ADDICTION — STARTING TO STOP WITH A FIRST STEP

From prescription pill addict housewives to cocaine addict business executives, psychologists working in South Africa's little known addiction recovery outpatient centres are saving scores of highly successful and functional people from 'the edge'.

Dan Wolf, Sandton psychologist and co-founder of the First Step Drug and Alcohol Recovery Centre, an exclusively outpatient facility.

They do this silently and cost-effectively without compromising their clients' daily work and domestic routines — and believe they are seeing only the tip of the iceberg.

Several therapists working in these outpatient addiction clinics, which have 1 - 6-week waiting lists, believe GPs and psychiatrists are either unaware of their existence or simply use pills to try to 'cure' what often presents as depression.

'There seems to be this unspoken rule that the standard 3 - 4-week inpatient model is the way to go and that this is a one-size-fits all solution,' says Mark Emmerich, co-ordinator of the 'Start to Stop' outpatient unit at the Kenilworth Addiction Centre in Cape Town.

Addiction outpatient centres are a relatively new phenomenon in South Africa.

Emmerich defines an outpatient as someone who has 'got to that stage in their drugging or drinking careers where they may realise they have a problem, haven't yet lost their job or their car, want to continue working and have a strong social support network'.

He says clients need to be fairly stable and have 'no major disorders', and not require detoxification.

Dan Wolf, co-founder of the First Step Drug and Alcohol Recovery Centre in Sandton, Johannesburg adds these criteria: 'They can fundamentally assume responsibility and perform and meet the minimum requirements of society, which may not necessarily be all that high — but they're certainly not actualising their potential.'

Wolf began his clinic as a response to 'the frustration of playing policeman' to clients in an inpatient environment.

'I was dealing with people who didn't really want to be there and didn't want to take responsibility for their recovery,' he adds.

Simultaneously he became aware of 'what a huge population needs treatment in a less restrictive environment'.

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'One guy comes to mind. He was in a small furniture business, down but not out.

He was adamant that he needed to keep the business ship afloat. He'd put about R3 million in cocaine up his nose, losing nearly everything, including his septum.

After 2 years of outpatient treatment, fellowship and aftercare, the man had reclaimed his life and saved his business.

When Wolf began 4 years ago, he says there was 'no-one doing anything like us'.

His first patients would traditionally have been encouraged to book into an inpatient centre and Wolf ran headlong into opposition from inpatient adherents and managers.

'It's very clear that inpatient treatment is sometimes necessary and I do refer – I won't admit someone into my programme without a good chance of success, firstly because of my integrity and secondly because it would be bad for them and bad for me.'

Emmerich says clients feel overwhelming relief at discovering people of similar backgrounds and experience in the same boat and that his clinic provides a caring, non-judgemental environment for them to confront their addictions.

Says Wolf, 'they anticipate getting judged and rejected but instead they get respect and empathy'.

Both men, themselves recovering alcoholics, are determined to reach medical professionals so that they can help patients deal with the primary illness of addiction.

'In September 1994, I convinced my GP that I was clinically depressed and I got what I wanted, antidepressants so I could continue drinking. It was only 18 months later that I came to terms with it being alcohol-induced depression,' said Emmerich.

Some psychiatrists are firm with their clients, telling them as early as the second consultation that they are unable to help them until they deal with their addiction.

Says Emmerich: 'There may well be a dual diagnosis such as an anxiety disorder or depression, but you can't treat this while they're drinking or drugging.'

His experience is that 'when you deal with the addiction, the majority of the patients' perceived problems disappear'.

The irony is that making a dual diagnosis requires that the addiction be treated first.

Most addiction outpatient facilities use the disease model and 12-step programme and require a daily 2½-hour client commitment for between 3 and 5 days a week for 6 weeks, plus abstinence.

Sessions run from 16h30 to 19h00, with the first hour consisting of lectures and information on addiction followed by 90 minutes of group therapy, considered to be the primary vehicle of recovery.

Defences are dismantled and clients 'own' their unmanageability, shame and guilt.

Says Wolf, 'It's amazing how perceptive they are – they're able to see right through one another's defences'.

The ultimate aim, once clients are 'engaged with recovery', is to reach self-acceptance.

The clients are also required to commit to at least one individual therapy session, plus two compulsory 12-step meetings a week (Alcoholics Anonymous, Narcotics Anonymous, Gamblers Anonymous or Overeaters Anonymous).

Most clinics conduct random urine testing and provide strong aftercare support with Kenilworth Clinic insisting its clients come in once a week for a minimum of three months.

Many outpatient clinics charge their clients on an income-based sliding scale and several of the more progressive medical aids provide reasonable cover.

The outpatient programme costs about R 5 500 (versus about R20 000 for an inpatient one).

'You don't have to be locked up to make a substantial commitment or change in your life – there are many people who can do it by putting the walls of the treatment centre in their head,' says Wolf.

Both men said addiction was a 'real phenomenon' among doctors and dentists, with alcohol and pethedine the drugs of choice, but said they only formed a small percentage of their outpatient groups.

'I think this is more a reflection of the small percentage of health care professionals in the population than anything else,' remarked Wolf.

Chris Bateman

The South African Medical Journal

100 years ago:

In reply to your request for some unscientific account of the medicine-men in the native territories and their methods, I venture to send you a short notice from my own observations, which is not intended to be a complete record of all native practitioners and their practices. A native woman was suffering from strumous inflammation of the glands of the neck. The witch-doctor diagnosed the necessity for killing a red ox, with an eye to the lion's share of a fat beast of that colour he had seen in the kraal. The ox having been killed, the head with the horns intact was placed inside the hut, which had been cleared of everything else and swept clean. The ox head was surrounded with green herbs and gourds, and the patient having been placed on the opposite side of the hut, was directed to look continuously at it. No satisfactory result taking place after some days of the treatment, due no doubt to the patient not carrying out the doctor's instructions, the friends accepted my suggestion, and the swelling was soon reduced with the aid of a pocket bistory.*

*Usually spelt 'bistoury' — a long, narrow surgical knife used for incising abscesses.

50 years ago: Pregnancy outside the membranes — grossesse extramembraneuse

Fig.1. Photograph showing the relation of the foetus to the ectopic sac as found at laparotomy.

In this condition the foetus develops outside the membranes and in the reported cases usually the pregnancy has been intra-uterine. Sometimes following rupture the membranes shrink and the foetus is left inside the uterus but outside the chorion. Grossesse extramembraneuse according to Munro Kerr usually manifests itself by a periodic bloody discharge, and has to be differentiated from hydrorrhoea gravidarum, in which the intermittent discharge is usually clear and yellowish, but only sometimes blood-stained... The child is generally born dead, but occasionally it is born alive, in which case it is feeble and poorly developed. Recently such a case was seen at King Edward VIII Hospital (Fig 1). At laparotomy, the foetus was found free in the peritoneal cavity.