Mendel University in Brno
Faculty of Regional Development and International Studies

COMPARATIVE STUDY OF THE DRUG ABUSE IN PERU AND THE CZECH REPUBLIC REGARDING WOMEN'S ROLES

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Abstract

This Bachelor's thesis investigates the differences in solving the drug abuse issue as an important socio-pathological phenomenon. The thesis focuses on comparing the issue and illustrates its solutions in the Czech Republic and Peru. The research is particularly focused on the women's role.

The primary purpose of this study is to carry out the analysis of the issue in both territories and specify those possibilities of treatment in the Czech Republic, which could be implemented in Peru and vice versa.

The theoretical part explains terms referring to drug issue, investigates situation in the Czech Republic and Peru, focuses on detailed description of therapeutic methods used by above mentioned countries, and describes their development.

The practical part of this thesis examines, by the method of qualitative search, an environment of the therapeutic community, where in the process of resocialization the patients are being treated. An essential part of the research represents case study of ten inpatients from therapeutic communities Kladno-Dubí and Takiwasi, based on personal semi-structured interviews, paying special attention to the role of women role in the given environment.

Key words: drug abuse, treatment, women

Resumen

La autora de esta tesis de la licenciatura investiga las diferencias en la resolución de problemas de abuso de drogas como un importante fenómeno sociopatológico. La tesis está enfocada en la comparación del problema y en la República Checa y el Perú, como país en vías de desarrollo, especialmente centrándose en el rol de las mujeres.

La finalidad del trabajo es realizar el análisis del problema en ambos países y especificar las posibilidades del tratamiento terapéutico en la República Checa, las cuales podrían ser respectivamente implementadas en Perú. Basándose en la eficacía de varios métodos terapéuticos de la República Checa, la tesis revela posibilidades aplicables a las condiciones Peruanas.

La parte teórica explica términos relacionados con el problema de la drogadicción comparando la situación en la República Checa y el Perú, destaca la descripción de métodos terapéuticos utilizados por los paises anteriormente mencionados y describe su desarollo.

La parte práctica analiza el entorno de la comunidad terapéutica, dónde los pacientes en proceso de resocialización están rehabilitados por el método de exploración cualitativa. La parte esencial de la investigación forma el estudio del caso de diez pacientes de comunidades terapéuticas Kladno-Dubí y Takiwasi, basándose en entrevistas personales semiestructuradas, centrándose en el rol de la mujer en ese entorno específico.

Palabras clave: abuso de drogas, tratamiento, mujeres

List of Abbreviations

AA – Anonymous Alcoholics

ACTP – Association of Peruvian Therapeutic Communitites (*Asociacón de Comunidades Terapéuticas Peruanas*)

EMCDDA – European Monitoring Centre for Drugs and Drug Addiction

ENLCD – National Strategy for Fight Against Drugs in Peru (*Estrategía Nacional de Lucha Contra Drogas)*

CEDRO – Informational Center and Education for the Drug Prevention *(Centro de Información y Educación para la Prevención del Abuso de Drogas)*

DMT – N,N-Dimethyltryptamine

DEVIDA – The National Comission on the Development and the Life without Drugs (*Comisión Nacional para el Desarollo y Vida sin Drogas*)

INEI – National Statistic and Informatic Insitute of Peru *(Instituto Nacional de Estadística de Informática)*

LSD – lysergic acid diethylamide

MDMA – 3,4-methylenedioxy-methamphetamine

MINSA – Ministry of Health Peru (*Ministerio de Salud de Perú)*

NIDA – National Institute on Drug Abuse

OCD – obsessive-compulsive disorder

PBC – basic paste of cocaine (*pasta básica de cocaina)*

TC – therapeutic community

THC – tetrahydrocannabinol

UNODC – United Nations Office on Drugs and Crime

Abbreviations regarding anonymous informants are explained in the Chapter 5.

Contents

1. Introduction

The topic of drug abuse as a major socio-pathological phenomenon in the intercultural perspective attracted my attention for years. It is very interesting to research how developing and developed worlds deal with this issue, each in different context and unique environment. Therefore the Bachelor's thesis explores the approaches to drug addiction treatment of Peru and the Czech Republic, represented by case studies of two concrete therapeutic communities: Czech Kladno-Dubí and Peruvian Takiwasi. Thesis examines the implemented drug addiction treatment, the composition and vivid microcosm of cohabitation, the importance of applied therapeutic methods and the role of women in the context of mixed and male communities. Understanding unique and different structures and processes used for drug addiction treatment can benefit both approaches, enrich each other and open them to intercultural cooperation. I am convinced, that responsible use of traditional Amazonian medicine is not contradictory to common western medical model, but they can successfully complement each other. The aspect of that I was able to study and research the Peruvian approach to the topic in Spanish language enabled me to understand the perspective of Peru more profoundly.

The concept of therapeutic community and its applications in Czech and international context was elaborated in detail by Czech psychiatrist and psychotherapist of psychodynamic orientation Kamil Kalina. Dealing with the issue in the Czech Republic is influenced by the specific and unique historic background, in which hierarchic and democratic approaches did not stand against each other. This information enabled me to understand the perspective of western medicine model based Kladno-Dubí. On the other hand, therapeutic community Takiwasi as a representative of Peruvian approach to the drug abuse treatment is based on the principles of use of the traditional Amazonian medicine. Doctor Rosa Giove - who worked in Takiwasi since its very establishment - introduced in her book *La Liana de los Muertos: Al Rescate de la Vida* the concept of therapeutic community, where hallucinogenic plant ayahuasca, a psychoactive herbal extract is utilized

for the treatment of drug addiction. This hallucinogenic beverage is integrated into the system of drug abuse treatment and psychotherapy. Bachelor's thesis complements the insight on the Peruvian situation by various statistics from Ministry of Health (*Ministerio de Salud de Perú*), The National Commission for Development and the Life without Drugs (*Comisión Nacional para el Desarollo y Vida sin Drogas*) and others.

In the first chapter, the thesis presents the therapeutic community and its development towards the conventional model known nowadays in so called western medicine, defining the common core of various approaches. This comparative study doesn't forget the specific development of Czech therapeutic communities in the historical context and complements this complex information by introducing the assumptions for successful treatment and characteristics of therapeutic community. Based on the latest report regarding drug abuse phenomena in Czech Republic, the thesis provides conclusions about the possibilities and approaches to the addiction treatment and the drug policy, including detailed research on Czech therapeutic community Kladno-Dubí, which I visited personally to assist with the qualitative research.

In the second chapter, after introducing the Peruvian situation regarding questionable number of therapeutic communities operating in legal conditions, thesis investigates the approach of Peruvian therapeutic community Takiwasi in the context of using the tradition Amazonian medicine for the addiction treatment. Including aspects such as ayahuasca ritual and its toxicity, the spirituality, this chapter is closed by research regarding women's roles in the drug abuse. The chapter introduces possible reasons, why law *Ley N° 29765, Ley que regula el establecimiento y ejercicio de los centros de atención para dependientes, que operan bajo la modalidad de comunidades terapéuticas* does not allow mixed communities and therefore presence of women inpatients in Peruvian therapeutic community Takiwasi.

The aim of my comparative study is to answer the hypothesis whether drug abuse treatment is conditioned by socio-cultural aspects. In the third chapter, the content analysis of the current status of drug addiction treatment in both territories

is carried out, with the emphasis on the treatment of women in Peruvian society. To achieve the aim of my thesis, I used the method of qualitative research, the content analysis of data gathered in both therapeutic communities as a place, where inpatients are treated in the process of resocialization. In order to bring the conclusions, the method of open coding is applied on semi-structured interviews of ten inpatients, five of them collected in Czech therapeutic community Kladno-Dubí and five of them coming from the background of Peruvian Takiwasi. I define four keys categories for each community which does not coincide, and I analyze the statements, providing my personal commentary on each key category, which appears as the subchapter.

2. Methodology and Aim of the Thesis

2.1 Aim of the Thesis

The aim of my comparative study is to answer the hypothesis, whether drug abuse treatment is condition by socio-cultural aspects with the emphasis on role of the women. My thesis is divided into three chapters, and my attempt is to present the theoretical knowledge accompanied by the results of qualitative research, making the thesis more homogeneous and complex. The theoretical parts are presented in the form of an expansive literature recherché. The advantage of qualitative research is the possibility to explore the causes and relations among the variables and its additional possibility to analyze core of the issue (Hendl, 2005). The three chapters are further divided into several subchapters. They are focused on describing and defining the differences in the structure of therapeutic community Takiwasi in Peru and Kladno-Dubí in the Czech Republic.

2.2 Hypothesis

The last chapter focuses on the hypothesis: is drug dependency treatment of women and men in the Czech Republic and Peru conditioned by socio cultural aspects? Based on the preliminary phase of the research I investigated, the hypothesis is verifiable; the drug dependency treatment of women and men in the Czech Republic and Peru is conditioned by socio cultural aspects. The initiatory phase of the research was characterized by reading the scientific publications in Spanish language, which I speak fluently on proficiency level in both oral and written form. Given the topic, the ability of studying the materials in two foreign languages gave me the opportunity and presumption to deepen my knowledge of the issue in the form as it was described by the native scientists.

According to the aim of the comparative research, in one of the subchapters, I focus on perception of the treatment by Czech women, on their behavior and the perception of the women's role in Peruvian society by Peruvian male clients.

I aim to carry out the analysis of the issue in both territories, and possibly including those structures of therapeutic treatment of in Czech Republic, which could be implemented in Peru and vice versa.

2.3 Methods

The qualitative research and data collection were lead in April and May of 2014, when I was allowed to assist my supervisor in doing the qualitative research on twenty case studies in two Czech therapeutic communities – Renarkon, and Kladno-Dubí, from which I chose five for my comparative study. I was assisting during the full length of qualitative research and analysis of the system of treatment in the Czech communities; however I used the Peruvian data from Takiwasi collected by my supervisor in Peru in October 2014. To fulfill the objective, the dialogues of 20 inpatients were recorded after the informed agreement was presented; all of my previously prepared questions for the research were covered during these dialogues.

I included the case study of all of the participating women in the Czech communities to my comparative study as it covers the emphasis on the role of women in drug abuse. I perceive the presence of women in communities in the Czech Republic as the main structural difference between both communities.

In the next phase I focused fully on research of Peruvian legislative system in order to investigate the structures restraining the existence of mixed type of therapeutic communities in Peru. The concrete law allowing to establish only non mixed communities is allocated in the law *Ley N° 29765, Ley que regula el establecimiento y ejercicio de los centros de atención para dependientes, que operan bajo lamodalidad de comunidades terapéuticas,* in the Article 12th.

After I submitted all the recorded dialogues for the transcription of audio records, I initiated the thematic analysis. The transcription of one dialogue in the average length of twenty two minutes lasts approximately five hours and I transcript ten of them. After converting the data into the processor MS Excel, I transmitted it into so called open coding. The unit of the analysis is the statement given in one para-

graph. The bases of the process of coding are two analytical processes, the first regards comparing and the second asking the questions (Strauss & Corbin, 1999). After the coding of whole sample is completed, I merge the codes into more general categories, which serve as the base for my interpretation. I use the processes of axial and selective coding. However, axial and open coding are different analytical processes, the researcher is constantly moving between both types of coding. After the qualitative research is completed, I obtain four essential concepts for both therapeutic communities which I work with in the fifth chapter.

I respect the following rules proposed by Merten (1995):

- the scheme of categories should be theoretically derived, i.e. it corresponds with the aim of the research
- the scheme of the categories should be complete, i.e. it should be sufficient to cover all possible subjects
- the categories should be mutually exclusive
- the categories should be mutually independent
- the categories should arise from unified classifying system
- the categories should be defined ambiguously.

I strictly keep the Spanish terminology of Peruvian terms in the context of drug abuse and treatment and this is marked by cursive. The majority of the source materials which are used for the Peruvian part of comparative study are studied in Spanish language and I translated them. All the data used to support the writing of thesis were used from available publications; the essential sources for the Czech communities were studied in Czech language, however based on the topic and the area I chose, the foreign sources prevailed. I used the Mendeley citation manager.

3. Drug Abuse Treatment in the Czech Republic

3.1 Therapeutic Community and Basic Presumptions

In this chapter of my Bachelor's thesis, I map the development of therapeutic communities and its importance for treating the abuse[1] as socio-pathological phenomenon, I illustrate the model of therapeutic communities in the Czech Republic and I analyze the territory. Unlike Peruvian Takiwasi, where clients are treated by traditional medicine of Latin America, Kladno-Dubí as representative of Czech communities uses the methods of structured program, rules and activities based on group therapy, free discussions and personal interview with psychotherapists.

According to the statement of Kratochvíl, the therapeutic community is a special form of intensive group psychotherapy where clients, mostly differing in age, gender and education level, live together for a certain period of time. Besides the group therapy, they share more kinds of activities together with work, which allows them to project the problems of their own lives, especially their relationships, into this small model. Community is therapeutic, because it provides not just evaluation of previous maladaptive behavior, but it also promotes self realization of overview of own problems, and the share in creating these problems. It should allow collective experience and support the training of more suitable adaptive structures of behavior (Kratochvíl, 1979).

Just as De Leon (2000) or Gibbons, Andreson, & Garm (2002) state, the therapeutic community can be observed in two aspects: as a socio organizational model, and as a treatment method.

At the very beginning one of the developers of therapeutic communities Main captures these two mentioned dimension thanks to the etymology into one term: "therapeutic community" – being the organized structure and the method of thera-

[1] As for the addiction, the present time puts ever increasing demands on the mental strength of man. The other side of the coin is that it demands time and profits, which are tangible. The crisis in experiential sphere can lead to a number of psychopathological phenomena and infamous reflects on the quality of life. The man is deprived in experiential realm, trying to escalate the intensity his experiences in his spare time (Kirchner, 2012).

py at the same time, using this term in Northfield Treatment Program in 1946 for the first time (Griffiths & Hinshelwood, 1995).

3.1.1 Characteristics of the Therapeutic Community

TC is characterized by organization, structure and safety (Kennard, 1998). From the psychological point of view, patients come broken, emotionally damaged and with trust issues in many of the cases[2], as I witnessed while doing my research in Kladno-Dubí. Therefore, TC must offer safe environment with certain, transparent and clear structure of boundaries and expectations; it provides highly structured environment with the web of cardinal and other rules; the key factor of the therapy in TC is openness and honest "examination of problems", which in practice means the ability to accept and provide the feedback in mutual relations in TC. Therefore, in the atmosphere of therapeutic communities, these feedbacks can be perceived as deeply profound, critical and harsh. Maladaptive, often destructive experiencing and behavior which is brought by clients to TC, is transformed into more honest, simplified and open (Kalina, 2008). The safe environment provides the space to not just accept this, but to process it as well. Pohl emphasizes the importance of conditions for encouraging an alcoholic for higher accountability of shaping their own destiny. Thus personal management of the department has to ensure that patients are accepted as people capable of taking their responsibility (Pohl, 1974).

As for the criticism of therapeutic communities; it is necessary to reject some of the unrealistic expectations regarding therapeutic communities, e.g. that an open communication itself is capable of solving most of the interpersonal problems (Kratochvíl, 1979).

[2] According to the studies of several psychiatrists, 30 % or more of individuals abusing addictive substances, suffer from mental disorder. Health problems are often untreated or not treated in time or continuously; because of a limited degree of cooperation with drug addict individual. The most common social consequences include complicated or broken relationships with family, school or work environment, and can be related with low qualification and unfinished education degree. Drug user or individual abusing drugs gradually lose work habits, reduces his adaptability, reduces his social ties and social competences, and loses responsibility, jobs and thus income, and eventually becomes socially degraded (Zvoníkova, 2014).

At the end, the therapeutic community for treating drug abuse[3], happens to be the laboratory in which the client is allowed to experiment safely with this new gained experience, new adaptive skills so these can be used "in real life" after returning back from the treatment (Kalina, 2008).

3.1.2 The Assumptions for Successful Treatment

Since my thesis is structured as comparative study, we are able to spot high number of similarities between two researched therapeutic communities in assumptions for successful treatment, and these lie in statement of Bloom:

- the environment of the treatment is based on the values, such as equality, honesty, openness and mutual trust
- the direction of the treatment unit is supposed to be more democratic than authoritative
- patients can be largely responsible for their own process of treatment

Patients are able to therapeutically prospect one to another (Bloom, 1999). Czech clinical psychologist Kratochvíl adds to the following points also the active share on the treatment and reciprocity, allowing the development of the sense of "us" (Kratochvíl, 1979). Psychologist Hartl among the above principles includes the need to create relationships between all members and the attitude based on mutual respect and acceptation of others despite the fact, that their behavior deviates from the norm (Hartl, 1997). The basic rules are also included in the therapeutic contract, i.e. the agreement between the client and the therapeutic community that will or will not do any action. Acceptance of the contract presents great importance for the entire therapy (Knobloch & Knoblochová, 1999).

Patients of this dialogue are responsible for the honest self reflection, empathic and critic evaluation of others and their different opinions, emotions, behavior and practical contribution to society. Clients are being motivated to take the individual chance to change, the chance for positive growth, in reaching the behavioral,

[3] International classification of diseases distinguishes following disorders for statistical reporting: 'mental disorders and behavioral disorders conditioned by "drugs" under the group of psychoactive substances' by statistical specification F 10–F 19 (Zvoníkova, 2014).

psychical, social, labor, health and spiritual optimum. The everyday experience of community cohabitation and work is considered just as important aspect of the treatment as formal therapy. In the structure of therapeutic community both of these aspects are closely interconnected. The tension and synergy between them are leading to reaching the change and strengthening it for the future (Kalina, 2008).

Compared to the traditional psychiatric structure, where the patients are passive, community structure allows everyone to express their capabilities and play active role in own process of healing. Mood swings, conflicts and personal crisis are becoming a valuable material for corrective experience and social learning in general. Mutual communication takes place on all levels no matter the hierarchic roles. The equality in decision making process takes place instead on taking orders from above (Hartl, 1997). Instead of being simply objects and consumers, they meet with members of this group at the level of mutual cooperation and overcome problems together.

There are found two basic tendencies: so called democratic, and so called hierarchical TCs for drug addicted patients, while each of them is presented by own definitions and terms, culture and traditions (Kalina, 2008).

3.2 The History and the Development of the Therapeutic Community

The idea of therapeutic communities originated in England during the Second World War. Wartime hardships brought into English hospitals numerous soldiers with reactive neurotic and psychosomatic disorders; therefore it was highly required to provide them an effective and rapid assistance. Attention was turned to the techniques of group psychotherapy and the possibility of wider use of the entire department events and relationships between patients and staff (Kratochvíl, 1979).

Bloom and number of other authors presented the group therapy model in its beginning as the opposition towards psychoanalysis, claiming that psychoanalysis and other schools are based on individual approach towards patient. London

school, leading a dialogue with group therapy and the analysis of ego was able to extract high amount of information for the research of primary matrix of interpersonal relations, family, and eventually group phenomenon thanks to Freud (1965). Primarily the interconnection between "therapeutic upbringing" with theory and practical involvement of London psychoanalysis happens to be the real rudimentary background of the TC in current meaning of the word (Kalina, 2008).

The important contribution to the formulation of therapeutic community principles and their distribution belongs to psychiatrist Maxwell Jones. He continued with his work after war in Mill-Hill between the years 1947-1959 as the leader of social rehabilitation department of the Belmont Hospital. This was determined for resocialization of psychopathic personalities. Workplace happened to be an important training center in the fifties, which has inspired many foreign visitors to establish therapeutic communities in their countries. Jones published his experiences in the book "Social Psychiatry" in 1958 and he kept using this terminology for his books (Jones, 1965). Social psychiatry in this sense was focused on processes of social rehabilitation with embracing of group dynamics in structured background. The hospital was perceived as the microcosm representing wider society; an experimental lab of social change. Therapeutic communities based on model of Jones and Main (later called as democratic) brought a wide range of revolutionary changes, transforming the relationship within TCs into more open, honest and democratic.

Under his influence, the first therapeutic community was founded in 1954 in Czechoslovakia by F. Knobloch in Lobeč (Kratochvíl, 1979).

The principle of the TCs was spreading worldwide promptly. Communities originated in Switzerland (Kreuzlingen), Germany (Lindau, Berlin and others), Poland (Warsaw). Following F. Knobloch, J. Skála established another Czech community in Apolinář and we cannot overlook the contribution of Kratochvíl in the community Kroměříž (Hartl, 1997).

Hierarchic communities (or so called "drug-free", "concept-based") are targeted on specific consumers: drug addicts, ensuring them drug free and clean environment and lead them to the life in complete abstinence.

A cradle of hierarchic TCs is often connected with Synanon. Its leader, Charles E. Dederich was not a professional from the field of mental health, he was former alcoholic. Synanon was not TC and was not claiming to be one. However, various authors agree on the fact that the study of the working methods and practices in Synanon[4] brings extraordinary knowledge about what is effective and healing in the therapeutic community, and what is on the other side harming, dangerous and risky (Deitch, 1997). It can be considered as the legitimate ancestor of the Oxford group, and from there the Anonymous Alcoholics[5] (AA) movement raised, to some extend (Kalina, 2008). Later on, the Daytop Village in USA, coming from the Synanon model, tried to present the community not as a long-term living alternative (as Synanon did), but as a way to live abstinent life in normal society.

3.3 Czech Therapeutic Communities

We could say, that Czech TCs reflect in their development the world model (the division into democratic and hierarchic models), since they are concentrated around two circles: in the field of psychiatry – psychotherapy and in the treatment of addictions. But we have to consider also the specific situation of communist Czechoslovakia as one of the crucial aspects, where TCs were not labeled as in this terminology, but they existed. The 1960s played the significant role in the development of Czech communities, when we got the access to the information about TCs in the last years and first home treatment systems originated.

In 1948 in the Faculty Hospital of 1st Faculty of Medicine of Charles University, the first department for the treatment of addictions was established, known today

[4] Synanon as the facility was mentioned various times in the popular literature. Autobiographic book about young teenage heroin addict Wir Kinder Von Bahnhof Zoo mentions, that the protagonist would rather choose Narkonon than Synanon. Both were considered to be a cult or sect that time, however in Synanon according to the author, they required extremely strong obedience and shaving the head of every patient to prove the motivation for the treatment (Hermann & Rieck, 1987).

[5] The AA is international co-operative movement, not a single organization, associating people with problems with alcohol or other addictive substances who want to overcome it. It arised in 1935 in USA and associates 96 000 of groups in 134 countries (Nešpor, 2000). Along the lines of AA, also the Anonymous Narcomans (AN) originated.

as Apolinář (Kalina, 2008). We cannot omit the practice model of SUR (stands for Skála, Urban, Rubeš), which originality lies in the intercorporation of practice community working on principles of TCs in the democratic direction.

The regime in Czech therapeutic communities is usually severe and tolerance towards differing behavior is smaller; the emphasis put on discipline, order and training is high. In a known and strict concept of Skála, life in a therapeutic community for alcoholics will strengthen the will, lead patients to develop new interests and activities necessary to induce states of natural euphoria and will allow patients to learn how to deal with the critical state of tension, frustration and bad moods without alcohol. An essential part of the system consists in a scoring system which is the control mechanism of the patient's medical activities and his misdeeds (Skála, 1987).

The feedback is very important part of the rehabilitation process not just in the Czech Republic, but also in Peru. Non verbal emotional discourse often reveals the hidden aspects (Kratochvíl, 2005).

In both communities they honor similar cardinal rules (abstinence of drugs, maintaining tolerant relationships within community, prohibition of physical violence, religious discrimination, etc.). Moreover, violation of these rules can be perceived as the reason to be expelled in both communities.

3.3.1 Current Situation Regarding Czech Drug Policy

Nowadays, capabilities of drug policies to cut down the vicious circle of repeatedly collapsing hope, addiction, mutual destruction and elimination are very limited. Drug policies fail to eliminate addiction as such.[6] Thus, Morávek recommends a strategy that embraces controlled drug use or, more generally, the art of controlling one's addictions (Morávek & Kabele, 2010).

[6] When addiction gets out of control, addicts lose accountability; stigmatization and exclusion from conventional roles often ensue. Many family members are trapped in uneven, dysfunctional relationships. Prohibitionist policies worsen the breakdown of reality construction, while medical and social rehabilitative policies have limited resources for remedy (Morávek & Kabele, 2010).

National drug policy strategy of the Czech Republic is elaborated in detail with scheduled procedures in Action Plan of the National Anti-Drug Strategy policy, at the moment for the period of 2013-2015.[7]

The year 2013 has revealed a total of 276 indoor cannabis plantations, seized 735.4 kilograms of marijuana, 73.6 thousand cannabis plants and 1.3 kg of hashish. 261 meth cooking labs has been discovered and 69.1 kg of methamphetamine with an average purity of 71% has been secured (Moravčík *et al.*, 2014). Drug use of the adult population in the Czech Republic is found over the last few years at a stable level. The most commonly used illegal drugs are cannabis and ecstasy which have been used at least once by 23-34% of people. The investigation reported about 360 thousand regular users of cannabis, 37 thousand methamphetamine users, 36 thousand users of ecstasy and 31 thousand users of hallucinogenic mushrooms(Zvoníkova, 2014).[8]

In the field of the drug treatment, in the Czech Republic we allocate twenty eight bed medical facilities, where approximately 6,5 thousand people are being detoxicated every year. Follow-up care is provided through outpatient aftercare programs (about 30 aftercare programs for drug users). Ambulant health facilities in the field of psychiatry provide services for about 40 thousand drug users within the treatment (Zvoníkova, 2014).[9]

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[7] As National strategy, also the Action Plan itself, have been approved by Government Resolution Priorities (Zvoníkova, 2014).

[8] Since 2010, the apparent increase in the incidence of new synthetic drugs, which have been experimented by 5% of people between 15 and 34 years of age. As for the alcohol, it is estimated that in the age category 18-64 years, about 990 thousand to 1,400 thousand people use alcohol in a harmful way and about 50 thousand to 150 thousand people are dependent on it (Ibid.).

[9] The model of services consists of the following elements: field programs, low-threshold and counseling services, detoxification, stationary treatment programs, methadone substitution treatment, outpatient treatment, short and medium term treatment, residential care in therapeutic communities, outpatient aftercare programs and sheltered housing, vocational rehabilitation, social work, the offer of leisure activities are considered as the standard in professional practice. Drug policy of the Ministry of Labor and Social Affairs is focused on providing social services aimed at addressing social problems related to drug use (Ibid.).

3.4 Kladno-Dubí

The target of my comparative study is Czech therapeutic community Kladno-Dubí, which I visited personally. Kladno-Dubí is the residential town facility providing protected (drug-free) environment with created programs to strengthen the mechanisms necessary to implement the decision of abstinence. The basic aim of the service is the overall change behavior and attitudes towards pro abstinent way of life of the clients, renewal or acquisition of skills advantageous for social functioning in terms of integration into everyday life in the profession, housing, relationships and taking responsibility for their own lives. Therapeutic team strives for a permanent change in a mechanism of client's behavior and offers a system of psychotherapy and socio-therapeutic programs, individual access, support and acceptance. Thanks to the therapeutic environment of the community and offered programs a patient can understand themselves, dealing with the past, accept their limitations and limits; learn to live in the present, solve legal and social issues; clarify priorities and realistic plans to meet their future and acquire skills to support and sustain quality decision to live with abstinence. The average age of patients was 33, 5 years in 2013. Six clients out of total 38 clients of TC completed basic three months program, and five clients completed the program in full duration, being the average length of treatment 85 days (Petráková, 2013).

Community of Kladno-Dubí is a mixed community. They accept men and women, 17 years old and older (in indicated cases 16 years old), addicted to addictive substances after absolving an ambulant treatment or short-term abuse treatment. The requirements for acceptance of new patients are:

- the applicant is coming from target group
- personal motivation
- application with cover letter, basic information and the date of completion of treatment
- personal consultation

- men and women who have completed treatment for alcohol dependence, non-alcoholic drugs, including drug addiction and gambling (at least detoxification in a medical facility)
- ability to pay for accommodation and food[10]

The regime is divided into three phases, making the total length of treatment eight to twelve months (Petráková, 2013). These are depicted in the Figure 1.
Most of the therapeutic communities are situated out of the centers of large cities – relative distance, which has to be overcome with high effort in most of the cases, as well as the fee payments for the treatment, play the key role as motivational factor in admission of new patients (Kalina, 2008). The capacity of TC Kladno-Dubí is 15 persons.

Figure 1: The lengths and phases of the program in TC Kladno-Dubí. Source: Author's archive.

1st phase (2-16 weeks)	2nd phase (2-3 weeks)	3rd phase (4-6months)
Therapeutic program according to the regime	The active search for employment and job	Regular job or school or individual program

The methods implemented in TC are following:
- psychotherapy supported by matrix program
- rehabilitation program
- work therapy and program
- social counseling program

TC offers all the ambulatory services, such as counseling, motivational psychotherapeutic sessions (for those after relapse or with no completed detoxification yet),

[10] In the context of payments, should be noted that unlike in Peru, the Czech Republic contributes in supporting the patients in material distress. This payment in TC Kladno-Dubí covers: 100,- CZK daily for accommodation and 70,- CZK daily as the subsidy for food. Takiwasi offers repayment schedule, respectively in certain cases allows also relief from payment (note of the author).

the aftercare programs, and the support groups for the close relatives of addicts (such as family or partner). All these services are provided free of charge.

Outreach harm reduction program is implemented as a mobile outreach program designed for the target group of drug users with powers in Kladno, Slané, Unhošť and Stochov. The program is simple evidence of contacts and if necessary, it provides this service anonymously.

According to Petráková (2013), street workers move one day a week in the afternoons and evenings in the selected areas in different cities and implement an outreach program which includes:

- providing information about the dangers of the chosen way of life,
- exchange of injection materials, providing medical supplies,
- social work - ensuring social benefits, office work etc.,
- in the case of longer cooperation it motivates the users for treatment recommendations,
- assistance in the implementation of legitimate interests in personal matters.

4. Drug Abuse Treatment in Peru

4.1 Peruvian Therapeutic Communities

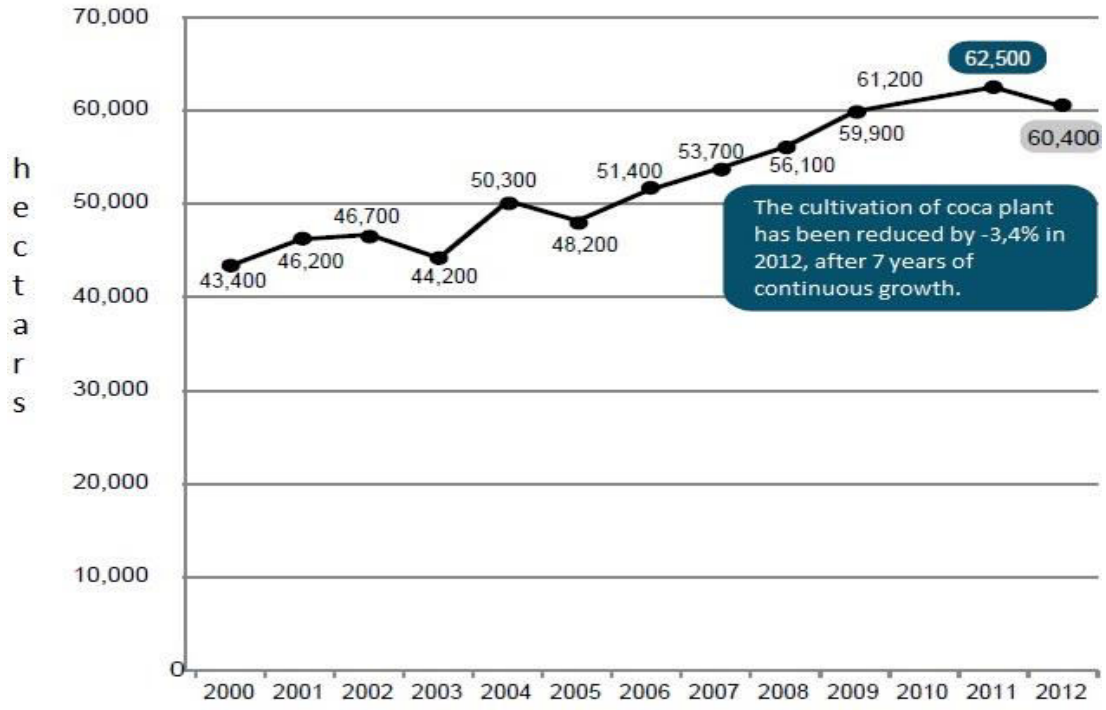
The outlook for consumption in Peru shows the need for create policies based on research and policies aimed at reducing biological, psychosocial and environmental vulnerability (Cabanillas-Rojas, 2012).

To calculate the concrete number of TCs is complicated in Peru. The Ministry of Health of Peru (MINSA) estimates that there are 400 rehabilitation centers in Peru and of these, 300 are in Lima. Formalization is slow because the communities do not meet the clinical requirements.

The Department of Mental Health of Peru visited last 108 rehabilitation centers in Lima in December 2013; the sector found that only 3% of them fulfill medical base and infrastructure of law *Ley N° 29765, Ley que regula el establecimiento y ejercicio de los centros de atención para dependientes, que operan bajo la modalidad de comunidades terapéuticas*. According to the statement of *Asociación de Comunidades Terapéuticas* Peruanas (ACTP) this law is too demanding. According to their statement, they are aware of the fact, that TCs need professionals, but doctors can visit only twice a week; according to ACTP they do not need to stay 24 hours. It is highly recommended that in the formulation of public policies and promotion intervention programs, they would provide a framework of complementarity of preventive areas (Cabanillas-Rojas, 2012).

Based on the *Comisión Nacional para el Desarollo y Vida sin Drogas* (DEVIDA) and the National Strategy for the Fight Against Drugs 2012 – 2016, the drug market with cocaine commits Peru significantly. The United Nations Office on Drugs and Crime (UNODC) estimated in Annual Report 2011, that most of the cocaine is produced in Colombia (42%), followed by Peru (39%) and Bolivia (19%). Coca crops have maintained an upward trend in the last 12 years. In 2012, however, the area of cultivation fell by 3.4% after seven years of continuous growth, rising from 62,500 hectares in 2011, to 60 400 hectares in 2012 (DEVIDA, 2013).

Figure 2: The evolution of coca cultivation in the period 2000-2012 in hectars. Source: DEVIDA, 2013.



According to DEVIDA, the coca production is rising from 48 200 kilograms in 2005 to 64 400 in 2011. In year 2013, the 2,4% of inhabitants (296 426 in total) are consumers of PBC. Against that, the state has only three official hospitals specializing in the treatment of addictions, all in Lima. The situation is worrying because the therapeutic range for drug addicts in the country is scarce (Fiestas & Ponce, 2012). The remaining patients have to go to clinics or therapeutic communities (Chaname *et al*., 2009).

In 2012, 292 local governments formed the Interdepartmental Committee for the Prevention of Consumption and 101 of them promoted international cooperation agreements for the implementation of prevention programs, according to their powers and functions under Article 73 of Law No. 27972 of the Organic Law of Municipalities (DEVIDA, 2013).

Despite the mentioned number of official and non-official facilities based on so called model of western medicine, I will turn our attention to the model of traditional Amazonian medicine, to introduce the case study of TC Takiwasi.

4.2 Takiwasi

The Takiwasi therapeutic community (in Quechua "the house of song") was founded in 1992 by a French tropical pathologist and expert in the area of biomedicine, Dr. Jacques Mabit, whose aim was to offer an effective alternative to more common approaches to drug abuse treatment (Horák, 2014). In Takiwasi, the patients are being treated by traditional medicine of Latin America (Horák, 2013). *"The term traditional medicine of Latin America can provoke a set of misunderstandings, therefore the correct explanation is the phenomenon known in our country more likely as shamanism"* (Kavenská, 2013, p. 9). WHO defines the tradition medicine as the sum of knowledge, practice and skills based on theories and experience coming from different cultures, which are explainable or not and serve to maintaining the health, prevention, and diagnostics for the mental and physical health (WHO, 2000). The most important and basic role of the shaman is curing (Eliade, 1997).

The Center for rehabilitation of addictions was founded in 1992, starting to take first patients in the August of the same year. Takiwasi starts its activity, taking place in Tarapoto, the main principal axis of the region which is leading producer of coca plant, revealing also other major issues, such as high rates of extreme poverty, narcotraffic or young population.

According to Giove (who has spent 7 years working in the TC Takiwasi - since the very establishing of the community in 1992 until the December 31th of 1999 - not meaning this model as the only structure suitable for patients, not as recommendation, but as very interesting topic to investigate), Takiwasi holds on traditional medicine unifying it with western and traditional medicine. Using the resources of traditional medicine, botanic and culture, these meet with the methodology of proximity of modern psychology, such as personal psychology, gestalt psychology, Jung psychology and psychoanalysis with the mark of western scientific investigation (Giove, 2002).

Traditional Amazonian medicine works primarily with the physic body as a medium, which will allow us to express the mental, emotional, existential or spiritual part of the unit, all in the repetitive, ritual context. The constant revelation of re-

sources for the treatment of drug abuse, which although can be applied to other treatment methods shows us, that there is no contradiction between the subjective and objective knowledge – but they complement each other (Giove, 2002).

All the methods used in therapeutic community were previously tested and verified on therapists themselves, and the maximum number of internet patients remains fifteen, same as in Kladno-Dubí. Takiwasi is acknowledged by the Ministry of Health in Peru (MINSA), and fulfills all the legal requirements (Giove, 2002). Along with ayahuasca sessions, Takiwasi implements diets. *"Diet is a therapeutic procedure during which the patients stay in rainforest for eight days on their own, following a prescribed eating regime and digest substances from plants"* (Horák, 2013, p. 62). Moreover, part of the traditional treatment are purges and various rituals, such as transitional ritual, ritual of commitment, ritual of sudatory shanty, ritual of an unborn child, ritual of earth and ritual of masks (Horák, 2013). The phases of the Takiwasi treatment are depicted in the Figure 3.

Figure 3: The lengths and phases of the program TC Takiwasi. Source: Kavenská, 2013.

1st phase (2 – 3 months)	**2nd phase (3 months)**	**3rd phase (since the 6th month till the end of treatment)**
Physical detox, purges, establishment of the relationship with the therapist.	The psychical level of the treatment, confrontation with the past, first diet.	Deepening of the work on the psychical and spiritual level.

The preliminary phase of the treatment lasts ten days, and during this time they collect the personal information and establish the contact of the patient. The revision of the language skills is mandatory, since the only official language used in Takiwasi is Spanish (Horák, 2014).

Requirement for the treatment:

- taking the full responsibility for the treatment
- Spanish language skills
- total abstinence – detoxificiation, based on emetic and purging plants, follows a specific procedure in contrast with, in contrast with other TC where this process is lead in mental hospital (Horák, 2014).

4.2.1 Ritual of Ayahuasca

According to Grof, psychedelics used responsibly and with proper caution, would be for psychiatry what the microscope is for biology and medicine or the telescope is for astronomy. These tools make it possible to study important processes that under normal circumstances are not available for direct observation (Grof, 1980).

Ayahuasca (*Banisteriopsis caapi*) is the liana considered the plant teacher (*Maestra de las Maestras*) in the region, as it is ascribed with the ablity "to teach" (Luna, 1984). Mixed with the precise proportion of *chacruna* (*Psychotria viridis*), "ayahuasca" is medicated. The drink, with the color in brown tone and characteristic scent, is being used for treating various times of problems, be it in different conditions or collective sessions. While the perspective or insight is the most important for the west, for the natives it's the purgative, or cleaning effect (Mabit, 1992).

The preparation is taking place in the very precise form, lasting twelve hours as minimum. The traveler's reports were found, informing that the plant Ayahuasca was known by the natives since the last century, although the western world identified its components since the 1920s, and the first studies regarding the plant are dated to the decade of 1960s, when it identifies its role as neurotransmitter (Giove, 2002).

"The substance itself is not so important. Special role here is played by the environment in which the psychoactive substance is administered. Drinking ayahuasca is rooted in a solid spiritual basis" (Horák, 2013, p. 25).

4.2.2 Using Ayahuasca Plant in Takiwasi

Dr. Robin Carhart-Harris is the first scientist in over forty years to test psychedelics on humans. Among others, he presented his positive attitude towards ayahuasca use in medicine in his lecture *Psychedelic Drugs in Science and Medicine* in April 2015[11]. I got the chance to ask him directly from the audience on his opinion regarding the use of ayahuasca in drug addiction treatment process and its application of this attitude in the so called western model of treatment. He agreed on the high addiction treatment potential of this plant which should be further examined for broader use in western medicine. At the same time, he accompanied this opinion by the information that ayahuasca is chemically very complex substance, which makes its use in western medicine more complicated than the use DMT, for instance.

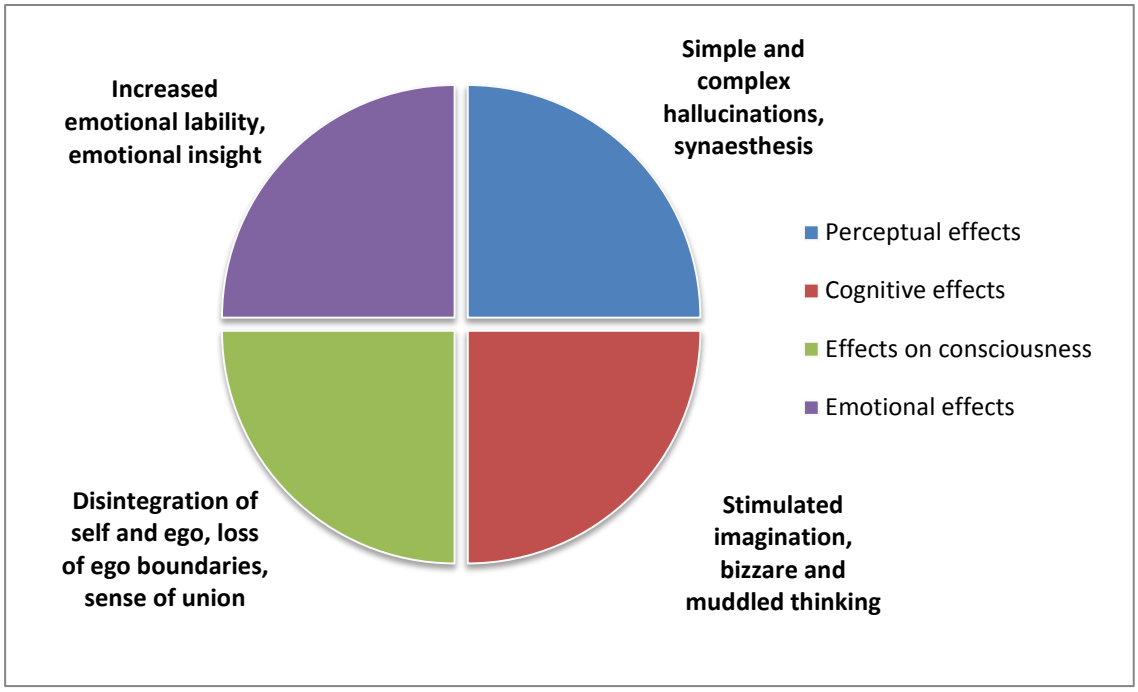
In Takiwasi, the ritual and treating sessions takes place twice a week (on Tuesday and Friday), while both patients and therapists participate, the work is considered mainly individually introspective, and the content of visions – also in group therapy – is mostly the graphic expression (Horák, 2013). The sessions are lead by night, under supervision; the patient is guided into the inner world in the experience which lasts for approximately four to six hours. According to statistics of Rosa Giove, 731 ayahuasca sessions took place between 1992 and 1999, which represents the total of 8071 registered individual doses.

According to Giove (2002), the effects of ayahuasca are simultaneous on different levels:

- physical effects
- psychical effects
    - the catharsis
    - dissociation
    - visions about drug dependency
    - the reconnection to spirituality and others

[11] The lecture Psychedelic Drugs in Science and Medicine took place on 24th of April 2015 in Brno (note of the author).

Figure 4: The psychological effects of psychedelics. Source: Author's archive.



The effects of catharsis, or cleaning effect manifested through vomiting or diarrhea, are allowing eliminating the negative in the body of patient. There have been spotted also crossed sensorial interconnection, such as hearing the colors or seeing the sounds, among another side effect we should mention hyperesthesia, the sensation of disproportion, confusion of perception, alternation in the position of organs or recalling the memories, while the intensity depends not just on the quality, but also at the patient and the therapist who is leading the session.

Apart from the affective – emotional catharsis, we observe the deep structural reunification and reconnection with the spirituality. The expression of emotions through the laugh, the cry or the rage "unlocks" the patient, and allows him to understand the influence of these events on the development of his problematic. The visualization of the mistakes allows reforming the adopted behavior. The desire of peace, letting go, the act of forgiving spontaneously or asking for forgiveness are very common. It's important to mention, that despite of the unpleasant content of the visions, there exists the sensation of being "correct": it's not the sensation of judging or punishment, but the feeling of that they are kindly showing us our defect in order to have the opportunity to correct them (Giove, 2002).

La muerte iniciática is the process acceptation of the death as the part of the vital process, understanding it as the end of one period or phase during the visions in the ayahuasca session. We can state this theoretically, but the experience in the session is extremely important, difficult and enriching at the same time, with the advantage that we are not talking about the real death, just about the approximation of vital conclusion, confronting the death, but without any danger in the end. People with this experience claim positive shift in the relations towards others (Valleur & Sueur, 1994).

We fulfill the paradox of death being the most healing and vital experience we can experiment with. This fact brings us back to the ethymology of the name of ayhuasca: *aya* meaning dead and *huasca* the liana, introducing us the meaning of *liana de los muertos*, the liana of dead.

4.2.3 Visions about Addiction

"*Takiwasi rehabilitation program is based on the assumption of a drug use related to the holiness. But the way a patient used to take drugs is considered pathological. Why? Because he did so idiosyncratically, i.e. he made decisions willfully about dosage as well as the context in which he will take the drugs"* (Horák, 2013, p. 24).

We do not choose to be addicted; what we choose is to deny our pain. In the perception of Peruvian vision about drug dependency, the drug is the diabolic entity, with vivid and own determination – in this scheme we find an addict to be a "victim", acting differently to his will and desire, and the drug being the entity punishing him. Its nothing extraordinary for the addict to see vision of himself taking drugs, recalling the friends and the effects of the drug in the session of ayahuasca (Giove, 2002). [12]

The difference spotted between Kladno-Dubí and the Czech model in general and Takiwasi lays in the tematics of craving. [13] While in Kladno-Dubí, the craving

[12] The cult of death has its own place, we can spot it in the tattoos, in the music interconnected thematically with death or in for instance, the patient's favorite place to take drugs: the cemetery (Giove, 2002).

[13] The craving is strongest in the situations where the subject is available; and in the early days of abstinence (Nešpor & Csémy, 1999).

is the feeling which should be suppressed, in Peruvian Takiwasi on contrary, they work with this feeling in natural way.

As we explained the ethymology of ayahuasca, we cannot omit the teaching capacity of the plant (*maestra de las maestras*). Lots of patients manifest to obtain valid and valuable information from the plant, in many cases exceeding the intellectual capacity or the imagination of receptor. The teaching is in many cases observed as surprising and authentic, nevertheless it is upon every patient to choose if he wants to continue with learning, according to that there is no scientific proof of dependency on the plant (Giove, 2002).

4.2.4 Spirituality

The patients without religious practice in certain cases exceed the approximation to the dogmas of Christianity, or they reveal the principles of zen, tao or Buddhism, for instance. These are the example Dr. Rosa found which contribute to the revealing of knowledge - the filogenetic leader and fundamental ethic, so called *maestro interior* (inner master). As for the main comparative aspect of my thesis, based on *the* semi-structured interviews carried out with inpatients in the Czech communities Kladno-Dubí and Renarkon I visited, it was very evident that in Czech facilities there is given very little (if any) emphasis on spiritual aspects of the rehabilitation process.

However, in Peru the religious (Christian) identity is not a requirement, but is logically predominant, given the historical Latin-American context. Rituals occupy a very important space in treatment by traditional Amazonian methods. The addicted patients were used to "invent" various rituals, they needed them and precisely, the ritual "protects" the realized act. However, they need to realize, that ritual cannot be invented, but it is a precise, energetic act (Giove, 2002).

4.2.5 Toxicity

There are no scientifically proved signs of toxicity, dependency, or addiction to the beverage, according to existing bibliography about the topic. "*There is no toxicity in this beverage if it is used in the traditional form of utilization,*

and prescription. On contrary, it could be used as very useful source for a treatment of various diseases" (Giove, 2002, p. 39). Since the second month, the patients start with the ayahuasca therapy. Not just any symptoms of toxicity were revealed, but the patients claim the improvement of their general immunologic state. Among the positive side effects we find temporal increase of plasma cortisol (Callaway, 1996), antidepressive (Ott, 1996), detoxicant effects, or increasing of serotonin in the platelets and others, such as in case of cancer as being the immunity stimulant.

Among other options, how can psychedelics in general be utilized, we find lowering the anxiety related to dying (Grob et al., 2011), tobacco addiction and alcohol dependence (Krebs, 2012), depression and OCD.

4.3 Women 's Role in the Drug Abuse

The addiction treatment in Peru is regulated by the law *Ley N° 29765, Ley que regula el establecimiento y ejercicio de los centros de atención para dependientes, que operan bajo la modalidad de comunidades terapéuticas* in Article 12th.

This Act explicitly claims that therapeutic communities can accept only adult persons of the same sex. Mixed communities are therefore excluded and Takiwasi remains to be a male community. As for Taiwasi, there are also factors playing not in favor of the women, such as prohibitions associated with use of herbal extract, which cannot be used during the menstruation and in certain occasions, special diet rules affect the rules which could be an obstacle for women during the menstruation.

In Takiwasi, as a male TC, women do not have access to enter the treatment as patients. The therapeutic team is entirely male, but there are some female employees. However, *"the perennial problem of Takiwasi is the lack of female therapists as their presence would contribute significantly to the balance of the medical institution. The absence of women in the fellowship of patients has genuinely practical meaning. If they were present, the patients would have coitus as it is normal mixed therapeutic communities,"* (Horák, 2013, p. 20).

When we compare TC Kladno-Dubí and TC Takiwasi, we can observe that the model of one sex community lowers the risks of conflicts cause by rivalry. In many cases, two patients who are visibly showing affections towards each other lead to either restriction towards their behavior in the community (they cannot spend time together, talk privately; this behavior is drifting the attention away from the treatment), or towards the banishment of the patient from TC.

In conclusion, the treatment of mixed sexes is prohibited by the law Ley N° 29765. According to National Institute of Psychiatry, it is important to recognize the different needs men and women and develop programs with a gender perspective (Medina-Mora, Real, Villatoro, & Natera, 2013). TCs for women in Peru however exist, but they do not meet the clinical standards and legal criteria according to MINSA; they operate illegally, they cannot be examined, and they often exist just in the form of various religious fellowships. Their standards are ambiguous.

Figure 5: The consumption and drug trafficking according to gender. Source: INEI, 2014.

Years	Total	Men	Women
2005	11 259	9 945	1 314
2006	6 944	6 210	734
2007	9 900	8 900	1 000
2008	12 332	11 030	1 302
2009	12 754	11 444	1 310
2010	8 959	8 205	754
2011	9 843	9 159	684
2012	12 227	11 361	866
2013	10 455	9 720	735

According to statistics from INEI, DEVIDA among men, 2.4% reported having used illegal drugs in last year, while in women the proportion is barely 0.4%. Marijuana was the illegal drug whose consumption was more prevalent in the past for both men (1.9%) and women (0.4%).

Regarding medical drugs, although annual prevalence were not high, the pattern is reversed: a concentration recorded slightly greater consumption in women (2.2%) compared with the men (1.5%) (DEVIDA, 2013). Women consumptions remain in lower quantities in most of the cases, but are still present.

5. Interpretations of the Interviews with Inpatients

In this chapter, I present the results of the content analysis of the semi-structured interviews lead in Takiwasi and Kladno-Dubí in year 2014. Applying the methodology of qualitative research, I found that there treatment in Czech and Peruvian system can be defined by six typical categories for each TC, which are included in the Annexes. During the processing in MS Excel, I divided the transcribed records from the six typical categories into four final key categories for each community, eight in total. These categories appear in the following text as subchapters.
In each subchapter, I provide my personal commentary on the topic and I develop the problematic. Categories don't coincide in the two therapeutic communities and if possible, I compare both communities in each subchapter.

Average length of the interview 22:02
Total time 3:47:17

Figure 6: Characteristics of an examinand sample. Source: Author's archive.

#	Code	Age	Nationality	Status	Date
1	KDA	19	Czech	unmarried	11. 4. 2014
2	KDC	46	Czech	unmarried	11. 4. 2014
3	KDE	51	Czech	divorced	11. 4. 2014
4	KDG	27	Czech	unmarried	11. 4. 2014
5	KDI	41	Czech	unmarried	11. 4. 2014
6	TA	31	Argentinean	divorced	20. 12. 2014
7	TC	23	Peruvian	unmarried	20. 12. 2014
8	TE	30	Peruvian	unmarried	20. 12. 2014
9	TG	29	Spanish	unmarried	20. 12. 2014
10	TI	30	Chilean	unmarried	20. 12. 2014

Individual informant's statements presented in the chapter are coded in order to preserve anonymity. All the codes involve identification of a certain person with two or three signs (e.g. TA or KDA) followed by number code on the basis of which a statement can be traced in an electronic database.

Explanatory note: KDA17, where KD stands for chosen TC (KD stands for Kladno-Dubí, T stands for Takiwasi), A stands for personal identifier, substituting the name of the inpatient. Number 17 represents the number of statement bounded by the length of one paragraph in MS Excel.

Final key categories for Czech community Kladno-Dubí are following:

- group therapy, the theme of time
- cohabitation in a mixed community
- subjective perception of drug abuse
- differences between treatment for men and women

However, final key categories for Peruvian Takiwasi are:

- plants, ayahusca, the purge, diets
- cohabitation in the male community
- religion and faith
- women's role in the drug abuse

5.1 Key categories identified in Kladno-Dubí

5.1.1 Grup Therapy, the Theme of Time

Kladno-Dubí can be perceived as a typical representative of the classic approach based model for drug abuse treatment. When asked to choose one most effective crucial technique for drug abuse treatment, inpatients almost never hesitate and convincingly claim: group therapy (often referred as "communities" or "groups").

Czech fifty one years old female inpatient explains the role of main program, balance of the past week and the feedback: *"It's a meeting of all members with therapeutic team. Mostly technical issues are being solved. And communities use to have a certain structure; for example feedbacks are important, when everyone can express to everybody – even to the therapeutic team – certain information, positive or negative"* (KDE50).

Seventeen years old Czech highlights the structure of group therapy: *"Actually, a person is the informer here; he informs therapists, because therapists use to alternate and informs team about what was happening in the last group. It goes like this: everybody says his gain from last group therapy, and therapists ask who needs extra time afterwards. If somebody wants it, the time is split up, and if nobody needs extra time, which sometimes happens, everybody work together"* (KDA52).

The outstanding feature of the program structure of Kladno-Dubí, is so called "the theme of time". All the inpatients get involved in the process allowing them to gradually enhance their competences in the time management of their own activities. *"Well, basically you stick to the program, all right. You just have the work planned, from what time till what time; some personal, sport activities, yeah"* (KDI20). *"Like, you feel after certain time, that if you don't fulfill something, you don't feel very good about it*; *because you already know, that you were supposed to do something. I mean, this changes person a lot. Or at least it moves with me, sometimes. That I know I was supposed to do it and I haven't done it*" (KDA22).

Addict's time is usually certainly not planned, allowing lot of free unstructured time without higher goal in their daily routine. Drug dependent people often oscillate between simply getting two doses of the drug. Many drug dependent inpatients I talked to confessed to me that the majority of the addict's time is just never ending waiting. Kladno-Dubí focuses on the reform of the individual's approach to the value of possessing limiting amount of time in the lifetime.

The patient agrees: *"Well, it should be like: today I do this or that, that's what is going to happen. This is the exact time to do it"* (KDI22).

The time planning and structured program is projected even to the chronologic change of the week arrangement. Young male inpatient follows: *"Here it is struc-*

tured like that - I would like to do it differently outside - however here it is structured in the way that the week starts on Friday" (KDA24).

The same inpatient follows: *"...from Friday till Thursday, because on Thursday there is the main program of the community: the open discussion. And there, like the person evaluates the past week"* (KDA26). "*From Monday till Friday, we start normally with alarm on forty past six, then we do a warm-up exercise, and on weekends we get up at seven, on Saturdays and Sundays. And we go to sleep usually at ten, except on Friday and Saturday, when we go to sleep on eleven*" (KDA68).

It is evident that the program is highly structured; however the supporting security aspect of closed "microcosms" offers the opportunity to start with the redistribution of individual's free time. Seventeen years old inpatient continues: *"So on weekends, you are allowed to really plant the activities you like, and there no that much of therapies, programs. So, in a certain way, it's like a test: to do the things which will follow. Without the programs, yeah*" (KDA28).

The mechanisms of craving[14] management, the presence of the therapists, self reflection and relaxation are bonded together. Compared to Takiwasi, where craving is managed and bonded with strengthening the will by prohibition of masturbation or with the work with craving on spiritual level; Czech communities have everything planned in details and scheduled.

Even the craving; the mottos and advices are written in the manual, or can be advised by so called "garant", personal therapist. *"Here the inpatient cooperates with the garant, every inpatient is bonded with the therapist, with whom they cooperate and work on steps, they sign the Agreement, plant long-term and short-term goals, and somehow communicate about it"* (KDA56). *"Always after sport we relax, three times a week"* (KDI92).

Despite that the majority of the inpatients in unison claim the most effective aspect of the treatment is the group therapy; the evaluation is highly dependent on psy-

[14] There are two typical images of the craving: the first is craving, which occurs after the intoxication of addictive substance. The second type of craving is craving that occurs after prolonged abstinence, for example when looking at an addictive substance, when confronted with a typical environment, or when confronted with people who take drugs (not of the author).

chical characteristics, such as introversion of individual, alienation, isolation of patient or his nature. Forty one year old woman from Czech Republic states: *"With my garant, it's like… I open up much more, because it's like… Little bit… More about trust, so after all, I confess with more personal stuff. Sure"* (KDI42).

Both communities are adapted to dealing with the emergency situation through the possibility of calling up an extra group therapy. Female inpatient agrees: *"Yes, it can happen that we call emergency community"* (KDE80).

The importance of structured program and planning is evident and clear. Woman who was dealing with alcohol dependency in the past, currently with completed therapeutic procedure in the post-treatment, closes the conversation: *"Simply, I am the supporter of having the program, you know. Nothing's gonna happen without the program. I mean, without the rules, the order"* (KDI130).

5.1.2 Cohabitation in the Male Community

Cohabitation in the community is one of the aspects me and also the interviewed inpatients consider as crucial. The feeling of not being isolated or lonely and the possibility to project own struggles into other inpatients and to measure individual's progress are used as healing aspects.

The new male inpatient who has just entered Kladno-Dubí nine days ago, claims: *"I am not sure if I will be completely objective after nine days, but first two days are totally easy. Everybody is nice, it is not mandatory for me to fulfill all the requirements as the rest, I am kinda protected by the initial period of time, but just since yesterday I realized, it is not easy at all, to coexist with all the people who have the same problem as you, but they call it, or imagine it differently. There is surely little bit of disagreement, this one is addicted to alcohol, that one to drugs, and me, if I am alike… I don't like it. I think that we are equal, and we should behave like that"* (KDG84).

"Sure, we help each other, while being on group therapies. The sulking and making-up (…) *and it actually the question of the communication, to again… Strangers are communicating and living together. It's like outside, yeah. It can be found in the job, the collective, another communication, in the shop, you know"* (KDI88).

Community life is certainly not easy. The fellowship and the necessity to cooperate with people of different nature, different habits and different visions on life can bring up a set of misunderstandings. Situation can get even more complicated, if female inpatients are closed in exclusively female community. When asked, Peruvian inpatients often acknowledged the need of international female communities operating in Peru. However, the idea of mixed communities was for the vast majority of them surprising and confusing (Chapter 5.8.).

Fairly new female inpatient with a previous experience in such female community, states: *"Of course, in Bohnice it's getting on the nerves, especially – and in this moment I'm probably happy, that some men or boys are here – because exclusively women collective are normally… problematic. You know what I mean"* (KDC70).

Inpatients agree on the fact that relationships between two addicted people tend to be extremely problematic: *"Sexually; relationships are forbidden here. Among the addicted people. It is forbidden, you can be expelled, actually"* (KDA70). "*You know, two addicts in the relationship, it is no good. One relapses, the other does the same. It is too… tricky"* (KDA72, KDA73). *"I have everything clear in the way, that hypothetically someone with other inpatient – which is something that could happen – he would fancy someone, and simply the relationship would be established, they would start thinking only about themselves, and the treatment ends, you know"* (KDC88).

Interviewed inpatients seemed very confident their ability of self- control: "*I have absolutely no idea. I am this kind of person, who knows these things, but simply, I completely control myself. It even almost… But I would never let it happen."* (KDC92) Other woman agrees and continues: *"I don't know, I think my opinion is different, I simply think this doesn't belong here. The trips to home are for that. There is telephone for that, it's kinda better to solve these things where we live. Why not to have the partner, you know. But here… it doesn't belong here"* (KDI126).

However, the option for gender-divided group therapies is available. Young male inpatient states: *"From what I saw in the program, although I have never experienced that, but there is an option to ask from only female or male group therapies"* (KDA132).

Drug relapse restrictions are completely clear in the case of both communities. The therapeutic community is the drug free, safe and non risky environment. *"And drugs… That's obvious, you know. A month or two ago, we witnessed a little group relapse, and here its forbidden: keeping the secrets"* (KDA76). "*Or at least, there should be none. So when somebody knows about a thing which shouldn't be here, he can't breathe*" (KDA80). "*When I come back to the mentioned relapse, it happened on Saturday, I came back on Sunday night. Nobody said a word about it, and I caught this information on Monday evening, at nine o'clock. And I was able to keep this information for half an hour and I just had to say it to therapists, I just couldn't hold it… Because when I keep secrets… that sucks"* (KDA82).

5.1.3 Subjective Perception of Drug Use

What is the reason behind the drug dependency? This is the constant struggle, the always present question, the journey, the goal. Czech inpatients are focused in the measure so wide on subjective perception of drug use in their interviews, they made this concept to settle to be the key category. As Jonathan Hari claims, the contrary to the addiction is not the sobriety, but the closeness with other people (Hari, 2015).

"Why? Because I do not value even myself. Not at all, you know. I have this need to hurt myself, I guess" (KDI18). "*So… I lock up myself at home, and that's wrong: because a bunch of catastrophic scenarios run through my head. I am not able to think… simply. I would say that I think over, but actually I haven't discovered much*" (KDC22).

The dual diagnoses are present in both therapeutic communities. Female inpatient with eating disorder confesses: "*And more or less I hurt myself, with the food I mean, then alcohol, it was just surviving later. Either yes or no. They call it "slow death", actually"* (KDI30).[15]

[15] Generally, we can say that longitudinal studies confirm the high mortality of drug users. Abstinence is measured most often in the range from 20% to 42%, depending on the definition. A considerable part of users continue to use drugs or to substitute them (Csémy *et al.*, 2012).

"It's like to have something helping me disposable all the time, I was easing myself by cannabis, for eight months I worked on marihuana without drugs, and then gradually, I relapsed into it. I wasn't anything extreme, it's not that different either, nonetheless I never shoot up, I always snorted or smoked it, and I never used extreme amount, I was able to cover it for a long time and they never found out" (KDG38).

Based on my study and my observation, the difference I spot between Takiwasi and Kladno-Dubí is the perception of inner psychics, the reformation of the religion and spiritual life. Takiwasi finds lot of answers in deep inner psychics of an individual thanks to the plants, which wouldn't be revealed without traditional Amazonian medicine. In many cases, the hole in inpatient's life is filled with spiritualism. In Kladno-Dubí, the solution and the answer for the struggle of vicious circle of drug dependency is rather individual. TC focuses on the theme of time and emphases restoring the previous nature of the patients, helping them to develop their abilities and find meaningful activities for his free time.

Takiwasi rather reorganizes his values and adds new, mostly previously unknown, spiritual aspect to his life.

"Simply I know lot of people, who gave up on drugs but they get drunk a lot, smoke a lot, basically they have to replace the hole. And I want to replace it with something meaningful" (KDG52). *"And I stop it by myself. In my case, the vicious circle is there, and I always stop by myself, only in the case of Bohnice I went there, because my doses were so high, that I have suffered an epileptic attack twice while the withdrawal. By the way, in those time when I drink, I really don't care about if I wake up the day after. I know that. And later on, I get worried about myself, but I think that's more about cowardice"* (KDC64).

For most of the patients, the drug abuse is perceived as the never ending disease, making the abstinence the only possible way to continue living. Various female or male inpatients of different age agree: "*In those times a year ago, neither me or her, none of us realized, it' a disease. This lasts the whole life. That's nothing like a flu, that would be cured and I would be allright. After five weeks in the therapy, I started to read a book, actually I read the first book of my life in the treatment*" (KD70).

"It's kind of a disease, but still you can say… It is nothing like the flu. But this is actually like… I am addicted to alcohol" (KDI80). *"Till the death, you know"* (KDI82). *"Well, you cannot be cured this way. For me, I feel like it makes the impression on the people outside, that you enter the treatment, you cure yourself and you're healthy. Like that"* (KDI94).

Both communities emphasize the importance of moving on with life, literally moving out of previous environment which lowers the risks of drug relapse. *"It made me recall the drug era. And I made mine drug career in Litomyšl"* (KDI72).

According to top level sport player, drug was there to fill the void: *"It was a lot of pressure put on me, people knew I can make it and I didn't handle it psychically at all, I just ran directly into it. I didn't even ook a one year break. Completely. And then I had nothing, I was searching for it all the time, and still, there was nothing else to find"* (KDI78). *"It's like being on the diet, and you have to get used to live forever with this diet"* (KDI96).

5.1.4 Differences Between Treatment for Men and Women

The crucial difference between Kladno-Dubí and Takiwasi is that the Czech community is mixed, while Peruvian Takiwasi is exclusive male community. How to prevent the risk of new relationships and therefore the loss of concentration on the treatment? The answer is strict rules and discipline. In my opinion, the risk of new relationship is no higher that the risks of drug relapse. The answer for Peru may not be establishing the closed gender-isolated communities, but look for examples in mixed communities, which are applicable and proved the strict regime can overcome these risks.

However, the Takiwasi is the special case. The crucial aspect of forbidden sexual life and masturbation for spiritual reasons is making the possibility of establishing Takwasi-like mixed community almost impossible. The fifty one year old Czech women agrees: *"The thing I like is really the aspect that we're mixed"* (KDI120).

The male inpatient adds: *"I definitely think, the treatment is harder for women. Or, in other words, women are more complicated. In the psychics. They are stronger than us, I can't even explain to myself why, but I guess it was supposed to be like that.*

Because when I was on detox at Apolinář, they told me the basic treatment for women lasts for four months, but for men only three. A did not understand why. Men had to write a CV for six pages, women for sixteen. It seemed really extreme to me, but I guess it happens for the reason" (KDG106).

Both of the communities agree that the treatment is not harder for women because of physical dominance of men; however it lies in specific psychics of women.

Czech male inpatient claims: *"It's definitely harder; already in Apolinář they said so. Actually, from what I have gone through or what I know, everyone says that Apolinář is so harsh to women. "I wound never go." "Never, ever". But I never felt that way. Okay, but for the reason I did the top level sport, so I know that just how there are the rules, here are the rules. So if I don't keep the rules in sport, I would never make it. And here's the same, if I won't stick to the rules, I can't be clean. It's like; I know I can't always do what I want. I have to do it for myself*" (KDI122).

In Kladno-Dubí, they fulfill the same criteria and procedures. *"No, I wouldn't say it*'s different, *we are two women here and it's the same"* (KDC94).

5.2 Key Categories Identified in Takiwasi

5.2.1 Plants, Ayahuasca, Purge, Diets

Our observations in the Peruvian Amazon yield a supplementary fact: not only the natural psychoactive substances used by indigenous peoples do not generate dependence, but they are utilized to treat the modern phenomenon of drug addiction. Indeed, psychoactive substances may be a treatment for "drug addicts," a fact that still seems paradoxical or impossible even to the specialists in question. And yet, the facts are there (Mabit, 2002).

Peruvian inpatient confesses: *"Still, I cannot omit using the plants. And I don't mean only entheogenes such as ayahuasca, but plant used for diets, too. And there is also the purge (la purga). It's unbelievable, how plants work. I realize more and more, how much are they helping me"* (TE53, TE55). *"It's a hard, tough work. The key are the plants, because they allow us to see"* (TE64). "*They allow me to see the person, I wasn't able to see. My self-esteem was on zero. I didn't believe in myself.*

I didn't believe in the good what people were saying about me, about all the good characteristics I have according to them. Now, plants help me to see myself with the eyes of others. I see the positive side I like about me, and also the negative one. I put it together and I feel more comfortable being myself. It is the aftermath of the effort established between me and the plants, the therapists. It's a compact thing" (TE94).

The same thirty year old inpatient continues: *"People are way more sensitive because of the plants. Everything provokes in them… uffff… it makes you reflect. I don't think it would work without it"* (TE138). "*If you submit to the plant as they say, it will answer. The spirit is responsible for it. For real, it is like that. It feels to me that I am doing the right thing. Thanks to Takiwasi, thanks to plants"* (TE216).

The diet practically follows this schedule: an inpatient moves to the jungle for 8 days and stays in the stay in a small shelter made of wood (so called *tombo*). Twice per day a *curadero* (healer) visits with the food and the extract from the plant. (Kavenská, 2013). A spanish inpatient from Madrid on his affection towards diets: *"What helps me the most, is the diet"* (TG73). "*Four*. A*nd later I am going to do the fifth one"* (TG77, TG79). "*I started with Ushpawasha, then I drank Chiricsanango, Uchu. I broke the diet while drinking Uchu. I ate the cookies on post- diet. I confessed, therefore they let me continue with another diet*" (TG81).

5.2.2 Cohabitation in the Male Community

The inpatient gets information about the behavior and about how verbal address or gestures affects and interacts with community structure. Based on this information, he can change, modify and train desired behavior. When they enter the TC, they confront the new type of behavior and they are supposed to adapt to it*: "Do what you see now, imitate, and one day you will understand"* (Kalina, 2008, p. 111).

"It is almost crucial key aspect of the structure, because in the coexisting with others, we spot factors, which are hidden inside us. Meanwhile, what we do – even without noticing it – it reflects on other people. Thanks to this we can reveal our personal problems, which I would find without this. We are also convinced that our past and our experiences are so similar. Regardless on which country we come from" (TA110). "*It's about certain primary, essential feeling of torment, which in many cases causes*

the need for support" (TA112) continues thirty year old divorced Argentinean inpatient.

The Peruvian young twenty-three man adds: *"Live with so many people coming from different countries, which lead different type of life from yours… That is helping to everyone. The others can piss you off"* (TC85). *"The coexisting in the community, when person expresses what he thinks, is helps the self-reflection"* (TE96).

"There is no space for intimacy. Nothing. You go to pee and you hear somebody singing just next to you. Sometimes you feel the urge for killing. Either yourself, or somebody else" (TG94).

The TC happen to be the laboratory where you learn how to embrace the feelings such as anger: *"Sometime you feel anger. You don't know where it comes from. Therapist asks you: "Why are you mad?"* (…) *If something makes you angry, you need to process that anger"* (TC146). At the same time, it is the constant teacher of responsibility, as Peruvian and Argentinean informers continue: *"Basically, it was about bad vibes (mala energía). I didn't pay any attention to it.* (…) *To be together all the time, young lads, who are forced to hold the abstinence from sex and drugs. Not everyone is here for the same amount of time.* (…) *For those who are here for a long time, it is the question of responsibility. They are responsible for the group holding together, and not making any problem a big deal* (TA114). *The part I don't like about myself, I also spot in other people"* (TE140).

"I think that the way I establish relations with other colleagues… Some of them are rather your brothers than colleagues… Is the same as the way you establish them outside, with those you live with. It's very important" (TE134).

Doctor Nešpor cites in his book Bažení (craving): společný rys mnoha závislostí a způsoby jeho zvládání: *"The craving is strongest in a situation where the subject is available. In other words, the craving for methamphetamine is stronger in a disco than in a Scout camp, which supports the importance of cohabitation in the community. We have to consider the availability of addictive substances as a factor which could induce craving"* (Nešpor & Csémy, 1999, p. 16-17)

Divorced Argentinean inpatient could find the parallel of the citation not just with the drugs, but also with the strict sexual life restrictions: *"I think it would be prob-*

lematic, if community would be mixed. It would be difficult. As you can see, we are all young men. The presence of the girls would complicate it. I don't know, if just for the treatment. To be honest, I didn't think too much about it. But it seems to me, that the concept is correct" (TA148).

"I think that's completely obvious. It is given by the fact that we cannot mix together. Here it is not like on high school, if you know what I mean" (TC175). *"I think we would be breaking the rules much more"* (TC179). *"From the side of women, jus as from the side of men. This is not the place for establishing the relations"* (TC180) continues twenty-three Peruvian man on known fact, that the relationships among addicts are problematic. *"It is not the place whe you should try to establish them"* (TC182). *"In my opinion, the inpatient would be more interested in the girlfriend that in the treatment. That's what happened to me in Chile. I men a woman, we started dating. Gradually I was less and less interested into the treatment. We were breaking the rules, we slept together"* (TI232). *"There wasn't forbidden to have sex. We didn't work with the plants on energetic level"* (TI234).

The Argentinean, Peruvian, Spanish and Chilean inpatients have the clear opinion on the reasons why is this treatment not accessible for women and why sexual life is forbidden: *"Because of the spiritual, energetic reasons. That's why they say that masturbation is forbidden"* (TG192). *"That's because of the energetic issue with the plants, not for the moral reasons. The thing is that the energy a man cleans himself, is accumulating in his body thanks to the plants. Ejaculation and masturbation is forbidden. It would possibly lead to the decrease of effort we invest on healing on energetic level, furthermore, we cound get crossed (cruzarse). That means that you feel awful. According to shamans, the plants are jealous"* (TA150). *"I started to consider it as important just recently"* (TI243). *"Live without sex here, that's like… taking away your beloved toy"* (TC190). *"For me it presents one of the biggest struggles. But I have confessed to my therapist. It happened to me yesterday, I couldn't control myself. I am working on it right now. It's a big struggle for me, I cannot control myself. Be able to claim: No, I am clean"* (TG194).

5.2.3 Religion and Faith

The treatment in Takiwasi does not push any concrete religion, but tries to develop further the faith of the inpatient. Takiwasi provides a framework where the inpatients, through using psychoactive substances, can reach a spiritual experience (Horák, 2013). *"Yes, that's surprising. I was raised in the Buddhist family whole my life. I perceived God as almighty, present. As God present in the universe and in the everything. Here I recently met God thanks to Devil, which has been shown by ayahuasca. I felt fear, I was terrified. There was demon inside me. I said to myself: "If there exists such thing, God has to exist." That was the moment, when I gradually started to get closer to God"* (TE56).

Argentinean inpatient continues: *"I have the proof thanks to the plants.* (…) *I had religion knowledge coming from family, school or friends though. But it was rather because they sent me to learn. Not because I would felt like doing it. It changed here. Now I know it's important. It makes me feel allright"* (TA143, TA145).

"The world can suddenly end. Your family, wife, kids or mother can die, but the supernatural power will always be with you. That's something which can give you enormous strength during difficult situations" (TE157). "*It's incredibly helping me. It helps me. It gives me the strength to continue in my treatment. Sometimes it' overwhelming, it knocks me down to my knees, it tries to defeat me. Then I pray and it gives me strength"* (TC168).

"I entered Takiwasi as agnostic. I realized the meaning of spirituality gradually, because Takiwasi strengthens this aspect. The emphasis is put on psycho-affective and spiritual problems. While drinking ayahuasca and being on diet I realized I am in serious spiritual trouble. Spirituality plays fundamental role in the life of man" (TA137).

"*I believe my spirituality is very corrupted. It's very dark. Because I was always attracted by everything dark, like going smoking to cemetery, open the graves"* (TI150, TI152). "*Yes. My father served in army during the coup in 1973* (Chilean, note of the auth.) *and his task was a murder. We had a human skull at the shelf at home. I used to use it during various rituals with friends"* (TI154). "*But I never perceived it as something wrong… For me, it was the game. I saw the skull various times during*

the ayahuasca sessions" (TI156, TI158). "*I felt the emptiness before. Nothing was making sense. I said to myself: 'How can you feel spirit, energy?' But now I know"* (TI207).

Is treatment conditioned by certain faith, religion, and belief? *"No. Every time they forced me to believe something, I rejected it"* (TI209*). "When I get order to do something, I simply won't do it. May it be the part of the treatment, or not"* (TI213). "*They can't force me. The faith, be it catholic or evangelic, is something personal. Now I'm looking for my spirituality.* (…) *I believe in God now, however I don't want to become catholic"* (TI215). "*I'm just trying to find myself right now. Thanks to my roots, I tend to Buddhism"* (TI219). "*I am trying to find the posture, in which I would feel comfortable. I attend mass, I talk to priest… I ask him, how other religions look to him, and then I will choose one"* (TI221).

"In my opinion, Takiwasi is highly focused on reparation of the religion approach. I don't perceive is that way normally, however Takiwasi does" (TG158). "*Look, my father was a communist. In the communist era in Spain, he was fighting against Frankists, I was raised in a hundred percent atheist family.* (…) *In the Takiwasi flyer and the web page there is stated, that this is the facility opened to any religion. It is, without doubts – and this is not criticism – center with Christian mass, priest who is Christian, Christian element appear in ayahuasca sessions. My perception of God is not that Christian. I perceive it more universally. It originates from the nature, the ground, people… I understand it like this and it's very important for me. I am not that arrogant that I would think I can handle everything by myself. I can't make it on my own, I need someone's help"* (TG160). "*You can perceive it in the way, that they force us to bring up some ability, which will make you to come to the side of Christianity, or you find something yours. I perceive it this way"* (TG169).

"Yes, definitely. There is no need to accept the Christian dogma, it's all about finding something, which will personal help you" (TG175).

5.2.4 Women in the Context of Male Therapeutic Community

The opinions on whether the treatment is more difficult for men or women differ. As for Takiwasi, women wouldn't be capable to fulfill the treatment because of re-

strictions of Amazonian traditional medicine while having menstruation, or because of high amount of accumulated energy in both genders for the restrictions about sexual life. However, speaking about general situation of non exiting internationally acknowledged women drug treatment facilities, Peruvian inpatients provide statements linked with the role of women in the society and the concept of *machismo: "I don't know how the treatment would look like. There are no women here. It's not like they are somewhere else. There are no communities for them. I assume there are no communities for women in Peru"* (TA155). The significant reason of the gender divided TCs in Peru is the concept of *machismo*. The Argentinean patient continues: *"The reason is that men, strictly speaking, rule the world. Women have the tendencies for alcoholism rather than drugs. But be careful, alcohol is the drug, too"* (TA157). *"Abuse of hard drugs, that's rather men's thing. In my opinion, it is linked with the distribution of power in the society"* (TA160). "*Women presents much more important role in Latin America than in Europe or other countries. Not talking about Asia. The situation there reminds me of middle age. In certain measure, the reason is that women play significant role. They raise the children. Their role is not identical with the men's role"* (TA167, TA168). *"It seems somewhat archaic to me. In 21th century the situation should be different"* (TA171). *"In my opinion, the reason for it is that men have more freedom. The man is more macho. He lives in machistic country… such as Peru. I actually think it's because we are the machistic country. And that's something which is really wrong – to be a machist. I used to be one, too. That's one of the topic I brought here to resolve"* (TC228, TC230).

Inpatients were not sure about the treatment for men and women, as there is according to legislative, none legal, clinic based TCs which would meet standards of Ministry of Health. *"I assume they solve it just by going to psychologist. Not by treatment. I would say that this kind of treatment for women should be here"* (TC218). *"I think there are some in Lima"* (TC222). *"I think there is one center for women in Lima. I don't know. It does ring a bell. I think there are such facilities. However, they lack international renomé. They operate on regional level. They are private"* (TC224, TC226).

"That's surprising. I had a couple of girl friends, who were able to stop with drugs for their kids. The kids changed them. Or for the parents, family, for the faith. And all of that without being in a treatment. However, yes, it would be good, great, if there was something for those cases who cannot handle the situation alone. If they would need help. It would be good, if there were more centers for women" (TE182).

The role of women in Peruvian society makes their treatment more difficult. Spanish unmarried inpatient continues*: "I made some friends among the leader responsible for treatment of women. According to their statement, the work with women is much more difficult. Firstly, the cohabitation among women is much more complicated.*

I even heard in Lima, that the number of successfully treated women (índice de recuperación) is much lower than in the case of men. Women live in very retrograde, conventional Peruvian society much more dependent on the man. For women, who have the problem with drug dependency, it's much more complicated to get better" (TG198). The opinions on the differences between the treatment for men and women differ according to the individual experience: "*Yes, I think men are weaker. Not physically, but emotionally. That's exactly what I think"* (TI266). *"In my opinion, minimal difference is there for sure. But it's almost the same. I think that it should be same in the case of women and men. Men and women are shaped and influenced by the same things. The difference should be in the "things of women". In those purely women things, can be understood only by them"*(TE208, TE210, TE212).

6. Conclusions

My Bachelor's thesis is focused on drug abuse as a major socio-pathological phenomenon in the intercultural perspective. The first chapter of the comparative research introduces the concept of therapeutic community based on the definition of European psychiatrists, who perceive therapeutic community in two aspects, as a socio organizational model and a treatment method, which is characterized by organization, structure and safety. Therapeutic community happens to be the environment which provides highly structured environment with transparent structure accompanied by mutual trust; we can perceive it as vivid microcosm where client largely responsible for his treatment and interacting with staff is allowed to experiment safely with new gained social knowledge.

In the field of drug treatment, Czech Republic allocates twenty eight bed medical facilities, and offer about thirty aftercare programs and follow-up treatment. On the other hand, the number of therapeutic communities operating in the region of Peru is unknown. The Ministry of Health of Peru (MINSA) estimates that there are four hundred rehabilitation centers in Peru, out of only three are legal and based on clinical standards, Takiwasi being one of them. Generally, Czech therapeutic communities are based on model of western medicine standards and the target of our comparative study Kladno-Dubí falls into this category. Authoritarian regime played historically significant role in the development of Czech therapeutic communities and shaped them into the model known nowadays, where the emphasis is put on discipline, regime, and time management accompanied by the use of psychotherapy, group therapy and given time matrix. Czech therapeutic community Kladno-Dubí is residential town facility, which aims to change client's attitude towards proabstinent behavior, acquisition of skills advantageous for social integration; it changes the mechanisms of client's behavior, and allows him to take responsibility for his live by looking for a job in second phases of the treatment.

As for the Peruvian approach to drug abuse treatment, Takiwasi is a functioning example, that responsible use of traditional Amazonian medicine is not contradictory to common western medical model, but they can successfully complement each other; Takiwasi uses the resources of traditional medicine, which meet with the methodology of modern psychotherapy. Drinking psychoactive herbal extract ayahuasca with no proven signs of toxicity, accompanied by diets and purges form basic pillars of treatment in this male community. The effects of catharsis, sensorial interconnection, the act of forgiving spontaneously or recalling memories are just some of the effects which lead to long-term understanding of one's addiction and allow him the confrontation with the past and the addiction itself. The specific role in Takiwasi belongs to spirituality, meanwhile in Czech communities there is given little, if any emphasis on the spiritual aspects of the rehabilitation process. Takiwasi is a functioning example of alternative way of dealing with drug abuse treatment; it allows us to observe, that there is another way apart from substitution and total abstinence; which are the only approaches we know from Czech perspective.

According to Peruvian legislative system, law *Ley N° 29765, Ley que regula el establecimiento y ejercicio de los centros de atención para dependientes, que operan bajo la modalidad de comunidades terapéuticas* does not allow mixed communities in Peru, and thus participation of women as inpatients in Takiwasi. Main factors playing not in favor women in Takiwasi, are prohibition associated with use of herbal extract during menstruation and prohibition of any sexual acts in Takiwasi. However, many Takiwasi inpatients connect them to the role of women in Peruvian society and the concept of *machismo*. Takiwasi, as men community lowers the risks of rivalry and conflicts. But given the fact, that there is no legal community for women meeting the standards of MINSA operating in the territory of Peru, I suggest to open up the question of establishing legal women community in this region. The number of addicted women in Peru is lower than the number of men, but this number should not be overlooked. Kladno-Dubí is a functioning example of mixed community, where men and women are treated together without any gender-based differences. As a main recommendation for Peruvian model

of drug-addiction treatment we can introduce the idea, that mixed community works successfully, when it is based on the system of cardinal rules, honest self reflection, and examination of the problems, emotions and behavior.

This comparative study proves the hypothesis that drug abuse treatment is conditioned by socio-cultural aspects. Using the method of qualitative research on selected sample of ten inpatients, we observe that for inpatients from Kladno-Dubí, the spirituality does not play significant role. On contrary, in semi-structured interviews inpatient focuses on group therapy, the theme of time and cohabitation with women in the mixed community. In Takiwasi, clients find as crucial ayahusca, diets, purges, the cohabitation in male community and the role of religion and faith in the treatment. As conclusion, Czech model of treatment offers patterns of behavior crucial for proabstinent life, and Czech inpatients are free to follow them. But in comparison with Takiwasi, spiritual aspect and most of all, the psychedelics in form of hallucinogenic herbal beverage ayahuasca allow clients and psychotherapists to study processes, which would otherwise remain hidden. Peruvian form of treatment makes them visible for direct observation and thus further understanding of the addiction.

This Bachelor's thesis provides complex conclusions of drug addiction treatment approaches in unique environments of Peru and the Czech Republic, opening the possibility for intercultural dialogue in order to deal with this socio-pathological phenomenon.

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8. Annexes

Subjective perception of drug abuse	family problems, uncontrollable behavior, inability to continue like this
Plants, ayahuasca, purga, diets	spirituality, understanding themselves
Coexistence in the male community	male community, sexual abstinence, the community as a whole
Motivation to complete the treatment and abstinence from drugs	motivation by family, by life, the change
Religion and faith	plants, God, religion, catholicism, supernatural force
Womens role in the drug abuse	alcoholism, machismo, the distribution of power in society, the central role of women, raising a family

Figure 7: The six key categories of content analysis for TC Kladno - Dubí

Subjective perception of drug abuse	not sufficient self-esteem, self-destruction, alienation, isolation, endless circle of addiction, the need for independence, family problems, obsessive behavior, excesses
Group therapy	main program, the balance of the past week, feedback, informing the therapeutic team, emergency and special community
Garants and individual therapy	individual approach
Coexistence in a mixed community	key, community as a whole, no privacy
Prohibition of establishing intimate relationships	strengthening the will, the concentration of therapy, focusing on their own problems, diverts attention from the problem, falling in love
Differences between treatment for men and women	changing preferences when choosing a partner, coexistance within the community, holding the boundaries

Figure 8: The six key categories of content analysis for TC Kladno - Dubí

Figure 9: Kladno-Dubí, the yard. Source: Author's archive.

Figure 10: The dinig room in Kladno-Dubí. Source: Author's archive.

Figure 11: The session room in Kladno-Dubí. Every minor offence is reported. Source: Author's archive.

Figure 12: *Maloca grande* in Takiwasi. Place where ayahusca session are held. Source: Miroslav Horák.

Figure 13: The inside of *Maloca chica*. Source: Miroslav Horák.

Figure 14: The products of Takiwasi. Source: Miroslav Horák.