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a case study report:

**HEROIN ADDICTION AND RECOVERY –**

**A SUCCESSFUL CASE STUDY IN CHRISTIAN THERAPY**

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PSYCHOLOGICAL PROBLEMS  
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**PREFACE**

The road to true recovery of substance dependency does not run through the secular world, but through that which is Divine. Only our Lord JESUS CHRIST can heal the heart, cleanse sin, grant salvation and restore a right relationship with GOD. This paper will consider just such a case.

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ABSTRACT

“Heroin addiction is, like all addictions, not simply an illness of the body and mind, but also an illness of the heart. Secular therapies for substance dependency often fail because they do not address the spiritual distress of the heart. A common Biblical model of addiction is that of idolatry, where the object of the addiction displaces GOD as the center of one’s life. Christian therapies offer the addict the opportunity to change the heart by treating addictions as sins of the heart that separate one from GOD. True repentance and confession of such sins before GOD and forgiveness of those sins in our Lord JESUS CHRIST is the basis for a Christian change of heart in the addict.”

DEDICATION

This paper is dedicated to GOD Almighty, who gives us the breath of life, His Holy Word and eternal salvation through our Lord JESUS CHRIST.

EPIGRAPH

PSALMS 119:105, “Thy Word is a lamp unto my feet, and a light unto my path.” [KJV]

EDITORIAL NOTE

All Scripture quoted is from The King James Version Bible.

## I. SUBJECT HISTORY

APPEARANCE - The subject is a 55 year old white male, well groomed and neatly attired. AFFECT - Mood is pleasant, interacts freely, makes direct eye contact, smiles often, polite and relaxed. COGNITION - Subject is lucid, thoughts well articulated, oriented to person, place and time, rational and consistent thought patterns. Denies any suicidal intentions or suicidal attempts at any time in his life.

BEHAVIOR - No apparent distress at present. Denies any psychiatric hospital admissions. Status post methadone programs 1 year each x 3. Status post 7 month detoxification and rehabilitation from substance abuse - heroin, alcohol and xanax - at a Christian recovery facility in 2001. Reports 100% abstinence since then from all substance abuse.

PHYSIOLOGICAL - No apparent distress at present. Walks with pronounced limp and cane. Non Insulin Dependant Diabetic; chronic bilateral hip pain; high blood pressure; status post heroin addiction, alcohol addiction, xanax addiction, cocaine abuse. Medications: glucovance, ziac, bisporal, viox.

SOCIAL HISTORY - Circa 1974 @ age 25 was homeless post discharge from US Army. 4 previous detoxification admissions over 10 years circa 1991 - 2001 for heroin, xanax and alcohol abuse without results. Declined all opportunities to enter rehabilitation. Subject reports he was "always functional from 1973 until the end" in 2001. In 2001 subject entered a short term hospital detoxification program x 1 week and then consented to enter a Christian rehabilitation residential program at a Christian facility x 7 months. Subject reports being abstinent from all substances since discharge circa 2001.

FAMILY HISTORY - Born 1949 in Philadelphia, PA. 2 brothers and 2 sisters - all Catholic Christians. 1<sup>st</sup> sister - living age 48, history snorting cocaine abuse. 2<sup>nd</sup> sister - living age 57, history anxiety, raped when younger. 1<sup>st</sup> brother - died at age 19 drug overdose of "downers." 2<sup>nd</sup> brother - died at age 44 heroin overdose. Mother died at age 55 from brain cancer, history alcoholism. Father living age 89, history of MI, no substance abuse. Parents divorced.

Patient has 2 sons now ages 32 and 29, born out of wedlock before subject married, no contact with children or mother of children x 20 years. Mother of subject's children has history of snorting cocaine abuse. Married circa 1984, divorced 1994 - stepchild age 2 to 12 during marriage. No contact with stepson or ex-wife since divorce. Reports divorced after arrested for armed robbery to obtain supplemental money for substance abuse; reports was very "wacked out" and verbally abusive, but denies any physical abuse. Now single

CAREER HISTORY - US Army @ age 17 - communications specialist, no combat, during Vietnam War era x 6 years. Spent several years in jail during same for heroin trafficking, released with undesirable discharge. Sales commercial hardware x 12 years and truck driver locally @ Philadelphia, PA x 4 years.

RELIGION HISTORY - Raised as Catholic Christian. Served as altar boy in Church choir as youth. Attended Church until about age 12 years. Attended occasional Christmas services with friends over the years. Reports no help for his substance abuse problems were ever offered to him by any Church, but admits he never sought out any such Church-based help. Converted to Protestant Christianity 2002, at which time patient received first communion and received first baptism.

Patient now attends an independent Evangelical Protestant Christian Church service Sunday mornings. Now attending a Christian recovery small group - "Celebrate Recovery" - at the same Church one evening per week. Now receiving pastoral counseling as needed from Minister at the same Church. Reports helps clean Church periodically. Reports co-runs a rehab group for addicts for Church members once per week.

EDUCATION HISTORY - High School GED completed 2003. No college.  
CRIMINAL HISTORY - Served 2 years in prison while in US Army as a young man for selling heroin, discharged with "undesirable discharge." Reports supplemented income by robbing people with a gun for money x 8, caught x 1 circa 1993 and went to jail. Reports arrested for illegal drug possession x 5

MEDICAL & SUBSTANCE ABUSE HISTORY - 1965 @ age 16 introduced to heroin IV by his brother. 1966 @ age 17 began intravenous heroin abuse x 35 years - est. average \$7 bags/daily, each bag \$10 before heroin abstinence beginning in 2001. Denies HIV/AIDS or hepatitis. In 1992 increased heroin to est. 10 bags/daily. 1992 first clear heroin overdose found by sister hallucinating & incontinent of urine and feces in his apartment, ambulance to hospital emergency room. History smoking crack x 1 year, abstinent crack since 2001.

Patient denies heart or lung disease. History alcohol abuse - 1/5 quart vodka each weekend and 1 - 2 8 oz beer daily during week at height prior to abstinence from alcohol in 2001. Denies liver disease. Xanax abuse bought illegally "on the street" - taking 4 mg orally daily x 3 years - abstinent xanax since 2001. Reports methadone programs 1 year duration x 4, resulted in 75% decrease in heroin usage.

full clinical death and required CPR resuscitation and 3 of which involved near clinical death. Denies being on ventilator or requiring defibrillation.

In 1994, a near clinical death involving an emergency room visit reversed easily with Narcan therapy. Subject reports he then returned to his car in the hospital parking lot and shot up with heroin, again was near clinical death and was returned to the emergency room by a friend for a repeat of same. In 1994 another near clinical death involved the subject having been involved in a car accident, had been driving after shooting up with intravenous heroin.

In 1995, subject recalls taking 1mg xanax tablets x 4 and shooting up 3 bags of heroin and then attempted to drive home. Apparently suffered another car accident and recalls waking up in hospital emergency room. Reports he had been clinically dead, again requiring CPR resuscitation and Narcan therapy.

In 1996 gangrene right leg & hip, requiring a right upper thigh muscle removal in surgery. (After peripheral veins used up by intravenous heroin, subject begin injecting heroin into his right hip.) In 1996 surgery for benign cancer of nose. In 2004 left hip replacement. Now ambulates with pronounced limp using cane.

## II. THE INTERVIEW

The following is the transcript of a one hour interview conducted with the subject, in which he shares on his substance dependency history and how his Christian faith lead to his full recovery from addiction:

*“Secular detox is a band aid on the problem; it heals at the moment, but doesn’t go to the deep problems. Christian recovery goes to the root of the problem. They want you to see why you did what you did. They hold out hope in GOD as a carrot on a stick. You must find faith inside yourself to believe. You must believe in something greater than yourself. Faith and hope inside of you is needed, because without GOD in our lives, we have no hope.*

*I had no personal relationship with JESUS before the Christian rehab. My only knowledge of GOD was from the “Ten Commandments” movie on TV. All my life I relied upon myself. I was a heroin addict for 35 years. My mother was a severe alcoholic who never gave me much love. My parents divorced when I was young. They gave me no love, no hugs, no kisses as a child.*

*I found fulfillment in alcohol, street drugs and xanax. At age 16, my brother introduced me to intravenous heroin. At age 17, while in the US Army, I started drinking. I ended up in military jail for 2 years for selling heroin. At age 25 after I left the Army, I was homeless. I lived in abandoned houses. I was eating out of dumpsters. I was sleeping under the subway. I started xanax abuse, which I bought on the street.*

*I never felt I needed psychiatric counseling. We all have idols in our lives; we still don’t trust JESUS to take them away. We don’t want to let it go. We must trust totally in JESUS. So therapy would be a false idol for me. I surrendered all idols to The LORD; I have received joy and peace beyond all understanding. I don’t need counseling now. I go to The LORD.*

*[Subject reports he co-runs Church recovery group for addicts that uses the Bible verse of II CORINTHIANS 5:17 for its motto. II CORINTHIANS 5:17: "Therefore if any man be in CHRIST, he is a new creature: old things are passed away; behold, all things are become new." ] Once you've accepted JESUS as Savior, the old is gone and the new is come in CHRIST. This keeps you going - knowing our sins are forgiven. Only JESUS can forgive. [The subject now attends a Christian recovery support group weekly at his Church which uses The Reverend Rick Warren's "Celebrate Recovery" addiction recovery program.]*

*Man wanted to condemn me, but JESUS stands there with open arms and says, "Come, I want to love you!" That's all I ever needed! GOD reached down His arms from Heaven and wrapped them around me and told me that He loves a sinner like me! What greater gift is there than that? The LORD loves you! I JOHN 4:4 says Greater is He who is in you than he who is in the world!*

*[The subject was asked why he ministers in his Church now by co-running a Christian recovery group for addicts.] Sharing my testimony reminds me of my past so that I may help others. In sharing the pain I went through, I relieve my own pain and the pain of others. [The subject recognized this as part of his recovery therapy.] But it's not me that does this. It's CHRIST that lives in me!"*

### III. MULTIAXIAL ASSESSMENT

The multiaxial system of diagnosing psychiatric clients are as follows: Axis I, Clinical Disorders, Other Conditions that May be a Focus of Clinical Attention; Axis II, Personality disorders, Mental Retardation; Axis III, General Medical Condition; Axis IV, Psychosocial and Environmental Problems; Axis V, Global Assessment of Functioning.<sup>1</sup>

AXIS I - This patient offers several major Axis I DMS-IV diagnoses, most of which may be classified generally under status/post Polysubstance Dependence (304.80) with sustained full remission. Of these, the primary is status post Opioid Dependence (304.00) with sustained full remission. Secondary are status post Alcohol Dependence (303.90) with sustained full remission, status post Anxiolytic Dependence (304.10) with sustained full remission and status post Cocaine Abuse (305.60) with sustained full remission.<sup>2</sup>

The current DSM-IV-TR of the American Psychiatric Association qualifies this patient for a diagnosis of status/post Opioid Dependence (304.00) with Sustained Full Remission.<sup>3</sup> The primary diagnosis of status post "Substance Dependence" on page 110 of the DSMIV-TR is defined as "a maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by 3 or more of the following, occurring at any time in the same 12 month period:"<sup>4</sup>

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<sup>1</sup> 1, "Understanding Abnormal Behavior - Sixth Edition," Sue et al, p 255-286.

<sup>2</sup> 2, "Desk Reference to the Diagnostic Criteria from DSM-IV-TR," American Psychiatric Association. p 110-113.

<sup>3</sup> 2, Ibid., p 110-113.

<sup>4</sup> 2, Ibid., p 110-113.



1. Tolerance, as defined by either of the following: A need for markedly increased amounts of the substance to achieve intoxication or desired effect; A markedly diminished effect with continued use of the same amount of the substance.
2. Withdrawal, as manifested by either of the following: The characteristic withdrawal syndrome for the substance; The same or closely related substance is taken to relieve or avoid withdrawal symptoms.
3. The substance is often taken in larger amounts or over a longer period than was intended.
4. There is a persistent desire or unsuccessful efforts to cut down or control substance use.
5. A great deal of time is spent in activities necessary to obtain the substance, use the substance or recover from its effects.
6. Important social, occupational or recreational activities are given up or reduced because of substance use.
7. The substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.<sup>5</sup>

“Sustained Full Remission” is applied to this case, as “none of the criteria for Dependence or Abuse have been met at any time during a period of 12 months or longer.”<sup>6</sup> The similar criteria are met for this client to receive additional DSM-IV diagnoses of dependence on alcohol and xanax. However, this client’s use of cocaine appears to be that of only Substance Abuse. Here the criteria differs as described on page 114 of the DMS-IV-TR as “A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one or more for the following, occurring within a 12 month period:”<sup>7</sup>

1. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home...
2. Recurrent substance use in situations in which it is physically hazardous...
3. Recurrent substance-related legal problems...
4. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance...
5. The symptoms have never met the criteria for Substance Dependence for this class of substance.<sup>8</sup>

AXIS II - This patient may well suffer from an Axis II personality disorder that has led to consistent life patterns of substance dependence and abuse over long periods of time. More assessment is needed to specify the exact nature of any personality disorder present. Thus, for the present, the Axis II DSM IV diagnosis of Personality Disorder Not Otherwise Specified (301.9). General DSM-IV-TR criteria listed on page

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<sup>5</sup> 2, “Desk Reference to the Diagnostic Criteria from DSM-IV-TR,” American Psychiatric Association, p 110.

<sup>6</sup> 2, Ibid., p 110-113.

<sup>7</sup> 2, Ibid, p 110-113.

<sup>8</sup> 2, Ibid., p 114.

287 include:<sup>9</sup>

1. An enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture, manifested in two or more of the following: 1) cognition (i.e., ways of perceiving and interpreting self, other people and events), 2) affectivity (i.e., the range, intensity, lability and appropriateness of emotional response), 3) interpersonal functioning, 4) impulse control.
2. The enduring pattern is inflexible and pervasive across a broad range of personal and social situations.
3. The enduring pattern leads to clinically significant distress or impairment in social, occupational or other important areas of functioning.
4. The pattern is stable and of long duration, and its onset can be traced back at least to adolescence or early adulthood.
5. The enduring pattern is not better accounted for as a manifestation or consequence of another mental disorder.
6. The enduring pattern is not due to the direct physiological effects of a substance (i.e., a drug of abuse, a medication) or a general medical condition (i.e., head trauma.)<sup>10</sup>

AXIS III - This patient's general medical conditions include: heroin addiction, alcohol addiction, xanax addiction and cocaine abuse; clinical death due to heroin overdose requiring CPR x 3; methadone therapy x 4; chronic ambulatory dysfunction related to hip joint problems; Non Insulin Dependant Diabetic; chronic bilateral hip pain. high blood pressure; gangrene right leg & right hip; surgical removal right upper thigh muscle; surgery for benign cancer of nose; left hip replacement surgery.

AXIS IV - Psychosocial and environmental problems include single marital status post divorce; social isolation (now improving); no contact with children or stepchildren; limited mobility; unable to drive at present; compromised ability to earn a living.

AXIS V - Global Assessment of Function is described in "Understanding Abnormal Behavior Sixth Edition" by Sue, Sue and Sue as a number obtained when "the clinician provides a rating of the psychological, social and occupational functioning of the person... The clinician uses a 100-point scale in which 1 indicates severe impairment in functioning... and 100 refers to superior functioning with no symptoms."<sup>11</sup> Certainly this client's psychosocial and social functioning since his discharge from Christian rehabilitation in 2001 presents in the high end of normal. The client's occupational functioning potential has certainly improved markedly in view of the substance abuse abstinence x 3 years, but remains compromised because of the client's chronic medical conditions.

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<sup>9</sup> 2, "Desk Reference to the Diagnostic Criteria from DSM-IV-TR," American Psychiatric Association, p 110-113.

<sup>10</sup> 2, Ibid., p 287.

<sup>11</sup> 1, "Understanding Abnormal Behavior - Sixth Edition," Sue et al, p 88.

#### IV. A GENERAL BACKGROUND ON HEROIN

Heroin is an organic - as opposed to synthetic - narcotic Central Nervous System depressant classified as an opiate, along with codeine, morphine, opium and methadone. Opiates act to reduce pain, sedate, relieve anxiety, alleviate tension and produce the addict's sought after effects of euphoria and well being. They are also directly involved in brain pathways involved in behavior reinforcement.<sup>12</sup>

Heroin is widely available in the United States and widely sought after for its euphorogenic effects. Potential for abuse is high, as narcotics are highly addictive, resulting in dependency. Tolerance builds rapidly, and withdrawal symptoms can be severe. Heroin is often administered by self injecting into one's veins, and is associated with high rates of diseases such as hepatitis and HIV/AIDS. Opiate abuse disorders typically begin in the late teens and early 20's. About 0.7% of the US population has suffered from opiate abuse or dependency and is four times more prevalent in men than in women. Once dependent, use typically continues over years with brief periods of abstinence.<sup>13</sup>

The human Central Nervous System produces natural narcotic substances that are released and bind to various opiate receptor sites in the brain that produce the known effects of these substances. Endogenous opiates - those narcotics produced by the body itself - are released during such events as stress, fight or flight and sexual activity. They serve to deaden the sensation of pain and remove behavioral inhibitions that would otherwise interfere with these activities. Exogenous opiates - those narcotics artificially introduced into the body - bind to the same sets of Central Nervous System receptor sites, thus stimulating the same effects. Heroin is one such exogenous opiate widely in use as an illegal street drug in the United States.<sup>14</sup>

Heroin, not being regulated for standards of purity and dose, can lead to poisonings from other substances and impurities mixed with the drug. Heroin readily binds with brain centers that regulate vital functions, such as breathing, heart rate and blood pressure. Over-stimulation of these vital Central Nervous System centers can lead to life threatening suppression of vital signs and clinical death from respiratory arrest, cardiac arrest and blood pressure collapse. Therapy to reverse clinically life threatening effects of a heroin overdose is achieved with Narcan [naloxone], which displaces the heroin from the opiate receptor sites in the brain, thus reversing the depression of vital functions. Methadone therapy to prevent the sought after effects of heroin in the addict works in the same way in that it binds with brain opiate receptor sites and thus prevents any heroin introduced into the body from exerting its effects at the same opiate receptors.<sup>15</sup>

Because dependency associated with tolerance is usually quickly developed in ongoing opiate abuse, all normal social functioning of the client become compromised. Obtaining the opiate via any means possible and necessary becomes the focus of and reason for daily living. The escalating costs of increasing opiate addictions leads many clients to criminal activity to obtain increasing money for their habit. Since non-medical

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<sup>12</sup> 3, "Physiology of Behavior, Eighth Edition," Carlson, p 573-600.

<sup>13</sup> 1, "Understanding Abnormal Behavior - Sixth Edition," Sue et al, p 255-286.

<sup>14</sup> 3, "Physiology of Behavior, Eighth Edition," Carlson, p 573-600.

<sup>15</sup> 3, Ibid., p 573-600.

use of opiates is illegal, most narcotic addicts must do business with the criminal class to obtain their opiates. This is particularly the case for heroin.<sup>16</sup>

Sullum in “The Surprising Truth About Heroin and Addiction” however questions the more traditional definitions of heroin addiction. Sullum agrees that tolerance and withdrawal are common hallmarks of heroin addiction. However, he notes that withdrawal symptoms for a great many heroin addicts are minimal and akin to flu-like symptoms. He notes that many heroin addicts are able to voluntarily stop and start drug use according to their wishes without difficulties. He notes a greatly under-reported size of heroin users who use the drug casually for recreational purposes and in a controlled way in ongoing habits while remaining completely functional in society. He observes that dependent heroin use is not simply an addiction, but also a behavior.<sup>17</sup>

There are various theories on the causes of and risk factors associated with substance abuse disorders, including explanations based on biological, psychodynamic, personality characteristics, socio-cultural and behavioral models.<sup>18</sup> Indeed, the list of causes offered from secular sources seems endless.

Consequently, there are various treatment models, including biological therapies such as detoxification and drug therapies such as methadone maintenance; behavioral therapies such as self help groups, aversion therapy, skills training, supervised residential and community living; cognitive-behavioral therapies such as psychotherapy, relaxation, desensitization, group therapy, abstinence support programs and prevention programs. Treatment plans must be tailored to each individual client and his background. Treatment plans involving two or more therapy modalities are more successful than one therapy modality alone.<sup>19</sup>

## V. ON THE DESTRUCTIVE PSYCHOSOCIAL EFFECTS OF HEROIN

Sullum, in “The Surprising Truth About Heroin and Addiction” further points out that many of the devastatingly negative effects of heroin addiction upon the user and society around him may be in large part artificially created or at least magnified by the criminalization of the drug. As a result, heroin users face arrest and prison, a criminal record and the violence associated with the illicit drug trade itself. Sullum estimates that criminalization of heroin has elevated its cost in our society by up to 5000%.<sup>20</sup>

Sullum offers that such artificially elevated costs for heroin lead chronic users to criminal violence and siphons off money for routine life needs, resulting in debts, housing problems, poor nutrition and theft. High cost encourages heroin users to self administer by intravenous injection, which is the most cost effective route for maximum effect of minimal amounts. The legal restrictions on injection supplies leads to a sharing of needles, etc among heroin users. These effects serve to increase the spread of blood borne diseases among users such as HIV/AIDS and hepatitis. Added medical costs are

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<sup>16</sup> 1, “Understanding Abnormal Behavior - Sixth Edition, ” Sue et al, p 255-286.

<sup>17</sup> 4, “The Surprising Truth About Heroin and Addiction,” Sullum. Reason 35 Number 2, p 32-40. 2003.

<sup>18</sup> 1, “Understanding Abnormal Behavior - Sixth Edition,” Sue et al, p 255-286.

<sup>19</sup> 1, Ibid., p 255-286.

<sup>20</sup> 4, “The Surprising Truth About Heroin and Addiction,” Sullum, Reason 35 Number 2, p 32-40.

seen by society because of the unregulated nature of the illicit heroin industry's products containing impurities and poisons, thus leading to overdosing and related problems.<sup>21</sup>

## VI. ON THE CHARACTER TRAITS OF HEROIN ADDICTS

Westenberg et al, in "The Treatment of Substance Addicts: A Judgment Analysis of Therapists' Matching Strategies," conducted a study among therapists to analyze the judgment of professional staff in matching treatment models with character traits of heroin abusers. The spectrum for designing therapy programs for clients ranges from a need of total control and structure with motivation being primarily external to that of a need for insight and introspection being primarily internal. Although there was widespread agreement among therapists in this study as to the top client characteristics that are vital in predicting a positive outcome to treatment, the study not surprisingly noted there was widespread disagreement as to what types of therapy models are best suited for what character traits in clients.<sup>22</sup>

What is of interest in this study are the top personality traits themselves identified as most common in heroin addicts by the therapists. This data gives recognition to the already mentioned concept that the chronic heroin habit is not merely an addiction, but also set of behaviors. Addressing these behaviors characteristics in drug rehabilitation for heroin addicts should no doubt be central to the plan of care. The study identified these in its Table 1 from roughly highest to lowest order below as follows.<sup>23</sup>

1. Insight (The extent to which the client is capable of recognizing his or her own problem.)
2. Frustration tolerance (The client's fortitude to cope with frustration.)
3. Cognitive condition (Condition of client's reasoning power and memory.)
4. Intelligence (Client's intelligence level.)
5. Confrontation strength (The client's capability to experience his or her own problem.)
5. Traumatic past (The extent to which client was traumatized by experiences in the past.)
6. Psychiatric disorders (The severity of psychiatric disorders the client suffers or suffered.)
7. Social functioning (The extent to which client can cope with the addiction problem in daily life.)
8. Client goal (The treatment target of the client.)
9. Bonding (The extent to which client is capable of entering into constructive bonds.)
10. Duration of addiction (Number of years of addiction.)<sup>24</sup>

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<sup>21</sup> 4, "The Surprising Truth About Heroin and Addiction," Sullum, Reason 35 Number 2, p 32-40.

<sup>22</sup> 5, "The Treatment of Substance Addicts: A Judgment Analysis of Therapists' Matching Strategies," Westenberg et al, Clinical Psychology and Psychotherapy 5, p 39-46, 1998

<sup>23</sup> 5, Ibid., p 39-46.

<sup>24</sup> 5, Ibid., from "Table 1. Client characteristics and percentage of therapists selecting them," p 42.

## VII. THE BRICKMAN MODEL OF CLIENT RESPONSIBILITY

Brickman et al in “Models of Helping and Coping” propose a model for balancing client responsibility for creating problems versus solving those problems. Four models are proposed. The a) moral model recognizes a client has high responsibility for causing his problems and high responsibility for solving his problems. Such clients are in need of motivation. The b) compensatory model recognizes a client has low responsibility for causing his problems and has high responsibility for solving his problems. Such clients need empowerment.<sup>25</sup>

Further, c) medical model recognizes a client has low responsibility for causing his problems and low responsibility for solving his problems. Such clients need structured treatment. The d) enlightenment model recognizes the client has high responsibility for causing his problems and low responsibility for solving his problems. Such clients need discipline.<sup>26</sup>

Brickman et al observe that a wrong choice of therapy helping models that do not take into account a client’s characteristics and circumstances is more likely to undermine the effectiveness of helping and coping.<sup>27</sup> As to which therapy model or models may work best for what type of clients under what circumstances is something that needs to be assessed for each condition being treated in each case individually.

## VIII. THE EFFECTS OF LONGER TREATMENT TIMES

Simpson, Joe and Brown in “Treatment Retention and Follow-Up Outcomes in the Drug Abuse Treatment Outcome Study (DATOS)” attempted to identify factors associated with positive long term recovery in heroin-cocaine dual addicted addicts enrolled in various programs, including long term Residential (LTR), long term Outpatient Methadone Treatment (OMT) and long term Outpatient drug Free (ODF) programs.<sup>28</sup>

They measured a number of predictors of compliance and abstinence post therapy for patients in such programs for drug abuse, including ongoing mental health care, medical treatment, satisfaction with therapy, attendance of community support groups, help from social services entities, vocational training and school attendance. Increased compliance and abstinence was measured by looking at such variables as amount and frequency of substance abuse, number of times arrested, legal status and work status.<sup>29</sup>

At 3 and 12 month follow up of these clients in the above various drug abuse recovery programs, they found that a higher length of enrollment in such programs was directly related to a higher rate of positive outcomes in this sample of drug addicts. This study also looked at the same data for heroin-cocaine addicted clients enrolled in short term treatment of 28 days or less. It was found that full compliance with such

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<sup>25</sup> 6, “Models of Helping and Coping,” Brickman et al, American Psychologist, Volume 37, Number 4, p 368-384. April, 1982.

<sup>26</sup> 6, Ibid., p 368-384.

<sup>27</sup> 6, Ibid., p 368-384.

<sup>28</sup> 7, “Treatment Retention and Follow-Up Outcomes in the Drug Abuse Treatment Outcome Study (DATOS),” Simpson et al, Psychology of Addictive Behaviors, Volume 44:4, p 294-307. December 1997.

<sup>29</sup> 7, Ibid., p 294-307.

short term programs was not a predictor of lasting long term abstinence. What is not addressed are the inner psychological workings of the troubled heart that turns to chronic substance abuse.<sup>30</sup>

#### IX. ON THE PROBLEMS WITH METHADONE PROGRAMS

Woody, McLellan and Obrien in “Psychotherapy in Community Methadone Programs: A Validation Study” studied heroin addicts enrolled in urban community outpatient methadone maintenance programs in three US cities. They determined that clients scoring high on the “Addiction Severity Index” and related drug abuse intensity evaluation scales showed better outcomes after six months of treatment consisting of psychotherapy, drug counseling and methadone maintenance as compared with similar cases receiving only drug counseling and methadone maintenance. They concluded in part that a high percentage of illicit drug addicts also have major psychiatric problems that call for psychotherapy.<sup>31</sup>

The same group had previously conducted a similar study of heroin addicts receiving treatment through a Veterans Affairs program via a university research hospital. In that study, it was possible to adjust methadone dosing based primarily on urine test results on a regular basis. However, in the community methadone programs, dosing was adjusted based primarily on clients’ subjective complaints. It was noted that the methadone dosing at the community programs were significantly less than those typically given at the Veterans Affairs affiliated research hospital program and probably inadequate. The authors state of the typical dosing at the community clinics at which is inadequate dosing is too low to produce full narcotic receptor blockage in the brain, it is enough to suppress withdrawal symptoms for up to 24 hours.<sup>32</sup>

This study reveals the many problems with long term community methadone maintenance programs for heroin addiction: “two of the clinics had staff turnover exceeding 100% during the course of the study, and the clinical director of one program changed more than three times... there is a clear need for more informed methadone dose adjustment, more urine testing, more clinically relevant regulatory control, stability of staff, improvement in physical facilities, availability of medical and other services, training of counselors, and general enhancement and stabilization of program funding.”<sup>33</sup>

#### X. SECULAR PSYCHOLOGY ON SPIRITUAL DISTRESS

A revealing secular psychology study that looks into client responsibility for one’s problems versus responsibility for one’s solutions based on the Brickman models [medical, enlightened, compensatory, moral] (6) looks at underlying internal versus external diagnosed etiologies for certain disorders. Worthington and Atkinson in “Counselor’s responsibility and Etiology Attributions, Theoretical Orientations, and

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<sup>30</sup> 7, “Treatment Retention and Follow-Up Outcomes in the Drug Abuse Treatment Outcome Study (DATOS),” Simpson et al, *Psychology of Addictive Behaviors*, Volume 44:4, p 294-307. December 1997.

<sup>31</sup> 8, “Psychotherapy in Community Methadone Programs: A Validation Study,” Woody et al, *American Journal of Psychiatry*, Volume 152 Number 9. September 1995.

<sup>32</sup> 8, *Ibid.*, p 6.

<sup>33</sup> 8, *Ibid.*, p 6.

counseling Strategies” recruited a sampling of college psychologists whom they provided with 2 case studies - one a client with an adjustment disorder and the other client with an identity disorder. The psychologists were asked to design a psychotherapy plan for each case study and identify the apparent underlying causes of each case. The researchers then identified the Brickman models of therapy used and discussed them at length.<sup>34</sup>

What is relevant here is not the study’s stated purpose, but rather the number of sources of both internal and external psychological stressors that modern psychology acknowledges. These authors identify items such as specific life traumas; unresolved negative feelings; lack of self-understanding; stress; irrational thinking; maladaptive learning. Indeed, caring for these and a variety of similar stressors is central to the healing process dealt with in Christianity.

Avants et al, in “Spiritual Beliefs, World Assumptions, and HIV Risk Behavior Among Heroin and Cocaine Users,” conducted an interesting secular psychology study to determine if increased levels of religiosity and faith had any effect on decreasing heroine and cocaine use and HIV avoidance risk behaviors among urban heroin-cocaine dual addicted clients enrolled in long term methadone maintenance programs. Although not stand alone predictors, they found that such clients with higher levels of religious and spiritual convictions enrolled in long term methadone maintenance care showed lower degrees of lapsing back into heroin-cocaine use and higher rates of HIV risk avoidance behaviors.<sup>35</sup>

What is of interest in this study is not simply the quite reasonably expected findings, but the methods by which secular psychology uses to evaluate a client’s religious/spiritual state. In doing so, once again we see secular psychology acknowledging that the human condition is more than simply body and mind and that holistic care needs to at least recognize the triune body-mind-soul nature of man.

For example, to assess the strength of religious faith of individual clients, this study used the “Santa Clara Strength of Religious Faith Questionnaire” (SCSORF). The SCSORF scale addresses ten areas, which the client grades on a subjective scale of 1 to 4, where 1 = strongly disagree, 2 = disagree, 3 = agree, 4 = strongly agree.<sup>36</sup> The criteria the client is asked to grade include the following statements:

1. My religious faith is extremely important to me.
2. I pray daily.
3. I look to my faith as a source of inspiration.
4. I look to my faith as providing meaning and purpose in my life.
5. I consider myself active in my faith or Church.
6. My faith is an important part of who I am as a person.

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<sup>34</sup> 9, “Counselor’s responsibility and Etiology Attributions, Theoretical Orientations, and Counseling Strategies,” Worthington and Atkinson, *Journal of Counseling Psychology*, Volume 40:3, p 295 -302. July, 1993.

<sup>35</sup> 10, “Spiritual Beliefs, World Assumptions, and HIV Risk Behavior Among Heroin and Cocaine Users,” Avants et al, *Psychology of Addictive Behaviors*, 0893 -164X, Volume 17, Issue 2. 6/01/2003.

<sup>36</sup> 10, *Ibid*.



7. My relationship with God is extremely important to me.
8. I enjoy being around others who share my faith.
9. I look to my faith as a source of comfort.
10. My faith impacts many of my decisions.<sup>37</sup>

This study found that higher SCSRFQ scores were indeed associated with increased sense of religious/spirituality, increased self-esteem, increase belief that God will help with problems and decreased interpersonal sensitivity. These findings are hardly surprising to orthodox Christians, as these are but a few results of a committed relationship with GOD through the Savior JESUS CHRIST.

Further, it is also of interest that this same secular psychology study employs another similar assessment tool for use in predicting a positive relationship between the client's inner belief system and the success potential for drug addiction recovery. For example, this study also employs the "World Assumption Scale," which is "a 32 item instrument that assesses one's basic assumptions about the world." Eight categories are scored by the client from "1 = strongly disagree" to "6 = strongly agree." The scores are then combined into three groupings: Benevolence of the World; Meaningfulness of the World; Worthiness of the Self - each of which receive a score.<sup>38</sup> The categories are as follows:

1. benevolence of people ("People are basically kind and helpful.")
2. benevolence of the world ("Good things that happen in this world far outnumber the bad.")
3. justice in the world ("Generally, people deserve what they get in this world.")
4. controllability of the world ("People's misfortunes result from mistakes they have made.")
5. randomness of the world ("The course of our lives are largely determined by chance.")
6. feelings of self worth ("I am very satisfied with the kind of person I am.")
7. feelings of self controllability ("I take the actions necessary to protect myself against misfortune.")
8. luck ("I am basically a lucky person.")<sup>39</sup>

The point of interest here is that once again secular psychology recognizes that spiritual needs play a vital role in the course and outcome of recovery therapy for substance addiction clients.

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<sup>37</sup> 10, "Spiritual Beliefs, World Assumptions, and HIV Risk Behavior Among Heroin and Cocaine Users," Avants et al, Psychology of Addictive Behaviors, 0893 -164X, Volume 17, Issue 2. 6/01/2003. From "Table 1 Strength of Spiritual/Religious Faith," p 3.

<sup>38</sup> 10, Ibid., p 3.

<sup>39</sup> 10, Ibid., p 3.

## XI. ON THE ARBITRARY NATURE OF THE DSM-IV SYSTEM

John Babler, in “A Biblical Critique of the DSM-IV” questions the scientific validity of the American Psychiatric Association’s DSM-IV system. The DSM system labels people showing clusters of specific behavior problems with medical sounding mental health diagnoses for the purposes of classification, treatment and insurance billing. The person so labeled takes on the identity of this psychiatric label, stressing his or her behavior as a disease process over which he has no control. Thus, the need for confessing sin, repenting and turning from those destructive behaviors are eliminated. The client becomes a passive agent, requiring not a penitent heart before GOD, but instead a needy handout of therapy and medication from secular therapies.<sup>40</sup>

Babler notes that, although some mental health conditions are biologically caused, many DSM-IV diagnoses are rooted in an etiology of sin, rather than underlying physiology and mental illness. Thus, therapy for many such supposed DSM-IV conditions rests in the redeeming work of CHRIST and counseling based on The Bible. Sin properly identified, confessed and repented of offers the most certain cure for a life in rebellion to GOD’s Word. Babler ably summarizes on page 29 many such clients who have been labeled with a DMS-IV mental health diagnosis that seek Christian counseling:<sup>41</sup>

“When those you counsel have been diagnosed with one of these disorders, they often come believing that the DSM-IV’s perspective is correct. They believe they have an objectively scientific mental disorder... First, the diagnosis frees them to see themselves as victims of a “disorder.” But, second, they are legitimated in blame shifting their core spiritual problems onto a mental or emotional diagnosis. There is no hope embedded in a DMS-IV label, no CHRIST to sympathize with our weaknesses and struggles, to give mercy to forgive us, to give grace to help us and change us. You have the opportunity to enter such people’s lives in a relationship of love. You can label problems the way GOD does, and apply truth from Scripture that sets people free.”<sup>42</sup>

## XII. THE CHRISTIAN VIEW THAT ONLY GOD CAN CHANGE THE HEART

The Christian therapist Sandra Wilson, in “An Interview with Sandra Wilson,” calls for a reclaiming of soul care from secular psychology based on The Holy Scriptures and the transforming power of JESUS CHRIST. She points out that only by knowing about GOD and knowing GOD can a true internal changing transformation take place in the hearts of clients faced with life issues. She challenges why Christian mental health care professionals should cede to self proclaimed and culturally biased organizations like the American Psychological Association more authority to care for the souls of people than Christianity and the Holy Bible.<sup>43</sup>

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<sup>40</sup> 11, “A Biblical Critique of the DSM-IV,” Babler, *Journal of Biblical Counseling*, Volume 18, Number 1, p 25-29. Fall 1999.

<sup>41</sup> 11, *Ibid.*, p 25-29.

<sup>42</sup> 11, *Ibid.*, p 29.

<sup>43</sup> 12, “An Interview with Sandra Wilson,” Vassilades, *Edification*, Society for Christian Psychology, Volume 1, Issue 2, p 2-4. Spring 2004.

Wilson points out that, given an open full disclosure to clients that therapy will be CHRIST-centered and based on The Holy Bible provides the opportunity to reach people in counseling with life changing and soul saving therapy: “Scripture portrays our Savior GOD as a Passionate Pursuer, not some intellectually manageable idea or collection of ideas... JESUS did not go to the Cross so that we could have more accurate ideas about GOD!... [Christian therapy takes] Biblical promises from the head to the heart and makes GOD’s transforming love an experienced reality rather than only a theological certainty.”<sup>44</sup>

Sandra Wilson, in “Why Do I Try So Hard But Change So Little?,” expounds on the need for converting intellectual knowledge of GOD and His Word into heartfelt awareness of and appreciation for GOD through JESUS CHRIST. Entering regularly into “practicing the presence of GOD” calls for a two-way line of communication where one not only prays and reads The Holy Bible, but also listens to and searches for GOD’s replies. Through this process Wilson points to the need for Christian counseling to offer clients, not only finding answers to issues in the Holy Bible, but also in developing a close relationship with GOD Himself.<sup>45</sup>

“GOD delivered transforming truth in a relational package - the person of His Son. That truth came in the form of One with whom we can have an intimate relationship. We experience deep change through the Person who is Truth, not by merely believing precepts of truth. Truthful propositions remain vitally important for us to learn, memorize, and assimilate into our belief systems. And this happens most effectively in intimate relationships and dialogue with a person - ideally with the One who names Himself Truth [JESUS CHRIST]... Spending time with GOD in solitude, experiencing the reality of His presence, and cultivating inner quietness create the condition in which we can hear Him more clearly. And as we share our hearts with GOD and hear Him share His heart with us, our relationship grows deeper, closer. More real. That’s how friendships work.”<sup>46</sup>

### XIII. THE DISEASE MODEL VERSUS THE SIN MODEL

Edward T. Welch, in “A Letter to an Alcoholic” addresses the issue of substance dependency - in this case alcohol - as a disease versus a sin. The American Medical Association says such conditions are an illness, but the Holy Bible says clearly such conditions are sin. The disease model implies the addict is a victim who has reduced or even no responsibility for his addiction, while the sin model holds the addict is a sinner who has responsibility for his addiction before GOD. The disease model mindset encourages addicts to place the blame for their destructive behaviors upon a supposed biological cause or causes.<sup>47</sup>

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<sup>44</sup> 12, “An Interview with Sandra Wilson,” Vassilades, Edification, Society for Christian Psychology, Volume 1, Issue 2, Spring, 2004, p 4.

<sup>45</sup> 13, “Why Do I Try So Hard But Change So Little?” Wilson, Edification, Society for Christian Psychology, Volume I, Issue 2, p 5-8. Spring 2004.

<sup>46</sup> 13, Ibid., p 6-8.

<sup>47</sup> 14, “A Letter to an Alcoholic,” Welch, Journal of Biblical Counseling, Volume 16, Number 3, p 19-26. Spring 1998.

If one denies GOD, then one is clear of responsibility and can blame shift one's addiction to one's genetically predetermined physiological makeup. If one concedes that GOD created man with this bias, then one is even inclined to blame shift onto GOD Himself for making the biological need for substance dependency part of one's predetermined makeup, thus accusing GOD of creating evil. So here we have the essence of the conflicting views of the biological medical model espoused by the secular world versus the moral Biblical model espoused by traditional Christian faith.<sup>48</sup>

Thus, difference between this disease model and the Biblical model differs not in the recognition of the suffering and dysfunction of the addiction, but rather in the responsibility for the causes and solutions to them. Welch compares the presentation of alcoholism and substance abuse between the DSM-IV and PROVERBS 23:29-35, concluding that there is little difference between the modern and Biblical identification of the symptoms of addiction. He points out further that, although genetic factors may predispose one to falling into substance dependency, there is no clear scientific evidence that genetics determine and cause substance dependency. The medical disease model then removes motivation for stopping the addictive behaviors; denies the importance of the heart's desires and passions; denies the need for a change of the human heart.<sup>49</sup>

Welch points out that a substance dependency is a relationship between the addict and the substance that displaces all other relationships, most importantly the relationship between the individual and GOD. The Biblical model of addiction clarifies this idolatrous relationship in ROMANS 13:13-14: "Let us walk honestly, as in the day; not in rioting and drunkenness, not in chambering and wantonness, not in strife and envying. But put ye on The Lord JESUS CHRIST, and make not provision for the flesh, to fulfill the lusts thereof:"

"Addictive behavior is a behavior that is against other people, and, even more, it is against GOD. We could put it this way: we love what our substance does for us more than we love GOD (or other people)... addictions are more than self-destructive behaviors. They are violations of GOD's laws: His laws that call us to avoid drunkenness and immoderate self-indulgence (ROMANS 13:13), His law that calls us to love others (1 JOHN 4:7), and His law that calls us to live for Him rather than ourselves (1 CORINTHIANS 10:31). This means that addiction is more about someone's relationship with GOD than it is about biology... It brings us to that all important question, Will you live for the fulfillment of your desires or for GOD?"<sup>50</sup>

#### XIV. FAILURE OF SPIRITUAL RECOVERY MODELS WITHOUT CHRIST

Welch evaluates for deficiencies in these regards the spiritual based recovery programs for addiction well known as Alcoholics Anonymous (AA). AA is actually an enlightened model type of recovery program, in that it calls alcoholism a disease state with no responsibility for the cause of the addiction, while offering a works based program that requires a high degree of personal responsibility for abstinence. (6) In light

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<sup>48</sup> 14, "A Letter to an Alcoholic," Welch, Journal of Biblical Counseling, Volume 16, Number 3, p 19-26. Spring 1998.

<sup>49</sup> 14, Ibid., p 19-26.

<sup>50</sup> 14, Ibid., p 23.

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of Welsh's above quote, AA's flaws are self evident.<sup>51</sup>

First, such programs make GOD optional, leaving open the interpretation and even existence of GOD to the whims of the individual addict, which renders the concept of a Creator as limited in power according to the subjective conveniences of the sinful human mind. Second, such programs make no judgment that addictions are sins of the heart against GOD. Third, such programs clearly make The One who offers repair of the broken relationship between GOD and man - our Lord JESUS CHRIST - optional and is, in fact, not even mentioned.<sup>52</sup>

Welsh concludes with the orthodox Christian solution for restoring man to GOD in the face of all sins, which he has shown applies clearly to recovery from substance dependency: "Along with the truth about ourselves, we must know the truth about GOD. Specifically, we must know that GOD hates sin but freely offers grace and forgiveness to sinners who turn from it..."

Without forgiveness, we would be condemned for our past sins and future sins, so there would be no real hope. Satan would be unbridled, free to provoke despair and paralyzing guilt. With forgiveness, there is peace with GOD and a boldness to pursue the risky task of sobriety. In short, JESUS, in His death for sins and resurrection from the dead, is the centerpiece of all change. We, as struggling sinners, must keep looking at Him until we see and know that He is the fullest expression of GOD's hatred against sin and love for His people. We keep looking until we believe that JESUS paid the penalty for our sin and delights to give us power to fight against it."<sup>53</sup>

## XV. THE BIBLICAL VIEW OF ADDICTIONS AS SIN

Edward T. Welch, in "Addictions: New Ways of Seeing, New Ways of Walking Free" further examines the sin-based Biblical theory of substance dependency. In early addiction, he notes the heart desires one more use of the substance which offers the body brief satisfaction. This escalates because the idolatrous heart wants more of the substance which satisfies the body's increasing demand for more. Thus, the addict becomes a slave to the substance for the physical satisfaction of the body and the idolatrous desires of the heart.<sup>54</sup>

Welch points out that battling against substance dependency is a constant war in which four Biblical sins that entice the human heart can be identified: idolatry, adultery, foolishness and surrendering to the attacks of a wild beast. First, addiction is like idolatry, in which case the substance displaces GOD in our lives so that we come to worship and serve it rather than our Creator. Second, addiction is like adultery, in which case the substance becomes the most important relationship in our lives so that we come to be wedded to and live with it rather than having a relationship with our Creator and others.<sup>55</sup>

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<sup>51</sup> 14, Ibid., p 19-26.

<sup>52</sup> 14, "A Letter to an Alcoholic," Welch, Journal of Biblical Counseling, Volume 16, Number 3, Spring 1998, p 19-26.

<sup>53</sup> 14, Ibid., p 26.

<sup>54</sup> 15, "Addictions: New Ways of Seeing, New Ways of Walking Free," Welch, Journal of Biblical Counseling, Volume 19, Number 3, p 19-30. Spring 2001.

<sup>55</sup> 15, Ibid., p 19-30.

Third, addiction is like foolishness, in which case the substance is short term immediate satisfaction is pursued without any thought or consideration of the wisdom and consequences of use in our lives. Forth, addiction is like surrendering to the attacks of a wild beast, in which case the substance tears apart our lives as it consumes and destroys us in every way.<sup>56</sup>

Welch offers Biblical examples of each sin operative in addiction: First, in idolatry, he cites for example DEUTERONOMY 4:23: "Take heed unto yourselves, lest ye forget the covenant of The LORD your GOD, which He made with you, and make you a graven image, or the likeness of anything, which The LORD thy GOD hath forbidden thee." Second, in adultery, he cites for example PROVERBS 7:1-27: "...And behold among the simple ones, I discerned among the youths, a young man void of understanding... And, behold, there met him a woman with the attire of an harlot, and subtle of heart... Her house is the way to hell, going down to the chambers of death."<sup>57</sup>

Third, in foolishness, he cites for example PROVERBS 17:24: "Wisdom is before him that hath understanding: but the eyes of a fool are in the ends of the earth." Forth, in surrendering to the attacks of a wild beast, he cites for example 1 PETER 5:8: "Be sober, be vigilant; because your adversary the devil, as a roaring lion, walketh about, seeking whom he may devour."<sup>58</sup>

Welch offers the following prescription of daily warfare for overcoming these four sin states that underlie addiction: "Don't excuse it. That would simply encourage the self-deceptive consequences of sin. Confess it as sin against GOD. Look to JESUS as the One who shows grace and mercy to idolaters. Grow in faith by knowing your GOD as He reveals Himself in Scripture. Learn to delight in obedience. Search out Scripture to find ways to obey. Don't rely on yourself but partner with and be accountable to wise people. Pursue wisdom - the skill of godly living that comes out of reverence for The Lord. And pursue it aggressively."<sup>59</sup>

Further, "Don't just avoid sin; hate it. Realize that addiction, like all sin, doesn't impose itself on us unless we have been willing to entertain the seeds of it in our imaginations. Therefore, change must be deeper than overt behavioral change. We are targeting our hearts... Be very careful of how you live. (EPPHESIANS 5:15) Put on the full armor of GOD. (EPHESIANS 6:11) Prepare your minds for action. (1 PETER 1:1-3) Make every effort. (II PETER 1:5) Be self-controlled and alert. (1 PETER 5:8)."<sup>60</sup>

## XVI. THE KESWICK MODEL OF CHRISTIAN RECOVERY

"America's KESWICK" is a Christian ministry organization that offers for example an overview of how to daily break free from addiction based on The Holy Bible.<sup>61</sup> Their Director of Addiction Recovery Ministries, Michael P Woods, in

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<sup>56</sup> 15, Ibid., p 19-30.

<sup>57</sup> 15, "Addictions: New Ways of Seeing, New Ways of Walking Free." Edward T. Welch. The Journal of Biblical Counseling, Volume 19, Number 3, Spring 2001, p 19-30.

<sup>58</sup> 15, Ibid., p 19-30.

<sup>59</sup> 15, Ibid., p 25.

<sup>60</sup> 15, Ibid., p 25.

<sup>61</sup> 16, "America's KESWICK." A Christian addictions recovery program.

“Addiction - The Rule of the Puppet Kings - A Biblical Perspective,” offers a four step program of first recognizing that CHRIST is sufficient; second reckoning oneself dead to sin; third renewing the mind in CHRIST; fourth remain accountable to others:

1. Recognize that CHRIST is sufficient. Many people turn to addictive activities because they believe they need something more than what GOD can give them. That is a lie! Colossians 2:9-10 informs us that “In Him (CHRIST) dwells all the fullness of the Godhead bodily; and YOU ARE COMPLETE in Him.” (NKJV emphasis mine). No matter what may come your way, the indwelling Christ is able to “keep you from falling” (JUDE 24) into that sinful behavior.
2. Reckon (consider as true of) yourself dead to sin. (ROMANS 6:11) Because CHRIST has set you free. Because you are complete in Him. You are also dead to the power and rule of sin over your life. Give GOD the control over your life since you have died to sin.
3. Renew your Mind. Because you are a new creature in CHRIST (II CORINTHIANS 5:17) you need to look at your life and your sinful activities that were enslaving you the same way GOD views your sin. Renewing the mind is the process of allowing GOD’s Word and the application of it’s principles to mold your thinking in order that you can recognize when you are enticed to act contrary to the character and revealed will of GOD (temptation). When you see yourself the way GOD sees you, you will begin to act the way God wants you to act. This only can begin to take place by renewing your mind (ROMANS 12:1-2).
4. Remain accountable to others. Friends, family, and church activity are essential in the process of breaking free. GOD created us with the need for fellowship. First with Himself, secondly with others. He ordained the church to be a fellowship of believers to nurture and grow as each member does its part (EPHESIANS 4:16). Finding a local support group in the church will also help as you seek to break free from your besetting sin.”<sup>62</sup>

## XVII. THE CELEBRATE RECOVERY MODEL OF CHRISTIAN RECOVERY

The Reverend Rick Warren has developed a distinctly Christian Bible-based recovery program for addictions designed specifically for use in the small group Church setting called “Celebrate Recovery.” The program’s foundation lies in a Biblical understanding and application of the steps of recovery.<sup>63</sup> The purpose statement of Celebrate Recovery is “...to fellowship and celebrate GOD’s healing power in our lives through the ‘8 Recovery Principles.’ This experience allows us to ‘be changed.’”<sup>64</sup>

Further, “By working and applying these Biblical principles, we begin to grow spiritually. We become free from our addictive, compulsive and dysfunctional behaviors. This freedom creates peace, serenity, joy and most importantly, a stronger personal relationship with GOD and others. As we progress through the program we discover our personal, loving and forgiving Higher Power - JESUS CHRIST, the one and only true

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<sup>62</sup> 17, "Addiction - The Rules of the Puppet Kings - A Biblical Perspective," Woods, America's KESWICK, <http://www.gospelcom.net/keswick/arAddictionPub.shtml>.

<sup>63</sup> 18, “Celebrate Recovery,” Warren, 2001 -2004, <http://www.celebraterecovery.com>.

<sup>64</sup> 18, Ibid.

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Higher Power.”<sup>65</sup>

Consider for example the spiritual but distinctly non-Biblical and non-Christian addictions recovery program like the “Twelve Steps” of Alcoholics Anonymous:<sup>66</sup>

1. We admitted we were powerless over alcohol - that our lives had become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of GOD as we understood Him.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to GOD, to ourselves and to another human being the exact nature of our wrongs.
6. Were entirely ready to have GOD remove all these defects of character.
7. Humbly asked Him to remove our shortcomings.
8. Made a list of all persons we had harmed, and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with GOD as we understood Him, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics and to practice these principles in all our affairs.<sup>67</sup>

A recovery program for addiction that is not CHRIST-centered can not, as has already been noted, produce a changed heart and restore a right relationship with GOD for the individual. Nor can such programs address the sins that lead to addiction. Only a Christian recovery program can address such issues. Here “Celebrate Recovery” offers this great changing hope through a distinctly Biblical Christian Twelve Steps in “The Twelve Steps and Their Biblical Comparisons [of Celebrate Recovery].”<sup>68</sup>

1. We admitted we were powerless over our addictions and compulsive behaviors. That our lives had become unmanageable. I know that nothing good lives in me, that is, in my sinful nature. For I have the desire to do what is good, but I cannot carry it out. (ROMANS 7:18)
2. Came to believe that a power greater than ourselves could restore us to sanity. For it is GOD who works in you to will and to act according to his good purpose. (PHILIPPIANS 2:13)

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<sup>65</sup> 18, Ibid.

<sup>66</sup> 19, "The Recovery Program," Alcoholics Anonymous, [http://www.alcoholics-anonymous.org/default/en\\_about\\_aa\\_sub.cfm?subpageid=17&pageid=24](http://www.alcoholics-anonymous.org/default/en_about_aa_sub.cfm?subpageid=17&pageid=24).

<sup>67</sup> 19, Ibid.

<sup>68</sup> 20, “The Twelve Steps and Their Biblical Comparisons [of Celebrate Recovery],” Warren, <http://www.celebraterecovery.com/twelve.asp>.



3. Made a decision to turn our will and our lives over to the care of GOD. Therefore, I urge you, brothers, in view of GOD's mercy, to offer your bodies as living sacrifices, holy and pleasing to GOD—this is your spiritual act of worship. (ROMANS 12:1)
4. Made a searching and fearless moral inventory of ourselves. Let us examine our ways and test them, and let us return to The LORD. (LAMENTATIONS 3:40)
5. Admitted to GOD, to ourselves, and to another human being, the exact nature of our wrongs. Therefore confess your sins to each other and pray for each other so that you may be healed. (JAMES 5:1 6a)
6. Were entirely ready to have GOD remove all these defects of character. Humble yourselves before The Lord, and he will lift you up. (JAMES 4:10)
7. Humbly asked Him to remove all our shortcomings. If we confess our sins, He is faithful and just and will forgive us our sins and purify us from all unrighteousness. (1 JOHN 1:9)
8. Made a list of all persons we had harmed and became willing to make amends to them all. Do to others as you would have them do to you. (LUKE 6:3 1)
9. Made direct amends to such people whenever possible, except when to do so would injure them or others. Therefore, if you are offering your gift at the altar and there remember that your brother has something against you, leave your gift there in front of the altar. First go and be reconciled to your brother; then come and offer your gift. (MATTHEW 5:23-24)
10. Continued to take personal inventory and when we were wrong, promptly admitted it. So, if you think you are standing firm, be careful that you don't fall! (1 CORINTHIANS 10:12)
11. Sought through prayer and meditation to improve our conscious contact with GOD, praying only for knowledge of His will for us and power to carry that out. Let the Word of CHRIST dwell in you richly. (COLOSSIANS 3:1 6a)
12. Having had a spiritual experience as the result of these steps, we tried to carry this message to others, and practice these principles in all our affairs. Brothers, if someone is caught in a sin, you who are spiritual should restore him gently. But watch yourself, or you also may be tempted. (GALATIANS 6:1)<sup>69</sup>

### XVIII. DISCUSSION

A case example of a long term polysubstance dependant addict whose habit focused primarily on heroin use was evaluated. The primary DSM-IV diagnosis was identified as status post "Opioid Dependence" (304.00) with "Sustained Full Remission."<sup>70</sup> The subject's nearly lifelong polysubstance addictions escalated quickly to exact high costs for the subject, including a ruined military career, multiple prison sentences, loss of a marriage through divorce, a life of crime, the deaths of 2 siblings from drug overdose, estrangement from children, significant health consequences and multiple episodes of near death and death events related to overdose from heroin use.

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<sup>69</sup> 20, "The Twelve Steps and Their Biblical Comparisons [of Celebrate Recovery]," Warren, <http://www.celebraterecovery.com/twelve.asp>.

<sup>70</sup> 2, "Desk Reference to the Diagnostic Criteria from DSM-IV-TR," American Psychiatric Association, p 110-113.

Of interest is the subject's total lack of response to secular therapy, particularly multiple enrollments in methadone programs, for treatment of his heroin addiction. This is contrasted in this subject by complete remission of all substance addiction in response to an intensive residential Christian rehabilitation program. The subject's abstinence since then has been sustained by an intense Christian faith, active and regular Church worship, attendance of a weekly Christian addictions recovery support group and involvement in a Church-based ministry to reach other addicts with a Bible-centered outreach program. The material used for the Christian recovery groups the subject is involved with at his Church was designed specifically by a clergy member [The Reverend Rick Warren] for Church based Christian small group addiction recovery based on The Holy Bible [Celebrate Recovery].<sup>71</sup>

The etiology in particular of heroin addiction was reviewed. The same Central Nervous System opiate receptors designed to respond to the body's naturally produced and released endogenous opiates readily respond to exogenous opiates introduced into the body artificially. When stimulated, these brain receptors produce among other effects feelings of euphoria and are involved in reinforcing behaviors. The heroin addict becomes increasingly dependant upon the effects of chronic heroin abuse, requiring more and more of the substance to elicit the same desired effects. This is accompanied by changes in the body such that heroin quickly becomes part of a new homeostasis, the disruption of which leads to withdrawal effects from mild to severe. Since heroin is an illegal street drug in the United States, users are obliged by definition to engage in criminal activity to obtain their ever increasing needed supply from criminal elements.<sup>72 73 74</sup>

Without treatment, the course of heroin addiction leads to escalating use due to tolerance, which requires an ever greater focus of activities to maintain the required supply. Since heroin addicts widely inject the substance intravenously and find themselves using and sharing unsanitary needles and syringes, this population experiences high rates of HIV/AIDS and hepatitis. The personal and social implications for large populations of heroin addicts engaging in the criminal activity needed to support and purchase their heroin supplies is catastrophic. Premature clinical death due to poisoning from combinations of other substances and drugs and suppression of the brain centers that control vital signs by the heroin itself are not uncommon. Without treatment, heroin addiction is characterized by a lifetime of dependency, often associated with crime, family breakdown and periods of abstinence that are usually not sustained. Thus, the urgent need for treatment of heroin addiction for both the individual and for society.<sup>75 76 77</sup>

The subject interviewed underwent 4 one year treatment periods with outpatient methadone maintenance therapy in an attempt to treat his heroin addiction, each without success. The subject noted that, while on methadone treatment, in order to effect the

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<sup>71</sup> 17, "Addiction - The Rules of the Puppet Kings - A Biblical Perspective," Woods, America's KESWICK, <http://www.gospelcom.net/keswick/arAddictionPub.shtml>.

<sup>72</sup> 1, "Understanding Abnormal Behavior - Sixth Edition," Sue et al, p 255-286.

<sup>73</sup> 3, "Physiology of Behavior, Eighth Edition," Carlson, p 573-600.

<sup>74</sup> 4, "The Surprising Truth About Heroin and Addiction," Sullum, Reason 35 Number 2, p 32-40. 2003.

<sup>75</sup> 1, "Understanding Abnormal Behavior - Sixth Edition," Sue et al, p 255-286.

<sup>76</sup> 3, "Physiology of Behavior, Eighth Edition," Carlson, p 573-600.

<sup>77</sup> 4, "The Surprising Truth About Heroin and Addiction," Sullum, Reason 35 Number 2, p 32-40. 2003.

desired alteration of his mood, he found it effective to turn to other addicting substances, such as alcohol and xanax obtained illegally. Noted is the subject's refusal during his long heroin addiction to submit to regular psychiatric care, psychological therapy or group support until his effective cure at a lengthy residential Christian recovery facility. A non-compliant client undergoing methadone maintenance therapy who declines these other sources of secular care - such as psychotherapy, counseling and group support - is less likely to develop any lasting abstinence recovery from heroin dependency. Noted also is this subject's report that methadone maintenance merely reduced his needed amount of heroin usage, but did not eliminate its effects, which suggests a chronic under dosing of methadone in this case.

Indeed, this is exactly one of the primary problems with such outpatient community methadone maintenance programs noted in this discussion in such non-compliant subjects. What is interesting is that the methadone programs allowed this subject's continued participation in spite of his lack of participation in other supporting treatments. This case points out that, although lengthy enrollment periods in methadone programs can lead to higher rates of abstinence, they are less likely to succeed unless combined with other treatment modalities.<sup>78 79</sup> The arbitrary and subjective nature of the DMS-IV system itself has been noted, which is often simply secular psychology's retelling of Biblical models of dysfunctional behaviors without a divine perspective.<sup>80</sup>

Given the prevailing disease model mentality of secular therapies for drug addiction, it is not surprising that they often fail to instill a lasting motivation in the addict to be cured. To do so requires a change of the heart and a submission of the will which secular approaches seem unable to offer. It is interesting that many secular authorities acknowledge the spiritual dimension of such conditions as substance dependency and identify religious faith as a key predictor of recovery potential. Yet, these same secular authorities seem hesitant to incorporate the religious faith system that works most directly on changing the heart and submitting the will for curative purposes, which is that of Christianity.<sup>81</sup>

Thus the secular models for responsibility for abstinence from substance dependency often fail dramatically when based on a low responsibility on the part of the client. However, Christian models that call for a high responsibility for abstinence on the addict's part offer the ability to change the heart and will, which is what we see in this particular subject. Christian counseling thus calls for more than simple behavior modification. By identifying substance addiction with well understood Biblical models of sin such as idolatry, adultery, foolishness and surrendering to destructive temptations, the door is opened to changing the heart of the addict.

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<sup>78</sup> 6, "Models of Helping and Coping," Brickman et al, American Psychologist, Volume 37, Number 4, p 368-384. April, 1982.

<sup>79</sup> 7, "Treatment Retention and Follow-Up Outcomes in the Drug Abuse Treatment Outcome Study (DATOS)," Simpson et al, Psychology of Addictive Behaviors, Volume 44:4, p 294-307. December 1997.

<sup>80</sup> 11, "A Biblical Critique of the DSM-IV," Babler, Journal of Biblical Counseling, Volume 18, Number 1, p 25-29. Fall 1999.

<sup>81</sup> 10, "Spiritual Beliefs, World Assumptions, and HIV Risk Behavior Among Heroin and Cocaine Users," Avants et al, Psychology of Addictive Behaviors, 0893 -164X, Volume 17, Issue 2. 6/01/2003.

Once the sins of the heart that make possible the addiction have been confessed and repented of before GOD, restoration of the Christian relationship between the addict and GOD is made possible by The Savior JESUS CHRIST. Restoring this relationship broken by addiction enables the individual to place GOD on the throne of the heart, rather than allowing sins related to the substance to occupy that place. This in turn facilitates a desire to submit the will to GOD by seeking His direction daily. The primary source of such life changing therapy in Christian therapy is The Holy Bible.

Here then are the three primary theological doctrines that are the basis for the Christian recovery care that has delivered this subject from longstanding multiple substance addiction: In DEUTERONOMY 4:23, the sin of idolatry is forbidden: "Take heed unto yourselves, lest ye forget the covenant of The LORD your GOD, which He made with you, and make you a graven image, or the likeness of anything, which The LORD thy GOD hath forbidden thee." Although others have been identified, idolatry is a widely used first line Biblical sin model in Christian counseling to understand why addictions are sins of the heart.

Consulting ROMAN S 13:13-14 reveals the Biblical objective of sobriety: "Let us walk honestly, as in the day; not in rioting and drunkenness, not in chambering and wantonness, not in strife and envying. But put ye on The Lord JESUS CHRIST, and make not provision for the flesh, to fulfill the lusts thereof." In 1 JOHN 1:9 we have the Christian doctrine of forgiveness of sins through our Lord JESUS CHRIST: "If we confess our sins, he is faithful and just and will forgive us our sins and purify us from all unrighteousness."

This case highlights the need for Christian addiction recovery residential and outpatient facilities to meet the large population of addicts who have failed to obtain recovery from substance abuse from secular therapies. This case also highlights the need for Christian small group Church based recovery support groups for addicts. Indeed, this particular subject has benefited from the "Celebrate Recovery" program designed by The Reverend Rick Warren specifically for this purpose.<sup>82 83</sup> This case further highlights the need for The Church to accept into herself those suffering from substance addictions to minister to them, convert them and work to sustain their Christian faith in a community of believers within a Church congregation and a small group. The growth of Christian counseling offers another source of faith-based therapy. This subject has benefited from The Church's efforts in these first three areas, although he has declined to obtain assistance in the fourth.

Components of a successful Christian recovery program for addiction requires a Bible-based and CHRIST-centered curriculum, such as that of "Celebrate Recovery."<sup>84 85</sup> The primary Brickman responsibility model is a modified moral model, in that the

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<sup>82</sup> 18, "Celebrate Recovery." The Reverend Rick Warren. 2001-2004.  
<http://www.celebraterecovery.com>.

<sup>83</sup> 20, "The Twelve Steps and Their Biblical Comparisons [of Celebrate Recovery]." The Reverend Rick Warren. <http://www.celebraterecovery.com/twelve.asp>.

<sup>84</sup> 18, "Celebrate Recovery." The Reverend Rick Warren. 2001-2004.  
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<sup>85</sup> 20, "The Twelve Steps and Their Biblical Comparisons [of Celebrate Recovery]." The Reverend Rick Warren. <http://www.celebraterecovery.com/twelve.asp>.

client must face both his responsibility for the cause and the solution to his addictions.<sup>86</sup> However, the client can not effect a change in his addictive behavior without confession, repentance and forgiveness before GOD through our Lord JESUS CHRIST.<sup>87</sup> The client needs to become integrated into a local Church congregation and attend worship services regularly. The client should be attending a weekly small group Christian recovery and support group within The Church.<sup>88</sup>

Further, accountability to stable Christians - including a clergy member, the small group and an individual accountability partner within the small group - should be established.<sup>89</sup> Referral to secular medical and psychiatric sources for medical and psychiatric stabilization and clearance should not be overlooked for both acute urgent and chronic non-urgent physical and emotional problems as needed. The character strengths and weaknesses of the individual addict should be considered in building a support network for that person within the Church.<sup>90</sup>

## XIX. IN CONCLUSION

Heroin addiction is, like all addictions, not simply an illness of the body and mind, but also an illness of the heart. Secular therapies for substance dependency often fail because they do not address the spiritual distress of the heart. A common Biblical model of addiction is that of idolatry, where the object of the addiction displaces GOD as the center of one's life. Christian therapies offer the addict the opportunity to change the heart by treating addictions as sins of the heart that separate one from GOD. True repentance and confession of such sins before GOD and forgiveness of those sins in our Lord JESUS CHRIST is the basis for a Christian change of heart in the addict.

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<sup>86</sup> 6, "Models of Helping and Coping." Philip Brickman, Vita Carulli Rabinowitz, Jurgis Karuza Jr, Dan Coates, Ellen Cohn, Louise Kidder. *American Psychologist*, Volume 37, Number 4, p 368 -3 84. April, 1982.

<sup>87</sup> 20, "The Twelve Steps and Their Biblical Comparisons [of Celebrate Recovery]." The Reverend Rick Warren. <http://www.celebraterecovery.com/twelve.asp>.

<sup>88</sup> 20, Ibid.

<sup>89</sup> 17, "Addiction - The Rules of the Puppet Kings - A Biblical Perspective." Michael P. Woods. America's KES WICK. <http://www.gospelcom.net/keswick/arAddictionPub.shtml>.

<sup>90</sup> 9, "Counselor's responsibility and Etiology Attributions, Theoretical Orientations, and counseling Strategies." Roger I. Worthington and Donald R. Atkinson. *Journal of Counseling Psychology*, Volume 40:3, p 295-302. July, 1993.

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The heart being thus restored to GOD, the former addict can then more easily submit his will to GOD to live a sober life. Christian recovery facilities, outreach of the Church congregation to convert and take into its ranks those suffering from addictions, Christian Bible-based small group recovery programs within the Church and Christian counseling offer the collective Church opportunities to truly reach those lost in substance addictions.

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