Chapter 1

Therapeutic Communities: Evolution and the Need for Theory

The therapeutic community (TC) has proven to be a powerful treatment approach for substance abuse and related problems in living. The TC is fundamentally a self-help approach, evolved primarily outside of mainstream psychiatry, psychology, and medicine. Today, however, the TC is a sophisticated human services modality, as evident in the range of its services, the diversity of the population served, and the developing body of TC-related research.

Currently, TC agencies in the United States serve thousands of individuals and families yearly (The 1996-97 TCA Membership Report, 1997). TC clients are a diverse group: individuals whose drug histories consist of an ever-expanding menu of drugs and who, in addition to chemical abuse, often present complex social and psychological problems.

The TC's basic approach of treating the whole person through the use of the peer community, which was initially developed to address substance abuse, has been amplified with a variety of additional services related to family, education, vocational training, and medical and mental health. Staff compositions have been altered to include an increasing proportion of traditional mental health, medical, and educational professionals serving alongside the recovered paraprofessionals (Carroll & Sobel, 1986; Winick, 1990-1991).

The traditional TC stay of 12–18 months has evolved from planned durations of stay of 2–3 years (Cole & James, 1975). Recent changes in client population, clinical realities, and funding requirements have encouraged the development of modified residential TCs with shorter durations of stay (3, 6, and 12 months), as well as TC-oriented day treatment models (e.g., Karson & Gesumaria, 1997; Lewis, McCusker, Hindin, Frost, & Garfield, 1993). In addition, correctional facilities and

From: The Therapeutic Community
DOI: 10.1891/9780826116673.0001

community residences and shelters, overwhelmed with alcohol and drug abuse problems among clients, have implemented modified TC programs within their institutional boundaries (De Leon, 1997a; Jainchill, 1997; Wexler & Williams, 1986). Some educational programs have incorporated basic elements of the TC's drug-free philosophy and view of "right living" into their programs (e.g., Bratter, Bratter, Bratter, Maxym, & Steiner, 1997; Moberg & Thaler, 1995).

Research into the TC has also increased significantly since 1976 when the National Institute on Drug Abuse (NIDA) organized the first Therapeutic Communities of America (TCA) planning conference, including a panel of only six researchers (De Leon & Beschner, 1977). In contrast, the 1992 TCA planning conference included some 20 researchers and a program with a considerable number of scientific papers and symposia (Proceedings of the TCA Conference, 1994).

Although not quantitatively analysed, the increase in TC-related research is evident in several indicators: (a) the number of published studies in American journals collated in bibliographies and reviews of TC research (e.g., De Leon, 1985; De Leon & Ziegenfuss, 1986; Tims, De Leon, & Jainchill, 1994); (b) the number of federally funded TC-related grants and contracts and TC agencies themselves that receive grants; and (c) perhaps the most convincing indicator of the developing status of TC research, the existence of the NIDA-funded Center for Therapeutic Community Research (CTCR) at National Development and Research Institutes (NDRI), the first such center exclusively devoted to studies of a specific treatment modality (Millstein, 1994).[1]

ISSUES OF EVOLUTION

The evolution of the TC reveals the vigor, resourcefulness, and flexibility of the TC modality to expand and adapt to change. However, the evolution of the TC also contains a number of issues that provide the fundamental rationale for the present volume.

The Wide Diversity of TCs

The adaptation of the TC to different settings and different populations has resulted in a proliferation of programs with unique treatment protocols

[1] For example, activities relevant to the present volume are supported in part by NIDA Grant #5P50 DA07700.

and varied durations of stay. Even the long-term traditional model is variously implemented. The range and extent to which these adapted programs retain the basic elements of the TC model is not known. Moreover, this wide diversity of programs makes it difficult to evaluate the general effectiveness of the TC modality and underscores the need for defining the essential elements of the TC model and method.

The TC Treatment Process is Not Understood

Although much is known about *whether* TCs work in terms of successful outcomes, less is understood as to why and *how* TCs work. The link between treatment elements, treatment experiences, and treatment outcomes must be established to firmly substantiate the specific contribution of the TC to long-term recoveries. Moreover, illuminating the treatment process is essential for improving the TC treatment itself. Thus, wise modification of the approach must be guided by an understanding of the active "ingredients" in the treatment model, the course of recovery, and the complexity of individual change.

The TC Approach has been Conveyed Orally

Teaching the TC approach has been primarily accomplished in the oral tradition. The model and method of the TC emerged from the trial and error experience of its first participants creating and managing their own self-help communities. Since then, three generations of participant workers, or "paraprofessionals," have learned the TC approach, primarily through personal experience and apprenticeship. This oral tradition, while an essential and intimate mode of communication in the TC, has limited the broader application of the TC approach.

The Limits of Personal Experience

In the course of the last 30 years, many of the daily activities of the treatment programs have hardened into habits and routines. This reflects the fact that the fundamental therapeutic and educational reasons underlying these activities are often unclear to the participants. Why the TC does what it does is often understood only from personal experience: "It worked for me," or "That's how it was when I came through," or simply, "That's the way things are done."

The knowledge gained exclusively from the experience of personal recovery and program ritual tends to remain static, unresponsive to

individual differences or circumstantial change. A conceptual or theoretical understanding of the TC approach is therefore essential to adapt its principles and practices for the greater diversity of clients entering treatment today.

Call for a Return to TC Basics

Successive generations of staff who have recovered in TCs have become quite removed from the original roots of the approach. This has contributed to a progressive weakening in the application of clinical methods and tools of the TC and laxity in maintaining the structure of the traditional program. In response to these negative developments, there has been a call for training in the "basics" of the TC (Brieland, Gelormino, & Snook, 1990). In this regard, an explicit theoretical framework is needed which defines, conceptualizes, and illustrates the basics of the TC. Indeed, such a framework could facilitate the development of a consensus in the field as to the basic principles and methods of the TC.

Increasing Numbers of Professional Staff

There are increasing numbers of conventional professional staff (social workers, nurses, psychologists, etc.) working in TCs. Based on their education and professional training, they introduce various concepts, language, and methods that often counter or subvert the fundamental self-help features of the TC. An explicit theoretical framework can provide a common perspective for training *both* professional and paraprofessional staff so that they can be united in their approach to treatment.

Counselor Certification

The sophistication of the TC is evident in the fact that Therapeutic Communities of America (TCA) has established criteria and procedures for evaluating counselors and certifying their competency (Kerr, 1986). However, a theoretical framework organizing the knowledge base of TCs is needed to strengthen the professionalism of TC staff. Clear theory and methods can help define the wide range of skills, competencies, and information that workers must possess to be effective within the TC.[2]

[2] Specifically, material in the present volume has facilitated the development of curricula and procedures for staff training and education in the TC model and methods. Requests for further information should be forwarded to the author at the Center for Therapeutic

Program Accreditation and Quality Assurance

Many drug treatment programs label themselves TCs. Whether these are valid TC models is often unclear. Thus, there are pragmatic reasons for developing standards for TC programs: to maintain quality assurance and best practices, to guide staff training, and to evaluate the effectiveness and cost benefit of TC treatment. A theoretical framework of the essential elements of the TC is needed to facilitate the development of program standards for formal accreditation and licensure efforts.

Misperceptions

The traditional TC has been perceived by those on the outside in many ways, both positively and negatively, often without sufficient information. Given its history as an unconventional, "alternative" treatment approach dating back to the early 1960s, there is a particular need to accurately portray the contemporary TC as effective, safe, and credible. An explicit account of the perspective, rationales, principles, and methods underlying the TC approach could help correct some of these misperceptions and provide a more balanced picture of the TC's place in a spectrum of human services.

The above issues of evolution have defined the general purpose of this volume—the delineation of the TC approach as a theory, model, and method. The volume's aims, however, are several: to communicate the essentials of the approach to those within and outside of the TC, to facilitate staff training based upon a codification of TC, to serve as a catalyst for the continued refinement of the TC method and model, and to stimulate research into the TC process.

THEORY AND TCS

Contrary to the myth that TCs are anti-intellectual, most contemporary programs are intellectually open-minded and receptive to new information and ideas. Indeed, good programs thrive on information, viewing intellectual expansion as essential to personal growth and recovery. It is not new information but *abstract* formulations that TCs have questioned

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or rejected, often seen by staff as irrelevant to real life inside and outside of the TC.

The present volume presents the author's formulation of the TC as theory, model, and method. It evolved from clinical and research experience obtained primarily in the traditional long-term residential TC. This model still serves as the prototype for the current diversity of TCs, and its effectiveness has been documented (Anglin & Hser, 1990b; Condelli & Hubbard, 1994; De Leon, 1985; Gerstein & Harwood, 1990; Hubbard et al., 1989; Hubbard, Craddock, Flynn, Anderson, & Etheridge, 1997; National Treatment Improvement Evaluation Study [NTIES], 1996; Simpson, Joe, & Brown, 1997; Simpson & Sells, 1982).

The TC is presented in a social and psychological framework. Though not in the jargon of TC participants, the vernacular of this framework has been accepted over the years by TC workers, in my writings and those of others, and to a considerable extent in general TC practice. The concepts, language, and techniques from different schools of psychology and therapy are both present and past influences in the TC. These include psychoanalysis, gestalt therapy, regression therapy, role therapy, conditioning and behavior modification, social learning theory, relapse prevention, and cognitive-emotional therapy, among others. Many of these were discovered or rediscovered in TCs independently of their original sources, while some were, and continue to be, directly introduced to the TC by outside "experts" as TCs widen their scope.

This social and psychological framework formulates the concepts and principles that the TC uses to understand and explain itself. It is broad enough to communicate the extraordinary work of the TC to mainstream education, mental health, and human services professionals, to students, and to the lay reader as well. This is in accordance with the general purpose and specific aims of this volume.[3]

SOME CAVEATS AND LIMITS

Theories and codification of elements and methods seem to inherently contradict the dynamic nature of community life. Some of the more problematical examples of this caveat are briefly noted along with other limits concerning the framework presented.

[3] Sugarman makes the distinction between "native theory," the TC as understood by the residents themselves, and formal theory as developed by academic workers (Sugarman, 1974). The present framework reflects both academic and native theoretical properties.

Rigidity

Codification could lead to rigidity in practice. Not infrequently, the flexibility required to accommodate changing problems and individual differences can be hampered by the specifics of the written word. Spontaneous innovative strategies are often inhibited by writings that appear to be doctrinaire or to mandate selected procedures. Thus, codification contains some risk of fostering orthodoxy and rigidity.

Artificiality

TCs do not conceive of themselves analytically nor did they devise their methods from a theoretical plan. In their perspective, individual change results from the global impact of community life. Thus, dismantling the approach into simple elements presents a somewhat artificial picture of TCs. Moreover, the therapeutic and educational features, which are common to most TCs, are implemented in each new setting as a vital process of *re-creating* communities that can heal and teach.

Variability

No two TCs are alike. As separate, self-contained communities, their cultures evolve uniquely. In addition to more obvious differences in client composition, staff experience, program age, size, and resources, differences in beliefs and leadership style may evolve as well. Although traditional TCs are more alike than different, a single theoretical framework cannot actually capture these important nuances in culture, practice, philosophy, and psychological grounding.

Lack of Consensus

The framework presented does not represent a consensus position in the field. Rather, it aims to facilitate such consensus by assisting workers in defining the TC as a model and method for the treatment of substance abuse and related problems in living. The validity of this—or any theoretical framework—lies in how closely it represents clinical and research experience. Its real utility will be measured in how much it stimulates the field to understand and improve itself.

Utilization

Written texts are not substitutes for training and experience. Thus, the present volume should be viewed not as doctrine, but as one *resource* to facilitate staff training and treatment planning and to provide a conceptual balance to experiential learning.

Literature Cited

There are limits as to the literature cited. The explicit aim of the present work is to provide a comprehensive framework of the addiction TC, based upon the clinical and research experience in TC programs. Neither the TC, itself, nor the present framework *derives* from mainstream addiction treatment, social science, psychology, or psychiatry. Although principles and practices from social learning, group process, and psychotherapy are recognizable in the TC, they are not the a priori basis for the present theoretical framework. Thus, reference to the general sociological, psychological, and addiction treatment literature outside of the TC would be distracting to the reader.

The relevant literature is mainly discussed in the initial chapters. These selected citations illustrate general clinical and research support for factual assertions about substance abusers being treated both in and outside TCs. Subsequent chapters undertake an exposition of the present framework that requires relatively few references to literature. These illustrate clinical research and observational support for some of the theoretical assertions in the framework.

Finally, the resident statements in the text that are in quotation or block quoted are for purposes of illustration. They are the author's representations of actual clinical examples recalled through paraphrase, reconstruction, and construction over the years.

CONCLUSION

The successful evolution of the TC for addictions defines the basic rationale for the present volume. An explicit theoretical formulation of the TC is needed to assure the fidelity of its broad application and to retain the distinctive identity of its approach. The proposed theoretical formulation represents a convergence of *the real* and *the ideal* features of TC by clarifying the essential elements of the approach. The sources for these elements are explored in the following chapter.