A Systemic Description of Drug Rehabilitation Programmes

By

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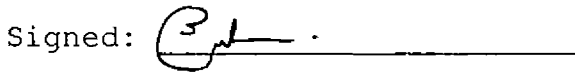
Declaration

I declare that: A Systemic Description of Drug Rehabilitation Programmes is my own work, all sources used or quoted have been indicated and acknowledged by means of complete references, and this dissertation was not previously submitted by me for a degree at another university.



Signed: ______________ Date: 22.01.03

Summary

Title: A Systemic Description of Drug Rehabilitation Programmes

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This research study describes drug rehabilitation programmes from a systemic perspective. For this purpose substance abuse, rehabilitation and various elements as well as concepts related to systems are reviewed. A qualitative research methodology was followed to obtain rich descriptions from the research participants. Themes, supported by the literature review, are identified and discussed from a systemic perspective. A systemic approach to rehabilitation describes the process of change and thereby aims to enrich drug rehabilitation models. This process of change as well as the basic assumption of placing the symptom in the context of the sustaining system, as opposed to viewing the symptom in isolation, will be addressed throughout.

Key Terms

Boundaries

Circular Causality

Drug Abuse

Drug Addiction

Drug Rehabilitation

Hierarchy

Homeostasis

Morphogenesis

Rules

Second-order Cybernetics

Systemic Perspective

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Tuynhuys Private Bag X1000 Cape Town 8000

Our country is faced with a growing problem of substance abuse. This has serious implications for the millions of citizens because it contributes to crime, domestic violence, family disintegration and other social problems. This National Drug Master Plan will strengthen our efforts to stamp out drug abuse and its associated problems in a holistic and coordinated manner.

Young people are often enticed by drug lords to become pedlars and consumers of illegal substances. We must help empower them to become part of the solution instead of the problem.

We do not underestimate the scale of this challenge. However, it is my sincere wish that every one of us will help implement the National Drug Master Plan, so that we can together eradicate the drug problem in South Africa.

Let us stand together against drugs and make South Africa a better and safer place to live in.

Nelson Mandela

President

Republic of South Africa

March 1999

(Former President Nelson Mandela, National Drug Plan, 1999)

Chapter 1: Background to Study

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Introduction

Background to the Study

- Contemporary Global Drug Abuse Trends
- Contemporary Drug Abuse Trends in South Africa

Research Statement

Conclusion

. . . .

Introduction

Introductory texts of most books or chapters on substance use and abuse report the vast impact that substance abuse has on our society. The far reaching implications of the problem are reported on a daily basis in newspaper and magazine articles, depicted in television shows as well as in box office movies. Various systems, politicians, policy makers, health departments, schools, families, religious bodies etc. deliberate about the most efficient way to target the problem and curb its devastating impact. The extensive attention this problem has been receiving in the media, as well as personal encounters with people struggling with substance abuse and

abstinence in the counselling situation, stimulated the initial interest for this research topic.

Background to the Study

Contemporary Global Drug Abuse Trends

Illegal drugs have throughout history made their entry into most conceivable systems, from the most obvious such as the individual, family, culture, society, school etc. to the more unexpected such as political or religious systems (Grills & Grills, 1988). Attempts to counter drug abuse can be noted in all countries, with individual variances depending on drug availability, related crime etc. However, most countries have been linked in their fight against drugs through the intricate network established by drug producers and traffickers whereby the production of drugs takes place in one country, whilst processing, refining and selling of the merchandise takes place in other countries (Drug Advisory Board, 1999). Cocaine is mostly smuggled from South America to South Africa through various neighbouring countries, with large quantities being re-smuggled to Europe. Similarly heroin is smuggled into South Africa from the East for rerouting to Europe and America. The above demonstrates the importance of recognising the global scope of drug related problems, which in turn necessitates international collaboration if drug abuse is to be curtailed.

According to Pinger, Payne, Hahn & Hahn (1995), the cost of drug abuse in the United States of America is high in terms of lives and monetary value. The use of drugs is often associated with a number of different crimes, violence and accidents. Figure 1 below graphically presents the participatory role substance use played in various violent acts and events leading to death (expressed as a percentage of each act or event).

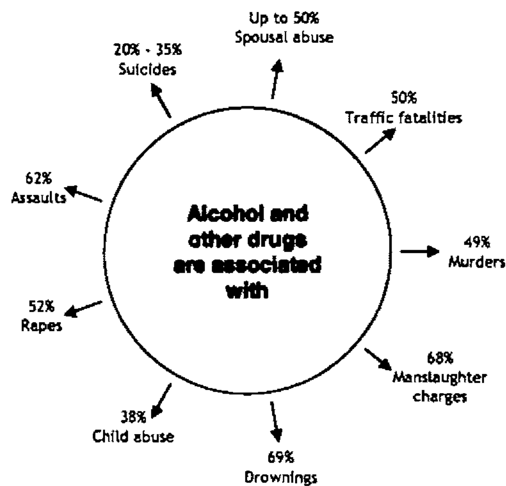

Figure 1: Violent events and deaths associated with alcohol and drug abuse (Pinger, Payne, Hahn & Hahn, 1995, p. 2.)

Globally, drug abuse is not only escalating but is also, in response to various efforts to counter the problem, becoming increasingly complex. Drug abuse is not only a problem in first world countries or among the privileged, but has increasingly become a means of survival for the

underprivileged. The desirable image of drug abuse further adds to the problem. The United Nations Drug Control Programme (UNDCP) estimates that 4,2 percent of the world population are probably abusing illegal drugs, indicating the following trends:

Opiates : 13.5 million people (9 million heroin)

Cocaine : 14 million people

ATS[1] : 29 million people

Cannabis : 144 million people (UNDCP, 2000)

Contemporary Drug Abuse Trends in South Africa

According to the Drug Advisory Board (1999), former President Mandela identified substance abuse as a social pathology that should be combated. Substance abuse may be considered a major contributing factor of crime, poverty, reduced productivity, unemployment, dysfunctional family life, political instability, increase in chronic diseases such as AIDS and tuberculosis, injury and premature death (Drug Advisory Board, 1999). The impact of substance abuse breaks through social, racial, cultural, religious and gender boundaries affecting the South African population as a whole, either directly or indirectly. It is suggested that the unacceptable increase in our society's substance abuse may be directly linked to the social and political transformation

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[1] Amphetamine-type stimulants (e.g. ecstasy, crack)

currently taking place. Problems with high availability are exacerbated by our global position, centralising South Africa for major trafficking routes between various continents, which is furthermore complicated by weak border control.

According to the Drug Advisory Board (1999) substance abuse patterns may be influenced by geographical location, social class, age, gender etc. Cannabis has been identified as the most commonly used illegal substance followed by a mandrax and cannabis combination (White Pipe). Reportedly there has also been a significant increase in abuse of over-the-counter and prescription medications (e.g. tranquillisers and slimming pills). Opium has been identified as the least common substance of abuse in South Africa. South Africa has been identified as one of the world's largest producers of cannabis.

Organisations such as Ravesafe have been established in order to collect and distribute information about drug abuse among ravers. According to Prinsloo (1999), the rave parties are targeted because of the newcomers at every event. These newcomers may be relatively naïve about substance abuse and may therefore be easily misled about substance abuse. Organisations such as these neither condone nor condemn substance abuse, but rather aim to refrain from passing judgement and provide accurate and objective information, thereby empowering individuals to make informed decisions.

Prevention programmes such as TADA (Teenagers Against Drug Abuse) and POPPETS (Programmes of Primary Prevention Through Stories), are facilitated by the South African National Council on Alcoholism and Drug Dependency (SANCA). POPPETS focuses on the education of primary school children, providing information on substance abuse as well as addressing self-image and peer pressure issues. TADA initiates youth action groups in high schools, which focus on prevention of substance abuse whilst promoting healthier alternatives (Drug Advisory Board, 1999).

According to the United Nations Drug Control Programme the estimated cost of drug abuse can range between 0,5 to 1,3 percent of a country's annual Gross Domestic Product (GDP), this translates into between R2,5 to R7,1 billion Rand for South Africa (Drug Advisory Board, 1999).

Substance abuse affects society negatively on numerous levels. Important areas of function that are necessarily affected include school performance, health, family life, productivity, as well as safety and security.

A systemic approach will be followed in this study, not only to gain insight into the patterns of factors that influence the drug abuse behaviour, but also because of the far reaching implications that drug abuse has at various levels. A systemic approach will be useful to describe the systems that both influence drug abuse and are influenced by it. The researcher is of the opinion that this problem should be researched

within the interacting systems involved / implicated in the drug abuse problem. However, an extensive study of all the systems interacting is beyond the scope of this research study. Therefore the study will focus on selected, closely linked systems. Those systems most directly related will be identified and consulted to gain insight into their experience of the drug abuse and in defining the problem.

Research Statement

A systemic conceptualisation of drug rehabilitation programmes with the focus on the process, rather than on the content of the programmes.

Conclusion

The right to dignity, protection, life, freedom and security in the South African Constitution instigated the South African Government's commitment to the fight against drugs, leading to the implementation of various actions and programmes. Appeals for assistance have been made to various government departments, professionals, religious organisations, traditional healers, schools, individuals as well as the media, private sector etc. However, unco-ordinated efforts have hindered efficacy and the mismanagement of insufficient resources has led to the duplication of certain services and the unavailability of others. Furthermore, actions undertaken have been ineffective because of the lack of an overall

strategy for the fight against drug abuse (Drug Advisory Board, 1999). The South African National Drug Master Plan has been developed as a strategy for a holistic approach to the fight against drugs.

This dissertation has been written according to the publication guidelines, as set out by the 5th Edition of the American Psychological Association(APA), (2001b) (Struwig & Stead, 2001 and The Royal Windsor Society for Nursing Research, no date).

Chapter 2 and Chapter 3 will review literature on drug rehabilitation programmes and systems theory respectively, thereby providing the context for the research undertaken. Chapter 4 will address the research methodology followed, and Chapter 5 will present the research results. Chapter 6 will offer a discussion of the results and themes that have been identified. The concluding Chapter 7 will present an integration of all of the preceding chapters.

Chapter 2: Literature Review - Drug Rehabilitation

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Introduction

Substance Abuse

Substance Dependence

- The South African Situation

Drug Rehabilitation

- Detoxification
- Approaches to Substance Abuse Treatment
  - In-patient Treatment
  - Out-patient Treatment
  - The South African Situation
- A Systemic Approach
- Relapse Prevention

Conclusion

. . . .

Introduction

The following chapter will discuss drug rehabilitation. In discussing rehabilitation, it is necessary to provide clarity on certain accepted concepts related to drug rehabilitation. Firstly, some background information will be provided on substance abuse, followed by a discussion of substance

dependence, according to the fourth edition of Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) criteria. Drug rehabilitation will then be addressed, commencing by considering detoxification as the initial step for rehabilitation. This will be followed by a discussion of approaches to substance abuse treatment in general as well as a specific consideration of a systemic approach to rehabilitation. The chapter concludes with a discussion of relapse prevention as the concluding concept of the rehabilitation process. The term 'drugs' used throughout this dissertation will refer to the illicit drugs as defined in the Drugs and Drug Trafficking Act No. 140 of 1992 (Government Gazette of the Republic of South Africa, 1992).

Substance Abuse

According to Barlow and Durand (1995) drug abuse can be defined as the extent to which the drug used interferes with a person's life. The DSM-IV criteria for substance abuse are:

> A. A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, during the same 12-month period:

1. Recurrent substance use resulting in a failure to fulfil major role obligations at work, school, or home (e.g. repeated absences or poor work performance related to substance use; substance related absences, suspensions, or expulsions from school; neglect of children or household)

2. Recurrent substance use in situations in which it is physically hazardous (e.g. driving an automobile or operating a machine when impaired by substance use)

3. Recurrent substance-related legal problems (e.g. arrests for substance-related disorderly conduct)

4. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g. arguments with spouse about consequences of intoxication, physical fights)

B. The symptoms have never met the criteria for Substance Dependence for this class of substance.

(DSM-IV, APA, 1994, in Barlow & Durand, 1995, p.466)

From these criteria it can be said that substance abuse has physical, social as well as emotional effects on an individual and at a societal level. According to Loneck, Garrett & Banks (1996), drug abuse is associated with a range of problems including neonatal disorders, crime, violence and increased risk of HIV infection. The effects of drug abuse reach into every corner of society and there is a heavy price to pay in

terms of lives, emotional turmoil as well as economically (Barlow & Durand, 1995). Rounds-Bryant, Kristiansen & Hubbard (1999) note that prolonged and regular substance abuse is not only characterised by an association of these problems but also by the continued use in spite of the concurrent problems.

The obscurity of early signs of drug abuse together with attempts to disguise these, make drug abuse detection particularly difficult for many professionals (e.g. nurses, teachers, psychologists) who come into contact with substance abusers. Furthermore, characteristic behavioural changes may often coincide with the developmental process of the individual. Gilles (1997) highlights the following indicators, which may suggest the possibility of drug abuse:

- Behavioural Indicators
  - Escalating and unexplained changes in mood and/or behaviour, e.g. detached, secretive, withdrawn.
  - Changes in daily routine or eating and sleeping patterns.
  - Signs of secrecy about friendships, activities or whereabouts.
  - Signs of lack of concentration, motivation and interest in for example school activities.
  - Lack of interest in and attention to personal appearance and hygiene.
  - Dishonest behaviour, e.g. lying, stealing.

- Physical Indicators
  - Weight loss and decreased appetite.
  - Trembling, poor co-ordination and dizziness.
  - Distinctly dilated or constricted pupils, bloodshot or watery eyes.
  - Continual sinusitis, repeated nosebleeds or sore throat.
  - Bruising, sores, scabs or needle marks on the arms, legs, hands etc. caused by injections.
  - Frequent vomiting or complaints of abdominal pain.
- Other
  - Excessive use of camouflaging agents, e.g. mouth spray, incense to disguise identifying odours.
  - Constant use of eye drops or wearing sunglasses to hide bloodshot eyes.
  - Unknown tablets, powders, seeds or pips in clothing pockets, handbags or other suitable hiding places such as the motor vehicle or bedroom.
  - Obscure devices, e.g. pipes, needles, syringes, razor blades, burnt spoons.
  - Brown stains or traces of glue and other inhalants on fingers, handkerchiefs etc.

The above indicators demonstrate the importance of professionals to be well versed with the effects the various drugs have, in order to identify drug abuse. A good

understanding of the prevailing drug culture, as a system, is of great importance for effective intervention in substance related problems. This would not only facilitate counselling goals, such as empathy and rapport, but also rehabilitation goals of ultimate lasting abstinence.

As a result of the rapid increase of drug abuse in South Africa it has become a serious social problem, worthy of research. Drug abuse and drug dependence may furthermore be differentiated, where dependence refers to drug abuse over a prolonged period of time, causing the body to become accustomed to the presence of the drug (Snyder & Lader, 1989).

Substance Dependence

The DSM-IV criteria for substance dependence are:

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

1. Tolerance, as defined by either one of the following:

a. a need for markedly increased amounts of the substance to achieve intoxication or desired effect

b. markedly diminished effect with continued use of the same amount of the substance

2. Withdrawal, as manifested by either of the following:

a. the characteristic withdrawal syndrome for the substance (refer to criteria A and B of the criteria sets for Withdrawal of the specific substances (DSM-IV))

b. the same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms

3. The substance is often taken in larger amounts or over a longer period than was intended

4. There is a 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 (e.g. visiting multiple doctors or driving long distances), use the substance (e.g. chain smoking), 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 or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (e.g. current cocaine use despite recognition of cocaine-induced depression or continued drinking despite recognition that an ulcer was made worse by alcohol consumption)

Specify if:

With physiological dependence: evidence of tolerance or withdrawal (i.e., either item 1 or 2 is present)

Without physiological dependence: no evidence of tolerance or withdrawal (i.e., neither item 1 nor 2 is present)

(DSM-IV, APA, 1994 in Barlow & Durand, 1995, p.467)

Additional terms that require clear definition include:

Cross-dependency: a drug that is substituted with another in order to prevent withdrawal in physically dependent users (Bennett & Woolf, 1991).

Withdrawal: the drug-specific symptoms that appear if the drug is no longer administered. The type and severity of symptoms experienced depend on the drug used, the duration of use, the doses as well as factors such as speed of weaning (Bennett & Woolf, 1991).

Tolerance: refers to a state of decreased responsiveness to the effects of a specific drug due to prior administration,

necessitating increased doses to achieve the same effect previously attainable by smaller doses (Ghodse, 1995).

There may be various reasons or causes for substance dependence (also referred to as addiction) and various combinations of influences may maintain the dependence, which need to be addressed in rehabilitation with the ultimate goal of complete abstinence (Galanter & Kleber, 1994).

The South African Situation

According to Wilkinson & Potgieter (1999), in the Gauteng province nearly 75 percent of persons in treatment for substance abuse are between the age of 20 and 49 years. The primary substances of abuse have been identified as alcohol and cannabis, with heroin showing a steady increase, tripling in frequency over the period January 1998 to June 1999, and crack doubling over the same period (Wilkinson & Potgieter, 1999). Table 1 below indicates the primary method of ingestion for the Gauteng province over the period January 1998 to June 1999, excluding alcohol usage.

Smoked	74.7 %
Swallowed	13.9 %
Snorted, sniffed and Inhaled	07.5 %
Injected	03.9 %

Table 1. Method of Ingestion of Primary Drug (Wilkinson & Potgieter, 1999, p. 10)

Research conducted by Sukhai (1999) indicates that as much as one third of patients treated for injuries (as a result of violence and traffic or other accidents) in six hospital trauma units, tested positive for at least one illicit substance. Table 2 compares substance abuse among trauma patients for three major cities.

	Cape Town	Durban	Port Elizabeth
Cannabis	33.0 %	34.2 %	42.7 %
Mandrax	22.0 %	11.4 %	13.2 %
White Pipe	21.0 %	10.2 %	13.2 %
Cocaine	03.0 %	02.5 %	00.0 %
Opiates	07.0 %	04.4 %	00.0 %
Methamphetamine	00.0 %	00.6 %	00.0 %
Amphetamine	00.0 %	00.0 %	00.0 %

Table 2. Drug Abuse by Trauma Patients (Sukhai, 1999, p. 72)

Cerff (1999) suggests the following with regard to the duration of substance abuse, comparing trends in Cape Town for the periods July-December 1996 and January-June 1999.

	Jul - Dec 1996	Jan - Jun 1999
0-4 years	14 %	33 %
5-9 years	21 %	19 %
10-14 years	19 %	18 %
15-19 years	05 %	12 %
20 years +	41 %	18 %

Table 3. Duration of Substance Abuse Trends (Cerff, 1999, p. 82)

The above indicates a significant decline in the duration of substance abuse over the last few years. Where in 1996 65 percent of users abused substances for periods of 10-20 years and longer, in 1999 52 percent of users abused substances for nine years or less. Although the report does not provide an explanation for this decrease, it is considered highly significant since it reflects how systems, currently interacting with drug abusers, function. Extended periods of use complicate the rehabilitation process even more. The following chapter will discuss the systemic concepts in more detail.

Drug Rehabilitation

"Treatment is a process aimed at promoting the quality of life of the drug dependant and his/her system (husband/wife, family members and other significant important persons in his/her life) with the help of a multi-professional team." (Drug Advisory Board, p. 41, 1999).

Parry & Bennetts (1998) point out the following deficiency in the provision of services:

- numerous services are available in urban areas whilst townships, informal settlements and rural areas remain under-serviced;
- the Northern Cape has no specialised in-patient treatment facility;
- inadequate and sometimes non-existent detoxification services, especially in hospitals;
- insufficient funds and a shortage of staff threaten the continued existence of services and hinder further development;
- inadequate or non-existent after-care services, for re-integration into the community;
- the recent closure of various key facilities.

Gossop, Marsden, Stewart & Rolfe (1999) suggest that rehabilitation programmes vary on numerous important elements, including philosophy, structure, intensity and duration. Rehabilitation services are typically provided by social

workers, nurses, doctors, religious organisations and traditional healers. Frequently health care professionals misinterpret symptoms of substance abuse and dependence. This lack of accurate information and an addict's sense of denial and manipulation skills may often mask the urgency for treatment (Bennett & Woolf, 1991). For many physically dependent drug users the first method of treatment is detoxification.

Detoxification

Detoxification refers to the process of weaning a person off the drug that he/she is physically dependent on (Galanter & Kleber, 1994). The goals of detoxification include:

- clearing the body of physiological dependence
- reducing withdrawal symptoms
- aiding the person in overcoming the initial obstacles in abstaining from drug use
- creating an environment conducive for long-term commitment to treatment as well as referring clients
- treating associated medical problems or referring clients
- initiating health education and relapse prevention, and exploring issues related to family, career and legal matters that may require referral (Galanter & Kleber, 1994).

According to Harrison & Asche (1999) the goals of short-term in-patient detoxification differ from those of rehabilitation. Detoxification should not be considered as a holistic treatment method for long-term abstinence from drugs, but rather as a first step in a long process of rehabilitation and continued abstinence. Ideally detoxification should include psychological intervention and education to prepare the addict for the next phase of rehabilitation. According to Snyder & Lader (1989) the addict should become aware of the severity of the drug problem, be informed about the nature of the addiction and encouraged to enter treatment at other levels of care. The nature of the addiction and rehabilitation process will be discussed in more detail in Chapter 3.

Approaches to Substance Abuse Treatment

"Recovery from drug abuse is a lifelong undertaking." (Snyder & Lader, 1989, p. 47). Substance abuse treatment can follow a variety of approaches and may at least partially be determined by the needs of the individual and circumstances around the substance abuse. Substance abuse treatment is by nature long-term, the individual may therefore enter treatment on various levels (i.e. detoxification, in-patient and out-patient treatment) throughout the process.

In-patient Treatment.

In-patient treatment may be recommended for the following reasons:

- to assess the state of dependence;
- to stabilise opiate addicts - withdrawal symptoms may include insomnia, yawning, nausea, vomiting, diarrhoea, watery eyes, runny nose, goose bumps (hence the name cold turkey), cramps, increased heartbeat and blood pressure (Snyder & Lader, 1989);
- to stabilise and detoxify barbiturates and other sedative hypnotic drugs addicts - withdrawal from sedative hypnotic drugs may be life-threatening, symptoms may include nightmares, anxiety, tremors, insomnia, vomiting, seizures, delirium (Galanter & Kleber, 1994);
- to treat secondary complications of drug abuse, e.g. HIV infection, abscesses, infections (Ghodse, 1995);
- to assess the mental state for memory, language, motivation, complex cognition, mood and effect as well as arousal and attention (Kaplan & Sadock, 1998).

Out-patient Treatment.

Various approaches may be used with varying success for the rehabilitation of an addict. According to Galanter & Kleber (1994) there has been a shift in the focus of substance abuse treatment. Where previously the focus and main goal of

treatment were the achievement and maintenance of abstinence, this is now only recognised as an essential first step, which does not necessarily imply optimal life functioning. As will be discussed in more detail in Chapter 3, people function as part of various systems on numerous levels. The drug abuse is considered as an expression of a dysfunctional system and therefore should be addressed within the context of the systems in which it develops. For this reason Galanter & Kleber (1994) suggest that client-oriented goals may be divided into:

- Goals that aim at achieving abstinence: this is an essential goal of treatment since many addicts believe that they can control the use of substances. Rebuilding a substance-free life must be highlighted with the appropriate changes to daily living patterns.
- Goals that enhance functioning on various levels: including medical functioning, identifying and treating psychological symptoms and disorders, exploring familial issues, addressing spiritual issues and improving occupational functioning as well as financial management. Functioning on these levels both influences and is influenced by the drug addiction and rehabilitation process.
- Goals that are aimed at relapse prevention: stressing the importance to develop awareness of potential relapse together with a plan of action for anticipated future

encounters. Relapse prevention will be dealt with in more detail under that heading.

Goals related to the drug rehabilitation programme, as an integral part of the system, should furthermore also be considered and include:

- Economic and political realities: both realities determine the importance accorded to the problems surrounding substance abuse and therefore the policies regarding availability of rehabilitation possibilities and facilities.
- Financial and staff resources: these should be carefully considered, with cost and simplicity as guidelines.
- Staff philosophy: the theoretical approach of the rehabilitation programme must be clearly stated and understood by staff. This may enhance an integrated approach with clearly defined goals for the rehabilitation process.
- The cost-benefit ratio: by striving to use treatment that provides the most possible benefit with the least possible risk involved. It must be remembered that no treatment can be said to be totally safe for all clients. Risks may include adverse reactions to medication and exhaustion of scarce resources such as time and money.
- Careful consideration of the treatment effectiveness: because substance abuse problems tend to fluctuate in

intensity, valid research should be used to investigate the usefulness of any treatment programme or intervention strategy. During the early investigation stages of this research it became apparent that this goal is largely absent in many South African rehabilitation programmes.

Galanter & Kleber (1994) furthermore also highlight some potentially inappropriate goals. It is suggested that clients should generally not receive pharmacological treatment for psychological symptoms experienced during intoxication and withdrawal, such as insomnia or depression. Withdrawal related psychological symptoms should be expected for physically addictive drugs, which are usually intense initially, but improve over a number of weeks.

The South African Situation.

Table 4 below indicates the primary source of payment for treatment in the Gauteng province for the period January 1999 to June 1999.

Self	24.0 %
State	21.4 %
Family	20.7 %
Medical Aid	15.9 %
Employer	07.9 %
Other	04.6 %
Unknown	04.3 %

Friends	01.2 %

Table 4. Source of Payment for Treatment (Wilkinson & Potgieter, 1999, p. 12)

Table 5 below indicates the referral source for a substance abuse centre in the Free State province for the period 1 April 1999 to September 1999.

Social Worker	27.5 %
Family / Friends	16.5 %
Doctor	12.3 %
Employer	12.3 %
Self	11.4 %
Religious Body	11.0 %
Psychologist	04.7 %
Justice	02.1 %
Other	02.1 %

Table 5. Referral Source for Treatment (Froneman, 1999, p. 14)

A Systemic Approach

The above discussion of the various client-oriented goals and those related to the rehabilitation programme all indicate the need to take into consideration the system as a whole. The goals consider the individual as a whole, i.e. physical, psychological, spiritual, as an active member of society, a family and industry. The goals furthermore consider supra-systems, such as politics, the economy, rehabilitation

facilities and medicine. Various systems both influence and are influenced by substance abuse, dependence and rehabilitation. Figure 1 below graphically represents the various factors or systems that influence use and abuse.

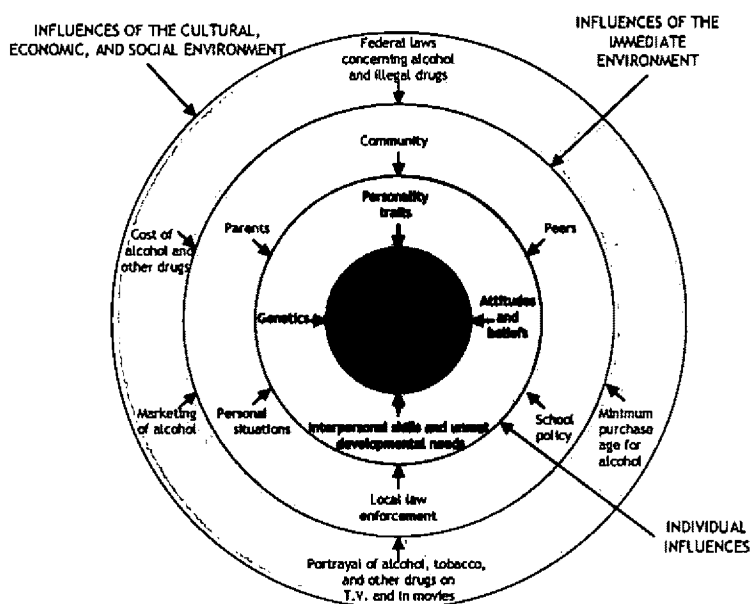

Figure 2: Factors that influence the use and abuse of alcohol and other drugs. (Pinger, Payne, Hahn, & Hahn, 1995, p. 24.)

Chapter 3 will discuss the systemic approach to drug abuse and rehabilitation in more detail.

Relapse Prevention

"Broadly considered, 'relapse' is defined as any discrete violation of a self-imposed rule or set of rules governing the rate or pattern of a selected target behaviour." (Galanter & Kleber, 1994, p. 287).

It is suggested that the addict owns a sense of control while maintaining abstinence, which may continue until he/she is faced with a high-risk situation (i.e. any situation that may threaten the sense of control and increases the possibility for a relapse). Possible high-risk situations identified by Galanter & Kleber (1994) include:

- a negative emotional state,
- interpersonal conflict,
- peer pressure,
- negative physical states (e.g. withdrawal),
- testing own sense of control,
- reaction to substance cues (e.g. cravings),
- revisiting a central part of the drug abuse life (e.g. friends, clubs).

The probability of relapse may be decreased if an addict is equipped with an effective response for high-risk situations, which then increases his/her sense of perceived control (Ghodse, 1995). For this reason it is of great importance to address substance abuse and rehabilitation by placing it in context, thereby addressing interaction with various systems and preparing the individual for this interaction (Crome, 1999).

Conclusion

The above discussion of substance abuse, dependence and rehabilitation is very broad and is mostly considered in the general sense. A more detailed discussion of various aspects such as substance specific problems and considerations as well as a clearer description of various substances would be well beyond the scope and available space of this dissertation. Specific drugs identified by the research participants, and their effects on the human system, will be briefly discussed in Chapter 5, for each case study. The above aimed to draw attention to global areas of concern related to substance abuse, dependence and rehabilitation.

As indicated in Chapter 1, it is deemed useful to consider drug rehabilitation programmes from a systemic perspective because of the nature of both drug abuse and drug rehabilitation. It is a phenomenon that has far reaching implications for society at large and also reflects the undercurrent of various systems of society (Pinger, Payne, Hahn & Hahn, 1995).

Chapter 3 will provide further background information on systems theory.

Chapter 3: Literature Review - Systems Theory

Introduction

Systems

Systems Rather Than Individuals

Homeostasis

Morphogenesis

Circular Causality

Second-order Cybernetics

Relationships of Systems

Elements of Systems

- Boundaries
  - Enmeshment
  - Disengagement
  - Alliance
  - Coalitions and Triangulation
- Hierarchy

Punctuation

Therapy

Conclusion

Introduction

In this chapter the systemic perspective and its various elements will be discussed. The chapter starts off with a description of systems, followed by a discussion indicating the necessity to look at the individual in context rather than in isolation. The terms homeostasis and morphogenesis, referring to the maintenance of stability and the evolution to a new state, respectively, will then be addressed. A description of circular causality as opposed to linear causality and the relationships of systems will then follow. Elements of systems, i.e. boundaries, hierarchy, will then be discussed. This will be followed by a discussion of punctuation and therapy from a systemic perspective.

Systems

According to systems theorists such as von Bertalanffy (1968), no person exists in isolation, but is part of a larger whole. He/she is therefore part of a system, which is a subsystem of another system and so on. An individual is part of a system such as a family for example, which is a subsystem of a greater subsystem such as the community in which the family lives etc.

Systems function to maintain homeostasis, resisting change in order to keep the system constant (Becvar & Becvar, 1982). Homeostasis is achieved through a process referred to as negative feedback. Negative feedback functions by detecting

change within the system and altering subsystems in such a way that change is resisted (Bentovim, Barnes & Cooklin, 1987).

Psychological problems experienced by individuals are seen to originate for example from the present interaction between individual members of a family, and between family members and other subsystems, rather than the individual being focused upon as the locus of the psychological disorder. Presenting problems, such as substance abuse or dependence, are considered symptoms of a dysfunctional system. The therapist therefore considers the social systems of the individual, who is presented as displaying some symptomatic behaviour such as drug addiction or abuse, and assesses the related systems as well as the interaction between these, and not merely the individual in the system. According to Keller, Galanter & Weinberg (1997), substance abuse may be regarded as a symptom of the underlying process operative within the family system, which not only initiates the disorder but also operates to maintain it.

Problems can be found in the nuclear family, in the extended family or in the interaction of numerous other subsystems. The problems arise because of some fault in the system, and thus the system needs to change in order for the symptomatic behaviour to disappear.

According to Barker (1986):

- a system is more than the sum of its parts;
- the system's functioning is controlled by general rules;
- all systems have boundaries;
- boundaries are semi-permeable (i.e. allowing selected things to pass through whilst keeping others out, furthermore some things may only pass in one direction and not the other);
- although systems strive towards a relatively steady state, it is not a totally steady state, thus change is possible and can be stimulated in a variety of ways;
- mechanisms for communication as well as feedback between the various elements are important determinants of the functioning of the system;
- behaviour is explained by circular causality rather than linear causality;
- open systems (systems which show interaction with the surrounding systems) seem to have a purpose;
- systems consist of smaller subsystems and are part of larger suprasystems.

The above characteristics of systems, from a human perspective, will be described in the text to follow.

Systems Rather Than Individuals

"The term 'homeostasis' refers to the vital principle that preserves the intactness and continuity of the human organism, the capacity for maintaining effective, co-ordinated functioning under constantly changing conditions of life." (Ackerman, 1994, p. 68). From a systemic perspective it is thus essential to look at the individual within the context of a system, rather than the individual in isolation. The individual is therefore placed into the context as a subsystem, which both exerts influence on the system and is influenced by the system. Consequently the focus shifts from the individual to the system.

Homeostasis

Habitual patterns of interaction are employed between various transitional points (e.g. developmental milestones), which are predictable, recurring and well known to the system (Barker, 1986). These habitual patterns are in congruence with the belief system and relationship patterns of the system. This enables the various subsystems to plan and make sense of their roles in the system, as there is an expected response to various situations.

Negative feedback operates to decrease deviation from acceptable behaviour during periods of stability, in order to maintain homeostasis (Simon, Stierlin & Wynne, 1985). A range of acceptable behaviour is permitted during periods of

homeostasis, which may vary from very rigid to flexible. Transgression past these limits will result in corrective action being taken.

In a new developmental phase where transgression from these limits can no longer be corrected by the same regulating relationship rules, the limits have to be reviewed for the evolution of the system. Therefore change must take place (Burnham, 1993). For example, the parental system constantly reviews regulatory rules as children pass through various developmental phases.

It is important to consider the functioning of negative feedback for the maintenance of homeostasis in the drug rehabilitation process. The system's tendency to return to habitual patterns of interaction, both maintains the drug addiction and increases the likelihood of relapse.

Morphogenesis

For evolution to take place, change is inevitable. Behaviour and belief experimentation (e.g. regarding rules of interaction) may take place during transitional phases. This may change the definitions of various relationships in the system. Positive feedback encourages deviation from previous norms (Simon, Stierlin & Wynne, 1985). During the transitional phase the system discards the previous habitual patterns, which were predictable, recurring and well known to the

system, in order to form new patterns and a relatively stable state.

Whereas negative feedback refers to deviation counteracting, positive feedback refers to deviation amplifying, which enables evolution to a new state. "Positive feedback is characteristic of living systems." (Levant, 1984, p. 13).

The deviation from previous norms and the development of new patterns form a vital part in the transitional phase of the drug rehabilitation process. It therefore becomes necessary to abandon previous habitual patterns of interaction. This may enable evolution to a new drug-free state.

Circular Causality

Psychological problems were traditionally thought of in linear terms, with causal explanations for disorders (Cottone, 1991). The individual was thought to be the locus of the dysfunction. It can then be said that in linear causality event "A" causes event "B" and event "B" has no effect on event "A".

A >>>> B

However, from a systemic perspective, causality is said to be circular rather than linear. Behaviour is the result of the various parts in the system mutually influencing one another, indicating bi-directional causality (Anchin & Kiesler, 1987). From a systemic perspective problems are considered in context

and the mutual influence of various parts in the system is explored. "A" affects "B" and "B" also affects "A".

A >>>> B & A <<<< B

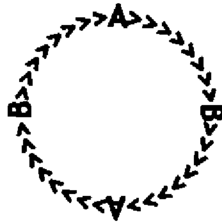

Figure 3: Circular Causality

For example, a stressed mother shouts at her crying child, the child cries even more, stressing the mother more etc. Systems are made up of subsystems, which interact with each other in the system. It is therefore thought that the system, rather than the individual, is dysfunctional, since each part interacts with other parts of the system, contributing to the dysfunctional system (Barker, 1986).

The bi-directional interaction of systems on various levels therefore functions to initiate and maintain substance abuse, as well as initiate and maintain abstinence.

Second-order Cybernetics

Viewing the therapist as an objective observer with expert knowledge who is able to prescribe a cure and is seen as a separate entity from the observed system, shifted to viewing the therapist as a part of the system. This is referred to as second-order cybernetics (Atkinson & Heath, 1990). Due to the

influence the therapist has on the system he/she must be included in the observation of the system. "One of the key issues in second-order thinking is the questioning of the expert position commonly adopted by family therapists." (Reimers & Treacher, 1995, p. 181). A first-order approach therefore attempts to restructure families (or systems) in accordance with the expert knowledge of the therapist, rather than acknowledging the multiple ways in which families (systems) may function successfully. This implies that the therapist adopts a view of being able to understand fully the reality of another individual and is thereby in a position to prescribe behaviour.

In the second-order approach, the therapist is considered a co-author in the reality rather than an expert, shifting the focus from patterns of communication to patterns of meaning. The therapist therefore forms an integral part of the drug rehabilitation process in terms of co-authoring the reality. Chapters six and seven will expand on the second-order cybernetic view of the researcher as an integral part of co-authoring the reality of this research study.

Relationships of Systems

The family structure refers to the 'rules' according to which various members in the family relate to one another. These repeated sequences in behaviour indicate the family processes which guide expectations and serve to maintain

homeostasis (Becvar & Becvar, 1982). The exchange of opposite behaviours demonstrates a complementary sequence of interaction, e.g. retreat in response to aggressive behaviour. The exchange of similar behaviour, on the other hand, demonstrates a symmetrical sequence of interaction, e.g. aggression in response to aggressive behaviour (Barker, 1986).

Families have various sub-systems, for example the parental sub-system (mother and father), sibling sub-system (children), spousal sub-system (husband and wife) and extended sub-system (aunt, grandparents, etc.). Each sub-system may play various roles in the system, usually determined by factors such as age, gender, community and culture. For example, an individual in a family can be part of the spousal and parental sub-systems, or parental and sibling sub-systems. Each sub-system in the system is expected to fulfil appropriate roles and functions (Corey, 1996).

It may therefore be said that the rules according to which various interacting systems function, provide insight into the drug addiction and rehabilitation process.

Elements of Systems

Boundaries

All systems have boundaries that are essential to their functioning and for controlling interaction between various systems (Barker, 1986). This may suggest that boundaries in

human systems serve to control the extent of interaction between various systems, thereby distinguishing for example a newly married couple from their families of origin. The permeability of various system boundaries differs (Barker, 1986). However, most system boundaries are to some extent semi-permeable (allowing some things to pass whilst preventing others from passing), thereby maintaining the system's distinctness from its surroundings.

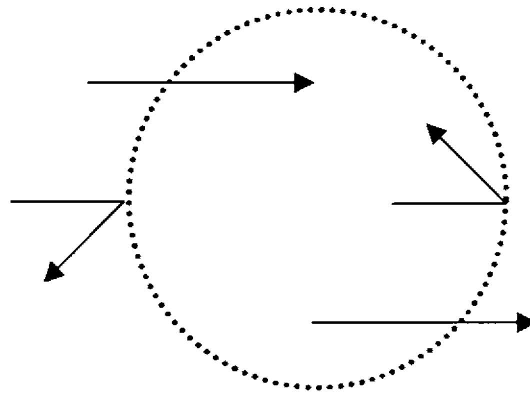

Figure 4: Permeability of System Boundaries (Barker, 1986, p. 42)

Enmeshment.

Enmeshment refers to an over-close relationship between parts of the system. Problems often occur in families where boundaries between systems are diffuse, thereby allowing most things to pass through (Fox, 1993). Enmeshed relationships imply that the behaviour of an individual in the relationship will have a significant effect on the individual with whom he/she is enmeshed. The over-involvement of individuals can lead to a lack of independence. Systems should have clear

boundaries that establish the extent of involvement within parts of the system (Corey, 1996).

Disengagement.

Disengagement between parts of the system indicates relationships where the boundaries are too rigid, thereby limiting interaction between certain parts of the system (Corey, 1996). Very rigid boundaries may lead to the isolation of individuals in the system and a break-down in the relationship with little involvement in each other's lives (Barker, 1986). Disengaged relationships imply that the behaviour of an individual in the relationship will have no or little effect on the individual with whom he/she is disengaged.

Enmeshment and disengagement can be viewed as two opposite poles on a continuum. On the left, enmeshment, allowing most things to pass through the diffuse boundaries, and at the other end, disengagement, preventing things to pass through the rigid boundaries.

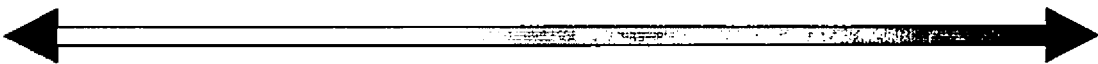

Figure 5: Continuum of permeability

The balance between diffuse and rigid boundaries characterises healthy relationships in systems, where

individuals are afforded the opportunity to feel part of a system and develop a sense of identity throughout various developmental stages (Corey, 1996).

Alliance.

According to Freeman (1992) alliances are any connections between individuals in a system for mutual support. The sharing of common interests or projects constitutes the formation of alliances. An alliance affords the individual the opportunity to discuss matters with another individual, which for example he/she feels cannot be discussed with others in the system. The individual is thereby still enabled to feel part of the system. Various types of alliances include:

- dyads (between two individuals);
- triads (between three individuals);
- intra-system alliances (between individuals of a system);
- extra-system alliances (between individuals of various systems).

Although alliances can be useful and contribute positively to the functioning of a system, they can also become maladaptive (Freeman, 1992). Maladaptive alliances include the formation of for example coalitions and triangulation.

Coalitions and Triangulation.

Coalitions are formed when parts of the system join forces against another part of the system. Partners in a coalition are typically selected on grounds of perceived usefulness for attaining a set objective, and therefore tend to be fragile (Tesser, 1995). Coalitions often involve the transgression of appropriate structural boundaries in the system, for example when a mother and son form a coalition to conspire against the father.

Triangulation refers to incidents where two parties in conflict approach a third party to win support or sympathy in the conflict, for example when divorced parents approach their son in order to win support or sympathy by blaming or accusing the other party (Hoffman, 1981).

Hierarchy

Hierarchy refers to the system's organisation in terms of how power is distributed (Barker, 1986). Various factors determine the hierarchical structure of a system, for example age, gender, status, knowledge. The hierarchical structure may shift when addressing different concerns, for example the father may be in a superior position when making financial decisions for the family whilst the mother wields more power in educational matters. Problems in systems may arise from hierarchical boundaries, which are either too diffuse or too rigid. Ivey, Ivey & Simek-Morgan (1993) assert that

symptomatic behaviour is frequently the result of a family's deviation from the traditional hierarchical structure in which parents have control over their children and where older children are afforded more power and privileges than younger children etc.

The permeability of boundaries and the hierarchical structure contribute to the definition of rules for interaction. The struggle for power and the extent to which behaviour influences others, functions to initiate and maintain the drug addiction - as a defined symptom in the family system of the addict - and thus the rehabilitation process.

Punctuation

Punctuation, from the systemic perspective, deals with the identification of various patterns of interaction between parts of the system (Watzlawick & Weakland, 1977). The purpose of this is to establish problematic patterns in communication which give rise to symptomatic behaviour in individual parts of the system.

Systemic therapists frequently make use of a genogram as a means of organising information systemically, providing a framework for inquiry of alliances, boundaries etc. (Simon, Stierlin & Wynne, 1985). The diagrammatic representation of relationship patterns in a system illustrates patterns and

themes which may influence interactions between members of the system.

The distinction between various levels of communication also provides the therapist with vital information about the system's processes. The two levels of communication which can be distinguished are 'digital' and 'analogue' communication, where digital refers to the content of verbal communication and analogue to the way in which it is communicated (Barker, 1986). Analogue communication therefore refers to all other means of communication which accompanies digital communication, such as verbal (e.g. tone) or non-verbal (e.g. facial expression). How we feel about others and ourselves, for example, is communicated primarily on an analogue level of communication (Anchin & Kiesler, 1987). It can therefore be said that it is impossible to not communicate, as even silence is a form of communication on an analogue level. Similarly, symptomatic behaviour can also be viewed as a form of analogue communication, e.g. attempted suicide as a cry for help (Burnham, 1993).

Patterns of interaction may be identified with the aid of a genogram. Complementary sequences of interaction are often evident, with parental efforts to contain the consequences of the addiction by for example paying for items that an addict has stolen. Increased tolerance to the drug and the interactional patterns with fellow abusers may be considered as examples of symmetrical sequences of interaction. The drug

addiction may furthermore also be considered as an analogue form of communication.

Therapy

According to the systems approach, presenting problems are considered symptoms of a dysfunctional system (Avis, Pauw & van der Spuy, 2000). Because the family therapist operating from a systems framework looks at the social systems of the individual, who is presented as displaying some symptomatic behaviour, such as drug addiction or abuse, the therapist will assess the related systems and not merely the individual in the system. This premise makes a systems approach basic to all family therapy (Barker, 1986). Problems can be found in the nuclear family, in the extended family or in other subsystems with which the individual enters into a relationship. The problems arise because of some fault in the system, and thus the system needs to change in order for the symptomatic behaviour to disappear. "Two themes that have repeatedly emerged in family process studies on families of illicit drug abusers are interpersonal boundary issues, such as enmeshment and disengagement, and parental control/discipline." (Ripple & Luthar, 1996, p.151).

van den Borne (1998) recommends that it is important to examine not only the client's needs and problems, but also those of other parties involved, such as professionals or the

client's family, in the development of rehabilitation programmes.

Furthermore, according to Stanton (1997), studies comparing family/marital therapies to non-family approaches showed that non-family conditions had higher dropout rates.

The above recommendations to include family and other significant members in addition to the identified client / drug abuser in drug rehabilitation programmes, supports the idea of taking a systems approach to this research. By adopting a systems approach the functioning of the interactional context within which the client lives will be highlighted, rather than focusing on intra-psychic problems.

Conclusion

In the above text an attempt was made to indicate numerous aspects considered to be important when adopting a systemic approach for addressing various psychological disorders. According to Visser (1999), worldwide trends indicate that drastic socio-economic and political changes, as experienced in South Africa, often influence high-risk behaviour. High-risk behaviour can be related to social and community factors (e.g. exposure and access to illegal substances), social norms (e.g. tolerance of the abuse of illegal substances) and lack of social support for the individual (Visser, 1999). Macro-level systems such as political, law enforcement and social turmoil influence various sub-systems, for example families,

educational organisations and peer groups. Drug rehabilitation programmes must therefore consider the influence on the individual of numerous micro-level systems, i.e. friends, teachers, rehabilitation centres, family members. It is therefore suggested that a systems approach to this research, by considering various macro and micro-influences, will facilitate a more holistic rehabilitation programme.

The following chapter will address the methodology followed for the research.

Chapter 4: Methodology

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Introduction

- Problem Statement
- Research Question
- Aim
- Objectives

Research Design

- A Case Study
- The Population
- The Sample

Collection of Research Material

- An Interactional Stance
- An Interpretive Stance
- The Data Collection Process

Research Material Analysis

Ethical Considerations

Problems Encountered During the Research

Conclusion

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Introduction

"A trip ... is an entity, different from all other journeys. It has personality, temperament, individuality, uniqueness. A journey is a person in itself; no two are alike. ... we do not take a trip; a trip takes us." (Steinbeck, 1980).

Problem Statement

Drug abuse and dependence are major social problems facing South Africa. Instead of concentrating on their future, too many young adolescents in our country are trapped in the vicious downward spiral of drug related problems. Drug abuse furthermore impacts negatively on the South African economy, in terms of medical expenses, loss or damage of property, loss of manpower etc. (Drug Advisory Board, 1999). It is therefore important to ensure that efforts to rehabilitate our youth are effective.

The DSM-IV criteria for substance abuse, set out in Chapter 2, indicate that substance abuse has physical, social as well as emotional effects on the individual and on society. The effects of drug abuse reach into every corner of society, for which a heavy price is paid in terms of lives, emotional turmoil as well as economically (Barlow & Durand, 1995). Rehabilitation programmes therefore need to consider the system(s) in which drug abuse takes place, as the context for the rehabilitation process.

The rapid increase of drug abuse in South Africa makes drug abuse a serious social problem, worthy of research.

Research Statement

A systemic conceptualisation of drug rehabilitation programmes with the focus on the process, rather than on the content of the programmes.

Aim

The aim of this research study is to report on selected drug rehabilitation programmes from a systemic perspective.

Objectives

The objectives of this study are to report on drug rehabilitation programmes in terms of:

- local rehabilitation models from a systemic perspective;
- their clients - single case studies of clients who have recently completed the rehabilitation programme;
- the significant role players identified by the research and their contribution to the rehabilitation process;
- recommendations to drug rehabilitation programmes.

Research Design

A qualitative research design was deemed appropriate for the purposes of this study. Methods used in qualitative research

provide a deeper and richer understanding of social processes than would be obtainable from methods employed in quantitative designs (Miles & Huberman, 1994). The deeper and richer understanding of social processes obtainable from qualitative methods complements the systemic perspective employed in this research study. The suitability of a qualitative methodology for this research study will be discussed in more detail below. The quotation from John Steinbeck in the introduction refers to both the methodology followed for the research and the process of drug addiction and rehabilitation.

A qualitative research design provides the researcher with an opportunity to gain insight and understanding of words and images, rather than numbers. It furthermore allows for the observation of natural occurrences by means of unstructured interviews and observation, where science is not viewed as a model and understanding is aimed at meaning rather than behaviour, from the perspective of the person being studied (Silverman, 2001). The research allows for inductive hypothesis generation rather than testing.

The reality of drug addiction and rehabilitation processes to be studied consist of people's subjective experiences, therefore an interactional stance will be adopted, which indicates the following methodology:

- interactional - interviews and essays
- interpretive - evaluation

- qualitative - treatment of data (Terre Blanche & Durrheim, 1999).

These will be dealt with under the headings Collection of Research Material and Research Material Analysis.

A Case Study

According to Ragin & Becker (1997) the term 'case' and various terms linked to case studies, have not been defined sufficiently in the social sciences. Understanding a case study within this research design, may be done by explaining the context of the research itself. The research design chosen aims to provide a richer description of drug rehabilitation programmes. Where in a quantitative study the outcome may be described as a value of a variable, in a qualitative design the outcome may be described as a different way of putting together various interdependent activities. As discussed in Chapter 3 a qualitative design facilitates the process for considering the context in which a symptom may develop. The research design therefore allows the researcher to consider similar cases and to analyse these as to how they may differ. The interrelationship between various elements is considered as multidimensional, the character of which cannot be adequately expressed quantitatively. Ragin & Becker (1997) argue that the empirical world is limitless in its detail, complexity, specificity and uniqueness, and that the way in which we can make sense of its infinity is to limit it with

our ideas. A number of motivated limitations therefore impacted on the delineation of this research study, including:

- the researcher's interest,
- the identification and specification of a social phenomenon,
- the focus on a study population,
- the scope of the research study, leading to the selection of an attainable research sample.

Creswell (1998) contends that a case study is an exploration of a bounded system by collecting in-depth data through multiple sources of information that are rich in context.

The Population

Babbie (1992) defines a study population as the aggregation of elements from which a sample is selected. This may include all units which may be included under the delineation of the research study. Therefore the study population will be local drug rehabilitation centres, identified clients and key informants / significant role players in the rehabilitation of the identified clients.

The Sample

Random selection from a population is often considered as an acceptable sample for a research project. However, Maykut & Morehouse (1995) contend that qualitative research sets out to

select a sample with a different goal in mind. In order to gain a deeper understanding of some phenomenon, experienced by a group of people, it is necessary to purposefully select individuals, thereby acknowledging the complexity that characterises human and social phenomena. A purposefully selected sample of cases was drawn as case studies:

- two local drug rehabilitation centres
- one case study (an out-patient client who had completed the drug rehabilitation programme) from each centre
- significant others, as identified for each case.

Collection of Research Material

The objective of the research study is to systemically describe rehabilitation programmes in terms of their models and philosophies, their clients, as well as the contribution of significant role players, by adopting an interactional stance.

An Interactional Stance

In-depth data collection involved multiple sources of information considered to be rich in context. According to Creswell (1998) multiple sources of information may include observations, interviews and documents, which situate the case within a context.

The research study was introduced to the research participants during an interview where further explanations for the written text documents were provided.

A motivated essay moving beyond surface talks to a rich discussion of thoughts and feelings was requested, to describe the contribution of the various role players participating (e.g. client, family members, therapist, teachers, police officer.) in the programme of the selected case studies. The essays were intended to obtain detailed material of for example the treatment setting and the influence of certain elements of the programme on the clients. Semi-structured essay instructions were provided, in which careful attention was paid to omit questions which are double-barrelled, introduce assumption before posing the question, include complex wording, are leading, include double negatives or act as catch-alls (Breakwell, Hammond & Fife-Schaw, 1995).

The respondents were encouraged to make use of their own words, values and thoughts when writing the essay. It was recommended that they write the essay as though they were having a conversation with themselves.

The essays were returned for the purpose of identifying further questions that might be answered in a follow-up interview and later transcription of the collected material.

An Interpretive Study

"In an interpretive study, there is no clear point when data collection stops and analysis begins." (Terre Blanche & Durrheim, 1999, p.139). It is more of a gradual change from mainly collecting to mainly analysing the collected material. Although analysis was initiated on the return of the essays this lead to further identification of research questions that would thicken descriptions.

The Data Collection Process

The data collection process was guided by the following principles:

- Identify potential research participants, i.e. case studies including the rehabilitating addict and a participant from the rehabilitation facility.
- Make appointments with the identified case studies for an introductory interview to request participation and provide background information about the research, including the following:
  - the purpose of the research,
  - the approach followed in the research,
  - a discussion of the essay topics which the research participants are requested to write about.
- During the first meeting background information about the research participants should also be collected by means

of a brief interview about the drug addiction and rehabilitation journey.

- Furthermore, the first interview should serve to discuss ethical considerations with the participants, as well as the identification of significant role players in the drug addiction and rehabilitation process.

Data collection was initiated with the principle being to identify access points for rehabilitating participants. Numerous rehabilitation facilities were contacted for possible participation in the research. A rehabilitation facility, later referred to as RF Four (see Chapter 5), agreed to participate and identify further potential participants.

The psychologist at RF Four provided the researcher with contact information about Philip, a rehabilitating drug addict. Philip was contacted and agreed to a meeting to discuss the research. During the introductory interview he was provided with the background information and in turn supplied the researcher with initial information. The researcher proceeded by explaining the requested essays and answering questions. (The various essay topics presented to the research participants are outlined in Appendix A.) The guidelines for the essay were discussed, a copy of which was handed to him for reference. The interview concluded with a request for Philip to identify significant role players in the rehabilitation process, including the rehabilitation institutions, who could be approached for further information

about the interaction within and among various systems as well as the rehabilitation process itself.

The identified patient (IP) was furthermore requested to sign a letter of consent providing permission for the researcher to approach identified role players and use information provided for the purposes of this dissertation. Case names were agreed upon to protect the anonymity of the individuals participating in the research. In the case of Philip, a psychologist, social worker and his father were approached for further information.

The psychologist at RF Four was contacted again to arrange an introductory interview regarding the case of Philip. At this meeting the psychologist was also provided with the guidelines for the essay.

Philip identified a social worker at RF Three, who granted the researcher an introductory interview during which participation was agreed upon. After numerous follow-up attempts the social worker informed the researcher of his inability to participate, due to government restriction with regard to client confidentiality, in spite of written consent obtained from Philip.

Philip's father agreed to participate and write an essay on behalf of himself and his wife to reflect on their experience of the addiction and rehabilitation process.

Philip, his father and the psychologist at RF Four all returned their essays with offers of supplying further information if needed.

Another rehabilitating addict, Miss X, was identified as a potential participant. She was contacted and agreed to participate. After the introductory interview and discussion of the essay guidelines, she identified her mother as a potential participant as well as RF One.

Her mother was contacted and indicated that she was not willing to participate by writing an essay. The researcher requested whether she would be willing to participate in an interview, which would then be transcribed and used as the equivalent of the essay. She agreed and an interview was scheduled.

The Superintendent from RF One put the researcher into contact with the psychologist who worked with Miss X when she entered rehabilitation. The background and purpose of the research were discussed as well as the guidelines for the essay. The psychologist agreed to participate but indicated that because he was very busy it would take a while to write the essay.

Research Material Analysis

A data analysis spiral offers a graphic representation of the general analysis process that qualitative research follows.

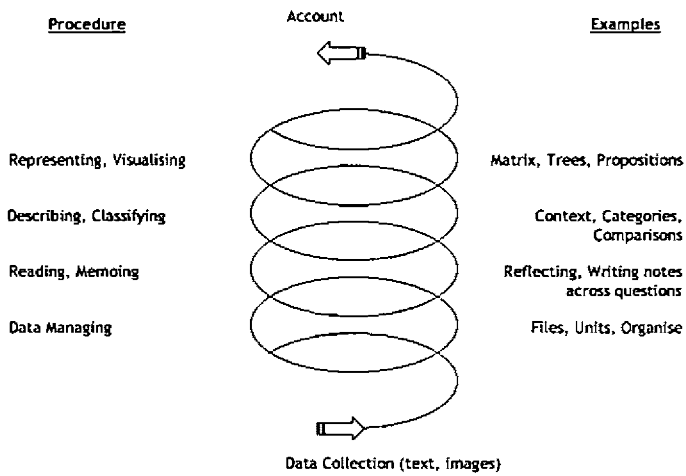

Figure 6: The Data Analysis Spiral (Creswell, 1998, p. 143)

The above figure indicates the circular process followed in qualitative research, rather than a linear approach. The spiral is entered with data of text, observations etc. and exited with an account or a description of the research. Once data collection has begun, the researcher enters the first loop of the spiral, data management, which entails organising data into files, categories etc. A text database is created with the conversion of files into text units for later analysis (Creswell, 1998). The researcher follows this loop, making some sense of the database as a whole by reading over it several times and making notes. This loop gradually develops from the reading loop into the describing, classifying and interpreting loop. The category formation which occurs in this loop represents the central focus of

qualitative research. Detailed descriptions of themes begin to develop, which provide interpretations based on the researcher's views and those of related literature. The process then moves into the final loop, where the researcher presents the data findings.

Data analysis used in this research entails the detailed description of the cases and their context. Creswell (1998) distinguishes the following five forms of data analysis for case study research:

- Categorical aggregation - by examining the data for a collection of instances, from which issue-relevant meaning will emerge. Chapter 6 will discuss various aspects of the essays from which meaning relevant to the research emerged.
- Direct interpretation - the case studies may provide single instances from which relevant meaning may be drawn.
- Patterns - may be determined, which allow for the identification of correspondence between two or more categories, thereby indicating a relationship between these categories.
- Naturalistic generalisation - may develop from data analysis, which may be used to gain insight into other processes.

- Description - of the case may provide rich detailed descriptions of some aspects of the case.

Generalisations of patterns were furthermore compared to and contrasted with literature and rehabilitation models.

Ethical Considerations

According to Breakwell, Hammond & Fife-Schaw (1995), the following ethical considerations should be addressed in any research study:

- protection and welfare of participants,
- the principles of informed consent,
- participant's right to withdraw from an investigation,
- the use of deception,
- the debriefing of participants,
- confidentiality and anonymity of data.

The above considerations were addressed during the course of the research and negotiated with each research participant. The nature of the research study did not pose any mental or physical harm to any participant. Informed consent was obtained by establishing voluntary participation and providing background information about the research, with regard to the aims and objectives, the reasons for the research as well as a description of the whole process. The IP was requested to sign a letter of consent providing permission for the researcher to approach identified role players and to use information

provided for the purposes of this dissertation. Participants were furthermore informed of their rights to withdraw at any stage of the research. The nature of the study did not require the use of deception, on the contrary, the participants' understanding of the methodology etc. added to their ability to contribute positively to the research study. Participants were assured of feedback after the completion of the research study. The researcher furthermore hoped that the participants would gain from their participation in the research by engaging in a process of self-reflection. Confidentiality was addressed by assuring participants of anonymity and allowing input into related issues, including case names.

Problems Encountered During the Research

The researcher anticipated that rehabilitated research participants might be unwilling to participate due to various personal reasons. However, the opposite proved to be true, the rehabilitated addicts responded to the request very positively.

In the case of Philip, he identified various significant role players who he thought would be equally excited about the participation. Miss X was more cautious in her inclusions.

The researcher furthermore had hoped that the rehabilitated addicts and significant others would experience the participation as an uplifting and beneficial experience, having been afforded an opportunity to reflect on the progress

made. However, feedback from several of the participants suggested that it was an experience which brought with it a lot of pain.

The researcher had furthermore not correctly anticipated the willingness of professionals and rehabilitation facilities to share their knowledge and participate in the research. Many rehabilitation facilities and professionals either declined or omitted to respond to requests for participation in the research. Some professionals, although agreeing to participate, did not return essays or respond to any follow-up enquiries as to their participation. This unfortunately continued to a stage where it was no longer feasible to include them in the research. In the case of Miss X the reason for the unwillingness of professionals may have been due to elements in the rehabilitation process which may be viewed as potentially damaging to the rehabilitation facilities and some professionals. This is evidenced by the mother's account of how they finally came to know about her addiction: A breach of client confidentiality, via the grapevine of the nursing staff and various relatives and acquaintances, brought the news home to her parents from a business associate of her father.

Even though numerous problems were anticipated and other obstacles overlooked, the data received from the research participants was rich in description and proved to be useful, interesting and relevant.

Conclusion

Chapter 4 provided a discussion of the research methodology and the process followed. The rationale behind the research was presented, followed by a breakdown of the research design. A discussion of the collection of research material as well as the analysis of research material was then presented. Finally some ethical considerations were addressed. The following chapter will present results and descriptions obtained from the process followed in this chapter.

Chapter 5: Results

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Introduction

Presentation of Data

- Case Study One: Philip
- The IP's Description
- A Psychologist's Description
- A Significant Other's Description
- Case Study Two: Miss X
- The IP's Description
- A Psychologist's Description
- A Significant Other's Description

Conclusion

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Introduction

The following text will present data obtained from the research process. The case studies will be presented separately under the agreed upon case names. The case of Philip will be discussed first. An outline of the data obtained from the IP himself and from a psychologist involved in his rehabilitation process will be provided, followed by data received from his father as an identified significant

other. The case of Miss X will then be presented, including her account as the IP, and that of her mother, as an identified significant role player.

Presentation of Data

The following section presents information obtained from the interviews with the research participants and their essays. It would be well beyond the scope and available space of this dissertation to include the complete interview transcripts and essays. However, the following text is a representation of the data obtained from the participants. The researcher has refrained from including personal ideas and discussions in this section. Chapter 6 will address emerging themes supported by extracts from the original transcripts and essays.

Case Study One: Philip

Philip is a 23-year-old male rehabilitating drug addict. His primary substance of abuse was heroin, administered by either snorting, intravenously or 'Chasing the Dragon', the latter referring to the inhalation of heroin vapours which result when the drug is heated, typically on tin-foil above a flame (Strang, Griffiths & Gossop, 1997). Heroin is pharmacologically similar to morphine. It induces analgesia and drowsiness and has an euphoric effect (Kaplan & Sadock, 1998). Generally, drugs with longer lasting duration of effect produce milder but prolonged withdrawal symptoms, and short-

acting drugs, such as heroin, produce shorter but more intense withdrawal symptoms (Galanter & Kleber, 1994). Withdrawal from heroin may begin within six to eight hours from ingestion after a one to two-week period of continuous use. The withdrawal symptoms peak in intensity on the second or third day, usually subsiding within the following seven to ten days, although they may persist for six months or longer.

The IP's Description.

In Philip's account of the drug abuse itself, he highlights the lengthy period of his substance abuse as well as the course his substance abuse took. An initial encounter with cannabis was shortly afterwards followed by heroin, cocaine, ecstasy and LSD (acid) abuse. Various attempts at rehabilitation only provided short interruptions in his patterns of abuse. Experimentation with peers initiated his six-year long pattern of drug abuse. He warns against generalised assumptions about substance abusers, such as childhood sexual molestation or 'wrong upbringing'. He comments on the potential for various achievements among members of the group with whom he first encountered drugs, highlighting their intellectual ability and numerous talents, such as sport. He suggests ignorance, boredom and a need for excitement as motivating factors for the initial interest in drugs, stating that he did not realise the effect the drugs

would have on himself and his family throughout the addiction period.

On a societal level, he believes that today's youth face tremendous pressure without the appropriate support. Philip states that it has become acceptable for youths to attend clubs etc. where they have access to knowledge about drugs. Philip writes that there is no control over the knowledge that youths have access to, and that there is insufficient effort to understand how they perceive this knowledge. He furthermore argues that the widespread belief in medicine for treating the complaints of young children reinforces acceptability of drug use. Philip states that society teaches children from a young age that medication is acceptable, because children are medicated at the smallest sign of illness. Although Philip is not of the opinion that societal pressures, beliefs and availability sufficiently explain drug abuse in all cases, he indicates that this had a major influence on his journey.

In his opinion, his personal encounter with various rehabilitation facilities places him in a position to provide an insightful account of the rehabilitation process. He resolved to report on four facilities only in his description of the rehabilitation process. The facilities will be referred to as Rehabilitation Facility (RF) One to Four in order to avoid disclosing their identity.

Philip's first encounter with rehabilitation was at a private facility to which his parents admitted him. Philip

expresses strong opposition to RF One, which in his opinion attempted to uncover deep-seated psychological problems that he reports not to have had. Philip furthermore compares the facility to a 'holiday resort' and highlights a lack of personal attention. He considers the relatively brief duration of the programme (six weeks) as insufficient for any addict to psychologically recover from the addiction. He furthermore argues that the tasks required from the addicts did not promote insight into their addiction problems. Philip states that drugs were readily available in this facility, since visitors were not searched before entering. He does, however, suggest that RF One's detoxification facility can be recommended. Philip states that this rehabilitation facility had all the necessary medication available for someone requiring detoxification.

Philip was then admitted to a government rehabilitation facility, following court orders. According to Philip, RF Two although a very good facility, was so flooded with drugs that it was never really necessary to stop abusing drugs while he was in rehabilitation. His continued use ended in his dismissal from the facility. He credits the facility's basic belief that all clients have to do their share of the work, suggesting that this promoted mental stimulation between therapy sessions. He did, however, note a lack of interaction between client and therapist. The extended period of rehabilitation, which may take longer than 6 months, in his

opinion, shows great credibility. The complete removal of drugs, he suggests, would make this a superior facility, which could have ended his substance abuse much earlier.

He notes that RF Three follows a very different process to any other facility he had experienced. He praises the facility for the strict and rigid rules, and notes that the people involved helped him back to a drug-free existence, by caring and taking a personal interest in his life. The success of this facility is enhanced by the rare availability of any drugs. Although Philip was admitted to RF Three on three different occasions, he suggests that abstinence may have been maintained if a support structure (other than his family) had been in place after leaving the rehabilitation facility.

He entered the RF Four out-patient programme after being discharged from RF Three for the last time. Philip agreed to his family's request that he enter the programme as a further means of support to maintain his abstinence. Philip recommends RF Four as the facility of choice.

He concludes his discussion on rehabilitation facilities by commenting that the cost of a programme and appearance of a facility do not prevent people from abusing drugs. Caring staff who guide the addict through the process and the will to abstain are suggested as the only factors that can put an end to drug abuse.

In Philip's description of the impact of the rehabilitation process he notes the intricate combination of internal and

external factors that contribute to the successful maintenance of abstinence. He identifies perseverance, hope, mental and physical strength, patience and trust as personal characteristics needed to abstain from drug abuse. He highlights patience as an important characteristic, since many addicts have expectations of rapid rehabilitation from a long-lasting drug abuse problem.

Family, friends and counsellors are identified as an imperative external support structure. He furthermore suggests that out-patient programmes should be implemented to recognise and prevent possible relapse.

Philip's description concludes with a reference to the gains and losses he has experienced in his journey. Although he describes his gains as 'endless', he refers to 'final peace of mind' and 'freed from the chains of addiction' as his main gain. His losses include any aspect of his previous life as an addict, and he guards against returning to any part of the life he led whilst on drugs.

A Psychologist's Description.

Philip identified the psychologist at RF Four as a significant role player in his rehabilitation journey. RF Four provided information on their out-patient rehabilitation programme that Philip was committed to for a period of seven months in 1999. According to the psychologist the programme included:

- a behaviour programme,
- individual psychotherapy sessions,
- group therapy,
- family therapy,
- regular urine tests,
- a recommendation to the parents to attend the Tough Love support group.

The programme involved co-ordinated efforts with Philip's parents to develop a punishment and reward system regarding various privileges, e.g. music, telephone, transport. Initially no or few privileges are given and limited privileges are only gained by producing negative urine tests (regularly conducted by both the parents and the therapist).

During the first six weeks Philip was directed to attend weekly psychotherapy sessions, which was reduced to a fortnightly attendance prerequisite for the following six weeks and finally, depending on the client's needs, to once monthly. Saturday mornings are spent in group sessions addressing various issues, e.g. self awareness, stress and conflict management, goals, the recovery process.

Family therapy sessions are arranged in accordance with the dynamics and problems experienced in the family.

The psychologist describes elements that contribute to the success of the RF Four treatment programme. In her opinion the recovering addicts are both annoyed and motivated by the

behaviour programme, which requires close co-operation between the parents and the therapist. A negative urine test increases the clients' sense of pride in themselves and is enjoyed with the additionally earned privileges as well as positive feedback from the significant role players. This furthermore provides clients with a suitable excuse when confronted by their friends.

She furthermore highlights the importance of a support system during the rehabilitation process. Restoring family relationships, together with the positive feedback, is considered an important motivational factor in the maintenance of abstinence along with the required change of unacceptable behaviour for the rehabilitating addict.

She continues her description by outlining further factors that may benefit the programme, which she refers to as a change of 'playground, playmates and toys'.

The weakness of the programme is identified as being limited to those clients who either live with their parents or have significant others who are in a position to monitor their behaviour. The denial of parents or their unwillingness to accept the drug addiction and take control is considered a further shortcoming. This may also be evidenced by the parents' non-cooperation with the behaviour programme, through premature return of privileges or the use of negative feedback. Lastly she mentions that the programme is of limited

use to those clients who have either exhausted their support structures or do not have any.

Her description continues with the focus on Philip. She reports that he found it difficult to accept boundaries placed on him by society, exercising strength in manipulation and the avoidance of responsibility for his behaviour, preferring to place blame on others for his life. The psychologist states that his substance abuse may have been inflamed by his need for recognition and acceptance from his peers. She furthermore suggests that Philip showed a challenging, fearless and confident attitude, which may have contributed to his need to find new challenges. Family patterns such as the helplessness experienced by his parents may have provided him with more power, aided by rescuing patterns during the course of his addiction.

She also suggests the possibility of unresolved familial problems that changed focus and enabled members to stand together in the face of 'Philip's problems', which helped them to avoid dealing with these problems. These patterns needed addressing once Philip's behaviour had changed.

According to the psychologist, personal characteristics that contributed to Philip's abstinence include his confidence, strong will and intelligence, with the ability to gain insight into the negative consequences of his behaviour. Eventually, failure to manipulate the household at will brought about a change. She furthermore describes his need for recognition as

a motivating factor in changing his behaviour to gain recognition in an acceptable way.

After various rehabilitation efforts and a prison sentence, financial and emotional sources of support had largely been exhausted. In her understanding, the support of his family was important enough for him not to exhaust the support system completely.

The psychologist concludes her description by commenting on the support his family had shown and their adherence to the programme as a major contributing factor to the successful completion of the rehabilitation programme.

A Significant Other's Description.

Among those identified as significant role players was Philip's father, who describes his role in the rehabilitation process as one of support. He reports having tried not only to provide care and support for Philip, but also for his wife (Philip's mother) and mother-in-law (Philip's grandmother) in their efforts to love and support Philip.

He describes how he attempted to correct Philip's mistakes by replacing items he had stolen, protecting him from the police and by financing his addiction.

His father indicates that they were only in a position to understand the characteristics of such an addict once it became clear exactly what his problem was. In trying to understand addiction, by reading magazines and books, they

came to the realisation that it was a much bigger problem than they had initially understood. Tough Love was a further source for information about addiction and provided the family with support. He comments on their realisation that Philip was to be the one who needed to make the real change, mobilising the family to build up reserves of energy for their role in the rehabilitation process.

Philip's father recalls a low point in his life when he found Philip one cold night in Hillbrow, where he initially did not recognise him. He describes Philip as smelling bad, being dirty, thin and hardly able to walk. This brought him to believe that Philip had gone beyond the point of no return.

His description continues with a statement that they believed rehabilitation to be the answer for addressing Philip's drug addiction and tried everything to have him admitted for rehabilitation. In hindsight he reports that rehabilitation was not the answer, since he tended to offer Philip the benefit of the doubt, and still tried to correct his wrongs.

His father suggests that after Philip had been admitted to four rehabilitation facilities, with the family continuing their support and their hopes being shattered with every relapse, they prepared themselves for the worst. This he refers to as the realisation that although they still loved him, heroin was too powerful and that they had insufficient power to defeat heroin.

In his father's opinion a breakthrough came one night when the police called and Philip's request for help was not met with the usual and expected response. His parents refused to pay bail and insisted that Philip stay where he belonged. His father recalls telling Philip that ruining his life is what eventually happens. Philip was scared and despised not being able to exercise free control over his life, in the cold and crowded prison where he was being held.

His father believes that Philip was trying to manipulate them by recounting possibly exaggerated stories about the harshness of prison. Although they noted a change, they insisted that the law take its course, as a last measure of desperation. His father mentions that Philip's realisation that he was not again being saved by his father may have signified a turning point for him. Although Philip thought he would get away with a rehabilitation sentence, thereby being saved from a jail term, his father reports to have worked together with the prosecutor by still refusing to pay bail or any fine imposed. Philip received a suspended jail sentence (of six months), which came as a big shock and in his father's opinion helped Philip most of all.

His father notes the work put in by himself and the prosecutor for the next court appearance, which resulted in permission for Philip to serve the remainder of his sentence in a rehabilitation facility. His father had requested that a proviso be included stipulating that breaking any requirements

within a five-year period would result in returning to prison. His father suggests that Philip realised after spending six weeks in prison that this would be his last chance at rehabilitation.

His father suggests that personal characteristics, which added to Philip's substance abuse, include his tendency to live for the moment and a lack of consideration for the consequences of his behaviour.

His father furthermore believes that Philip knew he had a loving family who were, however, not willing to sacrifice everything for him alone. He reports that Philip realised that everyone, including those in authority, have limits to what they will allow.

His father furthermore comments on factors that may improve the rehabilitation process and suggests that facilities should be stricter, allowing less time for freedom and personal activities. In the same line he criticises facilities for resembling a 'holiday resort' rather than places of recovery. He also notes the poor to non-existent availability of follow-up services on termination of rehabilitation.

Philip's father concludes his description with a comment that he is still hoping that it has worked.

Case Study Two: Miss X

Miss X is a 25-year-old, female rehabilitating drug addict. Substances of abuse included various drugs, e.g. lysergic acid

diethylamide (LSD/acid), MDMA (ecstasy), cannabis, prescription medications.

The effects of LSD start up to an hour after ingestion and may continue for approximately 12 hours. LSD is classified as a hallucinogen. The hallucinations produced may be auditory and/or visual and impair the addict's judgement, orientation, memory and emotion (Grills & Grills, 1988). Although LSD does not develop a physical dependence and therefore no withdrawal symptoms are experienced, death is often the result of impaired judgement and hallucinations produced by an adverse reaction to the substance (bad trip). 'Flashbacks', which refers to a reoccurrence of a 'bad trip', may be experienced up to several months after LSD was last ingested, and occur most frequently before falling asleep, whilst driving and during periods of high stress (Bennett & Woolf, 1991).

Ecstasy produces euphoria in low doses, but may produce hallucinations if taken in high doses (Pinger, Payne, Hahn & Hahn, 1995). Increased feelings of self-confidence, well-being and feeling close to others; a rise in blood pressure, body temperature and pulse rate; jaw clenching; teeth grinding; sweating; dehydration; nausea and anxiety may be experienced with the ingestion of ecstasy. Withdrawal symptoms experienced from the ingestion of ecstasy may include, lethargy, depersonalisation, irritability, emotional disturbances and depression (Australian Commonwealth Department of Health and Ageing, 2002).

Cannabis ingestion produces an altered time sense and impairs concentration; it may promote talkativeness, relaxation and an increased awareness of sound and colour (Galanter & Kleber, 1994). Cannabis ingestion does not produce physical dependence.

The IP's Description.

Miss X recounts her drug abuse and rehabilitation with painful memories, not only of herself but of others too. She titled her essay: "Looking Back at Me In-Sanity, A Slave to Humanity".

Her description starts off with an account of what she was like at the time and how she came to meet fellow drug abusers. She recalls her first encounter with cannabis, wanting to know what it was like and paying careful attention to doing it right. Miss X continues with a description of her first high and how she soon wanted more. This quickly developed into a pattern of regular cannabis smoking, averaging three to four joints a day.

During the same year she experimented with acid, but having been drunk and high already, she does not recall it affecting her. On the same night her friend nearly overdosed on cocaine, which although Miss X also wanted it, was not available to her. While also using slimming mixtures, her exposure to acid increased. She was counteracting bad trips with additional

cannabis, which left her paranoid, delusional and hallucinating.

Her description continues with the school becoming suspicious and her being sent for counselling for psychological problems. She was referred to a psychiatrist, who introduced her to sleeping tablets, tranquillisers and anti-depressants. An admission to a psychiatric clinic (also referred to as RF Five), exacerbated her addiction problems because of fellow patients teaching her about the great highs from prescribed medications. Her insistence that the medication was not working provided her with additional supplies together with those she resorted to stealing. She reports eventually obtaining the maximum dosage for an adult of such strong medication as the Schedule Six drug, Rohypnol.

In no condition to write her Grade 10 examinations, the school promoted her to Grade 11 because of her capabilities. She changed schools where she met new drug addicts and dealers. She recalls going camping for a weekend where everyone present was 'high'. She took sleeping tablets, tranquillisers, cannabis, LSD and ecstasy and does not recall the weekend at all.

She describes being caught by her father smoking cannabis in her room one morning, which resulted in her being taken to yet another psychologist who soon insisted that she be admitted for rehabilitation. A threat to be certified to a psychiatric institution convinced her to go.

She discusses her first admission to RF One, which she refers to as the bottom of hell. Her freedom was curtailed, she was forced to eat even though she was not hungry and had nothing to get high on. Drugs were freely available in this rehabilitation facility as visitors smuggled drugs, and Miss X made every attempt to cover up proof of taking drugs. Even coffee was consumed in excessive amounts, up to 15 spoons of instant coffee per cup. Miss X notes that therapy irritated her, they played games and watched movies about drug abuse and attended group sessions in which they were required to discuss their lives openly.

Feeling closed in, she decided to hide away. When she was found she received an injection to make her sleep as she reportedly had become violent and swore at the nurses, which she denies. When the staff at RF One became suspicious about her possible continued drug abuse she was tested and caught out. She now suggests that these tests should be routinely done even when there are no suspicions. She describes how two weeks after being admitted to the facility, a day or two before her 18th birthday, her withdrawals started, her whole body going into spasm. A cycle of receiving a 'cocktail' to help her fall asleep and waking up going back into spasm continued for a period of three days. She recalls her family thinking that she was going to die as well as feeling as though she was going to die and wishing that she would die so that the spasms could stop.

Whilst in RF One she received support from a heroin addict, which gave her hope. He was under the impression that she was a heroin or cocaine addict. At this point she reports realising how serious her addiction had become, which she had previously justified by thinking she was not on 'hard' drugs. She continues by explaining that after successfully completing her detoxification she felt more positive about stopping, but wanted her support structure (family) around her, which was not possible because her treatment was not over yet. A week later Miss X and three other inpatients ran away to town to buy alcohol and smoke cannabis. They returned, but their escape had been noticed and they received a warning. A second escape resulted in Miss X's dismissal from the programme, as it was believed that she could not be helped. She mentions that visitors should be searched for drugs, since they bring drugs in at will.

She initiated the next attempt at rehabilitation, and was discharged again because she was not co-operating. Miss X describes that she does not remember much about this time in her life. She changed to a new psychologist, who referred her to a psychiatrist and a neurologist, and was again put on medication, which she reports to have taken as directed.

Miss X notes how she reached a point where she was convinced that the medicine was killing her and she decided to inform all of the doctors that she was going to stop taking her medication and was not going to see them any more. Because of

their belief that she was ill and needed medication they did not agree with her decision. Only her psychiatrist supported her and stood by her whilst requesting her to keep him informed. She writes that she has not looked back.

Although Miss X is of the opinion that rehabilitation facilities are a good starting point, she indicates the need for the individual to decide for himself/herself to stop. She indicates that rehabilitation initiates the ideas of how to do it and forces the addict to have a clear frame of mind to make this decision. She furthermore notes that it was during rehabilitation that she realised she had a serious problem, which she had previously managed to deny.

Miss X's description continues with a statement about her continued need for drugs over a period of four to five years. Although she has been clean for four years she admits that it has not been an easy life. According to Miss X the first two years were comparatively easy. On meeting a new colleague she joined in smoking cannabis again. She recalls enjoying it but experiencing intense disappointment in herself and questioning whether this was a relapse. Convinced that she did not want or need a relapse and a return to her old ways, she decided to resign and seek new employment. To her despair, she found that at her new place of work she is also faced with the daily struggle of trying to avoid being sucked back in. Most of the staff abuse drugs and she feels under great pressure to maintain her abstinence.

Miss X's essay concludes with an admission that she feels truly stuck at this moment and feels she must fight on her own. She reports knowing that support systems are good, and that all she needs to do is say no, but finds this very difficult, which is why the threat of relapse keeps haunting her.

Miss X does not report to be fully rehabilitated, and because of the daily struggle does not believe that any addict can ever be.

Spirituality has served as a support system for her, her own strength of character has increased and she would like to use her experience to help others obtain and maintain abstinence. Miss X suggests that it is necessary for an addict to change his/her lifestyle if he/she wishes to maintain abstinence.

Miss X suggests that rehabilitation facilities should run support programmes for a number of years after completion of the formal rehabilitation programme. Should a rehabilitating addict require support in ten years' time, there should be a structure in place. She furthermore feels that family and friends should be aware of the long-term nature of rehabilitation to avoid causing further pain and disappointment if a rehabilitating addict seeks support.

Miss X feels alone in her struggle to prevent relapse, and fears that approaching someone for support would hurt and confuse her family. Since her family and friends are not aware of the long-term nature of rehabilitation, she fears that

seeking support would be considered as a sign of returning to her life as an addict. Her description is brought to a close with a statement about willpower not being enough for everyone. She fights relapse on her own by simply saying 'no', but notes that for other addicts this may not be enough and for them the addiction cycle starts again.

A Psychologist's Description.

No response was received from the psychologist, although he initially agreed to participate. After numerous unsuccessful attempts to obtain his continued participation the researcher decided to exclude him from the research study.

A Significant Other's Description.

Miss X's mother, identified by Miss X as a significant role player, agreed to participate in an interview about Miss X's drug abuse and rehabilitation. The interview transcript begins with a discussion of Miss X's mother's involvement in the rehabilitation process. She indicates that from the school side, which was where Miss X's drug abuse was first noticed, the family did not really fit in. She describes how a teacher at the school referred Miss X to a psychologist and that the family was not informed about the drug abuse, although both the school and the psychologist were aware of it. Miss X was soon afterwards admitted to RF Five where they were not allowed to visit her for the first week. Although she was only

supposed to spend a week at this facility, they were informed that therapy had not been completed and that the facility would like Miss X to stay a while longer. It was at this time that Miss X's parents found out that she smoked cigarettes, but they were unaware of the other drugs she was abusing. Although the facility reportedly knew about the drug abuse, she was not admitted for this, but rather for depression and was put on suitable medication. She mentioned to the researcher that Miss X deteriorated while she was at this facility. Miss X mutilated her arms while she was there, which according to her mother was new behaviour, nothing like this had ever happened before.

Miss X's mother indicated that she is under the impression that this was a side effect of the medication that she had been placed on. In response to Miss X's various complaints doctors placed her on more and higher doses of medication, which she was using to get her high. Her mother describes how Miss X even managed to manipulate her, when she personally monitored her daughter's pills, thinking that they were being taken correctly.

Although RF Five as well as the school and initial psychologist were aware of the drug abuse, no-one had informed Miss X's parents of the abuse. A breach in client confidentiality and a long path through the grapevine resulted in her parents being informed about her drug abuse. Miss X's mother recalls their confrontation with their daughter, during

which Miss X denied the drug abuse until her father threatened her with the Narcotics Bureau. The discussion continues with a description of where she obtained her drugs and how her mother unwittingly took her there to visit.

Miss X's mother recalls a long history of therapy and their trying out various medications while Miss X continued to deteriorate. Miss X's mother recalls reading about the side effects of the various prescribed medications, which indicated contradictions to her. She read that the side-effects of sleeping pills indicated depression and the side effects of anti-depressants indicated insomnia, suggesting to her that they were working in a circle. Advice from a relative lead to therapy with another psychologist, who soon realised he was wasting his time and refused to continue until she was admitted for rehabilitation. When Miss X's parents met the psychiatrist who had been treating her to suggest that Miss X be admitted for rehabilitation, the psychiatrist was unwilling to sign Miss X off for rehabilitation at RF One. She describes how Miss X's father was confronted by the psychiatrist, who argued that Miss X could commit suicide in rehabilitation and that if anything happened she would lay charges of murder against Miss X's father. She was eventually signed off by the psychiatrist and admitted to RF One, where she underwent detoxification, spending her 18th birthday in withdrawal. A few weeks or months after she was discharged she returned to RF

One for a second attempt at rehabilitation, but was asked to leave because she was not co-operating.

According to Miss X's mother a referral to a neurologist and subsequent brain scans suggested that Miss X had schizophrenia. This lead to further referrals to yet another psychiatrist and frequent appointments with both of them. Another treatment effort involved electro convulsive therapy, at yet another psychiatric institution. Her mother then notes that Miss X reached a point where she decided that she had had enough and was going to stop taking all the medication, to which only her psychiatrist agreed. From this point Miss X's mother noticed remarkable improvements.

She continues by explaining that her decision had nothing to do with her parents' efforts at getting her to stop, but was her own decision. Although Miss X reportedly suffered from flashbacks for a long time, her mother has noticed a complete shift in her attitude, informing others of the dangers, and being ashamed of her old friends and way of life.

Her mother informed the researcher of her own need to prepare herself mentally that her daughter was going to die. Miss X was suicidal and nothing that they did seemed to be working. She feels strongly that the medication was her downfall, and that everyone tended to ignore her drug addiction and concentrated on her depression.

She recalls that her daughter was a normal teenager, who then started self-mutilating behaviour, running away etc. and

says that this was not like her. Professionals wanted to treat her for depression and ignored the addiction problem. Miss X's mother is of the opinion that the addiction process should have been addressed, since Miss X was a drug addict out and out, and her behaviour indicated the addiction not the depression.

Her mother mentions that they now have full confidence in her, but at the time, when they would ask her to promise not to go back, she wanted them to trust her while at the same time she was breaking that trust. She furthermore is satisfied that relationships between their daughter and the rest of the family have been restored, whereas at the time of Miss X's addiction they had felt that she hated them and they were constantly fighting. They reached a point where they had tried everything and yet nothing that they did seemed to be helping. Miss X's mother believes that praying a lot for her might possibly even have helped a bit.

Miss X has, in an effort to soften the scars from the past, gone for laser treatment for the keloids that developed on her arm where she had cut herself. Although she is still very self-conscious about these reminders, her mother thinks that her honest attitude about the past has helped her in moving forward.

She continues by describing how everything has changed. Whereas in the past Miss X refused to buy decent clothes and

her clothes were torn and had holes in, she now takes pride in her appearance and herself.

Miss X's mother makes some suggestions that could benefit the rehabilitation process. She outlines a procedure implemented at her younger son's school that she thinks is beneficial. It involves peer counselling and a helping and open attitude towards drug abuse together with strict control. Miss X's mother is of the opinion that the school should have informed them as parents about the drug abuse when they became aware of it, since their daughter was in grade 10 and still a minor.

Miss X's mother indicates that her daughter is an emotionally sensitive person and wonders what motivated her daughter in her decision to abstain. She thinks that it may have been a friend of Miss X's who gave her the strength, after she had decided. She furthermore feels that Miss X needs someone like her friend to help motivate and encourage her to maintain abstinence, which she feels she and her husband could not do at the time.

Conclusion

The above presentation described the data collected. The following chapter, Chapter 6, will discuss themes that have emerged and been identified in the research and construct the data obtained into a coherent whole.

Chapter 6: Discussion of Results

Introduction

Discussion of Results

- Themes from Case Study One
  - Systems: Rules, Boundaries and Hierarchy
  - Homeostasis and Morphogenesis
  - Circular Causality
  - Second-order Cybernetics
  - Punctuation
- Themes from Case Study Two
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Overall Integration of Themes

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Conclusion

Introduction

"The meaning of the somewhat mystical expression, 'The whole is more than the sum of its parts' is simply that constitutive characteristics are not explainable from the characteristics of the isolated parts." (von Bertalanffy, 1968).

It is therefore not entirely possible to separate the themes and elements of systems, since they all integrate into a whole, that is not explainable as characteristics of its isolated parts. However, for discussion purposes, themes will be conceptualised as separate entities. The following chapter will offer the identified themes by considering the theoretical concepts related to a systemic perspective. These will be discussed by presenting each case study separately. In closing, the themes will be discussed by highlighting the comparability of the case studies.

Discussion of Results

The theoretical concepts discussed in Chapter 3 will be used as the basis for the description of themes, identified in the research, to be presented below.

Themes from Case Study One

Themes discussed in this section will refer to the case of Philip and his significant role players.

Systems: Rules, Boundaries and Hierarchy.

Themes identified in the descriptions about Philip's drug abuse and rehabilitation all place the process in the context of various systems, rather than considering his symptomatic behaviour in isolation.

Philip discusses his membership in his peer group, generation, society, school and family, describing his role and interaction in these systems as a part of his drug abuse journey. His part in various rehabilitation facilities is recognised, providing an account of the interaction between various systems in the rehabilitation process. He includes government, the private sector, legal authorities, facilities, numerous professions, the drug culture, drug suppliers, fellow rehabilitating addicts and individuals in his description. In his account he includes personal subsystems referring to his mental and physical condition, aspects of his own characteristics, his future as a subsystem of himself in a different space etc. Philip's description therefore indicates sensitivity to and insight into his own role in the addiction as well as the richness and complexity of the drug addiction.

He expresses the rules according to which these systems function. In his discussion he sets out various criteria for membership as well as his contribution to the re-writing of commonly accepted rules in certain systems. He writes:

"... most of us came from very good homes and families and all had everything going for us, so contrary to what many

therapists believe, there was no foul play in most of our childhoods and no wrong upbringing or no sexual molestations as children or deep psychological problems." (Philip, Personal Communication, April 09, 2002).

Philip's account makes reference to the boundaries of various systems, of which many are described as diffuse.

"We all basically started it as a fun thing, not really realising how dangerous heroin was and how addictive it could be and how it would be affecting us and our families at a later stage in the addiction." (Philip, Personal Communication, April 09, 2002).

His description of termination the rehabilitation may be considered as rigid, qualified by the lack of interaction within and between identified systems.

"I went to this clinic three times and each time was very close to leaving the drugs totally, except the only problem is that there was never a support infrastructure after the rehab, even though my mom and dad were as supportive as persons could humanly possibly be." (Philip, Personal Communication, April 09, 2002).

Philip's father's description refers to various systems interacting in the process, identifying his own interaction with others in the process. These included the family, the addiction, Philip, numerous facilities, legal authorities, prison and support systems such as Tough Love.

His father recalls various instances in which the rules of the system may be identified. He indicates how Philip's behaviour would define his (the father's) own actions in many instances, also suggesting diffuse boundaries. In his discussion of the characteristics of an addict, he seems to acknowledge their increasing understanding of the rules and hierarchy within the family system.

"Once we established the 'typical' characteristics, we started to slowly build up our reserves of energy to realise that we had a role to play, but Philip was the one who had to make the 'real' change." (Philip's father, Personal Communication, May 24, 2002).

The psychologist provides an account of various approaches involved in the rehabilitation programme of RF Four, and how interaction with various systems might be addressed. Her discussion highlights aspects of Philip's interaction with society, his friends and the drug culture. She furthermore describes how various systems at play in the family may have interacted to produce the symptomatic behaviour as well as the resolution thereof.

Her review includes a description of the value of understanding the rules of the family as an essential part of the rehabilitation process. The rules are reviewed and used as part of a negotiation system for the rehabilitation process. The rehabilitation furthermore addresses rules for interacting

with various systems, in this addressing boundary issues and the hierarchical structure of numerous relationships.

All three of the research participants identify a shift in the hierarchical structure of various systems. Power mostly wielded by the IP during the drug addiction stages and early rehabilitation process, became more equally distributed in the process of rehabilitation.

> "We still loved him throughout, but realised the drug was too powerful and we, 'powerless'. … The additional elements that added to Philip's abstinence were that he realised we would not tolerate his behaviour any longer and if he did not change he would lose us and end up in jail." (Philip's father, Personal Communication, May 24, 2002).

Homeostasis and Morphogenesis.

In Philip's account of the system's functioning, he discusses the systems, their rules, the boundaries and the hierarchical structure. He furthermore explains these by referring to relationship patterns of the systems and how negative feedback functioned to maintain homeostasis. He writes:

> "I started at the age of about 14-15 years old and continued into my early twenties, with not much of many breaks in between, probably a maximum of about six weeks due to certain rehabilitations, but as soon as I got out I would

start using again." (Philip, Personal Communication, April 09, 2002).

Philip returning to his drug abuse as soon as he was discharged from the rehabilitation facility therefore maintained homeostasis. Change was resisted by returning to habitual patterns of interaction well known to the system.

His recollection of the rehabilitation process makes reference to positive feedback as a means to encourage deviation from these established patterns and enabling the evolution of new patterns in the interaction of systems.

"The losses of not following the programme were eventual prison sentences and serious damage to the family structure and friendship circle. The only condition that could trigger a relapse is returning to any part of the life I led while on drugs. This includes friends and places of drug use." (Philip, Personal Communication, April 09, 2002).

This indicates the evolution to a new state, where positive feedback encouraged deviation from previous norms in order to form new patterns of interaction.

Philip's father furthermore also highlights negative feedback as a means to maintain homeostasis by commenting that,

"At first, I was always trying to make the 'wrong' things that he had done, right. I would try to replace items of others, who he had stolen from, to finance his very expensive habit, or to protect him from police action by

being on his side with my time and efforts." (Philip's father, Personal Communication, May 24, 2002).

It may therefore be said that Philip's father's actions facilitated Philip's drug addiction rather than opposing the addiction.

He suggests various efforts at promoting morphogenesis by stating,

"Once we established the 'typical' characteristics, we started to slowly build up our reserves of energy to realise that we had a role to play, but Philip was the one who had to make the 'real' change. … Whilst watching his change to realisation that he was not going to get dad to 'save' him this time, it appeared that maybe the 'turning point' had been reached." (Philip's father, Personal Communication, May 24, 2002).

The psychologist specifically identifies Philip's father's attempts at rescuing Philip as maintaining homeostasis. She writes,

"The fact that his parents, and in particular his father, initially 'rescued' him from experiencing the consequences for his own actions resulted in him maintaining his bad behaviour and habits." (RF Four Psychologist, Personal Communication, April 29, 2002).

Although she also highlights morphogenesis in other aspects of family functioning, which needed to be addressed once he maintained abstinence, she notes,

"The support of his family and their determination to adhere to the behaviour program and not reward unacceptable behaviour contributed largely to the success of the program. His father found it very difficult initially." (RF Four Psychologist, Personal Communication, April 29, 2002).

The above descriptions all indicate the system's tendency to maintain homeostasis and to resist change. As discussed in Chapter 3, a range of acceptable behaviour is allowed during periods of homeostasis, where transgression of the limits will result in corrective action. In order for change to occur, patterns of interaction have to be reviewed when transgression of the limits can no longer be corrected by the rules regulating relationship. Various beliefs promoting change in the definition of relationships in the system may be reviewed during periods of transition, thereby encouraging deviation from previously acceptable norms. This process of change forms the underlying assumptions of organisations such as Tough Love.

Circular Causality.

Philip acknowledges problems associated with linear causality in his description and recognises the circular nature of causality in systems. He enters into a lengthy discussion about how various systems interact and mutually influence one another, writing,

"I think on this subject it is very difficult for anyone to uncover what caused the problem, but looking back at it now, I could possibly put some causes to it and even causes for today's problem." (Philip, Personal Communication, April 09, 2002).

His explanation includes the bi-directional interaction of systems on various levels, identifying pressure, youth activities, a medicinal culture, availability, education etc. as interacting in the process of drug addiction. Furthermore, his account of the various rehabilitation facilities describes circular causality in the successful attainment of abstinence. Although he acknowledges his own role in the process, he also implicates that of the facility, fellow in-patients, the underlying principles of the treatment process etc.

"I found this institution to be a total waste of time due to the fact that all they try to do to you is force some or other psychological problem on you that you don't have. Another problem is the fact that the place is basically like a holiday resort and there is not really any personal attention paid to each and every patient." (Philip, Personal Communication, April 09, 2002).

His father's discussion refers to the nature of circular causality in the family system, indicating the family's role in maintaining the drug addiction through their interaction with Philip. He describes the interaction with other systems, such as Tough Love, as part of the process of bringing about a

change in the interaction with Philip, shifting from maintaining the addiction to fighting the addiction. Philip's father discusses how his 'saving' Philip functioned to maintain the drug addiction and that through the understanding of addiction the family realised their need to evolve and to define new rules for the relationships. His discussion furthermore highlights circular causality of other systems, such as the legal system and rehabilitation facilities. From the systemic perspective, behaviour is the result of mutual influence of the various parts in the system. Considering behaviour in the context of various systems rather than in isolation therefore not only applies to the presenting problem but also to the process of change.

> "He asked me to go to court and stand bail. I refused and for the first time told him, this is what eventually happens, you ruin your life. This was a big shock to him. He was held in a very cold and crowded prison, with little comfort, (if any). This scared him and he hated not being able to do his 'own thing'." (Philip's father, Personal Communication, May 24, 2002).

> With regard to rehabilitation facilities he writes,
> "The weakness in the system is that some rehabs are more of a holiday camp than a place of recovery. Secondly, the resources for follow up afterwards are poor, to non-existent." (Philip's father, Personal Communication, May 24, 2002).

In her explanation, the psychologist suggests circular causality on various levels. Her description of the rehabilitation programme takes into account the bi-directional interaction of various parts of the system, thereby incorporating and addressing these in the rehabilitation process. She furthermore notes the importance of this interaction by highlighting a lack of interaction as a possible weakness of the programme.

> "The behaviour programme cannot be implemented when the clients do not live with their parents or significant others that can monitor their behaviour; when parents are in denial and unwilling to accept the situation and means to control their child's behaviour; when parents do not stick to the behaviour programme and either give privileges prematurely or maintain giving negative feedback that demotivates the child; when a client has either largely exhausted his support structure or has none." (RF Four Psychologist, Personal Communication, April 29, 2002).

She discusses various aspects of circular causality with regard to Philip's drug addiction and rehabilitation process.

> "It seemed that he needed the recognition and acceptance from his peer group and probably enjoyed obtaining the image of 'being good at being bad'. The community he lived in often referred to him as really bad and not a good influence. It seemed that he was perceived by friends and others as high up in the hierarchy of drug abusers and was

not to be played around with." (RF Four Psychologist, Personal Communication, April 29, 2002).

Her description furthermore includes a discussion of the family process in maintaining the substance abuse and later the maintenance of abstinence. As discussed above, circular causality may explain both the addiction as well as the evolution to abstinence.

Second-order Cybernetics.

Philip's essay seems to show support not only for circular causality but also suggests support for the concept of second-order cybernetics. In various explanations he describes the importance of considering the therapist as a part of the system, who exerts influence on the functioning of the system. He describes RF One,

"I found this institution to be a total waste of time due to the fact that all they try to do to you is force some or other psychological problem on you that you don't have." (Philip, Personal Communication, April 09, 2002).

In his explanation of RF Two he suggests,

"I also found that there was no real interaction between therapist and patient and the sessions were very few and far between." (Philip, Personal Communication, April 09, 2002).

He refers to the influence of individuals at RF Three and Four by stating,

"This person will always hold a very special place in me and I believe that he and 'Z' (the psychologist at RF Four) were the final two people who got me out of the slump that I had got myself into. … The whole style she uses is strict yet caring and you honestly feel that you have a friend to talk to." (Philip, Personal Communication, April 09, 2002).

Although Philip's father does not specifically refer to the interaction of the therapist in the process, he infers support of a second-order cybernetic approach by stating,

"My view on what elements would contribute to success in improving the process, would be that rehabs are generally too 'soft' and allow far too much freedom and spare time on their hands, and discipline should be stricter." (Philip's father, Personal Communication, May 24, 2002).

Similarly the psychologist at RF Four does not delineate second-order cybernetics in her discussion per se, although acknowledging the concept in her description. Wording of various descriptions suggests support for the importance of this view, indicating understanding of her influence in the rehabilitation process. Her role seems to be that of a co-writer in the rehabilitation process, rather than that of a prescriber of the 'cure'. She writes,

"It is therefore important that parents conduct the behaviour programme correctly in co-ordination with the therapist." (RF Four Psychologist, Personal Communication, April 29, 2002).

The above descriptions all indicate that the philosophy of the rehabilitation facility and that of the therapist influence the rehabilitation process. The research participants therefore show support of a second-order cybernetic approach by viewing the therapist as part of the system. This view may be contrasted with that of a first-order approach where the therapist is considered as the expert in a position to prescribe a cure. Placing the rehabilitation process in the context of various systems, rather than considering symptomatic behaviour in isolation, necessarily implicates the therapeutic system, where the therapist is considered as a co-author of the reality.

Punctuation.

Patterns of communication, which provide information about system processes, may be identified in the case of Philip. In his essay he describes the patterns of interaction between various sub-systems, highlighting both complementary and symmetrical sequences. Symmetrical sequences may be distinguished in his discussion of drug abuse with his peers and his own interaction with the substances of abuse. Earlier interventions described by Philip may be considered as complementary sequences of interaction, destructive acts and interaction met with constructive acts and interactions. Negative feedback functioned to maintain this sequence of interaction and maintain homeostasis. Once the system's rules,

boundaries and hierarchy had shifted, interaction took place on a symmetrical basis. Co-written goals to maintain abstinence and negotiate interaction facilitated the rehabilitation process.

Philip's father describes the same sequences of interaction. He writes,

> "I worked with the prosecutor and explained his habit. Philip was aware that we were now trying to help him, but I would still not pay bail or any fine, which may be subsequently imposed. … At the next court appearance, it was the work put in by myself and the prosecutor that finally allowed him to 'serve his sentence' at rehab with a proviso that if he broke conditions he would go back to prison. This is what I had asked for and felt was fair." (Philip's father, Personal Communication, May 24, 2002).

Similarly his father's description addresses a shift from complementary to symmetrical interaction, which facilitated the evolution to a new state.

The psychologist furthermore notes how the dynamics of family interaction are addressed as part of the rehabilitation process. She comments,

> "The restoration of family relationships and positive feedback by parents seem to be of significant importance to the drug users and addicts and motivate them further to abstain from substance abuse and change their unacceptable

behaviour." (RF Four Psychologist, Personal Communication, April 29, 2002).

Again, a shift in interaction enabled the system to evolve to a new state and maintain abstinence.

Themes from Case Study Two

Identified themes for the discussion of Miss X's case will be presented in the following section.

Systems: Rules, Boundaries and Hierarchy.

The case study of Miss X, similar to the case study of Philip, identifies various systems that interacted in the drug abuse and rehabilitation process.

Miss X's description identifies systems including peers, drug culture, school, numerous professionals and institutions, her family, relapse, support structures and personal beliefs etc.

Miss X's description includes references to the rules of various systems. She writes,

"Knowing my friends did it, I asked my closest friend to help me try it. All arranged, we went to meet another friend living in an Art House in Sunnyside, with intensions of getting stoned for the first time. Smoke break, sitting in an old school yard, we passed that first joint round (me looking at everyone closely to make sure I do it right and

not be laughed at)." (Miss X, Personal Communication, April 20, 2002).

She furthermore also describes rules of interaction in her family system and in various rehabilitation facilities.

"Complaining to doctors that they weren't working, that I couldn't sleep or relax, I was eventually given the maximum dosage an adult can get. … I had no appetite whatsoever and was forced to swallow my food, with someone sitting with me." (Miss X, Personal Communication, April 20, 2002).

It is difficult to comment on Miss X's reference to boundaries within systems. Although many boundaries may be considered as diffuse, simultaneously these may be considered as very rigid. Her interaction with many professionals, as with her family, was characterised by great manipulation, effectuating a response of yielding to her demands. However, a lack of interaction between various parts of the larger systems promoted the enmeshment within subsystems.

"The prescription drugs made it easy for me to get high on anything without people being suspicious." (Miss X, Personal Communication, April 20, 2002).

Similarly, the hierarchical structure of systems may be considered as somewhat misleading. Miss X wielded considerable power in numerous relationships. Although appearing to be in a position of powerlessness, she forged the assumed power of numerous professionals and that of her parents. According to Miss X the power distribution shifted when the system changed,

by showing trust in her ability. Miss X held power by allowing the therapists and her parents to believe that they held the power and used this position to maintain her substance abuse. Once she renounced her power position and cast off their power, change could take place.

> "It was then that I told all the doctors that I was going to stop with the medication as well as seeing them. All but my psychiatrist weren't fine with this, they believed I was ill and needed it, but my psychiatrist who is a wonderful person whom I came to trust greatly stood by me and agreed with my decision. I have not looked back." (Miss X, Personal Communication, April 20, 2002).

In line with Miss X's description, her mother identified the same systems, but adding to these the extended family. Although both identified many of the same systems, Miss X's description focuses largely on her peers, professionals and rehabilitation facilities, where her mother focuses more on the school, drug suppliers (including professionals) and the family system.

Miss X's mother refers to the rules of various systems, mostly those interacting with the familial subsystem, rather than those within the familial system. She recalls the process of interaction between the family and various professionals and rehabilitation facilities. These rules contributed to defining the boundaries as mostly rigid with regard to their

interaction with the rehabilitation system, allowing little interaction between the two.

She continues to describe the hierarchical structure by indicating that the source of power remained mostly with the professionals and rehabilitation facilities and Miss X. Miss X's mother explains,

> "… my husband said, look I am putting her into '*RF One*', I don't care what you say. And she said, Mr … , I am telling you now, if your daughter commits suicide or if anything happens, I will have you up for murder. And he said, well have me up for murder, I will fight for my daughter." (Miss X's mother, Personal Communication, April 16, 2002).

This shift in power may have started the process of change.

Homeostasis and Morphogenesis.

In the case of Miss X, as in the case of Philip, the cycle of negative feedback maintaining homeostasis signifies the difficulty in reaching a lasting new drug-free state.

Miss X makes reference to various attempts of the numerous interacting systems to maintain homeostasis. Her description includes the negative feedback that functioned to maintain her addiction. She writes,

> "So I began having more A trips, almost every weekend, laughing at people and staring into mugs of coffee after the night out, admiring the patterns inside. Had some bad trips, but this didn't stop me from wanting more, when this

happened I would run outside and smoke a joint and I felt great again. Paranoid, delusional and hallucinating." (Miss X, Personal Communication, April 20, 2002).

The above statement indicates that the drug intoxication process also functions to maintain homeostasis by taking corrective action once the limits of acceptable behaviour have been transgressed. In her description she refers to the school system also functioning to maintain homeostasis.

"At school I didn't even do my exams, but because they knew my capabilities they promoted me to standard 9." (Miss X, Personal Communication, April 20, 2002).

Her account of her experience also suggests positive feedback, which enabled the progression to a new state. She explains,

"One needs to choose for yourself when you are going to stop. Rehabs are good places to begin to bring this idea forward, with your mind being clean and not high all the time. I found I didn't believe I had a problem until I went through what I did, and this is something I think most addicts go through. That word 'denial' just seems ridiculous at the time, but it's really very true, and I understand this concept completely since experiencing it." (Miss X, Personal Communication, April 20, 2002).

In the above statement Miss X refers to a stage in the process where the transgression of limits can no longer be corrected by the same regulating relationship rules, thereby

necessitating change. Positive feedback therefore functions to encourage deviation from previous norms.

Miss X's mother, especially refers to the predictable pattern of attempts to maintain homeostasis, in particular noting their frustration with this.

> "So two weeks go by and still no improvement. Eventually she was looking like a zombie, arms hanging and not focusing whatsoever. And the more I kept on going in there and saying, listen I feel we are not going anywhere. You're giving her anti-depressant, but I read side effects on anti-depressant are insomnia; you are giving her sleeping tablets, but the sleeping tablets' side effects are depression. We are going in a circle not achieving anything. No but we've got to find the right anti-depressant tablet for her." (Miss X's mother, Personal Communication, April 16, 2002).

Her description recounts numerous efforts, similar to the above. She mentions a limited number of attempts to evolve to a new state. Descriptions include,

> "So he phoned and he said, I refuse to see her anymore unless she goes into a drug rehab." (Miss X's mother, Personal Communication, April 16, 2002).

Miss X's attempt at evolving to a new state is described by her mother as,

> "So she then said she's had it now, she's going to stop all her medication. So I said, you just better phone 'Dr …'

quickly. And she phoned him and he said to her, well fine if that's what you feel, let's try it, let's try and see. Phone me in two weeks, and then he spoke to me and he said, let me know in two weeks how you think things are going. Two weeks went by and, wow, … things were starting to improve." (Miss X's mother, Personal Communication, April 16, 2002).

Similarly, this indicates that previous habitual patterns were discarded in order to develop new patterns. Positive feedback functioned to encourage deviation from previous norms.

Circular Causality.

Miss X describes circular causality throughout her essay. She identifies various systems in which she credits the bi-directional influence of various parts of different and related systems. Her discussion of circular causality focuses not only on the journey through addiction, but also on her rehabilitation. She acknowledges subsystems within herself in the interaction with various peers.

"Being a creative person, rather quiet, intelligent, wanting to explore life, I came to meet friends older than myself, pulling myself away from my school friends and wanting to be an individual not associated with the normal things in life. Sunnyside, what should've been became the start of my 'dark side'." (Miss X, Personal Communication, April 20, 2002).

She furthermore refers to the rehabilitation process as circular in nature by suggesting,

"Perhaps if they had kept me in a more secure place or looked at us more frequently it would not have happened, but then again if I wanted their help I wouldn't have jumped - maybe, all the maybes!" (Miss X, Personal Communication, April 20, 2002).

Circular causality thereby places the addiction and the rehabilitation in the context of various systems, as opposed to a linear view, which focuses on the individual as the locus of the dysfunction. Miss X suggests throughout her description the bi-directional interaction in the escalation of her substance abuse, the development of rules, boundaries and hierarchy, as well as the evolution to morphogenesis. Her description of the rehabilitation process also refers to daily interaction with systems and circular causality in relapse prevention.

"I think a good thing to bring into the rehab system is that they run it for years after your first treatment with them, that once you have completed your treatment with them, at any time of your life, be it in 10 days or 10 years, should you feel you need that support, that it is awaiting, and that the family and friends involved become aware of this in the beginning of the treatment so that there is no pain or hurt inflicted upon any of the parties. I say this because the words 'Do Not Relapse' are constantly on my mind and

although I would like to speak to someone concerning this, I know I can't because it would mean I have to confront a lot of people who I care about and love a lot and do not want to 'confuse' in any way." (Miss X, Personal Communication, April 20, 2002).

Again, this indicates circular causality in terms of the addiction and the rehabilitation process, where behaviour is the result of mutual influence of various parts of the system.

Miss X's mother supports the concept of circular causality in her discussion. She discusses the mutual influence of numerous systems in the maintenance and escalation of drug abuse, as well as the interaction of Miss X with various systems in the attainment of abstinence. She comments,

"... when she eventually came home with the medication, I carried it in my bag. I used to monitor the pills, I used to give them to her, I used to give her a sleeping tablet, Rohypnol, and she used to come into our room at ten, half past ten at night and say, I want my sleeping tablet I can't sleep, please give me another half. And then I'd say, but I can't, and then she'd say, but I can't sleep, I am wide awake. And then I'd break it in half and give her half. In the meantime, little did I realise this was all for getting high." (Miss X's mother, Personal Communication, April 16, 2002).

This statement furthermore serves to illustrate bi-directional causality, by highlighting the behaviour as a result of mutual influence.

Second-order Cybernetics.

A second-order cybernetic understanding of the rehabilitation process may also be identified in the case study of Miss X. Throughout her essay she describes her view of the professionals as influential on the process, though indicating their outlook as that of experts outside the system of change. She writes,

> "By this time I changed my psychologist, who also referred me to a neurologist and psychiatrist. I was put onto medication again, but drank it properly this time. At a point I felt as though I was going to break down, as if the medicine was killing me, it didn't make me feel good at all. It was then that I told all the doctors that I was going to stop with the medication as well as seeing them. All but my psychiatrist weren't fine with this, they believed I was ill and needed it, but my psychiatrist who is a wonderful person whom I came to trust greatly stood by me and agreed with my decision. I have not looked back." (Miss X, Personal Communication, April 20, 2002).

This statement strongly supports the importance of viewing the therapist as part of the system, and acknowledges the influence that this interaction has. As discussed in Chapter

3, a first-order approach views the therapist as the expert in a position to prescribe behaviour, whereas a second-order approach acknowledges that a therapist is not able to fully understand the reality of another individual and therefore functions as a co-author of the reality.

Miss X's mother recalls various interactions in which professionals did not follow a second-order cybernetic approach. In her description of the process she suggests support of a second-order cybernetic approach by including the interaction of the various professionals in her description of the escalation of the drug abuse. She explains how professionals commented on the process from a higher level, dictating and diagnosing across the spectrum. Explanations varying from depression to possession, to claims of schizophrenia, not addressing the substance abuse or integrating these in the co-created reality. She explains,

> "The real problem was she was a drug addict, out and out. And they were treating her for depression." (Miss X's mother, Personal Communication, April 16, 2002).

Punctuation.

Patterns of communication in the case of Miss X may be identified, and should be considered, on multiple levels of the interaction within various systems, although many professionals interacted with her in a traditionally accepted 'doctor and patient' relationship, in which from their view

they took the dominant position, placing her in an inferior position. Miss X engaged in a similar complementary relationship with the professionals, whereby she took the dominant position and determined the outcome of their interaction with her. Looking at both these perspectives, it may also be said that they may have engaged in a symmetrical relationship, whereby both elements of the system were competing for the dominant position.

She refers to this interaction throughout her essay, indicating how the drug abuse escalated through this interaction, in which she would express a need for and obtain additional medication by means of the professionals involved. Placing the addiction in the context of the system, indicates that this interaction prohibited change. A shift in this interaction then allowed for the evolution to a new drug-free state.

Miss X's mother also makes reference to the symmetrical relationship on various levels. She adds to this the patterns of interaction within the family system, suggesting a complementary relationship in which Miss X took the dominant position. She comments,

> "And I thought, I must listen to her because I have enough trouble emotionally with her, and I thought, let me just keep this child happy. We were trying to keep her happy." (Miss X's mother, Personal Communication, April 16, 2002).

Overall Integration of Themes

The above section has focused on presenting themes identified in the research separately for each case, highlighting the uniqueness of each case. However, looking at them systemically, certain common themes may furthermore be identified. These will be discussed in Chapter 7. They apply not only to these cases, but may be compared to other cases as well as literature.

Isomorphy.

Complex structures may be mapped onto each other, enabling the identification of comparable structures, referred to as isomorphism (Simon, Stierlin & Wynne, 1985). Systems or structures may be compared on grounds of the interaction that takes place in these.

Looking at the above case studies in this way, numerous themes may be identified.

- Systems: Rules, Boundaries and Hierarchy

  In both case studies the research participants placed the addiction and rehabilitation in the context of the systems, rather than looking at these in isolation. Rules of the system were described in both cases, as well as the permeability of boundaries.

- Homeostasis and Morphogenesis

  How negative feedback functions to maintain homeostasis was illustrated in each account of the experience, as was the evolution to a new state, through positive feedback.

- Circular Causality

  The research participants in both cases, describing mutual influence on various levels of the systems, set out the circular nature of causality.

- Second-order Cybernetics

  Although both cases support and identify the importance of a second-order cybernetic approach, reports vary with regard to an overall subscription to this belief.

- Punctuation

  Complementary and symmetrical patterns could be identified in both cases, as well as a shift in the sequences of interaction throughout their addiction and rehabilitation journey.

Conclusion

At this stage it is important to consider second-order cybernetics in view of the influence exerted by the researcher, in terms of the data received, the theory followed and personal characteristics, in order to arrive at the selection and description of themes. The essay guidelines

provided to the various research participants have been included in Appendix A to allow insight into how this may have influenced the data received.

An integration of the themes was introduced in this chapter which will be elaborated on in the following chapter. Chapter 7 will also provide a summary of the research project as well as drawing some final conclusions.

Chapter 7: Conclusion and Recommendations

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Introduction

Integration of Identified Themes with Literature

A Systemic Conceptualisation of Drug Rehabilitation Programmes

Recommendations

Conclusion

. . . .

Introduction

This concluding chapter aims to tie together the preceding chapters. The literature will be reflected on with regard to the themes identified in Chapter 6. This will be followed by a brief discussion of a systemic conceptualisation of drug rehabilitation programmes. A number of recommendations will then be presented, followed by a few closing remarks.

Integration of Identified Themes with Literature

A systemic conceptualisation of the themes identified in Chapter 6 reflects the literature review discussed in Chapter 3. This may be elaborated on by relating these themes to

research conducted in the field of drug rehabilitation programmes.

Ripple & Luthar, (1996) indicated similar themes in their research, suggesting interpersonal boundary issues and issues related to the hierarchical structure as two themes that emerged repeatedly. A study by Stanton (1997) showed increased success rates among programmes which include the family as opposed to those that do not consider larger systems. Visser's (1999) discussion about the influence of socio-economic influences on drug addiction trends implicates the interaction of macro-level systems.

The case of Miss X supports the potentially inappropriate goal, as identified in Chapter 2 by Galanter & Kleber (1994), of avoiding pharmacological treatment of insomnia, depression and anxiety observed during intoxication and withdrawal. In her case this not only exacerbated her drug abuse but also prohibited focus on the addiction and rehabilitation process.

The role of Correctional Services as a related system in drug abuse and rehabilitation has not received much attention in this dissertation. Philip's interaction with the correctional system warrants a brief discussion, although it is recognised that an elaborate account of their contribution would require extensive research in its own right. Galanter & Kleber (1994) suggest the following elements for successful rehabilitation in prisons:

- committed and qualified staff;

- separation from the general prison population;
- a comprehensive therapeutic approach, considering various aspects of the drug abuser's life, not merely the substance abuse;
- continued support after release from prison.

A prison environment may, however, be less conducive to the realisation of these elements than a residential rehabilitation facility.

Philip mentions the absence of rehabilitation programmes in prison and the ready availability of various drugs in prisons as a free passage for continued drug abuse with limited obstacles.

A Systemic Conceptualisation of Drug Rehabilitation Programmes

From the very outset this research has been contextualised in the systemic perspective. The literature reviewed paid particular attention to a systemic perspective of drug abuse and rehabilitation, as did the motivation behind the research. The research analysis furthermore took place in the framework of a systems approach and from this flowed the discussion of the data received from participants.

The data provided a rich discussion of the experience of several of the significant role players in the rehabilitation process. Considering these from a systems approach highlighted many useful elements for consideration of both the rehabilitation process and rehabilitation programmes. In

Chapter 2 a number of these elements were highlighted by suggesting client-oriented goals as well as goals for rehabilitation programmes as an integral part of the system. These all included the consideration of systems at various levels, including macro-level systems such as government policies and micro-level systems, i.e. the individual and his / her numerous sub-systems.

Meetings with numerous rehabilitation facilities indicated their intention to address various systems on various levels. They encourage active participation in policy issues at macro levels, and consider elements related to family and social functioning, the spirituality of the individual as well as health issues, including dietary programmes.

The experience of the drug addiction and rehabilitation process is indicated by all research participants as taking place within various systems. The rules, boundaries and power structures are identified, as well as explanations of how these operate. Circular causality is explained in the process of homeostasis and morphogenesis. All elements of the system affect the process and are affected by it, suggesting the importance of their active inclusion in the programme.

The data received could have been considered from various other theoretical orientations. It is nonetheless the aim of this dissertation to consider the data and drug rehabilitation programmes and to report on these from a systems perspective. It can therefore be said that the researcher recognises the

influence of the approach (e.g. the basic assumptions of a systemic perspective such as circular causality) and self (e.g. understanding, interpretation and selection of the research data) on the research process and findings, thereby subscribing to a second-order cybernetic approach.

Recommendations

By looking at drug abuse and rehabilitation from a systemic perspective and especially by considering the information supplied by the various research participants, the following suggestions may be proposed:

- that drug abuse and rehabilitation are placed in the context in which they develop and are addressed in this context, by an integrated effort to include significant role players in the process. According to Keller, Galanter & Weinberg (1997) family members and friends should be recruited to provide ongoing support and to promote attitude and behaviour change in the addict, to prompt the achievement of abstinence and the attainment of a drug-free adaptation to life. They furthermore consider the family members and friends an invaluable resource for the addict in the achievement of these goals.

  From the systemic perspective, behaviour i.e. addiction as well as abstinence should be placed in the context of

various systems, rather than viewing this behaviour in isolation;

- that rehabilitation programmes consider the long-term nature of the process. According to Gossop, Marsden, Stewart & Rolfe (1999) studies have shown that successful outcome in therapeutic communities is related to the length of time spent in treatment. This was also identified by some of the research participants. Philip remarked specifically on the long-term nature of psychological issues as opposed to the comparatively short-term nature of physical dependence.

  The process of negative feedback functions to resist change and maintain homeostasis. Transgression past limits of acceptable behaviour during periods of homeostasis results in corrective action. Once transgression of these limits can no longer be corrected by the same habitual patterns, evolution can take place. The process of homeostasis (resistance to change) and morphogenesis is long-term in nature and thereby reflects the long-term nature of the rehabilitation process;

- that in line with the above recommendation the system of time be included in this process, by providing suitable support structures after the termination of official rehabilitation programmes. This was a suggestion made by numerous of the research participants and identified by

Parry & Bennetts (1998) as a major shortcoming in the services available in South Africa;

- that not only a systems perspective is important in the rehabilitation process, but more specifically a second-order cybernetic approach. The professionals both affect the system and are affected by it, thereby necessitating a stance which takes this into consideration.

  A second-order approach acknowledges the multiple ways in which systems may function successfully. The first-order approach, which accepts the therapist's ability to fully understand another individual and prescribe behaviour, is therefore considered limiting.

  Similarly the interaction between various role players was furthermore highlighted, in which the co-written meaning of experiences was awarded more credibility than the subjective process of prescription;

- the previous suggestion also implies a need for the co-ordinated efforts of various rehabilitation programmes and other existing structures to counter drug abuse. Swarts (1997) supports this in suggesting the need for close co-operation among all role-players through a comprehensive initiative involving numerous systems including criminal justice, education, labour and industry;

- that serious measures are taken to control the inflow of drugs into rehabilitation facilities. Research

participants all highlighted ready availability of drugs as a major rehabilitation obstacle and noted that searching visitors or any conscientious effort would help curb the inflow.

Visitors therefore should be considered in terms of their role in circular causality and as a part of the rehabilitation system;

- that rehabilitation facilities in South Africa research the effectiveness of programmes with longitudinal studies, determining the rate of relapse and maintenance of abstinence. Initial inquiry at rehabilitation facilities about their success ratios suggested that most rehabilitation facilities, although claiming significant success, have no statistics available to support their claims. According to Apsler (1996) there is no single definition that constitutes effective drug abuse treatment. He suggests that a broad definition of effectiveness usually includes drug abuse, illegal activities, employment, length of stay in treatment, social functioning, intrapersonal functioning, physical health and longevity.

  Various interacting systems are therefore implicated in this broad definition.

The psychologist at RF Four provided a rich description of systems functioning and the interrelatedness of a complex

system by promoting a need for change in the 'playground, the playmates and toys'.

Conclusion

The impact of drug addiction and the attempts at rehabilitation will continue to be felt in times to come. It is assumed that placing this problem in the context of various systems will provide further understanding into the functioning of drug abuse and thereby also into the interactive process in rehabilitation. Of course, considering anything in terms of all interacting systems would neither be possible nor plausible. Yet it is argued that a belief in the interaction and the importance accorded to it would be an essential part of addressing drug addiction and rehabilitation issues.

The uniqueness of all situations and individuals should be respected, yet accompanied by understanding of patterns from various systems in the informed approach to guiding an individual to a drug-free life.

Crome (1999), argues that experience of working with substance abusers has shown that they present to substance abuse services with a vast array of needs and problems. Therefore any treatment plan must consider the complex psychosocial matrix in which addicts who come for treatment are embedded. Treatment for substance abuse must be considered as a dynamic process rather than a static process, in which

presented information and therapeutic judgement interact in order to develop the most favourable options for the rehabilitation.

Reference List

Ackerman, N. W. (1994). The Psychodynamics of Family Life: Diagnosis and Treatment of Family Relationships. New Jersey: Jason Aronson Inc.

Anchin, J. C. & Kiesler, D. J. (Eds.). (1987). *Handbook of Interpersonal Psychotherapy*. New York: Pergamon Press.

Apsler, R. (1996) Is Drug Abuse Treatment effective? What We Know. What We Don't. What This Means for the Nation's Drug Strategy. *Drugs, Society and Behaviour, 11,* 240-245.

Atkinson, B. J. & Heath, A. W. (1990). Further Thoughts on Second-Order Family Therapy - This Time It's Personal. *Family Process, 29, 145-155.*

Australian Commonwealth Department of Health and Ageing (2002). *Alcohol Handbook, Chapter 11: Ecstasy.* Canberra: Author. Retrieved August 18, 2002 from the World Wide Web: http://www.health.gov.au/pubs/drug/alc_hand/alc_c11.htm#alcohol%20hbk%20ch11%20WITHDRAWAL%20SYMPTOMS

Avis, P. , Pauw, A. & van der Spuy, I. (2000). *Psychological Perspectives: An Introductory Workbook*. Parow: Pearson Education South Africa.

Babbie, E. (1992). *The practice of social research (6th ed.)*. California: Wadsworth.

Barker, P. (1986). *Basic Family Therapy (2nd ed.)*. London: Blackwell Scientific Publications.

Barlow, D. H. & Durand, V. M. (1995). *Abnormal psychology: an integrative approach*. California: Brooks/Cole.

Becvar, R. J. & Becvar, D. S. (1982). *Systems Theory and Family Therapy*. Lanham: University Press of America.

Bennett, E. G. & Woolf, D. (Eds.). (1991). *Substance Abuse: Pharmacologic, Developmental, and Clinical Perspectives (2nd ed.)*. New York: Delmar Publishers.

Bentovim, A., Barnes, G. G. & Cooklin, A. (1987). *Family Therapy: Complementary Frameworks of Theory and Practice*. San Diego: Academic Press Limited.

Breakwell, G. M., Hammond, S. & Fife-Schaw, C. (Eds.). (1995). *Research Methods in Psychology*. London: Sage.

Burnham, J. B. (1993). *Family Therapy. First steps towards a systemic approach*. London: Routledge.

Cerff, P. (1999). Specialist Treatment Centres. *South African Community Epidemiology Network on Drug Use (SACENDU): Monitoring Alcohol and Drug Abuse Trends, Proceedings of Report Back Meetings, Phase 6,* 75-85. Tygerberg: Medical Research Council.

Corey, G. (1996). *Theory and Practice of Counseling and Psychotherapy (5th ed.)*. Pacific Grove: Brooks/Cole Publishing Company.

Cottone, R.R. (1991). Counselor Roles According to Two Counselling Worldviews. *Journal of Counselling & Development, 69*, 398-401.

Creswell, J. W. (1998). *Qualitative Inquiry and Research Design: Choosing Among Five Traditions*. California: Sage.

Crome, I. B. (1999). Treatment Interventions - Looking Towards the Millennium. Drug and Alcohol Dependence, *55*, 247-263.

Drug Advisory Board. (1999). *National Drug Master Plan.* Pretoria: Author.

Fox, R. (1993). *Elements of the Helping Process: A Guide for Clinicians*. New York: The Haworth Press.

Freeman, D. S. (1992). *Multigenerational Family Therapy*. New York: The Haworth Press.

Froneman, S. (1999). Brief Input on the Situation in Bloemfontein. *South African Community Epidemiology Network on Drug Use (SACENDU): Monitoring Alcohol and Drug Abuse Trends, Proceedings of Report Back Meetings, Phase 6,* 13-15. Tygerberg: Medical Research Council.

Galanter, M. & Kleber, H. D. (1994). *The American Psychiatric Press Textbook of Substance Abuse Treatment*. Washington: American Psychiatric Press.

Ghodse, H. (1995). *Drugs and Addictive Behaviour: A Guide to Treatment*. Oxford: Blackwell Science.

Gillis, H. (1997). *Counselling Young People*. Pretoria: Kagiso Publishers.

Gossop, M., Marsden, J., Stewart, D. & Rolfe, A. (1999) Treatment Retention and 1 Year Outcomes for Residential

Programmes in England. *Drug and Alcohol Dependence, 57 (2)*, 89-98.

Government Gazette of the Republic of South Africa. (1992). No. 140 of 1992: Drugs and Drug Trafficking Act, 1992. Pretoria: Government Printer.

Grills, J. & Grills, M. (1988). *Drug Abuse*. Oxford: Oxford University Press.

Harrison, P. A. & Asche, S. E. (1999) Comparison of Substance Abuse Treatment Outcomes for Inpatients and Outpatients. *Journal of Substance Abuse Treatment, 17 (3)*, 207-220.

Hoffman, L. (1981). *Foundations of Family Therapy: A Conceptual Framework for Systems Change*. New York: Basic Books Inc.

Ivey, A. E., Ivey, M. B. & Simek-Morgan, L. (1993). *Counselling and Psychotherapy: A Multicultural Perspective (3rd ed.)*. Boston: Allyn & Bacon.

Kaplan, H. I. & Sadock, B. J. (1998). *Synopsis of Psychiatry: Behavioral Sciences/Clinical Psychiatry (8th ed.)*. Baltimore: Lippincott Williams & Wilkins.

Keller, D. S., Galanter, M. & Weinberg, S. (1997) Validation of a Scale for Network Therapy: A Technique for Systemic Use of Peer and Family Support in Addiction Treatment. *American Journal of Drug and Alcohol Abuse, 23 (1),* 115-128.

Levant, R. F. (1984). *Family Therapy: A Comprehensive Overview.* New Jersey: Prentice Hall.

Loneck, B., Garrett, J. A. & Banks, S. M. (1996). A Comparison of the Johnson Intervention with Four Other Methods of Referral to Outpatient Treatment. *American Journal of Drug and Alcohol Abuse. 22 (2),* 233-247.

Maykut, P. & Morehouse, R. (1995). *Beginning qualitative research: a philosophic and practical guide.* London: The Falmer Press.

Miles, M. B. & Huberman, A. M. (1994). *An Expanded Sourcebook: Qualitative Data Analysis* (2nd ed.). Thousand Oaks: Sage.

Parry, C. D. H., & Bennetts, A. L. (1998). *Alcohol Policy and Public Health in South Africa.* Cape Town: Oxford University Press.

Pinger, R. R., Payne, W. A., Hahn, D. B. & Hahn, E. J. (1995). *Issues for Today: Drugs (2nd ed.)*. St. Louis: Mosby.

Prinsloo, A. (1999). Ravesafe. *South African Community Epidemiology Network on Drug Use (SACENDU): Monitoring Alcohol and Drug Abuse Trends, Proceedings of Report Back Meetings, Phase 6,* 41-43. Tygerberg: Medical Research Council.

Ragin, C. C. & Becker, H. S. (Eds.). (1997). *What is a Case? Exploring the Foundations of Social Inquiry.* Cambridge: Cambridge University Press.

Reimers, S. & Treacher, A. (1995). *Introducing User-Friendly Family Therapy.* New York: Routledge.

Ripple, C. H. & Luthar, S. S. (1996). Familial factors in illicit drug abuse: an interdisciplinary perspective. *American Journal of Drug and Alcohol Abuse, 22 (2)*, 147-163.

Rounds-Bryant, J. L., Kristiansen, P. L. & Hubbard, R. L. (1999). Drug Abuse Treatment Outcome Study of Adolescents: A Comparison of Client Characteristics and Pretreatment Behaviors in Three Treatment Modalities.

American Journal of Drug and Alcohol Abuse, 25 (4), 573-585.

Silverman, D. (2001). *Interpreting Qualitative Data. Methods for Analysing Talk, Text and Interaction.* London: Sage.

Simon, F. B., Stierlin, H. & Wynne, L. C. (1985). *The Language of Family Therapy: A Systemic Vocabulary and Sourcebook.* New York: Family Process Press.

Snyder, S. H. & Lader, M. H. (Eds.). (1989). *The Encyclopedia of Psychoactive Drugs. Getting Help: Treatments for Drug Abuse.* London: Burke Publishing.

Stanton, M. D. (1997). The role of family and significant others in the engagement and retention of drug-dependent individuals. Beyond the therapeutic alliance: keeping the drug-dependent individual in treatment. *National Institute on Drug Abuse Research Monograph.* 165, 157-179.

Steinbeck, J. (1980). *Travels with Charley: In Search of America.* New York: Penguin. Retrieved July 27, 2002 from the World Wide Web: http://www.flask.com/fl/index.en.shtml

Strang, J., Griffiths, P. & Gossop. M. (1997). Heroin Smoking by 'Chasing the Dragon': Origins & History. *Addiction, 92 (6)*, 673-683. Retrieved August 17, 2002 from the World Wide Web: http://www.biopsychiatry.com/heroin.htm

Struwing, F. W. & Stead, G. B. (2001). *Planning, Designing and Reporting Research.* Cape Town: Pearson Education South Africa.

Sukhai, A. (1999). Substance Abuse and Trauma in Three Cities. South African Community Epidemiology Network on Drug Use (SACENDU): Monitoring Alcohol and Drug Abuse Trends, Proceedings of Report Back Meetings, Phase 6, 69-72. Tygerberg: Medical Research Council.

Swarts, M. (1997). Evil Bedfellows: Drugs, Alcohol and Crime. *Focus Forum, 4 (5)*, 1-3.

Terre Blanche, M. & Durrheim, K. (1999). *Research in practice: applied methods for the social sciences.* Cape Town: UCT Press.

Tesser, A. (1995). *Advanced Social Psychology.* New York: McGraw-Hill.

The Royal Windsor Society for Nursing Research. (n.d.). *The APA Publication Style*. Canada: Author. Retrieved July 26, 2002 from the World Wide Web: http://www.windsor.igs.net/~nhodgins/apa format guidelines.html

United Nations International Drug Control Programme. (2000). *World Drug Report 2000*. Vienna: Author. Retrieved July 15, 2002 from the World Wide Web: http://www.odccp.org/wdr executive summary 2000.html

van den Borne, H. W. (1998). The patient from receiver of information to informed decision-maker. *Patient Education and Counselling, 34*, 89-102.

Visser, M. (1999). High-Risk Behaviour of Primary School Learners. *South African Community Epidemiology Network on Drug Use (SACENDU): Monitoring Alcohol and Drug Abuse Trends, Proceedings of Report Back Meetings, Phase 6,* 75-85. Tygerberg: Medical Research Council.

von Bertalanffy, L. (1968). *General Systems Theory: Foundations, Development Application*. New York: Braziller.

Watzlawick, P. & Weakland, J.H. (Eds.) (1977). *The Interactional View*. New York: Norton.

Wilkinson, J. & Potgieter, H. (1999). Specialist Treatment Centres. *South African Community Epidemiology Network on Drug Use (SACENDU): Monitoring Alcohol and Drug Abuse Trends, Proceedings of Report Back Meetings, Phase 6*, 4-12. Tygerberg: Medical Research Council.

Appendix A

Please write an essay on your drug abuse and rehabilitation journey. In this essay address the following topics.

- *Your experience of the drug abuse*

    Addressing in this:

    The drug abuse itself, i.e. which drugs you used, when you started, the length of use, dosage & frequency.

    How you came to abuse drugs.

    How you see personal characteristics adding to substance abuse.

- *Your experience of the rehabilitation process*

    Addressing in this:

    How you experienced the process of rehabilitation, including how you came to enter a rehabilitation programme, any problems that you may have encountered or facets that you found conducive to abstinence.

    How you see personal characteristics adding to abstinence.

    Please describe any suggestions that you may have for enhancing the process of rehabilitation.

- *Your impression of the impact of the rehabilitation*

  Addressing in this:

  Whether or not you have maintained abstinence, the duration of your abstinence. Describing any conditions under which you may predict a relapse.

  How you have experienced any gains/hopes or losses as a result of the programme.

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Significant Role Player

Please write an essay on your experience of Phillip's / Miss X's drug abuse and rehabilitation journey. In this essay address the following topics.

Including the following:

- Describe your role in the treatment process
- Discuss your view of the elements of success of the treatment process
- Describe, if any, considerations that may further benefit the programme
- Describe, if any, possible weaknesses of the treatment programme
- Discuss Phillip's / Miss X's personal characteristics that you think added to his / her substance abuse
- Discuss Phillip's / Miss X's personal characteristics that you think added to his / her abstinence
- Describe, if any, additional elements that added to Phillip's / Miss X's substance abuse
- Describe, if any, additional elements that added to Phillip's / Miss X's abstinence

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Psychologist / Social Worker

Please write an essay on your drug rehabilitation treatment programme. In this essay address the following topics.

1. *The drug rehabilitation programme*

Including the following:

- Describe the treatment programme
- Discuss your view of the elements of success of the treatment process
- Describe, if any, considerations that may further benefit the programme
- Describe, if any, possible weaknesses of the treatment programme

2. *The IP*

Including the following:

- Discuss Phillip's / Miss X's personal characteristics that you think added to his / her substance abuse
- Discuss Phillip's / Miss X's personal characteristics that you think added to his / her abstinence
- Describe, if any, additional elements that added to Phillip's / Miss X's substance abuse

- Describe, if any, additional elements that added to Phillip's / Miss X's abstinence

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