program can also be developed to incorporate the leisure time available to the individuals completing the program. Outings, the use of a library and sport activities should be categorized as occupational therapy activities.

- e) Physical activity – The benefits of physical activity to any individual is commonly known. The substance abuser benefits to an even greater degree from engaging in a regular and rigorous exercise program. The body's natural detoxification mechanisms are enhanced. Perspiration is also a means of detoxification, and thus speeds up the release of the toxic substances from the users body.

The body's physical faculties are compromised with abuse of certain drugs. Another benefit of a regular and rigorous exercise program is the strengthening of the muscles and improvement of blood circulation and absorption of vitamins and minerals.

The release of endorphins combats the depression, which sometimes accompanies withdrawal symptoms.

- f) Sauna – two and half to five hours of sauna therapy augmented with vitamin therapy to enhance detoxification and make withdrawal more tolerable.

- 4. Interdisciplinary team approach – The presence of a team of professionals including a medical doctor, psychiatrist, psychologist, social worker, occupational therapist, life skills facilitator and centre caregiver would lead to comprehensive service provision. As opposed to a multi-disciplinary approach, an interdisciplinary approach seeks to share skills that each professional can offer. Regular meetings to discuss the peers progress ensures that the team members are aware of the individual needs of the peers, and can implement simple techniques that each member of staff needs to, more regularly than only during their therapy session.

5. Family/caregiver awareness of the complexity of addiction - Often the family's inability to empathise with the substance abuser can be contributory to stress. The family is not aware of the debilitating effects that withdrawal symptoms and cravings can present with. These may include reclusive behaviour, agitation/aggression and pain.

The family/caregiver may also need to know certain aspects of the therapy process, or the structure that the therapy program will undertake. Obviously the individuals right to confidentiality should not be transgressed while discussions with the family are undertaken.

This information sharing session with the family can be done at the outset, or during the initial stages of the client's recovery process. It may also be done in the presence of the recovering peer. A 2 hour structured lecture and discussion session may suffice.

6. Prevention programs – These have been identified in the interviews as a responsibility of the centre. Schools and youth centres should be targeted. Unfortunately there is no distinction between high or low risk areas in terms of socio-economic strata, thus the workload is doubled. Prevention programs should include identification of drugs, symptoms of substance abuse, behavioural manifestations, risk factors and peer pressure. This should be an ongoing program for the centre, as the need in the community is high.

The recovering addicts can also be part of this program, as it will further consolidate the need to eliminate drugs from their lifestyle. The prevention programs can be teamed with sport tournaments, art competitions or social outings.

7. Spirituality – Last but not least. The need for heightened spirituality is fundamental, as identified by the interviewees. A spiritual program encompassing the faith of the recovering addict will allow him to find direction and emotional strength during this trying period of his/her life. The spirituality should become a part of his/her lifestyle, even after leaving the treatment centre. It may allow him to prevent a relapse.

4.4 RECOMMENDATIONS FOR FUTURE RESEARCH

- Future studies would do well to include quantitative research using larger sample sizes to improve generalizability of results with qualitative research as adjunctive.
- Research should be done focusing on a Holistic and Empowerment model for treatment in residential centres.
- Research regarding the success rates of the various models presently being implemented, as well as the success rate of the new proposed model, should be administered as a longitudinal study. More statistical investigation is seriously required to enable comparison of different treatment models. The bureau of statistics should document these.
- More research on the strengths and weaknesses of the different treatment models.
- The Narconon model should be studied more in detail, as there was not much academic research available.

4.5 PROPOSAL FOR THE EMPOWERMENT MODEL

To add the last words to this thesis, as a combination of recommendations and conclusions, one need to consolidate the weaknesses and strengths of the three models reviewed and compared in the course of the thesis. First and foremost, there needs to be a formulation of a model that would supercede the disease model of addiction, which came about through the abuse of alcohol (Jelinek, 1980).

This model is highly required in modern society where stress is ever on the increase – the pace of life is fast, the cost of living is soaring and the youth is only too vulnerable to take recourse to drugs of any sort to achieve succor, relaxation and as a means of coping with stress which is multifaceted – physical, psychological (mental), social and these are intertwined, interwoven leaving the stressed individual little time to reflect and plan, to be proactive.

The absence of statistics showing success rate at treatment centres makes it difficult to establish whether it is the absence of longitudinal research to keep statistics updated or in fact drug treatment centres are in fact failing generally – informal figures suggest that success rates are poor, only 15 to 20 percent success is accredited. It would seem that such success is probably due to the individuals themselves for it were the treatment at the centres then there would be greater success rate figures, i.e. greater than the figure of 20% that seems to be the estimate.

The disease model has now to be seen as outdated for as attested to by the Narconon treatment centres complete recovery is possible. Complete recovery from an addiction problem necessarily entails a reinforcement of the individual's philosophy of life and a wholesome, healthy lifestyle within society. A substance abuser in all probability has a confused and directionless life, living just to survive or if in the case of those for whom survival is catered for by a secure family background, living is geared towards maximizing the material pleasures of life.

If one has to consider any crisis in life, which within the context of the present writing is the crisis of having fallen into the dark, abysmal pit of addiction to chemicals foreign to the human biology, such a crisis is a time to reexamine one's assumptions about life. Yes, taking drugs is pleasurable in itself or as an escape from the painful reality prevailing in an individual's life.

Thus, in a new recommended model to treat addiction to artificial chemicals, the team of professionals and paraprofessionals have to have the individual undergo a total re-examination of his/her lifestyle and the philosophy of life by which he/she intends to continue living life without recourse to mind altering chemicals, drugs and/or alcohol.

It is for this reason that the twelve-steps of the Alcoholics Anonymous and Narcotics Anonymous were formulated – to guide life, i.e. as a guide to living without chemical dependency. Spirituality has a profound impact on the substance abusers outlook and has shown to be the most definitive factor in turning around, in reversing the condition of substance abuse.

Problems in life or experimentation through sheer pass time while socializing with friends at clubs and outings land an individual into a trap – the individual becomes addicted, develops withdrawal symptoms, seeks out drugs at any cost to quell the withdrawal symptoms and a vicious cycle fits and falls into place.

Human existence is characterized by a consciousness (Being) and a reflexive consciousness at that which has to be “filled” or “engaged” in for life to go on day by day.

At this stage of human evolution, such a consciousness is structured by vocation or occupation (to earn a living); spirituality which is achieved through religious practice entailing rituals, prayer and a belief in God, the creator of the universe, a Higher Power; relationships with others (Being-With-Others), these being friends, the extended family, grandparents, parents, siblings, uncles, aunties, brothers and sisters in law, nephews, nieces and cousins. Modern society, due to exigencies of industrial as opposed to rural settings, has limited social life to nuclear families comprising husband, wife and children. This is augmented by a network of friends, colleagues at work and acquaintances such as neighbors, family physician, artisans, and shopkeepers.

We are born with a consciousness which progresses into a social consciousness – a consciousness without society is inconceivable. It would be a void. This nature of consciousness in being a void or being able to become devoid is what makes it vulnerable to being “filled” or “engaged” with chemicals for after all such chemicals act on the brain which is the seat of consciousness.

A consequence of the evolution of the human brain is that it comprises neural cells that function by being receptors to which molecules of food bind (after metabolism by the liver) and the physiological processes from ingestion to metabolism and nourishment of neurons in the brain enable the body to remain alive.

An unfortunate setback is that chemicals other than biochemical molecules from the ecosystem are also able to be ingested and have mind-altering effects on the consciousness of the individuals.

It is more than well known that living organisms are pleasure seeking animals and it so happens that chemicals have come into production or have been discovered that create extreme pleasure – a state of euphoria, a sense of a loss of the self, of the void that consciousness is. It goes without saying that if the void of consciousness of organisms that are by definition pleasure seeking will opt to seek out the chemicals that make them euphoric, intoxicated and uninhibited, i.e. free. Apart from pleasure, humans want to be free to do as they wish however unrealistic this may be and whatever the consequences of doing what they want to do.

The great psychoanalyst, Sigmund Freud called this the *pleasure principle* for is it not nature's trick that it evolved the orgasm to attend the act of sexual intercourse with the opposite sex, a pleasurable feeling so compelling that we have the phenomenon of criminal rape that in a number of cases entails murder. Hence we have the problem of chemical addiction afflicting and plaguing the human condition.

Returning from the digression, in a nutshell human consciousness is a void that over social evolution through an interplay of nature and nurture came to be “filled” or “engaged” with work, play and social interaction, and a conception of God that makes the human being secure in existing (Being-In-The-World).

It is when wayward elements are used to occupy consciousness that evil is engendered in what could have been a peaceful co-existence of human beings. The topic of human existence as a reflexive consciousness is a very broad one and the foregoing discussion of it was to allow for the formulation of a theory of substance abuse or chemical addiction and an attempt at developing a treatment for this medical condition that targets the youth of society who are the very essence of building a better world for us to live in harmony and productive evolution into a technological society that with the inculcation of spiritual values based in a sound rationality which we pride ourselves on.

Clearly, then it can be seen that the traditional models have merely conceptualized addiction very superficially and hence their treatment programs are nominal. The therapeutic community model holds that it is the individual and not the drug that is the problem and needs to be corrected using behavior modification techniques developed by

psychologists such as Skinner, Watson and Wolf who denied the existence of the mind existing merely as a ghost in the machine (the human body). In the academic discipline of psychology, this known as the behaviorist approach.

Clearly, this viewpoint is countered commonsense which prevails to testify to our bodies having minds as opposed to being conditioned bundle of reflexes.

The Minnesota/Disease Model works purely by conceptualizing chemical addiction as a chronic disease with defects to the midbrain – this is a materialist model where the brain is the organ implicated in the fait accompli of the chronicity of chemical addiction.

The mind is at worst nothing but the concerted firing of neurons in the brain and at best an epiphenomenon that gives an illusion of a separate and distinct “mind” but in effect is just the presentation of the brain working its function in producing behavioral outputs to inputs of sensory-perception very much like a computer – the external world is the input, beliefs are the output by which the person conducts his/her life acting on the environment as enunciated by the foremost philosopher of the twentieth century, Willard van Orman Quine.

The Narconon Model is based on a doctrine known as Scientology, which I would characterize as a secular religion – not scientific, but a secular religion with the rigors and structure of science. Its tenets are education and integration in society within a niche according to the role an individual is able to play in society in a well-adjusted lifestyle. While it is neither a religion nor a science it models itself according to theses two poles by which society orientates itself. It has no spiritual component other than acknowledging the spiritual dimension of life.

The Persian poet Jalaluddin Rumi spoke of the essence of life as Love and Hubbard speaks of the essence of life as Learning. Hence the Narconon Model speaks of its clients as “students”. Drawing from the three traditional models reviewed and compared herein, it is recommended that a new model be developed, one that is able to extract the best of each of these and add innovative aspects based on an intensive literature search and review.

Next I look at three traditional models with a view to developing a blueprint for a new model that is not based in any particular school of thought or doctrine such Medical, Scientology or Behaviorism but which has pragmatic import where the truth of any tenet is if it works in practice, i.e. not because it emanates from a theory.

It may be said that this thesis has focused on the three dominant drug rehabilitation treatment models in the world due to the scope of the thesis but it would be recommended that future research geared towards the development of a new model inspect other treatment models through extensive literature searches, internet searches and review these to put together a model that would spurn drug rehabilitation centres the world over to address the scourge of drug and alcohol addiction that has blemished human existence and brought in its wake untold human suffering victimizing the youth of our beloved world, the youth that are the potential upholders, guardians and new leaders of this world.

In conclusion, until the blossoms of the seed that has been sown in this research is reaped and leads to the implementation of a new model, which I would as hinted earlier like to call the Empowerment Model.

I bring this thesis to a close by outlining the bare skeleton of this proposed new model with the ardent hope that I would build upon it in further research studies and hope as well that other students/scholars/researchers would take up their research tools to add body to the new proposed model that is being identified in this thesis based upon a critical study of the three traditional treatment models discussed above.

The form of psychotherapy would be client or person-centered therapy within the humanistic-existential or phenomenological paradigm of psychotherapy. Of course should the client require talking, an appointment could be requested with the psychologist and a time set for a session. Every morning clients would attend lectures in life coping skills to equip and empower the clients with knowledge about how drugs work, the power of addiction, avoiding relapse under conditions that may drive a person to drugging again, in high-risk situations such as stressful conditions, trigger situations

caused by the former environment in which drug taking first took place, most notably through peer pressure or frustrating relationships.

The idea is that through lectures knowledge is imparted to facilitate change in the behavior of the substance abuser by him/herself – both the drug and the individual is a problem. It goes without saying that drugs are bad but these are inert and cannot change but the user is bad if after knowledge empowerment and enlightenment still refuses to change his/her behavior.

From the time of admission through psychotherapy, both one-to-one and group therapy as well as lectures and seminars, the client will be going through detoxification and withdrawal which he/she will be helped through with by means of supportive care. Detoxification and withdrawal can be pretty grueling experiences which require patience, perseverance and persistence but once these hurdles are overcome, a significant part of the battle is over and psychotherapy/counseling needs to be stepped up to psyche the person up to avoid relapse once returning to the outside world. Aftercare would be available by way of telephonic contact, brief visits and possibly readmission.

The Empowerment Model is intended to tap into the self of the individual – a soul searching to discover the individual's reasons for drug use. The client completes a daily dairy entry on a loose-leaf sheet of paper, which is then handed to the psychologist. At the next one-to-one session, the dairy entries are discussed after the psychologist has analyzed them. These are then returned to the client who files them and takes them back home to have recourse to when tempted to use drugs again. It is also encouraged for the client to write any and every pertinent thoughts or questions to be asked in sessions with the psychologist lest they be forgotten and he/she would not have the opportunity to address the relevant issues troubling the person's mind. Concerning the lectures, a test is set periodically to ensure that concepts pertaining to drug addiction are well assimilated, accommodated and integrated into the psyche of the client to serve as armamentarium against drug reusage/relapse.

Another powerful tool in terms of MIND POWER is AFFIRMATIONS. Remember, the Empowerment Model serves to empower the mind of the individual. Affirmations are positive, short statements that one repeats over and over again to program the mind or in particular the subconscious – once repeated at every idle moment one has, the more reinforced these statements become in the subconscious and assert themselves at times when appropriate. For example, one may affirm: “Drugs are over for me now” or “I am resolute I will not relapse”. Individuals formulate their own affirmations or ask their counselor to coin one or even a few for the client. The best time to repeat affirmations is just before going to sleep when one is on the boundary between the conscious and the subconscious.

While the brain is the organ of the mind, soul and spirit or in short consciousness, it is the latter that has free will – CONSCIOUSNESS IS FREEDOM and can overpower the physical dimension of our existence. It is a central tenet of the Empowerment Model that Consciousness, encompassing mind, soul and spirit can overrule the body and can control neural pathways in the brain – this has gained currency in the relatively recent work done in Neuro-Linguistic Programming (NLP). It may seem strange that if the brain is the seat of consciousness, how consciousness can influence the routes and direction of neural pathways.

The answer is quite simple by analogy: do we not reside in houses of brick and stone? Yet we can alter the architecture, undo and redo the building of the house according to a different plan. So it is with our consciousness, it resides in the brain but has the power to manipulate the brain to suit its own ends.

The Empowerment Model strives to be holistic with a view to move away from the allopathic paradigm for after all even if medical drugs are used medicinally, these drugs comprise chemicals that are foreign to the body (unnatural) and have significant side-effects which call for more medication to eliminate the side effects thereby setting off a chain reaction and a vicious cycle.

Holistic approaches to addiction and alcoholism can be of great assistance throughout the stages of recovery. From detoxification to reducing stress and improving mental and physical well-being, holistic approaches play a vital role in regaining personal balance. For the recovering addict, holistic approaches should be accompanied by a professional treatment plan but can be effective well beyond the initial recovery phase. Recent scientific studies have demonstrated dramatically improved success rates with the addition of holistic treatment approaches.

Medical drugs have a place only for short-term usage, surgical procedures and post-surgical use. Of course medical drugs play a very important role in emergency situations as well. The proposed Empowerment Model would strive to adopt a natural and holistic approach where medical drugs are used only in the beginning stages of the recovery treatment program.

The Empowerment Model would use a variety of alternative or complementary practices. I go on to a discussion of such alternative options which would ideally all be offered at a drug rehabilitation centre since different individuals respond to different therapies due to genetically based constitutional variations.

The following alternatives or complementary practices are:

1. ACUPUNCTURE

Acupuncture developed in China over 2,500 years ago; acupuncture is part of a system of medicine that seeks to establish the free and balanced flow of energy (or chi) by the insertion of needles on specific points along the energy pathways of the body. It is based on the idea that blocked chi is the cause of disharmony in the body/mind, and therefore disease. It is non-invasive and has no side effects. There have been modern advances such as electro-acupuncture. For those who have a phobia for needles, stimulation of points on the body along energy pathways is now possible using lasers techniques.

With respect to the use of acupuncture in treating addiction, a number of studies have been published which goes to show that acupuncture is gaining ground through increasing research for various medical conditions. A notable study by Avants, Holford & Kosten (2000) was undertaken to evaluate the effectiveness of auricular acupuncture for the treatment of cocaine addiction.

Patients who received acupuncture in this study were significantly more likely to test free of cocaine at the end of the eight week treatment period. Researchers concluded that acupuncture shows promise for the treatment of cocaine abuse and should be further studied. Acupuncture is currently used in many drug treatment facilities, for example the treatment centre which formed part of this study where only one staff member was available to be interviewed is Horizon Halfway House in Cape Town and has a resident accredited acupuncturist trained in Malaysia.

2. AROMATHERAPY

Aromatherapy uses essential oils extracted from plants and herbs that can be inhaled or applied through the skin. Aromas derived from these natural plant sources have been shown in clinical studies to have positive effects on the mind and the body. These essential oils, which are composed of naturally occurring chemicals, can help to support emotional balance, a sense of calm, stress relief, and feelings of well-being.

Aromatherapy can be used to lessen symptoms such as anxiety, depression and insomnia that often complicate drug recovery.

3. BIOELECTRICITY

Rhonda Lenair is a healer and medical intuitive that specializes in addiction. She is based at *The Lenair Technique Centre* (lenair.com) Lenair sees addiction as an imbalance in people's bioelectric systems. Through her own energy system she transfers healing currents to restore equilibrium. The web site includes explanations of energy medicine in the context of addiction, details of the programs offered, and articles on her work, testimonials, and more. Although not available in South Africa, mention is being made of it to create an awareness of such a variety of alternative treatments to deal with the problem of addiction.

4. BIOFEEDBACK

Biofeedback is a scientific way of learning tension reduction. Biofeedback practitioners employ instruments to give a person immediate feedback about the level of tension in their body. People practicing biofeedback often say they gain psychological confidence when they learn they can control their physiology. Biofeedback has been found effective in several aspects of addiction treatment. Biofeedback information is available at bcia.org.

Research studies are ongoing; a noteworthy study relating to addiction, anxiety sensitivity and the role of biofeedback in addiction treatment is by Stewart & Kushner (2001). Anxiety sensitivity (AS) is characterized by a fear of arousal-related bodily sensations that are interpreted as signs of impending catastrophe on physical, psychological, or social levels. AS has been linked to increased risk for the development of panic attacks, anxiety disorders and more recently to substance use disorders. AS is thought to increase drug withdrawal severity and to lower tolerance for withdrawal symptoms. Biofeedback is a technique that is used to treat the type of anxiety sensitivity described above.

5. BRAINWAVE BIOFEEDBACK /NEUROFEEDBACK

Brain wave biofeedback (or neurofeedback) is a therapy in which patients learn to alter their brain wave patterns. In one type of neurofeedback the training involves normalization of alpha and theta waves, which are disturbed by long-term substance abuse. Brainwave Biofeedback has shown dramatic success in several studies to prevent relapses from drug and alcohol addiction (Kaiser, Othmer & Scott; Eegspectrum.com/Applications/Addiction/).

EEG Spectrum International is found at the site eegspectrum.com, which provides a good introduction to neurofeedback (EEG biofeedback) including its applications to various health conditions including chemical addiction.

Healthcare Connection of Tampa (healthcareconnectionoftampa.com/) specializes in the treatment of impaired professionals. Their program is based on the 12 steps of Alcoholics Anonymous and Narcotics Anonymous, behavioural modification and other

psychotherapeutic approaches, and innovative techniques such as neurofeedback and EMDR (Eye Movement Desensitization and Reprocessing).

In small clinical trials and case studies, specific EEG aberrations in substance abuse disorders have been noted, including very specific abnormalities likely associated with drug neurotoxicity. This suggests the possibility that specific EEG biofeedback protocols may be studied for their effect on these conditions. These EEG documented changes are further proof that addiction is an illness of the brain. Trudeau (2000) conducted a study on the treatment of addictive disorders using brain wave biofeedback.

6. CREATIVE ARTS THERAPY

The creative therapies can be very helpful in the process of recovery from addiction. They can provide time to get in touch with the inner self and with the higher power and can provide a form of expression for feelings that cannot be easily identified or put into words. Through helping the addict connect with his/her more authentic self, the expressive therapies can help raise self-esteem and provide an opportunity to create new experiences beyond habitual and painful emotional patterns. The creative arts foster a renewed ability to relax without drugs or alcohol.

Creative Arts Therapy comprises of the following:

- I. Colouring Therapy (www.coloringtherapy.com). Many people find meditation difficult to attain even though the benefits are well documented. In Colouring Therapy, the focus of meditation is easily attained through the activity of colouring itself. Colouring is used as a way to begin to quiet the mind, listen inwardly and open up to higher knowledge, healing, and creativity.

This alternative to formal meditation practices can help people of all ages in recovery improve coping and awareness skills through an enjoyable activity.

II. Creative Source (creativesourcesf.com).

Adriana Marchione, MA, CHT, specializes in working with recovery from all forms of addiction. Her work offers creative healing opportunities that complement psychotherapy and twelve-step programs. Her approach draws from a movement-based expressive arts therapy model and Depth Hypnosis - a method of hypnotherapy that utilizes hypnosis, meditation and shamanic techniques. Through individual and group sessions this therapeutic approach employs a variety of methods to support emotional and physical health, creative growth and a deeper connection to life. Recovery groups and retreats are also available that offer the opportunity for participants to express their stories in words, images and movement both in the studio and in natural surroundings.

III. National Coalition of Arts Therapies Associations (nccata.org).

Founded in 1979, this coalition brings together the professional associations dedicated to the advancement of six creative arts therapies. Their web site provides basic information on these approaches: art, dance/movement, drama, music, psychodrama and poetry. Each modality uses the creative process to support health, communication, self-expression, and positive change.

IV. Drumming (www.ncbi.nlm.nih.gov)

Drumming can be a simple yet powerful way to enhance recovery. New medical research shows that it can slow down brain wave cycles, enhancing theta-wave production and brain wave synchronization. This is important as addicts often have brain wave abnormalities as explained in our section on brain wave biofeedback.

V. Poetry

Poetry therapy is the intentional use of the written and spoken word for healing and personal growth.

7. HERBAL THERAPY

Herbs are natural botanical substances that have effects on the body. Many herbs have long been used in detoxification. Kudzu has the potential for moderating alcohol abuse. Kava and valerian can be used to treat the insomnia that accompanies withdrawal. Milk thistle has been shown to improve liver function.

The use of herbs in the recovery process may be most effective when used in conjunction with other strategies that support the whole person including nutrition, bodywork, acupuncture, relaxation and exercise.

This review summarizes studies that looked at the effects of ginseng on the actions of opioids and psychostimulants (Takahashi & Toduyama, 1998). Among the findings, ginseng was able to block the analgesic effects of opioids and inhibit tolerance to and dependence on morphine. Findings provide evidence that ginseng may be useful clinically for the prevention and treatment of morphine, cocaine, and methamphetamine dependence. An excellent study comprising a double-blind randomized controlled trial was conducted to demonstrate the efficacy of Passionflower multifariously for treatment of anxiety as well as for treatment of withdrawal from opiates (Akhondzadeh, Kashani, et al, 2001)

Clonidine-based therapies are used to treat the physical symptoms of withdrawal during opiate detoxification, but have not effectively addressed associated mental symptoms such as anxiety. The herbal extract Passionflower has been successfully used in the management of anxiety, and in this study the use of a daily dose of 60 drops of passionflower extract with a maximum daily dose of 0.8 mg of clonidine showed a significant superiority over clonidine alone in the management of mental symptoms associated with detoxification.

8. HOMEOPATHY

Homeopathy is a non-toxic system of medicine that uses highly diluted remedies to treat illness and relieve discomfort in a wide variety of health conditions. It is thought that homeopathic remedies are able to stimulate a person's bodily systems to deal with stress and illness more efficiently.

Research is currently being undertaken to understand how and why these remedies work on the mental and physical level. Specific homeopathic remedies may be helpful during the period of withdrawal from alcohol or drugs.

9. HYPNOSIS

Hypnosis is a state of focused attention and concentration induced by the self or a therapist. From that state, the mind is especially receptive to ideas and suggestions compatible with the person's goals. Some people have found hypnosis to be a useful part of a total recovery program.

10. IMAGERY

Imagery involves the use of the imagination to achieve specific healing and life goals. It can be effective in helping people cope with stress and regain a sense of control and well-being. As with all other mind/body techniques, interest, motivation and practice are keys to the successful use of imagery for health and healing.

11. MASSAGE & BODYWORK

Massage and bodywork address the mind/body/spirit, offering the possibility of healing and self-development on many levels. On a physical level they can facilitate the release of tension and holding and improve energy balance and flow. They also offer the opportunity to explore deeper levels of relaxation and peace, greater self-acceptance and awareness, and a deeper connection to self and others.

12. MEDITATION

There are many different types of meditation which all work to slow down the chatter of the mind and promote relaxation and mental clarity. The Internet Yogi (theinternetyogi.com). This web site was developed by David Shannahoff-Khalsa, a research scientist at the University of California, San Diego who specializes in treating psychiatric disorders with Kundalini Yoga. He has developed a protocol using Kundalini Yoga meditation to treat obsessive-compulsive disorders and addiction.

These techniques can also help improve mental concentration and mental stability, reduce anxiety and depression, and promote a deep sense of inner peace. The protocol uses unique intense active meditative breathing, chanting, and movement techniques (all while sitting in a chair).

Vietnamese Zen Master Venerable Thich Nhat Hanh is a Buddhist monk, poet, scholar, and human rights activist. Nominated for the Nobel Peace Prize by Dr. Martin Luther King Jr in the 1960's, he has been living in exile in France since 1969 because of his positions on peace during the Vietnamese War. Thich Nhat Hanh teaches the art of mindful living (to be deeply aware in the present moment of what is going on within and around us). While the abuse of drugs or alcohol can be a way of running from life by trying to forget one's difficulties and challenges, mindfulness is the opposite. It improves one's ability to cope with life by teaching how to be present with whatever is going on without getting overwhelmed or disturbed by it.

Large improvements in relapse prevention were seen with the addition of Transcendental Meditation (TM) or EMG biofeedback to the routine treatment program in an alcohol residential treatment facility. 65% of the TM GROUP and 55% of the biofeedback group compared to 25% of the standard care group and 28% for the neurotherapy group reported complete abstinence 18 months after leaving the centre.

The long-term positive effects of TM, in particular, seem to be correlated with a reduced relapse rate. TM may not only reduce tension and anxiety, but also enhance a sense of control in anxiety-provoking situations that strengthens the long-term resistance to stress.

It should also be noted that there are many ways to achieve a meditative state of mind. For those who have trouble sitting quietly for periods of time, various movement practices and martial arts, such as t'ai chi, qigong, and karate, can also focus and calm the mind and enhance feelings of self-confidence and self-worth.

13. NUTRITION

In dealing with the chemical imbalances that are both a cause of substance abuse and a result of long-term substance addiction, nutritional therapy can be helpful in several ways.

Nutritional supplements such as herbs, amino acids, vitamins and other nutrients restore the proper biochemical balance in the brain. These supplements are specified, according to your addiction, in an excellent book written by Charles Gant, MD, PhD, who has helped over 7,500 patients with his innovative nutritional program designed to help people addicted to drugs, alcohol, nicotine, or pain medication (Gant & Lewis 2002). In addition, eliminating certain substances such as sugars and simple starches and increasing protein intake can help to rebalance brain chemistry. Good nutrition can also help heal damage to the body caused by the depletion of nutrients common in substance abuse (Cass 2002; Larson 2001).

Another important area of the use of nutrition in recovery and relapse prevention is the addition of appropriate amino acids that serve as the building blocks for powerful chemicals in the brain called neurotransmitters. These neurotransmitters, including epinephrine and norepinephrine, GABA, serotonin and dopamine, are closely tied to addiction behaviour. With the use of various amino acids, brain chemistry can be changed to help normalize and restore deficiencies in the neurotransmitters that spur cravings that can lead to addiction and relapse.

4.6 CONCLUSION

This study has examined three traditional models of treatment for drug and alcohol addiction, i.e. substance abuse. Each of these models has been examined in the light of data collected by way of interview schedules and focus groups.

The strengths/advantages and weaknesses/disadvantages have been comparatively evaluated with a view to the proposal of a new model, which has been called The Empowerment Model.

The emphasis in this model has been on proactive alternative or complementary medicine with a place for traditional allopathic medicine only for short-term purposes and in the case of emergencies on a reactive basis. A number of alternative treatment modalities were discussed to inculcate the adoption of such a model in the treatment of addiction and substance abuse.

A view of human nature was presented as characterized by being Consciousness, which is a void needing to be filled. The maladaptive engagement of Human Consciousness is through the use of substances that in terms of the pleasure principle strive to increase and enhance pleasurable sensory experiences. Two of the traditional models, namely the therapeutic community model and the disease model focus exclusively on behavior and biology respectively having recourse to impacting on these to treat the problem of substance abuse. The Narconon Model has the most adaptive approach with its emphasis on learning and developing the human consciousness to greater levels of awareness that enable the treatment of addiction through an educative process – hence its reference to recovering addicts as “students”.

However, in this thesis a proposal is made for an Empowerment Model that incorporates behavioral intervention, minimal medical intervention in the short-term but with a view to supercede this with a conception of Human Consciousness as purpose driven towards empowerment and the evolution of Human Consciousness to such great heights that it is possible for the recovering addict to overcome addiction once and for all aspiring towards changes in lifestyle, relationships and optimal quality of life be this achieved through spirituality or existential excellence in terms of the belief system of the individual faced with the problem of chemical dependency and its eradication.

The problem of addiction is contextualized within the overall life plan of the individual. Given the encumbrances of allopathic treatment beset with chemical medication side effects be they anti-depressants, anxiolytics, minor or major tranquilizers. As for the therapeutic community model the focus is one sided on behavior change which misses the wood for the trees since the “wood” of human existence is purposive consciousness or soul or spirit as it may be variously called.

Once purpose in life for an individual consciousness is defined and the person, in this context the substance abuser, gears and empowers him/herself overcoming denial and self-deception, the battle against chemical dependency is won – victory is the central tenet of the empowerment model.

I end this thesis with a saying by Sir Allama Mohammed Iqbal translated from Urdu: “Elevate (transcend) the Self to such heights in a bid to reach for the stars in the firmament, i.e. to such an extent that God Himself before any fate is meted out to the individual asks the individual what is it that you wish your fate to be!”

The relevance of this saying for addiction is that the human being is a free willing agent of change that can reach such heights such as superman to allude to something to this effect said by George Bernard Shaw. The Empowerment Model holds that chemical addiction is within the control of the human agent to be able to overcome it in its entirety.

ANNEXURE ONE

CONSENT FORM:

Dear Respondent

I am currently enrolled in the Masters Program on the topic - TREATMENT FOR SUBSTANCE ABUSE at the University of KwaZulu-Natal. In order to meet my academic requirements, I am undertaking a research study of the current treatment model.

PURPOSE:

The purpose of the study is to investigate the treatment model this centre is using for the treatment for substance abuse and to what extent of the program material is implemented as part of a new proposed model so as to assist in achieving our common goals in treating substance abuse.

AIMS AND OBJECTIVES:

- a) To critically analyse the traditional rehabilitation model that is popular in the treatment of
Substance Abuse in S A.
- b) To identify strengths of current strategies used in the traditional approaches in Residential centres.
- c) To identify gaps/weaknesses of current strategies used in the traditional approaches in Residential centres.
- d) To obtain recommendations for the use of alternative strategies/approaches that could complement the traditional model.

PARTICIPATION:

Your participation in the research study is essential and highly appreciated. Respondents are not required to provide any identifying details of themselves or the organization that they represent. All responses will be kept highly confidential. The researcher will not at any point in the research study or report, identify any respondent or treatment centre.

At the completion of the study the data obtained will be destroyed. The research study will be undertaken under the guidance of the School of Social Work and Community Development at the University of KwaZulu-Natal (Natal campus).

INFORMED CONSENT:

There will be no payments made for participating in the study. You have a right to withdraw from the study at any stage and for any reason.

I agree to participate in the research study under the conditions mentioned above.

I.....the undersigned understand the contents and conditions of the research and consent to participating.

Signature.....Date

Thank you for your co-operation.

ANNEXURE TWO

A) INTERVIEW SCHEDULE:

1. Identifying Details:
Occupation:
Age:
Years of Experience in Centre:
Treatment Model?
2. Your model:
Brief description:
Its aim:
3. How does your model conceptualize addiction?
4. Describe with the help of statistics the success rate in using this model.
5. What factors do you believe facilitate recovery?
6. Advantages/strengths of this model.
7. Disadvantages/weaknesses in using this model.
8. Identify factors that you believe prevent recovery.
9. Discuss the role of after care in sustaining recovery at your centre. Do you have any suggestions in this regard?
10. Describe the incorporation of the following language in your program:
 - Disease
 - Incurable

- Once an addict, always an addict
- Life-long recovery
- Relapse is acceptable
- Powerlessness

11. How would you define a holistic model of treatment for abuse?
12. Do you use spiritual concepts in treatment? Explain.
13. How do you view intrinsic and extrinsic motivation in aiding recovery?
14. Do you use any alternate therapies to supplement/complement treatment? Explain.
15. Is there place for combining different treatment models in substance abuse treatment?
16. What supports (e.g. management support; in-service training etc.) do you need to ensure adequate treatment of the dependent in residential centres?
17. Do you have any recommendations for alternate therapies to be included in your program? Please provide.

B) FOCUS GROUP DISCUSSION:

Themes to explore:

1. Identifying Details:

Gender:

Age:

Number of years as a dependent:

Number of times in treatment and models used during treatment?

2. Current Treatment Program/Model:

- a) Identify beneficial aspects of the current treatment program.
- b) Identify aspects of this program that has not benefited you and explain.

3. Respond to the following words/terms/labels used in the treatment model:

- Addict/Alcoholic
- Recovery for life
- Chronic illness
- Disease
- Incurable
- Relapse
- Powerless
- Addiction

4.Recommendations

Recommend changes to the treatment program, what additional or alternative strategies that would you consider helpful.

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