

FROM STREET TO HOME

Community work in recovery process

Henry Dodoo Nyamekyeh

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Diaconia University of Applied Sciences,

Diak-South, Järvenpää Unit

Bachelor Degree Programme in Social Services.

ABSTRACT:

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Recovery is often defined as returning to a stable baseline or level of functioning. However many people, have experienced recovery as a transformative process in which the “old self” is gradually let go off and “new sense of self” emerges. People struggling with alcohol problems especially find this process very difficult due to many years of alcohol consumption.

This thesis will clarify in simple terms how community work and treatment methods of recovery has been viewed by theorist, experts and professionals over the years. There are many models and approaches to different kinds of alcoholic addictions. Many people also recover from alcoholism in different ways, either through community meeting groups or self help. This thesis also describes the necessity of choosing different treatment methods based on scientific research and client needs and also review of the treatment outcome literature, which illustrates that there are a number of treatments that are consistently supported by research. Some of the chapters also describes client to exact treatment and descriptions on how to use each particular treatment plan.

The process used for this thesis is a narrative transformation approach which will recreate the stories and experience of individuals through time. This approach allowed me to develop understanding of these experiences through the interviews and connect to theories. The main results will demonstrate significant experiences of individuals with alcohol problems to administer the appropriate treatment method, and community work process in recovery.

Keywords: recovery, addiction, community, treatment, narrative transformation, interventions

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1 INTRODUCTION

According to Giesbrecht et al (2005, 3), there are a number of challenges in raising the profile of alcohol-related damage and implementing effective and sustained alcohol policies and interventions. (Giesbrecht 2007, 1828.) These include, firstly, the strong international efforts to promote alcohol, and deregulate controls and secondly, the relatively modest public support for the most effective intervention and resistance to those with demonstrated impact (Giesbrecht 2007, 1828).

Thirdly, according to WHO (2002) the generic health and safety initiatives tend to give relatively low priority to alcohol, despite the evidence from WHO analyses of alcohol being a major factor for disability, disease and health. (Giesbrecht 2007, 1828.) Fourthly, alcohol problem prevention campaigns, with the exception of drinking and driving, have not to date, achieved the advocacy and resource capacity evident in other health promotion arenas (Giesbrecht 2007, 1828).

This thesis is very important to me because, my practical placement in one of the homes for substance abusers in Tikkurila gave me the inspiration to carry out this research and have more narrative transformation to understand how self-help, empowerment, community and organisation help in recovery process. Many people have gone through many different recovery processes but have never succeeded.

Also to understand the many various social control theories and treatment models and approaches to alcoholism, the narratives cases from the real people recovering from alcoholism, the communities work in recovery, and the methods used by researchers to treat these narratives stories from individuals. The result of this thesis has been natural, transformative process for me, in the conclusion, but definitely not a predetermined conclusion.

Community recovery is a voluntary process through which a community uses the assertive resolution of alcohol addiction-related problems as a medium for collective therapeutic, community restoration, and improved intergenerational flexibility.

Community recovery is more than the personal recovery of community members; it involves strengthening the connective tissue between those with and without such problems while restoring and sustaining the quality of community life.

Alcohol addiction have in recent times been a killer of many youth around the globe. How unlucky it is for someone to start the journey that result into the sunset of their life by towing that path of unreasonable alcoholism? Extreme use of alcohol kills, however some people by pure moral evasion appear to discover comfort and relief. I disbelief immensely the factors that can lead people into becoming uncontrollably alcoholic. Is it poverty, hard times, family issues, boredom or just that one want to speed up their exit (death) from this troubled world ?

In chapter two and three of this thesis, the different theories of alcohol addiction and treatment models and interventions are discussed by various researchers to demonstrate how people with alcoholic addiction (problems) react to different to many of the treatment models.

Chapter four discusses the method used in collecting the data for the thesis, many interviews were conducted and theories collected for this thesis. This increased my understanding of the fine grained models and treatments involved in therapeutic interaction in the community and reflect on the involvement of community work in recovery.

In chapter 5-7, I discuss the interviews (cases) and the theories. This helped me to discover and establish the experience of alcoholics and the kind of treatment administered to a particular client. It also helped me to establish the role of the community in the individual's journey to recovery.

2 THE ROLE OF COMMUNITY IN RECOVERY

Kielhofner (2002), claims that, the model of human occupation (MOHO) involves engagement in a balanced routine of work, play and daily living tasks, appropriate to the client`s environments, disabilities and developmental level. The MOHO encourages the engagement of occupations as a treatment strategy to produce adaptive skills (Boisvert et al. 2008, 208).

Just as (Moyers, 1992, Stoffel, 1993, Kielhoner, 2002), has stated, when combined the MOHO and the cognitive behavioural therapy (CBT) model are compatible in developing coping skills because self-concept and self-esteem can be seen as part of the volitional subsystem, which affects an individual`s willingness to act and is tied to the issues of self-competence, mastery and self-efficacy (Boisvert et al. 2008, 208).

Martin et al. (2008) utilized a MOHO approach to study the outcomes of a programme utilizing occupational therapy to develop occupational performance skills in persons undergoing treatment for substance use disorder (SUD) and found significant improvement and large effect size in occupational competence, occupational identity, and self-esteem and quality life. Each of these areas has an important role in the development and maintenance of recovery and is essential in a peer-supported community (Boisvert et al. 2008, 208).

But if we should fight this addiction, then we have to open the control of likeness in our minds. Occasionally rejection is so tough that merely an immense loss and pain can shatter the control of it grips.

We have to experience the addictive of being so that it can give way to new lifestyle community accept and prefer. When the rejection is no more there, the awareness of recovery process can be seen and the self realised addict can initiate on a daily basis plan of physical wellbeing, mental, spiritual and social exercise. To begin with exercising the mind is very powerful and very reflective for the addict to be away from the condition.

It can be liable to change the harmful aspect of our ego and start the normal self-esteem. Since the addict is in the process of recovery the ego-deflation and self-esteem start, and all educated and helpful community which is frequently a recovery group gathering or meeting of some sort models a well psychological cut own and training course for the beginners to follow. Additional skilled members of the community assist to keep the beginners with the certainty of recovery regular involvement in such a community is very positive.

According to White (1998), a recovery community following the recovery movement is a society or community in which citizenship is established by the status shared experience and susceptibility to relapse (Boisvert et al. 2008, 206).

Fisk et al. (2006), claims that, peer support communities are becoming integrated into formal substance abuse supportive housing programmes to help individuals in their communities initiate and sustain recovery from AOD use and homelessness and again overall wellness (Boisvert et al. 2008, 206).

Conforming to Deleon (2000) ideally residents of supportive community have an understanding of their disease and have been giving the foundations for the development of recovery lifestyle prior to entering the supportive housing part of the treatment continuum. While in the abstinence mandated supportive community, the resident are given the opportunity to forge new friendship and seek as well as offer peer support all of which enhances their chances at maintained recovery and abstinence. (Boisvert et al. 2008, 207.)

As stated in Deleon (2000), peer support communities are therapeutic communities, in which recovery is viewed as a global change in lifestyle and identity that occurs in the social learning context of the therapeutic community, the view of right living emphasizes explicit beliefs and values essential to recovery. (Boisvert et al. 2008, 207.)

Deleon (2001, 87) said, these beliefs and values guide how individuals relate to themselves, peers, significant others, and the larger society. Peers are the primary influence for change; they are the members of the community and often members of the

staff who have sustained recovery. They serve as role models and constitute regular peer-encounter groups that are designed to heighten individual awareness of specific attitudes or behaviour pattern that should be modified. (Boisvert et al. 2008, 207.)

2.1 Community work

Community work in recovery is voluntary in the sense that it involves a rising community consciousness (acknowledgement and clear definition of problems), community commitment, and community action. These three critical steps must rise from within the community and cannot be externally imposed. The ultimate test of the community recovery process is not the mass recovery of one generation, but breaking intergenerational cycles of problem transmission and imbedding personal, family, and cultural resistance and resilience as an enduring intergenerational legacy within the deepest fabric of a community.

Community work is a planned process where one or more professionals assist an organisation, a special interest group, or a local society that wishes to utilise their own resources in order to solve self identified problems, and to reach self defined goals. Community work is the process of assisting people to improve their own communities by undertaking collective action. Community improvement ranges from grass root mobilisation to influencing human relations in workplace environments, or improvement of the co-operation between different local agencies and actors and the local society. Local and regional authorities and the private and voluntary sectors are important agencies and actors in community work.

Community work is permeated by a set of values summed up in issues in community work. Firstly, people matters, policies, administrative systems and organisational practices should be judged by their effect on people. Secondly the value of participation in every aspect of life, thirdly a concern with the distribution of resources towards people who are socially disadvantaged in the community for easy transformation. (Gulbenkian, 1968)

It is necessary to present an analysis of power and know knowledge together with practical approaches to liberation, participation, empowerment, and transformation through community action in order to achieve a unity praxis (Ledwith & springett 2010, 171).

Participation evaluation means coming together to listen each others stories, learning what other people have been doing in other places, but also collectively looking at statistics data, published accounts and scientific papers. Through participatory processes people then can agree joint indicators of change based on the values, principles and goals they have agreed (Ledwith and Springett 2010, 182).

Ledwith and Springett (2010) believe that sustainable community will be promoted where many players in different roles and different interest and values are all provided with a flow of meaningful information, and where they have the opportunity for joint learning and innovative responses to this feedback from the environment and from other changes. It is this distributed interlligence which allows players in a community to anticipate and consructively address both individually and collectively the systemic problems the community continually faces and to deal with the threats and opportunities of natural and manmade disasters, the shifting global economy, and inequitable distribution of resources (Ledwith & Springett 2010, 183).

According to Freire (1972) empowerment is closely tied to the process of becoming critical. Critical conciousness involves understanding the nature of power and the way in which it permeates our lives. Gramsci`s concept of hegemony in particular help us to understand the subtle nature of power, and the way that the dominant ideas of society infiltrate our minds through the diverse range of insitutions in civil society- family and all formal and informal groupings to persuade us that the interest of the powerful are the natural order of things (Ledwith and Springett 2010, 19).

The power of Gramsci`s insight into the role of consent in the process of false consciousness help us to see that civil society also offers an opportunity for liberating interventions through a process of critical consciousness, beginning to question the status quo. This process of becoming critical leads to autonomy, and autonomy leads to

empowerment. True empowerment, however is not an individual state, but a collective state, which is why Freire stressed that true liberation involves a collective process if it is to be transformative (Ledwith & Springett 2010, 19).

According to Fay (1987, 29) Critical theory provides a passionate and motivating force that empowers people to act. Changed awareness of the injustices of existing conditions is sufficient to empower a collective movement for change, but this can not be left fluid and intuitive. Fay suggests that our goal can only be achieved when all three phases of the tripartite process of enlightenment, empowerment and emancipation are completed. (Ledwith & Springett 2010, 19.)

2.2 Different theories of Addiction

The "Soil of Addiction"

“Fundamentally, the alcoholic is not sick because he drinks but . . . he drinks because he is sick, and then becomes doubly sick”. -- Carroll A. Wise

Clinebell (1990), has questioned that, eighty million people in the United States of America use alcohol, but about seventy-four million do not turn out to be alcoholics why? Researchers have found out that 6 percent of drinkers are susceptible to alcoholism. Because 94 percent do not become addicted, alcoholism cannot be considered merely a property of alcohol. Evidently there is no doubt that, the "soil of addiction" is open to the seeds of alcoholism. Many people will refute that any particular "soil of addiction" is essential.

There are those who would deny that any special soil of addiction is necessary. A quote from Robert Fleming says that, "some ordinary individuals are able to get trapped in the fierce descending spiral of alcoholism, drinking sufficient alcohol over years. An alcoholic reflected that alcohol is the central root of alcoholism; he lamented that, "drinking much whiskey has ended him an alcoholic. It must be stressed that the opinion expressed by this alcoholic is personal.

Many have the notion that, for an individual end up alcoholic is easy and straight. An individual who is couple by social pressures will obviously end up drinking, the consumption escalates as he or she continues to drink. For 94 percent of drinkers to prevent being alcoholic, then it means that, these individuals have not being drinking for long.

In many of the drinkers or alcoholics cases it can be described as descriptive but not explanatory in the concept of alcoholism. This goes into the generalization that results in the wrong classification of a single root as the mere root of alcoholism. (Clinebell Jr. 1990.)

Prior to the 19th century, the English word “addiction” had a traditional meaning that was old as the language itself and was very similar to the meaning the Latin word which it was derived . To be addicted, meant either to be legally given over to somebody as a bond slave, or, more broadly, to have given oneself over, or devoted oneself, to somebody or something. Shakespeare, John Locke, David Hume, and other masters of modern English use the word addiction in the broad, traditional sense, since the belief that addiction was exclusively a disease of alcohol or drug misuse had little currency prior to the 19th century. (Rosenqvist et al. 2004, 11.)

According to Killinger (1991), by the beginning of the 21st century, addiction professionals had published many case studies of devastating, occasionally fatal, addictions without drugs. Account by investigative journalist and biographers (Pearson 1995) had further documented the harmfulness, prevalence, and endless diversity of addictions. According to Alexander & Schweighofer (1988), interview studies revealed that only a small subset of addictions involve alcohol or drugs. There was a multitude of self help books, recovery groups, for- profit treatment regimes, and websites addressing addictions that do not involve drugs as well as those that do.

In the long run, addiction is bound to lose its “chic”. Whether or not drugs are involved, severe addictions supplant many aspect of life that both society and the addicted person recognize as essential to a full existence. People who are severely addicted often feel

hopelessly “out of control” and appear that way to others. The desperate struggle to support an addictive lifestyle often incites dangerous, sometimes fatal behaviour. People who do not succeed in maintaining addicted lifestyles often react with depression, brutality or suicide. People who succeed often feel guilty or unfulfilled nonetheless (Rosenqvist et al. 2004, 12.)

The harm done by addiction extends beyond the normal materialistic boundaries of social sciences. Even a socially harmless case addiction adulterates life’s meaning and depth. The early temperance and anti-drug movement saw the “drunk” and the “junkies” as destined for eternal hellfire and concluded that they must be converted to pious abstinence. The spiritual harm produced by addiction need not to be described in Christian imagery nor overcome by Christian conversion, but can be comprehended within a variety of other spiritual and scholar perspective. More, the rediscovery of the traditional meaning of addiction reveals that the worst harm arising from addiction could continue to spread even if alcohol and drugs were successfully banished from the earth. Temperance thinking also oversimplified addictions by denying their genuine benefit, which explains why people cling tenaciously to them, even at the risk of their lives (Rosenqvist et al. 2004, 13.)

2.3 Other theories of addiction

A colleague amid the specifics relating to the roots of alcoholism is a condition which has several therapeutic and efficient protective actions. Results of the sciences are significant in dealing with social problems. The results have being carefully examined, especially in areas which have being haze by unclear information such as alcoholism.

What are the causes of alcoholism? No one has clear understanding of this phenomenon. To a certain extent, it can be referred to as a cryptogenic illness with an unknown cause or roots. To tackle this problem we need to take advantage of the available facts to outline an effective premise in addressing practically the problem that is has confront us. Currently in research it is impracticable to mention one particular as the causes of alcoholism. (Clinebell Jr, 1990.)

In a different research, results point out vehemently that alcoholism is a multifaceted illness in which diverse factors has a role to play. Psychological, cultural, philosophical, religious, and physiological are the factors that influence alcoholism, and all these factors will not function evenly on each stage (Clinebell Jr, 1990.)

Combining one or more of these factors will create work on each of these three levels: (1) factors which make one vulnerable to alcoholism; (2) factors which determine the selection of alcoholism as a symptom, as over against all the other types of psychopathological symptoms; and (3) factors which cause alcoholism to be self-perpetuating once it has reached a certain point. The most vital stage of these three levels is the last level since it will deal with the problem of why the alcoholic is typically powerless to know it and assistance when the sickness start to develop (Clinebell Jr, 1990).

2.4 Is alcoholism A Disease?

Firstly, there is discussion on whether alcoholism is a disease or not. Others are with the opinion that it is not and others say yes it is. The answer from those who have recovered will be yes it is. Alcoholism can not be referred to as a disease technically because does not fit the discription of a didease. some people even do not believe it existence. Expects have labelled it as a progressive chronic and fatal disease, all those who are addicted to it will not accept it as disease. Immoderate alcohol consumption indicate equal symptoms with that of diseases. inevitable (Clinebell Jr, 1990).

To clarify matters, alcoholism is an obsession which elicits a desire from someone to drink eccessively amounts of alcoholic beverages. An alcoholic has no control over his emotions and he gets more satified by it by drinking even more. Also, the drinking gradually increases through time. What started as a drink of two would become ten or more in a day. Because its progress happens in months and years, noticing that alcohol has taken over your life would be difficult. A lot of people would hesitate to call it a disease because it is not brought about by a germ or a virus (Clinebell Jr, 1990).

There are some who would argue that though alcohol is not a bacteria, it still is a toxin that enters the body through intake. Some would even point out that alcoholism is just an excuse to drink. No matter how different the medical world feels about this, doctors have referred to this as alcohol dependence syndrome. They would even point out that alcoholism is progressive and has different stages (Clinebell Jr, 1990).

A person begins to drink in compliance with social pressures, take a bottle of beer or two. Then, as time progresses, the addiction would proceed to the middle stage. Here, it would be very hard to stop someone's desire for a drink. And when all is lost, the alcoholic's addiction would roll on to the end stage wherein alcohol has totally gripped his life (Clinebell Jr, 1990).

Because of this gradual pace, a lot of alcoholics deny that they have lost control. The addiction did not happen overnight and therefore, most alcoholics suffer from this denial. Just as viral diseases are diagnosed, doctors have a way of diagnosing alcoholism, too. They usually conduct behavioral and medical exams to determine it. The behavioral exam would delve deeper into your alcohol intake, drinking patterns, behavioral history and other environmental concerns such as stress levels (Clinebell Jr, 1990).

On the other hand, the medical ination looks at the physical symptoms that alcoholics manifest. This is done to know whether alcohol has damaged some of your organs. With all of the points presented here, alcoholism is definitely a disease. Yet, this disease can certainly be managed with self-control and other people's support. Do not let the disease of alcoholism ruin your life (Clinebell Jr,1990).

At the moment inquiring from any recuperating alcohol-dependent if he or she has an ailment and with no delay, he or she will say to you yes. In mdern times, people have been delibrating whether alcohol addiction is a didease or not. One of the difficulties in seeing alcoholism as a disease is that, it is plain hence does not look like one. It does not look, sound smell and it certainly does not act like a disease. To make matters worse, generally it denies it exists and resist treatment (Lawrence, 2009).

So, one may ask, what is alcoholism? Alcoholism is a mental obsession that causes a physical compulsion to drink. In other words it is a crucial chronic disease with inherent, psychosocial and environmental causes influencing its development and manifestations. The disease is often radical and deadly. It is characterized by impaired control over drinking, preoccupation with the drug alcohol, use of alcohol despite adverse consequences, and distortions in thinking, mostly denial. Each of these symptoms may be continuous or periodic (Lawrence, 2009).

This alcohol intake happens slowly sometimes over the course of a few years and more often than not, you will never even realize when alcohol has taken over your life. Many people are hesitant to call alcoholism a disease because the cause of the disease is alcohol dependence. It is not a germ or anything invades your body. Some could argue that alcohol is a toxin that enters your body and causes the disease. Not everyone buys that though. To some of us alcoholism might just be an excuse to drink (Lawrence, 2009).

However, the medical field feels differently. Some doctors have begun to refer to alcoholism as "alcohol dependence syndrome". Many also state that it is a progressive disease and moves through stages. There is an early stage, which is when it might take only one or two drinks to get the cravings to stop. As it moves into the middle stage it takes more drinks to stop the cravings. Alcohol begins to have more control in the middle stages of alcoholism (Lawrence, 2009).

In the last level of alcoholism, he or she has no power to control his or her own life. Here the alcohol is making the decisions. Also the alcoholic may not have any idea about his or her current situation. One common symptom all alcoholics have is denial. Medical experts have diagnosed alcoholism as behavioral evaluation and a medical evaluation after an examination (Lawrence, 2009).

In the behavioral evaluation process the alcoholics drinking pattern, the history drinking patterns and even environmental issues like your stress level to determine what your alcohol use is. In the medical evaluation process, the medical doctor is more

concern with the physical symptoms of alcohol dependence. Test must be taken to confirm any traces of neurological disorder in the lungs. There is treatment for alcoholism like the other diseases (Lawrence, 2009).

2.5 Mechanisms of harm (toxicity, intoxication and dependence)

According to Edwards (2000) the last quarter of the 20th century, especially the past decade, it can be said that remarkable progress was made in the scientific understanding of alcohols harmful effects, as scientist discovered biological, chemical and psychological explanations for humans propensity to consume what has been called “the ambiguous molecule”. (Babor et. al, 2003, 19.) This knowledge is fundamental for understanding of alcohol capacity for physical toxicity, intoxication, and dependence. When it is said that toxicity, intoxication, and dependence mediate alcohol consumption and drinking problems, it is implied that each of these phenomena provides a mechanism by which consumption leads to problems and explains (at least partially) the connection between consumption and problems (Babor et al 2003, 19).

The figure below shows the relationships among alcohol consumption, the three putative mediating factors, and various types of harm. Patterns of drinking, characterised not only by the frequency of drinking and the quantity per occasion, but also but the variation between one occasion and another, represent the manner in which drinkers consume a certain volume of alcohol in a given time frame. Volume and pattern by which alcohol is consumed can lead to different types of problems. Chronic heavy drinking is related to the toxic effects of alcohol. Sustained heavy drinking, of the type that has been common in drinking countries, may not lead to much evident intoxication, but can tissue damage and dependence (Babor et al 2003, 20).

Daily drinking of even small amount of wine per occasion over a long period of time can lead to cirrhosis because of the cumulative effects of alcohol on the liver. In contrast, a relatively low frequency of drinking together with consumption of a high number of drinks per occasion can lead, through the mechanism of acute intoxication, to a variety of medical and social problems, such as accidents, injuries, interpersonal violence , and certain types of acute tissue damage. Finally, sustained drinking may

result in alcohol dependence. Once dependence is present, it can feed back to increase or sustain both the overall volume of drinking and the drinking pattern. Dependence can then lead to chronic medical problem as well as acute and chronic social problem (Babor et al 2003, 20).

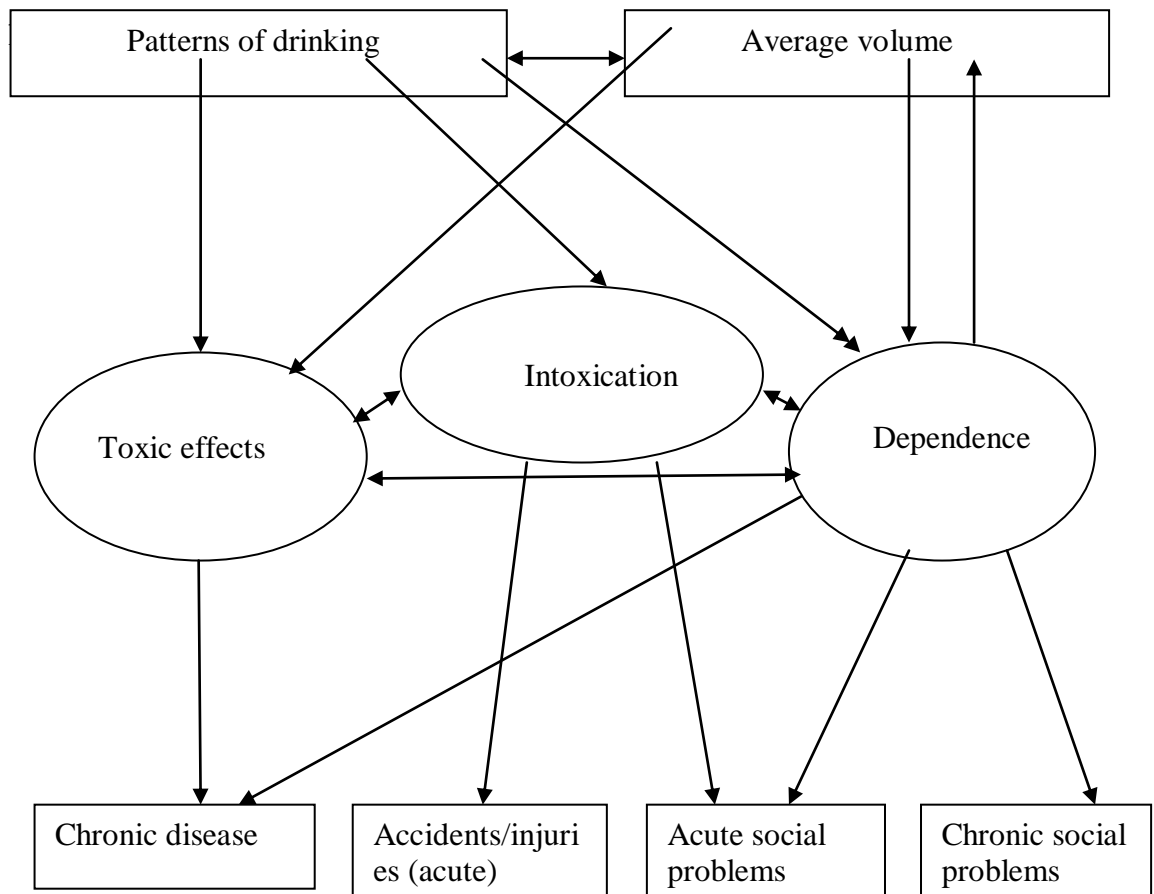


Figure 1. Relations among alcohol consumption, mediating variables and short-term as well as long-term consequences

Figure 1.source: (Babor et al 2003, 20).

3 THEORIES, ADDICTION AND MODELS

Our society has an appetite for the use and misuse of psychoactive substances and other addictive behaviour. Our addictive behaviours include the use of alcohol, drugs and chocolate, texting on mobile phones, jogging, watching soap on TV, gambling and internet addiction. The danger arises when we have some uncontrolled compulsive use of substance or activity despite the physical, psychological and social harm. The use of psychoactive substance such as drugs and alcohol continues to be a major concern for society, and alcohol and drug addiction are now regarded as a public health problem. The consequences of drug and alcohol addiction do not only affect the individual user but also their families, communities and the entire society and economy. (Rassool 2011, 13).

The moral theory or model is based on the belief that using alcohol or drugs is a sign of moral weakness, bad character or sinful people. The proponents of this theory refute the biological basis for addiction and suggest that the individual has deviated from the acceptable religious and socio cultural norms. The focus of intervention under this model is the control of behaviour through social disapproval, spiritual quittance, moral persuasion or imprisonment.

The disease theory of addiction maintains that addiction is a disease that is firmly attributable to the generic/biological or neurochemical processes or of some combination of the two. The theory views alcohol and drug misuse as a progressive, irreversible and incurable disorder and its primary symptom is the inability to control consumption. Abstinence is the only option (Rassool 2011, 29).

According to Goldstein and Stein (1976) an informed and undisciplined eclectic therapist may roam from one trend to another reaching into a bulging bag of tricks to draw out whatever feels convenient, interesting, familiar appropriate to the immediate case, Trial and error reign supreme. (Rassool 2011, 29.)

The treatment outcome researches support neither the “one true light” nor the uncritical eclectic approach. Instead, persuasive empirical evidence shows that a number of

different approaches are significantly better than no intervention or alternative treatment. No single approach stands out as better than all others, but neither all treatments created equal. The reason for hope and optimism in this field lays not the presence of one outstandingly effective approach, but it is the array of alternatives with reasonable empirical support, offering a choice among promising options. (Hester & Miller 2003, 1).

3.1 Models of recovery interventions

In the twentieth century, psychotherapists and counsellors were often trained to treat clients from a “one true light” perspective. Trainers expanded the subtleties of praxis in that mode, with compelling rationale for its superiority over other methods. Students memorised the faults and failures of other approaches to treatment and were taught that their own approach was the surest arena towards the lasting alleviation of alcohol problems (Miller & Hester 2003, 1.) According to Miller & Hester (2003) there are many models of recovery and interventions depending on the kind of addiction the individual has. They therefore explained the following models and interventions (Miller & Hester 2003, 1).

How do different treatment philosophies arise? A part they reflect disagreement and uncertainty regarding the nature and etiologic of alcohol problems. Expert in the field ascribe alcohol problem and alcoholism to a bewildering array of causes (Miller & Hester 2003, 1).

3.2 Moral model

There have not always been alcoholics. Indeed there were no alcoholics prior to 1849, when the Swedish physician Magnus Huss introduced the term to describe the adverse consequences of excessive drinking of course, the dangers of alcohol abuse have been recognized from the beginning of recorded history, but until relatively recently these were understood as the natural consequences of unfortunate personal decisions to drink excessively (Miller & Hester 2003, 2).

Moral models emphasize personal choices as a primary causal factor. At various points in history, public intoxication has itself been a perishable crime. In some societies the mere possession or consumption of alcohol is a serious offence. Whether understood as the moral or a criminal issue, these views point to the person as the primary causal facet in problems drinking. The individual is seen as making choices and decisions to use alcohol in a problematic fashion, and as capable of having made other choices. In a moral model which emphasizes choice and wilful behaviour social sanctions may seem the appropriate intervention and agent of change could included legislators, law enforcement personnel and the courts (Miller & Hester 2003, 2.)

3.3 Temperance model

Often confused with the moral model, the temperance model arose from a very different understanding of the causes of alcohol problems. In its early years the temperance movement emphasized just that: “the temperate, moderate and cautious use of alcohol” (Miller & Hester 2003, 2.) The temperance model, alcohol is rather justifiably as a hazardous substance, a drug with great potential for inflicting harm.

As the temperance view gained political moments it evolved into prohibition movement. Temperance advocates saw alcohol as a drug so extraordinary dangerous that no one could use it safely or in moderation.

How might one intervene to reduce and prevent alcohol problems from a temperance perspective? One approach is exhortation to practice temperance or abstinence. This would presumably be done by those who are themselves either currently temperate or abstinent. A second general approach is supply side controls on the cost, availability and promotion of alcohol to the general public (Miller & Hester 2003, 2.)

3.4 Spiritual model

According to Kurtz (1979) the dominant view of alcohol problems had been the temperance models that were caused by the pernicious nature of alcohol itself. For

decades, school based and other public health education had emphasized the evils of alcohol as a drug. It was just two years later in 1935 that Alcoholics Anonymous (AA) came into being with the meeting of two alcoholics struggling to resist drinking. It has grown into a widespread social movement emphasizing a new approach for understanding and recovering from alcoholism its original writings and current practices centre on 12 steps that provide broad guidelines for sober living (Miller & Hester 2003, 3.)

Again according to Kurtz (1994) although it is individual members espouse many different personal views, AA itself endorses no particular theory regarding the causes of alcoholism. Its source writing reflects openness to biological, psychological, and social influences, but the central focus is unambiguously on a spiritual approach to recovery (Miller & Hester 2003, 3.)

Alcoholism is understood as a condition that people are powerless to overcome on their own. The hope of powerless condition lies in appeal for help from a turning over one's life to a higher power, and in follow a spiritual path to recovery (Miller & Hester 2003, 3).

In a public statement published by Presbyterian Church (1986) Alcoholics anonymous (AA) is not off course the only spiritual model for understanding alcohol problems. Historically this view has taken various forms; major religions have long considered drunkenness to be sinful behaviour reflecting a state of alienation from one's intended spiritual path. The view implicit in AA writings that alcoholism arises at least in part from a more general spiritual deficit can be found in many forms. More rarely, alcohol problems have been understood as demonic possession, overtones of these views echo on the countries language, describing alcoholic beverages as "spirit" or denouncing liquor as "demon rum" (Miller & Hester 2003, 3).

3.5 Dispositional disease model

A very different understanding of alcoholism often confused with an AA approach Mille & Kurtz (1994) is with the view that it is a dispositional disease, a condition rooted in constitutional differences between alcoholics and other “normal people”.

A central assertion of this model is that alcoholism is a unique and progressive condition that is qualitatively different from normative. The implication is that alcoholism is inherent. In the physical and psychological make up of the individual within the context of dispositional disease model, it makes sense to assert that alcoholism is not caused by alcohol, a statement that sound absurd from other perspective (Miller & Hester 2003, 3).

The intervention implications of the dispositional disease model are relatively straight forward. People with disease of alcoholism must be identified, inform of their condition, brought to accept their diagnosis, and persuaded to abstain from alcohol for the reminder of their lives. Prevention efforts would focus on the early identification of people with this unique condition, and endeavour once termed “the quest for the test”. Because of their personal experience with the condition, recovering alcoholics may see as the optimal intervention agent to help others recognize, accept and adjust to their disease. Peer support groups provide an ‘ongoing resource for recovery (Miller & Hester 2003, 3).

3.6 Biological model

Begleiter & Kissin (1995) described the biological model as, sometimes blended with the dispositional disease model, true biological models emerged in the 1970 placing strong emphasis on genetic and physiological processes as determinants of alcoholism. Some models stressed the importance of genetic risk factors, drawing on strong evidence that the offspring of alcoholics have a higher susceptibility to alcohol problems themselves. (Miller & Hester 2003, 4.)

The intervention implications of biological models vary, where risk factors are emphasized special caution in the use of alcohol maybe advised for those at risk, and genetic counselling maybe considered proponent of models that focus on the pharmacological impact of alcohol on the body may counsel drinkers to honour “safe drinking” limits avoiding levels of consumption that are likely to cause bodily harm or activate the accelerating spiral of tolerance and dependence. People with heightened susceptibility might be advice to eliminate their risk by abstaining from alcohol all together (Miller & Hester 2003, 4).

3.7 Educational model

Implicit in such strategies is the assumption that alcohol problems arise from deficient knowledge from a lack of accurate information when armed with correct and up to date knowledge. Individuals presumable will be less likely to use alcohol or other drugs a hazardous educational fashion and to suffer the consequence some educational approaches have included an effective component as well, seeking to instil motivation to change as avoid alcohol abuse. The appropriate intervention agents within this model would be educators (Miller & Hester 2003, 5).

3.8 Characterological model

Characterological models emphasized that the roots of alcohol problems lie in abnormalities of personality. In the mid twentieth century, psychoanalysts propose a variety of hypotheses regarding the causes of alcohol problems. Some assessed that problematic alcohol use represent an early fixation of normal psychological development involving severe unresolved conflict regarding dependence. The central assumption here is that alcoholics are people with particular personality types or problem and the resolution of symptomatic drinking require a restructuring of the personality. A related belief is that alcoholics display unusually high level of certain character defence mechanisms, particularly the primitive defence (such as denial) associated with disturbs early in development (Miller & Hester 2003, 5).

A logical intervention within characterological models is psychotherapy to resolve the basic underlying conflicts and bring the person to more mature levels of functioning, preventive interventions would focus on fostering normal psychological development (Miller & Hester 2003, 5).

3.9 Conditioning model

As basic principles of learning and conditioned were clarified during the first half of the twentieth century psychologist began to speculate that such processes might explain how alcohol problems develop proponents of classical or Pavlovian conditioning (SR theory) emphasize the role of such associative learning in shaping drinking behaviour and craving for alcohol.

Researchers have studied a variety of potential incentives for drinking, including tension reduction, time out from social rules and positive social reinforcement from companions. The premise of conditioning model is the excessive drinking is a learned habit, responding ordinary principles of behaviour. It follows that the same principles could be employed to help an individual return behaviour pattern. A variety of treatment, strategies rely on classical aversion therapies, cue exposure, operant learning principles and the community reinforcement approach. Prevention efforts from a learning perspective might focus on reducing factors that create positive associations with alcohol advertising and on contingencies that encourage or discourage drink (Miller & Hester 2003, 5).

3.10 Social learning model

Like the conditioning models, the social learning models focus on interactions between the individual and the environment in shaping patterns of alcohol use. Researchers have examined the influence of peers and others more closely, emphasizing the importance of models of drinking behaviours and of peer pressure. Social learning perspectives also emphasize the importance of coping skills (Miller & Hester 2003, 6).

Alcohol can be used as a strategy for coping with problematic situations or for altering a person's psychological state. In the absence of alternative and competing skills, the individual may continue to rely on alcohol as a coping strategy. Studies have shown that heavy drinking companions evoke increased consumption among those around them and that parental drinking significantly influences the alcohol use of children. Interventions from a social learning perspective focus on altering a client's learning perspective, focus on altering the client's relationship to his or her environment (Miller & Hester 2003, 6).

Client may be advised to change their circle of friends in order to avoid further reinforcement for problematic drinking and exposure to negative models. A social learning approach often involves the teaching of new adaptive skills so that the person need not rely on a drug for coping purposes. Preventive interventions within this model are concerned with conditions of the social environment that further problematic alcohol use, provide heavy drinking role models or encourage the use of alcohol and other drugs to cope with problems (Miller & Hester 2003, 6).

3.11 Cognitive model

According to Brown (1993; Goldman, Del Boca, & Darkes 1999) learning theory in the latter twentieth century also went decidedly cognitive, emphasizing the importance of internal mental processes in guiding behaviour. Increased attention was devoted to cognitive processes in addictions, such as expectation effects of alcohol. Positive expectancies, beliefs that a drug causes beneficial and desirable effects may promote more frequent and heavy use (Miller & Hester 2003, 6.)

Cognitive restructuring may be used to alter positive expectancies, either within treatment or as part of preventive approaches designed to diminish harmful use. Cognitive therapies more generally are being applied to cope with craving and urges, manage concomitant mood problems and modify maladaptive beliefs that promote problematic use (Miller & Hester 2003, 6).

3.12 General systems model

From a general system perspective, individual behaviour is understood as an interactive part of a larger social system. Actions of the individuals problematic drinking cannot be understood without considering their relationship to other members and levels of the system to which the individual belongs. The person's actions are an inherent part of a bigger system interlocking with these larger patterns of relationships (Miller & Hester 2003, 6).

According to Stanton & Todd (1987) a general system model asserts that a system (such as family) tends to maintain an overall homeostasis even across generations and will resist change.

The system most often considered is the family. Several theorists have argued that alcoholism is a family disorder, requiring that the whole family system be treated. Transactional Analysts of Steiner (1971) described alcoholism as the product of international "games" in which there are payoffs not only for the drinkers but for other family members.

Family system approaches argue similarly that the individual's alcoholism represents a coping strategy within the family structure.

If the individual is treated alone the family system may resist change and if the individual does change the family system may destabilize or another family member may become dysfunctional in order to compensate from his perspective, only family therapy is likely to be effective in untangling the complex interactions that underlie alcoholic problems. The usually recommended path to recovery is to recognise the COA patterns accept one's dysfunctional history towards a more adaptive style (Miller & Hester 2003, 7.)

3.13 Sociocultural model

A still larger viewpoint to the role society and subculture in shaping an individual's drinking pattern and related problems. The level of per capita alcohol consumption in a

society, for example, is powerfully influenced by the availability of alcohol beverages: the cost, convenience of access, legal regularisation and so forth. Other cultural factors may also be important determinant of the level of alcohol, problems in society stress or alienation, encouragement or punishment for drunkenness attitudes about alcohol, and the symbolic or functional importance of alcohol within the society.

Interventions that follow from a sociocultural model are those that would impact all or a large part of the society (i.e., universal or primary prevention). The availability of alcohol might be restricted by increasing taxes on (and thereby the price of) alcoholic beverages as by tightly regulating the number, location and hours shops through which they are sold.

Advertising targeting young people or encouraging unrealistic positive expectancies about alcohol may be prohibited. Establishment serving alcohol may be encouraged or required to follow responsible server guidelines to discourage intoxication and drunk driving. The means for enacting such social policy are often legislative through the creating of appropriate laws as the actions of the courts. In this way a socio cultural approach overlaps with a temperance model in emphasizing the causal role of the drug itself but the goal is social control rather than removal of the drug from society (Miller & Hester 2003, 7.)

3.14 Public health model

The history of alcohol problems is largely one of contention among the previously described models. Each had its champions who have advocated for it as the most (if not only) correct understanding of the nature of alcohol problems. Emotion-laden debates have often revolved around a clash between two rival models of the nature of alcohol problems.

A public health model, the last to be considered does offer some hope for integration. Public health professionals have long espoused an approach that considers three major types of causal factors in understanding and intervening with any disease. A hallmark of the public health approach is its emphasis on the importance of considering and

addressing all three of these components. An approach that focuses on only one facet is likely to be limited in its ability to eradicate the problem (Miller & Hester 2003, 7.)

A comprehensive effort at knowledge the importance of agent host and environment. Within the alcohol field, a public health approach as knowledge that alcohol indeed a hazardous drug, which places any one at risk who consumes it unwisely or beyond moderation. It also recognised that there are significant individual differences in susceptibility to alcohol problems mediated by factors such as heredity, tolerance, brain sensitivity, and metabolic rates.

Finally it stresses the importance of environment factors in determining rates of alcohol use and related problems, attending to influences such as the availability of alcohol product. A public health model offers hope for integrating what have sometimes been seen as rival, even incompatible perspectives. It adopts from each perspective the factors that have been found influence the occurrence of alcohol problems integrating them into a complex and interactive model (Miller & Hester 2003, 7.)

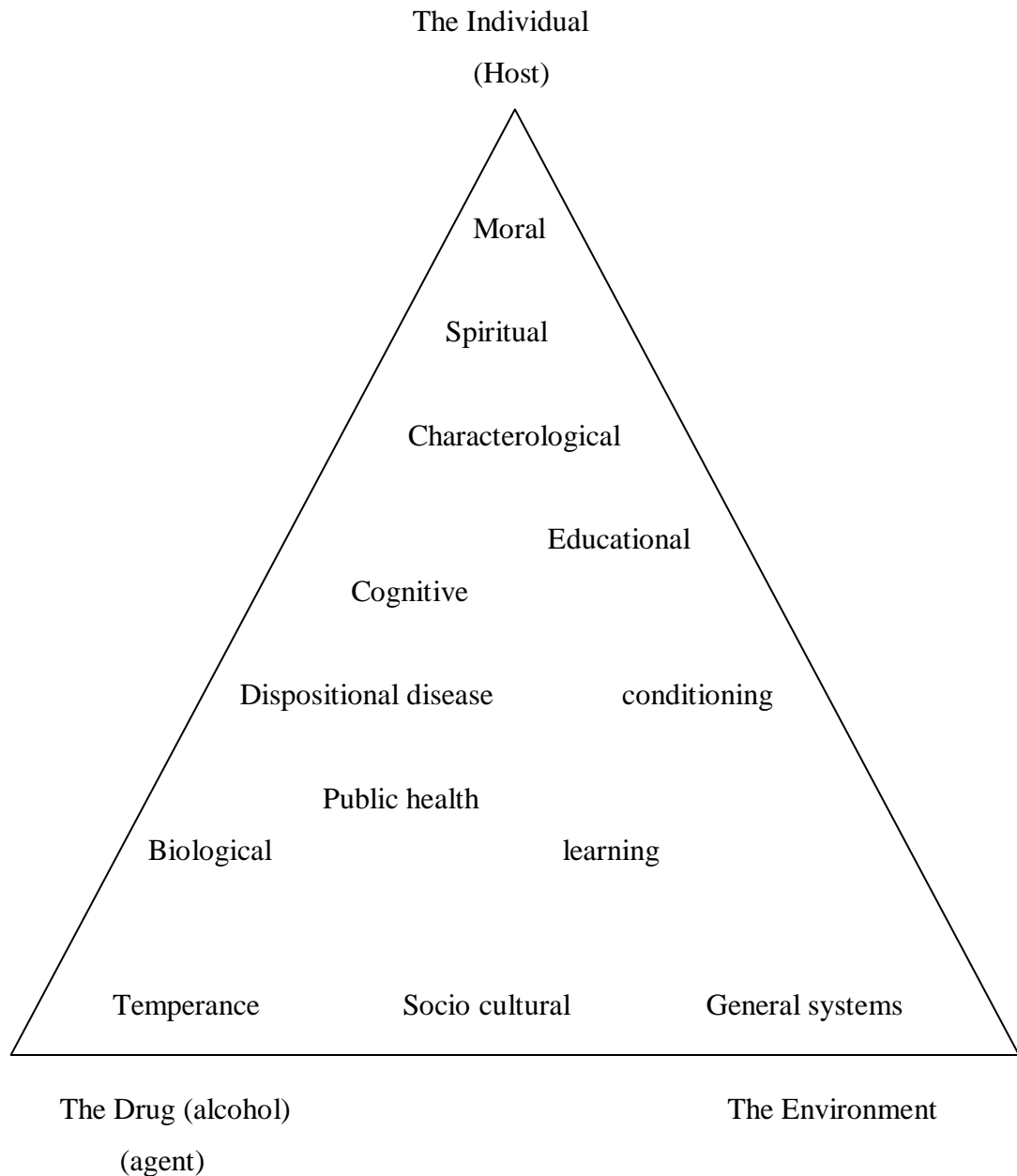


Figure 2. Relative emphases of models on the Agent (alcohol), Host (individual) and Environmental factors

Figure 2. source: (Hester & Miller, 2003)

The diagram above illustrates how Hester and Miller (2003) describe the three myths of alcoholism treatment. One of these asserts that there is single, outstanding effective approach that is better than all others. The other two (nothing works or everything works) reduce to the assertion that all approaches are equally valid. What is there

beyond these too-simplistic orientations—one devoted to the exclusive truth of a single position, the others ascribing equal merit to all alternatives. They proposed that future progress and practice should be directed to an informed eclecticism, an openness to a variety of approaches guided by scientific evidence. The central assumptions of an informed eclecticism centre on the following assertions;

A) According to Fletcher (2001) and Volpicelli & Szalavitz (2000) there is no single superior approach to treatment for all individuals. This is abundantly clear from a review of the treatment outcome literature. Instead, there is an encouraging array of promising alternative approaches (Miller & Hester 2003.) There is no one tried and true, state of the art treatment of choice for alcohol problems. Rather, the state of the science is an array of empirically supported treatment options.

B) Treatment programs and systems should be constructed with a variety of approaches that have been shown to be effective. If treatment is to serve individuals with different characteristics and needs, then it is important to offer a variety of approaches. Such a menu of options can address varying needs and provide backup alternatives when a initial approach is ineffective? In choosing treatment strategies to include in the menu, it is sensible to rely on scientific evidence, selecting approaches that have been shown to be more effective than no treatment or alternative treatments, at least for defined subpopulations.

C) Different types of individuals may respond best to different treatment approaches. It is not the case that the same type of individuals respond best to all forms of alcohol treatment. Although one might describe a generic “good prognosis” profile (socially stable, employed, married), prognosis does not rely only on the clients characteristics, but depends also in part on the treatment that is being offered.

A person who responds very well to treatment might do poorly in treatment B, whereas for another person, B may be a superior treatment to A. Even when treatments appear to be equivalent in their overall effects within a heterogeneous population, they may be very different in their appropriateness and effectiveness for a given subpopulation or individual. The appropriate question, then, is not “which treatment are

the best, but rather “which types of individuals are most appropriate for a given approach? Or For this particular individual, which approach is most likely to succeed (Hester & Miller, 2003).

Table. 1 below shows all the thirteen conceptual models and interventions that has been summarise to be clearer for readers to understand and choose the appropriate intervention treatment for a particular individual depending on the alcohol problem.

Table. 1 Thirteen conceptual models of alcohol problems

MODELS	CASUAL FACTORS EMPHASIZED	EXAMPLES OF INTERVENTION
Moral	Personal responsibility, self control	Moral suasion, social/legal sanction
Temperance	Alcohol	“Just say no”, supply-side
Spiritual	Spiritual deficit	Spiritual growth, prayer, AA
Dispositional Disease	Constitutional abnormality	Identification of alcohol abstention
Biological	Heredity, brain physiology	Risk identification, genetic counselling
Educational	Lack of knowledge and motivation	Education
Charactero-Logical	Personality, trait, defences	Psychotherapy, confrontation
Conditioning	Classical and operant conditioning contingencies	Counter conditioning,
Social Learning	Modelling, skills deficits	Skill training, appropriate modelling
Cognitive	Expectancies, beliefs	Cognitive therapy, ration, Restructuring
General System	Family rules and dysfunction	Family therapy, transactional analyses
Social Cultural	Environment, cultural norms	Social policy, control of supply
Public Health	Agent, host and environment	Multiple levels in interventions

Table 1. Source: (Hester & Miller, 2003, 8)

Rassool (2011, 49) has also categorised alcohol misusers into four categories; hazardous drinkers, harmful drinkers, moderately dependent drinkers and severely dependent drinkers.

Hazardous drinkers are drinkers drinking at levels over the sensible drinking limits, either in terms of regular excessive consumption or less frequent sessions of heavy drinking. Hazardous drinkers are more likely to have the whole gamut of alcohol-related problems and may benefit from brief advice/interventions. Harmful drinkers are usually drinking at levels above those recommended for sensible drinking but show clear evidence of some alcohol-related harm.

According to NTA (2006) moderately dependent drinkers may have an insight into their problems with drinking and they may not have reached the stage of `relief drinking` - which is drinking to relieve or avoid physical discomfort from withdrawal symptoms. (Rassool 2011, 49.) They can be described as `chronic alcoholics` and can often be managed effectively in community settings, including medically assisted alcohol withdrawal in the community (Rassool 2011, 49).

Severely dependent drinkers may have serious and long-standing problems (`chronic alcoholism`) and may have been heavy users over prolonged periods. This habit of significant alcohol consumption may be due to a desire to stop or limit the withdrawal symptoms. They have complex needs such as coexisting psychiatric problems, learning disabilities, poly-drug use or complicated assisted alcohol withdrawal; others may need rehabilitation and strategies to address the level of their dependence, or to address other issues, such as homelessness or social dislocation. However, more severely dependent drinkers may be in need of inpatient assisted alcohol withdrawal and residential rehabilitation (Rassool 2011, 50).

4 METHODOLOGY

From the time one identifies a research topic to respondent selection, questioning, and answering, and finally, to the interpretation of responses, interviewing is a project for producing meaning (Holstein & Gubrium 1995, 14). Storytelling, in its most common everyday form, is giving a narrative account of an event, an experience, or any other happening (Holstein & Gubrium 1995, 14).

According to Bruner (1990, 190) the essence of narrative theory is based upon the concept of reflexivity, our capacity to turn around on the past and alter the present in its light, or to alter the past in the light of the present (J mason, Malott & Knoper 2009, 455).

According to Nettles and Mason (2004) developmental researchers have examined various forms of self-narrative as a strategy for promoting psychosocial resilience and prevention (J Mason, Malott & Knoper 2009, 455).

Yawkey and Johnson (1988) stated that, central to understanding the dynamics and benefits of self-narrative in an effort to foster resilience, is the individual's capacity for integration. Integration is defined as the organization and use of experiences and observations about the self and multiple social and physical contexts (J Mason, Malott & Knoper 2009, 455).

Henry Murray (1938,1955) was one of the first to study individual lives using life narratives primarily to understand personality development(Holstein & Gubrium 1995, 4).

I carried out three interviews for my data collection, i interviewed individuals who are recovering from alcoholism or those who already recovered from alcoholism. I also had an interview with one professional from the area of theraputic counselling in a particular community working with people with alcoholic problems. These interviews helped me to analyze the data and come out with good understanding of the topic. In the

subsequent illustrations I will compare the real stories of alcoholics and the theories, models and treatment interventions from various researchers.

According to Anderson (1998) and Arnett (2005) societal narratives usually focus negatively on drug misusers' personal and psychological characteristics, without taking into account the life experiences or variable social, political and economic conditions that surround person's life and their relationship with drug misuse all of which impacts upon a drug misuser's sense of self and identity. (Etherington 2006, 234.)

What generally happens when we tell a story from our own life is that we increase our working knowledge of ourselves because we discover deeper meaning in our lives through the process of reflecting and putting the events, experiences, and feelings that we have lived into oral expression (Holstein & Gubrium 1995, 1).

In life story research we can hear the subjective meanings and sense of self and identity being negotiated as the stories unfold, while bearing in mind that stories are reconstructions of the person's experiences, remembered and told at a particular point in their lives, to a particular researcher/audience and for a particular purpose: all of which will have a bearing on how the stories are told, which stories are told and how they are presented/interpreted (Etherington 2006, 234).

Narratives allow us to create who we are and to construct definitions of our situations in everyday life and a near universal form of ordering our Worlds, narratives allow us to make connections and thus meaning by linking past and present, self and society (McIntosh & McKeganey 2000).

Finally, the interview brought out stories of people with a background of alcoholism who recovered for a significant life-altering transformation. The interviewed men inspired by their circumstances and stumbled along the way, but ended up facing the charge with humour, grace and respect. They granted the interviews to share their stories to ease their personal journey to recovery and to provide necessary motivation and inspiration to make whatever empowering changes you to envision for a better life.

4.1 Steps or process used in the narrative research

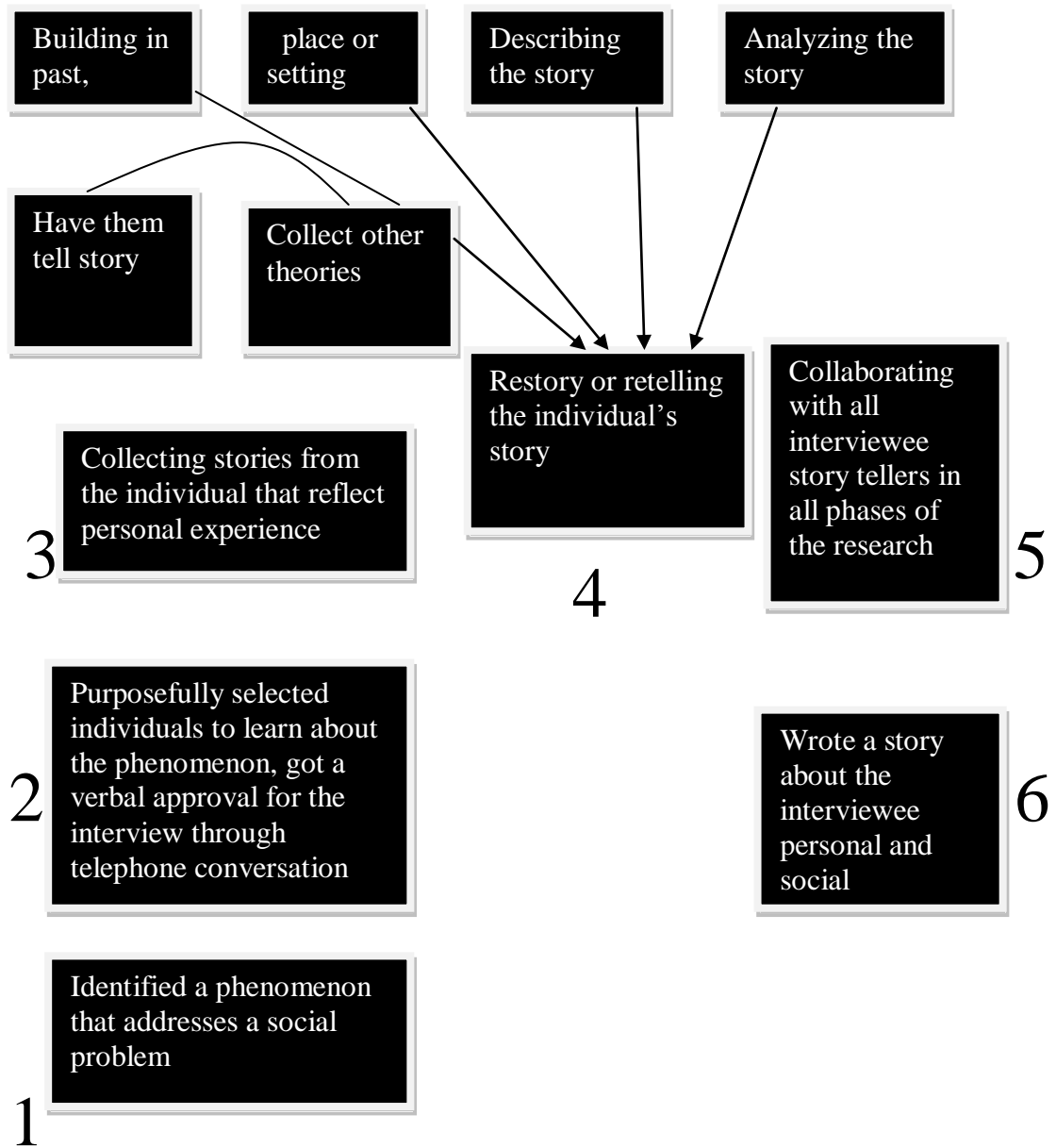


Figure 3. above show the samarised method use in collecting my data for the reseach.

4.2 Evaluating the stories

I put much emphasis on the temporal, chronological, sequence, including the past, present and future. I had also much collaboration with the interviewee. I adequately address the purpose and questions for the interview. I made sure that the interviewee stays in the confine of the place and not to go away from the setting.

I identified certain themes that emerge from the interview and wrote them down for easy reference. My focus was on mostly on the experiences of the individual. Finally, I re-story the interviewee story to have a clear and understanding to the story.

5 CASE AND THEORY

For the purpose of this thesis, special emphasis is laid on three interviews which were carried out to find out the role of community and individual, the models and treatment approaches described by many researchers played in the recovery process of the individual. These cases, filled with insight and raw emotions illustrate how others made lasting changes to enhance their lives after a long-term alcohol addiction. Getting interviewees for this thesis was not very easy I got these interviewees by using snowballing. I had a verbal approval from the interviewees by telephone. The questionnaires I prepare for the interviews was not properly used because the interviewee wanted to narrate their story rather than been ask questions.

I used the shorthand technique to write down the interviews then after rewrite the story or retell in my own words reported by the interviewee. This method helped me to reflect and elaborate the exactly words from the individual, no addition or deduction.

These cases will clearly create an understanding of the power behind the concept that we are “all-one” as we move through this life. The following cases or stories helped me to develop effective approaches in connecting these stories to theories. It gave the

opportunity for individual assessing, learning and reflecting on the strength and weakness that results from this problem of alcoholism.

5.1 CASE ONE

The first interviewee was a man with a background of heavy alcohol use in his childhood family. He started to drink at the age of 15 as he was working as a seaman. After five years, in the age of 20 he had already become an alcoholic.

During the years of alcohol abuse, the interviewee was involved in many criminal activities and he got arrested several times. After serving one of his prison sentences he became a Christian, stopped drinking, and got married and had two children. He was motivated and active in church activities, also educating people on alcoholism issues for 14 years. Nevertheless he relapsed into alcohol abuse and crime. This time while serving his sentence a priest visited him for a discussion and he accepted Christ as his saviour.

The interviewee was rejected and left aside by his children and old friends. His first wife divorced him, and since he got married again, the children from his first marriage as well as his step children did not want to see him. He lost contact with the children and he felt sad about that. He had many appointments to see the therapist and AA group but all to no avail until he fell sick and never recovered and died.

5.2 Case One and theory

Miller & Hester (2010, 4) described the biological model theory of addiction which is also sometimes blended with dispositional disease model where the offspring of alcoholics have a higher susceptibility to alcohol problems. Considering case one, there is adequate traces of this model in the case. This case has proved that truly strong emphasis should be place on the genetics and physiological processes as determinant of

alcoholism. But in analysing the case, the intervention treatment was not very effective considering the fact that, the individual was also one way or the other willing to recover but the family and community was not supportive. The genetic counselling intervention that Hester & Miller discussed was not considered to deal with the alcoholic in this particular case.

Just Anderson (1998) locates the beginning of drug-identity development during early childhood and adolescence, linking it with a sense of marginalization that affects an individual's social status in a negative fashion, and a loss of personal control in defining a satisfying identity. (Etherington 2006, 237.)

According to Van de Kolk (1987, 32) without a secure base from which to explore the world which normally is provided by parents was at risk of 'the earliest and possibly most damaging psychological trauma. (Etherington 2006, 237.) Since he lost his father in his adolescence stage, there was no proper care and attention from any family member according to him, this therefore lead him to be insecure in exploring the world at a risk as van de Kolk has described.

According to Tigerstedt & Törrönen (2005) motives, regulation and situationality are central aspects of drinking habits. (Törrönen & Maunu 2007, 366.) By motives, we mean the self-articulation of drinking. It is characteristic of drinking habits that the individual actively imitates and reworks them, and thus internalizes drinking habits to be part of her/his own competence and social capital. Through internalization, drinking habits have become bodily extensions, by which a person is able to act and be spontaneously and physically expressive in different social situations. By regulation, Törrönen & Maunu (2007) refer to the internal and external control of drinking (Törrönen & Maunu 2007, 366).

When drinking habits have formed into repetitive routines, they have ossified as the 'other nature' of the individual. When they are deeply entangled with everyday life, they have begun to guide the individual's perceptions, actions and interpretations. By situationality, we refer to the situational variation of drinking. Drinking habits retain

their usefulness through a renewal in the practical situations of everyday life (Törrönen & Maunu 2007, 366).

These drinking habits described by Törrönen & Maunu (2007) reflect the similar situation of the interviewee in case 1 where his drinking habits changed during his everyday life to the extent that he started with the AA 12 steps and recovered for 14 years but went back to drinking but this time drinks situational until he died of lung and kidney failure.

6 CASE TWO

The interviewed person got influences from the working class background and neighborhood of the childhood. At that time substantial use of alcohol was typical among the working class and alcohol use was a way of social inclusion into the mainstream. He learnt to get drunk every day (start drinking early in the morning till very soaked with alcohol). Alcohol abuse accompanied with unemployment brought along aggressiveness/violence, low self confidence, weakening condition and narrowing of the hobbies. The alcohol consumption increased as the years went by. Alcohol controlled of his mind and life.

In case two, the interviewee had to swallow the pride and shame so that he can manage the situation to go through the recovery and regain the respect he had lost in the society during the time of heavy alcohol consumption.

In more everyday language, AA notes the role which pride plays as an obstacle to recovery, in their notion of alcoholism as 'self-will run riot'; pride and shame might have to be worked through before further recovery can proceed (Weegmann 2002, 187).

The interviewee missed support or advice from his parents. His brother was in significant role in the beginning of his recovery process, by securing him a job as a caretaker in a church. After that, he approached a minister of the church and he

discussed about his recovering. As the minister recommended, he went to AA group and started the 12 steps of recovery. Although he did not go through all of the 12 steps of the recovery process, he felt not getting much help from the community, the family or the professionals, so the recovering was more depending on his own attitude change and self help. He was willing to have a new, meaningful life and to regain the respect in the society. It is a very difficult process to get back to the normal life after many years of drinking. One way to better the situation was to reconsider the company.

The alcohol saturated life lasted for 15 years, but he has been sober for 11 years now. The interviewee encouraged that recovering from alcoholism is possible but it requires will to be honest with themselves and faith or trust in overcoming alcoholism.

6.1 Case Two and theory

As far as social learning model theory is concerned, it manifested itself in the 2nd case, where the alcoholic had much influence from the friends and the environment. The social learning model explains that, the social learning models focus on the interactions between the individual and the environment in shaping patterns of alcohol use. Researchers have examined the influence of peers and others more closely, emphasizing the importance of modeling of drinking behaviors and of peer pressure (Miller & Hester 2003,6).

The intervention treatment for this particular case was very much use regarding the intervention treatment described by Miller & Hester (2003,6) which focus on altering a clients relationship to his or her environment. Clients are advised to change their circle of friends in order to avoid further reinforcement for problematic drinking and exposure to negative models. The client in this case stop been in the company of all those friends that were not very encouraging in his recovery and that helped him a lot. In this case also it was clear that self- help or self empowerment was his key element to recovery.

Klingemann and Sobell, (2001) said it is quite common for people to overcome alcohol misuse-related problems without outside help. (Karlsson, Raitasalo, Holmila, Koski-Jännes, Ollikainen, Simpura 2005, 1832.)

As his story drew to a close he began to reflect on the meanings of his life and experiences. His words helped me to understand that adopting an alcoholic identity may indeed have been a way of trying to solve life's problems, by providing a means for identity construction that others might find in more conventional ways, unavailable to him.

Through treatment discussions, in-session practice, and homework, participants increased their understanding of how their social network influenced their behavior and, in turn, came to understand the need to modify their networks toward more positive social influences. This new knowledge and skills increased confidence in their competency of the control and influence they possessed over creating a more positive social environment. Actively defining and evaluating their social networks and using this awareness for future planning appeared to be a strong theme across age, gender, and racial groups (J Mason & Knoper 2009, 465).

More research is needed to confirm this finding as generalizable, but it is speculated that the range of historical events and subsequent self-narrative formulations for entering treatment are unique enough to elude our attempt at thematic categorization. Moreover, connecting to current and future hopefulness is a common treatment ingredient and could be an underlying mechanism of integration of self, which this treatment may have contributed to, and thus provided the foundation for more positive current and future self-narrative evaluations (J Mason & Knoper 2009, 465).

7 CASE THREE

The other interviewee considered himself as a Christian during the years of his heavy alcohol consumption. Still AA (Alcoholic Anonymous) and going through the 12 Steps of recovery affected growth of his relationship with God, too. At the times of AA he had a desire to develop as a faithful Christian. AA is secular as its nature, but "Higher Power" which is a used term in AA, can be understood as power from God.

AA has a term H-O-W which refers to the first three steps: honesty, open-mindedness and willingness. The interviewed advised people with alcohol problems according to “H-O-W” to be open with oneself concerning the hopelessness in the excess of alcohol consumption. He recommended not hesitating but attending AA meetings, working through the 12 Steps and gaining knowledge from recovered alcoholics.

Also Christian recovery programs could be a great help for recovering. Christian recovery programs for alcoholism and other addictions are not uncommon components of the church today. Attending either AA or Christian recovery program weekly, getting occupied and working carefully would lead to achieve soberness and a new start of the life.

7.1 Case Three and theory

In this particular case the man tried to assimilate his past drinking life. I was in total agreement with him, relating to the individual identity which include a) self-concept b) coping strategies and c) the narrative according to Rosenqvist, Blomqvist, Koski-Jännes & Öjesjö (2004, 263). These three elements includes, the individual avoiding new relationship, avoiding the past, and also not discussing the past experiences with people not very close to you by building a new identity. Although its individual members espouse many different personal views, AA itself endorses no particular theory regarding the causes of alcoholism (Miller & Hester 2003, 3).

This case relate to the spiritual model describe by Miller & Hester (2003, 3) as a condition that people are powerless to overcome on their own. The hope for this hopeless condition lies in appeal for help from a turning over one’s life to a higher power and following a spiritual path to recovery

A A conceptualizes alcoholism as a spiritual and moral problem. Specifically, A A maintains that alcoholism is rooted in self-centeredness and grandiosity, as evidenced by behaviors such as refusing to admit shortcomings (e.g., inability to control alcohol consumption) and ignoring the needs and feelings of other people. The goal of recovery in A A is a state of spiritual peace, humility, and acceptance, known as “sobriety.”

Hence, in A.A., cessation of alcohol consumption (termed being “dry”) is only the first step of the recovery process. According to A.A., sobriety can be attained if alcoholics accept their human limitations and come to believe in a spiritual “Higher Power” (Humphreys 2000, 496).

I can say that; he moved away from the position of accentuating the past in terms of relating to the ideology of AA. Denzin (1987, 117) claims that a detailed ethnography communication would reveal how each member builds a biography out of speech events he/she produces within a sequence or network of AA meetings. As a whole, Denzin suggests that life-story telling is the central precondition for recovery in AA.

Rappaport (1993) has noted that in church communities and in GROW (a mutual help organization for persons with chronic, severe mental health problems), cross-person similarity in life stories is present because community narratives shape individual community members’ personal stories (Humphreys 2000, 498).

According to Cain (1991) composing and sharing one’s drunk-a-log is a form of self-teaching a way of incorporating the A.A. world view (Humphreys 2000, 498). According to Petty & Cacioppo (1981) this incorporation is gradual for some members and dramatic for others, but it is almost always experienced as a personal transformation. Assuming a role and making a public argument in support of it increases the Speaker’s identification with that role. (Humphreys 2000, 499.)

This process of construction brings the member’s life story more fully into harmony with the A.A. community narrative, and is one of the more dramatic examples of how a community-level phenomenon like the A.A. narrative influences individual-level phenomenon of a member’s life story in mutual help groups (Humphreys 2000, 499).

8 CONCLUSIONS AND SUGGESTIONS

According to Mulford (1976, 1978) and White (2002, 2003) there are pilots of community-level recovery resource development and mobilization from the 1960s and 1970s that could be refined and redeployed on a large scale to enhance the healing of individuals, families, and whole communities (Bison, 2002).

Recovery is a unique and difficult journey for each individual, therefore, there is no cook book approach (debatable), social work profession and community work base approaches must explore the special gifts and resources of each individual and help them mobilize these resources in the service of the recovery process. Recovery can be seen as a personal journey requiring hope, a secure base supportive relationship, empowerment, social inclusion, coping skills and finding meaning to the day to day activities of the individual.

An interesting issue is that; communities, cultures or societies that are close in relation to interfering in others people's problems, will be difficult for community meetings or groups to function well in preventing alcohol addiction or recovery process.

In a survey related to a local alcohol prevention project conducted in 1997-2000 (Holmila 2002), 62% of respondent thought that individuals have the biggest responsibility of preventing drinking problems whereas only 27% were of the opinion that the responsibility belongs mostly to the social network, such as the family and relatives, friends and workmates. The rest of the respondent thought that it was the formal actors, such as the state, who has the biggest prevention responsibility.

According to White (2009) achieving this integrated vision of personal, family, and community recovery will require addiction treatment programs and recovery community service organizations to move beyond intrapersonal models of addiction recovery and conceptualize broader and more sustained interventions. More specifically, this will require strategies of outreach by extending the reach of treatment organizations into the community, inreach involving indigenous community recovery support resources within the treatment environment, and community-based recovery

resource development by facilitating broader processes of community healing (White, W, Evans, A.C. & Lamb, R. 2010, 15).

8.1 professional view on recovery process

My first professional interview was with a therapist who is employed by the city to recommend treatment for people with addiction problems. He said some of the addictions are biological and moral so it takes the professional to approach each problem with different methods.

He mentioned that, one of the major problem recovered alcoholics have is getting back to work if the person was working before, it is very difficult for recovered alcoholics to get back their job, some of the employers has the fear that they will certainly go back to drinking again since there is no guarantee that he or she has totally recovered from the addiction. The community does not give much help in the recovery process since some the alcoholics have not been given much support by their families or in other circumstances the treatment is very expensive. On the issue of the municipal social services, he said, the municipality will look at the intensity of the addiction before they recommend that you see a therapist, they are responsible for patients in substitution treatment.

He recommended that, anyone get some useful information on how to provide help for the alcoholic. However, he thinks many people react differently in different situations. As an ex alcoholic himself, he claimed that you need to decide how much you are willing to take, and then set the limits and make these limitations clear.

I asked him about his view on theories and reality, he said, some theories that have been given in some books on how to help an alcoholic and of course everyone believes these theories on how to extend help to vulnerable ones. However, from his experience it came to light that; being recovered alcoholic is very different from the theory. You cannot use one approach to treat all. Professional should be cautious in administering help to the alcoholics. Theories and opinions can be destructive if they are given as complete fact, or if they criticize or mistreat the individual offering the assistance.

The interviewee went on to say that, accepting the dynamics primarily to the alcoholic actions will assist the people supporting and challenge the alcoholic to improve his or her life condition.

Accommodating the alcoholic's vital needs, everything the alcoholic believes is impairing their life situation needs to be explored. Be realistic and pragmatic with giving assistance. Ideas should not be directed to the alcoholic but lay down realistic goals for the particular needs of the individual.

8.2 My professional development (suggestion)

My three and a half years of studying community development work in diakonia university of applied sciences, I have developmy professional career in social service. Diakonia university of applied sciences has provided many opportunities that has help me in the course of my studies to develop my skills. My professional development has been involved much with, intellectual discipline, conceptual understanding and practical application of the knowledge from teachers.

I have had practical placements places both in Finland and outside Finland, which has also broaden my experience and develop my professinoalism. As diakonia university of applied sciences offers courses on community development work , I have worked with many organizations that are more involved in community work.

This thesis has developed my thinking on the issue of alcoholism or alcohol addiction, models, and treatment intervention. The emphasis laid on collaborative learning has encouraged me to develop relevant knowledge, skills and attitude to make effective use of the theories, models and treatment intervention as a professional.

My interview with Magnus a professional therapist has deepened my understanding of these addiction models and treatment, community work, and self- help. My professional development in relation to this thesis was as a result of the interview granted to me by Magnus and the many theories and approaches from researchers.

This has gained a momentum owing to an apparent breakdown to effectively support inclusion into their communities, and study shows that many people can recover. Recovery process has now clearly been accepted as the guide to standard way of getting back to the “normal” way of living from addictions. Standard actions which include a well enhanced process to help some aspects of recovery process. Presently there is some difference between the professionals working in the recovery models. Many treatment centers have adopted a community-based recovery model based on group skills building within a community context while others have adopted the self- help individual based and other models.

I have developed more interest in the area of addiction when I started working with people with alcohol addiction problems. With experience and research I have had on alcoholism and treatment I have grown more interest working with people with alcohol addiction problems. I have therefore come up with suggestions that may help individuals and groups recovery from alcohol addiction. As many researchers have said in their books, alcoholism addiction has no one common treatment. I have therefore name my suggestion as “Actions to recovery from alcoholism”

Recovery process is an approach to addictions “disease” (especially with alcohol) that emphasizes and supports those persons to live a complete life while coping with the addiction diseases. Recovery can be seen as an individual voyage requiring wish, a protected foundation, helpful relations, empowerment and inclusion, cope skill, and to find meaning to it. Applying the concept of recovery of addictions treatment emerged as the public awareness was created as resulted in more people with alcohol addictions living in many various communities globally.

Every person has a different recovery process which is extremely private and it does also rely on a person’s community and life conditions. In spite of a person’s nature, there are a many characters that are generally central to actions in all recovery.

The following suggestions are the treatment plan that i designed when conducting this research. If an individual has the capacity to realise and admit that he or she has a problem with alcohol, the suggestions below will be an ultimate steps to recovery;

i) Wish/hope

Discovering and developing hope is the first solution to recovery. It includes not just hopefulness but a sustainable faith in the individual and a motivation to persist during doubt and failures. Hope can begin at certain time in course of the recovery, or become known slowly as a little and weak emotion, and might change with anguish. This includes being bold to belief in yourself, professionals, relations and close ones in order to avoid disappointment and additional harm.

ii) Protected foundation

Proper accommodation, a adequate income, self-determination from violent behavior, and sufficient access to healthcare is basics to recovery.

iii) Helpful relations

A general feature of recovery from alcoholism is the presences of those who are giving the support and trust in the person's possible recovery. As recovery professionals can recommend a certain restricted people, relations and assist encourage hope, relationships with friends, family and the communities are mostly of wider and longer-term significance.

The experienced people with the same kind of difficulty and are in the process of recovery, be able to be of help in many other ways of significance. Individuals who with the similar values, expressions and generally may as well be of importance at times, the “normal way” relations whereby you always get help can really be devaluing. Shared interaction and collective support networks can be of more value to self-esteem and recovery.

iv) Empowerment and inclusion

Empowerment and self-determination are keys to recovery, as well as managing the control. It can indicate increasing the self-confidence for self-determination in decision-making and seeking for help. To achieve total inclusion might need support and can also involve difficult shame and discrimination about alcoholism.

v) Cope skill

The growth of individual coping strategy, as well as self-management or self-help is a vital aspect. It can entail creating the use of prescription or treatment if the individual is entirely educated and listened to, together with open discussions regarding difficult situations and also concerning which recovery methods is best enough to handle the person's life and the process of recovering from alcoholism.

The order to develop your skill to cope and skill to solve difficult situations to manage individual behavior and setbacks which directly does not show any symptom of alcoholism, may need the individual fitting in to be the best architect of their problem to recognize key stressful areas and likely crisis points, and to value and grow personal ways to respond and cope.

To be capable to progress on in life can imply you must be able to cope with feelings of loss, which may possibly include hopelessness and resentment. Once the person is prepared, it can signify a progression of anguished. This also may well involve accepting past anguish and lost opportunities or lost moment in time.

To find meaning

In order to establish and sustain the recovery process from alcoholism, there is the need to build up a meaning which is the primary focus in recovery and it's very

significant. This can be achieved by improving a common task. This may well also entail renewing and discovering a guide to help to have new values, etc.

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Appendices

Appendix 1: Interview questions

Can you tell me how it all started?

How long did you get involve?

When you did you realize it's a problem?

Were there any challenges during that time?

Did you get any help?

From where?

Family

Friends

Community

Professionals

States

Appendix 2: pictures

FROM STREET



TO HOME

