

# **Issues and Difficulties in Researching the Impact of a Holistic Approach to the Management of Addiction**

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# 1. Introduction

The researchers are currently engaged in developing a research programme exploring a biopsychosocispiritual model of addiction management developed at Thamkrabok Monastery Thailand (the Thamkrabok programme). We have completed preliminary research (Phase 1 or ‘the pilot study’) which is described below, together with our proposals for a more in depth study.

## 1.1 The Aim of the study

To explore and achieve a better understanding of a biopsychosocispiritual approach to the management of addiction and relapse prevention

## 1.2 The Research Objectives of the study

- To further explore the effectiveness of the current Thamkrabok programme
- To clarify ways of measuring the different elements that make up the Thamkrabok programme
- To compare and contrast the 12 step approach to addiction with the Thamkrabok programme
- To map and monitor the progress of patients' physical, mental and emotional recovery throughout the Thamkrabok programme and at the end of the program and up to 12 months' follow-up

## 1.3 Context

England & Scotland have significantly high rates of drug misuse and drug related co-morbidity (particularly anxiety and depression) compared to similar developed economies (DOH 2007; Reuter and Stevens 2007). Within current medical orthodoxy treatment remains substantially concentrated within a biochemical response model to a range of health related issues (Helman 2006) and this is particularly evident within the field of addiction management (CFSJ 2010).

Methadone is used extensively within the UK to treat heroin addiction with claimed levels of relative success (Schilling et al 2006; George 2010). Mean international completion rates for opiate detoxification treatments are placed at about 73% (inpatient) and 45% (outpatient) Gowing Ali and White (2000). Within the UK (England and Wales) for those addicts engaged with treatment services the rates of effective drug free treatments remain low with an estimated range from 12% (NTA 2010) to 4% (CFSJ). By way of some contrast anecdotal figures from the Thamkrabok programme managed by East-West Detox (E W Detox) suggest a > 95% completion rate with effective drug free treatments placed at 60%. Hayes and Leighton (2008) debate the effectiveness of methadone treatments and explore a range of other treatment options. There is some evidence of need to develop more generally a non-substitute, more flexible and more holistic response to addiction management (Webster et al 2009; McIntosh and Saville 2006).

We suggest that addiction and the suffering attached to it could be seen as a general imbalance or dysfunction, a loss of homeostasis, affecting the whole system (DOH 2007; Hayes and Leighton 2008). A significant element of the holistic model of health for some researchers is the spiritual domain. Freshwater (2002) and Helman (2006) believe that any effective treatment for significant health issues, must address the four quadrants of physiological, psychological, social and spiritual needs of the patient or client. The clear links between addiction, anxiety, depression and limited motivation now are acknowledged by the Health Service together with the importance of psychosocial interventions in effective addiction therapy (DOH Report 2007; NICE Guidelines 2007).

Research on addiction management has explored the use of meditation, mindfulness and visualisation as a potential contribution to healing, with possibly some evidence of sustained relapse prevention (Witkiewitz et al 2005; Bowen et al 2006). Witkiewitz et al (2005) suggests that mindfulness meditation may help to enhance existing Cognitive Behavioural Therapy (CBT) approaches to the management of addiction.

The biological, psychological, social and spiritual dimensions of addiction are all parts of the treatment programme at Thamkrabok.

## **1.4 Location and Participants to the study**

Part of the research will be undertaken at Thamkrabok monastery Thailand (TKB) and interviews will be undertaken both at TKB and within the United Kingdom (UK).

## **2. Methodology**

A mixed methodology employing both quantitative and qualitative methods will be used.

- Phase I of the study will involve a pilot study and field work trials.
- Phase II of the study will use substantially quantitative research and
- Phase III of the study will explore the qualitative elements.

This combined process is known as crystallisation (Ellingson 2009) and is more reflective of multidimensionality and complexity of issues such as addiction.

The questionnaire/monitoring form (monitoring form) we are currently trialling and would propose to use for phase II of the study has been developed from the evidence-based literature and from a review of instruments designed to measure addictions recovery (Ralph et al 1999; Ralph 2000). We are inviting a critique of the questionnaire and suggested amendments to help ensure both its content validity and face validity (Appendix A).

As far as practicable the research will involve participatory methods of research design, data collection and dissemination of results. This will involve subjects as co-researchers. This is intended to reflect a model of participatory action research and to involve co-researchers in a process designed to effect social change (Speziale and Carpenter 2007).

### **2.1 Monitoring Forms**

The study will use a monitoring form (Appendix A). These forms are designed to capture information regarding any adverse mental or physical symptoms the subject is suffering from, any treatments they have been taking and the quality of their sleep, food and fluid intake. A mixture of open questions and Likert (Likert1932 in Politt and Beck 2006) style questions are used. Data analysis will consist of time series analysis (Chatfield2003) and trend analysis along with testing the answers for randomness using standard survey modelling methods. We will also look to see if there is a difference in responses from different sub-groups of substance abusers, e.g. do heroin and alcohol abusers respond to the recovery programme in a different way. Care will be taken to monitor the statistical significance of any results based on the sample size of any sub-group created, e.g. we would not be able to draw any conclusions regarding tranquilizer abuses due to the low number of subjects abusing the substance. We will also look into whether there are any statistically significant differences between initial starting severities of withdrawal.

## 2.2 Phase III Methodology

For phase III of the study it is proposed that this research will use narrative analysis (Bruner 1991; Redwood 1999) and Case Study analysis helping to place treatment and individual experience within context.

## 2.3 Sampling

It is proposed that this study will use non-probability convenience sampling (LoBiondo-Wood & Haber 2006) using Network and Opportunistic sampling.

## 2.4 Pilot Study (Phase I)

The researchers have commenced a pilot study to develop both fieldwork techniques, to develop and refine the questionnaire and to develop the approach to interviewing with sensitive subjects.

## 2.5 Data Analysis Phase II (Pilot Study)

### 2.5.1 Subject Demographics

Currently we have monitoring forms for 49 subjects; each subject was followed up during their treatment for a number of days, the distribution of which can be found in Table 1. In 30 cases (61%) there is evidence of heroin and/ or methadone use. Each form per subject represents a different day, with some days being omitted. For example, if a subject has filled in 16 forms, this might span a three week period.

Minimum	Maximum	Mean	Standard Deviation	Total
1	29	12.163	7.278	596

Table 1: Distribution of Monitoring Forms

Each subject was asked about their substance addiction. Many indicated that they were addicted to more than one substance (Table 2 and 3). From Table 2 it can be seen that approximately two thirds specified that they were addicted to one or two substances, whilst the remaining third specified three or more. From Table 3 it can be seen that heroin, cocaine and cannabis are by far the most common substances of addiction. The data suggests a non-relapse rate of 58% across an average period of 9 out of 12 months. This figure is comparable with data held by EW Detox.

Number of Subjects	Number of Substances
14	1
18	2
9	3
6	4
2	5

Table 2: Number of Substances per Subject

<b>Substance</b>	<b>Frequency</b>
HEROIN	29
CANNABIS	25
COCAINE	14
ALCOHOL	12
METHADONE	10
AMPHETAMINES	6
ECSTASY	4
VALIUM	3
YABA	2
CRACK COCAINE	2
TRANQUILISERS	1
SUBOXONE	1
MORPHINE	1
ANTI DEPRESSANTS	1
Table 3: Substances Addiction for Subjects	

As far as practicable the research will involve participatory methods of research design, data collection and dissemination of results. This will engage some of the subjects as co-researchers; intended to reflect a model of participatory action research and to involve co-researchers in a process designed to effect social change (Speziale and Carpenter 2007).

### **2.5.2 Ethical Issues**

Ethical approval has been obtained for this work. The exploration of addiction therapy is considered to be a sensitive subject and the researchers would propose to adopt a ‘vulnerability strategy’ in approaching a potentially ‘hard to reach’ group (Mikhailovich and Morrison 2009). The study will ensure as practicable and possible the protection of the respondent’s anonymity at all times in accordance with good research practice (Polit and Beck 2006).

### **2.5.3 Potential Strengths**

Potential strengths of the study might include the opportunity to explore the lived experiences of the subjects; the generation of theory with a view to informing and effecting social change (Speziale and Carpenter 2007). Finally an effectively completed study might help to inform the practical development of addiction therapy.

### **2.5.4 Funding**

This research is not supported by any funding grants and is managed by the staff and volunteer research team at East-West Detox.

### **3. Key Issues for Critical Discussion**

1. Are current treatment programmes often limited to dealing with symptoms?
2. Is there evident need for paradigm development within addictions research?
3. Is a genuinely more holistic model of addiction causation and treatment called for and what form of challenge would this pose to a well-established model of treatment?
4. Are there concerns about the limited service choices available with current treatment interventions and the relative lack of research outside the medical model?
5. Are there concerns about the lack of funding available for both research and treatment outside the medical model and substitute medication?
6. To what extent do these issues compound the difficulties faced in exploring a biopsychosociospiritual model of addiction management and therapy?
7. The maintaining of effective contact with subjects ( longitudinally) many of whom represent a vulnerable, socially fragile and ‘nomadic’ population
8. A critical appraisal of the current research proposal methodology and proposed methods

### **4. Conclusion**

Current treatments options are limited and substantially rest within a symptom management model. The human being comprises the physical, psychological, social and spiritual. Addiction like any other disability rest within those domains and effective treatment has to address all four quadrants. There is limited research addressing a four quadrant approach to addiction therapy, this perhaps partly reflects the still dominant medical model and the medical management of symptoms. The exploration of a biopsychosociospiritual approach to the understanding and more effective management of addiction is required .The lack of funding support disrupts and delays such extended and holistically directed research. It is hoped however that the current research project addressing the model of therapy at Thamkrabok Monastery, will help to better inform research and practice here within the UK and within this area of addiction therapy.

The discussion paper has been produced in order to open up the study to the audience of professionals and policy makers for comment on the methodology and to explore and develop a research tool to measure an alternative holistic approach to addiction, before the larger main study is completed.

We plan to proceed with a larger main study following feedback from the discussion paper and are exploring possible sources of funding.

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## Appendix A – Monitoring Form



### East-West Detox

#### Post 5 Day Detoxification Monitoring

Client:

Detox from [substances]:

Day \_\_\_\_\_ of detox Date (DD/MM/YYYY):

1. Physical symptoms [e.g.: 1 = very tired, 5 = energetic]

- |                           |   |
|---------------------------|---|
| a) tiredness              | 1 |
| b) nausea                 | 1 |
| c) stomach cramps         | 1 |
| d) breathing difficulties | 1 |
| e) chest pain             | 1 |
| f) joint/bone pain        | 1 |
| g) muscle pain            | 1 |
| h) numbness               | 1 |
| i) tremors/shaking        | 1 |

Have you had any form of treatments since last interview?

How would you describe your sleep pattern?

Quality:

Quantity:

Nutrition

How would you describe your daily food intake?

Daily fluid intake

How much water/juice did you drink in the last 24hours?

2. Mental/emotional symptoms [e.g.: 1 = very depressed, 5 = very happy]

- a) depression/happiness 1
- b) anxiety/calmness 1
- c) fear/confidence 1
- d) anger/equanimity 1
- e) pessimism/optimism 1
- f) ability to enjoy experience 1
- g) ability to interact socially 1

Can you be specific about any particular fears or anxieties?

Are you experiencing any cravings? If so what for?

3. How do you rate the importance of each element of the programme.

[e.g.: 1 = not important, 5 = very important]

- o) Journey 1
- p) Vow 1
- q) Herbal Medicine 1
- r) Meditation/Mindfulness 1
- s) Environment 1
- t) Culture change 1
- u) chanting 1

How are you now managing your time?

Have you contacted or do you plan to contact anyone at home?

If so, what emotions does that stir for you?

What creative activities are you engaged in, or would like to be engaged in?

Are you having any dreams and if so are you remembering them?

Can you describe them?

Have you participated in any of the spiritual practices here?

Have you had any spiritual experiences or insights?

What emotions are being stirred in you?

Please describe any other thoughts or feelings you are experiencing.

**Once it is deemed appropriate, the following questions, relating to going home, may be asked. Do not ask these too soon after completion of the 5 day detoxification as the promise is to stay there for 28 days. It is suggested that these questions be asked around day 15, unless the patient is already talking about returning home.**

How do you feel about returning home?

Have you thought about what you want to do when you get home? If so what?

Have you any specific activities planned towards your recovery? If so what?

- Residential support
- Community support
- Returning home
- Training
- Coaching
- Work Experience
- Employment
- Extended stay at Thamkrabok
- Other:

What are your thoughts about getting involved with the East West Support Network?

Any other comments?