Journal of Psychoactive Drugs

ISSN: 0279-1072 (Print) 2159-9777 (Online) Journal homepage: https://www.tandfonline.com/loi/ujpd20

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To cite this article: Meredith Huey Dye , Lori J. Ducharme , J. Aaron Johnson , Hannah K. Knudsen & Paul M. Roman (2009) Modified Therapeutic Communities and Adherence to Traditional Elements, Journal of Psychoactive Drugs, 41:3, 275-283, DOI: 10.1080/02791072.2009.10400538

To link to this article: https://doi.org/10.1080/02791072.2009.10400538

Published online: 09 Sep 2011.

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Modified Therapeutic Communities and Adherence to Traditional Elements†

Meredith Huey Dye, Ph.D.*; Lori J. Ducharme, Ph.D.**; J. Aaron Johnson, Ph.D.**; Hannah K. Knudsen, Ph.D.*** & Paul M. Roman, Ph.D.****

Abstract—Traditional therapeutic communities (TCs) are characterized by confrontational group therapy, treatment phases, a tenure-based resident hierarchy, and long-term residential care. Many TCs have modified the structure and intensity of the traditional model, tailored services for specific client populations, and hired more professionally trained staff. This study examines the extent to which modified TCs are able to retain the underlying core technology of the TC. Using data from a nationally representative sample of 380 self-identified TCs, six traditional TC elements are identified. Results from a structural equation model indicate that offering services for specific populations and professionalization of staff has limited impact on the six TC elements. Modifications to structure and intensity of TC programming evidenced the strongest effect. Specifically, outpatient-only TCs showed significantly lower adherence to five of the six elements. Short-term residential programs showed a similar negative trend. Findings suggest selected modifications are possible without significantly impacting the TC model's core technology.

Keyword—substance abuse treatment, therapeutic community

Traditionally, therapeutic communities (TCs) for addiction treatment have been characterized by a treatment philosophy of "right living" and "community as method" delivered in long-term residential programs largely directed and managed by clients. The TC model has emphasized a reliance on confrontational group therapy, treatment phases, and a hierarchy based on tenure in the program and community roles (De Leon 2000; De Leon & Ziegenfuss 1986).

The TC model is widely recognized in both the U.S. and Western Europe, and for nearly four decades researchers have documented its history, both positive and negative aspects of its method, and its results (De Leon 2000). Even as new addiction treatment technologies have emerged, studies have consistently shown the TC model to be an effective form of treatment, particularly for certain subpopulations that may be difficult to reach through other treatment methods. Recent studies have reported positive outcomes for the homeless mentally ill (De Leon et al. 2000), clients with co-occurring disorders (Sacks et al. 2008), and adolescents (Edelen et al. 2007). Other studies have examined the effectiveness of the model in other cultures. A recent study by Dekel and colleagues (2004) reported positive long-term outcomes in three TCs in Israel.

†The authors gratefully acknowledge research support from research grant R01-DA-14976 from the National Institute on Drug Abuse.

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In order to address the changing demands of the addiction treatment field, TCs have modified aspects of their traditional programming (Melnick et al. 2000; Melnick & De Leon 1999; De Leon 1997). One notable change has been the tailoring of TCs to meet the needs of specific subpopulations, such as women (Stevens, Arbiter & McGrath 1997; Stevens & Glider 1994; Coletti et al. 1992), adolescents (Jainchill 1997; De Leon & Deitch 1985), and clients with co-occurring substance abuse and psychiatric conditions (De Leon et al. 1999; Sacks et al. 1998, 1997; De Leon 1993). To serve these client populations, many TCs have employed more professional staff, including physicians, psychiatrists, and counselors with postgraduate training. In addition, TCs have incorporated less confrontational therapeutic styles, more flexibility in treatment phases, and more individualized treatment. Although TCs initially developed as sites of long-term residential care, many now also offer shorter-term residential programs and outpatient services (Melnick et al. 2000; Melnick & De Leon 1999).

The frequency with which modifications are discovered raises concerns that such changes may affect adherence to the underlying cultural, structural, and programmatic traditions characteristic of the TC model. The extent of such alterations may obscure the TC's distinctive treatment method, and may, in turn, undermine the effectiveness of the modality documented in prior research.

Using items adapted from the *Therapeutic Community Survey of Essential Elements Questionnaire (SEEQ)* developed by De Leon and colleagues (Melnick et al. 2000; Melnick & De Leon 1999; De Leon & Melnick 1993), this study examines whether a nationally representative sample of 380 self-identified TCs display the essential elements identified by De Leon (2000) in his seminal work *The Therapeutic Community: Theory, Model, and Method*. Dimensions derived from a factor analysis of the *SEEQ* items are included in a structural equation model to assess the extent to which a variety of modified TCs adhere to the traditional TC model.

THE SEEQ AS A MEASURE OF THE THERAPEUTIC COMMUNITY MODEL

The SEEQ was developed by De Leon and colleagues (Melnick et al. 2000; Melnick & De Leon 1999; De Leon & Melnick 1993) to identify and codify the "core technology" of the therapeutic community model. The essential TC elements in the SEEQ were broadly organized into six dimensions: (1) TC Perspective, (2) The Agency: Treatment Approach and Structure, (3) Community as Therapeutic Agent, (4) Education and Work Activities, (5) Formal Therapeutic Elements, and (6) Process. In separate studies, data from 59 member organizations of Therapeutic Communities of America (TCA) and 19 self-identified TCs that participated in the Drug Abuse Treatment Outcomes Study (DATOS) demonstrated the utility of the SEEQ in describing the core characteristics of TCs (Melnick et al. 2000; Melnick & De Leon 1999). Both studies revealed a high degree of adherence to the essential elements, as evidenced by average scores on the items that were highly skewed towards the maximum ends of the scales.

Although the SEEQ has been shown to have high face validity and acceptable reliability, it has not yet been administered in a nationally representative sample of organizations that identify as therapeutic communities. Likewise, the SEEQ has not been subjected to a confirmatory factor analysis, as Melnick and De Leon (1999) note that they lacked the statistical power to conduct such an analysis. Instead, applications of the SEEQ in published research have primarily focused on using it to differentiate traditional and modified TCs, and then comparing the caseload, staffing, and other characteristics of these two groups. To date, there has not been a study with a sufficient sample size to address the extent to which particular types of modified TCs demonstrate adherence to the traditional TC model. The present study overcomes these shortcomings by using data from a nationally representative sample of 380 self-identified therapeutic communities.

METHODS

Sample Construction and Data Collection

This national study of community-based therapeutic communities was conducted in 2002-2004. A two-stage sampling design was used to randomly select a panel of 380 TCs. First, all counties in the US were assigned to one of ten strata based on total population. Counties were randomly sampled within strata. Within the sampled counties, efforts were made to enumerate all substance abuse treatment facilities using published directories, including federal and state provider listings. From these lists, treatment facilities were randomly selected proportionate to the total number of facilities in the sampled counties. This ensured proportional representation of facilities in urban, suburban, and nonmetropolitan areas. A brief telephone screen was completed with each sampled unit to assess eligibility for the study. Facilities that were ineligible or refused to participate were replaced with others randomly selected from the same geographic stratum, and this continued until the target sample size was achieved.

Three criteria were used to determined eligibility for the study. First, the facility was required to provide substance abuse treatment. Second, only "community-based" facilities (those open to the general public) were included; facilities that operated within the Veteran's Administration Health System or correctional settings were not eligible for the study. Third, when asked to select from a set of options describing the services offered, the facility needed to self-identify as a therapeutic community. Although information such as membership in Therapeutic Communities of America (TCA) and adherence to De Leon's TC model was collected during the subsequent in-depth interviews, such

criteria were not used in sample selection. This approach allowed for measurement of the variation among facilities that identified themselves as TCs, thereby capturing the diversity of TCs within the US.

The 380 TCs included in these analyses represent 86% of facilities that met the study's eligibility criteria and agreed to participate. Organizational-level data about each TC were collected during face-to-face interviews with its administrator and/or clinical director. These interviews averaged about two hours in length, and participating TCs received a $100 honorarium. The study protocol was reviewed and approved by the University of Georgia's Institutional Review Board.

Measures

SEEQ and traditional TC concepts. The original SEEQ included 139 Likert-type items; such a lengthy battery was ill-suited for a face-to-face interview that included many additional items and topics. Because the psychometric properties of the original SEEQ had not been documented, there was no predetermined basis for reducing the original survey to a manageable set of items. Prior to beginning data collection for this study, a focus group was held with 11 directors of therapeutic communities. The purpose of the focus group was to inform the project staff on the unique structure and philosophy of therapeutic communities, and to discuss how these elements may be affected by recent trends in the modification of TCs. Based on the focus group, 49 items from the original SEEQ were selected for inclusion in the field interviews. These items measured structural, philosophical, and clinical concepts that were identified as most salient to the core technology of TCs by the focus group participants. In the field interviews, the Likert-type format was maintained, and respondents were asked to rate on a scale of 0 (no extent) to 5 (very great extent) the extent to which each element characterized their TC.

Independent and control variables. In the analyses that follow, the SEEQ items are used to describe TCs in terms of their adherence to the core traditions of the modality. Several variables are used to define modifications to traditional TC structure and philosophy. One such modification is the delivery of services to specific client populations. One set of dummy variables is used to describe the gender mix of clients served by the TC: women only, men only and mixed gender (the reference category). A second set of dummy variables characterizes the predominant age group served by the TC: adolescent only, mixed ages and adult only (the reference category). A third measure related to client populations is the provision of integrated substance abuse and mental health treatment for clients with co-occurring substance abuse and psychiatric conditions (1 = yes, 0 = no).

Two variables measure the TC's staffing characteristics, and are intended to identify the degree of professionalism or formal credentials among counseling staff. One variable measures the percent of the TC's counselors holding a Master's degree or higher. The second variable measures the percentage of counselors who are themselves in recovery.

Another recent modification relates to the structure of TCs, which have traditionally operated as long-term residential programs. A set of dummy variables characterizes the sampled TCs in terms of planned duration and structure of treatment: outpatient only, mixed residential and outpatient, short-term (less than 180 days) residential only, and long-term (more than 180 days) residential only (the reference category).

Three control variables are also included in the analysis. Each of the self-identified TCs in the sample was asked about formal membership in the TC professional association, Therapeutic Communities of America (TCA). TCA membership is represented by a dichotomous variable where members are coded 1. Analyses also control for the age of the TC (years since founding) and size based on the number of full time equivalent employees (FTEs). Because the distributions of age and size are skewed, the log transformation of each is used in the multivariate analyses.

Analyses

Analyses are conducted using structural equation modeling (SEM) techniques in the Mplus software package (Muthen & Muthen 1998). Because there are multiple variables measuring multiple dimensions of the therapeutic community model, SEM is the most appropriate means of analyzing these data as it is capable of parceling out measurement error as well as allowing some observed variables to be more heavily weighted measures of a latent variable than other observed variables. SEM also permits the researcher to have a single observed variable loading on or contributing to the measurement of more than one concept.

RESULTS

Descriptive Statistics

Frequencies for each of the predictor and control variables are presented in Table 1. As shown, there is a high degree of adherence to traditional TC structure in terms of clients served, staff qualifications, and levels of care. At the same time, however, there are measurable levels of adaptation in these domains. While the majority of this sample of self-identified TCs offers services for both men and women (59.2%), the remainder is about evenly split between women-only and men-only programming. Likewise, while the majority (68.8%) offers services for adult clients, a nontrivial number of adolescent-only programs (10.5%) are also found in the sample. Roughly half of the sampled TCs offer integrated substance abuse and mental health services for clients with co-occurring conditions.

In terms of staffing, the majority of counselors employed in sampled TCs have completed a bachelor's degree

TABLE 1
Descriptive Statistics for Predictor Variables (N = 343)

	% or Mean (SD)	Range
Special Populations		
Gender: Women Only	19.5%	
Mixed Gender	59.2%	
Men Only	21.3%	
Age: Adolescent Only	10.5%	
Mixed Ages	20.7%	
Adult Only	68.8%	
Integrated Care for Co-occurring Disorders (% offering)	49.3%	
Staffing Characteristics		
Master's Degree or Higher (%)	28.6% (29.2)	0 to 100%
Counselors in Personal Recovery (%)	57.5% (33.5)	0 to 100%
Levels of Care		
Outpatient Only	10.8%	
Mixed Levels of Care	35.9%	
Short-term Residential Only (< 180 days)	26.0%	
Long-term Residential Only (> 180 days)	28.3%	
Control Variables		
TCA Membership (% yes)	24.0%	
TC Age (years)	20.00 (12.37)	1 to 55
TC Size (number of FTEs)	23.33 (36.02)	1 to 530

or less education; just over one-quarter (28.6%) of the counselors in responding programs hold a Master's degree or higher. On average, more than half of the counselors in each sampled TC were in recovery.

Finally, TCs showed a noticeable degree of variation in terms of the intensity and duration of treatment offered. Among the study respondents, only slightly more than one-quarter (28.3%) provided exclusively long-term residential programming. By contrast, just over one-third of these TCs (35.9%) provided some combination of residential and outpatient services, while 10.8% offered exclusively outpatient services.

The average TC in this sample had been in operation for 20 years, and employed 23 full-time equivalent employees. Only 24% claimed membership in Therapeutic Communities of America.

Factor Analysis

An exploratory factor analysis (EFA) of the 49 SEEQ items was conducted using the Mplus software package (Muthen & Muthen 1998). Although there was evidence that a single factor for the 49 items yielded a high alpha reliability (alpha = .945), a single factor solution did not fit the model well and 14 of the indicators had loadings that were less than .50. An eight-factor solution produced the best fit statistics (RMSEA = .050, SRMR = .030), but there was evidence of overfactoring since two factors lacked any items. Thus, a six-factor structure was examined further. Through an iterative process, cross-loading items were trimmed from the model, and the factor analysis reestimated. A confirmatory factor analysis (CFA) was then conducted using a six-factor solution. This measurement model fit the data reasonably well (CFI = .942, TLI = .933, RMSEA = .047, SRMR = .052). Of the 49 SEEQ indicators, 31 items loaded on the six factors with loadings that exceeded .50. The remaining 18 items loaded on multiple factors and were dropped from further analysis (item list available from the authors).

Table 2 presents the descriptive statistics and factor loadings for the 31-item, six-factor solution identified in the CFA. The factors reflect six core TC principles and structures: the traditional TC views on "right living" and "community as method" (TC Perspective); stratification of roles and responsibilities for clients and staff (Hierarchy); client peer interactions related to therapeutic goals (Clients as Therapists); an emphasis on employment and vocational training (Work as Therapy); traditional programmatic elements such as meetings, program stages, and house rules (Aspects of the Program); and sanctions for violations of program rules (Disciplinary Actions). As would be expected in a sample of TCs, the mean scores for these items are skewed towards the maximum value of five. Only eight of the items have means that are lower than four, and none of the items have a mean of less than three. The lowest means are found in the Hierarchy and Work as Therapy factors. These responses to the elements of TC structure and culture provide considerable evidence that, on balance, this sample of self-identified therapeutic communities adheres quite closely to De Leon's model (2000).

Structural Equation Model

To assess whether modified TCs continue to be characterized by traditional TC concepts, a structural equation model was estimated in Mplus. Each of the six TC elements

TABLE 2
Descriptive Statistics and Factor Loadings of TC Elements

	Mean (SD)	Loading
Factor 1: TC Perspective		
Immaturity, conduct, or character problems and low self-esteem are typical psychological features of substance abusers.	4.64 (.76)	.587
Right living involves positive social values, such as the work ethic, social productivity, and community responsibility.	4.72 (.57)	.652
Right living reflects personal values, such as honesty, self-reliance, and responsibility to self and significant others.	4.84 (.47)	.701
Treatment encompasses developing individual responsibility.	4.86 (.42)	.667
Treatment involves caring and sustained responsibility to others.	4.73 (.58)	.697
Staff provides residents with the reasons and projected consequences regarding their decisions.	4.65 (.66)	.637
Counselors function as a role model, which is of equal or greater importance than their formal therapeutic capacity.	4.46 (.86)	.620
Factor 2: Hierarchy		
Clients are stratified by levels of responsibility and clinical status, such as Junior, Intermediate, and Senior.	3.98 (1.61)	.850
Senior residents acquire increasing responsibility for administrative and maintenance functions.	3.58 (1.89)	.761
Senior residents conduct important peer management functions.	3.78 (1.74)	.773
Residents facilitate some groups or seminars while staff monitors.	3.21 (1.91)	.619
Senior residents act as role models for more junior clients.	4.38 (1.24)	.724
Status advancement is used as a reward for clinical progress.	3.94 (1.62)	.750
Factor 3: Clients as Therapists		
Clients confront the negative behavior and attitudes of each other and the community.	4.28 (1.00)	.700
Clients provide affirmation of positive behaviors of others in the community.	4.52 (.85)	.692
Clients are aware of the therapeutic goals of fellow residents and try to assist them to achieve these goals.	4.10 (1.13)	.736
Factor 4: Work as Therapy		
The program uses vocational training and/or experience.	3.76 (1.66)	.648
Work is utilized as part of the therapeutic program.	4.20 (1.45)	.725
The program focuses on clients becoming more employable.	4.10 (1.42)	.697
The re-entry program utilizes live out or working out status.	3.65 (1.92)	.740
The re-entry program involves monitored or supervised work, training or education outside the agency facility.	3.17 (2.05)	.668
Factor 5: Aspects of Program		
General meetings are convened as needed to address negative behavior, attitudes, or incidents at the facility.	4.58 (.98)	.621
There are daily or frequent seminars that convene the entire facility to provide information on recovery and right living.	4.30 (1.34)	.619
Residents participate in program rituals and traditions, such as initiations and graduations.	4.29 (1.32)	.559
There are periodic house runs and thorough inspection of the premises.	4.43 (1.28)	.770
The program is designed as three main stages: orientation/induction, primary treatment, and re-entry with subphases in each stage.	4.24 (1.40)	.634
The goals of orientation/induction center on assimilating the resident into the community.	4.56 (1.10)	.723
There is an initial period in which new clients are assigned to senior residents or staff for introduction to the program for initial support.	4.28 (1.42)	.698
A main goal of the primary treatment stage is building a sense of ownership or belonging in the community.	4.41 (1.10)	.818
Factor 6: Disciplinary Actions		
Program provides sanctions for violating behavior rules.	4.62 (.84)	.857
Disciplinary actions are designed as learning experiences.	4.71 (.75)	.773

TABLE 3
Structural Model of Adherence to TC Essential Elements[a] (N = 343)

	Element 1 b (S.E.)	Element 2 b (S.E.)	Element 3 b (S.E.)	Element 4 b (S.E.)	Element 5 b (S.E.)	Element 6 b (S.E.)
Special Populations[b,c]						
Women Only	.068 (.070)	.314 (.198)	.133 (.127)	.235 (.160)	.136 (.087)	.266*(.118)
Men Only	.011 (.066)	-.232 (.190)	-.085 (.122)	.040 (.152)	-.017 (.082)	.047 (.113)
Adolescent Only	.123 (.086)	.072 (.245)	-.017 (.157)	-.797*** (.205)	.099 (.107)	.289* (.147)
Mixed Ages	-.002 (.067)	-.086 (.191)	-.141(.123)	-.103 (.154)	.009 (.083)	-.033 (.114)
Integrated Care	.095 (.053)	.212 (.149)	.114 (.096)	.099 (.120)	.091 (.065)	.217* (.089)
Staffing Characteristics						
Master's Level Counselors	-.150(.096)	-.556*(.271)	.117(.173)	-.213(.218)	-.102(.118)	-.298(.162)
Counselors in Personal Recovery	.112(.089)	.181(.251)	.456**(.163)	.272(.203)	.305**(.111)	.073(.151)
Levels of Care[d]						
Outpatient Only	-.046 (.100)	-1.497*** (.289)	-.473* (.184)	-.932*** (.239)	-.901*** (.138)	-.563*** (.171)
Short-term Residential	-.003 (.065)	-.691*** (.187)	-.108 (.119)	-.465*** (.153)	-.109 (.081)	-.119 (.111)
Mixed LOC	-.042 (.064)	-.147 (.183)	.039 (.118)	-.034 (.148)	-.036 (.080)	.003 (.110)
Control Variables						
TCA Membership	.132* (.057)	.596*** (.167)	.328**(.107)	.283* (.135)	.138(.073)	.148 (.099)
TC Age (log)	-.042 (.031)	-.058 (.087)	-.028 (.056)	-.022 (.070)	.000 (.038)	.019 (.052)
TC Size (log)	-.040 (.032)	-.042 (.089)	.028 (.057)	-.042 (.072)	.053 (.039)	-.094 (.054)
Latent Variable R2	.087	.231	.131	.219	.317	.144

[a]Element 1 = TC Perspective; Element 2 = Hierarchy; Element 3 = Clients as Therapists; Element 4 = Work as Therapy; Element 5 = Aspects of Program; Element 6 = Disciplinary Actions.
[b]Mixed gender programs are the reference category.
[c]Adult-only programs are the reference category.
[d]Long-term residential programs are the reference category.
NOTE: * $p < .05$; ** $p < .01$; *** $p < .001$ (two tailed)

described above was regressed on the TC modification and control variables. Listwise deletion of missing cases resulted in a sample of 343 TCs with complete data. Again, the model fit the data reasonably well (CFI = .881, TLI = .861, RMSEA = .05, SRMR = .05).

Results from the structural model are shown in Table 3. The six TC elements are represented in turn across the six columns, and unstandardized coefficients and standard errors are reported for each independent variable. Because the focus of this study is on identifying TC modifications that may compromise programs' adherence to these core elements, each of the predictor variables is reviewed in turn, and their association with each of the TC elements is described.

TC modifications related to the gender of clients treated showed little effect on programs' adherence to any of the core TC elements. Although women-only TCs were significantly more likely than the reference category of mixed-gender programs to utilize traditional Disciplinary Actions, neither of the single-gender TCs differed from traditional mixed-gender TCs on adherence to any of the other essential elements.

TCs that had modified their services to focus on adolescents were not systematically different from traditional adult-only programs in their adherence to the essential elements. The only significant effects were found for adolescent-only TCs, and for only two elements. Adolescent-only TCs were significantly less likely to emphasize Work as Therapy relative to adult-only TCs, and significantly more likely to emphasize Disciplinary Actions. Both of these tendencies, however, are likely more a function of the age of the clients rather than the modification of the TC per se.

TCs that provide integrated substance abuse and mental health treatment for clients with co-occurring disorders were significantly more likely to emphasize Disciplinary Actions relative to other TCs. However, this particular modification to traditional TC programming showed no significant effect on adherence to the other five elements.

The effects of staffing characteristics on the core TC elements were mixed. TCs employing a greater percentage of Master's level counselors showed significantly lower adherence to the traditional emphasis on Hierarchy—that is, structured and progressively more responsible roles for clients as they progress through the program. Although the SEEQ items do not provide detail, it may be that the higher-level responsibilities are shifted to the credentialed counseling staff in these programs. By contrast, TCs maintaining a greater percentage of recovering counselors showed significantly greater adherence to the traditional role of Clients as Therapists, as well as traditional Aspects of the Program.

Modifications to the structure and intensity of TC programming showed the strongest and most consistent effects on adherence to traditional TC elements. Net of the other predictors, and relative to traditional long-term residential programming, TCs that operated on an outpatient-only basis showed significantly lower adherence to five of the six traditional elements. Likewise, those offering short-term residential programming (less than 180 days) trended negative on all of the elements, while two of these (Hierarchy and Work as Therapy) were statistically significant. TCs that offered a mix of residential and outpatient services and lengths of stay were no different than long-term residential programs in their adherence to traditional TC concepts.

Among the control variables, it is notable that TCA membership was associated with adherence to traditional elements measured by the SEEQ. Although TCA is a voluntary membership organization and not a licensing body, TCs in this study that claimed membership in TCA showed significantly greater adherence to four of the six traditional elements relative to nonmembers. Net of the programmatic modifications included in these models, TCA members placed significantly greater emphasis on the traditional TC Perspective, Hierarchy, Clients as Therapists, and Work as Therapy. Neither the age of the program, nor the number of employees, were associated with adherence to any of the core TC elements.

Although the models include a limited number of structural variables and program modifications, the predictors accounted for between 9% and 32% of the variance in the latent variables identified in the CFA. The models accounted for the least variance in TC Perspective; the items in this domain tapped general philosophical principles underlying therapeutic communities that are probably least affected by structural and programmatic modifications. By contrast, the models accounted for almost one-third of the variance in Aspects of the Program, that is, the specific treatment practices that are hallmarks of traditional TCs and most likely to be impacted by changes to the structure of service delivery.

DISCUSSION

While many of the specific SEEQ items based on De Leon's original six dimensions were not confirmed in the factor analysis, a similar set of six broad categories representing essential TC elements was identified, encompassing a range of philosophical, disciplinary, therapeutic, and reintegrative features traditionally associated with TCs. Thus, the results derived from this study's factor analysis of 49 SEEQ items within a large nationally representative sample of TCs were a close approximation to Melnick and De Leon's (1999) findings. Overall, the high average mean scores on each of the elements indicated that the self-identified TCs in this sample largely adhere to the basic elements outlined in De Leon's classic TC model.

The multivariate models revealed two important patterns regarding these essential elements. First, none of the modifications considered in the models were significant predictors of the TC perspective scale. That is, as TCs have accommodated specific client groups, become more professionalized, and added nontraditional levels of care and lengths of stay, the unique TC perspective on recovery and "right living" has not been lost. This finding is in accordance with Melnick and De Leon's (1999: 311) conclusion that TCs report "a general acceptance of an overall view of the drug abuser and recovery . . . regardless of the populations served or the treatment modalities."

The other five models, however, did indicate some significant variations in adherence to the "community as method" elements of the traditional TC model. In most cases, these findings are intuitive and consistent with the literature on modified TCs. For example, TCs that employed higher percentages of counselors in personal recovery (a traditional job characteristic in the TC workforce) tended toward higher scores on all domains relative to TCs with fewer such staff. The use of Clients as Therapists and certain Aspects of the TC Program including TC phases, community meetings and rituals were significantly higher in programs with more recovering staff.

The results also indicated that TCs focusing their services on adolescents, women, and clients with co-occurring conditions placed a greater emphasis on Disciplinary Actions compared to more traditional TCs. Initially, this effect seems counter to prior evidence, since one of the most widely documented modifications in TCs for women and co-occurring disorder clients is the less confrontational environment. This finding, however, may point to the greater use of behavior modification techniques, including positive and negative sanctions, in lieu of more confrontational therapeutic approaches. Although the Disciplinary Actions scale did not include items measuring the use of confrontation, administrators were asked about their TC's therapeutic orientation toward the use of confrontational therapies. Consistent with prior research, women-only TCs in this sample placed significantly less emphasis on the use of confrontational styles than mixed gender and male-only TCs (0 – 5 scale; women only scored 2.77 versus 3.27 average for other TCs; $t = 3.268$, $p = .027$). Adolescent-only TCs, in comparison, placed more emphasis on confrontation than did TCs for adults (0 – 5 scale; adolescent scored 3.70 versus 3.12 average for TCs for adults; $t = -2.043$, $p = .042$). However, there were no significant differences in the emphasis on confrontation among TCs that offered integrated care for clients with co-occurring disorders and those that did not offer such services.

Of all the variables, the most significant and consistent finding focused on the effect of outpatient only (and short-term residential only) TCs on the adherence to essential elements. Relative to traditional long-term residential TCs, outpatient-only programs showed significantly lower adherence to

five of the six essential elements measured in these analyses, while short-term residential TCs trended negative on all six domains, two of which were significant. Melnick and De Leon (1999) previously noted that many of the key elements of long-term traditional TCs are not feasible in the TC-oriented outpatient and short-term residential modalities. Shorter-term and outpatient programs have less time to develop work and therapeutic groups as well as hierarchical community structures. In the analyses presented here, outpatient-only TCs demonstrated a remarkable reduction in their ability to adhere to the "community as method" approach despite exhibiting no significant variation in TC perspective. It appears, then, that among the range of modifications made by TCs, the transition to short-term and outpatient programming is potentially the most significant threat to the fidelity of the essential elements of this treatment modality.

LIMITATIONS

This study provides important insights into the current population of therapeutic communities in the U.S., the changing structure of TC services, and the impact of those modifications on adherence to traditional TC philosophy and methods. There are, however, several important limitations that must be considered. First, because of the cross-sectional nature of the data, this study could not measure change in the TC elements over time or the causal association between TC modifications and adherence to the TC elements. A longer historical perspective on these programs is needed to understand more fully the causes and consequences of changes in service delivery in these settings.

Second, this study utilizes elements of the SEEQ, which provides quantitative data to describe the TCs and the essential elements. Qualitative evaluations may provide more detailed information on the types of modifications in these TCs and the subtleties of how these modifications may have altered the beliefs and practices of personnel within these programs. In addition, some of the survey measures do not perfectly capture the TC modifications. For example, the variable representing integrated care does not provide information on the specific services offered to clients with co-occurring conditions or the percentage of clients needing such services.

Lastly, the study inclusion criteria required that treatment programs self-identify as TCs. In designing the study, alternative sampling strategies were considered, including (a) limiting the study to TCA members, and (b) asking potential participants to complete a short version of the SEEQ to determine eligibility. However, each of these options was rejected in favor of self-identification because either alternative would exclude programs that actively market themselves as therapeutic communities, and would artificially truncate the variance found in the sample. TCA is not a licensing or credentialing body and therefore membership does not necessarily convey adherence to specific programming requirements. Given the variation among programs identifying as TCs, however—particularly those that have made modifications to the length and intensity of treatment services—this segment of the treatment system might benefit from consensus-building around what constitutes minimum standards for a program to position itself as a "therapeutic community."

CONCLUSIONS

This study used a large-scale nationally representative sample of TCs to extend the research of Melnick and De Leon (1999). Items from the SEEQ were subjected to a factor analysis and the dimensions derived from this analysis were used to examine this sample's adherence to the essential TC elements. The high mean scores for each of the TC elements indicated that this sample of TCs adhere closely to the traditional TC model described by De Leon (2000) and his colleagues. The multivariate models suggested that TC modifications did not significantly alter adherence to the TC perspective of "right living." Modifications did have some effect on the "community as method" practices including Hierarchy, Clients as Therapists, Work as Therapy, Aspects of Program, and Disciplinary Actions. The significant effect of outpatient-only programs on adherence to the TC elements has important implications for both research and practice. Future research should be aimed at understanding more about how outpatient-only TCs operate and the key ingredients that help these programs maintain their TC identity.

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