The Teen Challenge Therapeutic Model

by Douglas Wever

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by **Douglas Wever**
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ABSTRACT

This is a preliminary document to describe the Teen Challenge (TC) therapeutic process for delineation of the TC therapeutic model. This report is a description of what exists in TC today from the standpoint of what, how, and why we do ministry.

We argue that the methodologies and goals of TC are most analogous to church ministry, especially as it is realized in pastoral counseling. We also argue that the traditional comparisons of TC to the drug and alcohol therapeutic industry only provide information regarding the presence or absence of compulsive deviant behaviors. Behavioral measurements such as Hess (1975) accomplished do not reflect that the absence of deviant behavior achieved by TC is an effect of the much larger, central, and *a priori* issue of Christian discipleship. While compulsive deviant behavior often provides impetus for enrollment in TC, such behaviors are symptomatic of much deeper issues which the section, "Therapeutically" will detail.

We also bring to the fore suggestions for improving our existing model through understanding it (included is an example of a counselor teaching on forgiveness). Such detailed description can point to training and student services needs in this unique discipleship environment, given TC constituency consensus regarding the enclosed precepts of this document.

Also included is a review of the literature regarding programs in the areas of success factors, failure factors, and long vs. short term program comparisons. This is an important section in that it further distinguishes TC from the drug and alcohol treatment culture from the perspective of that industry's report regarding themselves.

WORDS

What do we mean by words such as therapy, psychotherapy, counseling, and pastoral counseling? Psychotherapy is a generic term which covers a broad spectrum of theories for the widest possible assumptions about how people change and how to help them. In 1984, Strupp and Binder identified 260 distinct schools of psychotherapy. In the presence of such diversity, it should be of little surprise that pastoral counselors, counselors, clinicians, and researchers have not agreed upon a specific definition of psychotherapy or counseling.

Historically, *psychotherapy* was thought to be more appropriate for "deeper" problems. The focus was on personality change rather than adjustment to situational and life problems. *Counseling* typically worked within existing personality structures to help people adjust to current demands on them. More recently, authors have begun to use the terms interchangeably as the distinctions have become increasingly hard, if not impossible, to separate (Jones and Butman, 1992; Altmaier, 1985).

When describing a therapeutic model for Teen Challenge (TC), such description does not place TC among any given school or orientation. At most, "therapeutic model" identifies that there is a way in which the ministry of TC can be described in terms of how the ministry helps people, and how that help is accomplished. Consequently, many aspects of TC which are far removed from a traditional clinical or formal counseling context are nevertheless "therapeutic."

In this document the reader will find that conventional ideas of therapy will not fit. Therapeutically, the TC effort may be summarized as, "Providing the most conducive environment possible for the work of the Holy Spirit." How this environment is provided gives further detail regarding a therapeutic model.

When reviewing this document, the author and subsequent reviewing committees used this description to address and describe the uniqueness of TC. Like the Church, TC is a healing community. And, like the church, TC exists to evangelize and disciple. Healing is intrinsic to successful evangelism and discipleship. It is how TC facilitates evangelism and especially discipleship which provides our therapeutic model.

FORMING THE DESCRIPTION

The mission statement of TC is (National Teen Challenge Accreditation Standards, 1976, 1990):

> To evangelize people who have life-controlling problems and initiate the discipleship process to the point where the student can function as a Christian in society, applying spiritually motivated biblical principles to relationships in the family, local church, chosen vocation, and the community. Teen Challenge endeavors to help people become mentally sound, emotionally balanced, socially adjusted, physically well, and spiritually alive.

A significant amount of past research has examined the efficacy of the TC ministry in affecting the presence of compulsive deviant behavior over the long term (Robinson, 1985; Hess, 1975; Fredericks, 1992; Packingham, 1992). For example, the United States Department of Health, Education and Welfare (HEW) found that eighty-six percent of TC graduates were still "cured" seven years after graduating the program (1975). They were able to get a ninety-two percent subject respondent rate for this research, and used subject self-reporting and urinalysis to detect substances. This study was funded by the National Institute on Drug Abuse (NIDA) and headed by Katherine Hess, M.D.

In essence, what the HEW/NIDA study looked for was what percentage of TC graduates remained "cured" over the long term, referring to the eighty-six percent figure as a "cure rate." Being cured was defined as the long term absence of compulsive deviant behaviors of substance abuse. This study only looked at drug addiction. Like other reports on the efforts of TC, the study reached only a slice of what we are. By inference, it numbers the TC ministries among substance abuse rehabilitative efforts based on this limited scope, comparing TC only to drug and alcohol addiction efforts.

Whatever TC is therapeutically, it has in each previous case been surveyed within conventions and paradigms that compromise a pristine description. The most significant similarity with the for-profit and non-profit drug and alcohol rehabilitation industry is that a significant percentage of TC students are engaged in compulsive deviant behavior. Further, since TC has promoted its model based on research which focused on the absence or presence of compulsive deviant behavior, it is within these terms which TC has been described. Resultingly, the religious centrality of TC is clouded by an impression that this religious model functions in

significant part within conventional rehabilitative program design structures; and, that TC is a conventional rehabilitation program with a strong and even central spiritual dynamic. This perception is wrong.

Traditional residential substance abuse rehabilitative structures clearly do not provide an analogy for the TC model. TC is, in all issues of therapy, direct and indirect, a purposeful comprehensive focus on the whole life of the student relative to that student's functionality as a Christian disciple. As a component of this, behavior management is a transitory and interim intervention pending transformational spiritual growth which removes all causative impetus for previous compulsive behaviors. Whatever life-controlling problems one refers to - bulimia, sexual addiction, alcoholism, drug addiction, gambling, victim abuse, etc. - these are symptoms of a deeper problem.

The literature reflects the relevance of spirituality to psychological process (Prasinos, 1992), but the spiritual dynamic in TC is definitive and foundational. Spirituality in TC must be detailed and distinguished from references which see spirituality only in human terms or with ambiguous metaphysical references (Witmer and Sweeney, 1992). The analogy for TC is clearly found in a traditional evangelical church context.

The following pages present a therapeutic, structural, and theological overview of TC. Each of these sections contribute in more detail to concepts already presented.

THERAPEUTICALLY

This section is written to provide a general and broad understanding of the process of therapy in TC. TC functions from a Christian love/support environment, employing an *educational* model within which *pastoral counseling* facilitates the internalization of the educational content in both residential and non-residential ministries. The educational content is biblical information which is written at the National Teen Challenge headquarters for the purpose of Christian discipleship. The materials instruct individuals on living as Christians. Pastoral counseling is employed to assist individuals in relating the educational content to their individual life situation. Where preaching may bring biblical concepts forward to contemporary society, pastoral counseling seeks to further apply these concepts to specific life issues and circumstances.

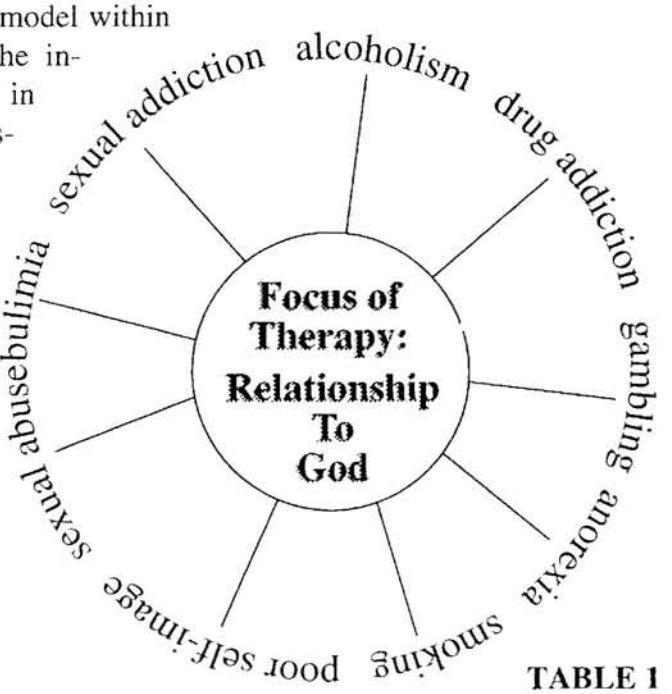


TABLE 1

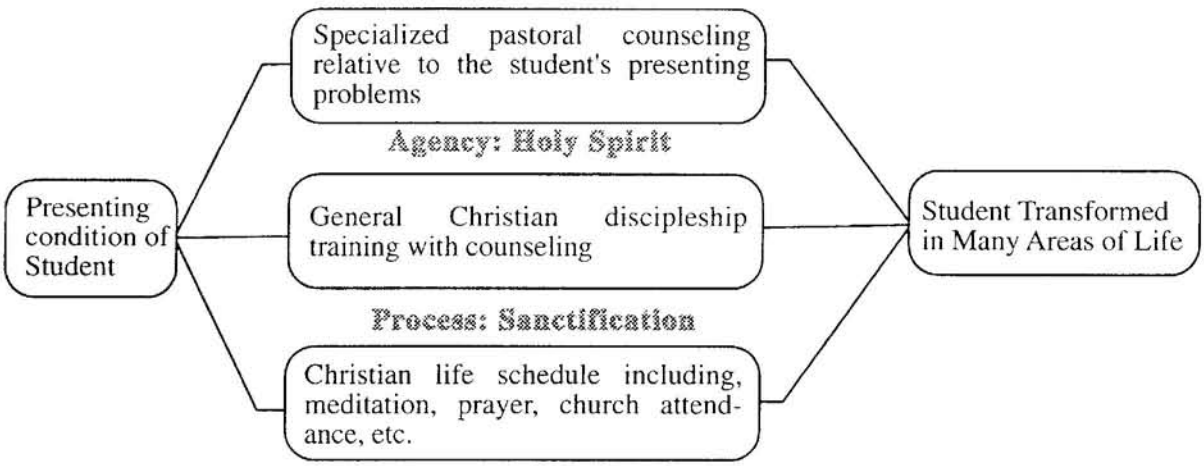
Satellite issues requiring transitional and interim behavior management

In all the descriptions which follow, it must be emphasized that TC pastoral counse-

lors are facilitators of work which is actually occurring by agency of the Holy Spirit as understood in evangelical Christian circles. TC counselors seek to be guided by the Holy Spirit for the good of the student. Hence, it is the primary responsibility of the TC counselor to provide an environment where the student can receive the work of the Holy Spirit.

The cause of compulsive deviant behavior as defined by TC is man's separation from God, which is the result of his self-centeredness. Sinful behavior, including compulsive deviant behavior, is engaged in to fill the void of meaninglessness in life. When man becomes Christ-centered, his symptoms of meaninglessness and compulsive deviant behavior are replaced by a meaningful life that enables him to realize his fullest potential. Teen Challenge believes, as Lewis Chafer stated, "every created thing realizes its greatest destiny and purpose only as it is conformed to the will of God." (1948). These are processes as opposed to culminating events, although certain life areas do culminate in spiritual resolution where the student is free of the problem. In the presence of severe pathology, TC will generally not admit such a student, or will work with a clinical specialist such as a psychologist.

For a therapeutic description, the process which facilitates the transition from meaninglessness to fulfillment is described. For this reason, our mission statement says nothing regarding behavioral measurements, but the exercise of Christianity in all aspects of life. As mentioned previously, behavior management in TC is *transitional* and *interim*. There is the need to manage certain behaviors until the relationship with God is strong enough to remove the impetus for them.



Whatever the compulsive deviant behavior, these are uniformly seen as "satellite" issues which are effects of a deeper problem. The fact that they are satellite issues does not mean the behaviors are not intimately part of the destructive process. In TC, therapy which impacts behavior involves an interpretation or identification of *why* the deviant behaviors are occurring, and then a contextualization of these reasons as a function of what erroneous assumptions are in place regarding meeting basic needs. Through discipleship curriculum and ongoing pastoral counseling relative to the curriculum content, the students are able to discover their incorrect assumptions for meaningfulness, and replace them with content from the God relationship. Table 1 shows how TC views life-controlling problems relative to the deepest issue from a therapeutic standpoint.

To be sure, a tremendous amount of work takes place to traverse the spokes of the wheel in operationalizing the compulsive behavior as it relates to the individual's relationship with God, as well as the various steps and issues which lie in that middle ground. However, Table 1 should

be understood primarily as illustrative of behaviors relative to a root issue. Table 2 illustrates the process - what is going on in the spokes of Table 1's wheel. Additionally, the process of spiritual transformation affects not only the deviant behavioral areas of the student, but helps the student develop a new identity.

The primary focus of TC is, then, the student's relationship to God. TC finds students in various states of meaninglessness. This concept is analogous to what Larry Crabb means regarding the search for security and significance (1977). TC students have acquired dysfunctional routes, behaviors, and attitudes to satisfy primary needs of meaningfulness, or security and significance. TC believes that to meet these needs, a process which facilitates the student coming into proper relationship with God is required. Therefore, the discipleship process is instituted. Of the three areas of therapy identified in Table 2, specialized formal pastoral counseling receives the least effort *relative* to the other two areas. This is due in part to the intrinsically therapeutic qualities of the other two areas, and due to the lack of counselor training found nationally in Teen Challenge. Moreover, other forms of counseling take place throughout the program due to its structure.

Closing Thoughts

A full effort to accept God's love and power will lead to the five following results described by Maddox (1981): (1) the spontaneous remission of anomie and depression; (2) reorganization of the entire personality over time; (3) ititiation of the development of an entirely new self identity; (4) the onset of mind control which facilitates the modification of behavior; and, (5) a new comprehensive definition of reality. We would add a sixth result: an ongoing personal relationship with God as first initiated through faith in Jesus Christ.

The national Teen Challenge counseling materials are based on principles in Larry Crabb's book, *Effective Biblical Counseling*. Like Crabb, TC sees the student with faulty beliefs regarding security and significance (or what TC has called meaningfulness). The student is demonstrating dysfunctional behaviors because of dysfunctional belief systems recognized as either false or dual belief systems at conscious and unconscious levels.

False belief systems. These are wrong basic beliefs about issues such as, but not limited to, significance, self esteem, or any area where beliefs contrary to biblical teaching can affect the individual psychologically. For example, in the student's effort to meet needs of security and significance, s/he acquires certain ineffective routes. These routes are dysfunctional. Healing occurs when the student replaces these dysfunctional belief systems with other beliefs which are capable of meeting the student's goals. The goals must also be appropriate, or they must be dealt with too.

Dual belief systems. These are the same as false belief systems except that they are held in the presence of other incompatible or contradictory beliefs. These dual belief systems are often unconscious to the student. For example, a TC student may have a highly developed and accurate biblical understanding of security and significance as it is met through a relationship with Jesus Christ. However, in certain contexts the student abandons this belief system for a dysfunctional one. Restated, this is sinning in the presence and knowledge of appropriate biblical information.

Appropriate belief systems are more than an intellectual assent. Rather, they are a product of the student's relationship with Jesus Christ. The agency of healing is the Holy Spirit, and the TC counselor's role is to be used by the Holy Spirit as a facilitator of this healing process. The

healing process is the process of sanctification. In TC, the conversion experience is the result of a non-believer becoming a believer, and by faith actively appropriating God's love and power to infiltrate every aspect of his being, thus enabling him to become a new person. In many cases, the student may already be a believer, but not one who is currently actively accepting God's love and power.

The TC emphasis on man's need to find meaning has not been formally written on in circumstances such as sexual abuse or other established precipitators of compulsive behaviors. For example, many TC students in the women's centers have a comprehensive understanding of the Christian faith in exercise and content. Moreover, they actively accept God's love and power, but find compulsive behaviors unavoidable due to precipitators which are often dysfunctional coping efforts. These are case in point examples of dual belief systems - these students have received and understand the relevant biblical information, but have not fully implemented (internalized) the teaching in certain areas of dysfunction. Future study should seek to clarify the function of meaningfulness seeking in coping behaviors and other factors presented by students, and then design intervention which can more quickly eradicate root causes.

The Question of Psychological Integration

Student counseling and education must involve areas of information to which the Bible does not directly speak. Often, counselors take training in counseling eating disorders, sexual abuse victims, sexually addicted, etc. This information is used to help contextualize biblical principles in these specific areas. These specialized areas of pastoral counseling generally involve the integration of psychological principles from various psychological disciplines and with varying philosophical underpinnings. TC embraces the appropriation of this information where it can facilitate discipleship. As a facilitating component of TC therapy, integration is seen in its proper perspective, as being in service to other more central components of the TC therapeutic process. Key: The balance of integration and discipleship is defined by the individual presenting problems of the student, and how integration can be brought in service to the discipleship process in the presence of the student's problems.

Christian discipleship is not realized in TC through strictly an integration focus utilizing psychological techniques which indirectly affect discipleship (Table 3 [1]); nor, a central God relationship by which integration techniques facilitate a discipleship life-style [2]; nor, a focus of pastoral counseling for a discipleship life-style [3]. TC therapeutically is [4] a God relationship where these different elements combine to facilitate growth in the God relationship. Integration techniques, Christian education, work details, pastoral counseling, and prayer and devotions are key areas in which the student is provided with relevant help to build the most conducive environment for the Holy Spirit's work.

Emphasis is, as stated in the therapeutic section, on Christian education whose content internalization is facilitated by different elements of the ministry including integrated psychology. However, integrated psychology generally plays a comparatively limited role in the ministry, while discipleship education is more central. Where it is appropriate for the student to be provided long-term integrated therapy, the appropriateness of the TC placement must be questioned.

One of the ways where confusion has existed in TC ministries is where ministries have implemented an integration focus. Integration focuses have previously made significant

differences in the program structure and operations of ministries. This focus concentrates on applying biblically consistent psychological dynamics through which the ministry endeavors to effect discipleship (represented in Table 3 [2] or [3]). On the other hand, TC focuses on discipleship, and calls on integration where it can facilitate understanding and internalization of discipleship issues. Hence, in TC, integration must clearly be viewed as the servant of discipleship, not the primary means to an end. Most Christian therapists would state that certainly the goal of any sound therapeutic process is discipleship. In TC, then, the distinction must be identified in those areas which are therapeutically distinctive, even when compared to other Christian therapeutic orientations. The distinctives of *how* we facilitate discipleship (delineated in the section, "Therapeutically").

TC recognizes and embraces the need for information which benefits from the integration of the Christian faith with biblically consistent psychological principles. It is the implementation of such information relative to the other components of TC which define the appropriateness of integration in the TC context.

The Question of Rehabilitation

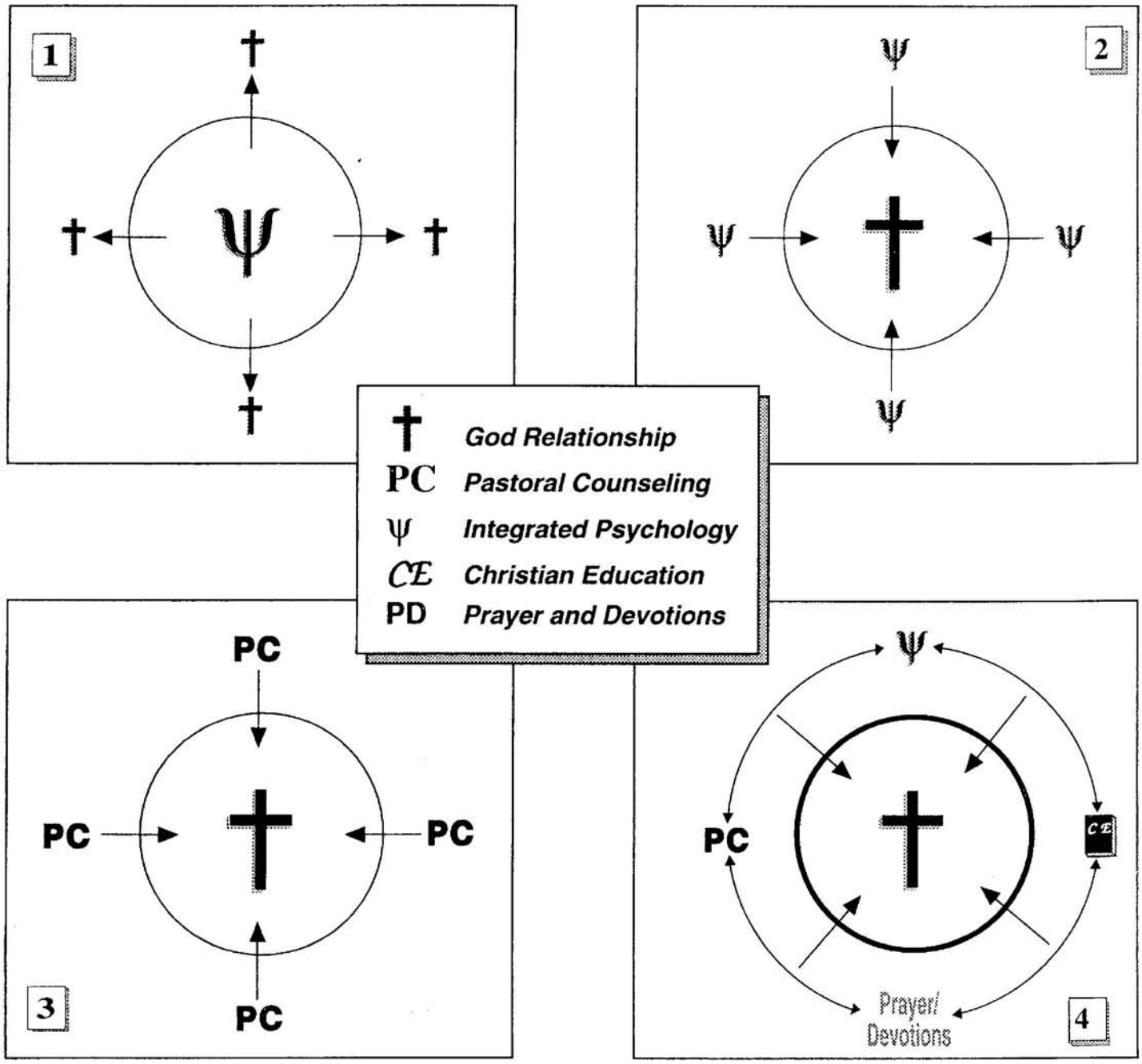
In Robinson's 1985 work, ". . . Program Effectiveness of Teen Challenge," Robinson describes the TC process as the client's movement from, "deviant to ex-deviant to non-deviant" (1985); or, other writers reporting on TC also employ wording which involves the movement of the client from an original state to a deviant state, and back to their original state such as non-deviant. These descriptions suggest that TC rehabilitates people. In rehabilitation, one is *re*turning to an original state such as non-drug use or non-purging for the bulimic. In TC, the final state of the client is *not* a return to a previous state except to the extent that particular compulsive behaviors have been extinguished to the level the client previously maintained as a non-user. However, the student has fundamentally changed to a completely new state significantly enough that the term rehabilitation is ill suited. *TC is a discipleship training environment.* So, rehabilitation is only to be thought of in TC as a return to an absence of compulsive behaviors. Cognitively, the TC client is different from any previous existing states in many ways.

In describing TC, Christian *habilitation* is a much more accurate term; that is, equipping the individual to do something he has never done before. This equipping affects behavior, world view, personal ethics, and relationships. Hence, the resulting cessation of destructive behaviors are not a return to a previous state, but an arrival to a new one. Discipleship training in TC is infinitely more than behavior cessation.

The Question of Drug and Alcohol Program

The Church provides the best analogy for TC. While TC has worked with many people in life-controlling problems, the TC discipleship material has also been used as church curriculum and in church youth groups. This raises an important distinction. The mission of TC ministries is identical in purpose to mainline evangelical churches: the evangelism and discipleship of people. (Indeed, some TC ministries are incorporated as churches, there are TC churches in numerous inner cities, and TC has mothered churches.) The distinction of TC is that its "congregations" are living with some type of life-controlling problem where a severity is present that traditional church intervention structures are not prepared to help.

TABLE 3



TC ministers as the Church in a unique situation. As a function of goals and counseling methodologies, TC is clearly a church, and it is here where comparisons are most fitting. TC students' deviant behaviors are sin, and part of the same process for *all* Christians as described in First John 1:8 which guarantees the presence of sin in the Christian.

The Christian effort, then, is sanctification, and the traditional church exists largely to facilitate this. TC is no different. The TC facilitation process is only distinct in the *types* and *frequency* of the intervention environment. Pastoral counseling seeks in both contexts to provide biblical information which brings the believer to a closer relationship with their Lord.

When working with life-controlling problems which involve substance abuse, TC finds that it is rarely singularly dealing with this issue. Rather, life-controlling problems typically come in sets. From a therapeutic standpoint, the issues of substance abuse are a component of other behaviors, and symptomatic of other causative issues (see Table 1). Consequently, by itself, the issues of drug and alcohol are a very small window with which to view the efforts of TC.

Given the three major thrusts of TC ministry represented in Table 2, we should recognize that area one is the only area where similarity can be drawn to traditional drug and alcohol programs because of the emphasis on counseling. Even here though, the counseling is very different based on intent and the other distinctives discussed in the therapeutic section. Further, neither general Christian discipleship training or Christian life-style involvement characterizes traditional drug and alcohol programs. In TC, students spend at least 20 - 30 hours per week in these latter two areas.

Presently the question is raised regarding the relationship of TC to the human services industry, especially as it is represented in drug and alcohol treatment programs. TC has been compared in literature repeatedly to these models. It is important to ask to what extents, if any, TC is a part of this therapeutic community. This question is especially important of late as certain state governments have insisted that TC is to be licensed by drug and alcohol treatment regulatory agencies.

Teen Challenge pastoral counseling focuses in areas of forgiveness to others, self forgiveness, repentance, faith, prayer, confession, fellowship, and a two-way metaphysical relationship. All of these components are realized through the Bible as the final authority in issues of conduct and exercise of the faith. The centrality of the religious relationship, the pastoral counseling which delves into at least the aforementioned areas, and the behaviors which are viewed strictly as symptomatic of failures in the God - man relationship is distinct to TC and the evangelical church.

By contrast, drug and alcohol programs deal with the problem in a number of ways, but seldom through a distinct and personal metaphysical relationship which all aspects of the program, directly and indirectly, singularly serve. It is interesting to note that there is a growing movement among mental health professionals in which the validity and value of spiritual experience are being recognized (Prasinos, 1992). If there is a correlation between effectiveness and spiritual experience, we expect to see the types of results reported by HEW (Hess, 1975). For TC to be numbered among these programs is a mistake, except in the limited measurements of behavior.

A number of TC ministries are licensed as drug and alcohol programs in their respective states. In such cases, states have looked at the type of people these ministries deal with, and viewed their effort as halting substance addictions through an "alternate program," or "non-traditional program." While this typically has not been problematic, legislation has changed in some states causing the TC ministry to move from some of its distinctives. The irony in one state where this occurred was that originally the state could not understand why TC should be licensed. Now they demand it. Often there has been a clashing of philosophies of treatment. Resultingly, TC centers have been forced to stray from their mission statement. A clear statement to agencies, especially regulatory, regarding what TC is should legitimately move TC away from being considered part of what drug and alcohol efforts are doing.

STRUCTURALLY

TC must be viewed from three perspectives in describing its structure: (1) An overall view of the Church, and TC's role for and in the Church; (2) a view which examines the overall ministry structure of the traditional five phases of TC; and (3) the program's structure as therapy.

The Church at Large

TC must be thought of as part of the Church, with trained ministers who specialize in ministry to acutely hurting people. Depending on the severity of their problem(s) and the capabilities of the local church to effectively intervene, TC intervenes at a number of levels where the church's resources are expired or incapable. This intervention preserves in whole the intent, process, and goals of the church because TC is the Church; that is, it evangelizes and facilitates sanctification in people. The level of pastoral counseling needed is dependent upon the severity of the problem. There are five types and/or levels of intervention the Church and TC can make:

1. Turning Point provides intervention through training and subsequent support groups, dealing with problems which can not always be dealt with using traditional pastoral counseling in the church.
2. Specific training is provided for the church by TC in pastoral counseling for intervention in life-controlling problems. Turning Point faculty hold seminars at churches where instruction is given to equip individuals to lead support groups. Moreover, support group members are trained regarding their own participation. TC currently has 600 churches using Turning Point in the United States (Lee, 1992).
3. The is a proposed twenty-eight day residential concept with a Turning Point after care. This would bridge the rather broad jump from Turning Point intervention groups to the one year residential ministry in TC.
4. The is a five phase TC system which generally comprises at least one year of residential intervention.
5. There are various TC inner-city churches.

The Teen Challenge Centers

Point four above represents the 120-plus primarily residential TC ministries which must be considered separately with regard to structure. These ministries generally begin with evangelism. Evangelism is a key and historical component of the ministry. In 1991, the 120 TC ministries recorded over 12,000 conversions to the Christian faith (National TC statistics, 1991). TC then provides crisis intervention for the convert, if needed; both residential and non-residential. Following, individuals are placed for three to four months in highly structured residential induction centers. After completing the induction phase, the student goes on for a minimum eight month stay at a training center. Some students go to re-entry for re-integration assistance.

The Residential Program Structure

Seeing the program structure itself as therapy is important to understanding TC. As a Christian discipleship ministry, TC finds therapy occurring in many components of the program. The daily schedule itself provides an overall environment conducive to change and Christian

growth. It also occurs in work details and experience, chapel services, recreation, meals, personal counseling, groups, prayer, meditation, Bible study, discipleship classes, and the TC curriculum - all are integral therapeutic contexts for Christian sanctification. Many TC ministries have comparatively little one-on-one formal counseling sessions or groups, but therapeutic ends are constantly being facilitated by other means which further distinguish TC from other models of intervention.

In summary, TC is structured to allow flexibility in ministering to needs. Where residential care is needed, TC offers a well developed five phase discipleship training program; or, a combination of residential and support group ministry are represented in the proposed twenty-eight day model.

THEOLOGICALLY

This is not a theological document. However, given the purpose of Teen Challenge, it is necessary to identify Teen Challenge theologically. TC adheres to an evangelical statement of faith. TC is interdenominational. The basic doctrines regarding salvation and discipleship are common ground among evangelicals and even mainline denominations. Further, the teaching in the TC curriculum is not on denominational distinctives but biblical life-style (TC Curriculum author Batty, 1992). Many students come from distinct theological traditions and return to them (Batty, 1992)..

Given harmony with the TC Tenets of Faith and that TC discipleship content is not on denominational distinctives but biblical life-style, TC is a context where evangelicals of different stripes can largely co-minister. Resultingly, today many denominations are represented at all levels of TC.

TC believes in and relies upon the power of the Holy Spirit to transforms the lives of students. The pastoral counseling training for staff is to assist them in applying biblical principles to the student's situation.

Deliverance theology has provided contradiction for some because of the designed long term nature of both the residential and non-residential TC ministry. Theology which prescribes time in place one-time experiences for complete eradication of life-controlling problems is embraced by TC as possible within the sovereignty of God, but it is not a normative ministry experience of TC. At the same time, TC views the progress a student makes as characterized by ongoing supernatural Divine intervention. Where deliverance does occur, the need remains to teach the student the new Christian life-style through discipleship training. Deliverance alone is not the sign of Christian maturity.

A THERAPEUTIC EXAMPLE: FORGIVENESS

This section serves as an example of the types of training which needs to be developed once the therapeutic model has been identified and agreed upon for Teen Challenge. The

"Forgiveness" teaching should be followed up with practical steps for the TC counselor to assist in facilitating this process in students.

To be an effective TC (pastoral) counselor one must have an in-depth knowledge of forgiveness. This includes the stages of forgiveness, the factors affecting the ability to forgive, and the common errors in facilitating the forgiveness process (Rosenak, 1992). Forgiveness is used to excuse, condone, pardon, release, and trust (Veenstra, 1992). Through forgiveness we grow in grace and experience the unconditional and unending love of God (Wahking, 1992).

Secular psychology has not dealt adequately with this topic (Shontz and Rosenak, 1988), but it is the effect of Christ's work on the cross, and therefore central to the Christian message. A TC student may have trouble receiving forgiveness, giving forgiveness, or both. It is essential that the TC counselor identify this problem and address it appropriately. The practice of giving and receiving forgiveness is vital for the student's spiritual growth. Forgiveness work is as essential to spiritual growth as is worship, Bible study, prayer, and spiritual direction (Wahking, 1992).

There are many commonly recognized stages of forgiveness (Linn and Linn, 1978). These are the hurt stage, the anger stage and the information seeking stage. There are additional stages involved if reconciliation as well as forgiveness is sought (Rosenak, 1992). The stages may be worked through in a day or it may take years, depending on the offense.

To be aware of the anticipated stages in the forgiveness process is to be able to assess the student's stage of growth and the levels of growth yet to be achieved. To accomplish forgiving, most individuals need to move through certain emotional states regardless of who the offending party is and regardless of the depth of the hurt incurred. Very frequently forgiveness involves the family of origin, especially parents.

The hurt stage. Some students are aware of the origins of their emotional wounds while others evidence denial about the reality of the hurts, or the situation of the hurt may be repressed and the student have no actual memory of it (frequently seen in sexual abuse). A female student may express dissatisfaction with herself generally, and occasionally approach self hate. In exploring this, the counselor may find the student talking frequently about the lack of parental support, approval, and nurturing in her childhood and of late. She may perceive that her parents have nothing to do with her current self image. The offense is not even recognized; vague hurt feelings are present, but they are not yet connected to their source.

The Blessing, by Gary Smalley and John Trent (1986) is appropriate to help students understand traits of functional families. Through this, the student may begin to identify her feelings with her family.

Some students will come already in the hurt stage, but feel hopeless that anything can be done to alleviate the pain. They may also be unwilling or unable to move into the anger stage because of their fear of dishonoring their parents. Others may be fearful of their parents continued ability to hurt them.

The anger stage. Job was angry with God regarding his trials (7:11). God never specifically reprimanded Job for his anger. Job's willingness to confront God with his anger may be a testimony of the depth of his faith in God. However, in the case of parents, it is difficult for a student to forgive before dealing with the truths of their shortcomings. When they try to, it is false, and feels that way.

Students need assurance that anger expressed by them in counseling will not hurt their parents. Strong self esteem seems to facilitate the ability to express anger, and this is a necessary stage in the student applying forgiveness.

The information seeking stage. In the information-seeking stage it becomes painfully necessary for students to gather information about the offender so that they can understand the shortcoming of the offender. When sought at the proper time (after the anger stage) this information is helpful in facilitating forgiveness. Once the student recognizes his or her own hurt and pain, it becomes easier for the student to see denial and rationalization concerning their offenders. This can create empathy for the offender, which paves the way for true forgiveness.

There are a variety of variables which will mediate the student's movement through the stages. For example, the passage of time is able to heal wounds, which become scars, and healing has taken place. Sometimes passage of time and unforgiveness lead to even deeper bitterness and resentments.

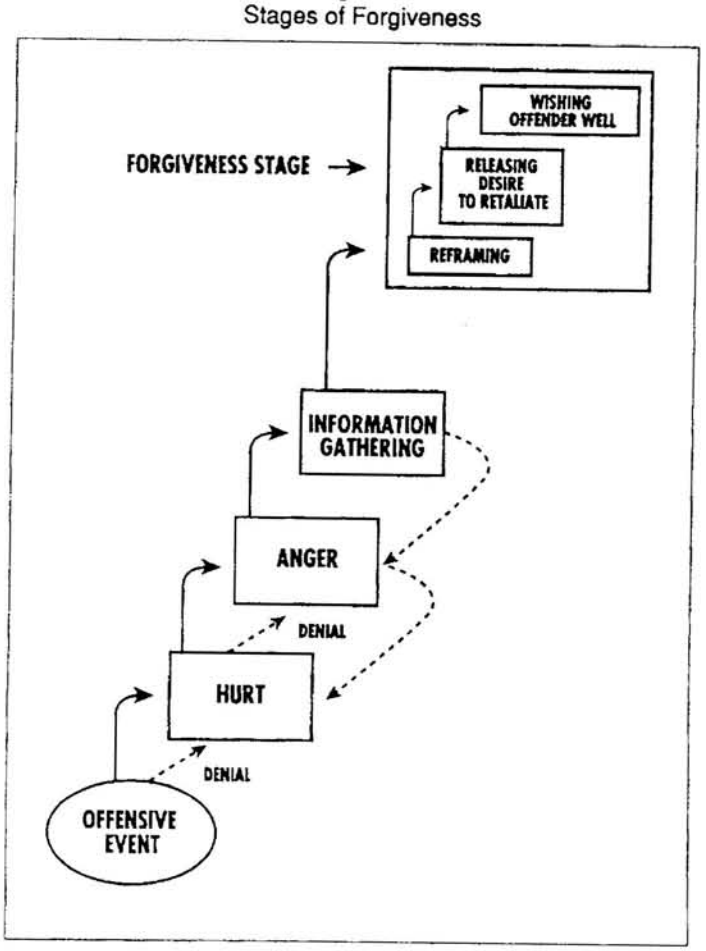
There are eight factors which relate to the ability to forgive (Rosenak and Harnden, 1992):

1. Severity of the wrong.
2. Whether the offender acknowledges the offense.
3. Whether the hurt was intentional or unintentional.
4. The frequency of the wrong.
5. Whether the offended person is committed to the individual who offended them.
6. Ego strength of the offended person.
7. The decision to forgive.
8. The student's personal history with forgiveness.

This section on forgiveness is dealing with primarily psychological issues in forgiveness. A biblical teaching on the subject should precede this section in an actual training document. For example, other important factors which should definitely be pursued with the student are prayer and fasting, and the seeking of divine intervention. We cannot predict which way the Holy Spirit will move nor when (John 3:8). God answers prayer (Matthew 7:7) and God has intervened in the minds of persons (Exodus 10:20). Table 4 outlines these areas:

Table 4

Stages of Forgiveness



There are a number of things the TC counselor will want to avoid when facilitating forgiveness. The decision to forgive is not necessarily forgiveness, but it is an important beginning. After this decision, it may be necessary for the student to go through a process of grief. In Hosea 11:8-9 we see God grieving over the unfaithfulness of Israel. A student who states that he or she has completely forgiven based on a decision to do so may still be seeking revenge or retribution. This is a sign that forgiveness has yet to take place. Another mistake is to try to get a student to forgive an offender before issues of self-esteem are resolved. Forgiveness is not to be confused with toleration of sin. When the Pope forgave the gunman, it did not follow that the gunman was released from jail. When forgiveness is seen as toleration of sin this is often a sign of codependence (Rosenak, 1992).

"You will know that forgiveness has begun when you recall those who hurt you and feel the power to wish them well" (Smedes, 1984).

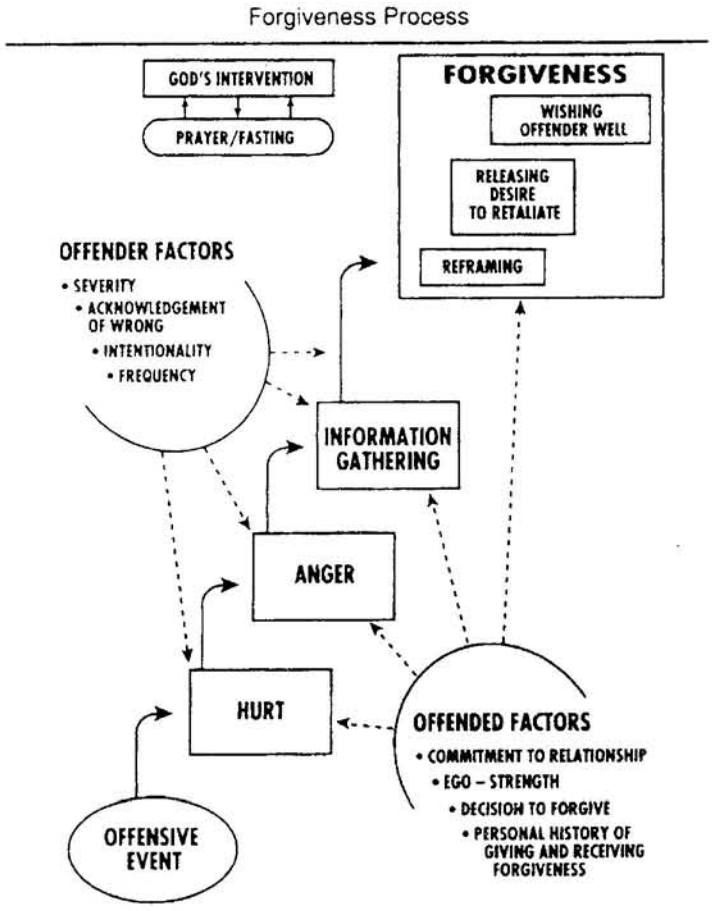


Table 5

Review of Secular Literature

Purpose

The following literature review reflects articles which generally seek to describe efficacy in traditional drug and alcohol programs. Taken together, this literature provides a description of these programs. This description when considered relative to the previous sections of this document, further distinguishes TC from these types of programs.

Factors Related to Success or Failure in Treating Chemical Dependency

Success Factors

One of the major factors related to the success of most rehabilitation programs is the length of stay. In a review of current literature, Allison and Hubbard (1985) found that a longer amount of time in treatment was associated with more favorable outcomes. In fact, Charuvastra et al. (1992) identified the length of time in the treatment program as the primary determinant of success or failure in a study of military veterans with chemical dependencies. One of the reasons why the length of time in therapy is important is because patients who leave treatment early do not receive the full benefits of the program (Gottheil et al., 1992). These benefits were demonstrated by McLellan et al. (1982) who showed a significantly better outcome for patients who stayed in treatment longer in the areas of employment, abstinence, legal status, and psychological functioning. A change in lifestyle is also essential for continued abstinence. Marlatt and Gordon (1985), for example, suggest exercise as an alternative to using drugs. Exercise seems to have a positive influence on self-concept, which is instrumental in promoting a change in behavior (Brownell, Marlatt, Lichtenstein, & Wilson, 1986). Regardless of the method used, therapy is most successful when the patients are able to change their lifestyles once they leave treatment (Page & Mitchell, 1988). Consequently, recovery is a continuous process which involves continuous commitment to building a healthier and more fulfilling lifestyle (Prezioso, 1987).

In a nonempirical article, Lefever (1992) suggests that an addiction is a disorder of mood, and that the success of the Twelve Step program can be attributed to self-regulation of mood. This reinforces the need for a change in lifestyle during treatment.

Many researchers insist that rehabilitation is a family process (Feigelman, 1990; Sandberg et al., 1991). McLellan et al. (1986), for example, found a minor relationship between being married and success at follow-up. Conversely, Charuvastra et al. (1992) identified a relationship between longer average stay and patients who were separated from their spouses. This seems to indicate that problem marriages are a source of stress for the addict, and drugs or alcohol provide a way of escaping. Even though social factors are a crucial part of changing behavior, variations in these relationships make it unlikely that any single approach will be appropriate for each individual (Brownell et al., 1986). It is clear, however, that family involvement maintains treatment in the natural environment and reinforces the client's social support system (Siddall & Conway, 1988).

Kosten, Rounsaville, and Kleber (1986) found that patients were more successful reentering the program after a brief amount of time out of therapy. This may give patients the opportunity to establish an internalized incentive which Miller (1991) identified as essential for

success. Utilizing a single treatment program does, however, allow the patients to position themselves within the program (Yohay, 1986).

The motivation for seeking treatment may also be an important component of success. Legal pressure serves as motivation for many patients to successfully complete treatment (Sandberg et al., 1991). In fact, Siddall and Conway (1988) found that involuntary admission, associated with criminal justice involvement, differentiated successful from unsuccessful clients.

Sustained employment significantly improves the potential for success because it is another form of motivation for many patients (Siddall & Conway, 1988). In their review of the literature, Allison and Hubbard (1985) found that having a job was one of the strongest correlates of long-term success. It should also be noted that by the virtue of their employment, these patients are likely to be more socially stable and have less severe problems (Miller & Hester, 1986). When treatment is necessary, however, compulsory hospitalization combined with A.A. meetings is the most cost productive and successful option for employers who want to help their workers (Walsh et al., 1991).

The large number of factors relating to treatment success makes it hard for any program to be inclusive. However, Lefever (1992) suggests that it is possible to integrate spiritual principles, human behavior, neurochemistry, and genetics into the treatment process. This gives the patient the best chance of being successful.

Failure Factors

Ferrell and Galassi (1981) indicate that without some form of follow-up treatment and environmental modification, relapse is likely to occur. Therefore, treatment programs should be designed so that patients do not drift away from the treatment facility (Leukefeld & Tims, 1989).

Patients with psychiatric problems may not benefit from treatment regardless of the length of stay (Gottheil et al., 1992). The psychiatric stability of the patient has been identified as the most important characteristic of patient treatment for a successful outcome (McLellan et al., 1986; McLellan et al., 1982).

In an analysis of relapse prevention, Brownell et al. (1986) identified a number of variables which related to treatment failure. The first of these was individual and intrapersonal factors. These factors include negative emotional states, inadequate motivation, initial response to treatment, and coping skills. The second category was any physiological factor. The third, and last, category was environmental and social factors, which includes social support and environmental stimuli. These three areas combine and interact to determine the probability of failure.

Early Dropout Factors

Early termination of treatment can be a serious problem for any rehabilitation program. This problem was addressed by Allison and Hubbard (1985) who suggest that there is a minimal length of time which must be spent in treatment before the program can be effective.

Leaving treatment early is an important component of any research in the area of rehabilitation. Gottheil, McLellan, and Druley (1992) limited the ability to generalize from their study on length of stay because the patients had not been treated in a program designed for short-term stays. It is very likely that the patients in these two groups would differ significantly in motivation, and this may be an important part of the treatment process (Leukefeld & Tims, 1989).

Feigelman (1987) discovered a number of factors relating to treatment completion. Some of the things that increased success were: age, ethno-religious identification, higher occupational

status of the father, self-referral, being the only child, and mutual parental concern. The factors that decreased success were: parental drug abuse, criminal records, and depression.

Charuvastra et al. (1992) identified some important trends in the age and race of individuals who enter treatment. In 1973 the majority of patients were single, White, and between the ages of 18-25. In 1985 the typical patient was age 30 or older, and had an even chance of being from a minority or Caucasian heritage. Stark (1992) indicates that lower social class status positively correlated with dropout. If these findings are compared with Feigelman (1987) a shift can be identified in drug and alcohol abuse. The target population seems to be expanding toward lower class minority groups.

Patients entering the program through a slow intake procedure are more likely to drop out than those receiving rapid intake (Allison & Hubbard, 1985). Clients that receive rapid initial response, individual attention, continuous care, and small group interaction tend to continue in the treatment longer (Stark, 1992). This process should be reinforced by maintaining a friendly and comfortable environment. One of the most important factors in preventing attrition is a clinician who is committed to the patient's success (Stark, 1992). Sansone (1980) found that retention rates could be improved by focusing attention toward the patient during the early stages of treatment, especially when dealing with women, adolescents, and Hispanics. This commitment, however, may involve giving the patient a certain amount of autonomy. Miller & Hester (1986) suggest that patient in less staff-intensive programs will demonstrate greater improvement.

Allison and Hubbard (1985) found that patients exhibiting psychological disturbances, especially depression, were more likely to leave treatment early. This parallels the findings of many researchers who have identified psychological state as the most important predictor of treatment success (McLellan et al., 1986; Gottheil et al., 1992).

Craig, Rogalski, and Veltri (1982) identified a number of variables that effect treatment dropout. One of these variables was the time of day in which the client was admitted. Patients who complete treatment tend to be admitted during the evening. It was also found that attrition rates increased whenever a large number of patients were admitted during a short period of time. No explanation was given for the effects of these two variables by Craig et al., but it could be that the patients in these groups received a greater or lesser amount of individual attention, respectively, by the staff (Allison & Hubbard, 1985; Stark, 1992).

In a similar study, Siddall and Conway (1988) associated involuntary admission, family involvement, social support systems, and employment at discharge as variables related to retention. Patients who are employed at the time of admission have significantly higher completion rate and a longer length of stay compared to those that are unemployed (Novick et al., 1987).

In a review of recent literature, Stark (1992) noted that a younger age can be moderately associated with failure to complete treatment. Other variables which were related to leaving early were social isolation and socioeconomic status. Consequently, including the family in therapy and making treatment less expensive may increase retention rates by increasing treatment accessibility to low income individuals. It was also noted that attrition and retention may also be influenced by severity of addiction, forced admission, psychopathology, and client expectations.

Less impaired patients may actually find it beneficial to leave treatment and reenter later. At reentry, patients tend to function better than when they first sought treatment (Kosten, Rounsaville, & Kleber, 1986). Sansone (1980) also indicates that patients are better prepared for treatment at readmission. However, Stark (1992) notes that patients may not necessarily return more prepared for treatment. His review of literature indicates that patients have as good a chance of completing their first treatment episode as they will of completing any additional therapy.

Model Therapy Plans

The goal of any treatment program should be to modify destructive behaviors. De Leon and Rosenthal (1979) suggest that this must be accomplished through a lifestyle change which eliminates drugs and anti-social behaviors, and develops employable skills, self-reliance, and honesty (cited in Allison & Hubbard, 1985). As we saw earlier, it is important for the program to be long enough to accomplish these goals (Page & Mitchell, 1988).

Admission Screening. Since there are a number of important factors in treatment success, careful screening is necessary to identify individuals that could benefit from short-term treatment. McLellan et al. (1986) found that demographic information cannot be used to predict the post-treatment outcome. In a similar study, Craig (1984) found that personality tests were not reliable in predicting which patients would successfully complete treatment. However, McLellan et al. (1986), and later Gottheil et al. (1992), discovered that the best predictor of patient success was the psychiatric severity rating on the Addiction Severity Index (ASI). It should be noted that McLellan developed the ASI and was involved in both of these studies.

In TC the issue of screening is quite different. Prediction of post-treatment outcome is based on the individual's desire to look to Christ for help; and, in many cases, TC simply admits anyone desiring help and who is willing to follow the rules of the ministry. As TC directors increasingly rely on instruments in their treatment process, they should take note that these instruments seem to be of little use in predicting outcome.

Psychiatric severity is an important issue in the development of a rehabilitation program. McLellan et al. (1983) identified greater pretreatment psychiatric severity with poorer outcomes in every case. In an earlier study, McLellan et al. (1982) found that patients who could make it through treatment usually had an improvement in their psychological functioning. Therefore, the screening process is an important part of targeting the addicts for a therapy plan that will fit their needs and focus on the individuals with the greatest chance for success (Brownell et al., 1986).

Gottheil et al. (1992) measured the effects of psychiatric severity in a program with a recommended 90 day length of stay. With an average stay of 47 days $\pm$ 40 days, it was found that the low and mid severity groups showed much more improvement than the high severity group. Therefore, some type of selective admission may be necessary to utilize a short-term program effectively. In that many TC ministries have not dealt with patients who are emotionally disturbed, this selection is already in place.

A crucial part of the evaluation process is screening for patient suitability. This is the stage where identifying motivation is important, because there must be a match between the client's aspirations and the objectives of the program (Miller, 1991). For any program to be effective the patient must be committed to change (Brownell et al., 1986). In TC again it is noted that the implementation of our admission process does not formally ask this question. Many

ministries merely determine the student's willingness to abide by the rules and work with the student.

Client screening and intake should be guided by the history of the patient, including length of drug use, type of use, and any other related variables (Leukefeld & Tims, 1989). Intake screening and evaluation provide a good opportunity to develop an individualized plan for each patient. In fact, a dual diagnosis may be necessary for effective treatment (Sandberg, Greenberg, & Birkmann, 1991).

Identifying individuals who will benefit from each particular program may be difficult. The importance of this process was emphasized by Sandberg and Conway (1988) who found that admission screening could reduce the probability of premature termination. Their plan includes assessing motivation, close supervision, and treatment induction training for the client and their family. The ASI has been widely utilized as a tool for evaluating the condition of the patient, most importantly their psychiatric stability (Gottheil et al., 1992; McLellan et al., 1986).

Individualizing the Program. It is important to understand client motivation and decision making in the treatment process. Part of this process involves professional education and inservice training to discuss new concepts and put them into practice (Leukefeld & Tims, 1989). This insures that each therapy plan can be individualized, and the strengths of each patient can be developed properly (Miller, 1991). This process includes assessing and developing the social skills of the client (Ferrel and Galassi, 1981). Miller & Hester (1986) suggest that treatment methods for each patient can be determined by social stability and the severity of the addiction. In addition, individualizing each therapy plan will make it possible to keep a patient in treatment the shortest amount of time possible (Sansone, 1980).

Patients that fall into a high psychiatric illness group may not benefit from any form of treatment (McLellan et al., 1983). Sandberg et al. (1991) identifies four treatment methods which are dependent upon the psychiatric severity of the patient. These therapy plans generally consist of four groups:

1. The first group is a primary psychiatric diagnosis group in which a disorder has preceded any significant chemical dependency. These patients would benefit the most from inpatient psychotherapy, outpatient psychotherapy, pharmacotherapy, and A.A./N.A. meetings.
2. The second group is the addictive disease group, and it is designed for patients who have developed a significant chemical abuse problem. This group should be involved in a 14-21 day rehabilitation program, outpatient drug counseling, and A.A./N.A. meetings.
3. The third group is the antisocial behavior group. The chemical abuse or dependence for these patients is complicated by a life-style characterized by antisocial behavior. Individuals in this group would benefit most from involvement in a residential therapeutic community, outpatient drug counseling, and A.A./N.A. meetings.
4. The final group is a mixed group consisting of patients with a combination of chemical dependency and some type of fragile personality disorder. Treatment for this group must be developed specifically for individuals with a dual diagnosis, and therefore it will vary.

McLellan et al. (1983) suggests that, from a practical perspective, it may be beneficial to recommend outpatient treatment for low-severity alcohol and drug abusing patients. It was also indicated that for this group, non-abstinent goals may be possible. In a review a 16 studies on inpatient therapy, Miller & Hester (1986) found that residential care did not have superior results over less expensive treatment alternatives. However, De Leon, Wexler, & Jainchill (1982) found a relationship between residency in the therapeutic community and client status at follow-up.

Spiritual Implications

The spiritual side of rehabilitation should not be overlooked when examining the factors relating to success. Since spiritual pursuits and addictive behaviors are frequently associated with altered states of consciousness, a deep spiritual life may fill the void left by the absence of the addictive substance. Therefore, patients should attempt to be in touch with their spiritual needs as part of the treatment process (Marlatt & Gordon, 1985).

Prezioso (1987) contends that addictions are spiritual as well as physical. Therefore, spirituality is the key to any successful treatment and recovery. He feels that an addiction is an attempt to be one's own god. Recovery in this context includes establishing healthy relationships with self, others, and a higher power.

Prezioso (1987) suggests six treatment components to emphasize the spirituality in rehabilitation. The first is periodic inservice training on the subject of spirituality and its relationship to rehabilitation. The second is a staff discussion group which meets once a week. Third is a series of three lectures, one week apart, which spurs discussion among the patients on the subject of spirituality. The fourth component is a weekly discussion group for patients centered on values, control, higher powers, honesty, responsibility, and vocation. The fifth is a weekly presentation for family members to familiarize them with the subject. The last component is an individualized therapy plan which addresses the issues facing each patient.

Life skills Development. Identifying and developing the social skills available to addicts is also important for success (Ferrell & Galassi, 1981; Siddall & Conway, 1988). Miller (1991) found that identifying the strengths, resources, supports, and coping skills already available to the patient was essential so a base could be formed from which new skills could be established. The difficulty in implementing these types of programs is that social and work skills, values, and community involvement are best approached in their natural settings and not in treatment (Peele, 1990-91).

It may be necessary, however, to encourage patients with severe psychosocial problems to remain in treatment longer so these skills can be fostered (Kosten et al., 1986). More severe and less socially stable patients seem to do better in more intensive inpatient therapy. Patients who are socially stable may not benefit from this type of inpatient treatment (Miller & Hester, 1986).

The importance of employment to successful treatment seems to imply that vocational rehabilitation should be an integral part of any treatment (Allison & Hubbard, 1985). A successful treatment program may actually improve the employment opportunities for the patient (McLellan et al., 1986).

Follow-Up Procedures. Each program should have a designated system of follow-up therapy (Leukefeld & Tims, 1989). Van Meter and Rioux (1990) have found that by utilizing a definitive aftercare plan, developed to fit each patient, they can reduce the length of stay, increase abstinence, and help adolescents stay current in school.

Miller & Hester (1986) found that regardless of the length of treatment, there was a positive correlation between improvement and participation in outpatient aftercare. Brownell et al. (1986) placed a similar emphasis on a maintenance phase of treatment. This phase should include continued monitoring, social support, and general lifestyle changes.

Long-Term Treatment Plans

The traditional method for substance abuse treatments has been long-term inpatient therapy. Yohay (1986) contends that the 12 to 15 month ACI program in New York has an 85%

success rate for their graduates. Statistics like this seem to support the effectiveness of these programs.

Simpson (1979) found that patients who spent less than three months in treatment were not significantly different from the patients that only went through detoxification. A similar study by Bale et al. (1980) arrived at a similar conclusion, but their findings indicated that 50 days was the cut off for minimal amount of treatment. A number of studies have supported the idea that longer treatment was associated with more favorable results (Allison & Hubbard, 1985). This reinforces the conclusion of Page & Mitchell (1988) who noted that programs need to be long enough to accomplish their objectives.

Sandberg et al. (1991) suggests that patients with antisocial behaviors may benefit the most from long-term inpatient therapy. Patients in this group usually have an onset of chemical abuse early in life. Therefore, these programs should utilize encounter group therapy, with educational and vocational components.

Short-Term Treatment Plans

Weddington, Brown, Haertzen, and Cone (1990) reported that 28 days of abstinence for cocaine addicts, was sufficient for steady improvement in mood states, craving, and sleep. Miller (1986) suggests that very brief interventions may fulfill the necessary requirements for change in the patient.

For patients who are trying to maintain employment, short-term treatment may be the only alternative (Walsh et al., 1991). Similar restrictions may be placed on an adolescent in school. Properly structured short-term inpatient treatment, however, should be effective when it is coupled with follow-up therapy (Van Meter & Rioux, 1990).

Prezioso (1987) developed a program specifically designed for 21-28 day treatment programs. The key to recovery in this program is a spiritual healing as well as physical healing. Since the addiction can become a type of god to the addict, a spiritual healing can serve as a replacement for a long treatment program. It should be noted, however, that no empirical evidence was given to support these conclusions.

In a study comparing a six-month outpatient program and two short-term inpatient programs, with an average lengths of stay of 31 and 28 days, McLellan et al. (1986) discovered that all three treatments were effective in reducing drug and alcohol use, and that more treatment was generally associated with more improvement. Improvement was also noted in the areas of employment, illegal activity, and psychiatric status. In addition, the diversity in treatments and patients strengthens the generalizations made through these findings.

Comparison of Long-Term and Short-Term Plans

Charuvastra et al. (1992) compared a one-year program to a three-month program and found that the longer treatment had a 21% lower failure rate. The short-term treatment in this study had a 53% success rate six months after release, and the long-term treatment had a 74% success rate after six months. The same percentage of abstinence was found in a six to twelve month follow-up survey by Van Meter and Rioux (1990), but their 74% success rate came from a 21-day intensive intervention program for adolescents. Their treatment was equally as effective in producing abstinence, and required less time in therapy. Part of the success of this program was attributed to decreasing the stress of these adolescents by keeping them current in school, and keeping them involved in outpatient therapy.

A similar intensive short-term program may also be a reasonable alternative to employers that want to help workers who have a substance abuse problem. Walsh et al. (1991) compared

the effectiveness of three therapy options for workers who were recently identified as alcohol abusers. The therapy methods used were compulsory inpatient treatment, compulsory A.A. attendance, and a choice of options. Six months after treatment the short-term inpatient therapy was found to be more cost productive and successful in stopping alcohol and drug use than outpatient treatment only. These types of programs make it possible for some individuals to maintain employment while getting treatment.

It is clear that completing the rehabilitation program, regardless of length, is an important component of success. Consequently, treatment programs should be long enough to allow the goals of the program to be achieved (Page & Mitchell, 1988). Patients who stay in these programs longer will benefit the most from the treatment (Simpson, 1979).

Miller (1986) clearly indicates that there is a variety of treatment options open to an individual with a chemical dependency. The effectiveness of each program will ultimately be dependent upon the history and behaviors of the patient (Sandberg et al., 1991). The lack of information comparing the effectiveness of long-term and short-term treatment clearly illustrates the need for research in this area.

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