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Addiction Treatment and Recovery Mutual Aid in Greece: An interview with Dr. Phoebus Zafiridis

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Phoebus Zafiridis, M.D., is a social psychiatrist and founder of the Therapeutic Community "ITHACA" (1983), the Therapy Center for Dependent Individuals (KETHEA, 1987), and the Self-Help Promotion Program of the Department of Psychology at the Aristotle University of Thessaloniki (2000), where he currently serves as a scientific supervisor. From 1995 to 2013, he served as associate professor of the Department of Psychology of 'Aristotle University of Thessaloniki' (AUTh), where I taught the courses of 'Clinical Psychology of Addictions' and 'Humanistic Psychology Psychotherapy'—the first time these courses were taught at a Greek university. He was the founder and director (1997) of the first postgraduate program (Master's Degree) in Greece in the field of addictions—a program of AUTh entitled 'Social Clinical Psychology of Addictions'. He has served on the Executive Council of World Federation of Therapeutic Communities (WFTC) and the Board of Directors of European Federation of Therapeutic Communities (EFTC). Dr. Zafiridis is the author of *From Daytop to Ithaca* (1990) and *Addictions and Society: Therapeutic Communities, Self Help Groups* (2009) [in Greek]. In early 2017, I had the opportunity to interview Dr. Zafiridis about his evolving views on the treatment of addiction and the history of addiction treatment and recovery support in Greece. Please join us in this engaging discussion.

Background

Bill White: How did you come to devote your professional life to working in the addictions arena?

Dr. Zafiridis: My first contact with the field of addictions was very coincidental. It was in 1978. I was living in Western Germany at the time, specializing in Social Psychiatry, which was a very radical and innovative approach to mental health problems in Europe. It was a movement relevantly similar to the Community Psychiatry movement in the US. This is how I came to work in a federal pilot program for Social Psychiatry in Saarland. Along with the 13th District project in Paris, these were the only cases where this new approach was being applied in Europe. Within this new wave, and for the first time in the history of psychiatry, psychiatric morbidity was directly associated with social and economic factors. The program I was working in was based on the Psychiatric Reform of Franco Basaglia in Italy, the anti-psychiatry movement of David Cooper, Ronald D. Laing and Thomas Szasz, as well as Humanistic Psychology, which was a rather innovative field in Europe. Meanwhile, this program integrated many elements of Community Psychiatry. The new approach to psychiatric and psychological treatment was mainly applied in the psychiatric sector, which provided care for about 200,000 people.

This whole new understanding of the organization of mental health services aimed at abolishing confinement in mental asylums, psychiatric repression and violence, all of which had been common practice in conventional psychiatry since its inception. The psychiatric unit was responsible for primary, secondary and tertiary prevention, which meant prevention, treatment and rehabilitation of psychological and psychiatric disorders. For this, there was a central interdisciplinary crisis-intervention unit, surrounded by various psychiatric and psychological support structures, which aimed to respond to all mental health problems for people living in the area. The use of electroshock was out of the question and psychiatric medication was used sparingly. Conversely, humanistic psychology was the main treatment approach adopted in all cases, including acute psychotic episodes.

Social (Community) Psychiatry held that, for the most part, psychological problems derive from work stress, competiveness, egocentrism and a lack of real interpersonal relationships. Thus, as far as prevention was concerned, interventions were planned and applied in workspaces, schools and disadvantaged neighborhoods, in order for things to change. This radical humanistic perspective profoundly affected my scientific and professional career. This is why I mentioned the circumstances of my early professional psychiatric career, where I gained experience in addiction treatment.

During my training I had to work for about a year in the Center for Physical Detoxification and the Therapeutic Community. This was part of my medical rotation, which was obligatory for all interns. I was not interested in working in addiction at that time, as I knew

that in Greece, where I would return once my training was over, drug abuse was rare and there was still relative restraint within alcohol abuse in that society.

Bill White: So how did you finally decide to work professionally in the field of addiction? When did this happen?

Dr. Zafiridis: In 1982, after I returned to Greece and while I was working in the Athens Child and Adolescent Psychiatric Hospital, the Ministry of Health asked me to develop an innovative program, knowing about my experience in the addiction treatment field. In Greece, up to that time, addiction had been exclusively treated with psychiatric medication after voluntary or forced confinement of the user in psychiatric asylums. When I returned from a 45-day educational trip to Holland, Switzerland and Germany, which included my visiting various therapeutic programs, I submitted my proposal.

What I proposed was the creation of a multiphase "drug-free" pilot therapy program, something like a therapy chain. The first stage was the Counseling Center (Introduction Center), which aimed at bolstering the user's motivation and informing them about how the program worked. Then came the Center for Physical Detoxification, where the users could stay for a maximum of 30 days. This was followed by the Therapeutic Community— open or closed, depending on the case— where the user could spend a maximum of 12 months. The final stage was the Rehabilitation phase, where the users could also spend up to 12 months.

The Ministry of Health accepted my proposal and in September 1982 I was asked to take charge of its implementation. The preparation, search for a site and staff training lasted about a year. In August 1983, the first stage of our program began with the opening of the Introduction Center and the Detox Center. The latter was closed down a few years later, when we realized that withdrawal syndrome was not an actual problem and that it could be treated as effectively in the Therapeutic Community, without the use of psychiatric medication.

In November of that same year, we inaugurated the first Therapeutic Community in Greece, on a farm that was allocated to us by the Ministry of Health for this specific purpose. I proposed to the members and staff that we call this Community "Ithaca", inspired by the eponymous allegorical poem by the Greek poet Constantine Cavafy. Ithaca is worthwhile read for any human being wishing to reflect on the course of their life (see the link where Sean Connery reads Cavafy[1]). One year later, the Social Rehabilitation stage was also servicing users. This program worked as a pilot program for 4 years. In 1987, after the positive results coming out of its evaluation, I submitted a proposal for the creation of an independent public organization called KETHEA- ΚΕ.Θ.Ε.Α (Therapy Center for Dependent Individuals). The aim of this organization was to create

[1] https://www.youtube.com/watch?v=sl3uKXU6VLI

multiple "drug-free" therapy programs all around Greece, which would respond to the country's increasing demand for treatment.

Bill White: Back to the 1980s when you worked in the addiction field. How is this specialty viewed by other academics and service professionals in Greece?

Dr. Zafiridis: At that time, very few health professionals and even less academics in Greece, could see themselves working in the field of addiction treatment. For most of them, drug addicts were doomed criminals, who stand no chance of curing themselves and that would spend the rest of their lives going in and out of prison. So health professionals saw themselves as managers of an incurable medical disease. They deeply believed that addiction was incurable, at least until adequate medication would be discovered.

I remember that the day when we announced the opening of our program and especially of the Therapeutic Community ITHACA, in 1983, many colleagues told me that I was crazy to start up such a venture- especially when it's based on the experience of former addicts. These people freaked out just by the mere thought that one could ask former addicts their opinion on what helps people fight addiction, because, for them, addiction was a path of no return. They believed that the only thing that a health professional could do was manage the problem by prescribing big amounts of psychiatric medication, tranquilizers and substitutes, according to the dominant scientific approach of the time. It is thus obvious why most psychiatrists were not willing to work in our program. The only exception was Giorgos Bardanis, a young psychiatrist who had just finished his internship. He's the one who directed successfully the open (no stay) Therapeutic Community "Strofi", in 1988. Strofi was part of KETHEA was the first community globally which was addressed to adolescent addicts and showed very good rehabilitation results.

Bill White: And how did they react later?

Dr. Zafiridis: The situation changed later on. Whatever hesitation existed on behalf of the Scientific Community, was then followed by a direct attack by certain groups of academics and psychiatrists. They accused the Therapeutic Communities of undertaking a venture which is not based on scientific knowledge but on the experience of few addicts in the States, and predicted that it was thus bound to fail. Their claims were not confirmed in action, thanks to the addicts themselves and their families, who embraced this venture from the beginning as if it were a personal challenge. This did not come by surprise, as those people compared the dignity and the honor they felt in the Therapeutic Community, to the humiliation they had experienced "on the corner", in the traditional psychiatric departments and in prison. So, thanks to the enthusiasm of the staff, the members of the Therapeutic Community and the constant and coherent support of their families, the Therapeutic Community model progressively established itself in Greece. ITHACA and the other five Communities we founded later on were recognized by the majority of the

scientific community and the society as the only place in the country where addicts could change and give their lives a new meaning (NA had not appeared in Greece). This was also due to the fact that the results in first few years of their functioning, the therapeutic Communities were impressive.

ITHACA and KETHEA

Bill White: What was the philosophy behind the Therapeutic Community ITHACA and the KETHEA, which you founded later on?

Dr. Zafiridis: As you probably know, there are two types of Therapeutic Communities for addicts, based on very different philosophies: the professional Communities, also known as democratic or loosely-structured; and those which are created by former addicts, which are called hierarchic or strictly structured Communities. The first were founded by mental health professionals and based on the psychiatric Therapeutic Community of Maxwell Jones, which was active in the end of 1940s in a military hospital in the UK. Jones' Community hinged on the realization that communal living was more effective in the treatment of soldiers' mental disorders than psychotherapy and medication. The addicts' communities that were inspired by this model had sufficient medical staff and assisting personnel (nurses, cooks, cleaning staff) for chores such as cooking, etc., to service a rather small number of members (around 15-20). Addicts were not considered participants in a community with a specific goal, but rather patients whose treatment required professional psychotherapeutic techniques. The member-staff ratio in these Communities was usually one to one (1:1).

The second type of Communities was not founded by mental health professionals. They were inspired by "The Concept Houses" that blossomed in the US in the 1960s. They were initially founded in the States by former addicts in a totally self-funded and self-managed way, without any professional staff of direction. The SYNANON Community in Berlin is a similar example, and it is still active today. Later on, these Communities were directly or indirectly funded by the State, including the Daytop Community, with a professional staff of former addicts. (In some cases, the staff were also mental health professionals who shared the same philosophical tenants as the Community). The number of professionals working in these communities was relatively small comparing to the high number of members. For example, the first Therapeutic Community of this type in Ithaca had a maximum of 8 professional staff members, even at times when its members numbered over one hundred. This could have never been achieved if the members had not been taking most of the responsibility for the Community's functioning upon themselves. As a matter of fact, the members participated in all the different levels of hierarchy in the Community, as well as in the various activities, such as farming, construction, cooking, administrative work, public relations, etc., all according to how long they had been living in the community, their capacity for taking responsibility and the support and solidarity they showed to younger members. Independently of their position

in the alternating hierarchy, the members would work for at least 8 hours a day servicing the needs of their everyday living. The mental health staff did not have a fixed time schedule. All critical decisions concerning the Community were taken by the Coordinator's Council, which consisted of some older members as well as one counselor, who was the only staff member. As a result, the main role of the staff was basically supervising and assuring smooth life in the Community. This is the reason why we consider this kind of community as part of the wider self-help/mutual aid movement.

As you can see, the model I chose for the first Therapeutic Communities in Greece was that developed by the former addicts. However, I introduced many alterations and new ideas. As a matter of fact, the fourth Community that we founded in the context of the Therapy Center for Dependent Individuals, named "Alternative Community Intervention (PAREMVASI)", was based on a totally new philosophy that was internationally recognized as the third generation of this approach.

Bill White: Can you elaborate on why you decided to create this Community? What were its differences from the other Communities you had formerly created?

Dr. Zafiridis: You can see a detailed analysis of the disadvantages of the Daytop model and the theoretical conception of the “Alternative Community Intervention (PAREMVASI)” (Zafiridis, 2011, 2009 [In Greek], 1993, 1991, 1990) according to my personal experience. In the same articles I elaborate on the origins of the idea of the "Alternative Community Intervention.” This new type of Community was totally extroverted, unlike the former, whose most common problems were related to its introverted structure. In this new Community, the communal spirit that had helped members deal with their addiction was now proposed to the broader community through interventions in disadvantaged areas and schools, targeting the treatment of their respective problems. The identification of the problem, planning and action were cooperatively undertaken by locals and members. This interactive procedure had very positive results for both members and citizens. Unfortunately, the Community functioned with this philosophy for only 2 years. A series of internal problems in the KETHEA led to the abolishing of its primary philosophy and brought back the traditional model.

Bill White: You mentioned that the first Therapeutic Community was also the first "drug-free" therapeutic program based on the former addicts' Community model in Greece. What were the difficulties you faced bringing such a new approach to your country?

Dr. Zafiridis: One of the main problems I had to deal with when I tried to apply the Daytop model in Greece was finding the right professionals. This model presupposed that the staff consisted of former addicts, or mixed staff with both former addicts and health professionals, as in the Marathon House. But in 1983, drug and alcohol addiction in

Greece was very new. There were hardly any rehabilitation programs and it was obviously difficult to find any former addicts. In addition to that, there were hardly any mental health professionals with experience in the addiction field.
In order to overcome this problem, I chose to work with young colleagues—professionals without much experience, such as social workers, psychologists and sociologists, who shared common values. Their interest was not to succeed in their professional career but to help people deal with their problems. They were uncomfortable with the way that society functioned; hence they saw addiction as a result of an ill society. They empathized, but at the same time they were willing to work on their own personal development alongside the addicts in the Community. There were ready to pursue both personal and social change.

My choice proved to be right, as the young professionals and the addicts seemed to bond well together. We got rid of our predefined social roles and started growing together. Personal development was a common goal for both groups in the Community. In the first Therapeutic Community in Greece in 1983, "Ithaca", there was no division between therapists and users, meaning passive addicts and active specialists. This was a determining factor in our relationship with the members. It created an atmosphere of solidarity and love. Members and staff felt that the Community was their home. We often said that in the commune everyone is equal and has the same psychological and emotional needs and existential frustrations. Some people simply happened to have a supplementary problem, being addiction.

The daily group meetings were based on my experience with Gestalt therapy. Every afternoon we discussed everyday life problems and tensions. Later on, psychiatrist Martin Kooyman provided us with some educational assistance regarding the learning and application of Casriel's Bonding Psychotherapy and Rogers' Encounter Group. Kooyman was the director of Emiliehoeve, the first Therapeutic Community based on the Daytop model in Europe, founded in 1972 in The Hague. In addition, Juan Corelli-Perres' assistance was equally important to me for the inner organization and functioning of the Community. He was the director of the Ce.I.S. in Italy, where the Daytop model had already been applied for several years.

Bill White: Although you are a mental health professional, you opted for a Community model not created by the scientific community but by former addicts, and which was evidently more complicated. Can you tell us more about why you made that choice?

Dr. Zafiridis: Despite the fact that I had worked in a professional Therapeutic Community in Germany, I decided to propose the creation of a hierarchically structured, Daytop model-based Community in Greece. This was at a time when David Deitch was still the director of the Community, before Monsignor O'Brien revised the model's philosophy.

There were two reasons why I made this choice. The first reason is that the hierarchic model of a strictly structured Community corresponded better to the profile of the addicts back then. That said, addicts' behavior was mostly delinquent at the time, or else they had a serious criminal background, poor to nonexistent social capital and a lack of basic social skills.

The second reason is that my experience in professional Therapeutic Communities (the one I worked in as well as others that I visited) showed that these kinds of Communities had very low rehabilitation rates. I guess it makes sense to elaborate on the reasons why this model of low social coherency, which was conceived by mental health professionals, failed completely in helping addicts, as opposed to the hierarchically structured and more socially coherent Communities that were built by former addicts in the US. First of all, when I opted for the former-addicts model of the US, my only criteria was its effectiveness, since I ignored the reasons why the democratic or loosely structured professional models were ineffective. It took me a lot of time and a lot of experience, such as that which I gained with Ithaca, to understand the innate disadvantages of the professional model. Sharing my everyday life with the members of Ithaca helped me comprehend what was essential to their treatment. Some important factors were social cohesion, honest relationships, companionship created by common activities and transparency on all levels of everyday life. The most important, however, was the honor and dignity the members felt by participating in the administrative and therapeutic decisions and in the configuration of the Community's policies regarding internal and external issues.
All these ran contrary to the passivity, the loneliness and the disappointment that the members felt in the Community in Germany, where I had worked as an all-knowing scientist and therapist rather than a participant in common life with a distinct role.

Based on these experiences, I figured that the low rates of success (about 10-12%) were due to the low levels of social cohesion and communal spirit in the professional Community. I also realized that social cohesion and communal spirit, which were both so important to recovery in the microcosm of the Therapeutic Community, were probably equally essential factors to the prevention and treatment of addiction in real society. Indeed, this is the case. A community with high levels of social cohesion has enough social capital (support, care, solidarity) to support its most vulnerable members, according to research such as that of Richard Wilkinson (& Pickett) 2010, 2005, 1996.

This idea is also suggested by a study on natural recovery conducted by Granfield and Cloud (2001). The researchers' conclusion is that an addict with large social capital has more chances of rehabilitation with the help of his fellow human beings in society and without any special scientific help. In fact, the close link between social cohesion and addiction has been historically proven. As Bruce Alexander argued, at any moment in the history of humanity, whatever the place, problems of addiction were much more present in societies undergoing crisis, deregulated societies, and societies with low or inexistent levels of social cohesion and integration (Alexander, 2010).

Bill White: So, if I get it right, you believe that Therapeutic Communities for addicts—displaying low or high levels of social cohesion and structure, depending on the philosophy adopted—are examples of micro-societies whose comparative study can furnish us with answers about the psychosocial problems of modern macro-society and the errors in treatment committed up to present.

Dr. Zafiridis: That's right. On the one hand there's the unsuccessful model of the Therapeutic Community created by mental health professionals. On the other, there's the successful model created by former addicts on the lookout for solutions to their problems. Both models can be very informative about the phenomenon of addiction as well as for the continuous failure of the politics of its treatment. The first model was based on dominant theories of addiction and the addict's needs. These theories emerged from quantitative research of dubious credibility and which, due to ideological preconceptions, naivety or self interest, focused exclusively on the biochemical operations of the human brain related to the consumption of drugs. This kind of research "forgets" to highlight the existential problems and agonies of human beings and ignores the economic and social factors that are related to the development of such problems. A quintessential example is the fact that dominant psychiatry and psychology, with the support of big organizations in Europe and the US such as NIDA, as well as the press, propagandize addiction as a strictly personal, hereditary, biological and psychological problem. At the same time, they avoid any reference to the thorough research by Zinberg (1984) and Alexander, Hadaway & Coambs [(& Beyerstein) 1981, 1980, 1978] which has proved the indisputable and determining role that environmental factors play in the genesis and development of addiction.

Bill White: Is the failure of the Therapeutic Community created by mental health professionals related to the lack of credibility of the dominant scientific theories?

Dr. Zafiridis: Correct. I believe that one of the greatest errors of the dominant scientific approaches (closely related to preconceptions and to the lack of credible research) is the professional Therapeutic Community, which ignored the role of social and cultural environment, ultimately leading to failure. The Community of former addicts focuses on environmental factors and communal values, and thus succeeds. This does not come as a surprise, since the pseudoscience constituted by all dominant approaches in the field does not wish to research or deal with the social and cultural causes of addiction. By focusing on the dysfunctional individual, who is the symptom, rather than on the dysfunctional society, which is the cause, this approach covers up the truth and fails to deal with the problem. The addict cannot be seen as the symptom because the symptoms and the illness are deliberately intertwined. Therefore addiction becomes a chronic relapsing brain disease and the addict becomes a medical patient. Hence, the modern economic growth model, which carries the real illness, remains untreated. Within this

model, the psychological and spiritual needs of human beings are unimportant and human happiness is measured according to citizens' capacity to consume.

Bill White: Are you implying that the dominant approaches to addiction deliberately confuse the symptoms with the illness, out of political or other interest?

Dr. Zafiridis: Yes. Otherwise I can't explain some people's persistence with ideas that make absolutely no sense. I have been working in this field for 40 years and I still can't explain the ideas that some colleagues and some organizations support. We are overwhelmed by neuroimaging evidence, as if any type of disorder in the brain's biochemical functioning could explain the enormous proliferation of addiction. In 1910, addicts represented less than 0.2% of the general population in the States (Musto, 1999) while today they are more than 10% (Center for Behavioral Health Statistics and Quality-SAMHSA, 2016). How could their approach explain such a difference?

Medical science, and the positivistic paradigm persistently adopted by psychiatry and psychology, never intended to deceive people to such a degree. We have never been told that by taking an aspirin to reduce fever our body would get rid of the virus, the real cause, at the same time. Symptoms and causes were never intertwined. For, according to Kuhn (1962), true science does not compromise with an ineffective scientific paradigm that uses mitigating approaches to cover up its failed practices. To the contrary, it examines the reasons for the failure of the dominant scientific paradigm and tries to negate it and replace it with a new one that can better correspond to the field's unresolved questions.

Such a thing has never happened in the addiction field. For the last hundred years, the policies upon which we're based—intended to deal with the expansion and treatment of addiction—have totally failed. However, the dominant medical paradigm has not been neglected. There are two reasons why this might have happened: either psychiatry and psychology are not real sciences and, hence, they are not subject to the epistemological rules that Kuhn has analyzed, or the negation of this ineffective epistemological paradigm is hampered by political intercessions and personal motivations.

I am more convinced by the second argument. I believe that policy makers over the last decades, in collaboration with the dominant scientific trend, have been trying in every possible way to avoid any association of growing psychosocial problems with the socioeconomic environment. The reasons are obvious. Such a correlation would imply a demand for political and social change. Therefore, manipulation of research in the specific scientific field is an essential condition for the maintenance of the status quo. The research in psychology and psychiatry that is unaffected by political or economic interests can illustrate the importance of transparency, social justice, social coherence, and decreasing inequality to the mental health of citizens. A first introduction to these ideas was made by G.W. Albee (1998), the godfather of American clinical psychology. This

research has also recently been confirmed by Wilkinson [(& Pickett) 2010, 2005, 1996]. By the way, I believe that similar misleading tactics—meaning the treatment of symptoms instead of causes—has been applied by western governments to other contemporary problems as well, such as environmental issues.

Bill White: Can you tell us more about the former-addicts model and its positive outcomes?

Dr. Zafiridis: The model created by former-addicts themselves can be considered as an example of participatory action research within contemporary epistemological research. Participants don't have a preconceived theory that directs their actions. It is based on their own experiences and addresses their personal problems and needs. They plan and implement actions for their treatment and review them when needed. In this way they produce a new theory based on their actions, often unaware of that fact. This theory is validated by its successful implementation. Apart from criticizing some of their particular practices, could anyone really question the effectiveness and the influence that AA and SYNANON have had on our theoretical understanding of addiction? Could anyone question the fact that for over 100 years, the scientific community has been unable to develop any effective treatment methods? Neither of these examples of self-help was based on any preexisting scientific theory. I published an article in the journal *Therapeutic Communities* (Zafiridis, 2011) in which you can read more about SYNANON and the way in which it altered our understanding of addiction and of psychology in general.

Another conclusion coming out of the comparison of these 2 models is mostly related to the configuration of the micro-social environment of the Therapeutic Community. Bear in mind that the failed micro-social environment of the professional model, with its very loose or nonexistent social cohesion, is in fact a reflection of the current social reality. On the other hand, the successful model of the former-addicts forms a micro-social environment based on communal tradition and inspired by a vision of a more humane society. Despite the fact that it has been designed by the addicts themselves, it is a utopian endeavor that covers the psychological and emotional needs of people, relieves their existential stress and assuages human pain—the pain, the agony and the needs of every human being. Therefore, we must pay attention to the political message that this utopian endeavor puts forth.

In my opinion, the former addicts in the US, with their self-managed communes, indirectly propounded a political proposal. They suggested a social structure in the form of a community, which could fulfill people's need for security, love, trust and true relationships, and hence keep them from resorting to addiction. Their initiative proved that the prerequisite for the well being of modern man is the fulfillment of existential, psychological and emotional needs by a functioning social environment. And this is why I believe that the study of both types of models of Therapeutic Community and their comparison are particularly interesting and offer fresh knowledge for the addiction field. The analysis of

the way that the professional Therapeutic Community worked and the investigation of the reasons for its failure to support addicts can lead us to some legitimate parallels with the current social reality. It might actually give us some answers to many important current issues such as: the responsibility that lies with social and political factors regarding the origin of the growing psychological and existential frustrations of people today; whether the economic political imperative of modern societies contributes to the well being of people; and finally, whether the rising psychotherapy industry, with its diverse therapists and numerous methods of treatment, could support the politics for the treatment of psychosocial problems, give meaning to lives misguided by false consumerist needs, and impede the spread of all kinds of addiction. This would imply that pursuing any radical change is unnecessary.

Bill White: You seem to be one of the few professionals that had the opportunity to work within both models of the Therapeutic Community. As a young psychiatrist, you worked in a democratic or professional Community in Western Germany. Later on, you created strictly structured Therapeutic Communities in Greece, similar to those created by former addicts in the US. Can you tell us more about the way the professional Community worked and the reasons for your disappointment?

Dr. Zafiridis: As I mentioned, my first experience in the addiction field took place in one of the 300 professional democratic Therapeutic Communities for addicts that existed in West Germany. At least 3,000 psychologists, social workers, psychiatrists and occupational therapists were recruited, but their work contributed to the recovery of only few hundreds of addicts. The model of this community was based on democratic community psychiatry as developed by M. Jones, and was funded, directly or indirectly, by the State. Its therapeutic approach was based on Humanistic Psychology/ Psychotherapy. The proclaimed goal of therapy was personal and family change. No substitute drugs were given apart from some psychiatric medication at the stage of physical withdrawal, and this only in rare cases and when the addict was living in the community. The main therapeutic tools were Gestalt psychotherapy for the members and systemic psychotherapy for their families. Everyday life in the Community was based on a system of reinforcement of coherent behavior and discouragement of negative behavior, inspired by behaviorist approaches in Psychology. The multitudinous professional staff, which was equal to the number of members, consisted of specialized psychotherapists and assistive personnel specializing in various fields and assuring the proper functioning and the good public image of the Community. Apart from Gestalt therapy, the psychotherapy sessions applied all modern techniques of the time, such as Psychodrama, Art Therapy, Dance Therapy and Meditation.

In theory, these procedures were aimed at reinforcing members' self-awareness, as well as their capacity to take responsibility for their feelings, behavior and life choices. But how could this ever reflect reality when all actual responsibilities regarding their everyday lives were assigned to the staff instead of the members themselves? Therefore, the goals of the

psychotherapy groups and the proclaimed goals of the Community were inconsistent with the reality that members experienced in their everyday lives. Most of the time, members were not even informed about problems related to life inside the Community. Such issues were discussed among the staff, who made all decisions. The members' decisions concerned insignificant issues such as planning their entertainment, while in everyday life they tended to secondary tasks. They were unaware of the administrative and economic policies. For them it was only natural that the staff members were responsible for issues regarding the structure and functioning of the Community, just like in a hospital.

Bill White: You have just described a context that reinforced members' passivity. Was that a conscious choice on behalf of the staff or was it due to ignorance?

Dr. Zafiridis: The assignment of all responsibilities related to the administration and the functioning of the Community to the experts/therapists was a political choice implemented in every professional Therapeutic Community. Upon initial consideration, this seemed unrelated to the therapeutic goals of the Community and the psychological progress of the members. This is what both the director and the staff believed. Nevertheless, this purely administrative choice—or so it seemed to be, at first glance—proved devastating to the therapy. It deprived members of the opportunity to grow and change, which could have been offered to them had they participated in the responsibilities of a true communal life. Since all responsibilities were assigned to the therapeutic staff, this particular administrative system tended to reinforce the preexisting passivity of the members. Communal life was meaningless for members—hence their psychological and emotional needs remained unfulfilled. This was the first time in my professional career that I realized how administrative political decisions concerning the functioning and the structure of human communities/societies could determine the fate and the emotional state of people.

Bill White: Was the staff or the director not aware of the intense contradictions you just described?

Dr. Zafiridis: The answer is undoubtedly no. In reality we were a bunch of people that knew nothing about rehabilitation. We were considered "addiction specialists" by society, political authorities and the majority of addicts only because we were mental health professionals. We had been trained in the wrong way, we believed in wrong theories and we implemented a wrong recipe for rehabilitation. However, there have often been some members who have pointedly criticized the contradictions between the goal of the therapeutic procedure, which was growth, and everyday life in the community. Sadly, we did not listen to them. Neither did the other members, for that matter. I believe that our inability to listen was due to a false underlying perspective on how personal development and change can be achieved.

According to this perspective, the political choices that directly or indirectly influence the way in which social and cultural life work are not related to the psychological state and the

change or therapy of people. Au contraire, "personal change can be achieved only during psychotherapeutic procedures and the implementation of specific techniques utilized toward that end." This was something like the word of God to us all, and especially to those who had been trained in this specific type of psychotherapy. In light of such a perspective, the communal co-existence of addicts made no sense, per se. It did not contribute to the members' personal development and change. It was important only in the sense that it could insure the members' participation in the psychotherapeutic procedures.

That the staff adopted this approach as if it were dogma was very limiting to our perspective and made us unable to realize that distilling common life down into a parody of communal life hampered therapy. None of us knew how extremely important interactions and other collective psychological and support procedures (within a healthy social and communal context) were to the treatment of addiction and other psychosocial problems. Nor did we know that true human relationships require a sense of collective meaning that extends beyond personal interest, which in turn helps people overcome their mistrust and come closer to one another. And finally, we did not realize that all this required active rather than passive members of the commune. It was thus impossible to collectively plan a Community capable of encouraging such engagement.

What's worse is that no member of the professional staff suspected that the problems of the clients, which we had been called upon to treat, were for the most part related to a dislocated society. As a result, the Community environment could not foster therapy until it stopped reproducing these conditions. So, we succumbed to the psychotherapeutic stereotype—according to which therapy and change can only take place through therapeutic procedure—and focused exclusively on such procedures. We saw the co-existence of addicts as an essential condition for them to avoid consuming medicine, first, and then to participate in the psychotherapeutic sessions. However, a simple hotel-style accommodation and arrangement of everyday life would suffice for such an end. The paradox was that although this type of accommodation was a choice made in order to assure participation in the psychotherapeutic sessions, in reality it sabotaged them.

The inchoate community/social life created by this kind of cohabitation was responsible for many problems in members' interaction. Without substantial interaction, members were bound to develop superficial relationships. It was not hard for one to notice the loneliness and the lack of trust and of honest relationships pervading their everyday lives. Under these circumstances, it was only natural that members try to make up for these gaps by participating in psychotherapeutic sessions. That's where they tried to find meaning for their lives, develop relationships with other members and fulfill their need for love, mutual interests and values. However, this persistent effort was not sustainable, especially in people's real lives, outside of the sessions.

Whatever its achievements, psychotherapy was not able to influence or improve the hard reality of members' everyday lives in the long term. The social life that emerged in such a

context did not encourage personal development. To the contrary, it hampered it, confirming Rogers' (1980, 1977) later claims that personal change is pointless unless accompanied by social change. The context and the coherence of communal life seemed to be the only factors affecting the quality of human relationships, behavior and mental state. As I've mentioned before, these things were regulated by the director and the staff members. The members thought that it was normal for them to have no say and did not make any efforts to change it. It was sad. People were satisfied with some good food, trips and the kindness of the staff. At the same time, they thought that it was completely normal to spend their everyday lives full of sorrow and loneliness, without any sense of meaning.

Bill White: You said that the psychotherapy sessions did not manage to produce positive results, promote personal growth or improve everyday life in an underprivileged social environment. Failure, for you, was due to an environment lacking in coherence. Can you elaborate on this?

Dr. Zafiridis: It is true that psychotherapy groups did not seem to be able to improve social life. As a matter of fact, what was happening was exactly the opposite. In an unexplained way, it seemed like poor social life was actually having a negative impact on the content and results of the therapeutic procedures. The non-participation in decision making, the lack of common actions and goals and the paucity of interaction obliged members to conjure problems out of their meaningless everyday lives or past experiences, simply to feed the needs of their psychotherapy sessions. As a result, members' psychotherapy sessions were restricted to a repetitive and almost forced examination of their selves and their relationships with close family members.

They didn't have a choice, anyway. The lack of any substantial interaction outside of therapeutic groups made it harder for them to identify their real problems and inter-relational difficulties in the "here and now" of their common lives. Hence, all the material brought to the psychotherapy group for processing was already "censured" and exclusively related to past experiences that the members considered important. Therefore, most of the hidden parts of one's self—and thus one's self-awareness—were left out of the procedure. By the end of each session, at the feedback stage, all promises regarding personal change were replaced with statements about how helpful the group had been to understanding such-and-such psychological problem, just to stroke the egos of the therapists. Yet, the next day, the members' lives did not differ from the previous, since the hotel-style environment was not offering any space to practice what was achieved during the psychotherapeutic procedures.

The negative results of this situation were evident from the high rate of member relapse. These relapses made all therapists, who were otherwise satisfied with the group work, feel rather uncomfortable. All evidence indicated that, despite the intentions of the therapists and the people receiving treatment, the lack of members' substantial participation Community life undermined the credibility the of therapeutic procedures in a radical way.

Hence, a lack of credibility affected the outcome and turned the sessions into an outlet for tensions, with no signs of meaningful personal change. I believe that my experience in the professional model of Therapeutic Communities once again confirms the tenants of Critical Psychology (Prilleltensky & Nelson, 2002; Sarason, 1981): if, during psychotherapy, human existence is divorced from its social environment and personal change is restricted to a constructed, specialist-designed psychotherapy group, therapy and self-awareness procedures can't be completed.

Bill White: Your claims suggest that the professional or democratic Community, in which you worked, was a simulation of real society. You also said that the goals of the psychotherapeutic procedures were personal change and self-awareness. So, do similar groups in real society fail to achieve their goals, too?

Dr. Zafiridis: I believe that this has been proven. Since the early 1960's, millions of people in North America and Western Europe have participated in various groups that, in one way or another, focus on the "self" and its problems and frustrations. Have you noticed any improvements? To the contrary, the rates of psychopathology, school violence, early teenage suicide and addiction have steadily increased. At the same time, the use of psychiatric medication, prescribed drugs and tranquilizers is at a peak (UNODC, 2011). All these facts force us to consider the relation of Western social problems to cultural and social conditions, rather than personal, medical, biological and psychological factors. Hence, I do believe that psychotherapeutic procedures would make more sense if they related people's personal psychological problems to the prevailing social conditions and promoted personal as well as social change. For it is self-awareness and the understanding of one's environment that make citizens claim their right to participation in political decisions that determine the quality of their lives. That is mature political action. This is the emancipatory version of psychotherapy, as opposed to the dominant manipulative version, which is content with appeasement and temporary relief of the symptom. This symptom is considered to be a very personal experience in modern societies. It is treated as a problem of separate individuals and most of the time is classified as a new disorder by a "neutral" scientific community, supported by the pharmaceutical industry. This is why psychology and psychiatry should investigate and address the social and cultural dimensions of personal problems, instead of covering them up.

And don't jump to the conclusion that these claims are all supported by some leftist psychiatrist. You'd be mistaken. Freud himself, in a letter he wrote to Putnam, fully expressed the dialectic relationship between personal change/therapy and social change in a repressive society: “therapy, utterly lucid as to its limit and strength within a repressive society, issues into a social critique and praxis of liberation" (Jacoby, 1975). This path has been neglected by dominant psychotherapy, which is obedient to professional and other interests. But this seems to be the only way for people to develop critical thinking and a holistic approach to their problems. *When consciousness goes beyond the understanding*

of a fact and starts placing it critically into the system of relations, then it surpasses itself, it goes deeper and becomes critical consciousness (concientization)- Paulo Freire (1970).

Bill White: I am particularly curious about the way in which the members reacted to the professional or democratic Therapeutic Community. Did they ever ask for changes that would improve life in the Community?

Dr. Zafiridis: You're right to wonder about the members' reactions, which were neither frequent nor collective, as one would have expected them to be. Yet I believe that they knew better than anyone else that what the Community offered them was useless to their rehabilitation. On the other hand, we should not forget that the professional staff did not offer any opportunity for them to develop critical thinking or put in question the way that the Community functioned. I think it's worth elaborating both on this, and on our own manipulations that prevented members from seeking changes to the chosen therapeutic system. This is how we did it: we levied our scientific discourse and prestige in order to defend the therapeutic system. This is exactly how dominant psychology and psychiatry work, attempting to defend the sociopolitical status quo.

Thus it's true that, in our regular Community meetings, members often criticized the professional staff for a centralist character of the model and for excluding them from decisions regarding their everyday lives. However, we were experts in fielding such criticism.

We used all of our scientific knowledge and psychotherapeutic tools to make undisciplined members obey. We interpreted their behavior as a projection upon the staff of an unprocessed relationship to parental authority. Abetted by our scientific prestige, this arbitrary interpretation would soon become unquestionable fact. We used various "scientific" arguments to prove that the defense mechanism of projection was a sign of immaturity. After congratulating the members for exposing themselves we referred them to psychotherapeutic sessions, where they were expected to work on their personal problems. If this was not enough to calm them down, we reminded them that our authority was applied with their own permission, and as a result of their "democratic" decision to join the Community. If they did not like the way things worked, they were welcome to leave and try another program.

This is a quintessential example of our repressive approach to a problem whose root was not psychological—as we falsely claimed—but rather political. Members' participation in organizational and therapeutic decisions depended on the given Community's policies toward a given issue. This was not accidental. It was taking place within a model that was by default procedural, attentive not to the root of problems but rather to the treatment of their symptoms. The true causes of members' negative behavior toward Community policies —a lack of democratic and communal procedures, for example— were concealed. The scientific staff attributed these valid member complaints to psychological problems,

for which treatment could only derive from psychotherapeutic sessions. Hence, the Community environment did not need any change or improvement. The members had to adapt to a given, unfair, normative context that could not be improved in any way. Community policies unfair to members were transformed into a personal psychological problem via the tool of Psychology. In therapeutic language, this disorientating procedure is called procedure of personal growth. It would make more sense if it were called "training to adapt unconditionally to an inflexible and inappropriate context". Obviously, if this happened in a psychiatric clinic, the disruptive member would also be given some psychiatric medication; this is how Soviet Psychiatry dealt with resisters, and it is still applied today by western Psychiatry, though in more covert ways. This microcosm of political and social repression has been particularly successful in modern western societies, where it's also supported by the scientific community.

Bill White: Has your scientific approach been influenced by your experience in these two different models of Therapeutic Communities?

Dr. Zafiridis: Not exactly. My scientific approach to addiction was not determined by my experience with the professional Therapeutic Community where I worked early on. Nor was it really influenced by my personal experiences in "Ithaca", which I founded in Greece and based on the former-addicts model. However, both experiences gave me the opportunity to come face to face with persisting questions in the addictions field. Such questions concerned the failure of all scientific therapeutic projects and state statutory policies to address the universal increase in all types of addiction. They helped me develop my critical thinking and place in question (hesitant, at first, but more determined later on) the central tenants of the dominant scientific current in the addiction field. I started off my career as a supporter, and with time and experience I ended up a passionate opponent of the dominant scientific trend.

Psychology and Psychiatry in the Service of the Political System's Imperatives

Bill White: You ended up very skeptical about the dominant scientific current of Psychology and Psychiatry. Can you elaborate on why this happened?

Dr. Zafiridis: I am more than skeptical. I challenge the credibility of what it espouses, especially when it comes to addiction. I believe that dominant approaches to addiction, which are partly or entirely based on biological approaches, have proven to be wrong. I have already talked about why I believe this. And yet, they remain "dominant". This is a paradox that many field researchers have analyzed (Alexander, 2014; Satel & Lilienfeld, 2013 ; Reinarman, 2005 ; Ford, 1996 ; Peele, 1989 ; Fingarette, 1988) and which drove me to look into the ways in which these approaches are "constructed". At this point we have to bear in mind that only in the last years an introduction of the approach of the social constructionism has been attempted within the field of addiction. In my new book, which

is about to be published, I tried to elaborate on this kind of questions. Hence, many of my answers here are based on the arguments you find in my book.

My conclusion was that research is done under pressure of personal beliefs and expectations (Hart, 2017). The criteria for these choices are not exclusively scientific, but depend on the possibilities for funding, publicity and acceptance by the field's dominant researchers (Ioannidis, 2016, 2011). Yet our research choices determine our scientific conclusions. For they depend directly on the area of the scientific field that we choose to focus on. For example, when we opt to focus on the effects of drugs on the human brain, the conclusions are insufficient to pin an entire framework on regardless of the validity of the research methodology. The research will therefore be based on real data but will lead to false conclusions regarding the nature of the phenomenon. Focusing on one specific relationship and leaving out other possible causal factors—social, cultural or political—represents bias.

So, research neutrality is different in humanistic sciences than it is in positive sciences. In physics and chemistry, researchers can easily remain objective, unless they have an interest to do otherwise. Humanistic sciences, especially Psychology and Psychiatry are very closely related to the social, cultural and political reality. So, it makes absolute sense that decisions and research choices in humanistic sciences—what will be investigated and what will be left out—are influenced by personal beliefs and lifestyle. It is wrong to believe that scientific neutrality, and thus credibility, is achieved by decontextualizing psychological problems from the sociopolitical circumstances in which they are developed.

Adopting such an approach says more about the researcher's worldview than the credibility of his or her research. Unfortunately we have been trained to believe that the political system and its cultural superstructure have nothing to do with personal problems and psychopathological disorders. Hence, any investigation into the causes of its development would put the credibility of our results in danger. It would affect the scientific "neutrality", considered by dominant Psychology and Psychiatry to be an essential factor in research objectivity. It would be dangerous because this investigation would supposedly be influenced by the researchers' social and political beliefs. As if ignoring social context weren't influenced by personal belief. What's the basis for this argument? Why does the dominant trend insist on ignoring different perspectives on psychosocial phenomena, whereas the paradigm in positive sciences changed decades ago? I wonder if these people have heard of the evolution in quantum mechanics and Heisenberg's "uncertainty principle", according to which observational results depend on the position/perspective from which phenomena are observed. However, the dominant approach insists on one specific perspective. Hence, most researchers in addictions (and other psychosocial problems) do not consider environmental factors to be potential causal factors.

Bill White: I do believe that there are some scientists out there who acknowledge the existence of a relationship between sociopolitical environment and Mental Health, even if a vague one. Do you believe that the relationship is very close?

Dr. Zafiridis: Yes, I believe that there's a direct interactive relationship. How could we forget Foucault's research (1965) on the social construction of psychological/psychiatric diagnoses and social exclusion in modernity? The French philosopher Helvetius (1773) had already depicted, in the 18th century, the importance of the sociopolitical environment to the development of a person's character, destiny and course in life. Furthermore, renowned intellectuals, such as Erich Fromm (1942), (even non-Marxists) such as philosopher, psychoanalyst and economist Cornelius Castoriadis (1996) [2] have since supported the same argument. Castoriadis claimed that the relationship between the political system and the human psyche is so intensely interactive that each political system produces its own anthropological type.

A wise Indian once said that men have two wolves inside of them: one good and one evil. What the man becomes depends on which wolf he chooses to feed. Unfortunately, the majority of people cede this choice—consciously or unconsciously—to the imperatives of the political establishment in which they live. All political systems, even democratic ones, are very well aware of this and use it to achieve the maximum of consensus toward their aims (Chomsky in Achbar, 1994). Had they been unable to produce the appropriate anthropological type and influence people's choices, they would not have survived to apply their irrational and self-destructive political plans.

Let's look at an indelible historical example: the thousand-year-long, prosperous empire of the Third Reich that the Nazi political machine promised to the German citizens. This example is very relevant to current reality: neoliberalism promised people everlasting economic growth, just as Nazism did, despite the consequences that this economic imperative has had for people and the environment. How could someone look into and interpret the psyche, the personal attitudes and the psychological problems of German citizens at the time of the Nazi regime and during WWII, without taking in consideration the environmental factors? Without shedding light on the sociopolitical imperatives and unprecedented mechanisms of enforcement developed by the Nazi political regime, and on the regime's capacity to puppeteer psychological need in ways that would make even today's advertising industry blush with envy? Such research would lead to false conclusions, since it would not take into account the interactive relationship between the political system and its citizens. It would thus ignore all the tools that the political establishment used in order to manipulate one of the most educated groups of people in the Western world, and to then construct an anthropological type that blindly obeyed irrational orders. This type of man was paranoiac, cold-blooded, and predisposed to

[2] The English translation of this book is available on : http://www.notbored.org/RTI.pdf ,
under the title *The Rising Tide of Insignificancy (The Big Sleep)*.

commit crimes. He was the true supporter of the Nazi political system and the new order of things.

I am afraid that such research, which removes human behavior from its sociopolitical context and its historicity, would certainly lead to the conclusion that 80% of the German citizens suffered from paranoid thinking, Manichean delirium, or at least antisocial personality disorders. Such research would convince us that Germany experienced high psychiatric and psychological morbidity at that specific historical moment. However, it would not be able to explain the causes of this morbidity. It would also not be able to justify the decrease in psychopathological behavior after the change of regime, and that without any medical or psychotherapeutic intervention. Of course, hardcore supporters of nosological and hereditary approaches do not look for interpretations to these phenomena. They hold that psychiatric and psychological disorders are not related to social and cultural environment. As a result, they opt for medical treatment, which is of course highly convenient for the pharmaceutical industry.

If neuroimaging techniques were as developed back in the time of Nazi Germany as they are today, they would find hyperactivity in soldiers in the regions of the brain related to reward. These were the soldiers who fought and died or committed zealously horrible crimes, doped by Nazi theories that promised the ascendency of the Nazi political system over the entire planet. The genocide of 6,000,000 Jewish people and the massacre of 12,000.000 soviet civilians are proof. So organizations such as the NIDA (National Institute on Drug Abuse), who believe that neuroimaging can sufficiently interpret human behavior, might argue that the fanatic behaviors and extremities committed by these soldiers were not a consequence of the specific political environment but of an inherent brain disease. This disease was spread all over the German people.

How credible can a scientific study of people, their habits, their choices, their personal attitudes and their pathological behavior be when it ignores sociopolitical factors? I believe that mathematician and philosopher Bertrand Russell has already provided us with some answers regarding the subject. In an effort to lampoon the absolute faith that people have in the righteousness of scientific research, he told a story about a turkey that was familiar with scientific research. The turkey found that, on his first morning at the turkey farm, he was fed at 9 a.m. Being a good inductivist turkey he did not jump to conclusions. He waited until he'd collected a large number of observations that he was fed at 9 a.m., and made these observations under a wide range of circumstances—on Wednesdays, on Thursdays, on cold days, on warm days. Each day he added another observation statement to his list. Finally he was satisfied that he had collected a sufficient number of observation statements to inductively infer that "**I am always fed at 9 a.m.**". However on the morning of Christmas Eve he was not fed but instead had his throat cut. Inductivist reasoning, based on true observations, led to a false conclusion (Chalmers, 1976). This did not come as a surprise, as the scientist turkey had arbitrarily decided to limit his

research to the food factor, and did not take into account the habits and the plans of his owners.

Bill White: You claimed that research and diagnosis of human behavior is unreliable when it does not take political and social environment into consideration. You also said that such research can end up advocating a political system. Can you provide more examples on the subject?

Dr. Zafiridis: There are many cases when psychiatric and psychological diagnosis, based on unreliable observations and research, are used in order to cover up the real sources of problems and thus discourage any necessary political and social change. I will briefly go over some of these examples.

The first one regards the construction of a new disease. This disease concerned slaves in the cotton fields of the American South, and was introduced by an "illuminated" American scientist (with perfect knowledge of the ancient Greek language, considering the names he gave to his "discoveries"). "*Drapetomania*" was identified, by the renowned Dr. Samuel A. Cartwright of Louisiana, as a psychiatric disorder in 1851, to explain the tendency of black people to flee captivity (meaning the field the "master"). At that time, Dr. Cartwright was one of the most prominent doctors treating black patients. As many slave owners believed that they contributed to civilizing and educating their slaves, it was hard for them to explain why the latter wished to escape. Cartwright claimed that it was a medical disease that could be treated, and prescribed whipping (so that the devil might come out of them). In the case of relapse, he suggested cutting off their toes, so that they could not longer run away. According to Thomas Szasz (1970), in the antebellum South, Drapetomania was considered a psychiatric disease. Its symptoms were the uncontrollable urge of the slave to flee captivity and pursue freedom. These "diseases" served two aims: first of all, they justified captivity as a therapeutic necessity. Second, they ceded responsibility for treatment of the disease to the slaves' masters (Szasz, 1970).

Cartwright introduced another disease, called “Dysaethesia Aethiopica”, to explain the slaves' evident lack of motivation to work. Once more, the suggested treatment was whipping the slaves. "Dysaethesia Aethiopica" was thought to affect both spirit and body. Its symptoms were described as follows: hebetude of the intellectual faculties and physical lassitude. He thought that the disease was prevalent among "free negroes", and was most often interpreted as laziness by the field masters. The diagnostic criteria were disobedience, lack of respect, unwillingness to work and deliberate destruction of equipment and tools. Apart from whipping, treatments included strenuous work, to "send vivid blood to the brain and liberate the mind". Dr. Cartwright also claimed that “The disease is the natural offspring of negro liberty--the liberty to be idle, to wallow in filth, and to indulge in improper food and drinks" (Cartwright, 1851).

These examples demonstrate the errors that science can commit when it refuses to study human behavior as a reflection of its socio-political environment. This was the first time in the modern, rational era that a new disease was discovered in order to conceal the true causes of a fundamentally political problem.

Bill White: One might claim that Dr. Cartwright's opinions did not reflect the prevailing medical view, though.

Dr. Zafiridis: It's true that people could argue that, but it would be hard for them to provide proof. Firstly, because Dr. Cartwright published these opinions, without any reactions from the rest of the scientific medical world. Secondly, his opinions were radically irrational and contrary to any scientific principle. So if scientists disapproved of these opinions they would have condemned them. Dr. Cartwright's effort to legalize political injustice toward black people and use diagnosis to transform a political problem into a personal psychological problem should not be considered an exceptional case. There are much more official examples.

Bill White: Can you give some?

Dr. Zafiridis: An official example from the addiction field is the Harrison Narcotics Tax Act, approved by the American congress in 1914. This federal law prohibited the free circulation of drugs. However, it includes some connotations that people have not paid enough attention to. The Harrison Act assigned indirectly the responsibility for the problem of addiction to the medical scientific community. Doctors were given the right to prescribe illegal drugs, based on their own judgment on each particular case. Maybe this was the only way, as most drugs were already being used in medicine for therapeutic purposes. But the permission to prescribe drugs was not limited to cases of people suffering from known medical diseases. Doctors could prescribe drugs to addicts as part of a planned therapeutic treatment based on gradual dose reduction. This, in my opinion, indirectly proclaimed that addiction was a medical scientific problem. The only way for people to get hold of prohibited psychotropic substances was through a medical prescription. This might sound normal to you today, but it was not the case back then. Up to that moment, addiction had been described as a moral, spiritual (Peele, 1990) or social problem. Lefty intellectuals realized that there was a growing predilection of the working class to opiate in order to deal with the horrid working conditions in the factories of that time. They thus saw addiction as a mainly political problem. As a matter of fact, President William Taft had referred to the social and moral characteristics of this problem, during his speech in the Congress (International Opium Commission, 1910, pp. 44-51).

I wonder what happened between 1910 and 1914 that made politicians change their minds and consider that it is a purely medical issue that could be treated with prohibiting measures. Despite my efforts, I could not find anything before 1914 that proved that addiction was considered to be a medical issue. I did not find anything relevant. Any

research trying to support the biological origins of addiction came much later on. This could justify health care measures. By the end of the day, it's obvious that the Congress changed the name of the problem, from social and moral to medical, in a totally arbitrary way.

This arbitrariness can be interpreted in two ways. Firstly, the United States Congress had been pressured by the temperance movement, as well as by the rising pharmaceutical and medical scientific community, which expected to make profit out of these bans. Secondly, political authorities realized in time that the acceptance of the growing problem of addiction as a result of an intellectual, moral or even social crisis would go against their political interests. Such an acceptance would mean that the capitalist model of development, promoted as the absolute means toward well being, wasn't healthy enough; it created a growing number of people who could integrate neither psychologically nor socially, and thus they resorted to drugs. All these "side-effects" would make citizens suspicious about the existent political system. Medicalization was used to abolish the potential danger as people tend to believe that it's absolutely impossible that medical diseases are connected to the socio-economic environment around us. Considering all the above, the Harrison Act achieved its objective. With the medicalization and "psychologization" of addiction, public opinion came to refer to addiction less and less as a social or political problem. Most people have been convinced that it is a personal psychological or medical problem. And yet, I must admit that the Harrison Act made sense and was coherent.

Prohibiting drugs through legislation as a public policy for dealing with their growing consumption presupposes an acceptance of the bio-medical perspective on addiction and the "infectious" effect of drugs. According to this perspective, availability determines the expansion of the phenomenon. Hence, banning drugs should result in control and progressive disappearance of the epidemic. Demand is an irrelevant factor. People come across drugs randomly in their lives and they become patients because of the substances' demonic addictive nature. In the case of infectious medical epidemics, the availability of the bacteria determines the range and the strength of the epidemics. Likewise, the availability of drugs determines the level of addiction. For the treatment of great medical epidemics, there have been health-service legislations, control measures and bans which aimed at limiting the infection factors and controlling the infected individuals. The Harrison Act of 1914 thus applied the same successful recipe. Indirectly allocating responsibility for the problem to the medical community was concomitant. Anyway, a series of epidemics had already been successfully treated with similar prohibiting regulations (such as the quarantine, etc.)

The instigators of the Harrison Act disregarded the fact that, up to that specific historical moment, all legislation regarding healthcare and the prevention of large-scale epidemics had been based on credible medical observation and research. This had come from empirical observation of contagious epidemics and the infectiousness of the bacteria causing them. The infectiousness of addiction, however, and the addictive properties of psychotropic substances, were based on nothing but assumption.

Bill White: Why are you focusing on the Harrison Act?

Dr. Zafiridis: I believe that the Harrison Act is very historically significant because it introduced certain "innovations". Political powers arbitrarily determined (in accordance with their own interests) the biological origin of addiction and assigned the scientific community the responsibility of dealing with the problem, while also legitimizing the decision through further scientific research. What's even more surprising is that the medical community willingly accepted this assignment, despite the lack of any legitimate research. To the contrary, they often went above and beyond the Harrison Act, not only failing to seek to reduce the dosage, but actually prescribing drugs in order to maintain it. This is one of the first known cases of official entanglement of the political and the scientific communities.

Secondly, by adopting the biological perspective on addiction, the act demonized and prohibited drugs, allotting them sole responsibility for the expansion of addiction. The act launched a war that has cost billions of dollars to tax payers. This misleading war did not manage to stop the expansion of drugs. On the contrary, it succeeded in covering the true causes of the phenomenon and exempting citizens and the political system from their responsibility.

Thirdly, with the assistance of the American government this pointless policy was made international, and has since been applied all over the world. Finally, prohibition legislations like the Harrison Act have been very helpful in the long-term in improving health conditions and eradicating epidemics like cholera. However, the same legislations failed completely in the case of addiction. This paradox can be explained in only one way: Addiction is not a disease.

Bill White: What other examples are there, apart from addiction?

Dr. Zafiridis: I do insist that the dominant trend in Psychiatry and Psychology has a very specific perspective on the psychological problems and frustrations experienced by people today. This is why it goes from one mistake to the next. And not solely in the field of addiction. Those who support this trend, backed by a pharmaceutical industry that funds their research, rush to introduce new diseases in every field. All existing problems caused by the irrational and inhuman modern developmental model are transformed into personal psychological or psychiatric problems. Consider, for instance, the case of Attention-Deficit Hyperactivity Disorder, or ADHD, and the rates of depression and suicide among adolescents.

When I returned to Greece in 1982, I was already a psychiatrist and had just completed my thesis at the University of Zurich Faculty of Medicine. I had enough experience from practicing psychiatry. My first job in Greece, as I already mentioned, was as supervisor in the Child and Adolescent Psychiatric Hospital of Athens. I was very surprised by the fact

that diagnosis of depression, ADHD and suicidal tendency among adolescents were very rare in Greece, as compared to Switzerland and Germany—two very technologically and economically advanced countries. I am mostly referring to Athens, where there were plenty of child psychiatrists, most of whom had been trained in the US and in Europe, and who thus had the necessary experience to detect such disorders. Twenty years later, these diagnoses started to be assigned more and more frequently to Greece's students.

Could this phenomenon be explained by nosological theories, and without taking into consideration the social and cultural changes that had been imposed by the country's transition to a free-market economy? Could such an interpretation ignore the new challenges and demands that the new generation of students had to confront? Children had to deal with a new reality at school. Stuck behind their school desks or in their classrooms, they would no longer have time to play with others. The new educational system was designed to serve the needs of an economy and free market, ignoring the psychological and emotional needs of children. Why didn't the dominant trend promote research that regarded the above factors as causes of ADHD and depression? Why did they not promote research that would investigate children's' disorders from a different perspective, and consider them as unconscious but justified reactions to a bad educational system? Why are the political and scientific authorities not funding this type of research? What are they afraid of?

Some years ago I discussed these issues with a friend of mine who is a child psychiatrist. Marios Markovitis is a prominent child psychiatrist and is considered the godfather of child psychiatry in northern Greece. He was the director of the Adolescent Psychiatric Unit in a major Thessaloniki hospital for many years. At that time, all the big textile factories were shutting their doors, one after the other, within the span of a few months. Free market laws obliged them to move to Bulgaria, where wages were much lower than in Greece. Markovitis confirmed that adolescent depression rates in those areas, where unemployment had caused serious social instability, skyrocketed within a few months' time. The increasing number of adolescents from these areas arriving at his clinic corroborated Markovitis' claim. Parents were doing just as bad, since guilt for their child's problem was added on top of their already existing psychological problems. So instead of promoting conventional drug prescription, he decided to start talking to the parents, the teens and the local community stakeholders about the effects of unemployment on the psychological state of families and children. This was a fortunate turn. If the director of the Adolescent Psychiatric Unit had been a supporter of the dominant scientific trend, instead of Markovitis, he would surely have prescribed the teens antidepressants. Then the pharmaceutical company would have provided him with money so that he could wander around international conferences telling people how amazing the results of the specific psychiatric medications were.

Markovitis told me about his experience successfully treating radical case of ADHD. It was the child of some family friends. Instead of psychiatric medication, Markovitis suggested to

the parents that they move from their city apartment to a farm in the suburbs of Thessaloniki. After they did what he suggested, the child's behavior changed radically and he ceased showing symptoms of ADHD. I don't mean to say that scientific research of psychological disorders must focus exclusively on the role of the sociopolitical and economic environment. I am very frustrated that it doesn't treat these factors equally. This is why I consider the dominant system's approach biased.

You do not have to support the political system in Cuba in order to be willing to investigate the reasons why this country -which according to our economic criteria is considered to be a failed country- has, according to WHO, comparable rates of mental and physical health to those of the US and Europe. And bear in mind that these rates exists despite Cuba's low per-capita income and despite the long-lasting embargo imposed by United States (Lamrani, 2014; Spiegel & Yassi, 2004). And most of all, I do not understand why respectable research such as that of Wilkinson [(& Pickett) 2010, 2005, 1996], Navarro (2002, 2004), Alexander (2010), which interprets the failure of capitalistically developed countries to ensure people's health—and sheds new light on the reasons behind this—is not part of the curriculum in university Psychology and Psychiatry programs.

Bill White: You claim that the dominant trend in Psychology and Psychiatry has given in to the temptation of power and money and put science in the service of the political system, rather than in the service of people. Can you elaborate on this?

Dr. Zafiridis: I do believe that, in their own way, dominant Psychology and Psychiatry today support the people in power. They conceal facts that would help citizens realize the true nature of their problems and urge them to fight for social change. This is not only achieved by constructing diagnoses and nosological theories to explain people's misery and suffering. It is achieved by the "psychologization" of everyday life, with the support of the television, popular media and multiple pop psychology publications. I have had enough of listening to personal dramas that center around a lack of meaning and emptiness; failed friendships, romances and relationships; financial and professional failures; deep sorrow caused by a pet's psychological problems; and problematic parental relationships, which are used by 40 or 50 year-old people as excuses for their misery, or even for the family drama caused by the inability to afford a summer house, etc.

And all this, at a time when our politicians are piling refugees from Syria into tents and unheated buildings, and people right next door can't have enough food to survive the day. We avoid looking at what's going on right next to us, ignoring the suffering that exists around the world. The more we focus exclusively on ourselves, the more we ignore other people's problems, and hence, the greater our misery seems. This is the price to pay for egoistic behavior. A citizen who's drowned into dozens of personal psychological problems- mainly due to social decay- cannot be critical and responsible for his or her choices. He or she is no longer a citizen of democracy, as defined by Aristotle, Socrates and other ancient Greek philosophers. He or she is trapped into personal, professional and

social conventions, excessive work stress, tensions, worries and anxiety, in a very competitive and insecure social environment. He or she experiences every day personal, family and professional dramas. As a result, his or her political function becomes insufficient. All of the energy is invested into the treatment of these problems, which is his or her "psychotherapy" that can provide him or her with individual solutions.

Dozens of disorders, made up by the scientific community of Psychology and Psychiatry (most remarkably, the "clinical syndrome of addiction"-) have been constructed in order to make this egocentric choice legitimate on a scientific, social and moral level. Every human behavior and choice is categorized as a disease or disorder (APA, 2013 ; Frances, 2013 ; Mosher, 1998). Hence, citizens, as formal "patients", are now justified to spend their day thinking about their suffering "selves" and their treatment. They retire from any active political action and remain ignorant about major political problems regarding poverty, climate change etc. This is a new model of manipulation. Psychologically manipulated citizens are, in my opinion, very easily controlled by political and scientific power and uninterested in life's crucial aspects as any citizen who's deeply alienated by the economic system[3].

Related Academic Interests

Bill White: Could you describe for our readers the current nature of alcohol and other drug problems in Greece and any trends that are of particular concern to you?

Dr. Zafiridis: In the beginning of the 1980's, which is a lot later than the US and the Western European countries, Greek society had to face for the first time in its history a rapid increase of drug and alcohol abuse. This coincides with the entrance of the country, at the end of the 1970's, in a transitional period characterized by intense and rapid changes. This transitional period with all the dramatic social changes was the result of changes in economy, turning rapidly from a state controlled and agricultural economy to free market economy. These changes in economy were imposed by consecutive governments that were passionately supporting the neoliberal model of development, as it had already been applied in the US and the other Western European countries. And as everywhere else, these governments talked about economic development, implying that the accumulation of wealth is directly affecting people's happiness.

[3] For readers who want to know more about citizens' psychological manipulation, I recommend the documentary film *The century of the self* (2002) by Adam Curtis, produced by the BBC (available on: https://www.youtube.com/watch?v=eJ3RzGoQC4s&t=29s) as well as the film *Manufacturing Consent - Noam Chomsky and the Media* (1992) by Mark Achbar and Peter Wintonick (available on: https://www.youtube.com/watch?v=AnrBQEAM3rE).

They did manage to keep their promises. Greek people's income started to increase precipitously. Consumerist habits are observed among the majority of the country's population. Color TV appeared and progressively started to take its place in the center of every household. Its purpose was one and only: Destabilize traditional family relations in the house and reform young people based on new cultural models and values, undermining any will for critical thinking and resistance to the radical changes that were taking place.

The new lifestyle imposed new ethics. Along the expansion of all sorts of addictive behaviors, new trends emerged especially when it comes to alcohol abuse, which did not exist earlier. In the past, alcohol consumption and alcohol abuse was basically taking place in the context of family dinners, parties or reunions, which means that it was under social control. This means that alcohol abuse did not take the form of "lonely drinking" and it very rarely led to uncontrollable drinking and addiction. In the 1980's, phenomena such as youth alcoholism, third age alcoholism, lonely drinking and addiction to hard drugs appeared for the first time in Greece. I strongly believe that this new form of uncontrollable abuse and addiction behavior was related to the loneliness and alienation emerging in the 1980's, especially in the country's big cities.

It seemed as this was also the consequence of the internal immigration of populations from rural areas to urban centers, as well as a result of the new lifestyle which was unable to provide people's lives with meaning. It was the price to pay for the economic development that the free market had promised to bring to the Greek society. Rapid economic changes eroded social cohesion, as economic inequalities increased, and destroyed the welfare system. The internal immigration from rural to urban areas, not only destroyed small independent communities whose survival was based on cottage industry, but it also promoted unemployment, chaos and alienation in big urban centers. The communal spirit that existed in the Greek countryside and the cities' districts even during the 1970's, started to back away or disappear.

Values such as empathy and solidarity were replaced by the news values of the free market. According to these, individuals should only care about themselves, and live for themselves. The apotheosis of the "minimal self" as Christopher Lasch (1984) said, as a means to survive in adverse and psychologically repressive conditions. Faith to God or a greater purpose, or a better world, which gave people strength in order to deal with the harsh aspects of everyday life and resist injustice, were now replaced by the belief in infinite economic development. No one was supposed to be worried for the personal and ecological price for this choice. Constant economic development could ensure an immediate and easy fulfillment of all kinds of desires and false needs, promoted deliberately by publicity and the Media.

It is also important to mention that Greece's introduction into the free marker did not only lead to increasing misery and personal problems, such as addiction, but it also led to an

unprecedented environmental destruction of a beautiful land. The religion of infinite economic growth did not help people find meaning in their lives. The new type of man, constructed by the new socio-economic environment in Greece, is a type of man that Philip Cushman (1990) named "the Empty Self". The Empty Self is soothed and made cohesive by becoming "filled up" with useless products promoted by publicity, and even psychiatric medication, alcohol, drugs, gambling, internet, publicity, lifestyle, worship organization, never ending pop psychotherapeutic sessions and anything else that the new technology and lifestyle could offer.

At the same time, the destruction of social cohesions and communal spirit deprived people from mechanisms of psychological support. Such mechanisms, like family, confession, religious rituals, neighborhood life, improvised creative street games, exchange economy based on solidarity, progressively started to disappear. From that moment on, addiction started to expand and psychological as well as psychiatric problems started to grow in the Greek society. The Greek society was not the only one to undergo the violent changes which were imposed by the free market economy and which led to uncontrollable addiction problems. Bruce Alexander, in *Globalization of Addiction* (2010) gives many historical examples that demonstrate that free market economy, when introduced into a society, leads to its destabilization and to a radical increase of the population of addicts.

Bill White: You said that the transition of the Greek society into the free market economy changed the traditional consumption and abuse of alcohol and drugs but also led to the increase of the number of addicts. Can you be more precise using numbers?

Dr. Zafiridis: Of course. I will give you an important example. In ten years' time, from 1982 to 1992, the number of drug addicts increased up to ten times. This made both me and my Greek colleagues realize that if the causes of addiction were related to the personal biological and hereditary functions of individuals, this rapid increase of the number of addicts could not be explained and understood. So, from very early on, we started to investigate the relation that exists among: expansion of drug addiction, and addiction in general, socio-economic environment, its effects on the cultural structures and the consequences on the inner family atmosphere and people's every day habits.

Bill White: What are your scientific interests today?

Dr. Zafiridis: Today I am mostly interested in helping addicts and their families acquire the right knowledge and techniques in order to form their own approach on self-help and mutual aid. I am mostly referring to addicts that do not feel that AA and NA can be helpful for them. Whatever initiative is taken by addicts themselves requires that health professionals remain strictly on the periphery of the venture. In my opinion, this must be the true role of mental health professionals, as it has been proven historically that we are

all (with very few exceptions) completely unable to carry in the long run the burden of the treatment process.

A new mutual aid approach would make sense if it could move beyond the existing ones, improve them and fill in the gaps that exist. This means that the new approach should not reduce itself to the importance of recognizing personal responsibilities. It should encourage participants to look into their social responsibilities and confront a society which ignites addiction through the suffocating conditions and the existential frustrations it triggers. In other words, a new self-help approach, should proclaim social change, and not only personal change.

This is a very important element for self-consciousness, as the hostile and pressuring socio-economic environment is the main factor triggering relapse in addiction. These things have to be analyzed and understood by the people who are personally involved with the problem. Usually, ill citizens are not able to connect their personal problems to the general social and political problems. They are not able to understand personal as political and vice versa. This could only be achieved if citizens had a very good knowledge of the political and social mechanisms, and the ways that these mechanisms affect the development of their personal problems. If the citizens, who suffer and want to change their lives, can't make such a connection, then who do we expect to do so? Can it be the counselors/therapists, who have related people's existential problems with their bank accounts, or the politicians, who are also addicted to power, publicity and money?

Bill White: Is that also the case with AA and NA?

Dr. Zafiridis: Yes. This is maybe something that the AA and NA groups should be careful with. The main approach of the AA and NA groups implies that addiction is a purely personal problem that can be fully and profoundly treated, in absentia of any environmental conditions. This approach isn't simply wrong. It reveals a fundamental contradiction between their theory and their practice (Zafiridis, Lainas, 2012). The majority of these groups claim that addiction is a brain disease but treat it as a psychosocial and existential problem. The ignorance or frustration resulting in such a contradiction is bound to create problems in the future. I personally know members of NA/AA who claim that they suffer from a chronic relapsing disease but believe that their faith in God can help them treat it. Do they believe in miracles? This frustration is not a good sign for the future. I do not underestimate the importance of faith, but I believe that it's time for AA/NA self-help groups to understand that a big part of their success is due to the communal spirit cultivated within the groups and to the system of values that emerges from such a choice. Such values are solidarity and commitment to the development of human relationships. Both of the latter counteract de facto social deregulation and egocentricism, on which economic development in modern capitalistic societies is based. Anonymous self-help groups, whether they admit it or not, have a very specific position regarding current social and political issues. All they have to do is accept it and come to terms with it. This will allow them to resolve a series of internal contradictions and reduce their tendency towards sectarianism.

Bill White: You claimed that the ability of AA and NA groups to help addicts is mainly related to the development of a communal spirit and less related to the functional characteristics of these groups. Can you elaborate on this?

Dr. Zafiridis: I have referred to my experience with the Greek NA/AA groups and my experience in the Therapeutic Communities. My experience showed that the only therapeutic thing in the TC, which promoted the addict's personal change, was the socio-therapy taking place within the Community. Sociotherapy, in one word, means re-foundation of a human community. That is, solidary people with common purposes regarding personal development and change, and the creation of a communal spirit promoting these procedures. This is what comforted and "cured" addicts in reality. The focus of psychotherapy on various personal/psychological problems, that took place within established procedures on specific times in the Therapeutic Community, played a complementary role. My conclusion was that therapy/change in a Therapeutic Community can't be based on traditional therapeutic approaches. It's mainly related to the reframing of the addict by a cohesive social context with many creative opportunities. Hence, therapy, as defined by traditional therapeutic approaches, should not be the main objective of a rehabilitation program, or it's pointless and ineffective. The objective should be the development of a communal spirit in the group, which means healthy human relationships and bonds of safety and love. These can set the therapeutic potential of the members free (Rogers, 1980, 1977) and can encourage the development of true mutual support, challenging the necessity of all constructed psychotherapeutic techniques.

Whatever is included in my definition of sociotherapy, are in fact the secret tools of self-help groups. It's not just the belief in a higher power that helps, as many of the members might claim. Self-help groups, when they are not introvert in a problematic way, they can provide people with a new identity, a feeling of belonging, the ability to develop human bonds, mutual support, solidarity and communal values. If the AA and NA groups recognize and admit these "secret tools"- which contribute largely to the efficiency of the groups- this would be a political statement. For admitting that men feel better and deal profoundly with their problems in a coherent social context, while go ill in a deregulated free market society, is indeed a political statement.

Bill White: What other academic and research interests do you have?

Dr. Zafiridis: I have always been interested in the history of addiction. In the last years, I have been studying history more and more. I am convinced that many answers to the questions of the field of addiction can be found in the history of addiction. Bruce Alexander shares the same belief. For example, White (1998), in his book *Slaying the Dragon,* has shed light on many of my questions regarding this issue. I think that no one can have a full understanding of the ways in which addiction can be treated unless they've thoroughly read about the history of addiction and its therapeutic ventures. For every young professional in the field of addiction in need of a theoretical guide to the field, I recommend White's *Slaying the Dragon* and Bruce Alexander's (2010) *Globalization of Addiction.* I suggest these books based on my personal academic and teaching experience. Both of

them, along with *Diseasing of America* by Stanton Peele (1989), should be taught in every university that actually wishes for its students to understand the phenomenon of addiction.

I am also very interested in studying the phenomenon of Natural Recovery in Greece. That means that some drug addicts recover by themselves, without any obvious help from professionals and self-help groups. This phenomenon has been very well observed and is common among smokers. However, in the case of smoking, it's not hard to understand. Nicotine does not have any stronger psychoactive substances than Theophylline, which is found in tea. Yet, smoking can seriously affect people's health.

At the same time, there are many more everyday habits that have the same effects, or even worse, on our health. Working stress, for instance. Or bad driving, extreme sports, or horse riding (as David Nutt's research has recently claimed.) Nutt's (2009) research showed that horse riding is much more dangerous than the abuse of ecstasy. It's important to mention that Mr. Nutt was not honored with any award or special mention for his scientific work. To the contrary, he was fired from his position as Chair of the Advisory Committee on the Misuse of Drugs (ACMD) in the UK. It's easy to imagine what would happen to any researcher who dares to claim that working stress is equally, if not more, dangerous than smoking.

Smoking aside, it's important to remember that people have always had bad habits and have always been able to quit by themselves, especially when they realized the effects these had on their health. However, it was hard to imagine natural treatment from alcohol and drugs taking place so often. I've been working in the field of addictions since 1982. In the 1980s, this phenomenon was very rare. The slogan "once an addict, always an addict" reflected the reality of that period. From the mid- 1990s and on, however, the number of people recovering "naturally" progressively increased.

Today it is certain, even in Greece, that a large percentage of addicts manage to recover by themselves. The increasing number of cases of Natural Recovery, especially after 2000, has obliged me and my colleagues to investigate existing international research on that matter. This is how we came across published work on Natural Recovery of Klingemann & Sobell (2007), Robins (1993, 1974), Granfield & Cloud (1996), Waldorf & Biernacki (1981) among others. It was a pleasant surprise for it confirmed our observations in the Greek field of addictions. Natural Recovery from substance abuse was a turning point in the field of addiction, as it challenged all existing perspectives on the nature of this phenomenon. As a doctor, I can confirm that there is no "chronic relapsing disorder" that comes as a result of people's own will (with breakouts and attenuations that depend on their choices) and which can be treated by people themselves, depending on their social capital and some psychological support. The medical model of addiction can't be accepted if a growing number of people manage to recover by themselves. Natural Recovery thus challenges the medical model's claims. It obliges its supporters to accept, at least, that their claims fail to interpret the majority of addiction cases today.

Bill White: Is Natural Recovery important because it disproves the medical interpretation of addiction, or are there more reasons?

Dr. Zafiridis: There's one more important reason. I believe that the study of this phenomenon can lead to a deeper understanding of the nature of addiction and open the way to a substantial scientific dialogue between the two scientific camps that were created at the end of the 19th century: the supporters of the medical model on the one hand, and the supporters of the environmental model on the other. Natural Recovery can help the two sides realize that, under specific research circumstances, both models can lead to credible—albeit controversial—conclusions. This can happen when one side exclusively studies severely dysfunctional cases (mostly found on the street, in prison or in substitution or closed "dry" programs), while the other side focuses on socially-functional addicts, who are numerous but rarely found in such places. Robins (1993, p. 1051) has elaborated on this subject.

Allow me, at this point, to share an important observation I made when I worked in the Therapeutic Communities in Greece. As I have already mentioned, during the first years of the Therapeutic Communities in Greece, the majority of the addicts were moderately to severely dysfunctional. Most of these people had no motivation to treatment. They came to out-programs for various reasons such as lack of money; the need to detoxify for a short period of time; pressure from their family, the police or other addicts; or just the feeling that they had gotten really low. So our main objective was to help them create positive motivation so that they would stay and complete their treatment. This would happen in the Introduction Center, and later on in the Community. Most of the times we succeeded. However, about 35% of people rejected our work and moved out of the Community within the first couple of months. Some of them would come back at some other time and complete their treatment. All these things were normal, and came as no surprise in such a "dry" rehabilitation program.

What I want to share with you is that among the people who quit the program, there was another subcategory of people. In the little time I got to spend with them, I realized that not only did those people lack motivation for change but they were also behaving like zombies. They could not orient themselves in space and time. An experienced therapist could easily realize that these people lacked something more than just motivation. No one could communicate with them on any level whatsoever. The only conversations that could take place with them concerned "the dope," the sacredness of the ritual of getting a "fix," and the places and ways one could get hold of heroine. They had an ongoing, unabashed thirst for heroin. They dreamt of it every day and often would ejaculate with the thought of it. When they could not get hold of it, they would take whatever there was in front of them, like pills, or even inhale gas and adhesives. They looked like people with diabetes who depend on the next dose of their medicine. They were incapable of understanding the consequences of their choices. As a result, many of them would end up dying from overdose or from the side effects of excessive dosing. Most of the times, these people did not have a house, as they had no family or their family had kicked them out. None of them had ever worked. They slept in parks or under bridges. Prisons were like home to them. They could have easy access to drugs, especially if they started

"dating" some leader. Living in or out of a prison made no difference to them. The only thing that was important was whether they could get their next fix.

People like that were ideal suicide cases and ideal scapegoats for a shattered and hypocritical society. Their cognitive functions were degraded. It seemed as if they suffered from a true brain disorder, but I didn't know whether this predated their abuse of alcohol and barbiturates (which create irreversible brain damages) or if it was a result of such behavior. The clinical information we had did not allow a clear psychiatric diagnosis. And yet, I had the impression that some very serious disorder was there. Someone on the staff called those people "fried," and I think that we all silently accepted this label. If some supporters of the medical model diagnosed these people as having a chronic brain disorder, I would find it very hard to challenge them. Nevertheless, I would try to remind them that this type of excessive behavior concerned a very small percentage of the dysfunctional drug addicts at that time. This percentage is even smaller today, probably due to the significant increase in the total number of moderately dysfunctional and functional addicts. I would also remind myself, and everyone who supports psychosocial perspectives on addiction, that many of the "fried" addicts did not seem to be victims of despair as one meets in the working-class areas of large cities. I wanted to share this experience with you in order to show you that there is no single theory capable of encompassing every aspect of addiction, and to make you aware of the dangers that exist in such generalizations.

Bill White: Let's come back to Natural Recovery. You said that a study of the phenomenon could lead to a better understanding of the causes of addiction. Can you elaborate?

Dr. Zafiridis: I have a basic assumption to make regarding Natural Recovery and the various interpretations of the phenomenon. I will raise some issues and then make a proposal. The basic assumption concerns the causal link between three variables: social environment, psycho-pressuring circumstances and the expansion of addiction. This relation is supported by research in Sociology and History. Both scientific fields provide us with the following knowledge: first of all, when a psychoactive substance is introduced into a culture, the people who abuse it and become addicted to it, with whatever major risk this implies, are mainly people with serious psychological disorders. Their need to ease their unusually serious psychological pain is greater than their fear of any potential danger. In fact, anyone abusing socially accepted psychoactive substances does it for the exact same reasons. In reality, these people choose a form of self-therapy, making use of the psychoactive effects of some legal or illegal substances.

Such a choice regards a very small number of people in a cohesive and functional society and depends on the particularities of certain individuals. This explains why societies that knew about the psychoactive nature of some medicines and used them in rituals did not have any real addiction problems. A quintessential example is the Incas, before the 16th century. As the Empire was growing and people where living happily in a coherent and just socialist society, no problem of massive addiction was ever recorded. And yet, coca grew in people's gardens (Mortimer, 1901).

The second historical and sociological fact is that, when the environment deteriorates, the psychological pressure increases and any type of addiction expands beyond control. This is what happened with the Incas after the destruction of their social structure at the hands of Spanish conquistadors (Naranjo, 1981). The same goes for Iran, after the imposition of the repressive theocratic regime (Madani et al., 2011 ; Mojtahed-Zadeh, 2007). And also in China, in the 19th century, with the crisis following the transition from an introverted economic regime to violent submission to western economy, imposed by western interests and in particular by the British East India Company, EIC (Courtwright, 2001 ; Brook & Wakabayashi, 2000). A similar situation was observed in the US and in post-war Europe with the establishment of free market economy. In Greece, this phenomenon developed more and more with the transition of the Greek economy to a free market system in the 1980s. Finally, Russia is the most recent and glaring example. After the fall of the Soviet regime and the country's entrance into free market economy, the levels of addiction jumped by 900% in a very short period of time (Csete, 2004) whereas alcohol abuse had doubled (Alexander, 2010).

All these examples allow us to conclude that an unpropitious environment, along with the psychological pressure it creates, is responsible for the uncontrolled spread of addictions. This relationship has been supported, in one way or another, by many field researchers. My proposal is that Natural Recovery should be added to these variables.

Bill White: Can you elaborate on your proposal and the reasons why you think that Natural recovery should be added to the list of variables?

Dr. Zafiridis: Sure. First of all, we should discuss whether Natural Recovery was as common in American society of the 1950s, meaning before the great expansion of addiction, as it is today. Let's then clarify that Natural Recovery concerned a very small number of addicts, which was also the case for Greece during the first years. If that's how things were, contemporary research shows a continuous increase of the phenomenon of Natural Recovery (reaching up to 71% of addicts) (Roizen, Cahalan & Shanks, 1978), so it's normal to associate the increase in Natural Recovery with the increase in addiction. This association allows us to add natural recovery to the three variables that I mentioned before.

So schematically, we have: Unpropitious social environment → stressful circumstance → expansion of addiction → increased numbers of Natural Recovery. How can we study this association? Could it be that both the continuous expansion of addiction and the proportionally increasing number of addicts who quit drugs in the last years without any help can be interpreted by the change in addict profile? Could it be that the continuous rise in addictions is possible because it's no longer a condition that regards dysfunctional people, but rather a condition that's more and more common among functional people with sufficient social capital, who, however, suffer from stressful circumstances?

If this is the case, then this new type of addict—which represents, in my opinion, the majority of addicts today—can manage his or her addiction decently and recover by

themselves when they wish to. The earliest research on Natural Recovery was conducted by Robins (1974) on Vietnam War veterans. The soldiers in Vietnam were not part of a sample with brain, hereditary or severe psychological disorders. We could thus not explain the large number of American soldiers addicted to heroin. Quite the opposite; these soldiers represented a very healthy sample of the general population and were led to addiction because of the extreme circumstance of psychological pressure in a stressful environment, being war. People with sufficient social capital pre-addiction would probably have never become addicted had they not been exposed to the stressful environment. These people are also very likely to recover by themselves.

Looking into the evolution of addiction in Greece in the recent years, you can see that the number of addicts without serious psychological and family problems is proportional to the number of people that can recover without any professional help. Maybe we should accept the fact that Natural Recovery is more and more common when the causality of addiction is linked to stressful circumstances rather than personal and biological characteristics. And vice-versa: the more we come across the phenomenon of Natural Recovery, the more we should consider the role of stressful environmental circumstances. The more we incriminate these stressful circumstances, the more we should focus our research on socio-cultural environment as the source of human misery. And this would be no great discovery! Freud already did it in his work *Civilization and Its Discontents (Das Unbehagen in der Kultur)*, in 1930.

Bill White: How might all of this lead to a mutual understanding among the different conflicting approaches?

Dr. Zafiridis: All my experience and thoughts could potentially contribute to a mutual understanding between the two existing camps of addiction specialty. Maybe this could help the passionate supporters of *chronic relapsing brain disease* to understand that their theory can only interpret the condition of a very small number of addicts, but not explain new dimensions of this same phenomenon, such as Natural Recovery. However, the other camp might also have to admit an indisputable fact: although stressful circumstances are responsible for the vast increase of the number of addicts, we can't deny that a small number of addicts might have been led to addiction due to personal psychological particularities or even genetic and biochemical reasons. In my opinion, studying the socio-economic circumstances can help us interpret the massive nature of addiction in modern societies, but it can't explain why, in periods of happiness and prosperity, there are still a small number of dysfunctional addicts. To explain this, we are obliged to study people individually and investigate people's psychological standards over the course of their lives, their family environment, and even their biological and hereditary background.

Based on all of the above, I would like to suggest the use of both the medical and the psycho-social model, depending on the percentage of addicts represented in the specific society or group being studied. I will give you three different examples. In the first case, we've got a society where the total number of addicts is very small, <1% of the total population. In this case, it is totally normal to take the medical model seriously. We must

also accept that the social environment is healthy enough with, a very low level of stressful conditions. As a result, we should be expecting very rare or zero cases of Natural Recovery.

In the second case, the number of all types of addicts is higher than 4%. In this case, we have to take into consideration the sociocultural theories of causality. We should accept that the social environment is dysfunctional and the levels of stressful circumstances are high. It is thus clear that in this case we no longer have to study individual cases of ill people who have no social capital, but rather an unhealthy environment that makes people fragile even when they have social capital. As a result, we expect high percentages of Natural Recovery.

Finally, when the percentage of addicts is somewhere in the middle, that is, around 2%, then both theories should be taken into account. All percentages mentioned here are absolutely hypothetical. Percentages have to be decided after thorough study.

Bill White: What are your other scientific interests at present?

Dr. Zafiridis: Lately I've been particularly interested in choice theories. More and more scientists in the field of addiction claim that addiction is a choice. I was very surprised that scientists such as Ole-Jørgen Skog, who used to interpret addiction through the medical model, have recently adapted the choice theory.

I do appreciate this researcher's scientific ethos. In an editorial in the journal *Addiction* (Skog, 2000), he forthrightly analyzed the reasons behind his conversion. Such an example of scientific courage is very rare. Especially in the field of addictions, I only know one other—that of Dole and Nyswander. These two scientists wrote the article *Heroin Addiction: A Metabolic Disease* (1967), in which they claim that addiction to heroin is a metabolic disease, like diabetes. The first methadone substitution therapy programs in New York were based on this claim. A few years later, the same researchers said that methadone substitution therapy programs can help decrease criminality but can't provide therapy to the addicts (Dole, 1989; Dole & Nyswander, 1976). For a program to be therapeutic, they claimed, it needs to provide addicts with honor and hope. And they added: "The stupidity of thinking that just giving methadone will solve a complicated social problem seems to me beyond comprehension..." (Dole, 1989). It's important to remember that what distinguishes science from charlatanism is scientific ethos and scientific method. And let's not forget that many of the scientific theories that were developed during the Nazi regime, such as Aryan racial superiority, were based on the methodology of positivistic inductivism.

Back to the choice theory, I want to share some of my thoughts and questions. First of all, no one can deny that the use and abuse of drugs and alcohol is a choice. No serious man can believe that a supernatural power "throws" psychoactive substances into people's bodies or forcefully imposes the habit of gambling or internet addiction. The

subject's complicity is prerequisite to abuse and development of addiction. Choice is an important element in the development of addiction. Also taking from the research and arguments proposed Heather & Segal (2017), Heyman (2009), Schaler (2000), Davies (1997) I am absolutely convinced that addiction is a choice. However, this claim can't fully explain the vast expansion of addiction in modern societies.

Why do people "choose" addiction *en masse*, especially in these last decades, as they didn't 50 or 60 years ago? This is a question that choice theorists have not been concerned with up to the present day. If we accept Cushman's (1990) claim that people use addiction to fill the painful emptiness provoked by modern societies, we can still wonder why people don't choose to fight to change this society. And why did the working class, at the end of the 19th and the beginning of the 20th centuries, decide to shift to a socioeconomic environment that provoked such misery and pain? Why do people today still opt for false relief of their problems and personal frustrations instead of radical treatment? Why do they not choose to overcome their problems through self-awareness and personal or social change? Since when have people started to move back to passive behaviors, similar to those found in societies before The Enlightenment, expecting institutions and religion to provide solutions to their problems? How did medieval societies differ from today's society, where we expect personal and social problems to be magically resolved by scientists and politicians?

These are the questions I am trying to answer in my book. Here are some of my thoughts: according to Existential philosophy, a man is born absolutely free. There's nothing that can predetermine his destiny. He is born like a tabula rasa. His choices determine his destiny. Jean-Paul Sartre (1946), the godfather of existentialism, summarized this argument in one sentence: *Man* is fully responsible for *his* nature and *his choices*. His freedom to choose makes him responsible for his own life. Existential psychiatrist Victor Frankl (1959) has concluded, from his experience in a concentration camp during the Second World War, that a man can choose his behavior and attitude even under the harshest of circumstances. Rollo May (1966), Irvin Yalom's teacher and the founder of existential psychology, shares the same view. Also, Niko Kazatzakis' literary and philosophical works, which many therapists have used as the basis for their work, are broadly inspired by concepts such as freedom of choice and personal responsibility. Classic literature in general has always exalted freedom of choice. There's no doubt that men are always free to make choices, regardless of the circumstances. This is also a way to explain why some people who grow up in totally hostile family and social environments become drug addicts, and some not—and why the war in Vietnam did not result in every single American soldier becoming a heroin addict.

However, we have to accept that the majority of people are not able to choose freely and independently of their surroundings. Most people choose to live in harmony, consciously or unconsciously, with the dominant culture they're part of. Therefore, the choice of addiction is not as free as it seems. It is a choice imposed by the cultural structure of the existing sociopolitical system. From the beginning of the 20th century, capitalistic culture has been promoting bulimic consumption, passivity, ill self-obsession and self-satisfying needs, all as imposed by the media. This is the type of man who can serve the continuous

increase of wealth for the privileged few on the planet. This culture is, in my opinion, the primary reason people routinely choose the easy path of drug, alcohol, gambling, internet, work, power, and money addiction—and compromise—instead of the hard road of personal and social change.

Reflections on Addiction Treatment and Recovery Support in Greece

Bill White: What was the nature of treatment for addiction prior to the development of specialized addiction treatment / recovery support resources in Greece?

Dr. Zafiridis: Before we launched our first "dry" therapeutic program in Greece in 1982, drug addicts were considered incurable and they were treated with very conventional treatment methods in psychiatric institutions. Therapy mostly consisted of psychiatric medication and electroshock. The situation changed radically after 1983. This was thanks to the first Therapeutic Community, ITHACA, and the other communities that followed after 1987. The role of these communities was a determining one, as they humanized therapy and provided the Greek society with cured addicts for the first time. Also, by changing dominant approaches to therapy, fewer and fewer addicts were taken into psychiatric institutions. So, in 1987, the state introduced a law prohibiting the hospitalization of addicts in public and private psychiatric institutions. However, the law was violated very often by private psychiatric clinics. These clinics, with the pretext of an underpinning psychiatric disorder, keep hospitalizing addicts to this day, often using similar violent methods of treatment.

When it comes to alcoholics, they would also get hospitalized in public psychiatric institutions and private clinics. Alcoholism was considered an illness and its treatment was thus a purely medical issue. There was only one unit in the whole of Greece, within the psychiatric institution of Athens, which provided specialized treatment for alcoholics, so to speak. The results were very disappointing. However, the open-minded director of the unit supported the creation of the first AA group in Greece, adjacent to the unit.

Bill White: What were the major milestones in the history of specialized addiction treatment in Greece?

Dr. Zafiridis: *I believe that the first major milestone was the launch of ITHACA in 1983.* It was the first Therapeutic Community and the first treatment program in Greece. For me, this was a very important moment that had many benefits for both society and addicts. There are two reasons why ITHACA was so important: firstly, the successful completion of the addict's therapy/change. This radically changed the perception of addiction that Greek society had held up to that moment. As I've already said, addiction was considered an incurable, chronic, relapsing disease in Greece. Secondly, this accomplishment encouraged the state to adopt and support "dry" therapy. This was applied in practice 4 years later when, in 1987, the state positively evaluated the work of ITHACA and accepted my proposal for the creation of the independent Therapy Center for Dependent

Individuals, KETHEA. This organization aimed at the creation of multiple "dry" treatment programs all around Greece, and introduced many innovations for the time. The Board of Directors was not appointed by the Minister of Health—as is the case for most public organizations—but was elected through a General Assembly. This ensured independence from the state and other political interventions and interests.

Another important innovation was the actual General Assembly that elected the Board. According to the legislative act, the members of the General Assembly were: 1. The professional staff of all programs, 2. Former addicts who were in the stage of Social Rehabilitation, 3. Representatives of the families from each program and, finally, 4. Prominent citizens who had been members of the Board of Directors at least once. The latter were the only members of the General Assembly that were appointed for life. I believed that their participation was very important to the G.A. in order to avoid the development of a closed institutional sub-culture. For the same reason, professional staff and former addicts and their families were excluded from the Board of Directors.

Despite the fact that it was not a complete democratic procedure, as the candidate members of the Board were chosen by the Director and the members of the organization, and only elected by the G.A. this was the first time in Greece that service recipients of a public therapy organization, and their families, could hardly participate in its management. I was the director of KETHEA until 1995, when I resigned. Today KETHEA is the biggest therapy and rehabilitation centre for addicts in Greece, and one of the largest in Europe. The rapid development of KETHEA was for the most part due to the management skills of my successor.

Today, dozens of specialized "dry" treatment programs for all types of addiction in the Greek countryside are part of the greater KETHEA organization. Personally, I am very skeptical when it comes to the results of such large, centralized, bureaucratic organizations. The size of such organizations tends to make addicts depend on hierarchic power and forces them to constantly violate the humanistic and communal values that inspired their approach to therapy. I was equally skeptical even as the director of KETHEA. I had already said back then that as the organization grows, it loses its radical qualities and turns into a factory that produces recovery of dubious sustainability. This is why I had suggested the decentralization of KETHEA, around 1993, I believe. This meant that the huge Organization would be separated into independent administrative and financial parts, which would have a Therapeutic Community in the centre. So every one of the 6 Therapeutic Communities, which were then part of KETHEA, along with the Introduction Centers, social rehabilitation centers and all the activities they offered, would be independent structures with their own director and Board of Directors. These structures would be linked with a loose confederacy, but without losing their self-efficiency. The confederacy would be responsible for the coordination of actions, scientific feedback and research and would be managed by representatives of each independent structure. I also suggested the establishment of a maximum duration of work for the staff,

which was 8-10 years. This would assure the radical character of our venture. After this time, the best members of the staff would stay in the structure as counselors and trainers for the new members of the staff.

These suggestions, which could define the future of the organization, provoked an organized reaction by a group of members who were drawn by corporate attitudes. These members were afraid that such policy would make the organization lose its political power and thus its capacity to demand funding. Most of all, however, they were afraid of the fact that they would potentially lose a job that was well paid and had a certain prestige within Greek society. Although the Board of Directors agreed to my reform proposals and encouraged me to fire the reacting members, I decided to resign. To justify my decision, I told the Board of Directors that radical ideas win or lose in people's hearts, and can't be imposed with administrative penalties. So I resigned in February 1995. I had already been leading the venture for 13 years. We started from scratch in 1983 and ended up with a big Organization, which by 1995 seemed to be already losing its effectiveness and turning into a bureaucratic institution. When I resigned, KETHEA had 6 Therapeutic Communities with 350 "dry" therapy positions and dozens of other support structures and specialized programs for addicts.

Bill White: You founded the first Therapeutic Community in Greece in 1983. Later on, in 1987, you founded KETHEA, from which you resigned, disappointed. Do you have bitter memories from the way things developed?

Dr. Zafiridis: I do not have bitter memories regarding my resignation. The whole venture of the Therapeutic Communities and KETHEA was a pleasant journey. I gave all I could to the addicts but I also gained many things from them. This is how I see it. I was worried because I knew that I left a real time-bomb behind me: an enormous power in the hands of a bureaucratic mechanism. When I was the director of KETHEA, I warned people multiple times about the potential dangers. The majority of the staff did not agree with me. They thought that my thoughts were pessimistic and were the result of an extreme fatigue. Some of my colleagues had already been enjoying the power they had and this influenced their way of thinking. My consciousness is right because there was nothing else I could do considering the polarized circumstances at that period. I believe that the reforms I suggested in 1993-1994 should have been suggested already in 1990 or 1991. I was too late because some ill institutional mentalities had already been established in the meantime. I take responsibility for this mistake. However, I believe that the creation of this large-scale public organization was the second major milestone in the history of addiction therapy in Greece. This organization contributed in a determining way to the development of positive social representations of addicts and addiction.

Bill White: What were the other major milestones?

Dr. Zafiridis: *A third major milestone in the evolution of addiction therapy in Greece was the foundation of OKANA (Greek Organization Against Drugs) by the state, with law passed on the parliament in 1994. This organization is closely supervised by the Greek Ministry of Health. The President and the Board of Directors are assigned directly by the Minister of Health.*

The establishment act assigned OKANA three separate and incompatible functions. First, the supervision and coordination of all existing rehabilitation and therapy structures. Secondly, the distribution of substitution therapy such as methadone and buprenorphine. Thirdly, the creation, scientific supervision and control of prevention programs. When OKANA was created, I was still the director of KETHEA. As such, I was invited to sit in on meetings with political and administrative members of the Ministry of Health, regarding the organization and operation of this new structure.

Since the very beginning, I thought that it was totally absurd that the Ministry wanted to assign the supervision of all therapy and prevention programs, as well as the distribution of drug substitutes, to OKANA. Even the name of the new structure, "Against Drugs," revealed its medical approach. This was confirmed by the fact that OKANA was responsible for substitution programs. How could an organization with scientific staff that supports the same medical approaches possibly supervise both "dry" and prevention programs based on non-medical approaches on addiction?

I addressed this profound contradiction, which, if voluntary, was probably aimed at favoring Substitution programs as opposed to "dry" programs. I believed that all research, supervision and counseling responsibilities should be given to a different organization than the one distributing methadone. Otherwise, this would be an evidently biased choice in favor of medical approaches to addiction. I also claimed that if the state had to be responsible for substitution therapy, this implied the acceptance that there's a constant need for drugs by a certain amount of people on a daily basis. If this was the case, it would be better if these drugs, or even heroin, were prescribed by doctors, instead of having the state legitimizing their distribution. Banning drugs on one hand and promoting free prescription of opioids on the other revealed a great contradiction on behalf of the state, not to say hypocrisy.

The new structure of OKANA aimed mainly at substitution therapy and support of medical approaches. It was thus scientifically inadequate for supervising "dry" and prevention programs. I still believe that behind the creation of OKANA lay a change in policy on behalf of the Ministry of Health. There was no more priority given to supporting "dry" therapy programs. On the contrary, substitution therapy programs were now the government's priority. That said, the medical model was henceforth the main political approach to the treatment of addiction.

The Ministry decided not to directly reveal the change of policy but rather impose it in an indirect way through OKANA. In this way, there would be fewer reactions from the public, the majority of which supported "dry" therapy programs at the time. It was also more than certain that the creation of such a bureaucratic organization, with a heavy "war-mongering" name and conflicting responsibilities, was encouraged by various political and academic interests.

By the end of day, Greek society adopted and accepted substitution therapy programs with methadone and buprenorphine. The propagandistic discourse that OKANA supported in public was direct propaganda and thus influenced the opinion and mentality of Greek society when it comes to drugs. Indeed, the creation of substitution therapy programs was accompanied by a parallel revival of medical approaches to addiction. The spread of such an approach in society, which had been marginalized up to that moment, thanks to the successful results of the "dry" programs of the Therapeutic Communities, was not only due to the Ministry's change of policy. It was equally due to the fact that addicts, who participated in such substitution therapy programs, and their families, fully adopted the whole chronic relapsing brain disease claim. This obviously helped them justify their controversial choice.

The fourth major milestone in the treatment of addiction was the great development of the AA and NA groups from 2000 onward. Their importance was major not only because they came to fill in a huge gap in therapy but mainly because they were the landmarks of a new era in the treatment of addiction in Greece. In other words, I believe that the future of therapy belongs to self-help groups, regardless of the critique one might make of some parts of their philosophy, or the degenerative elements in some of them.

AA and NA groups have more therapeutic characteristics and possibilities of adaptation to new circumstances than any professional program could ever dream of. Their greatest advantage is their organization, inspired by anarchist ideals. By assuring the self-efficiency of every small group, inspired by the 12 Steps, these groups resist degenerating. The founders of AA and NA groups should be honored. This organizational concept protects the members from any sort of degenerative crisis. Even in cases when this might happen, members are fully responsible for their choices.

Without a doubt, thanks to their decentralized [4] *and "de-hierarchized"*[5] *function, the members are fully responsible for every development within the AA and NA groups. In professional programs, to the contrary, addicts depend on the directors and the staff of each therapy structure. In large centralized organizations with traditional hierarchy, bureaucratic turpitude generally starts from the directors, passes on rapidly to the staff and ends up affecting the users of the services themselves. Spreading this crisis to the professional staff and the members destroys holistic values such as safety, transparency,*

[4] There's not an hierarchically higher center for decision-making.
[5] No member of the group has the right to represent the group.

trust, and true mutual interest, which are essential to the addict's true personal change. Hence, change exists only in theory, while in practice therapy is focused on stopping the drug dosage and reducing the damage cause by the specific addictive behavior.

This symptom therapy ignores the whole causal structure of addiction and excludes it from the therapeutic procedure. Hence, relapse comes as no surprise. At the same time, programs pass on the degenerative phenomena, one to the other, horizontally, developing an irreversible degenerative culture within the Therapeutic Organization. You might ask me, "What's the difference, after all?", since degenerative culture can develop within both a large bureaucratic organization and within self-help groups. There is a huge difference. In the first case, a degenerative crisis can trigger, in the best case, a sort of maturity for the directors and the staff, but for the addicts the consequences will be disastrous, as the potential for treatment will be reduced. On the flipside, crisis within self-help groups can trigger maturity for these groups because their independence hampers the spread of degenerative behavior and the destruction of the whole movement. So, even a serious crisis within self-help groups can end up helping people who are fighting for their lives.

Bill White: How would you characterize public opinion in Greece on addiction treatment and recovery?

Dr. Zafiridis: *In my opinion, the dominant trend of the scientific community in Greece, as in other EU countries, is medically oriented. They believe that addiction is a chronic relapsing brain disease that can be biochemically explained and thus therapy should be based on medication. With the help of political power, the scientific community and the media, this idea has become popular among citizens. However, despite the fact that this is the official approach, people don't seem to be fully adopting it. On the surface, many addicts and their families seem to be supporting medical theories, but when they develop a true will to rehabilitate, they tend to opt for "dry" therapy programs. Maybe this is a Greek particularity. And maybe it's explained by the fact that in Greece, "dry" therapy programs such as Therapeutic Communities existed long before methadone. They "had the time" to help thousands of people. So they constructed a "dry" therapy culture on which the rapid development of AA and NA groups was based, although methadone programs' services are used by a far larger population of addicts, comparing to "dry" therapy programs.*

Bill White: Are there recovery advocacy organizations in Greece led by people in recovery? If so, why have not developed yet?

Dr. Zafiridis: *In Greece, there are very few counseling and therapy organizations whose staff consists exclusively of former addicts. There are some private counseling centers that are created, organized and operated by members of NA. But these centers are not*

particularly popular because their services cost about four times the average salary in Greece today. All official "dry" therapy structures include a small number of former addicts.

Career Retrospective

Bill White: What would you say were the major challenges you have faced in your work?

Dr. Zafiridis: *The biggest challenge I had to face through all my years of fieldwork was to avoid abusing the trust of society, of the addicts and their families, for my own economic benefit or toward my own personal ambitions. I believe that this challenge concerns every therapist in addiction and every politician who deals with rehabilitation policies.*

Bill White: In looking over your career to date, what do you feel best about?

Dr. Zafiridis: I feel good about having seen the limits of therapeutic interventions early enough that I did not invest my professional and scientific work exclusively in "dry" therapy programs, as this would have narrowed my focus. To the contrary, I realized—without underestimating the importance of therapy—that the greatest importance lies in informing citizens about the true nature of the phenomenon. This is an essential condition for a long-term solution to the problem, and its key is personal and social change.

Bill White: What are some of the most important lessons you have learned in your work to date that might be helpful to others working in this area?

Dr. Zafiridis: Above all, people working in addiction should not be certain about anything. They should not believe that only they know the truth and no one else does. This is a common trap for professionals working in addiction. We tend to forget that ddicts using the services of a specific therapy program are not necessarily representative of the total population of addicts. Hence, we tend to generalize. The second most important thing I learned is that people working in addiction should have very good knowledge of the history of addiction. It is impossible to understand and treat addition without knowing its history. Thirdly, professionals, or those working with professionals, who want to support addicts, should have true concern for their fellow human beings, empathize with their problems and have a vision of self-improvement, as well as a vision for a better and more just society.

These are rare values in our modern society but they are essential to the well-being of people, let alone to the therapy/change of addicts. I also believe that people with serious psychological problems and personal frustrations should not work in the field of addiction. Regardless of whether they are professionals or not, they cannot help addicts. Unconsciously, they will progressively make use of the space to satisfy their personal needs, psychological or practical, and there will be very little space left for the addicts.

This kind of therapist does not have "supplementary" empathy to give to their fellow human beings and they end up getting "addicted" themselves to the therapeutic procedure. This is a very bad example for recovering addicts.

When it comes to large therapeutic organizations and professionals who work in addictions, I believe that they should have many safeguards in order not to abuse the power and the trust given to them by society. All these organizations and their staff have a lot to learn from the 12 Steps and personal attitudes of many AA and NA group members. What I mean is the "humility" of many members, who "hide" what they offer to people behind their anonymity and the generally decentralized organization of the AA and NA groups.

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