SUBSTANCE ABUSE TREATMENT:

A CASE STUDY

by

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Special thanks to my dear friends Mary and Wayne and of course my family for all of their encouragement and support throughout this endeavor.
ABSTRACT

Substance abuse issues have plagued modern society for decades and are among the most common and serious current social and health concerns. The personal, social and financial costs of substance abuse in North America are alarming. This project, is grounded in a search of the literature relating to substance abuse treatment, both historical and contemporary, and explores dominant attitudes towards substance abuse, both past and current. While this project contains a historical overview of substance abuse treatment approaches in North America, the major focus is on the biopsychosocial/biopsychosocial/spiritual approach, which is currently the official treatment approach used by Alcohol and Drug Services in British Columbia. Furthermore, it is based on a case example, from the writer’s practice experience, of a youth and her struggles to overcome her addiction.

The retrospective case analysis of the youth’s struggle with overcoming her addiction, coupled with the examinations of two Alcohol and Drug Services treatment programs, aide in uncovering the limitations possessed by mainstream substance abuse treatment approaches. The limitations of mainstream substance abuse treatment approaches are examined from a social development perspective. The aim of this project is to gain a better understanding of the limitations of mainstream substance abuse treatment approaches, especially in reference to clients from low socio-economic status. The social development approach, the critical lens through which the analysis is conducted, exposes the inherent micro bias that exists within mainstream treatment approaches and how this works to limit their effectiveness. The hope is that the findings of this study may assist in the improvement and increased long term effectiveness of substance abuse treatment.
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Acknowledgment

This Masters of Social Work Project, examining the limitations of mainstream substance abuse treatment approaches, arises from many years of working with at risk youth, many of whom have been battling addictions. It is my firm conviction that many of these youth may have been more successful in their battles if treatment had also addressed the macro issues which these individuals struggled with which contributed to their drug abuse. I hope that the findings of this project will assist in increasing the awareness and understanding of the needs of addicted individuals from low socio-economic status in their treatment. I believe that incorporating a more macro focus into mainstream substance abuse treatment may prove to be quite beneficial for clients in reaching their treatment goals.

My thanks and appreciation go to Professor Glen Schmidt, my MSW Project Supervisor. He has been a teacher, advisor and motivator. His critical perspective, guidance and patience have greatly facilitated my education and understanding. I would also like to express my thanks to Shereen Ismael, the second member of my project committee. Her words of encouragement and support have proven to be invaluable. Thanks also go to Sylvia Barton, the third member of my project committee. She offered valuable insight which contributed to my learning. Finally, I would like to acknowledge and thank the Social Work program at the University of Northern British Columbia for providing me the opportunity and the critical atmosphere within which to undertake my studies.
CHAPTER ONE

Introduction and Rationale

The Problem of Substance Abuse

Substance abuse problems (including alcoholism) are among the most common and serious social and health concerns experienced in modern society. People of all ages are dying from substance abuse at an alarming rate. In 1997, the Canadian Centre on Substance Abuse (CCSA) reported that there were 6,701 deaths and 86,076 hospitalizations attributed to alcohol in 1992. While motor vehicle accidents accounted for the largest number of alcohol related deaths, accidental falls and alcohol dependence syndrome accounted for the largest number of alcohol related hospitalizations. Furthermore, in 1992 there were 723 deaths, 7,095 hospitalizations and 58,571 hospitalization days attributed to illicit drugs in Canada (CCSA, 1997). Of the deaths attributed to illicit drugs, 308 were suicides, 172 were over doses and 61 were AIDS deaths due to intravenous drug use. The highest risk of death due to illicit drugs is said to be in British Columbia (CCSA, 1997).

The financial costs of substance abuse to society are equally as alarming. A British Columbia study estimated the cost of illicit drug use in the province to be $388 million in 1991, with the major cost being law enforcement (Coordinated Law Enforcement Unit, 1992). Moreover, according to a study done by Single, Robson, Xie, and Rehm in collaboration with Moore, Choi, Desjardins and Anderson (1996) alcohol accounted for more than 7.5 billion in costs, or $265 per capita, in Canada in 1992. The largest economic costs are reported as being $4.14 billion for lost productivity due to morbidity and premature mortality, $1.36 billion for law enforcement and $1.30 billion in direct health care costs. Meanwhile, the costs of illicit drugs in Canada in 1992 were estimated at $1.37 billion, or $48 per person (Single et al, 1996). Again,
the largest economic cost, $823 million, is for lost productivity due to morbidity and premature death. In addition Single et al (1996) reported $400 million in costs for law enforcement and $88 million in direct health care costs due to illicit drugs in Canada during 1992.

The personal and social costs of substance abuse are monumental. Reports also suggest that substance abuse problems are responsible for breakdowns in the emergency mental health systems of large urban centers, for many difficulties that exist in shelters for the homeless, and for the rise in crime and family violence (Hanson, 1991; Berger, 1991; Wodarski and Feit, 1995). Although substance use and abuse extend to all strata of society, studies have shown that the problems associated with substance abuse and the risk of becoming addicted are not equally distributed among society’s members. Research has shown that the critical factors associated with increased risk for substance abuse are disadvantaged socioeconomic status, age, sex, ethnicity, and a family history of alcoholism and/or other drug abuse (Hanson, 1991). Substance abuse problems amongst teens are frequently regarded as being either the cause or effect of stress experienced during adolescence (Wodarski and Feit, 1995). Ross (1994) notes that in the late 1970s, few programs existed for treatment of adolescents, little was known about the subject, training programs were sparse, the majority of chemically dependent adolescents were being diagnosed and treated as mentally ill, and a limited information base was available on how to diagnose and treat adolescent substance abuse. Currently, a great deal more literature exists on the topics of adolescent and adult substance abuse, treatment approaches, and success rates.

Where I Am Coming From--My Standpoint

Although I’ve never worked directly in the drug and alcohol field, I have worked with at risk youth (between the ages of thirteen and nineteen), many of whom were First Nations. My motivation for wanting to explore the topic of substance abuse treatment, particularly with youth,
has been primarily driven by my work experience and the repeating patterns I have noticed with clients who battled addictions. Unfortunately, even though many of these youth have seemed motivated to deal with their addictions, the majority have not been successful in maintaining sobriety after treatment.

Most of the individuals with whom I have worked came from low socio-economic backgrounds and had minimal education (most had only completed junior high school at best) and possessed very little, if any, work skills or training. Many clients have mentioned to me that after completing treatment, they ideally wanted to find work or go back to school but in reality were unable to achieve these goals. Thus, after struggling to change their lives and falling short of their goals, many youth have described that the only choice they felt they had was to resort back to their “old ways” in their “home environment” where they felt they had the support of peers and possessed the necessary skills to make money through illegal means (i.e. selling drugs, prostitution, theft). In addition, many youth have shared how much easier it is to do well in a treatment center where you are surrounded by others who are trying to “clean up” and there is a support network in place. Whereas it is much harder staying “clean” in their “home community” where they have very little supports, if any, and their peers and even some family members still abuse substances and are involved in illegal activities. I believe that the highly publicized case of the fourteen young Innu from the Labrador community of Davis Inlet, who were sent to Alberta for treatment, illustrates this point (Fennell, 1993). These youth had problems with alcohol and solvent abuse and as a result were sent to Poundmaker’s Lodge treatment centre. While at Poundmaker’s Lodge the youth did well and participated in group and individual counseling where they focused on their substance abuse and their underlying unresolved personal issues (micro focus). However, upon returning to their “home environment”, where the macro issues
such as poverty, limited opportunities, and lack of support to stay sober still remained unchanged and unaddressed, most of the youth regressed back to using alcohol and solvents. As this example illustrates, it is not enough to simply treat individuals and only focus on the micro issue, their substance abuse. Attention also needs to be paid to the macro issues (i.e. poverty, peer support, their community, environment) and how they impact and affect the individual’s substance abuse.

From my experience I have come to strongly believe that in addition to their needs for individual support and therapeutic counseling, to deal with past issues or events, attention also needs to be paid to the macro issues such as poverty, lack of education and work experience, as well as marketable skills that many of these youth require to maintain sobriety. Unfortunately, none of the substance abuse treatment programs, within British Columbia, that I have looked at so far, for youth or adults, address all of these issues. Furthermore, none of the literature that I have reviewed to date adequately addresses these issues. I believe that this short fall is a large part of the reason why many of the youth that I have known, and many others, have been unable to maintain sobriety after treatment. Although they had the opportunity to deal with some of the issues from their past, experience some personal growth, and learn about their addiction while in treatment, after completing treatment they returned to their “home” environments where they faced despair and lack of opportunity.

**Definition of Terms**

Before taking this discussion any further I think it is important to define some of the key terms that I am using. First, by mainstream substance abuse treatment programs I am talking about residential treatment programs, and the Alcoholics Anonymous and Narcotics Anonymous groups which are often partnered with many treatment programs. For the purpose of this paper, I
have chosen to narrow my focus on alcohol and drug services delivered in British Columbia. In 1996 the Ministry of Health Adult Clinical and Addictions Services Branch issued a policy stating that all treatment services/programs delivered on behalf of Alcohol and Drug Services would be consistent with the biopsychosocial/spiritual theory, which for the purpose of this project I will refer to as the biopsychosocial theory. This theory is a holistic approach to substance abuse treatment. It recognizes that substance abuse results from the complex interactions of a combination of psychological, social, biological and spiritual determinants. Furthermore, although I do realize that individuals may also access a variety of counseling agencies for their addiction, for the purpose of this study, I will be restricting my investigation to substance abuse treatment programs (therapeutic programs designed specifically to assist the individual in battling his/her addiction). In this project, I will be using the term substance to include alcohol, prescription drugs, narcotics and solvents. Substance abuse, or drug abuse, are terms that have been historically defined in a plethora of different ways. However, there is consensus in the literature that this term usually connotes social disapproval and illegal behavior (Peele, 1985). For the purpose of this paper, borrowing from Segal’s (1988) definition, substance abuse will be defined as the use of any chemical substance, taken for non-medicinal purposes or in amounts that are in excess of accepted limits and which causes the user to be at risk for adverse personal, health, social and legal consequences. In contrast, substance or drug misuse implies the improper or inappropriate use (i.e. used more frequently or in greater quantities than is warranted) of a social or prescribed drug. Furthermore, addiction refers to dependence on a chemical which includes an increasing tolerance to the drug’s effects and a withdrawal syndrome when the drug is discontinued (Doweiko, 1993). Addiction is recognized by a person’s heightened and habituated need for a substance, by the intense suffering that
follows the discontinuation of its use and by the individual’s willingness to make self-destructive sacrifices in order to remain taking the substance (Peele, 1985). Although as Segal states, debates as to the meaning or definition of addiction persist, the term continues to be used to imply reliance on a drug.

Furthermore, when I question whether treatment approaches have a more micro focus I will be wanting to examine if they rely solely on individual and group counseling, which focus on substance abuse as the primary issue, to aid clients in recovering from their addiction. Hence, the focus is solely on the individual and his/her addiction. Barker (1991) defines micro practice as being activities that focus on direct interventions in a clinical setting or with particular individual cases. In contrast, approaches with a more macro focus would focus on the environmental and structural issues that make up the individual’s reality and how these things (i.e. poverty, low education level, lack of marketable skills, unemployment etc.) impact upon the individual’s substance abuse problem. It’s my contention that although individual counseling is necessary to address problems of substance abuse, attention also needs to be paid to the macro factors that impact on individual substance abuse. Treatment also needs to focus on how these can be altered so as to ensure maximum effectiveness in helping people overcome their addictions. As such, my personal bias would be that substance abuse treatment approaches need to possess both a micro and macro focus.

I will be using the social development framework to critically analyze mainstream substance abuse treatment approaches so as to explore whether they do or do not possess a micro bias. I have chosen to use the social development framework because it is an approach that incorporates both a macro and micro focus. The social development approach, as defined by James Midgley, emphasizes the need for micro (individual) and macro (structural/economic)
change when dealing with social problems. Midgley (1995) defines the concept of social development “as a process of planned social change designed to promote the well-being of the population as a whole together with a dynamic process of economic development” (p.25). The social development approach focuses on the multi-causal nature of social issues, rather than on uni-causal explanations, and thus it emphasizes multi-level interventions (Elliott and Mayadas, 1996). Midgley (2000) states that the “social development perspective insists on the integration of economic and social policy and gives expression to two axioms: firstly, it requires that economic development should be inclusive, integrated and sustainable and bring benefits to all; and secondly, it proposes that social welfare should be investment oriented, seeking to enhance human capacities to participate in the productive economy.” (p. 24).

Overview of Paper

Within the context of this paper I will build my argument in regards to the limitations of mainstream substance abuse treatment approaches. I will be utilizing the social development approach as the critical lens through which I will be conducting my analyses of mainstream treatment approaches. I will provide a brief introduction to the social development approach as well as discuss its historical roots and contemporary applications. Furthermore, I will attempt to provide a historical overview of substance abuse treatment approaches, ending with the biopsychosocial approach, which is currently, the official treatment approach used by Alcohol and Drug Services in British Columbia. This will be followed by a closer examination of two Alcohol and Drug Services treatment programs. This examination will assist me in illustrating how mainstream substance abuse treatment programs and their underlying models tend to possess a micro focus, in that they only concentrate on the nature of the substance abuse. Following this, I will delve into my case example in order to demonstrate to the reader how this
tendency toward micro practice affected a particular impoverished First Nation youth, named Janie, in her battle against substance abuse. In doing this I will be highlighting the dominant themes, as I have understood them, in this individual’s struggle. Although I acknowledge that Janie’s story possesses a cultural component, this is not explored in this study. In my contact with Janie, she never indicated that culture was an important issue for her and I never pressed the issue. Aboriginal people are not a single group and there are a variety of world views, some which do not adhere to traditional cultural values (Morrissette, McKenzie, and Morrissette, 1993). The following chapter will explore the limitations of mainstream substance abuse treatment approaches from a social development approach. In closing, I will argue that the social development approach, due to its micro/macro focus, would be beneficial to use in conjunction with mainstream approaches in order to ensure the maximum effectiveness of substance abuse treatment services.
CHAPTER TWO

Social Development Approach

History of the Social Development Approach

The roots of the social development perspective can be traced back to colonial times. The term was first used in the context of British colonial welfare administration in Africa in the 1950s, when social workers attempted to transcend their conventional remedial roles. Thus, apart from providing remedial services for the disabled, children, the elderly, the mentally ill, and young offenders, these administrators sought to foster social programs such as mass literacy and community development that would enhance levels of welfare for the community as a whole (Midgley, 1994a).

During the 1980s, social development became the model of social work considered most appropriate to developing countries (Payne, 1997). This came after attempts, in the 1960s and 1970s, to develop Western social work throughout the world, failed. Western social work was deemed inappropriate to most indigenous cultures and social needs. Western social work developed and grew as an integral part of the predominantly European American model of social welfare, which is often referred to as the Western social welfare system. Inevitably, when attempts were made to transplant this social work approach to countries in which comparable social welfare system did not exist, they failed. On the other hand, the social development approach, due to its unique qualities, has been most strongly extended in developing countries (Payne, 1997).

Basic Tenets of the Social Development Approach

At this point I feel that it is important to acknowledge that there have been varying definitions of social development. Sullivan (1994) examines how different approaches to
defining social development have appeared within disciplines such as sociology, social work and development studies. Midgley (1994a) acknowledges how some writers such as Henry Maas view social development as a process of improving society through improving social relations. On the other hand, some definitions in social work equate social development with social work macro-practice. In addition, Hardiman & Midgley (1989), among other authors, equate social development with social service planning, community development, or the efforts by governments to enhance levels of living through social planning. For the purpose of this examination I will be focusing on the definition espoused by Midgley (1995). As defined by Midgley (1995), social development is “a process of planned social change designed to promote the well-being of the population as a whole together with a dynamic process of economic development” (p.25). This definition emphasizes social development’s link to economic development. Rather than seeing welfare as dependent on economic growth, this approach seeks to create resources for the community by linking social with economic developments (Midgley, 1999). In terms of the social development approach, the concept of welfare refers to a social condition. Social development may be viewed as an approach for promoting people’s welfare (or social well-being). Hardiman and Midgley argue that when families, communities and societies experience a high degree of social well being, a condition of social welfare exists.

In addition, Schmidt (2000) notes how the social development approach emphasizes localism. Economic changes are generated in ways which “empower and are sensitive to local traditions, opportunities, interests, and realities”(Schmidt, 2000, p.344). Social development is viewed as a comprehensive process which encompasses all citizens and fosters social solidarity (Midgley, 1994b). Midgley (1994b) notes that in contrast to approaches, which rely on treatment interventions, social development does not delegate the responsibility for human welfare to the
individual. Rather, collective mechanisms are utilized to include the entire population and promote general, as opposed to individual welfare. Thus, avoiding the marginalization of the impoverished.

This approach is progressive in nature. Economic growth is regarded as a vital component of social progress (Midgley & Livermore, 1997). Midgley & Livermore (1997) describe the social development approach as interventionist due to the fact that it promotes the active role of the state in economic and social development planning.

The social development approach stands apart from social philanthropy, social work, and social administration by virtue of its key aspects. This approach differs from social philanthropy, social work and social administration in several ways. For instance, unlike the social administration approach, which continues to compartmentalize the social services from the economy, social development seeks to harmonize social interventions with economic development efforts (Midgley, 1995). The social development approach also includes a strong notion of localism, which is often a factor that is lacking in the social administration approach. In contrast to philanthropy and social work, social development does not deal with individuals by treating or rehabilitating them to existing structures or providing them with goods and services (Payne, 1997). Instead, social development focuses on the community or society and aims to promote people's well-being through creating social changes so that social problems are managed, needs are met and opportunities for advancement are provided. Social development is also dynamic, involving a process of growth and change. Consequently, it seeks growth, rather than simply returning people to an existing level of well-being. In addition, the social development approach is comprehensive and universalistic. It transcends residualist approaches which target welfare on the most needy groups in a society and as a result seeks to enhance the
well-being of the whole population. Thus, the attempt to integrate social and economic policies and programs, in order to promote people's welfare, distinguishes social development from other approaches (Midgley, 2000).

The social development approach focuses on the multi-causal nature of social issues, rather than on uni-causal explanations, and as such it emphasizes multi-level interventions (Elliott and Mayadas, 1996). The values, goals and methods of social development are consistent with those of social work: social justice; cooperation; planned prevention and development; institutional change; empowerment; conscientization; human dignity and worth; growth and change; participation; democracy and peace (Midgley, 1995). Social development is interdisciplinary and intersectoral in that it includes social, economic and political levels of operation. The proponents of social development advocate for the adoption of a macro-focus, which directs attention to communities, regions and societies when dealing with social problems.

Although the application of the social development approach to social problems in Canada and the United States is in its infancy, it has been applied to communities and community development. It is important to consider this alternative while examining the historical approaches and attitudes toward substance abuse.
CHAPTER THREE

Historical Overview of Attitudes about Substance Abuse and Available Treatment

An Examination of Contemporary Views Around Substance Abuse

A review of the literature reveals that historical attitudes towards alcohol (the earlier literature focuses primarily on alcohol as opposed to other substances as this was the most predominantly used substance historically) consumption in North America have not remained static through time. Bennet and Ames (1985) have examined the social history of alcohol in the United States while Smart and Ogborne (1996) have done a comparable examination in reference to Canada. These writers show how in colonial times, alcohol consumption enjoyed a reputation of having numerous practical, social, ritual and medicinal purposes and meanings. Bennet and Ames explain how prior to the nineteenth century, alcohol was accorded very high esteem in both Britain and the American colonies. Kinman and Sanders (1994) describe that this was an era when beer was regarded as safer than water, granted river water at this time was often polluted due to factors such as poor sewage disposal. Furthermore, Kinman and Sanders note that medical evidence points out that calories from alcohol formed an essential part of the population’s energy requirements and beer made a major contribution to the nutritional contents of American diets. Bennet and Ames, note that during this period, the medicinal uses of alcohol included soothing indigestion, warding off fevers, fighting fatigue, and relieving aches and pains. In addition, alcohol was also an important ingredient in promoting liveliness at various social and church functions.

However, as Kinman and Sanders (1994) explain, the situation changed as the movement from a largely rural, agriculturally based socioeconomic system evolved into an increasingly urbanized, industrial based system. In effect, patterns of alcohol consumption were transformed.
With the labor force now beginning to work alongside, and to operate industrialized machinery, alcohol consumption was discouraged. Severe intoxication not only affected production and output, but also endangered workers. As Kinman and Sanders state, there emerged a sense in which alcohol consumption became a threat to the economic substructure of the new order. Furthermore, there was also an emerging association between moderation and sometimes abstinence from alcohol based on factors relating to social class and religious beliefs. As such, heavy drinking and “habitual drunkenness” became increasingly associated with the laboring, working class. Popular ideological discourse regarding the misuse of alcohol stated that alcohol contributed to the destablizing of social (including moral) and economic values.

In the late nineteenth century, alcoholism came to be regarded as one of the several diseases of the will (Valverde, 1997). As such, the object of treatment was seen as not only curing the craze but also strengthening the will. Valverde (1997) shares how the literature of the time reflected the need to change the alcoholic’s moral character. Alcoholism was defined as a defect in the liberal subjectivity. This defect, unlike insanity, affected not so much the rational but moral faculties, specifically the will. Alcohol was also believed to work to directly weaken the will (Valverde, 1997). Some people argued that drinking caused an erosion of willpower, whereas others stressed that previously existing character defects led to excess drinking. Nevertheless the end result was the same.

Many of the people diagnosed as alcoholics belonged to social groups which were believed to have quite small amounts of self-control and willpower. This included the vicious poor and the ladies of the middle and upper class. Valverde (1997) describes that ladies were thought to be especially susceptible to diseases of the will such as alcoholism and kleptomania while gentlemen were regarded as having much greater innate capacities for self-control. The
upper class were thought to be born with more willpower than the poor and similarly men were
thought to have more willpower than women of the same class and race. However, as many
physicians noted from their own clinical practice, alcoholism and other addictions affected even
the highest strata of society (Valverde, 1997). With that said though, it is evident from historical
accounts that treatment differed greatly across gender and class divisions.

Valverde (1997) explains that after the 1898 act alcoholics were divided into two groups:
those confined to private retreats (either voluntarily and privately, or else through the legal
machinery of naming oneself as an inebriate in front of a Justice of the Peace) and, on the other
hand, those confined to state reformatories. The two kinds of institutions were drastically
different from one another in terms of their programming and general treatment of patients. The
gentlemen’s retreats were full of jovial men whose ‘drink mania’ was often regarded as a
blemish. There were ample facilities for billiards, hunting, fishing and other gentlemanly
pastimes at these retreats (Valverde, 1997). The treatment applied to these gentlemen consisted
partly of removing the men from their usual source of alcohol and also an emphasis on
individualized pastoral care. However, as Valverde explains, less information is available on the
operation of retreats for women. Nevertheless, the limited available information seems to imply
that the ladies were given less individualized care than their male counterparts. The impersonal
architecture and temporal control of their facilities were much like those favored in lunatic
asylums (Valverde, 1997). Worse yet, Valverde argues that the reformatories, on the other hand,
were neither pastoral nor liberal and little moral treatment was provided in these facilities. The
1898 act instituted compulsory commitment procedures for some habitual inebriates who had run
foul of the law, and allowed for the building of special state semi-penal institutions known as
inebriate reformatories. Zender (1991) as cited in Valverde, argues that this group ended up, in
practice, being composed almost exclusively of working-class mothers who were charged with neglecting their children. Zender states that about 450 mothers convicted of child neglect were sent to inebriate reformatories for a three-year term. In contrast only a handful of male inebriates convicted of theft, assault or manslaughter were sentenced to the reformatories. Zender argues that the skewed reformatory population figures suggest that the reformatories in Britain were involved in policing of women’s sexual and reproductive conduct as much as, or more than the regulation of alcohol. During the moral panic of the early 1900s, the reformatory population was viewed in a new, even more sinister light and the alcoholics of the poorer urban classes were now labeled ‘feeble-minded’ (Valverde, 1997).

**Contemporary Models of Substance Abuse**

Predominant social and political attitudes concerning substance abuse in North America have evolved over time and influenced substance abuse treatment. Some historic views towards substance abuse and treatment still exist today, while others have been amalgamated with other approaches and belief systems to form new approaches and still others have been abandoned altogether. The following pages attempt to offer an introduction to the evolution of substance abuse treatment and the beliefs around people with addictions. This review will begin with the moral and disease/medical models and work its way through to the biopsychosocial model.

**Moral Model**

Until around the end of World War II, substance abuse problems, namely alcoholism, were generally thought of as being symptoms of moral weakness. The temperance movement began in the 1820s and a century later had achieved its goal of converting a large portion of the population to abstinence and getting Prohibition introduced in all areas of Canada (Smart and Ogborne, 1996). Smart and Ogborne (1996) explain that the Canadian temperance movements
were roughly modeled on those in Britain and the United States. However, the authors argue that the Canadian movement was more successful than those in Britain and the United States because the former never achieved Prohibition while the latter did so considerably later than Canada. Single (1997) explains that, according to the temperance perspective, the primary problem with alcohol is drinking per se. As such, alcohol use is viewed as an indicator of moral weakness and it inevitably leads to a decline in the moral behavior. Consequently, the goal of prevention is abstinence for the entire population which is achieved through moral education and legal prohibition.

The moral theory was the underlying theory used to understand substance abuse problems during this time period. According to this theory, addiction is considered to be immoral conduct. The Moral Theory maintains that substance abuse represents a refusal to abide by some ethical or moral code of conduct (Akers, 1992). Thus, excessive drinking or drug use is considered freely chosen behavior that is at best irresponsible and at worst evil. Since the addiction is seen as resulting from a freely chosen and morally wrong course of action, the logical way to “treat” the problem is to punish the alcoholic or addict. Thus, from this perspective, legal sanctions such as fines, jail sentences, and other punitive actions are seen as the most appropriate (Thombs, 1999). Since the substance abuser is not thought to be deserving of care or help, punishment is relied on to rectify past misdeeds and prevent further chemical use. Along these same lines, relapse is considered evidence of lingering evil in the addict; again, punishment is believed to be needed to correct the “slipping”. Thoms (1999) notes that in our society today, this perspective on substance abuse is typically advocated by politically conservative groups, law enforcement organizations, zealous religious factions, and groups of individuals who have been personally harmed by alcoholics/addicts (i.e. Mothers Against Drunk Driving).
Disease/Medical Model

With the repeal of Prohibition in the early part of the Twentieth Century in many Western societies, the temperance perspective was largely replaced by the disease model of alcoholism.

Disease theory, also referred to as the medical model, viewed the excessive consumption of alcohol or drugs as the result of an underlying disease process. The disease process is believed to cause compulsive use (Hanson, 1991). Addiction is thought to be a progressive disease having physiological determinants. As such, addicts are people whose body chemistry makes them susceptible to becoming addicted to drugs and/or alcohol. This physiological susceptibility may be inherited. According to this model, there are at least two explanations of etiology. First, certain people are born with a body chemistry that makes them potential addicts. When these people drink or use drugs, the interaction of the substance with the susceptible physiological make-up results in the symptoms of addiction. The second explanation is that long years of drinking or drug use may alter the biochemistry of some people which in turn causes further excessive and uncontrollable use. Regardless of which explanation is used, the final result is the same; the addiction has a physiological basis. Clinicians employing the disease model attempt to help the addict achieve sobriety or total abstinence and may be inclined to enlist the use of certain drugs to help ease the individual’s withdrawal symptoms.

The modern concept of alcoholism as a disease was developed by Jellinek (1960). Thombs (1999) notes that the exact nature of the illness is not fully understood at this point, but many proponents of the disease model believe that the illness has genetic origins. This view maintains that the alcoholic and addict are victims of illness. The afflicted individual is not evil or irresponsible, just sick. Thus, the chemical abuse is not freely chosen. Rather, it is seen as being beyond the control of the sufferer. Since alcoholics and addicts are seen as suffering from
an illness, they are seen as deserving compassionate care, help, and treatment. Medical treatment is seen as appropriate because the condition is considered a disease. In addition, this view implies that despite any other intervention, the only way to stop the progression of the disease and recover from the effects of substance abuse is abstinence (Hanson, 1991; Addiction Research Foundation, 1996). One of the beliefs in this theory is that “users are often ‘in denial’ and are not ready to address their substance abuse problem or make a change until they ‘hit bottom’.” (Addiction Research Foundation, 1996, p. 34).

Lender (1979) notes that modern conceptions of alcoholism as a disease have evolved from a variety of sources. Lender’s essay focuses on medical concepts advanced in the 1800s. Since the work of Benjamin Rush and Thomas Trotter in the late eighteenth and early nineteenth centuries physicians and laymen had viewed at least chronic drunkenness as a disease (Lender, 1979). Following the Civil War, physicians were arguing for the medical treatment of alcoholics and urging the construction of special “inebriate asylums” for the treatment and study of drunkenness; support gradually spread for asylums (Lender, 1979). Lender explains how, although Jellinek himself is said to have discounted these early efforts in his work, central features of Jellinek’s disease conception of alcoholism, including physical dependence, had taken recognizable form in the work of the American Association for the Study of Alcohol and other Narcotics, before the turn of the century.

Disease models are strongly advocated by the profession of medicine, the alcohol industry (brewers, distillers, and winemakers), and the “recovery movement” which is made up of individuals and families recovering from chemical dependencies (Thombs, 1999). All of these groups are seen by critics as having a vested interest in viewing addiction as a disease. Proponents of this model argue that it has helped hundreds of thousands of alcoholics and addicts
to return to healthful living (Roman, 1988; Berger, 1991; Addiction Research Foundation, 1996).

**Alcoholics Anonymous**

Alcoholic’s anonymous (AA) was founded in 1935 in Akron, Ohio by two chronic alcoholics, one a stockbroker (Bill W.) and the other a physician (Dr. Bob). From its onset, AA promoted the view that alcoholism, although incurable, could be successfully arrested if treatment was provided for withdrawal and alcoholics followed a 12-step program of recovery. The movement spread quite rapidly and the first Canadian AA meetings were held in 1943 (Smart and Ogborne, 1996). AA has gained acceptance as an important if not potentially necessary adjunct to other therapeutic work with substance-abusing clients (Berenson, 1991). The AA model defines alcoholism as a disease. The usage of the term disease usually has two separate but related meanings. First of all, the alcoholic is believed to have a disease of the body. The alcoholic’s body is affected differently by alcohol either because he/she has some inherited predisposition or because of some changed physiological response resulting from long years of drinking. Second, the alcoholic is seen to have a disease of the mind; an obsession with alcohol and its effects. This disease of the mind is often related to a spiritual failing.

According to this model, alcoholics are different emotionally and/or spiritually as well as physically from non-alcoholics and this is why some people can drink and not become alcoholics while others do. Thus, the potential alcoholic is said to be both psychologically and biologically susceptible to becoming an alcoholic. The treatment program of AA consists of joining together with other alcoholics to aid each other in staying sober. This process consists of periodic meetings in which the members of the group work through the well known “Twelve Steps”. In addition, it is typical for a new member, just beginning the recovery process, to have a sponsor. The sponsor is an AA member, often with years of sobriety, who helps the newly recovering
alcoholic during times of difficulty. Proponents of this model would argue that a true alcoholic can never be cured in the sense of returning to normal social drinking since the alcoholic is constitutionally different. As such there is the insistence upon complete abstinence in the recovery process. There are noticeable similarities between this model and the disease model. However, the therapeutic process for AA is totally drug free and social supports such as AA meetings are used in place of using other drugs to help in difficult times of withdrawal. Also, AA emphasizes the spiritual shortcomings of the alcoholic and attempts to help the recovering alcoholic achieve a better relationship with his/her higher power (whatever that may be). This model argues that even though the use of drugs to manage withdrawal symptoms may seem humane, the possible result is an addiction to alcohol and another drug. Proponents of the AA model argue that the likelihood of successful treatment for those who follow the AA program is very good. The long-term effectiveness of AA in addressing alcoholism is widely accepted (Sommer, 1997). Failures are attributed to those who did not follow the entire program.

Rotgers, Keller and Morgenstern (1996) argue that traditional approaches to substance abuse treatment have tended to advocate a relatively uniform approach for all clients, with a heavy emphasis on working the Twelve-Steps of programs such as Alcoholics Anonymous or Narcotics Anonymous as the preferred method for all comers. Although many treatment providers and researchers have begun to recognize that substance abusers are an extraordinarily heterogeneous group, most treatment programs still offer only a limited range of treatment options, typically based on Twelve-Step thinking (Rotgers, Keller and Morgenstern, 1996). Similarly, after my own review of many of the programs offered in Prince George under Alcohol and Drug services, it was evident that these programs also encourage clients to attend Alcoholics Anonymous or Narcotics Anonymous groups for added support in their treatment and recovery.
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However, although AA is widely used and accepted, it does have its critics. Davis and Jansen (1998) discuss how many professionals have been concerned that AA pushes "powerlessness" on people; step one of AA is admitting powerlessness over alcohol. The writers state that the acceptance of the metaphor of powerlessness, and thereby accepting individual limitations, goes against the dominant Western cultural messages of independence, competition, and will power. Furthermore, Davis and Jansen explore how, although AA states that it stands alone and has no opinion on outside issues, it is often criticized for its support and promulgation of the "disease concept" of alcoholism, especially by social workers who adhere to the strengths perspective. Furthermore, AA is criticized as promoting dependency in the alcoholic by providing a substitute addiction; the AA fellowship. Davis and Jansen explain that this is thought to be bad because it goes against the modern day idea that absolute and total independence is the cure for dependence. Furthermore, the AA greeting where individuals introduce themselves as alcoholics has been interpreted by some critics to be a countertherapeutic reinforcement of a negative label (alcoholic). However, as Smith (1993) has pointed out, it is understood by members of AA that within the context of the group the word alcoholic takes on a different and positive meaning.

Furthermore, in her article, Bewley (1993) illustrates how the AA fellowship can, through its structure and belief system, work against its members achieving further growth in recovery. Bewley argues that in an effort to sustain itself and promote recovery, AA encourages members to adhere to a belief system that includes a self-fulfilling prophecy of relapse. This fear of relapse is what keeps members who are in recovery coming to meetings and sharing their experiences in addiction and recovery with new members and as a result helping others recover and "carry the message" to other alcoholics who still suffer. Members are regularly reminded
that leaving the form of the program in any way (i.e. not attending meetings, reducing contact with their sponsor or other AA members et-cetera) is a set up for a “slip”. This is done in meetings when people for whom this proved true return to admit their mistakes. However, as Bewley states, AA members do not hear the stories of those individuals who have found a way to leave the group and stay sober.

Bewley (1993) also points out that another way in which recovery is limited in AA is that recovering AA members who are experiencing the impulse to grow are directed to work on other issues such as their codependency or relationship to food, instead of moving forward. Consequently, they may start over in AA or another Twelve-Step program, working on another dependency in the same old way. Bewley argues that this process can be one way of inadvertently redirecting people back to the beginning instead of assisting them with finding the way out. Lastly, Bewley explains that there are some that stay in AA for years and become dependent on the recovery process. Thus narrowing their life focus and involvement and avoiding opportunities for self-development in broader ways. As such, involvement in AA ceases to be life-saving and life-giving and becomes life-limiting. Bewley argues that growth is stifled as individuals narrow their world to the confines of AA as they once did in their alcoholism.

In addition, Alexander and Rollins (1984) liken AA to a cult. The authors contend that AA uses all the methods of brain washing, which are also the methods employed by cults. Using the eight brain washing techniques that Lifton (1961) identified as being used by captors of military prisoners, Alexander and Rollins argue that AA has many attributes of a cult. The authors demonstrate how these same eight techniques are employed in AA. For instance, milieu control, control over with whom one should interact, is common in AA. Members are instructed
not to have emotional entanglements outside of AA for the first year, sponsors may suggest a person change his/her job or move and so forth. Furthermore, cult confession, or the public admission of sins people committed while they were drinking (i.e. violent acts, theft, how they hurt others) is also an integral part of AA. Likewise, dispensing existence or the identification of alcoholics as separate and different from non-alcoholics is also a part of AA. In addition, Alexander and Rollins argue that AA tries to make the AA group the most salient social fact for the individual through the use of love-bombing and family substitution. In light of their study, Alexander and Rollins contend that due to this cult nature of AA, it does not work for all alcoholics. The authors argue that this method only seems able to help alcoholics of a given psychological type. That is people who can accept the intimacy that AA demands and are willing to lose their individual identity for the identity offered by the group.

Feminists also take issue with AA. Berenson (1991) states that AA was initially a program run by men for men. At first, women were denied admission to AA because of the belief that "nice" women didn’t become drunks. However, now women comprise from one third to half of the AA membership. In addition, there is a high percentage of women in the Twelve-Step offshoots of AA like Al-Anon, Adult Children of Alcoholics, Codependents Anonymous, and Overeaters Anonymous (Berenson, 1991). Some feminist thinkers and therapists are particularly concerned about the emphasis of powerlessness as liberating in these Twelve-Step programs. Many feminists take issue with the admission of powerlessness as a means to achieving recovery. They argue that most women suffer from the lack of a healthy, aware ego and need to strengthen their sense of self by affirming their own inner wisdom. Many women abuse drugs or stay in harmful relationships because they feel powerless in their lives (Kasl, 1992). As such, some feminists interpret steps two and three as sacrificing and martyring oneself
for the sake of others, notably men, and view AA as being simply another male institution dedicated to maintaining men’s oppressive and destructive value structure and hierarchy (Kasl, 1992; Johnson, 1989).

Narcotics Anonymous

The Narcotics Anonymous (NA) organization is the most significant application of the AA model to drug abuse (Peyrot, 1985). NA is the oldest and largest self-help group for the support of drug abusers. NA was officially organized during 1948. The primary reason for establishing NA was that AA did not necessarily deal with the problems that addicts faced. However, as Peyrot (1985) explains, NA never captured the imagination of the public as AA had done. This could be due to the relatively greater stigma attached to drug addiction as opposed to alcoholism. The Twelve Traditions, which state the purpose of NA and provide policies to guide NA activities, are the foundational principles of NA and all members and representatives must adhere to these principles. The theory of drug abuse posited by the NA program states that it is the individual’s addiction, the fact that he/she is powerless over drugs, rather than his/her use of drugs per se which results in life problems for the addict. Addiction is seen as a characteristic of the addict and not as a property of the drug. Hence, the addict is viewed as having an addictive personality or an incurable disease which gets worse over time (Peyrot, 1985). As such, the individual remains an addict even when not using drugs. This is a trait that an addict shares in common with other addicts, and it distinguishes them from all other people, non-addicts. This approach is based on the assumption that all of the members have the same problem. Thus, all treatment is directed toward a single common treatment objective, immediate and permanent abstinence from the use of all drugs and substances. However, the goal of NA is not mere sobriety, the ultimate goal is to transform the addict into the type of person who does not use
drugs; emotional sobriety. This would be someone who lives the way of life outlined in the NA program including continued participation in NA activity. NA meetings comprise the first contact that prospective members have with NA. The meetings fall into three broad categories: 1) discussion type meetings, informal question and answer type meetings, 2) literature study meetings, where members discuss one of the Twelve-Steps to recovery and how it has applied to them personally, and 3) testimonials where a guest speaker often delivers a talk about his/her own experiences which are often followed by testimonials from local members. New members are also assigned a sponsor, a recovering addict, to help them work their program. This relationship is said to be therapeutically beneficial for both the sponsor and the new comer, as it requires the sponsor to continually reimburse himself/herself into the program.

Psychoanalytic Model

Cahn (1970) states that discussions of alcoholism and its treatment appeared in the psychoanalytic literature as far back as 1915. According to this perspective, addiction is a symptom of some underlying personality disorder. Unlike the abstinence models, which emphasizes physiological dependence, proponents of the psychoanalytic model argue that if the underlying personality disorder of an individual is resolved, the alcoholic drinking will disappear. The classical psychoanalytical model places heavy emphasis on unconscious motivation in human behavior. As such, those who adhere to this model contend that addiction is the consequence of an unresolved psychological conflict, which has been repressed into the unconscious (Leeds and Morgenstern, 1996). This unconscious conflict is often thought to have its roots in early childhood.

Since proponents of this model argue that addiction is the result of unconscious conflict which often originates in early childhood, treatment is necessarily long and drawn out (Leeds and
Morgenstern, 1996). Typically, free association techniques and dream analysis are employed by the practitioner in efforts to uncover the underlying personality conflict. Thus, the emphasis of the psychoanalytic model is on resolving unconscious, inner psychological conflicts in the therapeutic process. Thombs (1999) notes that contemporary psychoanalytically oriented practitioners require alcohol and drug use to be stopped completely for treatment to be effective. The belief is that total abstinence is necessary so as to prevent power struggles between the client and therapist. Furthermore, therapists need to be aware that transference and counter-transference may occur. In such situations it is imperative for therapists to remain objective and to not take the hostility personally or become discouraged (Thombs, 1999). It is emphasized that progress in treatment is largely the responsibility of the alcoholic or addict.

Critics of the psychoanalytic view of addiction point out that there are several difficulties with psychoanalytic studies of addiction from a rigorous methodological standpoint. These are similar to those criticisms often directed at psychoanalysis as a whole (Leeds and Morgenstern, 1996). For example, conclusions are drawn from either single case studies or clinical reports based only on a few addicts. There is a frequent failure to distinguish among different types of addiction or levels of severity, and there are difficulties in establishing adequate control or comparison groups. Leeds and Morgenstern (1996) point out that significant advances have been made in the understanding of addictive behaviors in the last two decades. As a result, the authors argue that traditional psychoanalytic views and treatment techniques are “out of step” within an increasingly well-validated paradigm which views addictive disorders with an integrative biopsychosocial perspective.

Social Theory and Learning Theory

In the 1960s and 1970s the disease concept of alcoholism was increasingly questioned by
epidemiologists and the primacy of alcoholism as the major alcohol problem was challenged (Single, 1997). This gave rise to the public-health perspective and research and prevention programming began to focus on individual levels of consumption rather than alcoholism. Single (1997) notes that this perspective uses the classic paradigm of agent (i.e. alcohol), individual and environment to explain variations in problem levels and to address prevention efforts. Social theory and learning theory are examples of this type of reasoning.

For instance, social theory emphasizes the individual’s social and cultural environment as the primary contributors to substance abuse (Segal, 1988). Social theory demonstrates that sociocultural forces, such as ethnicity, poverty, family dysfunction, gender, class, war, etc. are key in determining the origin of substance abuse. Hence, social factors are seen as the critical variables in addiction patterns (Hanson, 1991). Social context is seen as the source of the problem, and substance abuse is the means of coping (Beigel & Ghertner, 1977; Stephens, 1991). Intervention based on social models of addictions assumes that in order to eliminate the substance abuse, one must change the social conditions which produce it (Hanson, 1991).

Consequently, treatment according to this theory focuses on modifying the individual’s environment and trying to improve his/her ability to function socially. Hanson (1991) notes that examples of “intervention such as vocational training and job development programs designed to give addicts access to the legitimate opportunity structure, therapeutic communities that remove addicts from pro-drug subcultures and place them in anti-drug environments, and worksite prevention programs aimed at organizational factors that normalize drug use,” are consistent with this theory (p. 70). Thus, rehabilitation may include life/social skills training, employment training, and relocation to another social context (i.e. halfway house, residential treatment) (Beigel and Ghertner, 1977).
In addition, learning theory argues that addictions are learned behaviors which are maintained by antecedent and consequent events (Hanson, 1991). It is argued that addictions are learned in the same way that any other behavior is learned. As a result, this theory holds that in order to understand one’s substance abuse, “the antecedent stimuli that elicit drug use, the mediating events that impinge on it, and/or the consequent effects that maintain it” need to be discovered (Hanson, 1991, p.69). Since proponents of this theory believe that the drinking and drug using behavior is learned, it can be changed through other learning. Therefore, practitioners using a cognitive-behavioral approach pay attention to the origin of the learning such as the media, family of origin, and peer group (Justice Institute of British Columbia, 1996).

Interventions based on learning models emphasize the individual’s behavior and the contemporaneous factors that affect it. It is assumed that breaking the addiction cycle involves disrupting the reinforcement patterns that support the addictive behavior (Hanson, 1991). McCrady (1984) states that “Stimulus control procedures, alternate skills training and behavioral marital therapy are behavioral treatments which aim to alter the antecedents to drinking” are components of treatment (McCrady, 1984, p.439). Hanson (1991) lists aversive conditioning, contingency management, cognitive restructuring, and skills development as examples of techniques used to interrupt drug use behavioral patterns and to develop alternative behaviors. Thus, attention is paid to assertiveness training, communication skills development, looking for triggers for drinking and drug abuse and relationship work. The goal of treatment is either abstinence or reduced drinking/drug use.

**Harm Reduction**

The late 1980s witnessed the emergence of the harm reduction approach, which represents a shift from the legal sanction debate to public health principles. The harm reduction
approach is based on public health principles and avoids the extremes of value-loaded judgments on drug use. At the practical level, the goal of harm reduction is to decrease the more immediate harmful consequences of drug use via pragmatic, realistic and low-threshold programs (Cheung, 2000). At the conceptual level, harm reduction maintains a value-neutral and humanistic view of drug use and the user. The focus is shifted away from the drug use itself to the consequences or effects of the addictive behavior. These effects are evaluated primarily in terms of whether they are harmful or helpful to the drug user and society in general. Abstinence is neither insisted upon nor rejected and the active role of the user in harm reduction is acknowledged. At the policy level “harm reduction generates a patchwork quilt of middle-range policy measures that match a wide spectrum of patterns of drug use and problems” (Cheung, 2000, p.1698). Needle exchange programs, methadone programs, and outreach programs for high-risk populations are just a few examples of harm reduction strategies. Erickson (1999) explains that there have been three phases in the development of harm reduction. Erickson states that the first phase of harm reduction stemmed from the growing concern about health risks associated with tobacco and alcohol use in the population during the 1960s. Then, the second phase began in the 1990s with a focus on AIDS prevention among intravenous drug users. According to Erickson, we are currently in the third phase where an integrated public health perspective is being developed for all licit and illicit drug.

Marlatt (1998) explains that although harm reduction has its historical roots outside North America, the movement is quickly taking hold as a public health alternative to both the moral model (“war on drugs”) and the medical model (addiction is a disease). The moral model and the medical model have long dominated North American drug policy and addiction treatment philosophy (Marlatt, 1998; Alexander, 1990; Erickson, Riley, Cheung and O’Hare, 1997).
Proponents of harm reduction see it as a grassroots movement which has emerged as a middle path between the polarized opposites of the moral and medical models. However, critics of harm reduction reject it as being overly permissive in its rejection of strict "zero-tolerance" policies and its promotion of alternatives to abstinence (Alexander, 1990). Marlatt states that some critics have even accused the harm reduction movement of being a "front" for drug legalization.

Marlatt (1998) states that there are five basic principles of harm reduction. First of all, as already discussed, harm reduction is a public health alternative to the moral (criminal) and medical (disease) models of drug use and addition. Marlatt explains that, as expressed in U.S. drug control policy, the use and/or distribution of certain drugs is a criminal offense deserving of punishment. He argues that as an extension of the moral model, the criminal justice system and national drug policy makers have joined forces in declaring a "war on drugs". The ultimate goal of this "war" is the development of a drug-free society. Thus, the goal has been on supply reduction, where drug dealers and drug users alike are arrested, and demand reduction techniques such as treatment and prevention programs.

Secondly, as opposed to the moral and medical models' insistence upon total abstinence as the only goal of either incarceration or treatment, harm reduction accepts the reduction of harm as an alternative to the ideal outcome of abstinence. In contrast to the medical or moral models, harm reduction distinguishes between lighter and heavier drugs and degrees of use. Marlatt (1998) discusses how life long abstinence along with continued attendance at Twelve-Step recovery groups is the only acceptable goal of most treatment programs. Furthermore, abstinence is usually always a precondition for treatment. Most treatment programs refuse to admit patients who are still using substances (Marlatt, 1998). Although harm reduction is not anti-abstinence, it places harmful affects of drug use on a continuum and encourages individuals
with excessive or high-risk behaviors to “take a step down” to reduce harmful consequences of their behavior.

Thirdly, harm reduction is a bottom-up approach based on addict advocacy rather than a top-down approach which implements policies promoted by drug policy makers. Many of the harm reduction projects Marlatt (1998) reviews in his text have originated at the local level and have often been promoted through grassroots advocacy. Fourthly, harm reduction promotes the low-threshold access to services (i.e. street-based outreach programs) as opposed to traditional, high-threshold approaches. Rather than setting abstinence as a high-threshold requirement for receiving assistance or accessing treatment, harm reduction advocates are willing to reduce such barriers in attempts to make it easier for individuals to access their help. This is done by being willing to meet individuals on their own terms and reducing the stigma associated with problems of addictions and substance abuse. Lastly, harm reduction is based on a compassionate pragmatic approach which accepts that harmful behavior happens, as opposed to a moral idealism. Marlatt states that harm reduction is a compassionate approach because it does not denigrate people who engage in substance abuse.

Biopsychosocial Model

Finally, we come to the official theory of addictions in British Columbia, the biopsychosocial/spiritual model. The Justice Institute of British Columbia (1996) states that the biopsychosocial/spiritual model has been “recently adopted as the guiding model for alcohol and drug treatment programs in British Columbia” (p.10). According to the policy document, which I have included as appendix A, Alcohol Drug Services Management determined the biopsychosocial/biopsychosocial/spiritual theory to be the most appropriate theory to use because it allows for the most comprehensive approach to providing services to individuals dealing with
substance abuse problems. This document argues that following this theory allows individual agencies the freedom to be able to “focus on specific dimensions of problems related to substance misuse and to deliver services tailored to the needs of their specific client population.” (Adult Clinical and Addictions Services Branch, Alcohol and Drug Services, 1996; p. 1). In addition, this document not only describes the biopsychosocialspiritual theory, but it also contrasts it with other traditional theories of addiction such as the moral theory, the spiritual theory, the disease theory, the symptomatic theory, the social theory, the chemical dependency theory, and the learning theory in how it incorporates strengths of the older traditional theories. Wallace (1985) states that this theory links varying perspectives of different disciplines, ideologies, and paradigms in its aim to create a more broadly based view of addiction.

There has been the addition of the spiritual dimension because Alcohol and Drug Services argue that the spiritual aspect of the biopsychosocial theory has generally been underemphasized in most discussions of the theory. However, as Soden and Murray (1997) note, the spiritual aspect of human existence, as identified by numerous clinicians and Twelve-Step mutual aide programs, is a component of the biopsychosocial model. As I have already mentioned, for the purpose of this paper, I will be using the term biopsychosocial, rather than the term biopsychosocialspiritual, as it is most commonly used in discourse.

The biopsychosocial model is a multi-variate approach to substance abuse. It accounts for the multiple pathways to addiction with specific factors playing a greater or lesser role for any given individual (Margolis and Zwehen, 1998). Substance abuse is understood as resulting from the complex interactions of a combination of psychological, biological, social and spiritual determinants (Donovan and Marlatt, 1988). Thus, neither physiological nor social, or cognitive or psychological factors alone are sufficient to explain addiction. Instead, addiction is viewed as
being an interactive product of social learning in a situation involving physiological events which are interpreted, labeled, and given meaning by the individual. Thus, the social and psychological factors and the physiological elements are fundamental features of the entire experience and process of addiction. The table in appendix B, taken from Margolis and Zweben (1998), illustrates how multiple pathways lead to alcohol and drug disorders. Along these same lines, the Addiction Research Foundation (1996) under recommended intervention states; “no single treatment approach is appropriate for all people, a wide range of treatment options should be available, it is best to match the client with treatment that most closely meets his/her needs, strengths and situation” (p. 34).

Soden and Murray (1997) state that, during the last decade, as we integrate different perspectives and develop more sophisticated conceptual models of substance abuse, the biopsychosocial model of addictions has emerged as the cornerstone of a new and more comprehensive approach to addictions treatment. Wallace (1985) argues that models failing to take biological, psychological or social components into account will be incomplete in their explanatory power. As Wallace (1989) states, “Elements of conditioning and learning are surely involved in alcoholism, as are neurobiological processes, genetics, cognitive processes, family systems, society and culture.” (p.332). Donovan and Marlatt (1998) explain that the “fragmentation of the past decade is being reduced, with an increased effort toward the development of general theories of addiction” (p.5). The emergence of the biopsychosocial model in the areas of health psychology and behavioral medicine is seen as a cornerstone in this effort (Schwartz, 1982). In a broad sense this model is seen as providing a framework within which psychological, biological, and sociocultural approaches to health and illness can be integrated (Schwartz, 1982). As such, substance abuse disorders are now seen as the result of
various characteristics within an individual interacting with numerous environmental factors. Upon commencement of my literature review on the biopsychosocial model, the wide acceptance and usage of this model in the health sciences became quite apparent to me. It seems that this model is used in looking at eating disorders, psychiatric disorders, illness such as coronary heart disease, and so forth.

Schwartz (1982) argues that previously, there had been many "reductionist" and "mechanist" approaches to addiction in that there was a tendency to view addictions as arising from a single, unidimensional causative factor. Thus, addiction was assumed to be a process involving a single cause and a single effect. Donovan and Marlatt (1988), argue that such reductionistic theories are overly narrow and restrictive and fail to adequately account for the entire addictive experience. Recently, there has been a move away from this type of thinking (Peele, 1985). Addiction is viewed as arising out of the interaction of psychological, environmental, and physiological factors. As such, both biological and nonbiological factors are viewed as fundamental components of addiction (Peele, 1985). Schwartz states that this view is consistent with the biopsychosocial approach to health and medicine. This model provides a metatheoretical framework in which psychological, biological, and social factors are believed to interact to determine a given health status (Schwartz, 1982). Thus, it is believed that an individual's status emerges as a consequence of the interaction of multiple causes. As such, addiction is seen as a comprehensive experience. It involves physiological changes in individuals (many of whom may be genetically and/or psychologically predisposed) as these are interpreted and given meaning by the individual within the sociocultural context in which the addiction occurs (Peele, 1985).

Donovan and Marlatt (1988) argue that the biopsychosocial model represents an emergent
paradigm within the field of addictions. As we know, the nature and focus of client assessments are guided by the assumptions of the theoretical system from which the clinicians operate. The theoretical orientations and paradigms help the clinician to focus his/her assessment, the nature and source of information considered to be pertinent or irrelevant and ignored, and the ways in which such information will be organized in order to provide an understanding of the client and the presenting problems (Donovan and Marlatt, 1988). There are a number of implications from the biopsychosocial model which bear on the assessment of clients with substance abuse issues. Since the biopsychosocial model is a move away from the reductionist view of illness, it is insufficient to describe a client as either well or ill. These types of binary “either-or” views have been replaced by a broader, holistic view (Donovan and Marlatt, 1988).

Furthermore, as Schwartz (1982) states, the biopsychosocial model assumes that treatments will interact with one another in addition to interacting with the person and his/her environment. Consequently, the assessment process is not seen as being static. Instead, it is seen as being a dynamic process. Thus, the assessment process assumes a more expanded and more prominent role in the biopsychosocial approach to addictions than it may have had in previous approaches. This approach involves the use of multiple assessment procedures and focuses on multiple target behaviors (Donovan and Marlatt, 1988). The biopsychosocial model contends that it is crucial that clinicians always consider the interaction of biological, psychological, and social factors when assessing a client’s condition and making appropriate recommendations for treatment (Schwartz, 1982). Therefore, the primary goal is to gain a sufficient understanding of the individual and his/her addiction in order to determine the most appropriate treatment option. Furthermore, the social and spiritual components of this model allow it to go down cultural paths and take cultural diversity into consideration. Thus, the underlying assumption is that the more
information gathered the better and the greater the likelihood of finding a suitable match between the client and the treatment.

Thus, a major tenet of the biopsychosocial model is on multiple systems and how they interact with one another. Addiction is seen as being determined by physiological, social, behavioral and environmental factors. The interaction among these multiple systems contributes to the set and setting which may influence both the development and maintenance of the addiction (Wallace, 1985). In form, the biopsychosocial model is compatible with the traditional medicine wheel concept. The biological, psychological, social and spiritual components of the biopsychosocial model bear some resemblance to the physical, mental, emotional and spiritual quadrants of the medicine wheel circle of healing (McGaa, 1990).

In contrast to traditional theories of substance abuse, the biopsychosocial model maintains that the problem is the result of a multitude of factors. In addition, it is recognized that individuals with substance abuse issues are a diverse group. Soden and Murray (1997) describe how these individuals vary with respect to their patterns of consumption, family history, current environment stressors, self-esteem and self-efficacy, coping skills, employment status and educational achievements, social supports, financial resources, physical and emotional health, and beliefs and attitudes, including those that pertain to their drug use. Hence, the biopsychosocial model recognizes that problems related to the abuse of substances may develop in anyone and are not confined to a single personality type. Likewise, they may result in numerous and differing consequences for people (Donovan and Marlatt, 1988). As a result, this model argues that it is essential that a variety of treatment options be considered and be available so that treatment planning can most effectively match interventions to the needs, strengths, and circumstances of each client (Pattison and Kaufman, 1982). Thus, successful treatment depends
upon accurate and comprehensive assessment and matching of individuals to the most appropriate available treatment options.

In sum, the biopsychosocial model attempts to integrate theoretical and empirical data from different schools of thought into an integrated conceptual framework. This model is based on the premise that biochemical factors, disorders of self, learned or conditioned factors, and family social factors contribute to the initiation and maintenance of the addiction. The biopsychosocial model stresses that there are multiple pathways to addiction and that the differential effects of these factors varies from individual to individual. As such, the population of substance abusers are seen as heterogeneous and comprehensive individual assessments of clients are vital in adequately determining individual client treatment needs.

Taking a Closer Look at Treatment Programs Guided by the Biopsychosocial Model

Thus, it becomes clear from this brief overview of theories that the biopsychosocial theory is indeed a more holistic theory than its predecessors. In addition, the biopsychosocial model is based on harm reduction, rather than simply abstinence. The primary goal of harm reduction is reducing harm and as such the focus is on the harmful consequences of use and not the use per se (Single, 1997).

However, although all of these theories differ in many respects, it is my contention that they all have a predominantly micro focus in that they narrow their focus to the individual and his/her addiction and ignore structural issues also faced by the individual. At this time I will direct the reader’s attention to a couple of substance abuse treatment programs in Prince George, which fall under Alcohol and Drug Services, to further illustrate my argument. First of all, let us explore the newly opened Nechako Youth Detox/Stabilization Unit. This is a residential treatment program which follows the biopsychosocial approach. Youth can come and stay in the
program for up to thirty days. During their stay the youth follow a very structured program
composed of individual and group activities. Ideally, youth attend about three groups a day
interspersed with physical activities and recreational activities such as going bowling, swimming
or to the movies. The groups deal with topics such as drug education (i.e. harmful affects of
drugs), and behavior modification groups which address self-esteem issues, conflict resolution,
family relations, goals, grief and loss, spirituality and cultural traditions, stress and self-care,
S.T.D.s, the drug and alcohol cycle of addictions and values and beliefs (Donna Skare, personal
communication, July 10, 2000). In addition, they attend Alcoholics Anonymous meetings once a
week or as needed, and are encouraged to do daily journaling. Skare (2000) also mentioned that
the youth access individual counseling which is focused on their substance abuse and what
causes them to use. Furthermore, the program also focuses a great deal on relapse prevention.
While the youth are residing at the Centre, they are restricted to one phone call per day and
visitation is discouraged. After a close examination of this program it becomes evident that this
much needed resource offers a lot of valuable services to the youth. However, the treatment is
focused on the individual and the drug use (i.e. drug education, dealing with past issues/events
that are believed to play a large role in the addiction). As such, it does not appear that there is
much attention paid to macro level issues such as poverty and lack of education and job skills
which also work to prevent these individuals from maintaining their sobriety after treatment.

On the other hand, there is also the Native Friendship Centre Alcohol and Drug Program,
which also falls under Alcohol and Drug Services. This is an outpatient program which is run
out of the Native Friendship Centre. This program employs two drug and alcohol counselors,
one of whom works with adults coming out of jail and through the courts and the other works
with youth and women who have substance abuse issues and have had their children removed by
the Ministry for Children and Families. During a meeting with Eileen Ishizawa, on July 26, 2000, I learned that she refers some of the women that she works with to groups and encourages her clients to attend Twelve-Step groups. In addition, Aldon Pompana, the spiritual advisor at the Native Friendship Centre, provides the spiritual aspect of therapy. Ishizawa (2000) stated that their belief is that alcohol and drugs are used by people to mask the trauma that they incurred in their pasts (i.e. residential schools, family violence, sexual abuse, et-cetera) (Eileen Ishizawa, personal communication, July 26, 2000). As such, the one-on-one counseling focuses on people’s underlying issues and is coupled with psycho-education (education about drugs and the harm they cause). After the stabilization work is done with clients in this program, they are referred to other counselors in the Native Friendship Centre. Individuals are able to work with more specialized counselors to deal with their past issues (i.e. family violence, sexual abuse, residential schools, et-cetera). In addition, the counselors also make referrals to residential treatment centers both within and outside of Prince George. Again, after a brief overview of this program it becomes apparent that it too focuses on the individual and his/her drug use (i.e. drug education, dealing with past issues/events that are believed to play a large role in the addiction).

Thus, it would appear that while attempts are made to deal with the micro issues during individual and group counseling, the macro issues such as poverty, and socio-economic status are left untouched.

To further illustrate this perceived reliance on micro approaches, I will use an actual case example of an individual I worked with a few years ago who came from a low socio-economic background and was trying to overcome her cocaine addiction. Through the following discussion of this individual’s struggle with her addiction, I hope to demonstrate how the focus of the treatment programs which she accessed undermined her success. However, before doing this I
would like to turn the reader’s attention to the method utilized in developing the current project report.
CHAPTER FOUR

Approach

Introduction

In this study, I will be engaging in a retrospective analysis of my case example using a social development framework. This project examines the story of a young adolescent (Janie) in her struggle with overcoming her addiction, as I have understood it. In writing up my case example, although I have conversed with past co-workers, I have relied mainly on my memory. I realize that reliance on my memory may cause some to question the accuracy of the accounts in this case example. However, at the time there were few case notes made about the progress of Janie, especially in terms of her substance abuse, and those notes that exist are confidential and inaccessible to me because I am no longer working in that setting. Furthermore, due to the fact that Janie is deceased, I was unable to check back with her to make sure that my reporting is completely accurate. However, as I have mentioned, I have had informal discussions with past co-workers in regards to my case example to check/confirm the accuracy of my recollections. This project takes the form of, what Hemingway (2000) has labeled, a modified case study as prescribed by the UNBC Social Work Program Handbook (Tang, 2000). Before entering into further discussion about the application of the modified case study approach, I would like to turn the reader’s attention to traditional case study research and why this approach was chosen for the current project.

Traditional Case Study

Moon and Trepper (1996) share that although the case study method has had a checkered past in which support for it has swayed, there has been a reawakening of interest in case study research in recent years. Furthermore, although there are many and varied definitions of case
study research available, they share common key features. Moon and Trepper argue that there are essential characteristics of case study methodology. First of all, they are in-depth studies of a small number of purposively selected cases (or a single case). The cases studied can be clearly bounded systems, such as individual clients, or less well-bounded systems, such as events or time periods.

Reliability and validity are important factors in field research and these are ensured in case study research in many ways. Lincoln and Guba (1985) state that rigor in case study research can be measured in terms of internal and external validity and reliability. Internal validity refers to the extent which the findings match the reality whereas external validity refers to the extent to which the findings can be generalized beyond the case. Finally, the extent to which the findings can be replicated refers to its reliability.

Moon and Trepper (1996) state that case studies can be conducted using quantitative, qualitative or mixed methods of data collection and analysis. However, Merriam (1988) disputes that although this is true, there is a tendency for case study research to be descriptive or qualitative where the objective is to describe and explain a phenomena rather than to predict or identify cause and effect as is the case with quantitative methods. Stake (1994) states that the case study optimizes the researcher’s understanding of the case rather than generalizations beyond. Furthermore, Yin (1994) states that the case study method is useful when researchers are examining contemporary and/or unique events. In addition, Merriam states that case study approaches are the preferred method when exploring issues where understanding of the issues is sought in order to improve practice. Thus, it is my contention that the case study appears to be appropriate for the current research because the aim of this research is to gain a better understanding of the experience of individuals from low socio-economic status in substance
abuse treatment in hopes of learning how to better assist individuals in treatment.

**Modified Case Study Approach**

The reflections and analysis of the researcher, in reference to a specific practice experience, make up the principle components of the modified case study approach (Tang, 2000). Tang (2000) outlines that, generally, the case will be an individual, group, process or policy with which the students are familiar from their professional practice experience (either field practicum or previous employment). Hemingway (2000) explains that the modified case study approach involves retrospective reflection of a case through the practitioner’s eyes. This is unlike traditional case study research which consists of structured data collection such as in-depth interviews with study participants. As such, data is gathered from personal observations, reflections, and recollections or documentary records, based on the researcher’s direct experience (Hemingway, 2000). Then, these data are analyzed within the context of a review of the related literature and “filtered through the lens of the researcher’s epistemological framework” (Hemingway, 2000, p.26).

In this report, the case examined is that of a young adolescent girl, who I refer to as Janie. I initially met Janie while I was working in a residential resource and then later worked with her again as an outreach counselor. This project is grounded in a search of the literature relating to substance abuse treatment, both historical and contemporary and explores some of the dominant attitudes that have existed in regards to substance abuse and what these have meant in terms of treatment. I have chosen the social development approach as “my lens” through which to analyze this case.

In accordance with Stake (1998), I realize that since this is an analysis of a single case, my study will primarily optimize the understanding of the case rather than generalization beyond.
However, although I will be analyzing the story of one youth, her experiences have been echoed in the literature and in the stories of the struggles of other addicts. Furthermore, my decision to include descriptions of substance abuse treatment programs in Prince George and their mandates and underlying models, and to also analyze these from a social development approach, has been in part driven by my motivation to make my research hold more merit. As Lincoln and Guba (1985) state, in case study research rigor can be measured by truth value (findings match reality), transferability (ability to generalize beyond case), and consistency (reproductive capacity). As such, I have employed a range of sources of information in my study. To ensure that my study is more rigorous, I have done a comprehensive literature review, case study, and a review of the mandates and approaches of two substance abuse treatment programs in Prince George. Moreover, I believe that the involvement of my committee in my study has contributed to the robustness and validity of my analysis and final report.

Now, with the method described, I would like to focus the reader’s attention on my case example; the story of a young adolescent’s struggle in trying to overcome her drug addiction.
CHAPTER FIVE

Janie’s Story

Case Presentation

My client, who I will refer to as Janie, had been a youth in the care of the province since she was twelve years old. From this time she frequently bounced back and forth between foster homes, group homes, and the Prince George Youth Correctional Centre. As one could imagine, this lifestyle of instability prevented Janie from being very successful in school. As she grew older and reached her mid-teens Janie began hanging out downtown with a peer group who had a similar past to hers. Much of their time was spent consuming alcohol and smoking marijuana. Shortly after, she began experimenting with harder drugs such as heroin and cocaine. By the age of seventeen, Janie was using cocaine and had resorted to prostitution and theft to support herself and her drug habit and had been discharged from the Ministry’s care due to her chronic running away from ministry approved residences (i.e. group homes and foster homes). She lived in motels with her boyfriend, who also used heroin and cocaine. Janie’s boyfriend, who I will refer to as Sam, sold drugs and robbed people as his primary means of making money. Sam had about a grade seven education and had no formal work experience. Often Janie’s boyfriend’s mother, who was also addicted to cocaine and heroin and involved in the sex trade, would stay with them.

As Janie had been abandoned by her own mother at a very young age, she had grown quite close to her partner’s mother and shared with me many times how she saw Sam’s mother as a kind of surrogate mother figure. However, regardless of whether or not anyone was staying with them, Janie and Sam’s place was a popular hang out and people were always getting high there.

My initial bond was formed with Janie during her stay at the last group home which she lived in when she was sixteen. It was here that she shared the history of her life with me.
Unfortunately this was also around the same time that she was beginning to experiment with drugs and alcohol and started seeing her boyfriend Sam, who was three years older than her. Janie would often run away from the group home to party with her friends. During those times when she returned to the group home and was “recovering” from the partying, she would often engage in conversations with me about her life and where she saw herself going. Janie shared that she enjoyed going out and partying with her friends and how they were like family to her. I recall Janie discussing how she felt a sense of belonging and actually being cared about when she was with her friends downtown. However, at this time Janie never thought that she would end up like her peers (drug addicted and involved in criminal activities to get by). She often talked about her dreams of working as a counselor with troubled kids when she got older. Eventually, Janie ran away from the group home permanently and began living with her boyfriend and his mother and I lost contact with her for about six months.

A couple of months later I heard from other youth in care that Janie wasn’t doing well and that she had been partying a lot, had lost a lot of weight and had began using cocaine. The next time that I had contact with Janie again was a few months later when I bumped into her while I was shopping downtown. I barely recognized her as she had lost a lot of weight and was looking quite weathered. She seemed quite excited to see me but was on her way somewhere so we agreed to meet later the next day to go for coffee. The next day I met with Janie and she talked about what she had been up to since I last saw her. Janie shared that she had been living with her boyfriend but that they hadn’t been getting along very well lately. Janie was thinking of leaving him because he was doing too many drugs and she was wanting to “clean up”. At this time Janie never really went into too much detail with me about her drug use or how she and her boyfriend were making their money. I never pushed the subject since I sensed that she was
feeling a little embarrassed about the turn her life had taken. After coffee I left her with my business card and explained that I was now working for the Elizabeth Fry Society and that if she ever wanted to chat or go for coffee she could reach me there. Although I never heard from Janie again for about eight months, I often heard from old colleagues and other youth in care that she was now prostituting and heavily using cocaine and heroin on a daily basis.

Then, in the spring of 1997 a colleague who worked in another program brought Janie in to see me at my office. Janie was three months pregnant. We went for coffee and Janie talked about what she had been up to. At this time she talked about how she had been prostituting and using cocaine and heroin quite heavily. She shared with me that she had tried to “clean up” a few times and had spent some time at a detoxification center in the past few months but found it quite difficult because she had no support as her boyfriend and all of their friends still used. The detox centre was a residential detoxification centre connected to the hospital which employed medical and paramedical staff and administered tranquilizers and sedatives to help alleviate withdrawal distress in individuals. At this time Janie stated that she had now decided to “clean up” for her baby and felt that she was now ready. She informed me that she was on the wait list for a treatment center and that she had been seeing a drug and alcohol counselor. Janie was again talking about how hopeful she was about the future and how she wanted to work as a counselor and help troubled kids. Janie accessed individual substance abuse counseling at an outpatient program which serviced clients who were primarily First Nations. These individual counseling sessions involved drug education, and a major focus on unresolved past issues (i.e. childhood abuse and family violence) in Janie’s life. In addition it was strongly encouraged that Janie also attend NA meetings on a regular basis. When Janie was focused and actively working to overcome her addiction, she would report attending NA meetings on a weekly basis.
Unfortunately Janie never made it into the treatment center because she had not been successful in abstaining from drug use for the entire two weeks prior to the time she was supposed to enter treatment. This was a residential treatment centre which employed the medical model and consisted of structured programming involving both group and individual work and required attendance at AA and NA meetings. The program had the condition that prior to entering it, an individual had to have already maintained a certain length of sobriety. After she was turned away from the treatment program, a combination of the feelings of guilt and disappointment led Janie back into the life of prostitution and heavy drug use again. Although I had tried to look for Janie on several occasions, as had other professionals, I was unable to reconnect with her until three and a half weeks later. At this time she was able to articulate her feelings better and was able to discuss how difficult it had been for her to maintain her sobriety, prior to entering treatment, when everyone around her was using and she had no supports. She stated that her partner had tried to support her initially by not using around her and cutting down on his use as well. However, this did not last long. Sam’s mother began supplying enough drugs for the three of them to use and she was constantly using in the house. In addition, their friends were constantly coming to the house and getting high around Janie. We discussed Janie’s experience and her feelings at length in several sessions after that and were able to do some brainstorming around what would make achieving and maintaining sobriety easier for her. Janie shared that her friends and partner meant a lot to her. Even when she talked about Sam’s mother, she talked about how much support and care she received from her. Although I don’t think that I actually recognized it then as well as I do now, her friends and her partner and his mother made up her support and social network, in essence they were her community. She valued her community a great deal and felt a real sense of belonging there. It was all that Janie had.
About a month later Janie learned from her drug and alcohol counselor, who she had been seeing sporadically in the last month, that an opening was coming up in a residential treatment center down south. We talked about her going down there and she shared with me both her desire to go to treatment and “clean up” as well as her fear and anxiety around leaving Prince George and leaving Sam and his mother and their friends. After a great deal of soul searching and meetings with her drug and alcohol counselor and myself she decided that she would go to the treatment center. This was an eight-week residential treatment program for male and female youth between the ages of thirteen and nineteen. The program was self-described as being an intense, structured program consisting of individual and group work. The pre-requisites for the program were that clients had to be “clean” and seeing a drug and alcohol counselor on a regular basis prior to entering the program. I met with Janie a few days before she left and she was feeling quite good about her decision and seemed to have some support from her partner and a few friends. Janie talked about her future plans and how after she came back from treatment she was going to get a job and get a place outside of downtown where she and her partner and their baby would live. Janie was quite confident that if she “cleaned up” and was able to get a job, and thus a legitimate income, that Sam would do the same. Janie predicted that by the time their baby arrived they would be doing okay.

Janie went away to treatment and did quite well in the program. She was looking much healthier and happier when she had returned and quite noticeably pregnant. However, she faced many battles in trying to reach her goals. Although she tried quite hard, she was unable to find a job due to her very limited education and the fact that she had no actual work experience. Eventually, she had to resign herself to staying with her partner and his mother because Janie felt that she had no means of supporting herself. She had even been attending some NA meetings
and had her partner go to a couple with her as well. Unfortunately though, the support from her partner did not last long. In addition, Janie stated that she had to deal with a lot of peer pressure from her friends about not using or prostituting anymore. Many of them would become quite offended and angered by her not using and she was often ostracized and bullied because of her choice. However, as time went on and Janie remained in her “home environment” she began using and prostituting again. From this time to until her baby was born, Janie struggled with “cleaning up” many times. She checked herself into a detox centre a few times, and once even with her partner. However, despite her efforts, her sobriety never lasted very long.

Then, when her child was born Janie contacted me as her baby had been apprehended by the Ministry for Children and Families. Janie was devastated. I accompanied Janie through the court proceedings and it was decided that the child would go into foster care and that Janie would need to be “clean” and sober and able to care for her child before he would be returned to her.

The next hearing was set for three months later to review Janie’s situation. In these three months Janie tried to “clean up” on many occasions. She even went as far as leaving her boyfriend on a few occasions and tried to apply for social assistance but found that the money she may be eligible to receive was too little and not “worth the hassle”. Unfortunately, the all too familiar roadblocks such as Janie’s limited education and skills prevented her from finding legitimate employment and she always felt forced back to making money the only way she knew how, “working the streets” with her peers. Needless to say, at the three-month hearing Janie never regained custody of her son. Although she was quite upset at this time, Janie remained quite focused and determined that she would turn her life around and have her son back soon.

Unfortunately seven months later, although Janie had been doing better and had decreased her drug use some, she died of a drug overdose.
Case Analysis

Unfortunately Janie’s story is a very sad one with a tragic ending. In my opinion, Janie needed specific supports and resources which were not available to her through the existing resources which she accessed.

It is my belief that if Janie’s treatment had included a greater integration of services (i.e. also linked with education/skills training program, financial assistance et-cetera) then perhaps her story may have had a different ending. If Janie was assisted through the whole process of accessing social assistance and finding decent housing for $325/month or liaised with other youth who were clean and sober and working or going to school, things may have been different for her. Furthermore, I believe that if she had assistance with job/skills training and having education and training incorporated into her treatment plans, and ongoing follow-up support and assistance, she may have received the extra aide that she needed in order to change her environment and remain drug free after treatment. I strongly believe that living on the streets in poverty with very little education, lack of job skills or experience and being surrounded by people in similar predicaments made it very difficult for Janie to access supports, maintain her sobriety and change the course of her life. As I have already mentioned, there were numerous times when Janie attempted to “clean-up”. However, issues such as poverty, and lack of education and skills acted as stumbling blocks in her battles.

Sadly, Janie’s story is not a unique one. It is my argument that the predominantly micro focus of substance abuse treatment programs is not enough to help these individuals like Janie (i.e. low socio-economic status, limited education and skills, poverty) overcome their addictions. Their needs beg for alternative approaches that take macro issues such as poverty, and lack of opportunity into consideration as well as the micro issues such as childhood abuse, drug
education, and family violence that are currently focused on in individual and group counseling sessions. I believe that the incorporation of a social development approach into practice could work to meet this outstanding need.

As I have mentioned earlier in this paper, the social development approach emphasizes the need for micro (individual) and macro (structural/economic) change when dealing with social problems. Critically examining mainstream substance abuse treatment programs from a social development perspective reveals how the majority of mainstream substance abuse programs focus on the individual’s substance abuse as the only issue and, for the most part, ignore the macro issues such as poverty and the role they play in the individual’s substance abuse.
CHAPTER SIX

Analysis and Implications

Although I strongly believe that the biopsychosocial approach to substance abuse
treatment, and its predecessors possess a great deal of merit, they are limited in application and
success. In general, mainstream approaches fail to deal with the social and economic factors
affecting individuals in their “home” environment (macro issues). I believe that this limitation is
illustrated in the case of Janie. When this case is viewed from a social development perspective
it becomes clear that the macro issues in her environment should have also been addressed and
dealt with in addition to the individual substance abuse issues which were focused on in
treatment.

With this said, I reiterate my argument that individuals and their environment need to be
treated alongside one another for optimal success to be ensured in overcoming addictions.
Attention needs to be paid to the macro issues such as the socio-economic struggles that many
addicted individuals face on a daily basis and how these contribute to their substance abuse.
Consequently, I believe that the social development approach lends itself to be a valuable
approach to substance abuse treatment and prevention efforts. It is a feasible alternative
approach to mainstream treatment because it incorporates individual and community healing and
development alongside economic development.

As I have already explained, the social development approach has been most strongly
extended to mainly developing countries. However, as Payne (1997) and Schmidt (2000) argue,
the experiences and success that this approach holds in developing countries is relevant to
Western countries as well. Writers argue that although Western countries possess much wealth
and development, wide disparities in poverty and economic development also exist within their
Social development is relevant to these developing regions of technologically advanced countries where poverty and lack of economic development are a harsh reality. However, as Schmidt explains, although social development is regarded as a legitimate paradigm for social workers in developing countries, it is seldom discussed in regard to developing regions within Canada. Proponents of the social development approach argue that this perspective has all situations relevance to marked by a high degree of poverty and deprivation.

For the purpose of further demonstrating the merit of applying the social development approach within technologically advanced nations such as Canada to deal with social problems such as substance abuse, I would like to turn the reader's attention to rural First Nations communities. First Nations communities generally face more extreme issues than other rural communities in terms of lack of resources and economic hardship. In fact, within the literature, the conditions within many First Nations communities have often been likened to Third World conditions (Report of the Royal Commission on Aboriginal Peoples, 1996).

Furthermore, these communities suffer from alcohol and substance abuse at alarming rates in comparison to non-Native communities. According to information presented in the 1996 Report of the Royal Commission on Aboriginal Peoples (RRCAP), 80% of Native people in Canada are directly or indirectly affected by alcohol abuse. Studies report that of the leading causes of death among First Nations people, four are directly attributed to alcohol abuse: accidents, cirrhosis of the liver, homicide and suicide (Walter, 1991). In addition to the excessive consumption of alcohol having serious physical health consequences, it has serious social and emotional correlates as well. These include accidents, suicides, family violence and breakdown, unemployment, criminal behavior and general failure of the peoples to thrive (RRCAP, 1996).
It is my argument that substance abuse problems are, to a certain extent, symptoms of distress. As I have just mentioned, stresses such as income security, poverty, unemployment and isolation are particularly high in these communities (Bernston, 1993). As such, I believe that adequate substance abuse treatment programs need to help people deal with these stresses (macro issues) in addition to dealing with individual substance abuse issues (micro issues). Watts and Lewis (1988) report that economic deprivation is not the sole reason why many First Nations people misuse substances, but it is a significant one. As recognized in the Report of the Royal Commission on Aboriginal Peoples (1996), dominant discourse on the subject consistently concludes that economic status (personal income and the general prosperity of communities and nations) is of great significance in reference to health and substance abuse. Among other things, the Report of the Royal Commission on Aboriginal Peoples recommends that efforts be made to support individuals’ social and economic development, including acquisition of education, training and employment. Similarly, the report argues that the social and economic development in the community, involving employment, health, housing, social services, education and training also need to be focused on.

As I mentioned earlier, Alkali Lake is a self-professed example of the successful implementation of the social development approach to dealing with community-wide alcoholism (Lucas, 1986). This First Nations community, situated approximately 25 miles north of Williams Lake, was able to attain a recovery rate of 95% over its 15-year battle with alcohol and substance abuse. As the video, The honor of all depicts, alcohol had adversely impacted the entire community. Common dysfunction included: alcoholism, spouse abuse, child abuse, child neglect, sexual abuse, suicide, homicide, excessive bootlegging, low employment, misuse of social welfare funds, and deterioration of the family structure. In Alkali Lake, the problems
facing the community and human needs were addressed on several levels designed to strengthen the community and as a result strengthen the individuals and vice-versa.

Thus, it becomes evident from this brief and narrow exploration of communities which face high rates of substance abuse and low levels of economic development that implementing a social development approach to substance abuse treatment would hold a great deal of merit.

In light of this discussion I would now like to turn the reader’s attention back to the case example presented earlier about Janie’s struggles to maintain sobriety. It is my argument that Janie’s peer group in downtown Prince George was in fact her community. A closer look at this community reveals that many of its members struggle with poverty issues, low levels of education and skills. This community could be described as lacking socio-economic development. However, as my brief analysis of community programs earlier in this paper demonstrated, much of the substance abuse treatment work done by professionals with members of this community tends to focus on micro-issues of the individual and his/her substance abuse. They tend to overlook/ignore the macro-issues such as poverty, lack of economic advancement opportunities and so on, which also impact the substance abuse of these individuals.

Furthermore, the example of the experience of the youth from Davis Inlet, I discussed earlier, also demonstrates this micro-focus in mainstream treatment and the potential it holds for undermining an individual’s ability to overcome his/her addiction(s).

Truan (1993) reiterates my argument in his article when he states that to effectively address social problems, such as addiction, we need to address the needs of the community as a whole in addition to working with the individual. Similarly, Gergen (1991) argues that psychologists and other mental health professionals have failed to confront the actual problem when they heal individual psyches and leave communities to fall apart. Writers such as these
argue that the current emphasis on individual causes and cures, instead of examining social and cultural causes is ineffective (Gergen, 1991; Peele, 1989; Truan, 1993). As such, Truan states that “instead of concentrating on the effects of addiction in our society, perhaps we should examine society’s role as an antecedent to addiction as well as to subsequent problems” (p. 493).
CHAPTER SEVEN

Conclusions

Concluding Remarks

The biopsychosocial approach, although more holistic and complete than its predecessors, still maintains a micro focus in its application. In theory it may appear to have potential to explore the more macro issues which contribute to substance abuse. However, in practice there is still the micro focus on dealing with the individual and his/her substance abuse largely through individual and group counseling and education. Nevertheless, this is not to say that I disregard the value of the biopsychosocial approach. On the contrary, I view it as a very valuable tool in working with individuals to overcome their addictions. The very fact that it recognizes that there are multiple pathways to addictions and that individuals with substance abuse problems are a heterogeneous group speaks volumes about its potential to surpass its predecessors. Along these same lines the biopsychosocial model contends that comprehensive individual assessments are a necessity in order to adequately determine the individual needs of clients. As such, it recognizes that the same treatment approaches will not work for all people.

Thus, it is quite apparent that the biopsychosocial model holds a great deal of merit in working with clients who are struggling to overcome addictions. However, my argument stands that if we are to truly help people be as successful as possible, there needs to also be a focus on the macro issues that affect individuals' substance abuse. My contention is that this focus is particularly important when working with people from low socio-economic status such as the individual (Janie) from my case example.

Proposals for Future Research

I recognize that the ideas put forth in this paper around addressing the more macro issues
which impact substance abuse such as lack of education, skills training, and poverty could probably prove to be quite costly in the short term. However, in light of the staggering figures in regards to the financial costs of substance abuse to society in terms of health care and law enforcement and not to mention the monumental personal and social costs, the magnitude of this social problem becomes apparent and the need to adequately address it becomes more pressing.

With that said, I recognize that what I am proposing would be an immense task for individual professionals working in treatment programs to take on alone. I am sure that many people currently working in this field would attest to how high their workloads are already. On the contrary, I am proposing that there needs to be more integration of services where addictions counselors would continue to do their work with individuals and that other professionals such as education and skills training professionals, also work with the individual clients during their treatment. This would mean a comprehensive individual assessment of people’s education and skills levels in order to determine the macro issues affecting clients and then linking clients with specialized resources and supports to help them to work on these issues. As we have already explored in the body of this paper, the efforts made to bring the community of Alkali Lake out of catastrophic levels of substance abuse looked quite similar to what I am suggesting.

Clearly, the ideas that I am putting forth are very rudimentary and further research and planning would be necessary to understand exactly what an approach of this sort to substance abuse treatment would look like and what it would entail. However, with the growing awareness of the social development approach and pressures to address the more macro issues which impact upon social problems in our society, I predict that there will be more changes to come in the area of substance abuse treatment.
References


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### Policy

**Program Area:** Alcohol and Drug Services

**Topic:** THEORY of ADDICTIONS

**Policy Statement:** Alcohol and Drug Services (ADS) designs and delivers treatment services to meet the needs of persons served in four dimensions: physical, psychological (thoughts and emotions), social/cultural, and spiritual. All treatment services/programs delivered on behalf of ADS will be consistent with this "biopsychosocial/spiritual" (or holistic health) theory.

**Policy Objective:** to maximize consistency in the nature and quality of services that are delivered across British Columbia by harmonizing ADS service delivery with the predominant theoretical model in the international addictions field.

**Background:**
- The ADS System of Care evolved over many years from independent and unique agencies which vary in their approach to substance misuse and treatment of substance misuse.
- In order to ensure that treatment services provided on behalf of ADS are congruent with current professional practice in the addictions field throughout the world, ADS Management has determined that the "biopsychosocial/biopsychosocial/spiritual" theory allows for the most comprehensive approach to providing services to people with substance misuse problems. In addition, adherence to this theory also allows agencies the flexibility to focus on specific dimensions of problems related to substance misuse and to deliver services tailored to the needs of their specific client population.

**Protocol:**
1. Approval of agency Program Proposals, as required in the contracting process, will require congruence with the biopsychosocial/biopsychosocial/spiritual theory.
2. Assessments and treatment plans will reflect consideration of all four dimensions of the biopsychosocial/biopsychosocial/spiritual theory.

**Standard:** Standards 4.A.1, 4.A.4, 4.B.5, 4.B.6
# Policy

**Program Area:** Alcohol and Drug Services  
**Issue Date:** January, 1996

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**Amendment Date:**  
**Policy Number:** 4.A.d

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The BioPsychoSocial Theory Approach

ALCOHOL & DRUG SERVICES

APRIL, 1996

ADULT CLINICAL & ADDICTIONS SERVICES BRANCH

MINISTRY OF HEALTH AND
MINISTRY RESPONSIBLE FOR SENIORS
THE BIOPSYCHOSOCIAL THEORY: A COMPREHENSIVE DESCRIPTIVE PERSPECTIVE ON ADDICTION
Alcohol and Drug Services

INTRODUCTION

This paper describes the Biopsychosocial Theory and contrasts it to the traditional theories of addiction. Included in the discussion is how the new theory incorporates the strengths of the older traditional theories while remaining a distinct entity with a unique set of hypotheses, and the addition of the spiritual dimension, which, from the Alcohol and Drug Services' (ADS) perspective, has generally been underemphasised in most discussions of the biopsychosocial theory. ADS also views this theory as an articulation of the “holistic health” or “public health” concept of total health. Therefore, the term “biopsychosocial” will be used for convenience throughout this paper to represent the “biopsychosocialspiritual” or “holistic health” concept.

Before discussing any substance misuse theory, a general description of what a theory is and what a theory does should be considered. An addiction philosophy or theory is an abstract framework that organizes the concept of substance misuse into a set of fundamental intuitive principles. As such, any theory permits its adherents to prioritize problems and to search for and discover solutions to these problems within the context or boundary conditions of the theory. Through distinct relationships between terms and concepts, each theory provides a unique perspective of substance misuse easily recognizable to its proponents. Finally, a good theory is scrutinizable, and rigorous scientific evaluation via randomized controlled trials is considered to be the “gold” standard. Such a verification mechanism permits adherents to become increasingly confident in the correctness of their choice as empirical support accumulates.

Once a critical mass of individuals is 'tuned into' both the aesthetics and the problem solving potential of a theory, the group is then ready to be guided in their behaviour by the principles of the theory. These principles become the rules of the game. Because these rules are accepted almost unconditionally, members of an
organization are able to focus their attention on the fulfilment of the mission of the organization without constantly having to debate underlying philosophical principles. Instead, they concentrate on articulating goals and objectives evolving out of the world view established by the theory. Relevant problems are isolated and potential viable solutions are visualized allowing the process of problem solution to proceed at a quickened pace.

TRADITIONAL THEORIES OF ADDICTION

1. Moral Theory

The moral theory denotes substance misuse as a vice or a sin. The theory implies that some individuals, through their own free will, make a conscious choice to become substance misusers.

Within the context of the moral theory, treatment involves: holding people accountable for their substance misuse, very often through the application of shame and blame; avoiding enabling of their substance misuse, and; not protecting them from the consequences of their substance misuse. In some instances, treatment may be punitive, e.g. religious persecution or criminal incarceration, with the expectation that specific punishment will eliminate the "bad" behaviour.

2. Spiritual Theory

The spiritual theory attributes substance misuse to the absence of a metaphysical focus within the affected individual. This theory suggests that some individuals are powerless over their substance misuse. With regards to the spiritual theory, recovery is only possible if affected individuals acknowledge their inability to self-correct without the assistance of a spiritual force guiding them through the process of recovery.

3. Disease Theory

In this instance, substance misuse is deemed to be a unitary disease characterized by specific features including loss of control over substance use or consumption. Substance misusers are considered to be different from non-misusers. Substance misuse is a progressive illness with an identifiable natural history as well as a permanent condition or lifetime illness. A percentage of the total population inherits a genetic predisposition for the disease.
Some implications of the disease model are:

a) all substance misusers require the same treatment goal, i.e. abstinence.
b) individuals with a family history of substance misuse are at higher risk of
becoming substance misusers themselves due to the presence of an inherited
defective gene(s).
c) treatment is required in order to avoid the consequences of untreated substance
misuse up to and including death.
d) spontaneous recovery is unlikely.
e) even with treatment, the potential for relapse is always present regardless of the
duration of sobriety.

4. Symptomatic Theory

Within this context, substance misuse is a symptom of another primary mental
disorder, e.g. anxiety, depression, neurosis, personality disorder.

The major implication of this theory is that treatment of the underlying psychiatric
disorder will lead to remission of substance misuse. Therefore, attention is focused
on diagnosing and treating coexisting psychiatric illness. Like the disease theory,
this theory discounts the possibility of recovery without formal treatment.

5. Social Theory

This theory hypothesizes that substance misuse develops and endures as a result of
disruptive social forces such as unemployment, poverty, violence, family
dysfunction, as well as gender and
age inequities. These forces are believed to act as social stressors and substance
misuse is considered to be an adaptation to the resultant misery and unhappiness.

Treatment concentrates on environmental modification and attempts to improve the
ability of the affected individual to function socially. Rehabilitation may include
the development of job and social skills plus modification of the daily living
environment. Broader social modification might be achieved through decreasing
the availability of various substances along with the application of constraints upon
patterns and styles of use of substances or by reducing social inequities confronting
disadvantaged groups such as women, the elderly and racial minorities.

6. Chemical Dependency Theory
Here, substance misuse is a syndrome characterized by a clustering of both biological and psychological phenomena, as described by Lindstrom (1992). These phenomena are signs and symptoms of:

a) An altered behavioural state:
   - an increase in substance use that transcends both social norms and former individual consumption levels; diminished variability in pattern of consumption; lack of concern about the opinion of others regarding personal consumption patterns; a continuation of heavy consumption in spite of serious consequences such as physical illness, poor work performance, family dysfunction or legal problems.

b) An altered subjective state:
   - lack of control over consumption; a heightened desire for substances, i.e. craving; a preoccupation with substances to the extent that daily routine narrows to activities that involve substance use.

c) An altered psychobiological state:
   - presence of withdrawal symptoms such as trembling, sweating, vomiting, anxiety, depression, irritability; withdrawal symptoms relieved by further substance use; an increased tolerance to the effects of specific drugs such that increasing amounts are required in order to achieve intoxication.

The dependency theory implies that cognitive factors regulating consumption (i.e. cognitive impulse control) and the potency of biological factors (i.e. genetic predisposition; chemical and structural central nervous system damage secondary to substance abuse) are both important prerequisites of substance misuse. The theory also separates signs and symptoms of dependence from the consequences of substance misuse; within this framework, one can be a heavy user who has suffered from negative consequences of misuse without being dependent. At a severe level, dependency resembles a disease state as defined by Maltzman (1994): a constellation of signs and symptoms following a predictable and recognizable pattern - a syndrome which deviates away from a normal state of health and may be life-threatening. One very important feature of this theory is that it permits measurement of severity of dependency through the application of standardized assessment or testing.

7. Learning Theory
This theory contends that substance misuse is learned through the complex processes of behavioural acquisition and reinforcement. Many learning theories have evolved from simple classical and operant conditioning theories through to more complicated social learning theories that emphasize the interactions between personal dispositions and environmental situations.

There is general agreement that a complex behaviour like substance misuse cannot be acquired through a single learning mechanism. Several contingencies appear to reinforce or maintain substance misuse including: the psychopharmacological properties of specific drugs, social aspects of substance use, individual ability to tolerate aversive environments and/or aversive physical states related to substance use, and individual need to alter unpleasant psychological states.

The learning theory implies that treatment should focus on creating and maintaining behavioural change usually through a structured system of behaviour modification.

THE BIOPSYCHOSOCIAL THEORY

Over the past decade, researchers and clinicians have been developing and testing a model known as the Biopsychosocial Theory. This theory postulates that substance misuse is the net result of a complex interaction between a combination of biological, psychological, social, and spiritual determinants. By adopting a multivariant approach, the biopsychosocial theory has provided a new conception of substance misuse that directs attention towards a new set of questions about the nature of substance misuse, although the causes may be vague. One writer has summarized these questions as follows: "what substance misuse syndromes at which stage of their development and in what kinds of patients respond under what conditions in what short and long range ways to what measures by whom?" (Lindstrom, 1992)

Although knowledge of causality remains elusive, several hypotheses related to how we think about and respond to addictions can be generated from the biopsychosocial theory including:

1. substance misuse embraces a variety of syndromes including dependency syndrome and substance misuse related disabilities.
2. substance misuse lies upon a continuum of severity.

3. the development of substance misuse follows a variable pattern over time and may or may not progress to a fatal stage depending on the type of syndrome and/or degree of severity.

4. because the elements in the experience of addiction will differ between individuals, there is no one superior treatment for all substance misuse.

5. the population of substance misusers is heterogeneous and defy stereotyping.

6. successful treatment is contingent upon accurate and comprehensive assessment and matching of affected individuals to the most appropriate treatment.

7. recovery may or may not require abstinence, depending upon the degree of severity and/or the type of syndrome.

ADVANTAGES OF THE BIOPSYCHOSOCIAL THEORY

Consideration #1

The Biopsychosocial Theory is a conceptual framework that allows attention to be focused on all problems related to substance misuse.

This allows those who develop policy and programs for, or provide services to, people affected by substance misuse (either their own or someone else's) to address the broad range of problems, from problems which are just beginning to those that are long standing. The continuum of substance misuse generates a continuum of services. Furthermore, early intervention services for those clients with less severe substance misuse problems are considered to be as important as services for people with more severe problems.

The Biopsychosocial Theory characterizes the population of substance misusers as heterogeneous and recognizes the importance of comprehensive individual assessment in order to adequately determine client treatment needs.

The Biopsychosocial Theory also allows for the delivery of harm reduction services...
that minimize health risk to substance misusers who continue to engage in high risk behaviour. The Theory considers substance misuse as embracing a variety of substance misuse disabilities and supports the concept of a hierarchy of harm reduction outcome goals including abstinence related goals.

Consideration #2

The Biopsychosocial Theory is amenable to empirical scrutiny.

The hypotheses generated by the theory can be tested scientifically. Moreover, the intuitive appeal of these hypotheses creates a sense of optimism that scientific support is attainable. At present, this theory is still primarily a set of working hypotheses requiring further testing and verification. It is important to understand that the purpose of scientific investigation is not to verify the theory absolutely. Contemporary philosophers of science have argued persuasively that no theory can be proven absolutely right or wrong (Kuhn, 1970). No amount of empirical evidence can remove all scepticism nor does a single falsification necessarily result in negation. However, the level of confidence in the correctness of the theory heightens as increasing empirical support is gathered. Support for this theory should accumulate as more studies are developed and scientific trials are performed. Already, research exists supporting the notion that there is no one superior treatment for all substance misuse, and at least one large multicentre trial is underway testing the matching hypothesis.

Historical empirical support for the older theories of addiction ranges from none for most to substantial for a few. For example, there is virtually no scientific support for the Moral Theory. The hypothesis that low moral standards or bad character cause substance misuse has not been substantiated by research. In fact, studies show that antisocial behaviour is normally a consequence of addiction rather than a cause.

Sometimes misrepresented as a Disease and/or Moral Model (Miller and Kuntz, 1994), the Twelve Step Spiritual Theory pioneered by Alcoholics Anonymous has also been studied. However, most outcome research pertaining to AA is correlational and frequently confounded by other treatment variables. Therefore, the relationship between AA involvement and reduction or cessation of drinking is uncertain. There is a paucity of prospective and longitudinal studies, and both female and young AA members are underrepresented in existing research, especially considering nearly a third of AA members in North America are female.
Future prospective, as opposed to retrospective, research is needed in order to better understand AA; hopefully some of the traditional barriers to researching this very popular and important organization will be removed.

Although the Symptomatic Model predicts remission of substance misuse if the underlying mental disorder is treated, the scientific literature shows poor outcome results with insight oriented psychotherapy along with high drop out rates during treatment. Most would now agree that, although substance misuse and psychiatric illnesses co-exist and interact, these conditions are distinct. With respect to the Social Theory, there is little evidence to support a direct causal relationship between social problems alone and the development of substance misuse.

Chemical Dependency Theory has been intensely debated over the past decade. Some researchers have interpreted the scientific evidence as suggesting that chemical dependency syndrome does not exist (Fingarette, 1988; Peele and Brodsky, 1991). However, recent reviews of the literature present a convincing argument that this syndrome is a real phenomenon (Lindstrom, 1992; Malzman, 1994). The concept of chemical dependency has important clinical applications and helps to guide research into the biological determinants of addiction.

The Learning Model has also accumulated abundant empirical support although this theory tends to ignore the biological processes that are triggered and accelerated by excessive substance misuse. This model has lead to the application of many effective non-pharmacological treatments that focus on creating and maintaining behavioural change (i.e. reduction or cessation of substance misuse).

In the spirit of preserving empirically sound elements of older theories, the Biopsychosocial Theory incorporates both the concept of chemical dependency as well as certain principles of learning theory. The Biopsychosocial Theory hypothesizes that substance misuse lies upon a continuum of severity and embraces a variety of syndromes and substance misuse related disabilities including dependency syndrome. Therefore, prior research related to chemical dependency syndrome is acknowledged; dependency syndrome is accepted as a real condition; clinical application and future research pertaining to this syndrome is encouraged. As biotechnology improves (e.g. medical imaging, genetic screening) the role of biology in the development and maintenance of addiction should become clearer. Furthermore, the Biopsychosocial Theory hypothesizes that successful treatment is contingent upon thorough assessment and proper matching of clients to appropriate treatment options. By incorporating important principles of learning theory, the new theory preserves many valid concepts that have lead to the development of
effective behavioural therapies successfully applied in the treatment of substance misuse.

Consideration #3

The Biopsychosocial Theory preserves appealing intuitive concepts of older theories that have either not been previously tested or, in some instances, not tested properly.

This theory postulates a role for social and spiritual factors in the development of and recovery from substance misuse and allows for future analysis of these elements.

Consideration #4

The Biopsychosocial Theory unifies prior biological, psychological, and social theories of addiction.

The net result is the synthesis of a unique conceptual framework comprised of a unique set of hypotheses. The new theory is not simply a bolted-together version of the older theories, each of which: prioritizes problems differently; has its own distinct relationships between terms and concepts; and essentially locks practitioners of different theories into separate worlds isolated from one another. The Biopsychosocial Theory appears to be a supreme candidate beckoning a diverse population of addiction professionals to work together towards solutions to a wide variety of serious problems under the umbrella of common terminology and concepts.

Consideration #5

The Biopsychosocial Theory of substance misuse is congruent with other modern theories of health and education.

To cite two examples, both women's and older adults' health issues are beginning to be framed within models that: acknowledge population diversity on all dimensions of health; promote the matching of individuals with certain characteristics to specific treatments; and measure treatment success along more than one dimension. Within the context of these models, assessment is crucial to
understanding the needs of the client and emphasis is directed towards achieving
outcomes that are in the client's best interest. Similarly, in education, modern
constructivist learning theories accent the importance of understanding the
individual learner's capabilities and potential. Comprehensive assessment is
followed by the selection of an educational experience most suited to specific needs
and abilities.

By adopting a substance misuse theory that is consistent with other helping
disciplines, linkages to prevention and treatment components within and outside of
the health care domain are facilitated. True case management becomes possible
through the medium of common terminology and concepts. Smoother, less
traumatic, movement of clients through the broad system of care eases the stress to
both providers and beneficiaries of services. Because most substance misuse
prevention efforts are through the application of education strategies, consistency
between substance misuse and education theory is essential in order to maximize
success in the area of prevention.
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