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**Relieve Me of the Bondage of Self:  
Addiction Practitioners From Three Treatment  
Centres in New Zealand Discuss the Use of  
Community as a Method of Healing the Self.**

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requirements for the degree of Masters of  
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Derek Ross Quigley

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# Abstract

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At the time of writing, there are as many as 6,000 people in New Zealand who are currently receiving a state benefit because of chemical dependency or addiction. A Ministry of Health survey (2009) estimated that there are 700,000 problem drinkers and that half of our population aged 16-64 have used drugs for recreational purposes in their lifetime. Many thousands of New Zealanders have reached a point of desperation and have sought assistance from a residential treatment centre in order to receive vital help for their addiction issues.

So how do these 'places of healing' turn someone from a state of self-pity, self-loathing, selfishness, and being in denial when they walk through the doors, to one of self-acceptance and self-awareness when they leave? I embarked on a study of three residential treatment centres, interviewing the agencies' practitioners, discussing how living in a separate community of alcoholics and addicts sets someone on a path to recovery, and how 'community' is used as a method to achieve 'relief from the bondage of self'. The study seeks to describe the addicted self and the relationship it has with community, and how community methods are used to understand and connect with the conscious self. Anthropological literature is used to describe concepts of 'self' and 'community', along with a mixture of psychological, sociological, and anthropological references to describe treatment methods.

I contribute my own 'insider' experiences as a former client of two residential addiction treatment centres to give a level of understanding of what similar addicts experience when they go through such a significant period of change in their lives. I am so grateful that there are addiction treatment facilities available free of charge to the public in New Zealand and I hope this work gives a voice of hope to the many who pass through their doors.

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## Introduction

*“God, I offer myself to Thee- To build with me and to do with me as Thou wilt. Relieve me of the bondage of self, that I may better do Thy will.”*

*Third Step Prayer, Alcoholics Anonymous*

Every day across New Zealand, thousands of men, women and children seek help for drug and alcohol addiction. They may have reached a point of desperation in that they are willing to do anything to get some relief. Some are mandated to seek help by the Justice or Corrections state agencies. Some do it because they are not sure and are relenting to a loved one’s wishes, while others have no other alternative; they have no one and nothing and have nowhere left to turn. There are many reasons for entering treatment, and there is an air of inevitability of outcome for someone’s life if they don’t. “Jails, institutions or death” is a phrase commonly touted in Twelve Step recovery programmes. As one participant said to me:

They’re plagued with terminal uniqueness. The world was created for them and nobody has a story like theirs. And that may be so, but the pathway into the black hole of addiction is the same. What they end up doing and how they do it becomes highly predictable and not very unique at all.

There are dozens of residential treatment centres across the country seeing alcoholics and addicts come through their doors on a daily basis. These people are bereft of hope, full of anger, rage, sorrow, confusion, angst, and frightened for their future. Still in denial that they can carry on using the drugs of their choice, so they can have one more taste, one more hit, one more drink – a temporary relief from the pain that life has dealt them. For addicts and alcoholics, their using has become like an automated default setting for dealing with life and its joys, challenges and sorrows. They’re full of self-loathing, self-obsession, selfishness, self-pity, self-indulgence and are fully self-absorbed.

But what happens when alcoholics and addicts walk through the doors of the residential treatment centre and how do they present themselves? How does a temporary removal from society, into a rehabilitation community, help with turning their lives around? What methods do therapeutic communities use to relieve alcoholics and addicts from the *bondage of self*, mentioned in the Third Step Prayer? How does a community as a method of treatment, or a community reinforcement approach, lead one with drug and alcohol addiction to become self-aware, selfless in their acts of love and human kindness, and have a real sense of their own self-identity?

The aim of the study is to reveal my findings of how addiction treatment practitioners from three treatment centres in Auckland, move people from addiction to recovery. I wish to explore the ways in which the 'self' in addiction is presented, constructed, identified, controlled, relieved and managed in these treatment settings. I seek to obtain the practitioners' views of how they use community as a method of treatment and sustained recovery. I was kindly granted interviews with Johnny Dow, Director of the Higher Ground Drug and Alcohol Rehabilitation Centre, Kathy Mildon, former Chief Social Worker at Higher Ground, and Brett George, a consulting Psychologist to Higher Ground. From the Salvation Army Auckland Bridge Programme I was delighted to interview the Assistant Director, Clare Luamanuvae and the Programme Manager, Cynthia Young, while from the Odyssey House Auckland Rehabilitation Centre, I was very grateful to have interviewed Kerry Manthenga, who has held clinical case management and learning and development roles with them. I was also able to interview practitioners who wished for their name and the organisation they worked for to remain anonymous. I do not use the voices or views of the rehabilitation centres' clients in this research, but as an alcoholic in recovery, I draw upon my own experiences with treatment, self, community and recovery. I chose the three residential treatment centres – Higher Ground, Odyssey House and the Salvation Army Bridge Programme - as they are based in Auckland, where I was living at the

time of this research, and because they all use 'community' as a way of healing their clients and I'll pick up the discussion about this again in a later chapter.

In Chapter One I will investigate what the anthropological significance of studying drug and alcohol addiction treatment is by briefly putting forward some of the key arguments and findings anthropologists have proposed. I will provide a brief overview of how big the addiction problem is in New Zealand and the rest of the world to put into context what treatment centres are dealing with. I will then use various sources of academic text and participant interviews to highlight what addiction is. When I use the term "addict" or "addicted" I am including alcoholics, drug addicts, problem gamblers, sex and relationship addicts, pornography addicts, food addicts and any addictive object that can lead to compulsive behaviour (Sellman, 2009), unless I make a distinction between them or am quoting a direct piece of text. Understanding the arguments for what addiction is I then briefly describe a selection of treatment modalities on offer in New Zealand and what the differences are between them. I will end the chapter with definitions of what recovery is, in order to set a scene of what the end goal is for addiction treatment practitioners, to understand further why they do the things they do.

In chapter two I explain why I've written about this topic and what it has meant to me, using my own reflexive ethnography. I discuss the methods of enquiry that I considered for this study, including commentary on methods I discarded and why. I debate the benefits and shortcomings of using qualitative and quantitative methodology and give examples on my rationale for methodology selection. I also advise what I was not seeking to do from the outset, for reasons of ethical and emotional safety.

Chapter Three discusses a broad history of recovery and therapeutic community techniques, in order to provide a context in which this work can be placed. I attempt to chart the modern day recovery movement with its beginnings in the United States and



Great Britain. I describe the early work of the Oxford Group and the Emmanuel Movement and how Alcoholics Anonymous stemmed from these. I detail the steps and traditions of Alcoholics Anonymous, and show how these started to filter into addiction therapy. I discuss the burgeoning therapeutic communities and how these came to be, then offer a brief history of the New Zealand experience, focusing on key moments of treatment history. I then provide some limited background information on the treatment centres who kindly agreed to be included in my study.

Chapter Four provides a behavioural snapshot of the 'self' and I describe what treatment communities face when newcomers reach their doors. What's going through the mind of the addict when they reach treatment and what are they feeling? I ask the treatment practitioners to reveal what they're thinking when a client states they 'don't know who they are', or that they've 'lost themselves'. I ask my interview participants what kind of motivating factors they come across from clients when they first enter treatment, and end with a discussion on the pervading experiences of fear and denial and how these disrupt recovery and treatment outcomes, and what the treatment practitioners' views on Cohen's (1994) 'basket of selves' theory are.

In chapter five I focus on how community is used at the different treatment centres with a focus on 'community' as a method of treatment, the community reinforcement approach, spiritual communities (including Twelve Step communities) and discussion on some of the 'group work' that takes place in the centres, such as family groups and encounter groups.

In chapter six, I seek to explain what it's like for the client leaving treatment and comment on what subject matter experts say about the importance of preparing the client for re-entry into the community. I will also discuss what happens when someone relapses

and what this means to recovery. I will then provide a brief summary of why community works as a therapeutic tool and then give my view on opportunities for further research.

## Chapter One: The Anthropology of Addiction

*"Oh little brother," I thought, "Your arms have been pierced by the tiny fatal arrows of the Kingdom of the Small. Let heavy stones be tied to their necks..."*

*Thomas Belmonte, The Broken Fountain*

One day while I was attending group therapy as a resident in a drug and alcohol treatment centre, the clinical psychologist taking the session started talking about the 'addicted self'. I recalled from my previous dalliance with anthropology a decade earlier, the work of Anthony Cohen and his theory of "the basket of selves" and self-consciousness. In the preface to *Self-Consciousness: An Alternative Anthropology of Identity*, Cohen (1994:p.x) argues that '[e]xamining and reflecting on the self is not an alternative to addressing 'society' or social relations: they are mutually implicated'. There I was, in a drug and alcohol residential treatment centre, where the community was helping each other to examine themselves, and where the community was being used as a principal method to treat the individual. At that point an "inner-light" went on for me in my early recovery. Community was going to play an important, pivotal role in helping me stay clean.

Mary Douglas (1987:4) in her work on drinking and anthropology wrote that:

The general tenor of the anthropological perspective is that celebration is normal and that in most cultures alcohol is a normal adjunct to celebration. Drinking is essentially a social act, performed in a recognised social context. If the focus is to be on alcohol abuse, then the anthropologists' work suggests that the most effective way of controlling it will be through socialisation.

Socialisation is a key method in the armoury of drug and alcohol treatment centres.

When people make the decision to seek help for their excessive drug and/or alcohol use within the confines of a residential drug and alcohol treatment centre, a therapeutic process of change in the individual begins. Understanding systems and rituals of healing is well established with the anthropological discipline. Within the alcohol and other drug

(AOD) treatment milieu, the idea of residential treatment centres offering a therapeutic process of healing is comparable to Victor Turner's (1969:131-132) idea of ritual process and rite of passage within a *communitas*, where 'relationships between concrete, historical, idiosyncratic individuals' occur, and 'direct, immediate and total confrontation of human identities' takes place. The participants, or residents, of the treatment centres undergo the sequence of actions, phases or stages of treatment, and the process often extends beyond the therapeutic event itself (Csordas and Kleinman, 1990).

The mediums long at the centre of anthropological enquiry such as "culture," "community," and "self" are consistently used throughout the AOD treatment studies. Tom Main (1967) is cited by Hinshelwood (1999:43-44) in describing a process of ritualization between therapeutic communities and their clients, positing that the therapeutic community (a specific treatment modality) "must establish and sustain a specific culture – a 'culture of enquiry'" and that this analytic relationship continually needs to "address the question: 'What is going on between us?'" Anthropological methods offer a significantly rich discourse with which to do this.

Rex Haigh (1999: 249-254) defined five key ingredients of a therapeutic culture, being:

1. Attachment: A culture of belonging where the first task of treatment is to reconstruct a secure attachment, where community members can feel a sense of belonging and feel valued.
2. Containment: A culture of safety achieved through enforcing boundaries and knowing what is and isn't tolerated and allowed. This creates the environment necessary for residents to feel safe while exploring their distress and reconnecting with feelings and emotions that "may be boundless."
3. Communication: A culture of openness that encourages intimate (non-sexual) contact with others, enjoying "a mutual understanding of common problems" and finding "meaning through this connection."
4. Involvement: A culture of participation and citizenship where "all interaction and interpersonal business conducted by members of the community belongs to everybody". Everything that happens in the community, from verbal interaction, process groups, kitchen duties, sporting activities etc. can be used to therapeutic effect.

5. Agency: A culture of empowerment where any member of the community may have something valuable to contribute, and where the client's "unconscious knows better where to guide the therapy than does the analyst's expertise, and the commonly accepted notion that most therapeutic impact comes from the work the patient does, rather than the therapist."

William White (1996:xix-xxv) describes addiction and recovery from addiction as two quite distinct cultures, one which 'promotes the excessive use of psychoactive drugs' with its purpose being 'the organisation and promotion of excessive drug and alcohol use'. This culture must be shed upon entering the treatment process, where the clients begin to engage with the culture of recovery, which 'promotes radical abstinence from mind-altering substances'. He went on to explain that elements within the cultures of addiction and recovery include mediums that 'transmit values and shape the behaviour of their members,' including 'language, symbols, rituals, history, mythology, dress, diet, music, and art'.

Alcohol and other drug (AOD) studies are multidisciplinary. When we look at addiction and recovery, it's important we take a holistic view of the person, their psychology, their economy, their society, their culture, their history, their physiology...and the list goes on. The AOD practitioners I've spoken to consistently say they treat the person and not the symptom. 'The holistic model may owe its emergence partly to strong links within the treatment system with social work, psychotherapy and psychology', (Stewart and Casswell, 1992:140). On this basis, it would appear that anthropology is an ideal discipline to investigate systems of addiction treatment.

Yet anthropology, argues Paul Antze (1987) garnered scant interest in self-help groups such as Alcoholics Anonymous or treatment centres for some time. Antze (1987:149) asked the question in his study of Alcoholics Anonymous, 'how much culture can there be in a group that exists only to help problem drinkers stay sober?' If we apply

Antze's question to residential drug and alcohol treatment centres, along with his response to the question, it 'makes for a fascinating case study in the power of symbols to generate new patterns of action by re-construing the experience of persons in a standardised way', and that these organisations draw the alcoholic or addict 'into a community that globally reorders his life. It provides him with a new understanding of himself and his motives as an actor – in effect a new identity' (ibid).

In a similar dialogue seeking to explain the absence of some social sciences from alcohol and other drug addiction, Hunt, Milhet and Bergeron (2011:3) argue that:

Within the study of drug use and addiction, specific scientific paradigms, methods and tools have dominated – epidemiology, psychiatry, neurobiology – while other approaches have remained more marginal (including anthropology, history, sociology, and cultural and gender studies).

They concluded that this scientific dominance naturalised patterns and cultures of drug consumption through medical explanations, making use of psychoactive substances 'culturally innocent' (ibid).

In my yearning for knowledge and understanding of how community methods for healing addiction work, and how the discipline of anthropology could facilitate this, I read that there is a growing need for research that explores the therapeutic processes in order to help better understand the nature of therapeutic communities (Lees, Manning, Menzies and Morant, 2004). I knew that anthropology's quiet, unassuming qualitative theories and disciplines were an ideal way for me to be able to pursue my cathartic line of enquiry.

When we look at drug and alcohol addiction as a cultural process that affects the way people think about themselves and others in relation to the world, we can begin to understand the self-obsessive, self-loathing, self-destructive, manipulative, compulsive world view of many addicts. This thesis seeks to describe how three residential treatment centres use community methods to help people recover from their addiction(s) by changing

thinking patterns and consequent behaviours and 'seeking a new conceptual awareness of themselves and the world around them' (Wilcox, 1998:p.xiii).

Residential treatment centres are a way for people with chemical dependency issues to bring their substance abuse under control. Douglas (1987:6) stated, '[c]ommunity authority, community rituals, community solidarity, they seem to bring drinking under control'. It's sufficed to say that understanding how an isolated community of alcoholics and addicts helping each other to get well, is of some anthropological significance. But how large is that community, and how big is the addiction problem?

## What's the Problem?

Addiction, substance abuse and the ensuing social consequences are key public health and justice issues in New Zealand. The harm alcohol and drug use causes in New Zealand includes physical and psychological dependence, relationship harm to family and friends, loss of productivity and lack of work, impact on finances, along with violence, crime, injuries, disease, incarceration and death (Ministry of Health, 2009). Stewart and Caswell wrote:

In common with most other Western societies since World War II, New Zealand has seen an increase in consumption of absolute alcohol, deregulation of controls on alcohol availability, and a steady increase in the incidence of alcohol-related problems.

Stewart and Casswell authored this in 1992. I had to ask myself, in the ensuing twenty-one years, what's changed?

Evans (1988) says we can gain tremendous insights into the way a society functions on a cultural level by the way it frames its laws regarding alcohol (and illicit drugs). In their current term, the National-led government of New Zealand has passed the Misuse of Drugs Amendment Act and is legislating laws regarding the sale and purchase of alcohol. The

Prime Minister and Cabinet launched a series of initiatives with the aim of reducing the supply and demand of methamphetamine and targeted funding for extra places in residential treatment centres for methamphetamine addicts (Wilkins, Sweetsur, Smart, Warne and Jawalkar, 2012). Why was there the perceived need for the government to do this at all? If we look at some of the statistics from published research on drug and alcohol use and its consequences, we can begin to appreciate the scale of the problem, and begin to grasp the important role treatment centres have in our society.

The National Committee for Addiction Treatment New Zealand (2011:5) reported:

- Serious alcohol and drug misuse and addictions affect 3.5% of the total population or around 150,000 New Zealanders. For youth aged 16 to 25 years this figure rises to 9.6%;
- Methamphetamines are used by 2.5% of the adult population each year. For 18 to 24-year-olds, this rises to 8.7%;
- The New Zealand needle-exchange programmes distribute 2,000,000 syringes annually;
- 29.0% of the adult population regularly consumes alcohol at levels which result in significant harm to individuals and their families;
- 34,000 people were treated by DHB-funded sources in 2010/2011;
- \$120 million per year is the health budget for alcohol and drug treatment.

Similar recreational drug use patterns were found in the Ministry of Health's (2010) New Zealand drug use survey of nearly 6,800 randomised respondents (excluding alcohol, tobacco and BZP party pills, which at the time of the survey were a "legal high"). They found nearly one in two adults (49.0%) had used drugs for recreational purposes at some point in their lifetime, equating to approximately 1.3 million people in New Zealand, and that one in six adults had used drugs in the last year. They also found that overall, 2.6% of people who had ever used drugs had wanted help to reduce their level of drug use at some time in their life but not received it, equating to about 33,000 people.

A similar survey was completed by the Ministry of Health (2009) on alcohol use. Again, the survey revealed some astonishing patterns of New Zealand's drinking behaviour, including the frequency of use, help-seeking behaviours, and the harms people experience



from both their own use and from other people's use. They found that eight in ten (85.2%) of adults aged 16-65 had had an alcoholic drink in the past year, and that of this population, approximately 152,000 people drank alcohol on a daily basis and 494,300 people drank 3-6 times per week. Wodak (2011) argues that community consumption of alcohol is unequally distributed in that 20% of the heaviest drinkers consume 70% of the alcohol. Professor Tom McLellan, one of the chief advisors to the White House on drug control said in an interview with the New York Times (Kershaw, 2009) that, 'if someone is having three or more drinks a day, or 14 per week, that should raise a red flag'.

The Ministry of Health (2009) alcohol use survey went on to find that a large number of their survey respondents like to binge drink, when one in eight past-year drinkers had consumed a large amount<sup>1</sup> of alcohol on one drinking occasion at least weekly in the past year, and that one in ten people had consumed a large amount of alcohol on a drinking occasion aged 14 years or younger. This is of concern as Young, Oei, Crook and McCallum (1988:44) state, 'Social learning research has consistently proposed that outcome expectancies of drinking are largely shaped by peer or parental attitudes and behaviours as well as media influences such as advertising and television'.

In relation to seeking treatment for the drinking behaviour, the Ministry of Health (2009) survey on alcohol use found that in the past year, 1.3% of adults had received help to reduce their level of alcohol. About 1.2% of adults had wanted help to reduce their level of alcohol use in the past year but had not received it. Subsequently they discovered that one in forty adults (2.4%) reported that they had wanted help to reduce their level of alcohol use but had not received it, at some point in their life. Another grave area of public concern regarding alcohol use is Foetal Alcohol Syndrome and Effects. The survey found

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<sup>1</sup> A large amount of consumption was categorised as more than six standard drinks for men and four standard drinks for women.

that about one in four (28.7%) women who had been pregnant in the past three years reported that they had consumed alcohol while pregnant.

Wilkins, Sweetsur, Smart, Warne and Jawalkar (2012) authored an annual report on behalf of Massey University's centre for Social and Health Outcomes Research and Evaluation (SHORE) that collated recent trends in illegal drug use from 2006-2011. "The Illicit Drug Monitoring System (IDMS) is conducted annually to provide a 'snapshot' of trends in drug use and drug markets in New Zealand" (ibid: 22) and is conducted as part of the National Drug Policy. The report is significant because the authors have been interviewing close to 400 frequent illicit drug users since 2006, a difficult task to complete as it's such a personal, clandestine activity. The report revealed:

- The proportion of drug users who noticed a new drug type in the last six months increased from 9% in 2006 to 34% in 2011;
- The proportion of frequent methamphetamine users who accessed an ambulance rose from 3% in 2006 to 14% in 2011;
- The proportion of frequent methamphetamine users who reported committing a violent crime in the previous six months increased from 11% in 2009 to 30% in 2011;
- The proportion of frequent methamphetamine users who received drug and alcohol treatment as part of their conviction increased from 32% in 2009 to 50% in 2011;
- Sixty-nine per cent of the frequent injecting drug users and 58% of the frequent methamphetamine users were unemployed or on a sickness benefit in 2011;
- Twenty-nine per cent of the frequent methamphetamine users and 20% of the frequent injecting drug users believed they needed 'a lot' of help to reduce their drug use;
- Twenty-nine per cent of the frequent methamphetamine users, 25% of the frequent injecting drug users and 13% of the frequent ecstasy users said they had wanted help to reduce their drug use in the previous six months but had not got it;
- Sixty-nine per cent of the frequent injecting drug users, 38% of the frequent methamphetamine users and 9% of the frequent ecstasy users had been in drug treatment at some point in their lifetimes;
- There was a statistically significant increase in the mean number of times that the frequent methamphetamine users had been in drug treatment from 2009 to 2011 (from 2 to 3 times);
- Eighty-five per cent of the frequent injecting drug users, 84% of the frequent methamphetamine users and 40% of the frequent ecstasy users had been arrested at some point in their lives.

This paints a bleak picture for people with illicit chemical dependency issues who intend on sustaining such a lifestyle. Alarmingly, Wilkins, Sweetser, Smart, Warne and Jawalkar (2012:77) cite the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) (2011, 2012), who said the 'number of new psychoactive substances identified.....has increased from 13 in 2008, to 49 in 2011' and 'the total number of new drug notifications for 2012 is likely to exceed 60 new substances'. It's only a matter of time before the knowledge of how to make these psychoactive substances arrives in New Zealand.

Along with the introduction of Drug Courts in New Zealand, where sentencing can include mandatory treatment for substance abuse, the current trends with alcohol and drug consumption, frequency of use and availability, all point toward people becoming trapped in a chemically dependent relationship with the drug of their choice. It ventures to suggest that treatment centres will play a vital role in our communities by restoring people back to health. But how do we know who's unwell and who isn't?

## **What is Addiction and Alcoholism?**

*"O! Thou invisible spirit of wine! If thou hast no name to be known by, let me call thee devil! O! God, that men should put an enemy in their mouths to steal away their brains."*

*Othello, Act II Scene III*

In order for drug and alcohol treatment centres to have become established, we can suggest there are symptoms or characteristics of drug and alcohol users that necessitate the act of seeking help. The academic literature about addiction is expansive and this section seeks to explain some of the more popular theories about what addiction and alcoholism are.

Traditionally, addicts have been viewed as a moral failing (Prentiss, 2008). Those who drank excessively and could not abstain demonstrated a huge weakness of moral fibre,

and this misconception is still somewhat prevalent today. There is a common train of thought that addicts and alcoholics lack willpower and “intestinal fortitude” and that they should “just say no.” Goldstein (1994: 219) states, “Drug addiction is much more than just using a certain drug; it involves total behaviour, social interactions, lifestyle. Whatever the form of treatment, therefore, treating drug addiction, like preventing it, entails much more than ‘Just say no!’”

The founding of Alcoholics Anonymous in 1935 in Akron, Ohio, has over the years created a paradigmatic shift in thinking of addiction from a moral viewpoint to a medical one, bringing forth the concept as addiction as a disease (White, 1996). The “Big Book” of Alcoholics Anonymous (2001:xxviii) starts with a foreword called “The Doctor’s Opinion,” written by William D. Silkworth, M.D in 1939. In it, he writes that:

The action of alcohol on these chronic alcoholics is a manifestation of an allergy; that the phenomenon of craving is limited to this class and never occurs in the average temperate drinker. These allergic types can never safely use alcohol in any form at all; and once having formed the habit and found they cannot break it, once having lost their self-confidence, their reliance upon things human, their problems pile up on them and become astonishingly difficult to solve.

While having an allergy to one’s drug of choice isn’t technically or medically correct (Shelton, 2011), Silkworth did recognise an important factor. The addicted brain reacts in a completely different way to the brain of the non-addicted. This difference, Shelton (2011: 9) argues, is the ‘key to today’s definition of addiction: addiction is a combination of substance use, consequences, and an individual’s brain functioning’, and that despite the serious consequences of continual and compulsive substance use, if the person cannot stop using despite all the will and desire to do so, characteristically, addiction is prevalent.

The first step of Alcoholics Anonymous (2001:59) is, “We admitted we were powerless over alcohol – that our lives have become unmanageable.” (Narcotics Anonymous swaps the word ‘alcohol’ for ‘addiction’). Shelton (2011) argues that one of the

clear indicative markers for addiction is the erosion and unmanageability of the addict's life, stemming from their constant and relentless substance abuse. Wilcox (1998:36) quotes Levin's (1987:43) explanation of the diagnosis of alcoholism. 'The essential characteristic of alcoholic drinking is its compulsiveness. The drinker continues to drink regardless of the consequences to health, relationships, emotional stability and financial well-being'.

Sandor (2009) supports Dr. Silkworth's argument of alcohol being like an allergy when he says that being an alcoholic means reacting to alcohol in a different way than normal drinkers. Sandor implies that when an addictive disorder is present in a person, the pathological reaction created when consuming alcohol isn't in the immune system (an allergy that may for example cause us to break out in hives or rashes), but in the central nervous system. He describes addiction as an 'automatism.' Just as we learn to read, write, or swim, these learnings become consolidated and automatized. We cannot "unlearn" how to do them. The same is for some people with their drug taking. It becomes a default mechanism for them to deal with life and becomes "automatized," with the central nervous system tricked into thinking that this is a necessary action for the individual's survival.

The Narcotics Anonymous (1988:3) "*Basic Text*" asks the question 'Who is an addict?' and responds with:

*"Most of us do not have to think twice about this question. WE KNOW! Our whole life and thinking was centered in drugs in one form or another – the getting and using and finding ways and means to get more. We lived to use and used to live. Very simply, an addict is a man or woman whose life is controlled by drugs. We are people in the grip of a continuing and progressive illness whose ends are always the same: jails, institutions and death."* (Italics and capitals as per original text).

Robert Dupont (2007), Director of the United States National Institute on Drug Abuse (NIDA) is quoted as saying '[a]ddiction is not self-curing. Left alone, addiction only gets worse, leading to total degradation, to prison, and ultimately to death'. Shelton (2011:9) quotes NIDA itself (2007), defining addiction as 'a chronic, relapsing brain disease

that is characterised by compulsive drug seeking and use, despite harmful consequences'. Shelton (2011) argues that despite serious, looming consequences of their substance use, when the person just cannot stop despite the desire to do so, addiction is evident. Wilcox (1998) cites Vaillant (1983) identifying alcoholism as a continuum of negative consequences. Wilcox (1998:pp.6-7) maintains that in all the credible definitions of alcoholism, there are common threads, including:

(1) the alcoholic is psychologically and/or physically dependent on the use of alcohol; (2) the alcoholic suffers harmful consequences from the use of alcohol; (3) the alcoholic suffers from impaired control over drinking behaviour.

Alcohol and drug addiction is boundaryless, caring not for geography, ethnicity, sexuality, gender, economic status, formal education or age, and no single specific factor has been found to explain it (Kolath, 1988). Some of the addicted are able to function (for a while) quite well in wider society and don't end up being a part of the criminal fraternity. Avram Goldstein (1994:2) argues that as a society we are accustomed to thinking that addicts 'belong to an underclass, that we align them with 'junkies' or street people', and 'even though many heroin and cocaine users are middle-class professionals, that image seldom comes to mind when we think about cocaine addiction'.

Yates and Malloch (2010:17) contend that the notion of addiction (a disease) is embedded in a cultural context where individuality and liberty lie above all else and that our behaviour within that context is our own individual responsibility. They quote the World Health Organisation's (1992) Classification of Diseases, where the diagnostic requirement for addiction is an 'impaired capacity to control substance-taking behaviour in terms of onset, termination or level of use', and 'a preoccupation with the substance of choice, which disregards other important concerns or alternatives'.

In 1956, the American Medical Association named alcoholism as a disease (Prentiss, 2008). Keegan and Moss (2008:146) refer to the *Diagnostic and Statistical Manual of Mental Disorders v.IV* (DSM IV) when describing addiction as 'the physical abuse of, dependence on, and withdrawal from drugs and other miscellaneous substances,' thus categorising it as a mental illness along with depression, bi-polar and schizophrenia. They posit that addiction cannot be cured and should instead be treated. Twelve Step programmes take the same stance in that addiction is something that cannot be cured, focussing instead on recovery as an on-going, day-at-a-time process (White 1996). Csordas and Kleinman (1990) contend that as the DSM IV is constantly being revised, this has unavoidable implications for the therapeutic process, as was the case for homosexuality, which was once considered to be a mental illness.

The DSM IV (1994:181-183) sets out the criteria for substance dependence as:

...defined as a maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring any time in the same 12-month period:

1. Tolerance, as defined by either of the following: (a) A need for markedly increased amounts of the substance to achieve intoxication or the desired effect or (b) Markedly diminished effect with continued use of the same amount of substance.
2. Withdrawal, as manifested by either of the following: (a) The characteristic withdrawal syndrome for the substance or (b) The same (or closely related) substance is taken to relieve withdrawal symptoms.
3. The substance is often taken in larger amounts or over a longer period than intended.
4. There is persistent desire or unsuccessful efforts to cut down or control substance use.
5. A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects.
6. Important social, occupational, or recreational activities are given up or reduced because of substance use.
7. The substance use is continued despite knowledge of having a persistent physical or psychological problem that is likely to have been caused or exacerbated by the substance (for example, current cocaine use despite recognition of cocaine-induced depression or continued drinking despite recognition that an ulcer was made worse by alcohol consumption).

But is addiction really a disease? De Leon (1989) argues that addiction is a disorder of the whole person, and maintaining sobriety involves making a change in the whole person, such as attitudes and emotional well-being. Room (2003:226) argues that our disease-model definitions of addiction are culturally specific in that time has become a 'commodity in our social structure' and addiction is viewed within 'a cultural frame in which time is...used or spent rather than simply experienced'. It's the sought after experience of inebriation that the addicted seek above all else, and this comes into direct conflict with how society dictates how people should be "spending" their time. Shinebourne and Smith, (2008:155) describe the alcoholic's experiences and engagement with alcohol as 'an experience of flux, oscillation and instability'.

Jellinek (1960) argues that the disease of alcoholism is characterised by a loss of control and a progressive nature. Supporters of the disease model of addiction argue that addiction is primary, progressive, incurable and ultimately fatal if left untreated. Opponents of the disease model argue that it's inappropriate to label addiction as a disease. If we are unable to identify any symptoms early in the onset of the progression of the addict from first point of contact to substance abuse to chemical dependency, how can we possibly label it a disease? Isn't it brought about by an individual's behaviour? McLellan (2010) argues that like most chronic diseases such as diabetes, hypertension and asthma, addiction is brought on by behaviours combined with genetics, which produces a significant public health issue. However, Hunt, Milhet and Bergeron (2011) argue that the development of addiction as a disease has its limitations, including allowing a wide range of behaviours to become pathologized to narrow, individual characteristics, while ignoring the wider socio-cultural factors of consumption.



Decorte (2011:36) argues that science itself has a fear of intoxication and that the knowledge base surrounding the act of “getting high” is biased towards the moral-medical concept of addiction. He states that:

[T]he concept of addiction is an effort to describe a pattern of use, when people are trying to get high with an intensity and frequency that makes them feel dependent. For addicts, being high is not satisfactory any more, and the substance is primarily used in order to feel not sick or in the best case normal.

Hunt, Milhet and Bergeron (2011) added that the pleasure of drug consumption is often overlooked in understanding drug use and the drug using community and that the focus is on what’s going on in the brain and the reward circuit system. But at some point, some people overstep a line of recreational use to abuse to dependency, where the drug of one’s choice is needed just to be able to function (albeit with great impairment) throughout the day.

McLellan (2010) discusses addiction in a bio-psycho-socio context, with addiction related problems being suffered in differing ways, as ‘some problems cause substance use; some problems result from substance use; and some simply emerge along with substance use as the result of genetic, personality and environmental conditions’.

A crucial element to our understanding of addiction is the impact to the “self.” De Leon (2000:40) argues that addicts deny or do not accept their own contributions to their problems, and that underlying this is an ‘individual whose self-view is characterised by disempowerment in regards to changing circumstances, lifestyle, or self’, and states that ‘hallmark characteristics in general are their lack of understanding and self-acceptance’ (ibid:327). De Leon (2010:71) then argued the addiction problem lies essentially with the person and not the drug. “Addiction is a symptom, not the essence of the disorder.” While Levin, (1987:3) addresses addiction as a disturbance of the self, of self-will ‘run riot’:

There are many reasons to consider alcoholism a disorder of the self. Alcoholism is by definition, a form of self-destruction by self-poisoning, of

suicide on the instalment plan – a fact which strongly implies that alcoholism is a form of self-pathology.

Berger (2008:43) acknowledges that the super ego of the alcoholic or addict is constantly having its self-esteem injured or wounded and that addiction is a 'self-disorder' where 'drinking or using fills up the hole in our soul, covering up an emptiness caused by these wounds to our self-esteem, which gnaws at us'. Keegan and Moss (2008:56) argue that one of the major themes of addiction is 'the concept of escape: escape from responsibilities, family, work, relationships, school, but mainly escape from ourselves'. White (1996:86) describes the addict, regardless of drug choice as a 'chameleon' who goes through kaleidoscopic changes depending on their audience in order to be the person they need to be in order to keep the door to the relationship with their drug of choice firmly open. He sees addiction as 'not an escape from reality; it is a confrontation with reality. It thrusts one into a reality fraught with risks and challenges that would be inconceivable to one outside the life'.

McAlister (2010:1) states that addiction is the 'opposite of freedom and in no way resembles abundant living. It is an acquired habit that is rooted in self-deception and fear'. He argues that addiction is so compulsive that it 'continuously occupies the focus of the individual'. So powerful is this focus on the need to have more of the drug-of-choice that it deludes the individual into believing that they can deceive others into getting what they need at any cost, whilst ultimately deceiving the self into thinking that what they are doing is justified and that everything is under control.

Although a great deal of the literature on addiction is centred in the discourses of psychology and neuro-science, Wilcox (1998) cites Bunzel (1940), and Horton (1940), in providing important early reports on anthropological enquiry on cultural drinking patterns. Bunzel (1940) studied and compared two separate Mayan Indian communities and found

that learned behaviour was essential to drunken conduct. Horton (1943) looked at 56 different cultural groups and claimed to find more drunkenness in cultures where resources were less predictable. Wilcox (1998: 17) argued that anthropology hasn't 'followed other social sciences in alcohol research', instead arguing 'they have begun to apply the concepts of culture and adaptation in a holistic manner'.

Carr (2011) and Wilcox (1998: 119) cite the work of Gregory Bateson (1971), stating, 'Bateson suggested that the alcoholic, when sober, is engaged in life on the basis of an epistemological error', and further that:

[T]he causes of alcohol dependence could be found in the sober state of the alcoholic. If the sober state of alcoholics compelled them to drink, then whatever motivated them in sobriety could not be expected to assist in the reduction or control of alcohol dependence.

This is one of the many paradoxes that can be found within the explanations of addiction and recovery.

## **What are the Treatment Modalities Available in New Zealand?**

Treatment is often described by the people involved as a journey of discovery on the road to recovery (Yates and Malloch, 2010). The 'journey is the individual process of recovery and personal growth' (De Leon, 2000:153). Treatment is not prevention. The challenge with treatment is 'to move addicts from an addicted to a drug-free state... or to at least free them from the compulsion of drug use, which dominates their lives' (Goldstein, 1994: 215). Kerry Manthenga from Odyssey House (Personal Interview, Auckland, 1 December 2012) says, 'treatment is an episode in your recovery. It isn't your recovery'. She says 'there's no one-size-fits-all' method of treatment for individuals who are suffering the consequences of substance abuse and 'because people vary greatly in the total circumstances of their addiction, what works well for one may not work well at all for another'.

Treatment programmes may be broadly grouped as residential and outpatient. In New Zealand, four of the main treatment modalities employed are outpatient counselling, detoxification, methadone maintenance (harm reduction) and residential treatment. Some people will respond better to treatment in a one-to-one or group outpatient setting, where they get to go home or return to work after the session – still trying to maintain an ‘ordinary life’. Outpatient counselling is the most common in New Zealand and can involve regular one-to-one counselling, group therapy, or intensive outpatient group therapy (for example, group sessions three days per week) with a trained AOD clinician, but the client gets to return to the familiarity of home and try to put what they’ve learnt into practice straight away. Organisations such as Community Alcohol and Drug Services Auckland (CADS), Salvation Army, City Mission, and CareNZ provide these essential services in New Zealand, provided free of charge and funded by the public health system.

Detoxification (detox) from a drug of choice can be extremely dangerous and in some cases life-threatening if the method used is “cold turkey.” This is particularly the case for people with physical dependence to drugs such as benzodiazepines (e.g. valium) and alcohol. A medical detoxification can help relieve the physical and physiological symptoms of withdrawal, such as vomiting, delirium tremens, cramps, shaking, and night sweats (CADS, 2012). For many it is the very beginning phase of their recovery. Services can be provided at the service user’s home through medical prescription if their symptoms are less severe, in some community residential treatment facilities as part of their treatment (such as Capri Hospital or the Bridge Programme), or admission to a local dedicated in-patient medical detoxification facility (Pitman House), or public hospital. Keegan and Moss (2008:104) state that:

Detox is not a treatment in and of itself, but for many people who have become physically and psychologically addicted to any substance, treatment usually commences with detoxification, the process over

several days of systematically withdrawing a person from addicting substances under medical supervision.

For some, abstinence from all drugs or alcohol is not a realistic short or long term goal, and harm reduction methods may be more appropriate, where work is focussed on reducing the amount of consumption, or replacing the harmful substance (such as heroin) with a prescribed drug (such as methadone) in order to reduce the overall risk and harm the client is doing to themselves (Clarke, 2000). Wodak (2011) argues that this intervention is used to reduce the harms associated with drug use for people who just cannot or won't abstain. Reduction of harm (e.g. HIV or hepatitis C infection, crime) is given the highest priority rather than the goal of abstinence.

Some people need to remove themselves from society altogether, and seek treatment in a residential treatment setting, which is the modality of focus for this thesis. Residential treatment is a generic term that defines treatment by setting (ibid). Clients will move into the setting for a period of time and become residents. Shelton (2011:75) states:

Residential facilities minimise risks of relapse because the substance abuse cues that abound in one's home environment are missing. And even if one is strongly tempted to use or experiences cravings, there is always a peer or staff member on hand to quell these emotions.

Residential rehabilitation settings provide very diverse AOD treatment and philosophies, usually over the course of several weeks and months. These include therapeutic communities and other non-medical treatments which require accommodation, or residence (Wodak, 2011). Residential treatment settings are places where individuals are removed from their normal social settings 24-hours-a-day, so that the wider community is unable to influence their drug or alcohol abuse (De Leon, 2000).

## What is a Therapeutic Community?

Within the broad spectrum of treatment settings, one type of treatment for substance abuse is the therapeutic community (Clarke, 2000). Traditional therapeutic communities (TCs) are characterised by a treatment philosophy of “right living” and “community as method” which utilise confrontational group therapy, treatment phases, a tenure-based resident hierarchy, and long-term residential care, largely managed and directed by the residents themselves (Dye, Ducharme, Johnson, Knudsen and Roman, 2009). Manning and Morant (2004:29) describe TCs as ‘small social systems in which interactions between individuals and social contexts are encouraged and facilitated through intense group experiences, and are brought to consciousness through continuous feedback’.

This drug-free community that adopts a “self-help” approach (De Leon, 2000) is like a miniature society, complete with its own rules and roles, all designed to promote the transitional process to wellness and recovery for the clients (Dawson and Zandvoort, 2010). The TC has been likened by residents, practitioners and observers alike to a “micro-society”, minus the drugs and alcohol and associated behaviours that go with it. ‘The TC contains many of the elements of the larger macro society – a daily regimen of work and education, social relationships, and especially, an occupational structure’ (De Leon, 2000:28). Johnny Dow, Director of Higher Ground says:

A therapeutic community forms a mini-society in which change can occur in an individual... a therapeutic community amplifies everything because it sends people back into their family of origin pretty quickly.

Therapeutic communities differentiate themselves from other residential treatment centres in two ways, according to De Leon (1995). Firstly, because substance abuse impacts people in multiple ways and areas, interventions should address the person holistically, and secondly, group dynamics within the community influence a person’s motivation to change (Clarke, 2000). De Leon (2010:75) states that:

The quintessential treatment element of the TC is community. What distinguishes the TC from other approaches...is the purposive use of the community to facilitate social and psychological change in individuals with substance abuse and related problems...The term therapeutic community connotes that community is the method to pursue the therapeutic goals that define recovery.

Gowing, Cooke, Biven and Watts (2002) cite Bale et al. (1984) in distinguishing TCs from other residential settings by the focus of the community being on the current behaviour of its members, its effects on others and the community as a whole, and the assimilation of new behaviours. These behaviours are influenced through group-controlled sanctions affecting every major aspect of the member's life including food, movement restriction, exercise, visitation, and inclusion and exclusion from the community.

Gowing, Cooke, Biven and Watts (2002) and Adamson, Deering, Hinerangi, Huriwai and Noller (2010:9) note that with the diversity of programmes that TCs offer due to their adaptation to changing treatment needs and health care environments, 'it should be unsurprising that a single definition of the therapeutic community is hard to find', and that there is 'no clearly accepted, simple definition of a therapeutic community'. De Leon (2000:1) says although the origins of the phrase "therapeutic community" are unclear, they 'descend from historical prototypes found in all forms of communal healing'. However, Adamson, Deering, Hinerangi, Huriwai and Noller (2010) cite Meyers (2008), as crediting the psychiatrist Tom Main with coining the term "therapeutic community". Main directed Cassel Hospital which he turned into a therapeutic community based on psychoanalytical theory and practices. Rapoport (1960:10) argues the name "therapeutic community" evolved from hospital settings 'organised as a community in which all are expected to contribute to the shared goals of creating a social organisation with healing properties'.

Lees, Manning and Rawlings (2004:52) break the TC into two main types, being 'democratic and concept based / hierarchical' where 'one [is] dealing with deeper intrapsychic change and the other with initial behavioural control'. Hinshelwood (1999:39) sees

psychoanalysis as the founding idea of therapeutic communities and states: '[t]he unconscious in human experiencing, and the transference, are the foundations of psychoanalysis and of the therapeutic community as well'. The National Institute on Drug Abuse (NIDA) (2002:1) describe TCs as:

[D]rug-free residential settings that use a hierarchical model with treatment stages that reflect increased levels of personal and social responsibility. Peer influence, mediated through a variety of group processes, is used to help individuals learn and assimilate social norms and develop more social skills. TCs differ from other treatment approaches principally in their use of the community, comprising treatment staff and those in recovery, as key agents of change. This approach is often referred to as "community as method." TC members interact in structured and unstructured ways to influence attitudes, perceptions, and behaviours associated with drug use.

De Leon (2000:123) states:

Although the social organisation of the TC is grounded in self-help concepts, it is managed as an autocracy. Authority is formally and explicitly defined by community position and job function and informally by community status. Staff members possess both formal and informal authority, while residents have little formal but considerable informal authority.

De Leon (2010:70) argues that the 'TC for addictions, as a treatment approach, is "explicitly recovery-oriented" and that the primary goal of treatment is recovery, which is broadly defined as changes in lifestyle and identity'. Gowing, Cooke, Biven and Watts (2002) cite Latukefu (1987) in defining the therapeutic community as a way of changing an individual's lifestyle through a community of concerned people working together to help themselves and each other, within a highly structured environment with very defined moral and ethical boundaries.

The therapeutic community for drug and alcohol addiction as a method of treatment appears to still be in its infancy when De Leon (2000:1) states:

As a hybrid, spawned from the union of self-help and public support, the TC is an experiment in progress, reconfiguring the vital healing and teaching ingredients of self-help communities into a systematic



methodology for transforming lives.

Like any culture or community, therapeutic communities have evolved over time, and De Leon (2000:337) went on to say that the therapeutic community is a 'culture of change'.

Kerry Manthenga (personal interview, Auckland, 1 December 2012) from Odyssey House says:

A TC is a place where people with similar struggles come together to help each other figure out what needs to be different in their lives so they can have the lives they want. There is a very strong focus on right living and a morality that comes with that. It is a place for holistic healing.

Brett George, Consultant Psychologist to Higher Ground (personal interview, Auckland, 17 September 2012) says, "It feels like coming into a huge family, which is so special...there's a sense of people, on the whole, attempting to move and develop together..."

Kathy Mildon from Higher Ground (personal interview, Auckland, 28 August 2012) defines a therapeutic community as:

Authenticity twenty-four-seven...and being real, and modelling. Modelling what we hope our clients can eventually achieve, so it's about...an environment that provides a safe process for clients to...do what they need to do while they're here, and our job is to support that, and reinforce that, and show that through our own journey.

Another of my participants (personal interview, Auckland, 9 October 2012) said that, "I think in its pure form, [a TC] is where the clients have... or the residents or the former users help themselves." They help themselves on a journey to recovery.

## What is Recovery?

'Recovery is contagious' (Her Majesty's Government, 2010, cited by Best and Ball, 2011:10). Recovery is an individualised way-of-life and a deeply personal experience for people who no longer live the addicted lifestyle. When I first entered treatment, my peers, my counsellors, the clinical teams, the Twelve Step community, were all talking about recovery. People who had been abstinent for years were saying they're 'in recovery.' I often wondered when they could say they were recovered. Was there a defining point to being in recovery? Was it tangible, specific, measurable, attainable, realistic, timely, and all those

other buzz-words with which we associate goal-setting? At the time I thought that I really hadn't lost a lot in the way of relationships and assets, so what was it that I was recovering or recovering from? What was this thing called recovery? Thom (2010:52) sums up the difficulties with defining the term 'recovery', because the 'subjective nature of the recovery process means that the experience – and what 'works' – is different for different groups of people, for each individual and for different problems'. One of my participants said, 'It's not a state, it's an on-going process, which is different for the same people and the same for different people'.

When does recovery begin? At what point does an addict or alcoholic know that they're in recovery? Doweiko (2012:411) cites Prochaska's (1998, 1992) 'Stages of Recovery', which suggests that the whole process begins long before the addicted person even realises they have a problem.

The addict goes through stages of precontemplation (active use and no thoughts of giving up); contemplation (entertaining vague thoughts about giving up); preparation (a decision to quit in the immediate future); action (concrete steps are made to avoid substance use); maintenance (developing behaviours supportive of recovery and associated behavioural changes), and; termination (the person has made cognitive changes that support abstinence).

I had the great fortune of attending the Addiction Practitioners Association of Aotearoa New Zealand (DAPAANZ) conference in August 2011 and listening to Professor Tom McLellan's seminar on recovery. Professor McLellan is an advisor to the White House on drug and alcohol addiction strategy and sits on the Board of the Betty Ford Clinic. In 2007 he convened the Betty Ford Institute Consensus Panel and their definition of recovery is *"a voluntary maintained lifestyle characterised by sobriety, personal health and citizenship."*<sup>2</sup>

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<sup>2</sup> The definition offered here from the Betty Ford Consensus panel was taken directly from the notes I took from Professor McLellan's presentation slides. See also Betty Ford Institute Consensus Panel,

Best and Ball (2011:13) reveal that a subsequent panel meeting of the United Kingdom Drug Policy Commission produced a similar definition of recovery as a '*voluntarily sustained control over substance use which [maximises] health and well-being and participation in the rights, roles, and responsibilities of society*'.

Both definitions ascribe that recovery is *voluntary*. This is true. We can take it or leave it. We can make choices to sustain and maintain a life free from drugs and alcohol or not. Those choices we make ultimately have an impact on our day-to-day wellness. Yet when we talk about the "*responsibilities of society*," I think of my own addiction to alcohol, and even in "full flight" I held a job, was a productive member of society, paid my taxes, never got in trouble with the law, never went to hospital because of my drinking, albeit while loathing every fibre of my being in the process. Did that make me irresponsible to society and its expectations of me? Sure, the personal relationships I had were under immense strain, but society? What of my responsibilities to self and my own personal experiences and development within the recovery paradigm? I feel that the Drug Policy Commission's definition stigmatises and generalises *all* alcoholics and addicts as irresponsible towards society, ignoring an individual's own sense of functioning and relationship with self. Boyd (2004:159) argues that 'those who fail to self-govern their drug use are constructed as "social problems," justifying more intrusive interventions by family members, professionals, and the state'.

A conference delegate asked Professor McLellan whether a person who was successfully reducing their drug-taking over time, but still using the drugs (harm reduction) could be classified as being in recovery. He said, "No. If they're taking drugs they don't

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(2007). What is Recovery? A working definition from the Betty Ford Institute. *Journal of Substance Abuse Treatment*, 33, 221-228.)

want to know them.<sup>3</sup> He was also quick to admit that Betty Ford’s definition was a starting point for the recovery community and the public at large, and was something to work with. He advised the conference that they argued quite significantly about whether or not nicotine smokers should be included in the population covered by the definition, and in the end they agreed not to because this would probably exclude half of the active recovery population. The Betty Ford Consensus Panel and Consultants revisited their definition in 2010, debating the key issues about their recovery definition in a letter to the editor of the *Journal of Groups in Addiction and Recovery*, arguing:

- Recovery is not synonymous with a specific method of attaining it;
- Sobriety is synonymous with abstinence from alcohol and all non-prescribed drugs;
- People in recovery taking prescribed drugs in accordance with their prescription, where that medication has an abuse liability, are included in the recovery definition;
- The Panel did not require tobacco abstinence as part of the conditions for “being in recovery”.

Berger (2008: 19) argues that complete recovery requires total abstinence:

If we continue to drink or use other drugs, we cannot be fully present and accessible during the process of recovery. Recovery requires total honesty, open-mindedness and willingness. Using alcohol and other drugs interferes with our ability to be honest with ourselves, to be open-minded regarding our life and how we managed it, to experiment with new ways of dealing with life, and to discover a spiritual solution to our problems.

Best and Ball (2011:16) see full recovery involving:

- Abstinence from all illicit drug use and alcohol;
- Improved quality of life and well-being; and
- Engagement in meaningful activities.

Recovery and abstinence are not mutually exclusive to some of the practitioners I spoke to. There was a wide-spread belief that one could be abstinent from all drugs and alcohol and not be in recovery. A proportion of these people are sometimes referred to as “dry-drunks.” Even though they’ve stopped drinking, they’re still left with the behaviours of a

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<sup>3</sup> Professor McLellan was referring to the Betty Ford Panel “not wanting to know” active drug takers in the context of the definition of recovery, not necessarily from receiving treatment at a later time. The Panel are effectively excluding a population of people who are incrementally reducing their drug taking, from being part of the ‘recovery population’.

drunk, for example, temperamental mood swings, explosive anger, or compulsive behaviour. Sandor (2009:33) argues that, 'Abstinence, though necessary, is simply self-denial. Recovery, on the other hand, is the affirmation of a life wisdom that brings the abstinent alcoholic or addict to a place where he no longer wants to become intoxicated, no matter what life throws at him'. Michael Shelton (2011) defines abstinence as necessitating loss, while recovery involves building a new life. Doweiko (2012) questioned whether abstinence should be the goal of treatment or not and confirmed that this question is fiercely debated amongst the addiction treatment practitioners' fraternity.

From my own personal experience, stopping drinking was easy. Staying stopped required a whole different mind-shift and skill-set entirely. Many people I have spoken to in Twelve Step programmes agree that in early recovery you're going to have to spend as much time focussed on your recovery as you did when you were using or thinking of using the drug of your choice. White (1996:222) explains that addiction is an all-encompassing lifestyle and once this lifestyle is stopped, a void is left that needs to be filled by an equally encompassing lifestyle based around recovery. He says that recovery is a culture, an 'informal social network in which group norms (prescribed patterns of perceiving, thinking, feeling and behaving) reinforce sobriety and long-term recovery from addiction'.

The website of the National Committee on Alcoholism and Drug Dependence (2012) says that the public perception of recovery is seen as someone who is "trying to stop alcohol or use other drugs," and that recovery is much, much more than that. They state that essentially, 'recovery from alcoholism and drug addiction is a complex and dynamic process encompassing all the positive benefits to physical, mental and social health that can happen when people with an addiction to alcohol or drugs, or their family members, get the help they need'.

The Scottish Recovery Network (2009:44) states that:

Recovery is being able to live a meaningful and satisfying life, as defined by each person, in the presence or absence of symptoms. It is about having control over and input into one's life. Each individual's recovery, like his or her experience of mental health problems or illness is a unique and deeply personal process. It is important to be clear that there is no right or wrong way to recover.

I asked Brett George, Consultant Psychologist to Higher Ground (personal interview, Auckland, 17 September 2012) what he thought the ideal recovery looked like. He responded:

There is no ideal. That's a perfection statement. For me it...it needs to be good enough for the person. It needs to be healthy enough, functional enough, emotional enough, spiritual enough, connecting enough, for that particular individual because personalities are going to vary. Some people are more extroverted and some people are more introverted. Some people are naturally better at connecting than others. It doesn't necessarily mean that that person that doesn't is less than...less able in their recovery. So it's a very um, again it's a very individualistic and relative to that individual concerned.

In hindsight, I know I was looking for validation about whether what I was doing in my own recovery was right. Although not getting the validation I wanted from Brett was disappointing, it gave me something better – an understanding that my recovery was exactly that. Mine. I also had to remember that I'm after progress, not perfection. I asked the question differently of one of my participants: "What does the term recovery look like to you?" Kathy Mildon from the Outreach Team at Higher Ground (personal interview, Auckland, 28 August 2012) responded:

I'd say balance. So, I mean, if I think of people who have been in recovery, say five years more...five years or more, um, what I notice about them is that they are, um, executing very good self-care. Um, they're very engaged in their community and the world, they tend to be in healthy relationships, um, often they're working or they're at study. Um, and so it's kind of that...it's that overall balance that I would be noticing.... And they're also people that um, just probably radiate a very good level of self-care.

One of my participants (personal interview, Auckland, 9 October 2012) described it as strengthening a sense of well-being in order to be on-guard against chronic relapse:

Um, it's used in my opinion by the people who are on the way to recovery but haven't got there yet. So, they're on the journey of trying to recover more and more of, um, healthy living, and in a way you could say that in a bigger way that's the message of all of life, that we are on a journey of discovering and recovering more of our original goodness.

Cynthia Young from the Salvation Army Bridge Programme (personal interview, Auckland, 26 October 2012) saw recovery as building on foundations:

It's like a very layered thing to get someone fully into recovery. And I believe that everybody does the best that they can in the point that they're at, but there's just quite a lot of work to be done.

Clare Luamanuvae from the Salvation Army Bridge Programme (personal interview, Auckland, 26 October 2012) sees why the term 'recovery' has been used but that the word has limited use:

Um, my view of recovery is it's a name for a path of personal growth. But at the moment it's being specifically used in relation to people with problems with addictions. For me, it's a growth journey...spiritually, often physically, mentally, you know, um, socially, everything. That's what it is for me. That's what recovery is. Um, I don't know that recovery is the best word for it because I don't think people just recover what they had, I think they make it surpass what they had. So it's not recovery because recovery is...just says that you're getting something that you already had. That's what that word means to me. But I don't think it's what that means in this context. It means blossoming, you know. The "potential" word has been used this morning in this workplace, it's more about that. It's more about discovery than recovery. That's what I see it means. I understand why they've used the word, but I think it's a bit of a....it's surpassed that now.

Yates and Malloch (2010:15) support Clare's statement, saying that:

The notion of calling a halt to a pattern of futile self-destructive behaviour, of coming to an understanding of what drives that behaviour and changing it, is hundreds of years old. Traditionally we have called it 'recovery,' for many, the term 'discovery' may be more apposite.

Kerry Manthenga from Odyssey House (personal interview, Auckland, 1 December

2012) sees recovery as a process and not an event:

It's about every facet of your being as opposed to whether or not you drink and drug. How you make decisions, how you communicate with people how you feel about yourself and people and the world, and yeah, it's not just about one thing. It's a much, much bigger thing.

I often heard in my own early days of recovery that I had to put recovery first, above all else and everyone else. I heard people say in Twelve Step meetings that, 'Without their recovery, they were nothing'. I struggled immensely with those 'all-or-nothing' statements and the thought of putting me first above everything else sounded selfish. But, Berger (2008:66) says that, 'When we honour ourselves, our existence, our life, we are not being selfish. Learning to honour and care for ourselves is a hallmark of recovery'.

So having done treatment with my peers and listened to them and their hopes for recovery, having an on-going learning process with people who are in recovery and have been sober for many years, having followed the ideas and suggestions made to me from the rehabilitation centre clinical teams, something started to rub-off on me. It was my own burgeoning recovery. Maybe Her Majesty's Government was right. Maybe recovery is contagious.



## Chapter Two: The Cathartic Observer Effect.

*Man, know thyself, and thou wilt know the universe and the Gods.*

– Pythagoras

I need to be quite clear about why I'm writing this. A little over four years ago I held a well-paying job with a large financial institution, leading a team of people, looking after a multi-million dollar budget. I was living in a plush apartment with my best friend, who was a Cabinet Minister, and accompanied her to many functions where the heavy hitting power brokers of New Zealand politics were in attendance. I had a loving family and lots of very close friends. People thought that I'd 'cracked it' and was 'living the life'. The reality was a far different picture. My drinking was spiralling out-of-control, to the point that all my efforts to hide what I was doing were becoming unstuck. I no longer cared about very much, had lost my passion and drive for most things in life, and had to force myself to swallow my alcohol-based Listerine, followed by a swig of vodka to get out the door in the morning to face the world. I was miserable, disliked myself intently and was slowly killing myself.

My good friend saw my steady decline was turning into a very rapid slide, and she started to really challenge me about my drinking. My close friends did the same and soon my family were catching wind about what was going on. I felt like I was being boxed in and reacted rashly, angrily, fleeing for the other side of the world to start my overseas experience, leaving my workmates, friends and family very concerned for my welfare. I fled, taking all my problems with me, along with my 24 year old nephew who was my travelling buddy. He had little idea about what was happening as his much loved Uncle dived headfirst into an alcoholic abyss with great abandon.

We travelled through Thailand, Italy (where we were joined by my brother, his partner and my sister), then on to France, Ireland and to Northern Ireland where we met my father's family. I'd moderated my drinking throughout Thailand and Europe and when we got to small-town Ireland I became bored very quickly. My brother left for home and I realised that I was on my own, in another hemisphere, a long way from my support and peer network. I was frightened for my own future and did what I knew how to do best. I drank. I drank up to a bottle and a half of vodka per day. It was cheap and could be bought at supermarkets and petrol stations. I was staying with my cousin who grew tired of my behaviour pretty quickly. She was put in an unenviable position of having to show a relative some tough love and she asked me to leave her home. My nephew visited me while I was residing at a dark backpacker hostel and found me crying inconsolably into my vodka bottle. I knew the game was up and I had to come home and address my issues, my problems, my demons. My overseas experience was over before it had begun.

While I slowly made preparations to get on a plane bound for New Zealand, my family were making preparations to get me an interview and assessment at a treatment centre. When I arrived back home and saw my mother waiting at the passenger arrival gates, I felt lonely, isolated, guilty, shameful, anxious, fearful, depressed and a failure. She felt pride. I didn't get it.

I was admitted to the treatment centre and unknowingly began this anthropological and ethnographical enquiry from the perspective of an insider/outsider. An insider from the point of view that I was a part of a treatment centre community and an outsider in that I had no idea why treatment methods were being prescribed to me in the fashion they were. I did the programme compliantly and was very inquisitive. I listened to what my overworked case manager had to tell me when she could see me. I participated in groups and was open to the fact that I could well be an alcoholic. I attended Twelve Step

meetings for the first time. I graduated from the programme, went straight into work believing narcissistically that I was going to be the new poster boy for recovery. This was going to be easy. So I didn't do any of the things the treatment programme suggested I should do. I didn't go to Twelve Step meetings, I didn't participate in any after-care programmes, nor stay in an after-care facility. I didn't find myself a sponsor. I believed that I could just say "no" without all that spiritual Twelve Step stuff. I shut down and stopped talking about how I felt. I still harboured feelings that I could drink responsibly and I didn't want anyone to know. I must confess, I was in denial and planning my next drink.

But I couldn't drink. The treatment programme had placed me in a real dilemma. It had categorically removed all the fun that was to be had with thinking about drinking, let alone doing it. So my logical addicted brain thought, "If I can't drink you, then I'm going to eat you." I found a recipe for cider chicken. I could have alcohol and control it by eating it instead of drinking it. The meal was delicious. After I'd finished I saw there was approximately a glass of cider left over in the bottle, and I thought, "Who's going to know?" I drank the glass and felt a warm glow within me. I didn't feel like another glass and thought, "Yes! I'm not an alcoholic." The next night I had lamb shanks in red wine jus, the next night I made coq-au-vin, and throughout the week I was seeking out recipes that contained alcohol in them. Progressively, there was less that was going into the recipe and more into my gullet, and I remember as I was eating my chilled vodka soup, of which there was only one ingredient because I didn't have any jelly crystals, that I really didn't like vodka anyway and what a pointless tasteless alcohol it was. I lost three days to blackout, didn't turn up for work and my parents drove for 90 minutes from their home to find me in an ugly state. Relapse is hard and horrible and I frightened myself with the speed at which I went straight back mentally, emotionally and physically to where I'd come from months earlier, during the days staying at the backpackers' hostel in Belfast.

I kept refusing to admit defeat and relapsed again and again. I hadn't reached the point of burning my bridges but I was standing on them holding a petrol can and a lit match. Work was growing tired of my frequently unexplained absences and the friend I was staying with at the time showed me some more tough love and asked my brother to come and get me because she couldn't put up with my inebriated, selfish behaviour any more. Never, ever let an angry woman pack your bags. Somehow I ended up staying at my Aunt's house and I snuck many gulps of her cask wine while pretending to make cups of tea in my mismatched clothing. I infuriated her with stories of my adolescence that were better left untold. My parents made another mercy dash to come and get me. My world sank as I saw the look of despair in my Dad's eyes as he was looking forlornly out of the window at a rain-sodden bird bath. My older sister rang and jokingly threatened to send me to Saudi Arabia so they could cut off my right hand if I drank. Within six months of having graduated from my first rehab, carrying the hopes and best wishes for my future from those who knew and loved me well, I had shattered them all and I was checking into another rehab. I walked in there thinking I knew all of the answers, without really knowing what the questions were.

And then it came. That light bulb moment that I had been waiting for - my own epiphany. I was given an article to read and comment on about my own alcoholism. The article asked all the right questions and I felt the pieces of the addiction puzzle start to connect in my addled brain. I wanted to start a line of anthropological enquiry straight away but resisted all temptation to do so because I would have been in danger of 'taking myself out of the programme' through pathological writing behaviour (Raikhel, 2009). I stored the questions in the back of my mind and held on to the feelings of relief and hope that had leapt into my consciousness. I graduated from the programme with a more modest disposition than the previous rehab. I went and stayed in an after-care facility and worked with my case managers on my wellness. I took time to heal. I attended ninety Twelve Step meetings in ninety days, I found myself a sponsor, and I started volunteering at

the rehabilitation centre and for Twelve Step organisations. I submitted an after-care plan, one of the goals of which was to complete my unfinished Master's degree. I got to three months, six months, nine months, and one year of sobriety or clean-time. One year after graduating from my second treatment centre I was ready to fully start my line of anthropological enquiry. How do treatment centres work? How do they move people from a state of addiction to one of recovery? What are the methods they use?

I started reading all that I could get my hands on in the field of addictions. I had to be very careful with what I read and how I perceived it. Being armed with a little knowledge was a very dangerous thing for me in the early days of recovery, especially if I was having a bad day and was harbouring secret thoughts of drinking. If I acted out on those feelings and used academic argument I'd read against what my case managers were prescribing, it could have all unravelled very, very quickly for me if I picked up another drink at the whim of a moment's weakness. Those moments did eventuate and I had to put my recovery and well-being first and foremost at all times. It has meant putting the research to one side every now and again until I've felt strong enough to tackle the questions it has raised for me.

I needed a way to link anthropology with addiction treatment, which is mainly psychologically focussed, and I saw an opportunity to do so through community. Manning and Morant (2004:21) advise that, 'Research in therapeutic communities (and other mental health services) can be conducted from a range of different perspectives that are associated with different aims, methods and underlying principles'. I had been a client of one treatment centre that practiced a community reinforcement approach, and another treatment centre that was a therapeutic community. They were both using community as ways of healing very differently. I was intimate with these methods through being a receiver of their teachings, but had no idea scientifically why and how they worked. Anthropology was the perfect discipline to help me understand this.

De Leon (2000:119) argues:

From an anthropological perspective, the social environment of the TC more largely resembles an energetic village than an institution or service setting. From a social and psychological perspective the TC can be distinguished from other institutional or treatment settings in that its social environment is the treatment model. The main elements of this model, its social organisation, and social relationships are utilised for a single purpose – the reintegration of the individual into the larger macro-society.

I started out thinking that I would describe how treatment centres move people from a culture of addiction to a culture of recovery, but was limited by time and word count in attempting to establish that both cultures exist and demonstrating what's different between them in terms of language, clothing, diet, belief systems, social systems, hierarchy, gendered roles, music and recreation (White, 1996). This was going to take away much needed space for describing the methods that the treatment centres use, and I veered away from this discussion so I could narrow my questioning further in and not make the thesis 'bigger than Ben Hur'.

I had to list all of the research categories that might have been of relevance to my topic, and eliminate each one that I wasn't comfortable or experienced enough to critique. For example, I decided not to draw upon any discussions, or ask questions about success rates of the programmes. How does one define success? I remembered a quote that the difference between success and failure was only someone's opinion. I wasn't prepared to put a stake in the ground and say that a treatment centre was successful because they had over 50 per cent of clients reach one year or more of sobriety. That would mean I had to discount the client who made 360 days sobriety, then relapsed, then got back into recovery. I would be discarding their story and potentially the great relationships they rebuilt with their loved ones, because of a 'blip' before a 'deadline'. I would have to include the man who is 18 months sober and is miserable and isn't working on recovery and is in effect, a dry drunk.

I shied away from quantitative analysis. Statistics have never been a strong point for me and I didn't ever envisage having a large sample population from which to collect data. While numerical data is useful to compare groups or to measure change over time (Manning and Morant, 2004), I wasn't prepared to ask which treatment centre had the better success rates or better client outcomes, because I wasn't even entertaining drawing statistical inferences on sample populations. I also strongly doubted whether I would have been given access to the information by some of the treatment centres.

Manning and Morant (2004:32) point out a strong weakness with using quantitative analysis with the questions I had in mind for my topic.

In order to establish causal relationships between variables, the researcher needs a large degree of control over the research situation. For example, in a clinical trial, the researcher must ensure that treatment is delivered by all therapists in the same way, and that those being treated show similar mental health problems. There are considerable practical and ethical barriers to conducting this type of research in mental health.

The treatment centres within the scope of my topic vary significantly in the treatment methods they use. The client population is also different at any point in time. I didn't ask whether I could observe the treatment being delivered, as it would have no bearing on the outcome of my research. I was however, a former client of two of the three treatment centres in this study, so I had an intimate knowledge of what methods were being delivered.

Goldstein (1994: 131) debates the difficulties with using quantitative analysis and clinical trials on an addicted population, who're 'often poorly motivated and uncooperative, are not amenable to long term follow-up, and may not be truthful in reporting abstinence...One cannot simply assign patients randomly to different treatment modalities, as one would like to do in order to obtain valid comparisons'. Placebo is not a valid option when it comes to addiction treatment, nor is placing someone in a treatment environment

when it is known it will not give them any benefit or relief. The risk is run of the individual never seeking treatment again.

I decided to use a qualitative approach to researching the topic, supported by literature review. I wanted to complete a 'safe' thesis that would represent what the treatment centres were doing, supported by what the academic world was reporting. I use the word 'safe' in the context of my own fledgling recovery. Immediately, I chose not to ask the treatment centres if I could have access to their clients in order to conduct interviews with them to see what they thought about whether their programmes were working. I would ask the addiction practitioners themselves what they thought. This ensured the confidentiality, anonymity and privacy of the treatment centres' clients. By doing this, it kept me within some very firm ethical boundaries and it also kept me safe. With a lot of new clients in treatment, there is the potential to discuss personal stories of trauma and pain, and I honestly wasn't ready emotionally to hear them.

I chose to conduct interviews with key practitioners of the three treatment centres. I wanted to use their words and their experience to represent how they saw drug and alcohol treatment working, within the context of a community setting as the principal method of healing. I sought and was granted low-risk ethical approval from the University's Human Ethics Committee on this basis. I wrote to all the treatment centres and was granted interviews with selected staff. I ended up conducting nine interviews. I'm not prepared to discuss how these interviews were distributed, in case I give away the identity of my participants who wished to remain anonymous. Where I have named the people in the thesis, I have been given permission to do so by them. Where I did not gain permission to use their name or that of the organisation they worked for, I have only referred to them as "participants" to protect their anonymity. Rawlings (2004:137) argues that '[i]nterviews are also very useful in settings like therapeutic communities for ascertaining and exploring



organisational history or for looking at a range of different perspectives on a different topic’.

I met none of the resistance social scientists have sometimes come up against while I was requesting to interview staff. ‘Therapeutic community practitioners have not always been sympathetic to research, as a result of both a firm (and, on occasion defensive) conviction as to the superiority of their clinical interventions, and also a perceived need to ‘get on with the job’ and extend the range of therapeutic community settings’ (Lees, Manning, Menzies and Morant, 2004:10). On the contrary, I was welcomed into the houses of healing with an eagerness for stories to be told and questions to be answered, once formal ethical considerations had been agreed and my low-risk application accepted.

Qualitative analysis has allowed me to explore the addiction practitioners’ subjective experiences as to how and why treatment works, and I was able to conduct the research *with*, rather than *on*, my participants (Manning and Morant, 2004). I made it clear to my participants that I had been a client of two residential treatment centres previously and advised them of my clean time, at the time of the interviews. This was important for me to disclose, as I wanted them to know that I had a good understanding of what a treatment centre’s purpose was, that I had a steady recovery and wasn’t venturing into this project after one week of being out of treatment, instantly prone to triggers and relapses.

I was also at pains to establish that I wasn’t going to say that one treatment centre was better than, or more successful than any of the others. Validation of such a statement is difficult to achieve and serves no purpose for my topic. Nor have I tried to play one treatment centre off against another. Treatment is so personal and what works for one person, may not work for another person. I had to check my own thinking and personal biases when it came to fieldwork, having been a previous client of two of the three treatment centres I approached for interview. I made sure I was asking all my participants

the same questions, where time was permitting, and tried to contribute very little to the interview conversation from my own personal experience. But as Menzies and Lees (2004:158) have stated:

Whether the subject is quantum physics or social science it is now well recognised that the act of researching necessarily affects the subject being researched, a concept known as 'reactivity' or the 'observer effect.' In research, there is an interpersonal element, it is not only the act of researching but also the researcher him/herself that affects the results.

Upon reflection, I entered the interview process with some of my participants in awe of them, along with a sense of my own hero worshipping. How could I not? Although none of the people interviewed have been my case managers, some of them have had a big impact on saving my life. So I make no apologies for not personally being critical of the work they do or the methods they employ. I stuck to a deliberate script in an effort to describe how treatment centres work and why, straight from the people who are in the field. I hope that I've been able to do justice to the voices of my participants and the answers they gave.

I originally set out to complete a comparative study between three residential treatment centres, based on my knowledge of being a client of two of the treatment centres and that of the practitioners I was interviewing. There is one treatment centre in this research that I have very limited knowledge of and I just wasn't comfortable that I'd accumulated enough of an understanding of their methods to accurately make any comparisons. But the information I'd gathered was rich and I was reluctant to discard them from the research. So I reframed the research to focus on how the practitioners from three different treatment centres see the use of 'community' as a method of healing the addicted 'self', along with their descriptions of how the 'self' changes in the process.

Finally, I give you my main reason for doing this research. It has been a hugely cathartic experience learning more about addiction. It has played an immense part in my own journey of healing and well-being. And for that, I am eternally grateful.

## Chapter Three: A Brief History of Addiction Treatment

*“...they are called therapeutae and therapeutrides...because they profess an art of medicine more excellent than that in general use in cities; for that only heals bodies, but the other heals souls which are under the mastery of terrible and almost incurable diseases, which pleasures and appetites, fears and griefs, and covetousness, and follies, and injustices, and all the rest of the innumerable multitude of other passions and other vices, have inflicted upon them...”*

*Philo Judeas, Ca 25B.C. – A.D. 45*

The purpose of this chapter is to provide a very broad history of addiction treatment and therapeutic community techniques, in order to offer a context in which this work can be placed. It isn't possible within the body of this thesis to explain every nuance in therapeutic community technique, nor detail how they have developed over time. But it is necessary to provide an, albeit brief, historical perspective so that readers with little or no knowledge of addiction treatment can familiarise themselves with the therapeutic community and treatment centre movements. I attempt to track the beginnings of the modern day recovery movement internationally, along with the simultaneous evolution of therapeutic communities in the United Kingdom and the United States. I discuss some relevant New Zealand history, focussing on chronicles as they relate to treatment and less about the laws governing the sale and distribution of alcohol and criminalisation of illicit drugs. I also give some limited background information on the treatment centres who kindly agreed to be a part of my study.

Glaser (1981), cited by Gowing et al. (2002) and Adamson et al. (2010) use Judeas' quote at the beginning of this chapter as a supporting claim that therapeutic communities and their healing principles were evident over 2000 years ago in ancient Egypt, and interestingly they were occupied with the idea of healing 'diseases of the soul'. Archaeological evidence has determined that we have been using psychotropic, mind-altering substances since pre-history (Saniotis, 2010). McAlister (2010:30) states that it was well known the great philosopher Aristotle 'considered drunkenness to be insanity by

choice and overindulgence of any kind to be a detriment to society'. Glaser suggests the notion of the therapeutic community may be 'further traced through Alcoholics Anonymous...to early Christian practices described in the Dead Sea Scrolls' (Adamson et al. 2010:4). De Leon (2000: 11) argues that the idea of the therapeutic community 'recurs throughout history implemented in different incarnations. Communities that teach, heal and support appear in religious sects and utopian communes, as well as in spiritual, temperance and mental health reform movements'. De Leon goes on to cite Slater's (1984) work on historical perspectives of therapeutic communities where it's argued that the Dead Sea Scrolls detail the communal practices of religious sects, including a section on the "Rule of the Community".

White (1996) charts the history of the Recovery movement in the United States with pledges of organised attempts at abstinence by colonial citizens dating back to 1637. He describes the emergence of the Washington temperance movement in 1840, and the opening of Washington Hall in 1845 in Boston, Massachusetts, marking the first organised effort to house inebriates under one roof in a residential setting. White also maintains that recovery mutual aid societies in the United States stem from eighteenth century Native American recovery circles, which were followed in the nineteenth century by the Washingtonians, recovery-focused fraternal temperance societies, and many more of these groups which eventually collapsed and were never heard from again.

Glaser (1974) traced the modern therapeutic community's beginnings back to the Oxford Group, a Christian Fellowship whose doctrine was a return to the purity and innocence of the early church (De Leon, 2000). The group meetings, focussing on self-survey, restitution, service to others, praying in the personal struggle, attracted many alcoholics during its peak years in the 1920s (White, 1996). Similarly, the Emmanuel Movement, established in 1906 by two clergy, combined psychological and spiritual

approaches for working with the alcoholic in a group setting. They formed a new social institution where alcoholics met for mutual support, known as the Jacoby Club (ibid). Concurrent with the Emmanuel Movement and the Oxford Group, the Salvation Army had begun working with alcoholics since the organisation arrived in the United States in 1880 (ibid). They established many inebriate homes with the single purpose of bringing religious salvation and sobriety through Christ.

The 'Peabody Method' for treating alcohol grew from the work of Richard Peabody, an alcoholic himself and an early recipient of the Emmanuel Movement's treatment. He refined their technique by making some important philosophical changes and adding some psychiatric terminology to the original treatment, while still retaining the concept of the unity of body, mind and spirit, which was unique to American thinking at the time. It's purported that Peabody was the first known authority to state, "once an alcoholic, always an alcoholic," and proved this by allegedly returning to drinking and dying of alcoholism in 1936. His method of treatment was not known for its success or longevity of being practiced, but for the hope it gave the early researchers of alcoholism – that it was a treatable condition. His book, *The Common Sense of Drinking*, was read by the co-founder of a fledgling programme in Akron, Ohio, and a few phrases and helpful hints were incorporated into it. The man was Bill Wilson and the viable alternative to the Peabody method was the programme of Alcoholics Anonymous (McCarthy, 1984).

Michael Gross (2010:2362) explains:

Seeking to live by Oxford Group tenets, [Bill] Wilson assiduously began preaching to fellow alcoholics, who listened dutifully and kept drinking. Alone in Akron after a failed business trip, fearing he would resume drinking, Wilson sought out another alcoholic— [Dr. Bob] Smith—to sustain his own sobriety.

The founding principle of one alcoholic helping another was born. From that meeting, Smith went on to relapse one more time and asked Wilson for help. His "quit date" is

acknowledged as the birthday of Alcoholics Anonymous – 10<sup>th</sup> June, 1935. It was ‘Wilson’s first success at fixing a drunk’ (ibid).

White (1996:230) suggests AA’s founding:

...crystallised and built upon the most successful components of all previous approaches to recovery from alcoholism. AA brought forward the illness concept of alcoholism that had been the foundation of the inebriate asylum movement and modernised the concept by shifting the focus from cure to one of recovery as an ongoing process, sustained one day at a time. AA became the central institution within the American culture of recovery. And the Twelve Steps of Alcoholics Anonymous became an integral part of the recovery process.

The Twelve Steps of Alcoholics Anonymous are a suggested programme of recovery. Many within AA circles say that, “It’s a suggested programme of recovery because you can’t tell an alcoholic to do anything.” The Twelve Steps are:

1. We admitted we were powerless over alcohol – that our lives had become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God *as we understood Him*.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly asked Him to remove our shortcomings.
8. Made a list of all persons we had harmed, and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong, promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all of our affairs.

- Alcoholics Anonymous (2001:59-60).

As AA groups started expanding in numbers across the United States in the 1940s, it was recognised that in order to survive and not suffer the fate and demise of self-help

groups like the Washingtonians before them, an organisational set of traditions ought to be established for AA groups to follow. White (1996:231) argues that the 'Twelve Traditions of AA, perhaps equally important for AA's survivability, built in organisational safeguards to manage those conditions and influences that had often led to the destruction of earlier programmes and self-help movements.' The Twelve Traditions of AA are:

1. Our common welfare should come first; personal recovery depends on A.A. unity.
2. For our group purpose there is but one ultimate authority – a loving God as He may express Himself in our group conscience. Our leaders are but trusted servants; they do not govern.
3. The only requirement for A.A. membership is a desire to stop drinking.
4. Each group should be autonomous except in matters affecting other groups or A.A. as a whole.
5. Each group has but one primary purpose – to carry its message to the alcoholic who still suffers.
6. An A.A. group ought never endorse, finance or lend the A.A. name to any related facility or outside enterprise, lest problems of money, property and prestige divert us from our primary purpose.
7. Every A.A. group ought to be fully self-supporting, declining outside contributions.
8. Alcoholics Anonymous should remain forever nonprofessional, but our service centres may employ special workers.
9. A.A., as such, ought never be organised; but we may create service boards or committees directly responsible to those they serve.
10. Alcoholics Anonymous has no opinion on outside issues; hence the A.A. name ought never be drawn into public controversy.
11. Our public relations policy is based on attraction rather than promotion; we need always maintain personal anonymity at the level of press, radio and films.
12. Anonymity is the spiritual foundation of all our Traditions, ever reminding us to place principles before personalities.

- Alcoholics Anonymous (2009:189-192)

Gross (2010:2363), states:

As AA's operating principles evolved, they upended virtually every convention of organizational structure in a capitalist society. From what looks like anarchy—traditions ("AA ought . . .") rather than rules ("you must . . ."), maximum local autonomy and independence, and absence of centralized or layered tiers of authority—emerges consistency and stability. Without certification, evaluation, supervision, or internal or external monitoring, tradition sustains fidelity to the basic framework of meetings and work on the program's steps.

By the early 1950s Narcotics Anonymous (NA) was founded and adapted the AA programme for persons addicted to drugs (White, 1996). The “Minnesota Model” of treatment was emerging, the name coming from the state where three treatment centres were applying, ‘alcoholism as a primary and treatable disease within a residential “learning” milieu staffed by an interdisciplinary team who treated the alcoholic as a whole person. The model emphasised the need for lifelong abstinence and affiliation with AA’, (White, 1996:233).

Gross (2010:2361) argues that as a multimodal treatment apparatus emerged, Twelve Step programmes became interwoven into drug and alcohol treatment. Yet he was quite clear in pointing out that:

Despite the interpenetration of treatment and 12-step fellowship programs, AA warns that it is neither cure nor treatment. The essence of 12-step programs—one alcoholic or addict helping another— starkly differentiates them from the credentialed, hierarchical, and commercial structures of formal treatment systems.

Sandor (2009:88) draws the same distinction between treatment centres and Twelve Step programmes:

AA and the other 12-step programmes should not be judged in the same way that we evaluate professionally run treatment programmes. Treatment generally means something administered or conducted by a professional. The 12-step programmes by contrast, are overtly and intentionally not run by professionals but by recovering alcoholics and addicts themselves. This distinction is important because a recovering addict cannot “receive” the 12-steps in the same sense that he can receive treatment from a professional. In AA, the alcoholic is working among equals – fellow addicts and alcoholics – not placing himself under the care of someone who is getting paid to do something for him.

During this period, Manning and Morant (2004:24) argue that therapeutic communities evolved out of a research culture. ‘The therapeutic community originated simultaneously in two separate places, usually associated with the work of Tom Main and Maxwell Jones, both including research as an integral part of therapeutic work’. De Leon (2000:12) argues that the term ‘therapeutic community’ is a ‘modern one’ first used to



describe the psychiatric TCs that emerged following World War II, even though it drew upon various sources both ancient and modern. 'The emergence of the psychiatric TC is often viewed as part of the 'third revolution in psychiatry', a shift from the use of individual therapists to a social psychiatric approach'. Lees, Manning and Rawlings (2004:36) describe today's modern therapeutic community literature as either stemming from 'the democratic psychiatric settings, which began in the Second World War, or to the hierarchical concept-based houses which began in the USA in the late 1950s'. Manning and Morant (2004:27) see that:

The therapeutic community shared an intellectual heritage....combining two analytically distinct fields: organisational theory and in particular the interaction between structure, interpersonal process, and individual behaviour); and psychotherapy (the attempt to promote personal growth and change through guided conversation).

Adamson et al. (2010) cites Pines (1999), marking the birth of the therapeutic community in the United Kingdom in May 1946. Experiments were being conducted at Northfield Hospital during the time and as Adamson et al (2010:4) explain:

With army psychiatric services expected to heal hundreds of traumatised soldiers and return them to the front lines, the Northfield psychiatrists decided to focus on group rather than individual problems. Wards were structured as communities, with mutual support and cooperation encouraged, and non-directive group discussions conducted. The community was viewed both as patient and instrument of treatment. The aim was to train the community in problems of neurotic defences and interpersonal relationships.

Manning and Morant (2004) add that the experiments at Northfield Hospital were then used for the design of civil resettlement units for returning prisoners of war.

Maxwell Jones' work from 1940, at Henderson Hospital in the United Kingdom, developed the idea of group discussions, educating clients about their disorder, and using more experienced clients in a mentoring and tutoring role for 'neophytes' (ibid). The American anthropologist Robert Rapoport wrote his seminal therapeutic community text "*Community as Doctor: New Perspectives on a Therapeutic Community*" in 1960 based on

his participant observation of the work being carried out at Henderson Hospital by Jones (ibid.) The work classified four pillars to therapeutic communities, being democratisation, permissiveness, confrontation and communalism (Lees, Manning and Rawlings, 2004:37-38). The work was not well received by Jones at all and the findings nearly rejected, as Jones 'argued that Rapoport, as an outsider, had not fully understood all the nuances of therapeutic community life, and had thus misrepresented and misjudged some aspects of their activities' (ibid). The findings were subsequently accepted and Lees, Manning and Rawlings (2004:38) quote Jones (1968) directly describing his initial reactions:

For me to discover the discrepancy between what I thought I was doing as a leader, and what trained observers saw me doing was frequently a painful – but almost invariably rich – learning experience.

Simultaneously in the United States, a different kind of “therapeutic community” was emerging (Lees, Manning and Rawlings, 2004). De Leon (2000:17) argues that the fundamental elements of contemporary TCs for addictions were founded in 1958 with the formation of Synanon.

The founding force of Synanon was Charles Dederich, a recovering alcoholic, who integrated his AA experiences with other philosophical, pragmatic, and psychological influences to launch and develop the Synanon programme....Within a year, the weekly meetings expanded to become a residential community, and in August 1959 the organisation was officially founded to treat any substance abuser, regardless of chemical of choice.

Clients would stay for a minimum of two years. Legend has it that the name 'Synanon' came from an intoxicated addict who was unable to pronounce either of the words “seminar” and “symposium” while he was trying to attend one of the self-help groups. Van Gelder (1997) states:

Mr. Dederich discarded Alcoholics Anonymous's emphasis on religion and built a methodology around a therapeutic community, a tough, disciplined, drug-free environment with a dash of tender loving care. Attack therapy was an essential component of the treatment. Three times weekly, members met in small groups, for violently outspoken discussions, called games or synanons, in which they released pent-up hostilities.

This confronting form of group therapy became known as “The Game” and “The Encounter Group.” Synanon came to a rather dubious end late last century following cult accusations, tax evasion investigations and links to an attempted murder of a prominent lawyer (ibid).

## The New Zealand Experience

The arrival of European settlers at the turn of the nineteenth century brought alcohol and associated drinking practices into New Zealand. Symes (2004:91) cites Harrison Wright (1956) suggesting the initial introduction of liquor to Maori had little effect on the population as they had no taste for it. ‘Maori people had no traditionally fermented beverages prior to European introduction. When alcohol was first introduced to Maori society it was initially referred to as Waipiro (foul stinking water)’. But their taste for alcohol developed as more European settlers arrived, and thus a permanent European drinking population.

Mataira (1988) and Symes (2004) comment that alcohol and drunkenness had become such a problem for the Maori people that in 1847, Governor Grey imposed the Sale of Liquor Ordinance, banning Maori from buying and selling alcohol. It was largely ignored and had limited effect. Mataira (1988:73) states, ‘[b]y the 1870’s alcohol was common to most tribal areas and as one Ngati Porou leader was reputed to have said, “If liquor was not to be provided, the guests would not come to the maraes” (sic)’.

Such was the strong thirst for alcohol on some marae around the country, a new young, formidable Maori leader, Apirana Ngata, an Oxford graduate of Ngati Porou descent, intended on doing something about the destruction alcohol was causing to his people. Ngata was a well-known prohibitionist and Mataira (1988:74) comments:

This move was strongly resented by local men, especially those who drank, and their frustration led to the composition of a haka (war chant) still seen by many today as a classic. The haka Poropeihana (prohibition) was first performed on Mangahanea marae on the outskirts of Ruatoria during an official visit made by Ngata. In it, the men speak of being betrayed:

*“Ko ta Apirana Ngata ra te tangata*

*E taka rure mai nei ture o Poneke*

*Horohia mai o ture ki ahau.”*

*“Apirana Ngata is the person*

*Formulating the laws in Wellington*

*Expose your laws to us.”*

The haka went on to detail how these men were going to procure alcohol despite prohibition:

*“Ka minamina au ki te waipiro*

*Ka hokana i te po*

*Homai o ture ka wetaweta.”*

*“I thirst for alcohol and so*

*I will obtain it by illegal means at night*

*Expose your laws to us*

*Give us this law so we can rip it apart.”*

Butterworth (2004:13) explains that in our early colonial times:

Drunkenness was a matter for law and religion. In New Zealand, these two came together in the Reformatory Institutions Act 1909, which provided for the creation of Inebriates' Homes and Reformatory Homes, to which habitual drunkards could be admitted voluntarily or be committed by court order for up to two years.

Stewart and Casswell (1992:132) similarly argue that the responsibility for dealing with “chronic inebriates” lay with law enforcement and the penal system. ‘Chronic inebriates were initially consigned to mental asylums, but this practice came to be considered as an unsatisfactory form of treatment’, and they cite King (1904) in saying that treatment at the asylums was limited to physical work, healthy diet and enforced

abstinence. 'In 1909 the Salvation Army provided separate homes for inebriates at the request of the colonial government, a request that had parallels in other countries' (ibid). Cave et al. (2008:24) state, '[i]n terms of the NGO sector, the Salvation Army had utilised Rotoroa Island in the Hauraki Gulf since 1910 as a rehabilitation centre and it had a number of other services in the community for those considered less chronic'.

Stewart and Caswell (1992) see the formulation of the Welfare State in 1935, the introduction of the biomedical disease approach from the Salvation Army in the United States in the late 1940s and the introduction of Alcoholics Anonymous to New Zealand in 1945 as events that greatly shifted the way alcoholics were treated, from one of segregation and control, to cure and treatment. After admitting himself into Nelson Psychiatric Hospital in 1945, Ian MacE<sup>4</sup>, New Zealand's first member of AA in New Zealand, read an article in "Reader's Digest" magazine called "Maybe you can do it too" by Edward McG., an alcoholic who had recovered with the help of AA. Ian MacE. wrote to the contact address provided by a footnote in the article (for AA's World Service Centre) and by 1946 received a letter from co-founder Bill W., appointing him as the representative of AA in New Zealand. The first recorded meeting of AA in New Zealand was in September 1947 in Auckland (Butterworth, 2004), (Alcoholics Anonymous New Zealand, 2012). Cave et al. (2008), argue that from AA's humble beginnings in New Zealand in the late 1940s, by the 1970s it was a mainstay of post treatment adjunct to hospital treatment, where Queen Mary Hospital in Hanmer Springs had begun specialist treatment of alcoholism from the late 1960s.

In 1954, the National Society on Alcoholism and Drug Dependence (NSAD) was formed and became New Zealand's largest and one of the oldest voluntary organisations in its field (Butterworth, 2004). Dr. Jock Caughey, Professor of Neurology at the School of Medicine at Otago University, enlisted Ian MacE's help, and they agreed that New Zealand

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<sup>4</sup> It's common practice for Twelve Step community members not to use their full names, and only their first name and the first letter of their surname. This helps to protect their anonymity.

needed an organisation similar to the United States' National Committee for Education on Alcoholism. The stated objectives of the new society (NSAD) were to increase public understanding of alcoholism as a disease, its nature and treatment and promote the public realisation that the alcoholic can be helped through the establishment of support clinics for the study, diagnosis and treatment of alcoholism (Butterworth, 2004).

Stewart and Casswell (1992) cite Wainright (1985) by discussing that in 1963, hospital boards in New Zealand were mandated by way of ministerial directive to provide specialist alcoholism treatment units in general hospitals, and the resulting effect was that hospitals introduced medical detoxification, counselling, referral services and more beds on offer in their psychiatric units. They also critically point out that in 1966, the Alcoholism and Drug Addiction Act replaced the 1909 Inebriates Reformatory Act, shifting the 'custodial care and cure of patients from the Justice Department to the Health Department'. The state's involvement with the custodial care and treatment of alcoholics and addicts thus became more humanitarian.

The Aoteroa New Zealand Regional Service Committee of Narcotics Anonymous (2005) describe the beginnings of Narcotics Anonymous in 1969. A handful of self-help meetings were held in Auckland, the force behind them being James K Baxter, a renowned New Zealand poet. The Twelve Traditions, in particular the traditions relating to anonymity and public affairs weren't a priority as Baxter invited the media along to showcase a new way of recovery from addiction. The meetings quickly lapsed, as it was thought police surveillance was the biggest reason for non-attendance. It wasn't until 1982 that regular NA meetings took place in New Zealand.

Stewart and Casswell (1992) argue that the formation of ALAC (the Alcoholic Liquor Advisory Council) in 1977 by the National Government, following The Royal Commission on the Sale of Liquor, has "greatly influenced" the treatment centres of today in terms of the

treatment approaches they have taken, steering away from endorsing the disease model in favour of a more holistic approach drawing on a range of complementary models from differing disciplines. Butterworth (2004:43), states that ALAC's founding brief was:

- a) To encourage and co-operate in research and in the dissemination of information to the general public;
- b) To devise and encourage educational programmes for the public including children;
- c) To promote and co-operate in the treatment, care and rehabilitation of persons adversely affected by liquor;
- d) To make recommendations to Government departments and other authorities on any of these matters, and to make recommendations to the Minister of Justice in regard to advertising of liquor.

In 1979, NSAD established Aspell House, a therapeutic community for alcohol treatment, in Wellington. It was based on features of the long established Hazelden Foundation model. Another therapeutic community established by the society, Te Kiteroa opened in 1981 in Canterbury (ibid). This was the watershed time when the 'Mr Asia' crime syndicate was operating at its capacity in New Zealand, with large scale importation of heroin into New Zealand from South East Asia. The syndicate destroyed the lives of hundreds of New Zealanders through drug addiction, exploitation, extortion, jail terms, and death (Booth, 1980). The profile of chemical dependency from those presenting for treatment began changing from alcohol to poly-drug abuse (Butterworth, 2004).

However, the late 1970s and early 1980s weren't without their problems or challenges for the therapeutic communities or treatment field. As Adamson et al. (2009:7) explain:

The 1970s also saw the diversification of TCs gather momentum with the burgeoning use of drugs and its associated problems. Health budgets were strained by increasing numbers of clients with substance abuse problems. Cost cutting saw briefer interventions, the introduction of methadone treatment for opioid dependence and the introduction of public health objectives reflected in a harm reduction approach as a result of the threat of AIDS (Acquired Immunodeficiency Syndrome) in the mid-1980s (Strang and Farrell 1989). This led to growth in methadone programmes, needle exchanges and other harm reduction initiatives, and to difficult times for the potentially more expensive therapeutic communities.

In 1999, NSAD separated its trust functions from the operational functions and created a company called NZ Care Limited, which has since changed its name to CARE NZ, today one of the biggest treatment providers in the country (Butterworth, 2004).

In 2003 the Addiction Practitioners Association of Aoteroa New Zealand (DAPAANZ) was formed and was instrumental in ensuring registration of professionals in addiction treatment occurred, along with developing and maintaining the professional standards set for registration. DAPAANZ organises the annual conference for the addiction treatment sector and continuously works on providing professional development opportunities for its members (Addiction Practitioners' Association Aotearoa New Zealand, 2012). Johnny Dow, Director of Higher Ground, (personal interview, Auckland, 22 August 2012) has seen the professional development of the treatment industry change through the years:

The professionalism has grown a lot more over time...When I first started, the skills of the counsellors...there wasn't a lot of drug and alcohol counsellors and the profession was quite new in New Zealand back then...you know...skill wise...it's sort of changed to now that the people are really highly qualified and highly skilled, either psychotherapists, alcohol and drug practitioners, social workers...and most people are registered today, where people didn't have a registration back then.

Cave et al. (2008:103) state:

In 2004 the Ministry of Health contracted the National Addiction centre (NAC) to develop the National Addiction Treatment Workforce Development Programme (NATWDP). A ten year strategic plan to develop the addiction treatment sector workforce was written in consultation with the sector. The late Takarangi Metekingi described the vision of the programme as 'Matua Raki – the highest of the heavens, representing a striving for excellence'.

## **The Houses of Healing**

Three well established and well respected treatment centres kindly agreed to be a part of this study. Two of them are therapeutic communities. In introducing these treatment centres, their programmes and their background (where available), I must reiterate that there is no such thing as a single representative therapeutic community or



treatment centre (Bloor, McKeganey and Fonkert, 1988). Their cultures evolve uniquely (De Leon, 2000), as do the experiences of the people who move through them.

## Higher Ground

Higher Ground is a therapeutic community for addiction treatment based in the Auckland suburb of Te Atatu. It's a 52-bed facility, including an after-care house in the Auckland suburb of Sandringham, housing up to six clients who have graduated from the programme. The main house is set amongst beautiful gardens, has two main dormitories, male and female gymnasiums, a commercial kitchen, large dining rooms and lounges, an administration wing and whanau room. Three years ago, they purchased Haeata House, a few streets away from the main 'house' with the view to running a 'pre-admission facility' for clients prior to their entering the main body of their treatment at the main house. Higher Ground decided Haeata House wasn't working that well as a preadmission house and they turned it into a senior residential house, where senior residents of the main house could stay in the weeks before they left the treatment centre programme. The rehabilitation centre is run by a charitable trust and governed by a Board of Trustees.

Most of the residents will participate in the eighteen week programme and there is an option of a ninety day programme if it's deemed to be appropriate to offer the client, say, if they've already been through the programme before or attended another rehabilitation centre. The programme is split into three phases, the first phase focussing on the client's behaviours, the second phase looking at the core issues that have kept them sick, and the third phase prepares the client for reintegration into the wider community. The programme is based on Twelve Step principles.

Johnny Dow, Director of Higher Ground (personal interview, Auckland, 22 August 2012) says Higher Ground has been operating since 1984, 'because at the time there was

more of a narcotics problem in New Zealand. There were lots of places for alcoholics to go, but not so many for people with narcotic problems. So it started then because it was the 'Mr. Asia' time and there was a lot of heroin and home bake around at the time'. Higher Ground's first therapeutic community residence was in Manurewa, later moving to Remuera. Kathy Mildon from Higher Ground (personal interview, Auckland, 28 August 2012) explains:

It was a house in Upton Road provided by the Catholic Church, next to a...um, a nuns' residence. So right, that's about the time I started working there and right next door we had this group of Catholic nuns who were in residence there, who were community nuns, so they had jobs outside. It was wonderful because we always had them there and we could send our clients over to their chapel if they wanted. They were volunteers that came in and did stuff. It was wonderful being next to them from that spiritual point of view.

Higher Ground moved again to Mt Eden Road and then to St Georges Bay Rd in Parnell. "We did a swap with Odyssey [House]," says Kathy. It was a facility for 20-25 people. Johnny Dow recalls, "It was a big old villa. When that outgrew itself we moved out to Te Atatu Peninsula six and a half years ago."

I asked Kathy why Higher Ground decided to adopt a Twelve Step approach to treatment right from its inception. She responded that it came down to the people who were driving it at the time and that, 'one is in recovery herself and practices a Twelve Step programme, and obviously it's worked for her. And the other person that was involved at the beginning of Higher Ground, his son was an addict and died, and he used to come into a lot of family meetings where the Twelve Step programme was introduced through NA' (personal interview, Auckland, 28 August 2012).

Before clients are admitted into treatment they need to be drug and alcohol free, including all psychotropic medication such as anti-depressants or benzodiazepines. I asked Kathy Mildon why Higher Ground chose to make this a requirement for participating in the treatment programme. "I think it was the personalities around the Board at the time made

that decision and stuck with that decision. I've always supported it because again, it reveals that authenticity...it gives the client an opportunity to be drug-free and see what's happening" (ibid).

## The Salvation Army Bridge Programme

The Salvation Army runs an addiction treatment programme known as the 'Bridge' in fourteen centres throughout New Zealand. There are three treatment centres in Auckland, in Manukau City, Waitakere and Mt. Eden. Clare Luamanuvae, Assistant Director of the Salvation Army Auckland Bridge Programme says the Salvation Army in Auckland are contracted to provide 57 beds, spread amongst those allocated to District Health Board (DHB) clients, methamphetamine treatment beds, detoxification beds and a couple of beds for the new Drug Courts. For almost a century, the Salvation Army treated alcoholics on Rotoroa Island, a small island in the Hauraki Gulf. Clare Luamanuvae (personal interview, Auckland, 26 October 2012) sees one of the key differences from other addiction treatment programmes from the Bridge is its longevity:

We've been doing this for a hundred years in Auckland. You know, no one has been doing it longer than us. So we have a history....it's like a myth, you know? It's been that long, it's like, "Oh yeah, my Dad's brother went there...and he's in his eighties".

Cynthia Young from the Salvation Army Bridge Programme (personal interview, Auckland, 26 October 2012) explains the Army's rationale for moving the treatment programme off Rotoroa Island and into Mt Eden, an inner-city suburb in 2005:

Rotoroa Island was a very beautiful experience and a very nice respite for many, many people, however, they'd come back and relapse pretty quickly. So, the Salvation Army, to their credit, decided to have a good look and try and find something that was more effective, and what was more effective was to keep people in the culture and the community that they would be living in, and has kept them practicing what they would be learning on an on-going basis.

Clare Luamanuvae from the Salvation Army Bridge programme (personal interview, Auckland, 26 October 2012) adds:

The model of treatment as it stands right now, um, was really put into place about ten years ago. The Salvation Army decided it would look at evidence based models from around the world and try and recreate its own model of treatment based on some of the best research that was available.

The programme is eight weeks in length and practices the Community Reinforcement Approach to treatment (explained in the next chapter) along with Twelve Step principles. There is also a very strong emphasis on spirituality and the Bridge Programme has its own Recovery Church. The facility in Mt. Eden has its own gendered dormitories, commercial kitchen and dining room, gymnasium, gardens, a church and a space for reflection and prayer. In keeping with the spirit of Community Reinforcement, it is across the road from the main shopping centre in Dominion Road.

## Odyssey House

Since 1980, Odyssey House Auckland has treated New Zealand adults and adolescents with serious substance abuse, gambling and other addiction problems. Dr Fraser McDonald, then head of Carrington Hospital, established Odyssey House, Auckland's first dedicated facility in a rented house on Rose Road in Grey Lynn in October 1981 – with a staff of just one. (Odyssey House, 2013)

Odyssey House is one of New Zealand's foremost drug, alcohol and gambling addiction treatment providers and therapeutic communities, operating from eight treatment centres in Auckland, Manukau City and Whangarei, employing approximately 100 people (ibid). Their Adult and Young Services residential treatment programme is based in Avondale and treats people aged 18-22. It is co-located with the Family Centre, which offers addiction treatment for adults who have children under the age of twelve. Odyssey arranges for approved childcare and schooling for the children (ibid). There's a

residential treatment programme for children aged 14-17, and they attend the Odyssey House School.

Odyssey also specialises in treatment for people with co-existing disorders; people who have psychiatric disorders as well as addiction issues. This is run from separate locations in Auckland, Manukau City and Whangarei. On top of all of this, Odyssey provides much needed treatment opportunities for prisoners at their Drug Treatment Unit at Auckland's Paremoremo Prison.

I asked Kerry Manthenga from Odyssey House (personal interview, Auckland, 1 December 2012) about their main programme for the general population. Clients stay anywhere up to eighteen months and the programme starts with a four week pre-assessment stage. The programme is split into four phases or levels. At Level One, the client begins to work through the active phase of the treatment programme, learning to understand and use the tools the programme provides them. Level Two focusses on demonstrating a responsible, appropriate approach to the environment and clients are given responsibilities to organise and manage the setting up of groups, for example. Level Three concentrates on the clients' responsible concern and caring for others and their abilities to do it themselves. Level Four clients work on taking a responsible and concerned approach to their own welfare and their capacity to manage themselves in the wider community.

Three different treatment centres offering different methods of treatment for very different people with addiction issues. So what are the clients like when they step through the treatment centres' doors for the first time?

## Chapter Four: The Addicted Self Upon Arrival

*Life's but a walking shadow, a poor player  
That struts and frets his hour upon the stage  
And then is heard no more. It is a tale  
Told by an idiot, full of sound and fury  
Signifying nothing*

*Macbeth, Act V, Scene V*

Today, this passage from Shakespeare's *Macbeth* is how I feel about my life as a drinker, in particular the later stages of my active alcoholism. I used to regale in telling of my escapades of what I got up to when I'd consumed copious amounts of alcohol, which people in recovery commonly term 'war stories'. I liked to think these stories would take their place amongst legend, but I was delusional in thinking this way. Yes, there were some fun days and nights, but these were eventually surpassed with stories of isolation filled with empty sadness, 'signifying nothing'. I drank to feel nothing. Today I speak of these stories no more. My hour upon that stage came to an abrupt end when I took courage from walking through the doors of a treatment centre.

It's important to set a scene and provide a behavioural snapshot with what treatment communities face when newcomers come to their doors. What's going through the mind of the addict when they reach treatment? What are they feeling? Keegan and Moss (2008:6) argue that:

You can't possibly know how bad addiction feels unless you've been there. You can read a hundred books, see a thousand movies, even work with addicts every day as a counsellor or therapist. You still know nothing about the beast, the power, the emptiness, the broken heart, the numb mind. That voice that forever speaks in your head. That voice that pushes you, that beats you, that empties you – that voice that in the end, is your own.

There's a constant battle raging in the minds of the addicted to silence the down-trodden voice that keeps plaguing positive thought and action. Prentiss (2008:237) sees dependency as a defence against experiencing pain and of not being allowed a separate

sense of self. 'Underneath dependency is usually a core negative belief about the self, such as *I am unlovable. I am bad. I am not good enough. If people really knew me they would leave me*' (Italics used in original text). I'd heard addiction described as a disease of "not enough." My inner voice kept telling me I wasn't good enough, talented enough, attractive enough, or smart enough. I just wasn't worthy enough.

I arrived at my second treatment centre horribly hung-over, the result of a weekend where I said goodbye to all my favourite alcoholic drinks. I was anxious, confused, discombobulated, fearful, sleep deprived and craving for a drink. In the previous weeks someone had asked me whether I had lost enough and reached "rock bottom." I thought I hadn't lost anything significant to me before, so made deliberate efforts to lose my job, lose my license, lose my friends and lose my family. All of this of course, compulsorily involved drinking and it made perfect sense to me to sacrifice something legitimately (in my mind) so I could get to "rock bottom" quickly enough so I could start healing again. Together, my friends and family were too strong for anything I could verbally batter them with, nor were they prepared to carry on tolerating my behaviour. It wasn't until I reached treatment that I realised, when I was feeling sorry for myself, thinking about all the lost opportunities, that along the way I had lost 'myself'. I had been living life vicariously trying to be someone I wasn't. I had entirely lost my way. If I was wandering around trying to be somebody else, then just who was trying to be me?

*"If I am I, simply because I am I, and thou art thou simply because thou art thou, then I am I and thou art thou. But if I am I because thou art thou, and thou art thou because I am I, then I am not I and thou art not thou."*

*Rabbi Mendel of Kotzk.*

De Leon (2000:51-52) states that:

Residents in a TC display little self-respect and characteristically reveal poor self-perceptions as to their moral or ethical behaviour and their relations to family. Their poor self-esteem is inextricably associated with their antisocial or amoral behaviour, and frequently it is associated with their drug use and chronic inability to develop a productive lifestyle or

prevent the gradual erosion of that lifestyle. Residents find it difficult to like or value themselves because of who they have been to others and their perceived poor self-control. Their personal identity or concept of themselves as authentic people, is unstable or largely unformed. Many do not know who they are in terms of their real feelings, honest thoughts, goals and values.

This formed a line of enquiry for me in my interviews with treatment centre practitioners. I felt that it was necessary for them to describe what their clients are like when they first walk through the doors. What were clients dealing with intrinsically and did they have any sense of self? I was very interested in what their views were when someone revealed to them during treatment or pre-assessment, that they'd "lost themselves," or they "don't know who they are."

Kathy Mildon (personal interview, Auckland, 28 August 2012) has spent years interviewing clients of Higher Ground at their pre-admission assessment phase:

I often equate it, especially with methamphetamine users... I'll often equate it with refugees out in some of those leaky boats that they're out on, and that they're lost at sea. And when you meet with them, particularly the meth users, alcohol to an extent as well, you get a strong sense that they're in no-man's land. They are just...they're out there, drifting in very difficult circumstances and you're almost throwing this rope out to them to get them in to land.

Kerry Manthenga from Odyssey House (personal interview, Auckland, 1 December 2012) says:

Usually by the time people get here, so much of who they are has been focussed on getting and using and [physically] recovering and getting more and using more and recovering....Often not knowing who people are sometimes is a defence mechanism against a lot of that shame and that awfulness that they see as being internal to them, as opposed to attached to their behaviour, and so some of it is not knowing because of the chaos that comes with that life...Reflection and substance abuse are not particularly well linked.

Cynthia Young from the Salvation Army (personal interview, Auckland, 26 October 2012) thinks it is quite a common theme with people with addictions. 'The masks that they



wear; there's the habit of deception, self-deception as well as the deception of others, both unconscious and deliberate. Lying more often than not is part of someone's way of coping, or mode of operation when they arrive here'.

Clare Luamanuvae from the Salvation Army (personal interview, Auckland, 26 October 2012) is reminded of a previous job role when she hears people saying they've lost themselves:

I used to work with people who were 'class A' addicts on methadone programmes. And they always seemed like they'd lost half of themselves. It was a very strange, uh, addiction. That's what it makes me think of, and that I do think that people do shut down sometimes. Parts of themselves they don't want to accept....the mind is an amazing thing, and can close things down, and can put things in the Pandora's Box and lock them away and people can function with very little resource, and on many different levels and sometimes they can shut lots down. That's what it makes me think of. It's amazing how people can, um, function when they are so lost, but they do. We're very resilient. That's the upside to it and yes, that's a sad phrase and it sounds really sad, but actually it speaks to the resilience of human beings. "Even when I'm half lost I can still do this." You know? I still get up in the mornings, I still go here and I still do that, and I'm here. You know? They're half lost, they're still...you know, they're detoxing but they still turn up downstairs for an assessment. How awesome is that really?

One of my participants added, 'I get very excited when I hear people say they don't know who they are, because that's okay. That's a good place to start, really'.

Johnny Dow from Higher Ground (personal interview, Auckland, 22 August 2012) thinks of existential crisis when he hears someone say they've lost themselves:

That's where I go... the search for meaning. You know? Um, which I think most people coming in...a lot of people coming through have, you know, like, you take away the substance which has given them meaning or not given them meaning but sort of numbed them...then all of a sudden they're left with nothing but who they are and they have to start looking at that side of them which is why I think the spiritual side of um, Twelve Steps works very well, with the God of their understanding, or the Goddess of their understanding, or whatever. It's looking for meaning in life and purpose.

In comparison, Brett George, Consultant Psychologist to Higher Ground (personal interview, Auckland, 17 September) says:

It brings to mind first off, interestingly enough, an idea of a coherent enough self. A self that is um, that the person has some...enough coherency around that there's a realisation that they've lost something. So, and I think that's significant...that which is being is no longer present. So I think it's meaningful, it's a very meaning-laden concept, and again, I like the idea of um, in T.A. [Transactional Analysis] they talk about "Martian thinking" which is the notion that um, we don't take any given meaning...you don't have any assumptions around any given meaning. Um, so when any given person would say or make a comment like "I have lost myself" or "I am so far removed from myself, it's not even funny," the...their aspiration of what that self means for them is really important rather than me assuming that "I know what that self means," or, "I know what that self means for me," anyway, and it might not be appropriate for them."

Anthony Cohen (1994:3) explored a similar idea of the self and what it means to someone else, and it's particularly relevant to anthropology and the study of addiction treatment. He states:

As scholars began to focus on self-awareness and cognate phenomena such as thought, emotion and cognition, the characteristic anthropological problem inevitably arose to pose unanswerable questions: How do you know what the other person is thinking? How can you discriminate between the other person's consciousness and your construction of his or her consciousness? The answer to the first and second questions, 'I cannot know for certain', leads inexorably to the answer to the third: 'I cannot'.

Cohen went on to argue that the inevitable starting point for one's interpretation of another's selfhood was one's own, something Brett George argues may not be appropriate for the addict in treatment.

Goldstein (1994:217) describes the internal struggle going on with addicts when they present themselves for treatment as a powerful force – a real 'Jekyll and Hyde' situation. If there is no motivation to give to the drug, there is no way to begin treatment. But even if addicts present themselves for treatment, it is usually with ambivalent feelings. Some kind of pressure brought them to the treatment facility – perhaps insistent urging by the family, perhaps the cost of a drug escalating out of control, perhaps loss of a job,

perhaps trouble with the law, perhaps health concerns, perhaps dissatisfaction with self'. Urschel (2009:28) similarly sees the addicted brain struggling for clear thought where there's 'a battleground between pro-addiction thoughts (thoughts that push you toward drinking or using) and pro-recovery thoughts (thoughts that help you stay sober)'.

I asked the addiction treatment practitioners I interviewed what kind of motivating factors they came across from clients when they first entered treatment. I knew of some cases with the people I'd done treatment with where their motivation for doing treatment was a "get-out-of-jail-card" and they had no real desire to change their behaviours at all. The end result for some of these people was relapse and a return to incarceration. Similarly, there were some clients who used the 'jail card' and something in treatment worked for them and they continued a healthy recovery after leaving the rehabilitation centre.

Clare Luamanuvae from the Salvation Army (personal interview, Auckland, 26 October 2012) said:

We often have clients who coast through most of their first treatment here and come back again. But they normally come back choosing to come back, rather than having their arm up their back, which is quite interesting and it happens a lot. Um, we do challenge it but at the end of the day, we can't ask someone to leave without a good reason. So we can't just say, "We don't think you're putting any real effort into it," because you can go through the motions quite convincingly, like you can fill in all of the paper work that you need to do. So sometimes people do coast through, but, um, that's what they're ready for at the time. You have to accept people for where they are.

Johnny Dow from Higher Ground (personal interview, Auckland, 22 August 2012) pointed out one of the great paradoxes for some people with addiction issues entering treatment, often for the first time:

One of the funny things is that often people fight like hell to get into treatment and then as soon as they get here they want to leave. Yeah, which is understandable...it's a paradox. But....um, the pre-admission people have to get the person...they can see if a personality is going to be

kind of disruptive to the community, and so they have to start the work on that person at that stage getting them ready, so that they don't come in and it's a waste of time. That they get ready and you're going to have to do certain things to get into treatment, you know? It doesn't always work, but often, most often it does.

I asked Kathy Mildon from Higher Ground (personal interview, Auckland, 28 August 2012) about whether people's motives for attending treatment were for recovery or whether there were other motives at play. She responded:

There's always other motives, yeah, always other motives. So, there's women coming in whose children have been removed and their motivation is clearly they want their children back. And Child Youth and Family have said to them, "You need to come to Higher Ground in order to get your child back." So, they'll be coming in the door with that. There'll be people coming in here that have been charged with their third or fourth drink driving charge and they'll be threatened with prison, and so they're coming in, and that's their primary....primary motive. Um, there's other people that come in that um, there's been so many consequences around their addiction, that they're coming in and putting their hands in the air saying, "Okay. Tell me what I have to do." And they'll do it. So, it's all different ...there's always different motives. And you always check those out in pre-admission and name that stuff with them, so that they know we know. But that's okay, you know, you work...that's to be sorted out. And once they get in here as to whether that...they know they don't get through to Phase One or Phase Two or Three without doing that work. And often people for instance, come in on significant drug charges and end up doing really well, so you wouldn't be turning them down just because of that... What I do is I use that motivational interviewing all the time to suss that out with them. You know, just using that...all the time to get them to start talking about it and...yeah, to reflect on it."

Cynthia Young from the Salvation Army (personal interview, Auckland, 26 October 2012) said:

I guess we assume that someone coming into treatment means they're at least 51 per cent certain... "I've got a problem and I have to do something." There's another part of them that's, you know, still kicking and screaming and being dragged along. But the balance often shifts as they go along....They've created way, way too much chaos and devastation in their lives. They have not successfully managed. They've lost their jobs, they've lost their relationships, they've burnt the bridges with their families, and they've got into trouble with the law.

Wilcox (1998) on describing newcomers coming to Alcoholics Anonymous sees them as suffering from significant social estrangement and thorough social isolation. Clarke

(2000:46) sees support as being crucial to the therapeutic process. 'Clients are disaffiliated when they arrive at the TC. They become affiliated through a socialisation process in which they actively engage in a reciprocal process of supportive transactions with their peers in the community'. He argues that peers sharing experiences and identifying with them at a personal level was one of the most potent factors for change.

This is not an easy task as one of my participants pointed out to me (personal interview, Auckland, 9 October 2012) in particular when dealing with large antisocial personalities who first arrive for treatment. They spoke of a Drug Court conference where a presenter was 'presenting the moral model, and he was very clever. I listened to him once and he said, "It's not the addiction I'm fighting, it's the lack of morality in the antisocial person." So he thinks that lots of addicts have antisocial personality disorder and there he sees an added lack of morality. Um, and for the clients we see there is a lot of lack of morality, because there's a lack of attachment. You have a shitty life and people don't look after you so why should you look after anyone else?'

De Leon (2004:93) sees intensive, long-term treatment as the only way an individual can focus on themselves as a whole, changing their lifestyle and identity rather than just achieving abstinence. He describes the residents who turn up to therapeutic communities as 'the most severe substance abusers with wide-ranging personality problems and social deviancy in addition to their drug use'. My own form of social deviancy was to shut out the world, shut the curtains, shut the doors, shut off the mobile phone and shut myself down. I became very antisocial and would hope that nobody would ring, email, text, or visit and would internally bemoan them and vilify them if they did. And at times I was craving for human contact but I was afraid to go and find it.

There were some addicts and alcoholics I did treatment with who were born on the right side of the tracks, were well educated, held down jobs and were in relationships, were

loving parents and partners, had never been arrested, and who ended up in treatment, their penance for living in fear. They, like me, talked about living in their own past because of fear, as it was easier than living in the present. We imbibed mind altering substances to numb the fear and emotional pain, the fear of failure, the fear of change the fear of success, the fear of being the best person we could be. McAlister (2010:44) states:

Fear is an instinct designed to keep you safe in situations of perceived danger. This instinct causes an immediate reaction known as fight or flight. Fear is also an intense and unpleasant emotion that is often caused by the anticipation of events that have not yet taken place. You run into problems when you let this one emotion be the principal guiding force in your life. Living in fear is seductive and habit forming. It is as addictive as any drug; and much like addiction, it develops so subtly that it is well established before it becomes apparent.

One of my participants (personal interview, Auckland, 12 October 2012) said that 'Clients generally don't come through these doors all happy and smelling of roses. Often, um, what we see are the last throes of an elongated pattern of self-destructive behaviour, which is often fuelled by their own unease with the world, um, of feeling uneasy in their own skin and this fuels their own self-hatred.' Berger (2008: 11) says, 'While self-erasure and self-hate manifest themselves differently, they share a similar core dynamic: the alienation or rejection of the true self'. Berger describes self-erasing as going to great pains to not be noticed, making no waves and seeking emotional security through a lack of presence in one's own life. This supports a saying in Alcoholics Anonymous that, "Many of us have appointments with our own lives and some of us just don't turn up." Berger went on to describe self-hate as not living up to the idealised person we think we should be, and when the ideal is not questioned and the expectations are unrealistic and not challenged, self-hatred begins to manifest in our lives.

Is addiction a self-manifestation or are there larger forces at play? Campling and Haigh (1999:12-13) describe clients coming to treatment who are just struggling with the rapid change of society:

Maybe many people's experience of the world is becoming 'borderline', with little experience of safety or stability, of core identity or attachment to fixed points. Our therapeutic community patients often experience this to an extreme. They have had so little that is good and solid in their lives, so much betrayal and change, that many of them cannot imagine surviving until the next day: they have little sense of identity or their own continuity.

On top of the confusion, agitation, fear, uncertainty, shame, guilt, isolation, loathing, anger and the gambit of unpleasant feelings newcomers feel when they enter treatment, most of them must deal with the insidious defence mechanism of denial. Carr (2011:85) cites both Paolino (1991:219) describing 'addiction as a disease of denial' and Rasmussen (2000:114) 'that client denial distinguishes addiction'. I used denial as a way to keep the doors to the relationship with the drug of my choice firmly open. It was my protection so I could keep drinking. It was my house of cards tumbling around me. It was the lie I'd perpetrated that I was fine, so I could carry on doing what I was doing. I was the only one who believed it and I would argue and deny evidence to the contrary. A treatment centre poster I saw read "Denial = Don't Even Notice I Am Lying." Boriskin (2007:27) states that:

Denial is a complex process of selective perception that prevents an addict from seeing what is causing her pain...Denial stems from a place of wanting to believe that all will be fine and will return to how it was before the addiction reared its ugly head...Denial is what keeps sickness active; it is the oxygen feeding the illness.

Gorski (2000:54) says there are twelve types of denial and these include:

1. Avoidance ("I'll talk about anything but the problem!");
2. Absolute Denial ("No not me!");
3. Minimising ("It's not that bad!");
4. Rationalising ("I have a good reason!");
5. Blaming ("It's not my fault!");
6. Comparing ("Because others are worse than me I don't have a problem!");
7. Manipulating ("I'll only recover if you do what I want!");
8. Scaring myself into recovery ("Being afraid of the consequences of drinking and drugging will keep me sober!");
9. Compliance ("I'll say anything you want to hear if you leave me alone!");
10. Flight into health ("Feeling better means that I am better!");
11. Strategic hopelessness ("Since nothing will work I don't have to try!");

12. The democratic disease state (“I have the right to drink and drug myself to death!”).

I asked the treatment centre practitioners how they and their therapeutic communities knew the difference between when someone was in denial or when “the lights were on,” and someone was actively participating in their treatment. Johnny Dow from Higher Ground (personal interview, Auckland, 22 August 2012) explains:

Well I think you can generally tell through their behaviour and I think the residents themselves pick that up, rather than, you know, the therapists will pick it up, but....but the community, a therapeutic community of individuals or any community is really accepting. You now, they give people lots of chances to come in and be part of the community. And then when...if the person....and they accept mistakes and they accept resistance for quite a long time. But if it goes on for too long, the community gets tired of...of the person...And the community in its own way will say, “You’re not coming on board with us, this is not working.” So that’s one thing that happens, you know, which people will see...well, why isn’t it working? And they might get a light on in that respect. Um, denial is such a big thing in addiction...that sometimes you can’t break through. Occasionally you can’t break through the denial. It’s just so strong.

Cynthia Young from the Salvation Army (personal interview, Auckland, 26 October 2012) says:

You know, no case manager really wants to sit and listen to all the denial scripts, so one of the interventions is to give them a ‘Step One’. There’s a very nice ‘Step One’ resource that involves asking a lot of questions and having them write the answers, and there’s one about denial as well. Some people think, “Oh, what’s that?” and they don’t even know what denial is. So, um, getting them to interact on a one-to-one basis and share that with their case manager, and in the meantime they’re listening to everybody else, and of course, within an eight week programme you are going to have people well down, you know, who are going to be role models and examples for the people who are sort of still kidding themselves a bit.

One of my participants (personal interview, Auckland, 9 October 2012) sees denial in clients in very small, subtle ways that are felt rather than pinpointed.

Oh, um...there are many ways to be in denial. One is denial to, like lots of our clients who come in here, and they’re constantly alternating in a way that they’re outwardly complying and inwardly defiant, and so they do know the right things or... It’s a habit you brought in...um, and really it...it’s more of a bodily felt sense isn’t it? With some we know...“Oh this guy is really embodying a new way of being with himself”, because they say exactly the same thing, whether they are meaning it or not, but one rings true and one



not, so it's the way they breathe through...the way they look in your eyes, and people don't know that clever anti-socials can mimic all that, but you still haven't got the feeling that something resonates in me...he has got it...or it just water under....just empty talk. Um, and when I work with clients I can see whether something somebody has said or there's a change as the person relaxes, there's no more pretence. But it's a very subtle thing...it's not an energetic thing, it's not something I can put down to one little thing.

Kathy Mildon from Higher Ground (personal interview, Auckland, 28 August 2012) uses

a client's level of engagement as an indicator of denial:

So if they're engaged, you know, they're in the room and they're talking about stuff, as well as putting stuff into action, um, I'd say the light bulb may be on a little bit. I don't think the light bulb goes on totally until they've been here. So they have to be here. And they have to be um, they have to be going through this process. So we could, um, yeah...I like to use that phrase "opening the door." So we're opening the door. We're opening the door a little bit for them and there's a bit of a light there.

At the time I felt the glimmer of light was all I had to hold on to, along with a message given to me by one of the practitioners who saw me during my clinical assessments. That there's always hope. Having entered the doors of treatment, the work on my 'journey of discovery into recovery' was about to begin in earnest. I was about to 'be relieved of the bondage of self'. So just how do they guide people from full blown addiction, feeling self-pity, self-loathing, self-absorption and self-obsession to a state of recovery, self-awareness, self-worth and higher self-esteem? And do the clients bring their own basket of selves with them into treatment?

## The Basket of Selves

I knew that a certain amount of deconstruction would have to take place when I went to treatment, because within my own basket of selves, the "alcoholic-self" had hijacked my core being. It seemed that every action I was taking was revolving around the consumption of alcohol as I was slowly beginning to identify with being an alcoholic. I was keen during the course of this study to explore whether Cohen's (1994) 'basket of selves' theory as it relates to

identity, was any more or less relevant and unique when it came to addicts and their treatment. Was there an 'addicted-self' or was this something that was manifested by the other 'selves'? My mother once called me a 'chameleon' and I wondered whether this was a behavioural trait that was unique to alcoholics and addicts when they entered treatment. I'd worn many masks over the years in order to 'be who I needed to be' in order to stay in relationship with the drugs of my choice in terms of procurement and ingestion. This involved an immense amount of 'people-pleasing' and manipulation on my part, culminating in me becoming someone I wasn't. I was neglecting my core self.

Clare Luamanuvae from the Salvation Army (personal interview, Auckland, 26 October 2012) agreed with Cohen's 'basket of selves' theory, but didn't think that it was anything specific to addicts or their client group:

Our goal is to get the clients to realise that there are other aspects to them, not just those that have been taking up their time most recently with their addictive behaviour, that there are other identities, that there are other parts of themselves that are worth exploring and saving sometimes.

One of my participants felt that there were so many models of 'self' and that the 'basket of selves' was applicable to every person. He philosophised that 'the self' comes into the world 'and wants to be a unique expression of the universe' but the problem is that 'we come in without knowing how to make this work on the planet and follow the organic wish to do the next thing that makes it grow'. He posited that if a child is playing with pots and treating them like a drum kit, at some point they may be told by a parent to stop, because it was making too much noise:

And then if it's severe enough and long enough, the child stops and can't follow its organic wish and maybe for good reason. It can't trust the one in the world when it wants to. But there's a pain associated with that, um, both because the pain stopped it from doing it and also pain from not following the organic wish. So then...the 'self' splits at that moment into a compliant self and the defiant self. And that happens every time the organic wish is stopped, so at the end of the day you've got lots of little 'selves' which are all having the energy of the original self, but they can

only do one thing. They are not the essential thing: their whole energy is to protect you from pain or help you by defiance by usually very unsuccessful means or antisocial means to get back and get your organic mission read (personal interview, Auckland, 9 October 2012).

If my organic wish at the time of entering treatment was to continue drinking, my compliant self would help me 'slip under everyone's radar' by saying what I thought people would want to hear, while thinking about keeping the relationship with my drugs of choice active. This protected me in a way from the pain of experiencing loss and grief from ending the relationship and my defiant-self ensured that this wasn't going to happen, by doing the opposite to what I was telling everyone.

Brett George, Consultant Psychologist to Higher Ground (personal interview, Auckland, 17 September, 2012) thought 'the addict-self is a really good construct that is used a lot in recovery and so movement away from our relationship to narrated self then becomes crucial in not only diagnosis but also intervention and treatment, especially in after-care'. He sees the concept as having a lot of 'fluidity in meaning' and that it was a very 'meaning-laden concept'. He also tendered when it would not be useful to use the concept, for example those clients presenting 'with split or divergent selves'. So as a concept, while useful, is dependent on 'the context and the relativity to that person'. What Brett George then pointed out in our interview gave me pause for thought. He said 'the notion of self is for most people...an abstract one'. He started questioning 'how much the notion of self is even a subculture to psychology itself or anthropology itself? How much are these terms used outside of the discipline itself'? I started to wonder whether I had been treating the 'basket of selves' theory as a way of being able to label someone according to what I thought their behaviour was exhibiting. Brett George continued:

The appropriateness of these terms is another issue, you know, because otherwise they become, um, more therapist or practitioner driven rather than client driven. So that presents itself with another issue, you know, the appropriateness of language and the culture of language that we use, I suppose.

The practitioners I had spoken to had agreed that although useful in concept, the 'basket of selves' was no more applicable to clients seeking addiction treatment than from the general population. Yet to me, there were some generic 'self' identifying traits that new clients to treatment displayed, such as low self-esteem, low self-awareness, self-pity and self-obsession. How then, did the treatment centres use 'community' as a method of moving people to a modicum of self-acceptance, self-awareness and self-love? How are interventions used within the 'community' context for addiction healing?

## Chapter Five: “I Can’t. We Can.” The Use of Community in the Treatment Setting

*But the masks they wore were rarely affixed to their faces. In the poor quarters of Naples, every person becomes a playwright and an actor, seeking to determine and organise the reactions of an audience. But every person is a critic as well, more than ready to demolish the transparent devices and weaker props of his fellow. Thus the blunt and disarming frankness of the Neapolitan! Out of this interplay of dramas and critics, some fundamental understanding emerges. People who are unsophisticated in academic matters become masterful psychologists. They deal with one another and even attempt to love one another, fully aware of each other’s ruses and faults.*

*Thomas Belmonte, The Broken Fountain.*

Why is ‘community’ a proven method of treatment for people demonstrating such strong anti-social individualistic behaviour and how do the treatment centre practitioners apply its use? In one of the many rooms I was seated in while my addiction therapy was taking place, I saw a poster that said, “I can’t. We can.” So many of us previously harboured determined feelings to get well on our own, but for many of us it was to no avail. After a series of humbling relapses, crawling my way out of the dark hole for which I’d dug myself, I came to the conclusion that my alcoholism was something I couldn’t overcome on my own. I wasn’t capable of “Just Say No” strategies in isolation. I booked in for pre-assessment interviews at a residential therapeutic community and suddenly I formed a view that there was something very appealing about belonging to a community of people who cared for each other and were prepared to help each other in their burgeoning recovery.

In this chapter I intend to focus on how community is used at the different treatment centres with a focus on ‘community’ as a method of treatment, a community reinforcement approach, spiritual communities (including Twelve Step communities) and discussion on some of the ‘group work’ that takes place in the centres, such as family groups and encounter groups. Indeed there are a multitude of different psychology-based techniques that are used within residential treatment centres that are proven and tested, such as cognitive behavioural therapy, rational emotive therapy, gestalt therapy, motivational interviewing, transactional

analysis, psychotherapy and many more. De Leon (2000:9) describes the social and psychological frameworks that make up a therapeutic community. These very frameworks are used in residential treatment centres as well:

The TC is presented in a social and psychological framework.....The concepts, language and techniques from different schools of psychology and therapy are both present and past influences in the TC. These include psychoanalysis, gestalt therapy, regression therapy, role therapy, conditioning and behaviour modification, social learning theory, relapse prevention, and cognitive-emotional therapy, among others...This social and psychological framework formulates the concepts and principles that the TC uses to understand and explain itself.

It just isn't possible to go through the plethora of intervention techniques that are used by the treatment centres within the body of this work. Some of these techniques are mentioned where my participants have discussed their use in specific relation to how they use community as a way of getting a client involved in recovery. Community involvement for many addicts begins at the pre-assessment phase of treatment. Kathy Mildon at Higher Ground (personal interview, Auckland, 28 August 2012) uses motivational interviewing in order to 'get the client on board with what's going on'. She sees that it's a key component to start building a relationship with the client to prepare them for what they're going to go through, while beginning to confront their addiction issues, not through using 'in-your-face stuff with them' but through 'recognising the strengths the client has and working with that'. It's a fine balancing act to get this equation right, because if you're too confronting you may scare the client away from entering treatment and if you're too affirming, a client's expectations of treatment may be that it's 'easy'. Higher Ground is also a teaching facility and Kathy helps train the social work students on placement:

When we talk to our social work students that are here, you know, the two things that I say to them, is that there's two things you need to do here. You need to get the information and you need to get into relationship with the client. And that can be difficult if you're asking those really tough questions but at the same time you're trying to build that rapport and get into that relationship.

This is a difficult task. I imagined constantly trying to build a relationship with someone who may not want to be there, or see you, who's been through some exceptionally tough times in their life, may be agitated or coming down from a high. I thought of the skill required to engender a level of trust with the client in order for them to 'open up' a fraction and start the honest dialogue that's needed in order to complete a valid assessment. But at this stage it's up to the client to take a 'leap of faith' and proceed with what they need to do to be a part of the community, and this in part depends upon the client's level of desperation to get well. They must begin being honest with themselves and those around them.

De Leon (2000:325) states:

Within the "fishbowl" environment of TC life, trust develops from repeated experiences of personal safety. Individuals continually reveal vulnerabilities to others and encounter their social, interpersonal fears without hurtful consequences. This requires risk taking, trying new behaviours, exposing basic skill deficits, and disclosing weaknesses, fears and needs.

Using the "fishbowl" analogy is quite acceptable for residential treatment settings, in particular therapeutic communities. I couldn't help feeling that I was being watched. The fact of the matter is that I was. The community was watching me to see what I would do behaviourally, my case managers were watching me earlier in my treatment to see whether I was adapting and fitting in. It was not appropriate to isolate myself in my dormitory room and read a book on my own as that was not conducive to 'being part of the community'. It was continuously suggested that I 'reach out' and ask for help or discuss with the community what was top of mind if I was having a difficult time. The overarching expectation was that I would become a part of the community and there would be consequences if I didn't, such as being formally discharged from the programme. The community was being used as a method to help me get well.

## Community as Method

Clarke (2000:6) cites De Leon (1995a) in saying ‘the quintessential element of the therapeutic community (TC) approach may be termed “community as method.” In other words, clients, volunteers and staff model successful change and provide psychological support, and this is hypothesised to be the primary change agent’. The National Institute on Drug Abuse (2002:1) advise that it’s the use of ‘community as method’ that sets therapeutic communities apart from other forms of treatment. ‘TC members interact in structured and unstructured ways to influence attitudes, perceptions, and behaviours associated with drug use’. They also advise that ‘a second fundamental TC principle is self-help’. I’d previously viewed self-help as an individual taking responsibility for themselves and asking for help when they needed it. But my view was clouded by my own thirst for independence and a ‘take-it-or-leave-it’ approach. Having done one-to-one outpatient therapy prior to joining a residential treatment community, what I hadn’t encountered before was the “mutual self-help” element to therapeutic communities where ‘individuals also assume partial responsibility for the recovery of their peers – an important aspect of an individual’s own treatment’ (ibid). Caring for someone else and helping them in their recovery would become a cornerstone for my own and being part of a group in recovery was stronger than anything I could achieve on my own.

Manning and Morant (2004:29) state ‘[t]herapeutic communities are small social systems in which interactions between individuals and social contexts are encouraged and facilitated through intense group experiences, and are brought to consciousness through continuous feedback’. Johnny Dow (personal interview, Auckland, 22 August 2012) says Higher Ground uses ‘group therapy’ as ‘the main process’. Clients are assigned individual case managers who will do some deep therapy with the client outside the group. With some personal subject matters the client will be encouraged to ‘take them to group’ so they will be



using the client community to discuss, empathise, seek feedback on and potentially find a pathway to resolve the issues:

[S]o the person is using the community and then when they leave here they'll be using the...the um...Narcotics Anonymous and Alcoholics Anonymous community knowing it's okay to reach out to other people. So that's the kind of really important part; that it's okay to be in pain and reach out.

There were many different groups that clients were expected to participate in the treatment centres I interviewed. These included gender groups, family groups, spirituality groups, Twelve Step groups, exercise groups, relationship groups, whanau groups and encounter groups, to name a few. How much clients were or were not participating in groups was always checked and in appropriate cases highlighted. Manning and Morant (2004:29) state that:

'[w]ithin the psychology of personality and social action, we can also identify attempts to overcome individual / social dualism. One is the analysis of groups, and the way in which individuals seek to establish their personal identity through the social relations within and between groups, and another is the re-conceptualisation of individual personality and group relations in common terms as a study of the development and exchange of social meanings....'

De Leon (2000) sees one of the key indicators of a person's willingness to change is their level of participation in the community. Brett George, Consultant Psychologist to Higher Ground (personal interview, Auckland, 17 September 2012) says:

The relationship they have not only with themselves but others is really important. So that's why group work becomes quite an important modality because you're...it's not just you're present to one other person in the room, you're present to a whole group, and so that's a very powerful dynamic... there's a lot of processes that can be stimulated through um, traditional group work, and the group going through its developmental cycle as well, especially if it's in a closed group versus an open group.

Dawson and Zandvoort (2010: 98) cite De Leon (2000) in describing the community-as-method approach as 'a social leaning process, where residents learn from observing each

other and themselves. Importantly, the TC as a community, rather than a single therapist or counsellor, is the healing force that facilitates individual change.'

Johnny Dow (personal interview, Auckland, 22 August 2012) also says that using the community as a method of healing works because 'it's a lot more powerful for the intervention to come from other residents or people in the facility than the therapist. And I think the power of coming from another peer is...is why it works'. This is supported by De Leon (2010:74) when he says '[t]he main messages of recovery, personal growth and right living are mediated by peers through confrontation and sharing in groups, by example, as role models, and as supportive encouraging friends in daily interactions'. I talked for some time with Johnny about community spirit and community living and the central living that therapeutic communities provide:

Whereas in the past communities were a lot smaller and maybe they had the church or something around them, where that community spirit....today there's not a lot of community spirit, so I think when people come in here and suddenly encompass a whole group of people wanting to be a community I think it's a powerful therapeutic effect.

One of my participants (personal interview, Auckland, 9 October 2012) encouraged community as a method of healing for clients to take further:

Everybody will become everybody's teacher and everybody becomes everybody's pupil. And so the community is encouraged to learn from each other and um...even though I like that our community and also others are hierarchical, but in the learning moment... it can be you can learn something from me now or I can learn something from you now, if you accept the community as method then you say we are all here to grow. And because the purpose of the TC is that, it happens.

My participant had a wonderfully dry sense of humour, and added:

Also of course, the community is like...is a small mini political unit...there's lots of politics in a community all the time, so it teaches you how to stay and become more competent as a great politician, and lots of people and lots of anti-socials relate. They are very good political manipulators and that's not the most desirable outcome, but it shows there's an increase in skills. You have a much more skilful anti-social...

'Other aspects of the TC's "community as method" approach focus on changing negative patterns of thinking and behaviour through individual and group therapy, group sessions with peers, community-based learning, confrontation and role playing' NIDA (2002:4). When I was in active addiction I never liked any form of confrontation. I would avoid it in any way possible, even if it meant that the outcome was to my own detriment. Confronting something in a group therapy session was common practice in the residential treatment centres I attended. Although very uncomfortable at first, confronting someone about what they'd done and how I'd felt about it brought me closer to the individual at a relationship level and it drew me more into the community. One of the ways that residents could engage in healthy, honest confrontation was by participating in an encounter group.

## Encounter Groups

Being assertive and confronting an issue in a healthy, respectful manner was hardly in my repertoire of skills when I was in active addiction. People pleasing and manipulation were. So when there's a group of forty or more addicts and alcoholics living under one roof, someone is going to do something that is bound to anger, frustrate, annoy or even threaten someone else. Kerry Manthenga from Odyssey House (personal interview, Auckland, 1 December 2012) explains the use of encounter groups:

[T]hat's the primary conflict resolution tool within the community at Odyssey House, and so those happen several times a week in different configurations. Um, and that's the opportunity for residents to use a more structured format to address conflicts or concerns that may exist and those may be about something simple as, you know, somebody licked a teaspoon and put it back in the drawer or something as significant as um, you know, "I feel that the aggressive way that you've been talking to people is really undermining the safety of our group," kind of thing.

De Leon (2000:20-21) explains the use of encounters and the history of this form of group therapy:

In Synanon there developed the game or encounter group. These groups rapidly evolved a distinctive format marked by intense mutual

confrontation designed to expose and weaken defences against personal honesty and to encourage the disclosure and expression of authentic feelings....Thus in Synanon (and in later TCs) the aim of the group process was to help the individual uncover and change the characteristic behaviours and attitudes associated with addiction. Group interaction was used to raise individuals' self-awareness of those negative personality features through their impact on others, and group persuasion was used to raise individuals' self-awareness of those negative personality features through their impact on others, and group persuasion was used to elicit absolute personal honesty, self-disclosure and commitment for self-change.

At the daily morning house meeting held at Higher Ground, time is set aside for challenges or awareness of house rules. One can be challenged in an open forum meeting for behaving in a certain way that is contrary to house rules and community expectations. The person being challenged must thank the challenger for pointing out the behavioural infraction to them and "sit" with the challenge for 24 hours, which involves no discussion on the issue whatsoever and no 'tit-for-tat' challenging. This gives the client being challenged pause for reflection about what they've done and what they need to do to change and gives the challenger confidence that when they're being assertive they're not going to be argued with, in an aggressive or manipulative fashion. But this is only five minutes per day and not everyone is able to get their challenges out in the open, as 'air time' for challenges is fiercely contested. However, everyone has the opportunity to air their grievances in 'settling group' another encounter group held weekly.

Johnny Dow from Higher Ground (personal interview, Auckland, 22 August 2012) explains settling group as 'an assertiveness training group' and a healthy form of confrontation:

[O]n the whole I think why drug and alcohol treatment in a therapeutic community works is that it has a degree of confrontation, acceptable confrontation...I've got to be careful on that because some people find the word 'confrontation' too alarming...but in some ways I think in any therapy you have to confront at some stage. It's how you confront....you need to say what you see at the time I suppose. And therapeutic communities and the residents will do that.

Settling group is a very structured way of addressing the behaviour of clients who've done something to upset an individual client or whose actions are out of line with the community standards. Each resident had to come up with a settle. The premise is that if you care enough about someone in the community, you will tell them what they've done to upset you 'from a caring place', not from a place of aggression or ridicule. The group sit in a large circle with two facilitators at either end. In the middle of the circle are two chairs facing each other. A resident will get up, sit in one of the middle chairs and will call the name of another resident to join them in the opposite chair. A very carefully worded script is followed (which is plastered on the wall to act as a guide). "When you...[a brief description of what took place that has aggrieved the resident]...I felt...[the feeling that the resident felt such as frustration, anger, disappointment, belittlement, confused] and I encourage you to... [what the community would expect of the resident behaviourally, such as being mindful of their behaviour or to others, being congruent with their feelings, or reaching out and asking for help – to name a few]...and I require of myself [what the client will do to help the client being settled address the behaviour]. One cannot settle a person who has already settled them in the same session (tit-for-tat). If one person is settled several times in a session then that suggests that the individual has some work to do if they want to continue being a part of the community. The settling group is also a way of being affirmed, as the residents need to complete the same exercise again and complete a 'positive settle' with someone who they see has been doing good deeds in the community.

Kerry Manthenga (personal interview, Auckland, 1 December 2012) explains what happens after the encounter has finished at Odyssey House:

[S]o sometimes that's a really straightforward process and you can do an encounter in a minute, and sometimes that brings out lots of stuff and becomes a bit more of a process oriented piece of work....but what will often happen if it's an unresolved issue, sometimes we'll open it up and have some discussion in fifteen or twenty minutes, kind of get an understanding of where people are with this issue, and where they can take it so they have a more full process. So does it need to go back to the

Level group for more discussion? Do we need to close the encounter but have a separate process in a closed group to explore more fully with the community, you know? So we may not resolve everything in encounters but everything that needs to go somewhere else will go somewhere else.

Residential treatment centres are very structured environments with a set of rules designed to keep everyone safe. One of the reasons for the encounter group is to enforce within the clients of the therapeutic community adherence to house rules and cardinal rules.

## Structure and Rules

De Leon (2000:222) states '[a] defining element of socialisation in the TC is learning to live in a community with prescribed rules, norms and expectations. Adherence to rules is essential for social order but also indicates the individual's acceptance of the TC as a culture of change'. All three treatment centres participating in this study have very structured, prescribed rules, all designed to keep their clients safe and to guide them towards taking action in their recovery. Johnny Dow says that 'minor interactions can be quite big for the person in a therapeutic community and them working their way through those...forms a responsibility on the self. So that's probably that mini-society with its set of structures and rules is the way that someone gets well' (personal interview, Auckland, 22 August 2012).

Most of my participants alluded to the behavioural patterns of the newcomers to their respective programmes, with a general consensus that the addict and alcoholic is used to doing tasks in their own time, usually centred around the procurement of their drug of choice, or sleeping it off. They want what they want when they want it and they want it now. There is very little structure or order in their lives. One of my participants (personal interview, Auckland, 9 October 2012) offered their view on the importance of structure in any community and how this works well in the therapeutic community setting:

What really works, at least initially, is heaps of structure. And you could have another community where there wouldn't be so much structure...and it could still work...but structure on the whole is a very, very, good thing. And so with community, usually means there is structure. You can't have a

community without structure. So just community by itself means there is structure in life.

The structure and rules are enforced not only to ensure client safety, but also to promote a way of learning a life that is free of drugs and alcohol. NIDA (2002:4) states:

Typically, TCs are residential facilities separate from other programmes and located away from the drug-related environment. As a participant in the community, the resident in treatment is expected to adhere to strict and explicit behavioural norms. These norms are reinforced with specific contingencies (rewards and punishments) directed toward developing self-control and responsibility.

De Leon (2000:224-225) breaks the rules of a therapeutic community into two groups: 'cardinal rules' and 'house rules'.

Cardinal rules address behaviours for which there is near zero tolerance in the community. Violence or threats of violence, and drug use (based upon self-disclosure, peer report, or urine testing) or sexual acting out in the facility are considered direct threats to the physical and psychological safety of the community.

Breaking any of the cardinal rules was followed up with usually dire consequences for the client. This included being formally discharged from the programme, being sent back to a lower phase, or as a disciplinary action agreeing to a "contract to change". Being discharged from the programme carried a particularly heavy consequence for the clients bailed to the treatment centre, as usually that meant they had to go back to prison. Higher Ground's cardinal rules are:

1. No drugs including alcohol;
2. No sex;
3. No violence, threats of violence or harassment;
4. No stealing, dishonesty or criminal activity;
5. No leaving Higher Ground premises without permission of staff;
6. No withholding of any knowledge for any of the above.

The cardinal rules for Odyssey House are:

1. No sex or sexually acting out;
2. No drugs or alcohol or contraband;
3. No stealing;
4. No violence or threats of violence.

Sitting alongside the cardinal rules are the house rules, used daily to ensure the socialisation process into the community is kept going and behaviours of the addicts and alcoholics are changed to values more congruent with people in recovery. There's more flexibility with the house rules and the consequences for breaking them are less dire. They provide a daily structure within which addicts will work based in an understanding that we are human and we do make mistakes. De Leon (2000:225) states that house rules:

[M]ore closely represent the norms, values and expectations of daily life in the community. Adherence to these is necessary to preserve safe, orderly living in the community and to structure recovery and personal growth. Infractions of the house rules are expected in the trial and error learning process.

NIDA (2002:4) supports the rationale for the benefits of structure and order in the life of the client in treatment as these counter the 'characteristically disordered lives' of these residents, teaching them what De Leon (2000) describes as 'right living'.

## Community Reinforcement

The Salvation Army uses the Community Reinforcement Approach (CRA) as one of its principal methods of treatment. This holistic approach offers a client-centred view of what the individual needs from their community in order to sustain their own unique, healthy recovery from addiction. One of the strengths of this approach is that it gets the client thinking about what they want for their future and who they need to have helping them, supporting that vision. Miller, Myles and Hiller-Sturmhofel (1999:116) state:

The community-reinforcement approach (CRA) is an alcoholism treatment approach that aims to achieve abstinence by eliminating positive reinforcement for drinking and enhancing positive reinforcement for sobriety. CRA integrates several treatment components, including building the client's motivation to quit drinking, helping the client initiate sobriety, analysing the client's drinking pattern, increasing positive reinforcement, learning new coping behaviours, and involving significant others in the recovery process. These components can be adjusted to the individual client's needs to achieve optimal treatment outcome.



Cynthia Young (personal interview, Auckland, 26 October 2012) feels that the most important aspect of CRA is that it 'involves what that client's definition of community is, and that is unique for each individual'. The method doesn't focus on how bad addiction can be, as this 'isn't a strong motivator' for change as Clare Luamanuvae from the Salvation Army suggests. As addicts and alcoholics we already have a substantially thorough experience with personal suffering. Instead, CRA 'focuses on tipping the client's everyday balance of positive reinforcement in favour of sobriety' (Miller, Forcehimes and Zweben, 2011:146). Clare Luamanuvae (personal interview, Auckland, 26 October 2012) summarised CRA:

Well, the biggest parts of it are probably thinking of it as a course in self-management and also in um, finding ways of a person being fulfilled in their life outside of treatment. In very many ways it's about promoting a future lifestyle rather than just what's going on in treatment at this very moment, because it's actually about building community supports. At the very essence of it, it is removing the positive re-enforcers for the addictive behaviour and creating more and stronger positive re-enforcers for non-drinking, non-using behaviours. It's a behavioural model, but it's based very much in the community setting. It has um, a whole set of tools, which we use, such as a....a life satisfaction scale, a functional analysis of using and non-using, so it's looking at what the re-enforcers are for the using and the non-using behaviours. And those are used throughout the programme to look at how things are changing and improving. The life satisfaction scale looks at all the areas in life that people might want to set goals in and work on, and then those are those community areas which we are talking about: a family, jobs, relationships, you know, finance, legal issues, you know, the wider aspects of people's lives that they want to improve.

Cynthia Young (personal interview, Auckland, 26 October 2012) uses CRA to help her clients understand their own internal and external triggers for using the drug of their choice, in order to put them in a stronger position to think about 'how am I going to manage this'? By understanding the triggers, the clients can adapt their own strategies for coping with them, and bring in the support from their community to help them:

All of the [Salvation Army] groups are about up-skilling people and their self-awareness and, you know, helping them re-programme their brain in terms of stopping and thinking they've come from a very disorganised, impulsive way of life, and so obviously being in a structured programme and understanding a lot more about themselves and putting it into practice as they go out on weekend leave and mix with their friends and

the important people in their lives. And for some people it's recreating a new community of people in recovery because they know they can't go back to some of the old associates.

Ting (1988:89-107) sees that a community reinforcement model makes it 'clear that the social influence as the reinforcement for modifying addictive behaviour comes better from the addict's community such as family, peer group and so on, rather than from society.' If addicts feel isolated from society they can still be a part of a community in order to heal and be well. Cynthia Young (personal interview, Auckland, 26 October 2012) says:

Clients have 'often become very isolated, very alienated, and so that's another interpretation to CRA. That it's about rebuilding meaningful community. None of us are going to succeed on our own. We all need to feel, "I'm valued. I have something to contribute. I'm, you know, part of something bigger than myself."

For many addicts in recovery, a significant role is played by their own immediate family. In some cases, the family nucleus helps to provide the 'sense of value' and 'being part of something bigger than myself'.

## Family Involvement

What do you do if a loved one has become enslaved to their drug of choice? How do families cope as they watch the life slowly fade from their loved ones eyes as they become more deeply embroiled in their addiction? Not only are individual addicts powerless over their drug of choice but their families are powerless as well. Some will lie, cheat, steal and sever relationships with their families altogether. The drug is all that matters. Many families don't know where to turn or who to talk to. Often there's a huge sense of relief from the families as the addict enters treatment for the first time. Kathy Mildon from Higher Ground (personal interview, Auckland, 28 August 2012) talked about the initial pre-assessment interviews and that often it's a family member that will attend with the client as a support person:

[I]t's about naming what's going on. It's about being able to reconnect with the client...with the family, now that the client is stable, in here, drug-free and in routine, you know, and doing things that are starting to

get back on board. Um, I think just being here, probably, more than anything else just being in a place like this is, um, does wonders for a client because the family know the client's safe, the family are interested in the programme, um, the client is seeing, you know, the older clients that are in here – what they're doing in terms of family. Um, it doesn't mean, you know, I've often thought we need to review the family work we do in here, and maybe do something a little bit different. But having said that, I think we do a pretty good job, and we do that right at the beginning and right from the moment of first contact. You know, we encourage them to bring in family right from the beginning. In the old days, when it was mostly opiates, the family never came in. We told them to keep their family away. But all the evidence tells us now that that doesn't work. What works is getting the families involved.

Higher Ground and Odyssey House run family groups regularly. Higher Ground operates a model where each resident is expected to bring at least one, but no more than two members of their family into family group. If there are no family members available, then the client can bring in support people, such as a Twelve Step sponsor or close friend. The family groups are a way of the families expressing what they've gone through while their loved one was actively in addiction and also a way for the clients to resolve any family issues that were at the centre or contributed to their using. The notion is that to heal, you need to discuss what is causing you pain, and by telling your story, you no longer hold on to the secrets that keep you sick and embedded in shame. The narratives provide a release for the audience also, as they get to better understand and identify with other clients or family members and what they've experienced (Smith, 2003). Clients and family were also encouraged to write honest letters explaining what it was like and read them out in group. It was all designed in a way to bring the families together.

Johnny Dow (personal interview, Auckland, 22 August 2012) says:

When Higher Ground first started family therapy there was not a lot of family therapy around. In fact, in some ways when it started, families weren't involved at all, and that moved them away. Today the families are involved and that's been a big change in the treatment process. Family therapy is probably the most powerful component of the programme.... Families were often more unwell than the resident in treatment, or just as unwell and having problems. So it's a way of getting the whole family together and so we've used that model in a way that...that it is a family

illness...Because you have so many different families in a multiple family group, but they are a flowing...families come and go during the process. The older families leave and the newer families come in. It's the older families that have gone through the process that are much more powerful than...and will say to the new family coming in, "This is probably what you need to do. This is what we did." And that newer family can see what the older family has done and where they are. That's the change. It's that role modelling, so again, it's the role modelling of the older client in the community as well as the older family.

Higher Ground will also give their clients two independent one hour sessions with a family therapist specialising in addiction. In some cases it's just not appropriate to bring up some family history in a group setting, depending on the family history and the individuals concerned. The Salvation Army offers family counselling as part of their treatment programme. Cynthia Young (personal interview, Auckland, 26 October 2012) said 'we're always trying to get family involved. Because if someone says, "No, I don't want any contact with my family," it's like only part of them is here, and there's a lot of that duality that you know, there's a lot of eroded integrity with people with addictions'.

When I return to offer my time as a volunteer at one of the treatment centres I attended, often it feels like I'm coming home. There's a solid familiarity about walking through the doors and talking with my 'extended family' about addiction. The residential treatment centre can serve as a large family in its own right. De Leon (2000:28) states:

TC programmes also view themselves as families, or rather, surrogate families that correct historical injuries from the dysfunctional families of the clients they serve. Thus, the TC strives to sustain the main characteristics of the "good" family: structure to provide order in daily living; nurturance through physical and psychological safety; individual acceptance and encouragement, conditional only upon honest participation in the struggle to change; and the transmission of values through a daily regimen of activities for social learning.

One of my participants (personal interview, Auckland, 9 October 2012) gave a frank response about immediate family and the 'wider addiction family' when I asked them how important involvement with family was when people are in early recovery:

Well, everybody says it's super-important, but I don't really agree. At the same time the family is often as screwed up or more screwed up than the client. So just saying family involvement by itself, without further education of the family, it's not particularly useful. Um, lots of my clients come from families where everyone is a user. So sending them back to their family is normally not very helpful. Um, but nonetheless, I think one reason why the AA movement is so successful is not because it's full of wise people with words of wisdom, it's because you meet the same people again and again and you gain an attachment to them. You relate to them in a human way and that's extremely nourishing. And nothing is more nourishing for most of us than being connected to a family.

I've been very fortunate to have had a family support me in my efforts at recovery, even when I continually fell over in the early days. But not all addicts are blessed to be in such a position. Yet what my participant said about being connected to a Twelve Step family or spiritual family, has helped save millions of addicts and alcoholics over the years.

## Spiritual Communities

I heard from many of the "old-timers" in Twelve Step support groups when they were sharing their experiences, strengths and hopes that when they entered the Twelve Step rooms as newcomers they were 'spiritually bankrupt'. My AOD counsellors informed me that it was quite natural to go through a grieving process and sense of loss once the relationship ties to the drugs of my choice were severed. They said this could often leave a void within me and a way to fill the hole or gap that had been left by drugs and alcohol was to do so spiritually.

Johnny Dow (personal interview, Auckland, 22 August 2012) says:

I think spirituality has been left out of the medical model for so long in many ways. It's an important part of who we are. It's not about God or anything like that, it's about the world, the being, the earth, it's about...it's an important part of getting well. It is that existential dilemma really. Spirituality, however you find it, is really, really important. I think it is one of the big keys to staying well you know, and um, requires work for all individuals coming through.

Two of the three residential treatment centres I interviewed incorporate spirituality and Twelve Step methodology into their programmes. Both Higher Ground and the Salvation Army ran regular workshops on spirituality and Higher Ground also ran Tai Chi classes where

clients could experience Eastern forms of meditation and wellness. Twelve Step programmes such as Alcoholics Anonymous and Narcotics Anonymous are key methodological pillars of these two treatment centres, as NA and AA have helped millions of people worldwide over the years achieve a healthy sobriety. 'Recovering individuals who are actively involved in a number of 12-step activities are likely to have better outcomes related to abstinence, such as self-efficacy for abstinence' (Majer, Droege and Jason, (2010:157) and decreased stress levels in early recovery. I was interested to find out why these treatment programmes had such a strong focus on Twelve Step methodology. De Leon (2000:341) states:

Self is a central concept in the TC perspective. The disorder and the person are inextricably bound such that self is the nexus of the whole person. TC teachings speak to the individual as taking responsibility for their own recovery; they emphasise that change itself involves mutual self-help leading to self-esteem. Thus, residents are not simply treating their addiction, or modifying their behaviours and attitudes, they are working on changing themselves.

Recovery was described to me as a 'baton race' and that the treatment centre would only hold the baton for a limited period of time before handing it to a Twelve Step community. White (1992:246) argues that if addicts are to break free from the grips of their addiction long-term then clear linkages must be established between the treatment culture and the self-help cultures. He maintains that it just isn't feasible to have the addict stop without some plan of long-term recovery maintenance:

It is not enough that treatment disengage the addict from the culture of addiction and initiate the earliest stages of recovery. The treatment experience must provide the pathway to long-term recovery, either through linkage to the traditional self-help groups or to some alternative support structure.

The first group of the day at Higher Ground is a Steps Working Group, where residents will share a Twelve Step reading and how they're feeling in line with the first three steps. They also have a pool of volunteers who will collect a group of residents and drive them to a scheduled Twelve Step meeting six days a week. Guest speakers from Twelve Step groups will

attend in-house meetings and share their experiences, strengths and hope with the residents and explain how they have used the programme to stay well. Residents are also expected to have a Twelve Step sponsor to help guide them through the residential treatment programme and it's expected that they make contact each week. Johnny Dow (personal interview, Auckland, 22 August 2012) says:

Higher Ground believes that a Twelve Step focus and getting people into that community, either Alcoholics Anonymous or Narcotics Anonymous is the best way for someone to get free of substances and form a new community around themselves and that is healthier than going back into their old community of using and using friends.

It costs nothing monetarily to belong to a Twelve Step community, as they don't charge for their support and have a tradition of self-sufficiency, declining any outside contributions. My sponsor once told me that people may have already lost their home, their job, their relationships, their families, or the car – so it's already cost them a great deal and they've probably earned their seat. However, clients in residential treatment centres are only residents for a finite period of time. It seems like a natural progression to become part of a Twelve Step community after treatment has finished and this was strongly suggested to me as a client. Urschel (2009:114) contributes from the United States experience:

Due to financial considerations, most addiction treatment programmes only last four to eight weeks. This may sound like a long time when you enter into a programme, but it is impossible to completely overcome addiction in one or two months – even six months or a year. Addiction is a lifelong chronic disease that requires lifelong commitment. Unless you're prepared to pay for years or decades of treatment, the only place to go for that kind of continual care is AA.

Goldstein (1994:131) argues that '[t]here is a shared impression among most professionals that 12-step programmes are the best for most alcohol addicts. The method depends on peer support, honest self-examination, self-accusation, confession and acceptance of guidance by a 'higher power'. Goldstein's explanation of the Twelve Step method dependencies is mostly in tune with the desired outcomes for clients of the treatment centres

I interviewed, for example, 'peer support' and honest self-examination'. But there was one treatment centre that didn't have a specific spiritual element to its programme, and I was interested to see what Odyssey House's view on spirituality is. Kerry Manthenga (personal interview, Auckland, 1 December 2012) said:

Odyssey's view on spirituality is that it is a personal matter and we will support you to be spiritual in whatever way makes sense to you, so there isn't really a spiritual, um, a spiritual dictum, I guess, that goes with the programme in the way that the Twelve Steps have with that spirituality built in. Um, but, I think people also talk about the pillars of Odyssey House....those core values...as becoming almost a spiritual experience. Living to those values becomes in some ways, that....internalising that...those aspects of right living becomes kind of a spiritual experience. But it is an externalised thing. If people come in and they have a Twelve Step background, or they have strong Christian values, or they have strong religious values affiliated with whatever sect, um, the response is to do whatever we can to support them in not only engaging with that externally, but also to create an environment where they can talk about that, how that fits into their recovery, and we encourage it and we support it....it's seen as important and to be nurtured in people, that's for sure.

White (1996:261) sees that for 'many addicts, the spiritual zone of action and experience is the initiating and driving force within the recovery process. The zone broadly embraces empowerment from beyond the self, and openness to spiritual and/or religious experiences and the reconstruction of personal values.' For an organisation such as the Salvation Army Bridge programme, whose ethos is to transform lives through Christ, a spiritual dimension is very much a cornerstone of the treatment programme. Like Higher Ground, clients are similarly encouraged to attend Twelve Step meetings, guest speakers attend the facility and a Twelve Step meeting is held on-site weekly. On top of this, the Bridge programme has its own Recovery Church and services are held weekly on Tuesday evenings (for graduations and celebrations) and Sundays (for more formal church services). Clare Luamanuvae (personal interview, Auckland, 26 October 2012) explains the Bridge programme's approach to spirituality:



We have um, spirituality groups which are run by the chaplains and explore that inner self. Um, we do and look at the Twelve Steps, the first three of the Twelve Steps, but also explore other spiritual aspects to a person and that deeper relationship with who they are and then whatever is their Higher Power, which is the essence of them really. Um that's my.....that's how I see it. We have a Quiet Room which is um, for reflection. We have a church on site which is a recovery church, so it's a recovery community, but it allows people to see achievement and change in others which can ignite that belief in themselves. Um, we also run um, a relaxation group for four weeks....for the first four weeks. Trying out different ways of relaxing and just being with yourself, which is actually quite challenging for a lot of people, to actually even be still with themselves, and try and be just present, for twenty minutes; half an hour. It's hugely challenging but part of what we do, um because we think it's important to try and centre people and to ground people.

Cynthia Young from the Salvation Army (personal interview, Auckland, 26 October 2012) added that part of the Bridge programme is trying to rebuild a values system by creating a vision for the future, and providing an opportunity for rebuilding spiritual resources by 'tapping into Twelve Steps, it's part of the same thing. People don't have to do that but if they do take those opportunities, it does seem to work out very well for them. It connects them very strongly into Recovery Church, AA, um, if they remain along or more agnostic sort of path then well, they have to develop other sorts of resources. And that's fine, that's their choice'.

But in the field of addictions, spirituality is poorly defined and understood (Cook, 2004). Csordas and Kleinman (1990:14-15) highlight an interesting paradox of medical anthropology as it relates to non-medical forms of healing, that can be applied to how mutual self-help Twelve Step groups are viewed with healing their members. They argue the paradox is one in "which non-medical forms of healing are explicitly acknowledged as religious but analysis then abandons the explicitly religious to focus on 'therapeutic aspects of healing'." Twelve Step groups have a history rooted in Western Christian orthodoxy, as discussed in a previous chapter, and Wilcox (1998:109) adds that 'Alcoholics Anonymous is effective as a community of healers'. Proponents of the Twelve Step faith are quick to point out that it's not a religious programme, but a spiritual programme, and that all I needed to know was that 'it

works', which I read as, "Don't question the process, just do it." Csordas and Kleinman (1990:15) then contend that :

An important consequence for the study of therapeutic process is failure to distinguish clearly between traditional forms of healing such as shamanism and healing movements such as faith healing. The latter are not exclusive to industrialised, developed societies but are distinct from traditional healing in that they recruit adult participants. Unlike the prototypic case of a small-scale society where people take for granted and are familiar from birth with the shaman as healer, adult recruits to healing movements may never before have considered the possibility of divine healing, requiring secondary socialisation to establish a predisposition toward such healing. In addition, unlike healing in traditional societies, such movements typically attract two quite distinct groups, one consisting of committed disciples and the other of marginal participants seeking relief for particular complaints.

Twelve Step groups are 'healing movements' who are very careful not to 'recruit' members, as their traditions explain that membership is based on attraction rather than promotion and that you're an alcoholic or an addict when you say you are. However, the two distinct groups that Csordas and Kleinman explain above are very prevalent, for example, 'old-timers' (committed disciples) and 'newcomers' (marginal participants seeking relief).

## **Maori Spirituality**

Without going into too much depth, I want to acknowledge the remarkable effect that wairua (spirit) has in treatment centres, in particular for their Maori clients. I did not seek any permission from the University Ethics Committee about completing research on matters pertaining to Maori health, nor did I interview Maori AOD practitioners or clients. However, many of my participants acknowledged what a powerful therapeutic effect it is to have Maori (re)connecting with their culture in treatment. Johnny Dow from Higher Ground (personal interview, Auckland, 22 August 2012) says that one of the major changes to their programme has been the development of the Maori programme:

It was basically a Pakeha programme, and Maori had to fit in and now I think it's more cultural, we're a lot more culturally aware and working towards bi-culturalism in a healthier way. We have Maori that haven't had

any connection with their culture coming through here, or very little connection with their culture and that reconnection is quite amazing to watch when people come through. A lot of Pakeha sort of connect with the Maori culture as they come through, you know, because of the spiritual side.

Higher Ground runs a weekly 'whanau group' where residents have the opportunity to explore Maori culture through performance, reo (language) and waiata (song) to strengthen their wairua. A fierce 'addiction haka' (challenge) is also taught and performed by the residents. Upon graduating, residents will take part in a 'paua ceremony' where they will select two pieces of paua. One piece is glued to the Higher Ground 'po', a beautifully carved wooden panel that signifies how the addiction 'taniwha' is exposed. The piece that stays signifies that the resident will leave a piece of themselves behind. The other piece of paua is passed around the whanau group for them to hold and bless with their own good wishes. This is for the graduating resident to take with them as they begin their recovery journey. If the resident relapses then the paua is to be returned to the sea. There's also a pounamu (greenstone) ceremony for ex-residents who manage to complete attendance of ninety Twelve Step meetings in ninety days. The ex-resident will select a piece of pounamu and have it blessed by the matua. The programme is run by Higher Ground's Maori advisor.

Odyssey House is strongly committed to ensuring that their therapeutic community programme responds to the needs of Maori clients and their families and employs a full time Maori cultural advisor (Odyssey House, 2013). Similarly, Kerry Manthenga from Odyssey House explains the opportunities for Maori to connect with their culture in the programmes, including participation in kapa haka, te reo and weaving classes:

And there are opportunities for Maori and Pacific clients to um, explore and connect with spirituality with um, in a cultural forum as well, um, through the various activities, the cultural activities that happen. There are regular groups and here's kapa haka and there's other stuff, and I think that kapa haka for a lot of our Maori clients is, um, it is about wairua in many ways, sort of that connection, it filters through.

The Salvation Army acknowledges the Treaty of Waitangi and the place of Maori as 'tangata whenua' of the land. They're able to provide avenues for Maori clients to immerse themselves spiritually through their own Salvation Army Maori Ministry 'Te Ope Whakaora (The Army that brings Life), waiata and karakia (prayer). Each week the residents will learn a new song in Maori and perform it at the Recovery Church graduation ceremonies.

## Length of Stay

As therapeutic communities have evolved, durations of stay have adapted to accommodate the changes in therapeutic community design and societal expectations. The pace of life in society is changing and evolving more rapidly than when therapeutic communities were first developed. For those entering treatment for the first time, the length of stay can be viewed as an impediment, particularly as they have to remove themselves from the fast paced society. Some feel it's just not practical to stay in longer programmes in order to take the time to heal. George de Leon (2000:5) summarises the rationale behind reducing lengths of stay over time since the first modern TC's came into operation in the 1950's:

The traditional TC stay of 12-18 months has evolved from planned durations of stay of 2-3 years. Recent changes in client population, clinical realities, and funding requirements have encouraged the development of modified residential TCs with shorter durations of stay (3,6, and 12 months), as well as TC-oriented day treatment models.

One of the major differences between the three treatment centres taking part in this thesis is the length of stay, which varies from eight weeks, to eighteen weeks to anywhere up to eighteen months. I wondered whether length of stay in a rehabilitation centre was one of the many crucial factors to achieving sobriety for their clients. I wanted to know whether the length of stay at a treatment centre had an impact on any client outcomes in engaging with a recovery community. Kathy Mildon from Higher Ground (personal interview, Auckland, 28 August 2012) says, "I'm a huge believer in a shorter programme, a ninety day programme, um,

so for me it doesn't mean a lot. It's about what they have learnt while they're here. So a lot of people get discharged from here. Or leave here, who do perfectly okay." Johnny Dow from Higher Ground (personal interview, Auckland 22 August 2012) added:

In the Drug Courts in America they say that someone with a significant dependence problem, anything less than a hundred days treatment doesn't work very well. So, the duration of stay...we're 126 days. I think the duration is good because it gets people out of their environment for quite a lengthy period of time. It makes them stop and see. Because it takes quite a while for the...for the person to...to get back into them, in their body, get their cognitive processes going again in a healthy way. So it gives them time out to see what's going on.

Kerry Manthenga from Odyssey House feels length of stay is important. We talked about how a proportion of Odyssey's clients had tried the shorter programmes before attending Odyssey House. In some ways, they had viewed Odyssey as the last resort due to the length of the programme:

I think one of your questions in your letter was, "What are the barriers to people achieving sobriety?" and I think one of the barriers to achieving sobriety is, um, that there is increased pressure to get as many people as we can rocketing through and that's decreasing length of stay.... Some people don't need a big, long programme. But a lot of people who've had an addiction for years and years and years, you know, twenty-one days or whatever it is, it just isn't enough. It isn't enough to do the work that needs doing. I guess if you think of treatment as an episodic thing...that you do this bit and then you go out and things go wrong and then you come back in, you kind of end up with a longer treatment stay anyway don't you? You have multiple admissions. (Personal interview, Auckland, 1 December 2012).

Clare Luamanuvae from the Salvation Army Bridge Programme (personal interview, Auckland, 26 October 2012) sees the eight week length of stay as a factor to its success:

Some people we have for a shorter period of time and some people we have longer, but generally it's the eight weeks. How important is it? I think it is key with us, because the big part of what we do is the Community Reinforcement model, if we actually had people in a residential programme for six months, when actually we are about community, it wouldn't be a good fit. So for what we....for what our model is...it's very important that it isn't longer.

My participants had very different views on how important the length of the programme was. But they were all in agreement that the longer the person stayed in the programme itself – without being discharged or leaving voluntarily – the better chances the client had at maintaining a drug and alcohol-free recovery. The earlier their clients left treatment, the more gloomy the outlook. De Leon (2004:96) asked:

What is known about retention in therapeutic community treatment? Length of stay in treatment is the largest and most consistent predictor of positive post-treatment outcomes. However, most therapeutic community admissions leave long-term treatment permanently. Thus, understanding retention was and remains crucial for improving the impact and cost benefit of therapeutic community treatment.

## Chapter Six: Words Into Action

*A man may accomplish many feats and comprehend a vast amount of knowledge, and still have no understanding of himself, yet suffering directs us to look inward; if it succeeds, then there, within us, is the beginning of our learning.”*

*Soren Kierkegaard*

The therapeutic relationship in the residential treatment centre can only last for a certain period of time. In this chapter I seek to explain my own experiences of what it was like leaving treatment and demonstrate what subject matter experts say about the importance of preparing the client for re-entry into the community. I will also discuss what happens when someone relapses and what this means to recovery. I will then provide a brief summary of why community works as a therapeutic tool and provide an explanation of why it is brief. I will then give my view on opportunities for further research.

Having gone through my own therapeutic form of self-discovery, I neared the end of my treatment with trepidation and a small dose of optimism and real feelings of separation occurred. I was no longer living with forty others in a rigidly structured environment. Sometimes I was on my own, not because I was isolating, but because there was nobody else around. De Leon (2000:102) argues ‘residents must also learn how to cope with “culture shock” when they return to the real world outside of the TC. Thus programmes must achieve separation from and preparation for re-entry into the outside world.’ I stayed in an after-care home provided by the treatment centre and lived with other graduates who were slowly being socialised back into the wider community. We were armed with our after-care plans and the responsibilities that went with the freedom of being able to live our lives again drug and alcohol free. There was a requirement to attend one-to-one counselling, attend a minimum of three Twelve Step meetings per week, attend family groups and provide drug-free urine samples weekly. It was an unnerving experience stepping back into the community at large, and as Morant (2004:265) states:

The process of leaving a therapeutic community is an integral part of therapeutic community treatment, based on an assumption that detachment from treatment is equally as important as the earlier processes of attachment and engagement in therapy. Anticipating and managing painful feelings associated with separation, detachment and transition are often key areas of therapeutic community work (Norton 1982, Wilson, 1985). Leaving a therapeutic community involves the negotiation of psychological and social boundaries between 'inside' and 'outside' (Foster 1979). Particularly for those who have attended a residential therapeutic community, this is a major transition requiring adaptation to the norms of a different social context, coping with the loss of psychological bonds formed within the therapeutic community, and dealing with practical issues associated with housing, money and organising daily activities.

Suddenly we had bills to pay, government agencies to liaise with, relationships to return to and continue mending, jobs that were waiting for us, or obligations we had to maintain to receive benefits. Some of us had Court dates due where we were sentenced for our previous behaviour. Often we would share coffee and wonder what was going on with the peers we'd left behind in treatment and what they'd be going through in group. It was critical for me to be around like minded people during my reintegration back into society, as they knew me exceptionally well from the bonds I'd formed with them in treatment and they would be prepared to challenge me if they thought my behaviour was wayward. I stayed connected with the treatment centre and volunteered my time for them. For me, abstinence on its own wasn't enough. I'd already tried that in isolation from a community of people who were like me and that strategy had failed me. Sandor (2009:33-34) states:

Abstinence though necessary, is simply-self-denial. Recovery, on the other hand, is the affirmation of a life wisdom that brings the abstinent alcoholic or addict to a place where he no longer wants to be intoxicated, no matter what life throws at him. Abstinence necessitates loss, while recovery requires building a new life.

Every day since my graduation, I have woken with a battle going on in my head. I'm bombarded with advertising that appeals to my sense of what it means to be a man in New Zealand and that this must involve drinking alcohol, or that it's an essential component for enjoyment and relaxation. I see some popular culture that promotes recreational drug use as



being quite normal and often glamorous. I sometimes catch myself romancing about the first two glasses of wine, the smell of the subtle infusion of fruits and spices, the sound of clinking glasses, and the sight of the wine being swirled in the glass, rich in colour as its full body comes to rest in small streams down the side of the glass. I force myself to remember the confusion, pain, sorrow and regret that followed. I walk past the supermarket aisles filled with alcohol at reduced prices and pat myself on the back every time that I do. I'm one drink away from my past potentially becoming my future and I give a small moment of thanks each day that I don't return there. I'm still too young in recovery to remember what that euphoric moment was like. But today I'm genuinely enjoying my life and I'm chipping away at my own sense of happiness and today I don't want to return to the shell of the person I was.

Others haven't been so lucky. The first peer I met in my first treatment was a frail woman in her sixties. She was being medically detoxed for alcohol dependence and was in a constant state of confusion, shuffling down the corridors of the treatment centre sipping water with hands that shook and were covered in dark liver-spots. She died six weeks later in hospital due to complications from her addiction. I'm saddened that she never got to experience the joys of life without alcohol, but her passing has taught me that I treasure my own life, and for that I refuse to accept that hers was a waste. Two other addicts I'd gotten to know through my volunteering have taken their own lives, one through suicide and the other through overdose. There have also been so many who, for whatever reason, have made the decision to relapse.

## Relapse

From my own experience, relapse was and is horrible. I was frightened by how quickly I plummeted back to the state I was in when I first entered treatment. I'd managed to sustain five months of clean-time before making the decision to drink again. It took only a matter of a few days before I'd returned to my previous 'rock-bottom' levels. Although outwardly things were going well in terms of employment, living and health, inwardly I hadn't given up on the

idea of drinking in a controlled manner. I'd become separated from my treatment centre peers and had very little contact with them. Goldstein (1994:220) states:

Relapse is of course, always preceded by a decision to use, however vague and inchoate that decision may be. It is an impulsive decision, not a rational one; and it is provoked by craving – the intense and overwhelming desire to use the drug. Although craving is a constant feature of withdrawal, it may also occur from time to time even years after the last drug dose. That kind of craving which is obviously not part of withdrawal syndrome, is poorly understood but enormously important, for it can drive the ex-addict into relapse even after long-sustained successful abstinence.

Some in the recovery circles argue that 'relapse is a part of recovery'. I'm not sure whether they were telling me this in kindness in order for me to stop beating myself up because of my own impending-doom-outlook-on-life. They told me that it was a way of recognising that I'm human and fallible and that there were lessons that I could take away from the experience, such as learning about what triggered me and trying something differently. Prentiss (2008:139) differs from this view by arguing that 'relapse is not a part of recovery. Relapse is a part of failure. Relapse is a return to dependency. Sobriety is a part of recovery'. I'm quite glad that I hadn't read Prentiss' hard-line view at the time, to add to my already-then-low levels of self-esteem. De Leon (2000:72) states:

In the TC view of recovery, abstinence is a prerequisite for a more complete change in lifestyle and identity. However, TCs recognise the reality of relapse and its profound importance in the developmental process of recovery. Relapse, i.e. re-use of drugs after a period of abstinence, assumes different patterns, each having different implications for treatment and recovery. Relapse may refer to a single, discrete incident (i.e., a "slip"), a temporary period of high frequency use (i.e., a binge), or to a full-blown return to the pre-treatment levels of use. Relapse may or may not be accompanied by a reappearance of all the behaviours and attitudes associated with the pre-treatment lifestyle. Thus, relapse may not necessarily mean total regression in the recovery process'.

Goldstein (1994:222) argues that 'training in how to handle relapses when they occur is, therefore, an important part of drug addiction treatment'. Goldstein is correct, and I'd received said 'training' in my first treatment which I duly chose to ignore. Some in my

'recovery circles' told me I wasn't ready to embrace a life without drugs and alcohol, which at the time I thought was a 'cop-out'. I was ready when I turned up to the doors of my first treatment centre. Maybe at the time I just didn't 'want' what that life had to offer. Someone else told me to 'come back when I was ready' which Sellman (2009:105) argues is 'no longer an acceptable therapeutic response'. I wondered what the treatment centre practitioners thought when they'd learnt someone had relapsed. Clare Luamanuvae from the Salvation Army (personal interview, Auckland, 26 October 2012) summed it up for me:

That's the hardest clinical challenge for people in the industry, I think, is realising that you really don't have a huge amount of control over what people choose to do, or not to do. You can do your best. But at the end of the day, I can't make anyone do anything.

But it's not all doom and gloom and there are real success stories from people who have overcome their addictions after attending treatment. At the time of writing this, it's been nearly 1,000 days since I entered my second treatment centre and I've managed to stay clean ever since. There are ten others, like me, who left without touching a drop. There are at least ten others who've had minor slips along the way, but are still giving their own sense of recovery a decent, honest attempt. They are nothing like the people they were when they first entered treatment. I discussed in a previous chapter 'how' the use of 'community' works in treatment, and I wanted to conclude with my participants views on 'why' it works.

## **Why Treatment Communities Work**

Treatment communities and Twelve Step communities have completely mucked up my drinking and drug use. When I first relapsed after my first treatment, I had the nagging suspicion that 'picking up that first drink' was going to be a really bad idea and could end disastrously. During fleeting moments of consciousness I recall desperately wanting to be a part of the community that I'd so abruptly left after my decision to pick up the first drink. I no longer wanted to be isolated and full of pain and misery. De Leon (2000:18) states:

Both [Synanon and AA] shared the premise of self-help recovery, a belief that the capacity to heal and change lies in the individual, and that healing occurs primarily through the therapeutic relationships with others....For the TC, however, the power of change primarily resides within the individual and is activated through his or her full participation in the peer community.

Ting (1988:104) asked why community was the bedrock to treating addiction and not society. She argued that society is 'too remote to remedy any personal problem'. I'd seen many of my peers going through treatment feeling alienated from society. Ting then maintained that there's 'immediacy' with being involved in a community, and that communities change through collective efforts, through the mutually implicated personal growth of its many individuals. This, she argues is where the therapeutic effect should be grounded – through the promotion of personal growth. Today we see motivational interviewing as one of the principal methods of addiction treatment.

De Leon (2000:87) sees the use of community differently, one which 'fosters change in the social and personal elements of identity' based on participating in the community they're a part of and being 'mutually responsible' for one another. Caring for someone else provides an opportunity to take risks and share your stories with someone similar to you. Hinshelwood (1999:42) maintains that therapeutic communities must influence clients in some deeply personal way, and that this is achieved through insight – using the community to take away a new understanding of the self. Kathy Mildon from Higher Ground (personal interview, Auckland, 28 August 2012) sees the community approach working in treatment because 'addicts know addicts very well. So it's that level of realness. They get it. They get what's going on for the client...the authenticity. What you see is what you get, you know, working in the safety of an alcohol and drug free community. It's safe. Nothing's going to happen to them in here.'

Antze (1987) likens modern day recovery communities to Victor Turner's (1957) observations of the Ndembu of Zambia, where victims are initiated to a specialised community

of 'former-sufferers-turned-healers' and lasting bonds are made with people who are suffering the same affliction. Antze (1987:151) quotes Turner (1957:302) who states '[t]he affliction of each is the concern of all; likeness of unhappy lot is the ultimate bond of ritual solidarity. The adepts have themselves known the suffering the candidates are experiencing.' One of the reasons community works as a method, according to Brett George (personal interview, Auckland, 17 September 2012) is:

We relate to being in groups. You know, we're born into groups. We live in groups. Um, there's something inherently organic about that experience that is just intrinsic to being a human being. So I think that's what tends to replicate...so when we go into a therapeutic community, a lot of those family of origin issues get unconsciously or consciously resurfaced. Whether that's in a group or with your fellow resident, or with a supervisor, whoever it happens to be.

Wilcox (1998:61) sees the recovery self-help community as one which 'shares a common world view that is learned, expressed, transmitted, practiced, and perpetuated in the specialised language of unique speech community. The construction of this shared reality through language fosters a human view of existence on this planet that is very familiar to anthropology and to traditional human social organisation. Responsibilities and duties are shared by members and structured by an egalitarian ideology.' Wilcox maintains that reciprocity in the form of one addict or alcoholic helping another, defines the human relations of the self-help communities. The key philosophy behind this construct is that members get to keep what they have (their sobriety) by giving it away (the knowledge and experience they have gathered in staying sober). Thinking about someone else stops them from thinking obsessively about themselves. The Twelve Step meeting is the space that provides 'the foundation for the shared belief and action of the community, which in turn provide the foundation for healing' (ibid).

In writing this section on 'why it works' I saw an interesting 'trend' in addiction and recovery-based research. There's a vast amount of research on how people become addicted, what can be done to treat them and what the outcomes are. There's a disproportionately

smaller amount of research that reviews how and why it works, and what the addicts put into practice in the wider community once they leave treatment. Moos (2004:132) states:

Although clinicians have employed modern therapeutic community-based treatment modalities for almost 60 years, we know very little about how and why therapeutic community treatment does or does not work.

My participants feel strongly in their knowledge and belief that what they do works, however telling that story qualitatively and quantitatively can be difficult. One of my participants said, "I know we do really well and we've got different tools we're using and finding the best method to prove what we do sometimes gets a little difficult." So what are the opportunities for future research?

## Opportunities for Further Research

Leighton (2007:437) argues that 'recovery from addiction takes place in a cultural context'. The individual is an active player in the 'culture of recovery' supported by other people such as friends and family and treatment professionals. He contends that if it's our very culture that pushes people into addiction in the first place, then 'exit routes from addictions may well involve cultural factors. Culture changes: it is constantly created anew. The effectiveness of interventions may well depend on how well they understand and work with culture. Traditional addictions research hardly addresses these matters at all.' Decorte (2011:38-39) argues that we are richer and deeper in complexity than what the molecules are doing in our brains. As addicts we are more than a combination of neuro-transmissions, dopamine receptors, amygdala and synapses activity:

One can observe that the long-term use of a substance has had an impact on someone's brain, but that doesn't mean one knows what is going on in that man's or woman's mind. We cannot reduce everything that bears meaning in life (including substances to a user), and the possible problems of the mind or soul, to processes in the human brain. There is a need for more sociological, anthropological, and even economic research, because the social, political and cultural factors that contribute to an increase or decrease of the popularity of various substances deserve much more scientific attention.

NIDA (2002:1) is focussing its research efforts 'on the treatment processes in TCs to better understand how TCs work. Links between treatment elements, experiences, and outcomes need to be further studied to fully appreciate and enhance the contributions of TCs.' I think there's a real opportunity to follow a group of residents through treatment and complete some longitudinal research. What happens to them two years after treatment? What do they remember from treatment and what have they put into practice? Are they still connected with a recovery community or are they using again, and why? What was their experience of treatment and what are their reflections two years later? What's working and why? De Leon (2004:101) maintains 'specification of the active ingredients of the method and understanding the treatment process is critical to substantiate the validity of the therapeutic community approach, to justify its costs, and to improve the approach itself through research and training'. Can anthropological enquiry and evidence based practice be used to establish the long-term viability of health funding for the survival of residential treatment centres (Lees, 2004)? Moos (2004:132) states:

Much has been written about the underlying theory of how these change processes work, but they have rarely been examined empirically....By measuring specific indices of therapeutic community processes and services, and by linking these indices to patients' proximal and ultimate outcomes, researchers can make a contribution towards theory-based therapeutic community programming.

I see opportunities to complete ethnographic studies in clients when they leave treatment, when we can be at our most vulnerable and anxious as we return to the wider society and its expectations. This is a massive change in the addict's recovery lifestyle that cannot be underestimated. Morant (2004:265) states that 'perhaps because of the therapeutic community focus on dynamics within the community, there has been less research and clinical interest in what happens after clients leave the community. Follow up research has tended to

focus on relatively specific treatment-outcome variables measured quantitatively, and our understanding of what this transition feels like for clients themselves is relatively small’.

In my own volunteering work, I constantly see the message of recovery being lost on the very individuals it is aimed at. I often wonder whether the recovery-based-concepts are driven mainly from the United States and Great Britain and whether they are being ‘lost in translation’ once they reach foreign shores. Roth (2011:1) argues:

[R]ecovering requires surrender to something other than the drug or process that defines the addiction. Finding a path that is different from the path of addiction is therefore central to the process of recovery. For such a path to have sufficient appeal to the addict, the signs on the path need to be written in a language accessible to the addict. The language of the Twelve Step Programs, born and raised in the United States, may have language, and therefore ideas, that seem foreign outside of the United States.

The Twelve Steps were written over seventy-five years ago and our culture, our use of language and use of technology has changed since then. I can see some individuals struggle and grapple with understanding their own interpretation of the Steps and their own inability to take stock, slow down and really understand what’s going on. I once attended a seminar on the differences between ‘Baby-Boomers’, ‘Generation X’ and ‘Generation Y’ and the presenter said that with the rapid pace of technological change, it’s likely that new ‘generations’ will turn over once every six years. I wonder what recovery communities will do and can do in response? But regardless, there are people from all walks of life and all different ages who manage to maintain recovery and a life free of drugs and alcohol and addiction, and this begs the old question, “Why do they get it and others don’t?” My sponsor’s response:

“You can’t save them all. We’re only after *one*.”

Why stop there?



## Conclusion: There is Always Hope

In reflecting on the completion of this research, what has stood out for me is that it has been a hugely cathartic experience and one of tremendous personal growth. I left my last treatment centre having worked on so many personal issues but still armed with questions regarding why alcoholism had happened to me. Researching the first chapter, I began to understand more about what addiction is and where the field of anthropology has situated itself discursively within these academic debates. I was stunned by the Ministry of Health surveys and other agency findings that demonstrated behaviourally, just how big the potential for addiction within the adult population is in New Zealand. I discovered that the definitions of the term 'recovery' are as personal and varied to those who create them as they are to people who are 'in recovery'. In Chapter One I was able to understand and empathise why chemical dependency has happened to me.

In Chapter Two I was able to reflect on the life of this research itself (as well as my own) and how originally I'd wanted to show how treatment centres move people from a 'culture of addiction' to a 'culture of recovery', which I changed direction on when I thought about the amount of space needed to explain and confirm the two separate 'cultures'. I then thought of doing a comparative study between three treatment centres that use 'community' as a method of healing, and again changed my focus once the interview process was complete, as I hadn't obtained enough information on one of the treatment centres to confidently and accurately compare all three. In reviewing the rich academic discussions on the benefits of qualitative and quantitative analysis for therapeutic community research, I found that it was appropriate to use the voices of the practitioners who I'd interviewed to represent their views of the 'addicted self', the 'basket of selves' and how 'community' is used as an effective method of treatment.

In Chapter Three, I was able to trace the development of modern drug and alcohol treatment centres complemented with charting the modern day recovery movement with its beginnings in the United States and Great Britain. I was able to detail the steps and traditions of Alcoholics Anonymous, and show why these filtered into addiction therapy. I was able to provide a brief history of the New Zealand experience with addiction, drug and alcohol policy and treatment, and then provided some limited background information on the treatment centres who kindly agreed to be included in my study.

In Chapter Four I provided a 'behavioural snapshot' of the addict and alcoholic when they first enter the doors of treatment, seeking relief from the 'bondage of self'. I tried to establish a level of understanding with what the rehabilitation centre communities face each time a 'newcomer' is welcomed. I was able to ascertain with my participants that it's a familiar theme with people entering treatment for the first time, that they 'don't know who they are' or that they've 'lost themselves'. I loved the richness of their responses, from 'existential crisis', to 'having enough of a sense of self to know that they've lost it'. I discussed the pervading experiences of fear and denial and how these disrupt recovery and treatment outcomes, and what the treatment practitioners' views on Cohen's (1994) 'basket of selves' theory were. Though useful and 'meaning laden' in concept, they felt it was no more or no less applicable to addicts than the wider population.

In Chapter Five I discussed the use of 'community' as a treatment method, from the very structured therapeutic communities, to the community reinforcement approach. Again I was privileged to glean how the treatment centre practitioners used 'community' as a method of healing the 'self'. I looked at the use of group work in treatment, giving examples of encounter groups, family groups and whanau groups and how these provided a safe environment for clients to explore their own issues. I also reviewed the importance

of spirituality with healing from addiction and how Twelve Step programmes and spiritual methods are acknowledged and nurtured in the treatment centres.

In chapter five I focus on how community is used at the different treatment centres with a focus on 'community' as a method of treatment, the community reinforcement approach, spiritual communities (including Twelve Step communities) and discussion on some of the 'group work' that takes place in the centres, such as family groups and encounter groups.

In chapter six, I explained what it's like for the client leaving treatment and commented on what subject matter experts said about the importance of preparing the client for re-entry into the community. I also discussed what happens when someone goes through the horrible process of relapse and what this means to recovery. I provided a brief summary of why 'community' works as a therapeutic tool and pointed out that there's disproportionate amount of research that looks at how and why residential treatment centres work. It's an exciting time to be in the field of addictions research and I gave my view on opportunities for further research.

I am grateful that in New Zealand we have drug and alcohol addiction centres that are free of charge to the public. In my time with them as a client, volunteer and budding researcher, I'm consistently heartened by the professionalism and caring the staff display towards their clients and the passion they have for their work. In my volunteering work I'm always privileged to see people get well and experience those 'light bulb' moments that I did. The first person who interviewed me for a clinical assessment of my chemical dependency was a woman named Gay. I saw Gay when I'd just reached the two-year-clean mark in my own sobriety, and she was genuinely pleased to hear of another good news story about someone who had been through the treatment centre she worked for. She said that sometimes treatment centres are criticised for accepting 'recidivist relapsers' back into treatment. Gay

told me the delightful story of a girl walking along the beach with her mother as the tide was going out, when they came across hundreds of stranded starfish in the sand. The girl started picking up the starfish, frantically throwing them back into the sea. Her mother asked “Why are you doing this? It’s hopeless and there are too many.” As she threw another starfish into the sea, the girl replied, “Yeah, but I made a difference for that one.” And I remembered again that as a recovery community, in the words of my sponsor:

“We can’t save them all. But we’re only after one.”

To the addicts and alcoholics who still suffer: there is always hope that you can be “the one.”

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