Summary of

CRAVING, ADDICTEDNESS AND IN-DEPTH SYSTEMICS

Case Study of the Therapy Centre for Drug Addicts
START AGAIN in Zurich between 1992 and 1998

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The following paper is a summary of the main results and most striking insights derived from the case study entitled "Craving, Addictedness and In-Depth Systemics". The case study is based on the Therapy Centre for Drug Addicts *START AGAIN* in Maennedorf and Zurich, Switzerland. It was carried out for the Swiss Federal Office of Justice which considered this centre to be an "innovative trial model" due to its specific logic of intervention. Between summer 1995 and autumn 1998 the study was funded by the Swiss Federal Department of Justice and Police. The complete final report is approximately 400 pages long.‡

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1. Methodical and methodological framework of the case study

At the outset, the case study of *START AGAIN* was planned in such a way that a *methodically controlled approach* would allow for a comprehensive insight into the life of the therapeutic institution. This was meant to enable staff as well as outsiders to understand the rational evaluation of its goals and its methods.

In order to arrive at this goal, we employed the *research strategy of a mutually complementary combination of "reconstructive-qualitative" and "empirically-quantitative" methods from the social sciences*. These methods were conjoined in the programmatic sense of developing a grounded theory following the ideas of Barney G. GLASER and Anselm L. STRAUSS.[1]

A *reconstructive-qualitative approach* takes a case (an individual, a family, group or institution) as an independent unit of investigation. This means that the various expressions and the traces of social interaction which are produced by the case itself (often in a dialogue with the investigator) are recorded directly and unfiltered, and later evaluated by means of sequential analysis using the "case's very own language."

By taking recourse to the *methodology of Objective Hermeneutics*, developed by the German sociologist Ulrich OEVERMANN and others,[2] we can identify as the central object of investigation "objective structures of meaning" as well as "latent structures of significance" in expressions and actions. By way of analysing various kinds of data those structures are being integrated, a process which forms an increasingly pronounced hypothesis of the "structural regularities" of a given case.

From the systematic contrasting of different individual cases representing certain social groups (e.g. (ex-)drug addicts or professionals in *START AGAIN*) the respective "structural models" can be derived (e.g. a structural model of a life practice damaged by addiction or a model of in-depth systemic addiction therapy – see below).[3] But *empirical-quantitative* approaches perceive a case as one element in a group of carriers of characteristics which can be summed up in pre-existing operational categories or classifications.

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‡ The final report (German version) can be found on the WWW-side of the Swiss Federal Office of Justice: see www.ofj.admin.ch/d/index.html where you select under "Sicherheit und Schutz" the link to "Strafen und Massnahmen" and there you choose "Verzeichnis der Auswertungsberichte abgeschlossener Modellversuche".

In the case study of *START AGAIN*, the main emphasis lays on the systematic empirical contrasting of sub-clienteles who are characterised by certain traits (e.g. gender, conditions of entry or duration of stay in the institution) or different degrees of participation in the therapeutic programme (e.g. family therapy, external *Vipassana*-courses or therapeutic after-care) and on their descriptive and statistic characterisation. The recurrent problem with individual case studies is their use of varied and relatively small samples. This problem was counteracted by using new theoretical approaches as they form part of the mathematical sub-discipline of *probabilistic logic* (probabilistic logic is a conjoining of Bayesian statistics and information-entropic approaches strongly influenced by Edwin T. JAYNES).[4]

2. Outline of the case *START AGAIN*

Therapeutic fundamentals of *START AGAIN*

The *therapeutic concept of START AGAIN* consists of a combination of four mutually supportive elements:

(1) systemic drug addiction therapy (a synthesis of everyday life, intensive weeks centred around a topic and group settings, all with internal or external professionals),

(2) integration of the addiction understanding of self-help groups (NA, RRS etc.),

(3) the awareness training of *Anapana-sati* (based on observing natural breath) and the practice of V*ipassana*-meditation and

(4) systemic couple and family therapy.

Since its inception, *START AGAIN* works on the basis of abstinence. The therapeutic programme is embedded in an in-house period of approximately 12 months duration. During the first approximately 5½ years of *START AGAIN* the stay was strictly divided in three obligatory phases. Thereafter this was substituted by a model of seamless transitions between development segments, the main emphases of which were individually negotiated.

History of *START AGAIN* from October 1992 to September 1998

The *history of the concept and of the operation of START AGAIN* between spring 1992 and autumn 1998 can in hindsight be differentiated into six phases:

After a *founding phase* of 6 months, the programme commenced in October 1992 in Maennedorf (a small town about 10 miles outside of Zurich) and a *step-by step development* of the therapeutic programme followed in Maennedorf and in Zurich until about December 1993.

Between January 1994 and March 1995, there followed a *first phase of consolidation* of therapeutic and organisational-administrative processes.

Driven by the therapeutic and operational successes, the time between April 1995 and March 1996 saw an *expansion* (purchase of a property at the Steinwiesplatz in the midst of the city of Zurich) as well as efforts towards professionalisation. But the expansion went hand in hand with a recessive development of the demand for stationary addiction therapy (lower demand and therapeutic oversupply), in combination with an increasingly restrictive funding policy on state and federal levels as well as internal structural deficits. This led to an extensive financial crisis, which called for serious crisis management resulting in a thorough restructuring of the operational side of *START AGAIN*. The time

between April 1997 and August 1998 may be understood as a "*settling phase*" after the crisis and a phase of *anewed systematic conception* of the therapeutic programme.

A new therapeutic model with individual therapy programmes and an operational concentration at the Steinwiesplatz in Zurich is put into practice since summer 1998. Regarding the funding and therefore financing of stationary addiction therapy, the present situation in Switzerland is grim. It is a matter of utmost concern to develop reliable conditions as soon as possible, so that qualitatively sophisticated addiction therapy can be implemented, as opposed to a mere carrying out of "incarceration" measures.

From a structuralistic point of view, the following developments and complementary poles can be reconstructed as *the defining determinants of the history of the concept and the organisational history of START AGAIN*:

(1) development from an organised joint-family to a joint-familial organisation,

(2) from change as the constant to constancy in change,

(3) everyday living as therapy and therapy as everyday life,

(4) therapeutic vs. business management perspectives,

(5) orientation at the ideal of the learning organisation,

(6) professionalisation of therapeutic action, and professionalisation in general, and

(7) the socio-cultural contrast of city (Zurich) and country (Maennedorf).

Statistical profile of the clientele of *START AGAIN*

During 1993 and from 1995 to 1997, statistically, *very little* sets the clientele of *START AGAIN* apart from the client-pool of the united stationary addiction therapy institutions of Switzerland called FOS.[5]

The descriptive, statistical dimensions are those of socio-demographic data, situation upon entry (i.e. structural integration in the year prior to treatment), structural resources and deficits, social network, drug use and drug experiences, health, experience in institutions and with the law, therapy motivation. Among those (which are discussed in detail in the case study), the following two turned out to be the most important variables in which a marked difference occurs between the clientele of *START AGAIN* and the FOS client-pool:

(1) *Modality of entry*: the proportion of clients beginning treatment involuntarily (i.e. due to court orders, or due to an allocation by the guardian or doctor) to those entering the institution voluntarily is inversed in *START AGAIN* (accumulated from 1993 to 1997), where it is 62% to 38%, compared to the FOS client-pool, where it is 39% to 61%. The high proportion of involuntary clients in *START AGAIN* explains why the clients of *START AGAIN* are on average more experienced with institutions and the judicial system than those belonging to the FOS client-pool.

(2) *Urban clients*: the majority of the clients of *START AGAIN* (73%) come from the Canton Zurich; especially from the metropolitan area of Zurich, whereas only half of the FOS clients had their last residence before commencing therapy in a metropolitan area.

    This fact is made reference to by the programme of *START AGAIN*, which holds that addiction therapy has to be effected at the place where the addict was (at least partially) socialised and where s/he will in all probability live after the therapy, i.e. a met-

ropolitan area.

The following data is also determined from the entire clientele of *START AGAIN* between October 1, 1992 and March 31, 1998, the cut-off date for the study: in this period, 194 clients entered the institution (10 entered twice) and 174 exited either regularly or left early. 80% of the clients were male, the average age was 27.0 ± 5.5 years.

20% of the clients were not Swiss citizens and 61% of the clients had at least one foreign parent.

21% of the clients had minimal schooling (Special-, Primary-, and/or High School), 74% had Year 10 and 5% Year 12. 53% had completed an apprenticeship.

62% (29%) had previously begun at least one substitutional treatment (completed), 33% (12%) had previously started at least one outpatient drug therapy (completed) and 40% (31%) had previously commenced at least one residential addiction therapy (completed).

3. Addiction and addictedness from a structural point of view, from a neurobiological point of view and from the point of view of the *Vipassana*-practice

The structural model of a life practice damaged specifically by addiction

From a structuralistic point of view, *life practice damaged by addiction* is generally understood as damaged autonomy. This has been verified by the reconstruction of many behaviour records and individual interviews in *START AGAIN*. More specifically, this damaged autonomy is characterised by the fact that polarities, complementarities or contradictory units[6], which are characteristic of every life practice, are either split dichotomically into two unmediated extremes or that they are short-circuited into insufficiently differentiated forms of practice.

In other words: either a happy medium is missing (which really means the dynamic mediation between opposite extremes) or complementary types of action are insufficiently differentiated. Thus we find the pathological type of an either dichotomically split or of a short-circuited "*either-or-thinking, -feeling and -acting*" or a permanent "*everything-or-nothing*".

Specifically, we have reconstructed the following pathologically-distorted complementarities or contradictory units in the case of addiction:

(1) At the basis of every life practice, there is the contradictory unity of the compulsion to make decisions on the one hand and the obligation to justify them on the other hand. In addiction, however, this contradictory unit is short-circuited: Action (drug-taking) becomes the justification for action (drug-taking). Basically, in addiction, an attempt is made to escape from an unbearable tension between the compulsion to make decisions and the obligation to justify them. The basic motive here is escapism.

(2) The relationship between life crisis (the absence of established solutions) and routine (where established solutions are being put into practice), ultimately the relationship between life and death, is fundamentally problematic.

(3) In the tension between autonomy and heteronomy, phony autonomy is employed: when something could be made out of the circumstances, one pretends to be shaped

by them, but when one is actually shaped by circumstances, one pretends to be able to make something out of them.

(4) A deep gap separates sensations or feelings and reason.

(5) The relationship between the "I" and others is characterised by narcissism (self-absorption), by a problematic adoption of the perspective of others and a problematic I-others-separation.

(6) The complementarities of omnipotence and helplessness, of agent and victim, of self-interest and common interest fall apart.

(7) The difference between personal (so-called diffuse) and role-formatted (so-called functionally-specific) social relations is habitually subverted.

(8) The poles in the field of tension between rebellion and conformity, between the unusual and the day-to-day routines are not balanced.

(9) One's personal past and origin do not stand in a dynamic relation to one's future.

Against this background, addiction must not be understood as a mere dependence on addictive substances. Rather, it is a very basal disturbance. In the next section, addiction will be presented in the context of the genesis of autonomy during socialisation. In the section after that, we will situate it in the context of those central mental-cognitive processes which are responsible for the assignment of significance to specific situations and actions.

Pathogenic constellations in the primary socialisation possibly promoting addiction. After-socialisation vs. re-socialisation

Based on the reconstructive analysis of a number of family histories (genograms) and biographies of clients of *START AGAIN*, it can be emphasised that the *structural model of the primary socialisatory process*[7] as developed by OEVERMANN provides a very adequate backdrop against which sophisticated addiction rehabilitation work can be reflected and organised. This model is without doubt useful in other therapeutic and pedagogical contexts as well.

The model (presented in detail in the case study) understands the entire process of socialisation as the succession of four central crises of dissociation which occur after phases with different structural logics: 1. the dissociation from the primary symbiosis in the womb by birth; 2. the dissociation from the mother-child symbiosis around the 3rd year; 3. the dissociation from the manifest oedipal triad[8] approximately between the 6th and the 8th year; and 4. the dissociation from the family of origin in overcoming the crises of adolescence approximately between 17 and 20 years of age.

The results of the analyses in the case study can be summarised by the following thesis: all grave derivations from this ideal model of the socialisatory genesis of autonomy will lead to pathogenic constellations. These will lead to pathological "transferences" later in life. As OEVERMANN has stated, individually damaged autonomy will lead to "ruptures for re-staged, repeated floodings of undealt with original constellations from the primary socialisation" when current conflicts occur between adults.

From a typological point of view, the following types of pathogenic socialisatory constellations can be reconstructed from the biographies of drug-addicted persons:

(1) non-establishment of a basic feeling of primordial trust in the mother-child symbiosis,

(2) remaining in the symbiosis due to a overcaring, excessively sheltering bondage to the

mother-child symbiosis or due to a lacking development or absence of the consecutive phase, the oedipal triad, respectively,

(3) being stuck in the oedipal triad and thereby in the structural logic of personal (diffuse) social relations with the consequence of a lack of ability to form role-formatted (functionally-specific) social relations,

(4) breaking of the incest-taboo (constitutive for the oedipal triad) in sexual interferences, and

(5) lack of overcoming the crisis of adolescence by being bound in the pseudo-togetherness or the pseudo-enmity of the family of origin.

Two other types of pathogenic constellations are less common:

(6) traumatising conflicts based on jealousy or competition with siblings,

(7) remaining in identification with an authoritarian and overly powerful (for example professionally very successful) father.

Against this background, the task of addiction rehabilitation is not just one of implementing *re-socialisation*. Rather, *after-socialisation* has to be effected in a case-specific manner and at times to a large degree.

Addiction and addictedness from the points of view of neurobiology and of *Vipassana*-practice

The term *addictedness* indicates an action-inducing and action-structuring potential. It refers to the degree of routinisation of the general mental reaction pattern of reacting with craving first for the pleasant (including the craving for the absence of the unpleasant) and finally towards craving itself.

The term addictedness makes it possible to relate ancient Eastern models explaining (drug-)addiction and modern Western hypotheses on the neurobiology of addiction to each other (as is explained extensively in the study).

In the framework of the ancient practice system of *Vipassana*,[9] which goes back to the historical BUDDHA, addiction is understood as a fundamental mental problem of craving, of the unconscious reacting upon craving with craving. Thereby, the original object or substance which originally caused craving plays only a subordinate role.

From a neurobiological point of view, the unconscious mental reacting upon craving with craving coincides with an unconscious learning process, promoted strongly by the specific effect of addictive drugs upon the brain. This learning process accords drugs, their use and drug-associated stimuli the *significance of being essential for survival*, and this learning process gets increasingly out of hand.[10] It has to be emphasised that this cumulatively growing allocation of significance or salience occurs increasingly independent of hedonistic (positively enforcing) and anhedonistic (negatively enforcing) experiences.

From the point of view of the *Vipassana*-tradition, the *feeling of physical sensations* (*vedana* in the old indogermanic language Pali) plays a key role in development of and in the liberation from (universal) addictedness (*tanha*). The prominent importance accorded to the experience of physical sensations (*vedana*) in the practice system of *Vipassana* is derived form the fundamental insight of the historical BUDDHA:

> *vedana samosarana sabbe dhamma* – "everything that arises in the mind flows along with sensations."[11]

The *Vipassana*-programmatics towards healing of or liberation from addictedness is being explained as the transition from:

> *vedana paccaya tanha* – "In an ignorant mind physical sensations lead to craving or aversion", to:
>
> *vedana paccaya panna* – "In a knowing and aware mind physical sensations lead to wisdom and thereby to liberation."[12]

In other words: the maxime of recovery in *Vipassana* is the promotion of life-practical autonomy by realising the "mental attitude of an equanimous and clearly comprehending neither-nor", i.e. neither blindly reacting with craving towards the pleasant, nor blindly reacting with aversion towards the unpleasant. The goal is freedom to experience reality *as it is*, without entangling oneself unconsciously in it by way of reacting.

It is noteworthy that the newest neuropsychological insights indicate strongly that feeling of physical sensations is indispensable for very many cognitive-mental processes, in the sense that these processes are permanently connected back to feeling physical sensations.[13] In colloquial terms: human beings do not only reason with their brains, but although with their bodies.

4. In-depth systemics as innovation by *START AGAIN*

On the case structure regularity of *START AGAIN*

In terms of the general structural logic of *START AGAIN*, the core of the institution has to be characterised as a multi-layered and multi-dimensional contradictory unit. The different dimensions are ordered according to their specific scope for recovery: self-help in accordance with the twelve-step programme of the Narcotics Anonymous (NA) and (since spring 1998) according to the principles of the Rational Recovery System (RRS) for working with problematic *life style* elements. Then there is professional therapy for working with *life themes* and the *Vipassana*-practice system to work with *addictedness* and questions about the *meaning of life*. These methods form mutually opposing pairs, all with structural similarities and irreconcilable opposites. Additionally, each basic element of intervention presents a multi-dimensional contradictory unit itself. By way of its concept and its actual history, *START AGAIN* is to be understood as a multi-layered and multi-dimensional "as-well-as-Gestalt" which contrasts maximally with the "either-or-thinking, -feeling and -acting" of its clientele.

In-depth systemic addiction therapy as a new type of therapy

The process-oriented, in-depth systemic addiction therapy model of *START AGAIN* is characterised by two basic ideas:

(1) The genesis and maintenance of addiction is understood as a process of entanglement in which two main factors conjoin pathologically: a specifically damaged socialisatory and individual-biographical development process and a general mental-somatic reaction dynamics based on craving and physical sensations. This latter factor is affected by the physiological impulse and the neurobiological effect of drugs, but drugs are not the most basic element of this dynamics.

(2) In line with this understanding, the therapeutic intervention focuses on biographical work and after-socialisation (systemic dimension) as well as on methodical self-ob-

servation, self-experiencing and mental training (in-depth dimension).

The therapeutic process is to be understood as a path out of a pathologically split or short-circuited "either-or-thinking, -feeling and -acting" to a dynamic, open to the future "as-well-as-thinking, -feeling and -acting", whereby as a final goal a "mental attitude of an equanimous and clearly comprehending neither-nor" is projected onto the horizon.

Addictedness points to a fundamental phenomenon in human thinking, feeling and acting. Hence, the area of application of the in-depth systemic therapy model of *START AGAIN* is by no means limited to drug addicts. There is an obvious scope for general application of this model in the areas of rehabilitation, pedagogy, therapy, counselling and others.

5. Reconstructive and empirical process- and effect evaluation

On the practical significance of self-help in *START AGAIN*

Regarding the component of self-help (NA, AA, RRS etc.) and the participation in the respective internal and external meetings and conventions, the following dimensions were being reconstructed as being significant for the process of recovery:

(1) Meeting other addicts and ex-users who are clean promotes one's own motivation to live clean and to break the vicious circle of addiction.

(2) In the company of people with a similar history, it is possible to look at one's own life style as an addict without the need for justification (i.e. to look at deceit, tricks, camouflage, to look at the theme of "everything now and for free", at obsession, controlling, indulgence, fear of encounter etc.). This allows addicts to practice pragmatic action orientations and practical life skills in order to resist the craving for drugs and to live clean.

(3) Self-help groups resemble a *peer-group* and as such carry an important after-socialisatory potential.

On the effect of professional systemic therapy

Systemic therapy in *START AGAIN* is based on a specific model of the professionalisation of therapeutic action called *understanding the case in the encounter*.[14] The effect of professional systemic therapy in *START AGAIN* is based mainly on two forms of practice:

(1) *Working with one's biography* is like the red thread that runs through the entire duration of the therapeutic stay, though in different degrees of intensity. Central to this is the understanding that the course of events in the past cannot be altered – what has happened cannot be undone –, but the personal histories, insofar as they are constructed actualities, can be re-written or written anew. In this manner, time is being reorganised retrospectively which allows new drafts of the future to emerge.

(2) The fundamental, omnipresent operation in the stationary therapeutic routine of *START AGAIN* is the *process of negotiation with the clients*. This may occur in individual therapeutic sessions, in case discussions, in sessions on the occasion of important developmental thresholds, in shared-house groups, planning-groups or other therapeutic groups.

The re- and after-socialisatory effect potential of negotiation processes is based on the following causal chain: negotiation processes encourage clients to embrace the

perspective of the other which necessarily presupposes a common pool of routine knowledge. This knowledge is typically imbibed in the primary socialisation process in a shared socioculture and it is now worked out further in the after-socialisatory mode of therapeutically accompanied negotiation processes.

As an orientation for the design of these negotiation processes in *START AGAIN*: autonomy is being developed by availing oneself of the possible autonomy. A simile: one learns riding a bicycle by riding a bicycle.

On the effect potential of the practice of *Anapana-sati* and 10-day *Vipassana*-courses

Regarding the daily practice of *Anapana-sati*, the following model of progression has been established from a structuralist point of view: a *continuous focussing of awareness* on the object of natural breath results in an increased *attentiveness*. Analyses have shown that the practice of *Anapana-sati* may rightfully be termed *anti-stress technique* in Western parlance.

Regarding the effect potential of 10-day *Vipassana*-courses, five classes of potential effects (possible effects which may occur, but do not have to occur) could be reconstructed:

(1) effects on the level of social action (ethic orientation of action),

(2) somatic and psychosomatic effects with marked changes in various (psycho-)somatic symptoms,

(3) effects related to methodical self-observation, self-control and coping (e.g. *Anapana-sati*-practice as technique of coping in acute stress),

(4) effects of a deep psychodynamic nature (deep experience of well-being, of emotion, of euphoria, of dread, fears, psychic pains, sexuality, memories of traumatic experiences etc) which especially may include an immediate confrontation with one's own addictedness, and

(5) effects in the realm of wisdom and the promotion of life-practical calmness and of a basic structural optimism.

Regarding the last point, the above model of progression can be extended (see picture below): the continuous, methodically controlled observation of physical sensations on the basis of increased awareness – no craving towards the pleasant or aversion towards the unpleasant – leads to a *lief-practical calmness and basic structural optimism*. (Such optimism provides a solution-oriented confidence in such crises where routine solutions are not available.) This in turn results in increased life-practical autonomy.

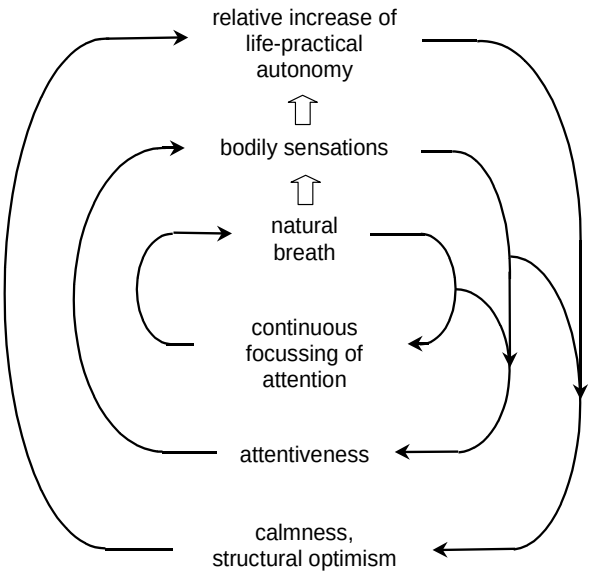
Based on the experiences in *START AGAIN*, it has to be noted that three *conditions* have to be fulfilled if the potentially effective *Vipassana*-courses, as they are being taught all over the world today, are to be used in the context of therapeutic work with autonomy damaged clients dealing specifically with addiction – and most certainly in other therapeutic contexts as well:

(1) a systematic intellectual and practical preparation for the course, incorporating, especially, a longer preparational phase of *Anapana-sati*-practice,

(2) ensuring the adequate accompaniment and counselling of clients who leave a course before completion, and

(3) post-course counselling which will differ from case to case and will be situated be-

tween the poles of "I experienced so much, I *have* to talk about it" and "it was a highly personal experience, I do *not* want to talk about it."



Progression model: from the observation of natural breath to the observation of bodily sensations to the increase of life-practical autonomy

In order to obtain the full benefit of increased autonomy from a *Vipassana*-course, the central question is whether one is capable of *practically integrating* the experiences and their implications which arose during a course. This is a subtle and demanding task, especially in the case of a damaged autonomy, and it is not easily or immediately achieved. Thus it is in need of therapeutic accompaniment.

Overview on the results of systematic follow-up evaluation of former *START AGAIN* clients in the second year after their leaving *START AGAIN*

Between October 1, 1992 and June 30, 1997, 58 completers, 36 late-leaving clients and 51 early-leaving clients left *START AGAIN*. In percentages: among the 145 clients of this period 40% exited after completing the full treatment, with an average duration of 1.40 ± 0.44 years, 25% left in a late phase of the treatment, after 0.77 ± 0.33 years (i.e. in the second half of the treatment programme), and 35% left early, within the first two months (0.15 ± 0.09 years), during a sort of "probation" period.

Of the 145 clients under investigation, 10 (7%) had died during the period of the catamnesis. Among the 58 completers 37 (64%) were definite therapeutic successes, among the 36 late-leavers 3 (8%). The average period of the catamnesis was 1.68 ± 0.48 years. *Definite therapeutic success* means no drug use during the catamnesis (with the possible exception of one or two singular "last trials" of drug intake after therapy) *and* a clear

relative increase of autonomy along the dimensions outlined in section 3. 10 completers (20%) and 24 late-leavers (67%) had to be classified as *serious relapses* (i.e. daily or almost daily drug use and no clear increase of autonomy). The remaining cases were indifferent.

Translated into chances for success and relapse risks (according to probabilistic-logical methods) this means that completers of *START AGAIN* have a conservative chance of success of (63 ± 6)%, and the probability of a heavy relapse lies at (18 ± 5)%.[15]

For all completers and late-leavers together (the "actual" clients of *START AGAIN* since the early-leavers do not really undergo its therapeutic programme) the probability of a heavy relapse comes to (36 ± 5)%. In other words: for the "actual" clientele of *START AGAIN*, the chance to be fully or partially rehabilitated in the second year after leaving therapy comes to (64 ± 5)%.

Empirical results of the effectiveness of the therapy programme of *START AGAIN* for different sub-clienteles

In relation to the main variable *mode of entry* into therapy, an *important trend reversal* has to be noted in the mid-1990's. The first half of the decade saw a markedly higher success rate for completers who entered therapy voluntarily (71 ± 11)% vs. (61 ± 11)% among non-voluntary clients (i.e. those who came by order of court or guardian). Since 1996, however, the chances of success have been inverted, though at a somewhat lower level.

This trend reversal has as its background the first half of the nineties when there was a strong demand for stationary therapy. This resulted in a shortage of therapy places for those wanting to voluntarily undergo therapy. It also meant that clients were more easily expelled for breaking rules or low motivation: there was a *strong selection*. The years 1996 to 1998 saw a sinking demand for stationary addiction therapy and were marked by financial problems of the institutions, resulting in a much lower degree of selection. It was characteristic for this situation that "*court order bonds to therapy*" which had a positive effect on therapeutic success.

For the first approximately 4½ years of *START AGAIN* (October 1992 until June 1997) it can be said that it was harder for *women compared to men* to go through the entire programme of *START AGAIN*. Younger women especially broke the therapy off, typically in the second part (young late-leavers), and thus made up the largest quota among women who left therapy early. In addition, it holds true that the female completers did not show a lesser chance for success than their male counterparts and that the late-leaving women had a markedly better success chance and a lesser probability of a heavy relapse than the late-leaving men.

From an empirical point of view, participating once or twice in an *external 10-day Vipassana-course* does not generally translate into a higher success rate; however, such participation does indicate a markedly lower risk of a heavy relapse.

The analysis of 9 cases, who practised the *Vipassana*-technique more or less regularly after leaving *START AGAIN* and attended at least one or more *Vipassana*-courses, suggests that by the continuous practice of *Vipassana* addictedness can actually be worked upon effectively, since all of these cases can be considered definitive therapeutic successes. The precondition, however, is that it is at the same time possible to develop or consolidate certain case-specific practical competencies in life, be they social, affective-emo-

tional and/or cognitive-mental: working on addictedness and increasing life-practical competencies have to go hand in hand.

The *systemic couple- and/or family therapy* in *START AGAIN* did not have a clearly differentiating significance regarding the success of the therapy or the probability of a serious relapse.

Different sub-clienteles differed strongly regarding the degree of participation in the therapeutic programme of *START AGAIN*. But the chances of success and the risks of a heavy relapse differed only marginally. This forms an empirical indication that the effectiveness of the therapeutic programme of *START AGAIN cannot be added up* as the sum of the effects of the various elements of intervention, but rather that success has its origin in the artful conjoining of the various elements, *in the therapeutic programme as a whole*.

Core thesis about the reasons for the therapeutic effectiveness of *START AGAIN*

The combination of the results from the empirical evaluations, the insights from the case reconstructions and the structural analysis of *START AGAIN* itself resulted in the following *core thesis about the reasons for the therapeutic effectiveness* of *START AGAIN*: the therapeutic effectiveness of *START AGAIN* rests on the therapeutic programme as a whole, i.e. *START AGAIN* as a whole represents a balance on the razors edge which is to some extent always threatened by failure. This balancing act occurs between a number of action orientations and interventional logics which are structurally opposed to each other but clearly bound within contradictory units. As such it provokes an *extensive climate of transformation* which can *awaken sustained self-healing potentials* among the clients – the foundation upon which actually any therapeutically accompanied recovery process rests.

A healthy measure of structural optimism is a necessary precondition for being able to face the demanding task of mediating between unresolvable pairs of opposites anew every day, a task that is moreover beset with possible failure. The practice of *Vipassana latently or manifestly sustains this optimism for both clients and staff*, in individually varying degrees. In the therapeutic practice, there is a connecting thread running through the practical work of mediating everyday life by way of the different action orientations and interventional logics. This connecting thread is spread out between reconstructive case understanding and the understanding of addiction particular to *START AGAIN* (in which the concept of addictedness is central).

On the significance of the outpatient aftercare in *START AGAIN*

Regarding the significance of the use of the outpatient aftercare offered by *START AGAIN* (i.e. counselling in bureaucratic, financial, educational and occupational matters, therapeutic aftercare, counselling in personal crises or episodic relapse into drug use etc.) the following can be stated: for the first five years of *START AGAIN* the use of aftercare was empirically a clearly distinct indicator of a higher chance for success and a lower risk of a serious relapse.

The propagation of a "comprehensive *case management service* and the efficient promotion of it, by virtue of its efficiency, on the market of support organisations" constitutes *START AGAIN*'s development goal for the coming years. Regarding this goal the empirical data suggest that, in a comprehensive case management, stationary therapy and outpatient aftercare have to be cast in the same mould.

6. Notes and references

[1] B.G. GLASER and A.L. STRAUSS, 1967, *The Discovery of Grounded Theory: Strategies for Qualitative Research* (Aldine de Gruyter, New York).

More extensive bibliographies can be found in the full version of the case study. Here only a few of the main works are listed.

[2] See for example: U. OEVERMANN, 1993, Die objektive Hermeneutik als unverzichtbare methodologische Grundlage für die Analyse von Subjektivität. Zugleich eine Kritik der Tiefenhermeneutik, in: T. JUNG and S. MÜLLER-DOOHM (Hrsg.), *"Wirklichkeit" im Deutungsprozeß. Verstehen und Methoden in den Kultur- und Sozialwissenschaften* (Suhrkamp, Frankfurt a.M.), 106-189; U. OEVERMANN, 1996, Konzeptualisierung von Anwendungsmöglichkeiten und praktischen Arbeitsfeldern der objektiven Hermeneutik. Manifest der objektiv hermeneutischen Sozialforschung, Manuskript (Universität Frankfurt a.M.); U. OEVERMANN, T. ALLERT, E. KONAU and J. KRAMBECK, 1979, Die Methodologie einer "objektiven Hermeneutik" und ihre allgemeine forschungslogische Bedeutung in den Sozialwissenschaften, in: H.G. SOEFFNER (Hrsg.), *Interpretative Verfahren in den Sozial- und Textwissenschaften* (Metzler, Stuttgart), 352-434; and B. HILDENBRAND, 1996[3], *Methodik der Einzelfallstudie: Theoretische Grundlagen, Erhebungs- und Auswertungsverfahren, vorgeführt an Fallbeispielen*, Studienbrief in drei Bänden (Fernuniversität Hagen).

[3] In the case study, all these steps are accompanied by exemplary analyses of various types of data (interviews, written "curricula vitae", genograms, session protocols, concepts, etc.).

[4] See for example: E.T. JAYNES, 1957, How does the brain do plausible reasoning?, *Stanford University Microwave Laboratory Report 421*; reprinted in: G.J. ERICKSON and C.R. SMITH (Hrsg.), 1988, *Maximum-Entropy and Bayesian Methods in Science and Engineering, Vol. I: Foundations* (Kluwer Academic Publishers, Dordrecht), 1-23; E.T. JAYNES, 1990, Probability theory as logic, in: P.F. FOUGÈRE (Hrsg.), *Maximum Entropy and Bayesian Methods* (Kluwer Academic Publishers, Dordrecht), 1-16; E.T. JAYNES, 1983, *Papers on Probability, Statistics and Statistical Physics*, R.D. ROSENKRANTZ (Hrsg.), (D. Reidel, Dordrecht); and E.T. JAYNES, 1996, *Probability Theory: The Logic of Science*, under preparation, see the WWW: http://bayes.wustl.edu or http://omega.math.albany.edu:8008/JaynesBook.html.

[5] FOS is the abbreviation for "Forschungsverbund stationaere Suchttherapie", the "research association of stationary addiction therapy" (subsidised by the Swiss Federal Office of Public Health) whose task is "a comprehensive evaluation of residential drug-therapeutic institutions in Switzerland."

[6] The dialectical term of *contradictory unit* encapsulates the productive (i.e. releasing certain dynamics) simultaneousness of related pairs of opposites, whose contradictions cannot be balanced out.

[7] See for example: U. OEVERMANN, 1979, Ansätze zu einer soziologischen Sozialisationstheorie, in: R. LEPSIUS (Hrsg.), *Deutsche Soziologie seit 1945*, Sonderheft 21 der Kölner Zeitschrift für Soziologie und Sozialpsychologie (Westdt. Verlag, Opladen), 143-168; and U. OEVERMANN and E. KONAU, 1980, Struktureigenschaften sozialisatorischer und therapeutischer Interaktion, manuscript (Universität Frankfurt a.M.).

[8] *Oedipal triad* refers to the multiply contradictory unit of the family interaction system consisting of father, mother and child. This system is structurally characterised by the paradox of exclusive demands which have to be shared continuously, i.e. through an unceasing motion of interactive in- and exclusion, and all of that on a basis of unconditional trust.

[9] The practice system of *Vipassana* (as it is being taught in the burmese-indian tradition of U BA KHIN and S.N. GOENKA and to the extent it was discussed in the case study) encom-

passes (1) a system of rules outlining ethical behaviour (*sila*), (2) the training of attentiveness and concentration by way of observing the natural breath (*anapana-sati*), (3) the actual technique of *vipassana*-meditation, which works with physical sensations and serves to develop experiential, penetrating wisdom (*panna*) resulting in liberation from general suffering.

[10] See for example: T.E. ROBINSON and K.C. BERRIDGE, 1993, The neural basis of drug craving: an incentive-sensitization theory of addiction, *Brain Res. Rev.* **18**, 247-291; G. DI CHIARA, 1995b, Psychobiology of the role of dopamine in drug-abuse and addiction, *Neurosci. Res. Commun.* **17**, 133-143; J. MIRENOWICZ and W. SCHULTZ, 1996, Preferential activation of midbrain dopamine neurons by appetitive rather than aversive stimuli, *Nature* **379**, 449-451; and A.R. DAMASIO, H. DAMASIO and Y. CHRISTEN (Hrsg.), 1996, *Neurobiology of Decision-Making* (Springer, Berlin/Heidelberg).

[11] From the collection of the short *Suttas* of the *Tipitaka*: *Anguttara Nikaya, Dasaka Nipita*, Book IV, p. 107, Pali Text Society (London).

[12] In free translation after S.N. GOENKA (given in 10-day *Vipassana*-meditation courses) from the conditional nexus (*paticcasamuppada*): *Majjhima Nikaya 38: Maha-tanhasankhaya Sutta*, Pali Text Society (London).

[13] See for example: A.R. DAMASIO, 1994, Decartes' Error. Emotion, Reason, and the Human Brain (Putnam's Sons, New York).

[14] See for example: R. WELTER-ENDERLIN and B. HILdenbrand, 1996, *Systemische Therapie als Begegnung* (Klett-Cotta, Stuttgart) and U. OEVERMANN, 1996, Theoretische Skizze einer revidierten Theorie professionalisierten Handelns, in: A. COMBE and W. HELSPER (eds.), 1996, *Pädagogische Professionalität: Untersuchungen zum Typus pädagogischen Handelns* (Suhrkamp, Frankfurt a.M.).

[15] Given the sample sizes in the case study of *START AGAIN* (i.e. N's typically between 15 and 50), the term $(m \pm \sigma)\%$ for the chance of success or the risk of a serious relapse of a particular sub-clientele means that the chance/risk lies in the interval between $(m - \sigma)\%$ and $(m + \sigma)\%$ with a certainty (or posterior probability) of at least 67%, or that the chance/risk lies in the larger interval between $(m - 2\sigma)\%$ and $(m + 2\sigma)\%$ with a certainty (or posterior probability) of at least 95%. See the respective literature in note 4.