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# The Therapeutic Community: Toward a General Theory and Model

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## THE NEED FOR A THERAPEUTIC COMMUNITY THEORY AND GENERAL MODEL

The maturation of the therapeutic community (TC) as a sophisticated human services modality is evident in the broad range of programs that subscribe to the basic TC perspective and approach and serve an estimated 80,000 admissions yearly. These admissions include a wide diversity of clients who use an expanded cafeteria of drugs and present complex social-psychological problems in addition to their chemical abuse.

The TC's basic social learning model has been amplified with a variety of additional services, including family, educational, vocational, medical, and mental health. Staffing compositions have been altered to include increasing proportions of traditional mental health, medical, and educational professionals to serve along with the recovered paraprofessionals (Carroll and Sobel 1986; De Leon, in press; Winick 1991).

Correctional institutions, medical and mental hospitals, and community residence and shelter settings, overwhelmed with alcohol and illicit drug abuse problems, have implemented TC programs within their institutional boundaries (Galanter et al. 1993; Wexler and Williams 1986). TC agencies have incorporated basic elements of its drug-free philosophy and view of "right living" into educational and prevention programs for schools and communities.

The evolutionary changes of the TC in the last decade reveal the vigor, resourcefulness, and flexibility of the modality to adapt to growth and change. However, evolution also highlights the need for a theoretical framework and model to advance research and to guide training, practice, and program development. Currently, this need is most evident in two

related issues: the diversity of programs and the complexity of the treatment process.

The adaptation of TCs for new clients and different settings has resulted in a proliferation of programs with unique treatment protocols and different planned durations of stay; even the long-term traditional model is differentially implemented. The range and extent to which these adapted programs retain the basic elements of the TC model is not known. Moreover, the wide diversity of programs raises questions about the general effectiveness of the TC modality and underscores the need for defining the essential elements of the TC model and method.

Illumination of the treatment process is essential to improving TC treatment. The absence of treatment process information has weakened conclusions concerning the effectiveness of TCs and has obscured efforts to improve treatment. If links cannot be explicitly established between program interventions, the course of client change, and eventual outcomes, the effectiveness of any TC-oriented model remains unclear, much less proven. Modification of existing TC protocols must be guided by an understanding of the relevance and timing of particular program components for different individuals. Knowing why and how individuals change in TCs is a prerequisite for introducing changes in treatment in order to increase retention and favorable outcomes.

This chapter provides a framework for a general theory and model of therapeutic communities, which is elaborated more fully in other writings (De Leon 1991*a*, 1994*a*, in press; De Leon and Rosenthal 1989; De Leon and Ziegenfuss 1986). The formulation presented has evolved from the research and clinical experience obtained in the long-term residential TC, which is commonly viewed as traditional. This model still serves as the prototype for the current diversity of TCs and has documented effectiveness (Anglin and Hser 1991; De Leon 1985; Hubbard et al. 1989; Simpson and Sells 1982).

It should be stressed that the framework presented is not a theory in the formal sense of a systematic account of how and why people change. It does not provide operational definitions for the main concepts; there are no explicit hypotheses, nor are specific cause and effect relationships postulated. The framework organizes the elements (e.g., perspective, concepts, assumptions, and program features) used in the TC *to understand itself:* These elements are judged to be essential toward

characterizing a general model and developing an empirically testable theory.

The first section of this chapter reviews the TC perspective in terms of its view of the disorder, the person, right living, and recovery. It describes the major TC treatment approach, *community as method,* and the main program components of a generic TC model. The second section formulates a framework of the treatment process in the TC in terms of program interventions, the dimensions of individual change, and the stages of change. A paradigm is outlined that incorporates behavioral and social learning principles with perceptions and experiences as mechanisms toward clarifying the change process. The final section offers some implications of the theoretical framework for research in the TC.

## THE TC PERSPECTIVE, APPROACH, AND PROGRAM COMPONENTS

The TC can be distinguished from other major drug treatment modalities in two fundamental ways. First, the TC offers a systematic treatment approach that is guided by an explicit perspective on the *drug use disorder, the person, recovery, and right living.* Second, the primary therapist and teacher in the TC is the *community* itself, which consists of the social environment, peers, and staff members who, as role models of successful personal change, serve as guides in the recovery process. Thus, the community is both the context in which change occurs and the method for facilitating change.[1]

### View of the Disorder

Drug abuse is regarded as a disorder of the whole person. Although individuals differ in their choice of substances, abuse involves some or all of the areas of functioning. Cognitive, behavioral, and mood disturbances appear, as do medical problems; thinking may be unrealistic or disorganized; and values are confused, nonexistent, or antisocial. Frequently there are deficits in verbal, reading, writing, and marketable skills. Finally, whether couched in existential or psychological terms, moral issues are apparent.

Abuse of any substance is seen as behavior with multiple determinants. Physiological dependency is secondary to the wide range of

circumstances that influence and then gain control over an individual's drug-use behavior. Invariably, problems and situations that are associated with discomfort become regular signals for resorting to drug use. For some abusers, physiological factors may be important, but for many these remain minor relative to the behavioral deficits that accumulate with continued substance abuse. Physical addiction or dependency must be seen in the wider context of the individual's psychological status and lifestyle. Thus, the problem is the person, not the drug. Addiction is a symptom, not the essence of the disorder. In the TC, chemical detoxification is a condition of entry, not a goal of treatment. Rehabilitation focuses on maintaining a drug-free existence.

## View of the Person

Rather than drug-use patterns, individuals are distinguished along dimensions of psychological dysfunction and social deficits. A considerable number of clients never have acquired conventional lifestyles. Vocational and educational deficits are marked; mainstream values either are missing or unpursued. Most often, these clients emerge from a socially disadvantaged sector where drug abuse is more a social response than a psychological disturbance. Their TC experience can be termed habilitation—the development of a socially productive, conventional lifestyle for the first time in their lives.

Among clients from advantaged backgrounds, drug abuse is more directly expressive of psychopathology, personality disturbance, or existential malaise. For these clients, the term *rehabilitation* is more suitable because it emphasizes a return to a lifestyle previously lived, known, and perhaps rejected.

Regardless of social class differences, substance abusers share important similarities. All reveal some problems in socialization, cognitive/emotional skills, and overall psychological development, which is evident in their immaturity, poor self-esteem, conduct and character disorders, or antisocial characteristics. Typical features include low tolerance for all forms of discomfort and delay of gratification; inability to manage feelings (particularly hostility, guilt, and anxiety); poor impulse control (particularly sexual or aggressive); poor judgment and reality testing concerning consequences of actions; unrealistic self-appraisal in terms of a discrepancy between personal resources and aspirations; prominence of lying, manipulation, and deception as coping behaviors; and problems with authority and personal and social irresponsibility (i.e., inconsistency

or failures in completing expected obligations and persistent difficulties in managing guilt). Additionally, significant numbers have marked deficits in education and marketable communication skills.

These clinical characteristics do not necessarily depict an "addictive personality," although many of these features are diagnostic of conduct disorder in the younger substance abuser, which often evolves into adult character disorder. Nevertheless, whether antecedent or consequent to serious drug involvement, these characteristics are observed to be correlated with chemical dependency. More importantly, TCs require a positive change in these characteristics as essential for stable recovery. Thus, all clients in TC-oriented treatment follow the same regime. Individual differences are recognized in specific treatment plans that modify the steps, not the course, of the client's experience in the TC.

## View of Right Living

TCs adhere to certain precepts and values as essential to self-help recovery, social learning, personal growth, and healthy living. Some precepts specifically orient the individual to the priority and meaning of self-help recovery. For example, they stress the personal present (here and now) as opposed to the historical past (then and when). Past behavior and circumstances are explored only to illustrate the current patterns of dysfunctional behavior, negative attitudes, and outlook. Individuals are encouraged and trained to assume personal responsibility for their present reality and their future destiny.

The view of right living also emphasizes explicit values that guide how individuals relate to themselves, peers, significant others, and the larger society. These include truth and honesty (in word and deed), the work ethic, learning to learn, personal accountability, economic self-reliance, responsible concern for peers, family responsibility, community involvement, and good citizenry.

The ideological and psychological views of the TC perspective are integrated into its teachings and methods to achieve specific social and psychological goals. For example, the requirement of truth and honesty in all matters counters the manipulation and deceitful character features of many substance abusers; the values of accountability and social responsibility are integral teachings in training and socialization. Acquiring vocational or educational skills and social productivity can be motivated by the values of achievement and self-reliance; healthy

behavioral alternatives to drug use are reinforced by a commitment to the values of abstinence. In general, sobriety is a prerequisite for learning to live right, but right living is required to maintain sobriety.

## View of Recovery

The aims of treatment are global in the TC. The primary psychological goal is to change the negative patterns of behavior, thinking, and feeling that predispose drug use; the main social goal is to develop a responsible, drug-free lifestyle. Stable recovery, however, depends on a successful integration of these social and psychological goals. Behavioral change is unstable without insight, and insight is insufficient without experience. Thus, conduct, emotions, skills, attitudes, and values must be integrated to ensure enduring lifestyle changes and a positive personal social identity. The social and psychological goals of the TC shape its treatment regime as well as define several broad assumptions concerning its view of recovery.

*Recovery is a Developmental Process.* Change in the TC can be understood as a passage through stages of incremental learning. The learning that occurs at each stage facilitates change at the next, and each change reflects movement toward the goals of recovery.

*Motivation.* Recovery depends on both positive and negative pressures to change. Some clients seek help, driven by stressful external pressures; others are moved by more intrinsic factors. For all, however, remaining in treatment requires continued motivation to change. Thus, elements of the rehabilitation approach are designed to sustain motivation or detect early signs of premature termination. Although the influence of treatment depends on the individual's motivation and readiness, change does not occur in a vacuum. Rehabilitation unfolds as an interaction between the client and the therapeutic environment.

*Self-Help and Mutual Self-Help.* Treatment is not provided but made available to the individual in the TC environment through its staff and peers and the daily regime of work, groups, meetings, seminars, and recreation. However, the effectiveness of these elements is dependent upon the individual, who must fully engage in the treatment regime. Self-help recovery means that the individual makes the main contribution to the change process. Mutual self-help also emphasizes the fact that each individual in the process contributes to the change in others. The main messages of recovery, personal growth, and right living are

mediated by peers through confrontation and sharing in groups, by functioning as role models, and as supportive friends in daily interactions.

*Social Learning.* Negative behavioral patterns, attitudes, and dysfunctional roles were not acquired in isolation, nor can they be changed in isolation. Therefore, recovery depends not only on what has been learned but on how, where, and with whom learning occurs. This assumption is the basis for the community itself serving as healer and teacher. Learning occurs by doing and participating as a community member; a socially responsible role is acquired by acting the role. Thus, changes in lifestyle and identity are gradually learned through participating in the varied roles of community life, supported by the people and relationships involved in the learning process. Without these relationships, new ways of coping are threatened by isolation and the potential for relapse. Thus, a perspective on self, society, and a life philosophy must be affirmed by a network of similar others to ensure a stable recovery.

## The TC Approach: Community as Method

The quintessential element of the TC is community. What distinguishes the TC from other treatment approaches (and other communities) is the *purposive use of the community as the primary method for facilitating social and psychological change* in individuals.[2]

Community as method means integrating people and practices under a common perspective and purpose to teach individuals to use the community to learn about and change themselves. Thus, all TC activities are designed to produce therapeutic and educational change in the participants, and all participants are mediators of these therapeutic and educational changes. The following specific features are distinctive to the community-as-method model.

*Use of Participant Roles.* Individuals contribute directly to all activities of the daily life in the TC, which provides learning opportunities through engaging in a variety of social roles (e.g., peer, friend, coordinator, and tutor). Thus, individuals are active participants in the process of changing themselves and others.

*Use of Membership Feedback.* The primary source of instruction and support for individual change is the TC membership. Providing

observations and authentic reactions to the individual is the shared responsibility of all participants.

*Use of the Membership as Role Models.* Each participant strives to be a role model of the change process. Along with their responsibility to provide feedback to others regarding what they must change, members also must provide examples of how they can change.

*Use of Collective Formats for Guiding Individual Change.* The individual engages in the process of change primarily with his or her peers. Educational, training, and therapeutic activities occur in groups, meetings, seminars, job functions, and recreation. Thus, the learning and healing experiences that are essential to recovery and personal growth unfold in a social context and through social intercourse.

*Use of Shared Norms and Values.* Rules, regulations, and social norms protect both the physical and psychological safety of the community. However, there are beliefs and values that serve as explicit guidelines for self-help recovery and right living. These guidelines are expressed in the vernacular and the culture of each TC and are mutually reinforced by the membership.

*Use of Structure and Systems.* The organization of tasks (e.g., the varied job functions, chores, and management roles) needed to maintain the daily operations of the facility is a main vehicle for teaching self-development. Learning occurs not only through specific skills training but in adhering to the orderliness of procedures and systems, in accepting and respecting supervision, and in behaving as a responsible member of the community upon whom others are dependent.

*Use of Open Communication.* The public nature of shared experiences in the TC is used for therapeutic purposes. The private inner life, feelings, and thoughts of the individual are matters of importance to the recovery and change process, not only for the individual but for other members. Thus, all personal disclosure eventually is shared.

*Use of Relationships.* Friendships with particular individuals, peers, and staff are essential to encourage the individual to engage and remain in the change process. The relationships developed in treatment are the basis for the social network needed to sustain recovery beyond treatment.

## The Generic TC Model: Basic Components

The TC perspective on the disorder, the person, recovery, and right living and its distinctive approach, the use of community as method, provide the conceptual basis for defining a generic TC program model in terms of its basic components. These components are adapted in different ways and in various settings, both residential and nonresidential.

*Community Separateness.* TC-oriented programs have their own names, often innovated by the clients, and are housed in a space or locale that is separate from other agency or institutional programs or units and from the drug-related environment. In the residential settings, clients remain away from outside influences 24 hours a day for several months before earning day-out privileges. In the nonresidential "day treatment" settings, the individual is in the TC environment for 4 to 8 hours and then is monitored by peers and family. Even in the least restrictive outpatient settings, TC-oriented programs and components are in place. Clients gradually detach from old networks and relate to drug-free peers in the program.

*A Community Environment.* The inner environment of a TC facility contains communal space to promote a sense of commonality and collective activities (e.g., groups, meetings). The walls display signs that state the philosophy of the program-the messages of right living and recovery. Corkboards and blackboards identify all participants by name, seniority level, and job function in the program, and daily schedules are posted. These visuals display an organizational picture of the program that the individual can relate to and comprehend, which promotes affiliation.

*Community Activities.* Treatment or educational services must be provided within a context of the peer community to be effective. Thus, with the exception of individual counseling, all activities are programmed in collective formats. These activities include at least one daily meal prepared, served, and shared by all members; a daily schedule of groups, meetings and seminars, team job functions, and organized recreational and leisure time; and ceremonies and rituals (e.g., birthdays and phase/progress graduations).

*Staff Roles and functions.* The staff members are a mix of recovered professionals and other traditional (e.g., medical, legal, mental health, and educational) professionals who must be integrated through cross-training

that is grounded in the basic concepts of the TC perspective and community approach. Professional skills define the function of individual staff (e.g., nurse, physician, lawyer, teacher, administrator, case worker, or clinical counselor). Regardless of professional discipline or function, however, the generic *role* of all staff is that of community members who are rational authorities, facilitators, and guides in the self-help community method.

*Peers as Role Models.* Clients who demonstrate the expected behaviors and reflect the values and teachings of the community are viewed as role models. Indeed, the strength of the community as a context for social learning relates to the number and quality of its role models. All members of the community are expected to be role models—roommates; older and younger residents; and junior, senior, and directorial staff. TCs require these multiple role models to maintain the integrity of the community and to ensure the spread of social learning effects.

*A Structured Day.* The structure of the program relates to the TC perspective, particularly the view of the client and recovery. Ordered, routine activities counter the characteristically disordered lives of these clients and distract them from negative thinking and boredom, which can predispose drug use. Structured community activities also facilitate the learning of self-structure for the individual in time management, planning, setting and meeting goals, and general accountability. Thus, regardless of its length, each day has a formal schedule of varied therapeutic and educational activities with prescribed formats, fixed times, and routine procedures.

*Phase Format.* The treatment protocol, or plan of therapeutic and educational activities, is organized into phases that reflect a developmental view of the change process. The emphasis is on incremental learning at each phase, which moves the individual to the next stage of recovery.

*Work as Therapy and Education.* Consistent with the TC's self-help approach, all clients are responsible for the daily management of the facility (e.g., cleaning activities, meal preparation and service, maintenance, purchasing, security, coordinating schedules, and preparatory chores for groups, meetings, seminars, and activities). In the TC, the various work roles mediate the essential educational and therapeutic effects. Job functions strengthen affiliation with the program

through participation, provide opportunities for skills development, and foster self-examination and personal growth through performance challenge and program responsibility. The scope and depth of client work functions depend upon the program setting (e.g., institutional versus free-standing facilities) and client resources (level of psychological function and social and life skills).

*TC Concepts.* There is an organized curriculum for teaching the TC perspective, particularly its self-help recovery concepts and view of right living. The concepts, messages, and lessons of the curriculum are repeated in the various groups, meetings, seminars, and peer conversations as well as in readings, signs, and personal writings.

*Peer Encounter Groups.* The main therapeutic group is the encounter group, although other forms of therapeutic, educational, and support groups are utilized as needed. The minimal objective of the peer encounter group is similar in TC-oriented programs—to heighten individual awareness of specific attitudes or behavioral patterns that should be modified. However, the encounter process may differ in the degree of staff direction and intensity, depending on the client subgroups (e.g., adolescents, prison inmates, or the dually disordered).

*Awareness Training.* All therapeutic and educational interventions involve raising the individual's consciousness of the impact of his or her conduct and attitudes on themself and the social environment and conversely the impact of the behaviors and attitudes of others on themself and the social environment.

*Emotional Growth Training.* Achieving the goals of personal growth and socialization involves teaching individuals how to identify feelings, express feelings appropriately, and manage feelings constructively through the interpersonal and social demands of communal life.

*Planned Duration of Treatment.* The optimal length of time for full program involvement must be consistent with the TC's goals of recovery and its developmental view of the change process. How long the individual must be in the program depends on their phase of recovery, although a minimum period of intensive involvement is required to ensure internalization of the TC teachings.

*Continuity of Cafe.* Completion of primary treatment is a stage in the recovery process, and aftercare services are an essential component in the

TC model. Whether implemented within the boundaries of the main program or separately as in special halfway houses, the perspective and approach guiding aftercare programming must be *continuous* with that of primary treatment in the TC. Thus, the views of right living and self-help recovery and the use of a peer network are essential to the appropriate use of vocational, educational, mental health, social, and other typical aftercare or reentry services.

The use of community as method assumes that individual receptivity and willingness to learn and change is fostered by an affiliation with others engaged in a similar struggle to change (De Leon 1991*a*). Thus, the basic components in TC-oriented programs focus upon strengthening the *perception of community* among all participants, staff, and clients. However, creating and sustaining the perception of community is a constant challenge for the TC-oriented programs that serve a wide diversity of populations in various settings. Thus, the range and implementation of the basic TC components are flexible and reflect the need for constant innovation.

## THE TREATMENT PROCESS IN THE TC

A framework for understanding the process of change in the TC reflects its perspective, approach, and model. A disorder of the whole person means that change is *multidimensional.* Thus, change must be viewed along several dimensions of behavior, perceptions, and experiences. The main approach for facilitating change is the use of the community as method, which consists of *multiple interventions.* Recovery unfolds as developmental learning, which can be described in terms of characteristic *stages of change.* The following section outlines the main elements of a process framework as well as the interventions, dimensions, perceptions, experiences, and stages of change.

### Interventions

In the TC, *all* activities are designed to produce therapeutic and educative effects. These activities, singly and in various combinations, constitute *interventions* that directly and indirectly impact the individual in the change process. Indeed, it is this element of using every activity for teaching or healing that illustrates the meaning of community as method. Illuminating the complexity of TC interventions can be approached through a classification of the range of activities and a description of their

characteristics. The diverse community activities that are basic to the TC model can be organized into three main classes of interventions: *therapeutic and educative effects, community and clinical management, and community enhancement.*

*Therapeutic and Educative Effects.* These activities consist of various group formats as well as individual counseling. They promote the expression of emotions, divert negative acting out, permit ventilation of feeling, resolve personal and social issues, increase communication and interpersonal skills, examine and confront behavior and attitudes, and offer instruction in alternate modes of behavior. The main groups are encounters, probes, tutorials, and marathons. These activities are amplified by special theme groups that focus on issues related to ethnicity, gender, and age.

*Community and Clinical Management.* These activities maintain the physical and psychological safety of the environment and ensure that resident life is orderly and productive. They protect the community as a whole and strengthen it as a context for social learning. The main activities/interventions are privileges, disciplinary sanctions, house surveillance (house run), and urine testing.

*Community Enhancement.* These activities facilitate the individual's assimilation into the community and strengthen their perception of community and therefore its capability to teach and to heal. They include the four main facilitywide meetings: the morning meeting; seminars; the house meeting held each day; and the general meeting, which is called when needed. Ceremony and rituals also are regular facilitywide events that enhance community. These include deaths, birthdays, phase/progress landmarks, and program and school graduations. Finally, certain national and ethnic/cultural holidays are celebrated by all members with seminars, special meals, music, and plays.

*Additional Activities and Interventions.* These consist of a variety of activities that are not distinctive to the TC model, although they are ancillary or supplemental to the community interventions. They include relapse prevention training; special skills groups such as parenting; various academic, social, and educational groups; and vocational and life skills training groups.

*Characteristics of Interventions.* All TC activities constitute interventions that are delivered by different people in various settings.

How, where, and for whom these interventions are delivered can be organized in terms of the following broad characteristics: interactive, formal and informal, community, and individually oriented.[3]

*Interactive Interventions.* The impact of particular interventions may be enhanced, delayed, or moderated in their interaction with other activities. For example, the messages delivered in seminars may be clarified by informal peer conversations preceding and following the seminars, or an individual's acceptance of the observation made in the encounter group may not occur until he or she observes and confronts the same behavior in another member in a later encounter group. Thus, separate and various combinations of activities are required for some duration, intensity, and frequency to produce individual change.

*Formal and Informal Interventions.* Activities may be planned or unplanned, occur in designated or arbitrary settings, and be mediated by staff or residents. Typical planned activities are the scheduled groups and meetings and one-to-one counseling sessions conducted by staff or by residents under staff supervision. Many interventions are unplanned and informally mediated in the daily peer interactions. Residents are expected to monitor and instruct other residents in matters of security, rules, regulations, role model expectations, social manners, and civility. Finally, personal disclosures and mutual sharing are spontaneous and constantly occurring interventional activities.

*General Community Interventions.* Although all interventions are intended to change the individual, some may be delivered directly to the person and others indirectly to the community. General community interventions comprise the schedule of planned activities, including meetings, groups, seminars, job functions, and community meals directed to the general membership. They are not contingent upon any specific event or problem in the community, and their impact depends on the daily participation of the membership.

*Specific Community Interventions.* These interventions are not routinely scheduled; they are specifically dependent upon community needs. For example, community "pull-ups" (corrective reminders to the membership), house bans, general meetings, special recreational events, and communitywide retreats are implemented to address specific issues of the general membership, such as problems to be corrected and needs for inspiration or affirmation. These specific interventions may be signaled by actual or anticipated events or problems in the general community,

such as unexpected dropouts, violence, drug use, poor participation, or low morale.

*Specific Individual Interventions.* Certain interventions are specifically contingent upon the individual's behavior. These may be delivered by peers as pull-ups, confrontations, affirmations, suggestions, or instructions that occur both in and outside the clinical groups. They also may be delivered by staff as privileges, job changes, phase changes, one-on-one brief or extended counseling sessions, verbal reprimands, or various disciplinary sanctions.

Although interventions may be targeted to specific individuals, they are delivered in a community context. For example, disciplinary consequences that are devised and implemented by staff are informed by the observations of peers. Peer involvement elevates both the incident and the corrective intervention to a communitywide teaching. In this way, the individual, the peers, and the general membership are collectively *accountable* for the conduct of the community.

## Dimensions of Change

Partitioning the individual into separate dimensions is a somewhat artificial device that is analogous to attempts at classification of the TC milieu into separate interventions. Thus, a complete description of change in the whole person includes both the *objective* behavioral dimensions as well as *subjective* changes reflected in self-perceptions and experiences. These are discussed separately for purposes of clarity.[4]

Behavioral change can be described along four broad dimensions that reflect the TC perspective. The dimensions of *community member* and *socialization* refer to the social development of the individual, specifically as a member in the TC community and generally as a prosocial participant in the larger society. The *developmental* and *psychological* dimensions refer to the evolution of the individual as a unique person in terms of their basic psychological function, personal growth, and identity. Each dimension refers to the same individual from different aspects in terms of observable behavioral indicators.

*Community Member.* This dimension refers to the evolution of the individual as a member in the TC community. It can be described in two related domains—affiliation and *role model.* The behavioral indicators in these domains reflect how much the individual utilizes the community as

method and how well they exhibit the behavioral expectations of the community. Those members who are affiliated understand the TC perspective and the philosophy of the program, and they transmit and illustrate the concepts of recovery and right living.

*Socialization.* This dimension refers to the evolution of the individual as a prosocial member of the larger society. It can be described in three related domains—*social deviancy, habilitation,* and *right living.* The behavioral indicators in these domains reflect the individual's repertoire of mainstream social skills, attitudes, and values. For most clients in TCs, a prosocial lifestyle has been rejected, was never acquired, or has eroded with continued drug use. Thus, life in the TC permits the acquisition or reacquisition of a socialized lifestyle.

*Developmental.* This dimension refers to the evolution of individuals in terms of their personal growth. It can be described in two related domains—*maturity* and *responsibility.* The behavioral indicators in these domains center on self-regulation (e.g., impulses and delaying gratification); social management (in relations with staff/authorities, peers, and the community); and consistency in meeting obligations to self and others.

*Psychological.* This dimension refers to the basic cognitive and emotional skills that underlie change in the other dimensions. The behavioral indicators of these skills are grouped under two domains—*cognitive skills* (i.e., awareness, judgment, insight, reality, and decisionmaking) and *emotional skills* (i.e., communication and management of feeling states). Without improvement in faulty cognitive and emotional skills, affiliation as a community member, enduring change in socialization, and developmental maturity are not possible. A third psychological domain consists of typical signs or symptoms of emotional and mental disturbance.

## Characteristics of the Dimensions

Change or improvement in all of the previously discussed dimensions must occur to ensure a stable recovery. There are characteristics, however, that underscore the complexity of individual differences and the dynamic nature of the change process itself. These can be summarized as *interrelated, interactive, variable, asymmetrical,* and *individualized* dimensions.

*Interrelated.* The domains of each dimension share common behavioral indicators. For example, some indicators of role modeling may be the same as those of maturity, and some maturity indicators are those of socialization. However, it is the organization of the indicators that defines the domains and distinctions across the dimensions.

*Interactive.* The dimensions may be mutually influential. For example, changes in community membership (e.g., role modeling) may facilitate those in the developmental dimension (e.g., maturity). Also, increased awareness, a basic skill in the psychological dimension, is a prerequisite for changes in all other dimensions.

*Variable.* Within a domain, not all behaviors change at the same rate. In the domain of maturity, for example, the resident may show a reduction in cursing but continue to talk back to staff. Within the psychological domain, awareness may be raised concerning the consequences of negative behavior before the behavior itself changes.

*Asymmetrical.* Across domains and dimensions, the *rate* of change is not necessarily correlated. For example, the resident may improve in role modeling more quickly than in maturity.

*Individualized.* Individual differences are the rule with respect to change on any dimension. Not all residents start at the same place on the dimension, nor do they progress in a uniform way. Although members are expected to arrive at certain points in the treatment process, individual rates of change vary. These differences can be accommodated within limits if the program focuses on the *fact* of change rather than on the magnitude of change and on the individual's willingness to continue in the process.

## Essential Perceptions and Experiences

Although the TC is behaviorally oriented, the process of change is understood by the participants in subjective terms, perceptions, and experiences. Individuals not only actively engage in the behaviors and attitudes to be changed, they must *feel the feelings* associated with this engagement, *understand* the meaning or value of the change, and come to see themselves, others, and the world differently. Perceptions and experience are viewed as subjective aspects of behavioral change. Although they may be considered as dimensions or domains, they are

described separately for purposes of illuminating their distinctive contribution to the process.

As ongoing events, perceptions and experiences can be defined on a moment-to-moment basis leading to an endless listing of such events. The qualifier terms *essential* and *critical* underscore those particular perceptions and experiences that staff, residents, and observers agree are *necessary* for the individual to remain in and benefit from the treatment process.

## Classification of Essential Perceptions

Although community life in the TC contains an omnipresent message to "stay the course," residents constantly struggle to remain in the treatment situation. How they perceive their problems, progress, peers, staff, the program environment, treatment demands, and outside influences demands contemplation to continue in the process, almost on a daily basis. These perceptions can be grouped under the following themes: *circumstances, motivation, readiness,* and *suitability.*

*Circumstances.* A number of life situations and conditions can drive people to seek treatment in TCs. They display *fears and worries* concerning legal, fiscal, health, family, social, domestic, and employment problems. Typically, individuals report explicit fears of jail or the court process, injury, violence, drug overdose, illness, or death. Other fears and anxieties are associated with actual or anticipated losses (such as employment, school, family, and relationships) or of simply being homeless and destitute. Although these various conditions differ across individuals and may change over time for the same individual, they are all perceived as some form of *external pressure* that compels the individual to seek admission to, remain in, or leave the treatment situation.

*Motivation.* In contrast with perceptions of external conditions, individuals are motivated or moved to seek and remain in treatment by various inner reasons for *personal change.* These reasons are based on both positive and negative perceptions of themselves and their life options. Typically, positive perceptions are expressed in terms of self-efficacy, possibilities, desire for a new lifestyle and to attain the good things in life, or for personal growth or better social and family relationships. Negative perceptions are expressed in more self-deprecating terms, such as desire to abate or eliminate feelings of guilt,

self-hatred, or personal despair based on hurting and failing themselves or others. Intrinsically motivated individuals come to perceive that they are the problem, rather than the drugs or their life circumstances, and they learn to accept that they must change, not the world around them.

*Readiness.* Individuals who come to TCs may be motivated to change, but many have not accepted the necessity for treatment. Those who are *ready for treatment* have rejected all other options for change; that is, they perceive treatment as their only alternative. Motivated individuals who are *not specifically ready* to engage in the treatment process may perceive nontreatment alternatives as viable, such as managing their own problems through self-control; making situational changes in employment, relationships, or geographic location; or getting help and support from religion, family, or friends.

*Suitability.* Residents in the TC may be motivated and ready for treatment but do not perceive the TC as appropriate for their needs. Thus, suitability is the *self-perceived match* between the individual and TC treatment. Suitability for treatment in the TC is indicated by the resident's acceptance of the TC approach: its goals, philosophy, and teachings (e.g., commitment to a drug-free lifestyle involving changes in behavior, attitudes, and values of right living); its daily regime (e.g., community living, lack of privacy, privileges and sanctions, and rules and regulations); its social learning methods (work as education and therapy, peer interaction, group participation, and personal disclosure) and its long-term time commitment (interrupting one's life during the residential treatment period).

## Characteristics of the Essential Perceptions

The characteristics of the four classes of perception are similar to the dimensions of change in that they are *interrelated* or *interdependent.* For example, readiness for treatment cannot occur without motivation, and suitability for a particular treatment such as the TC is unlikely in an individual who is not ready to engage in any treatment.

Extrinsic circumstances or pressures often induce or clarify intrinsic motivation. For example, repeated problems with the law, health, employment, and social and family relationships eventually lead many individuals to acknowledge their problems with drugs and their need to change themselves. However, although extrinsic pressures may bring the

individual to treatment, it is intrinsic motivation that sustains continued participation in the process.

A third characteristic of these perceptions is their *changeability*. Shifts in motivation, readiness, and suitability can occur daily. Residents continually make decisions concerning their reasons for treatment and their needs for a long-term residential program. These shifts reflect the attractions and pressures from outside the program, such as friends, family, social, and employment circumstances. They also relate to the influences inherent in residential life, such as positive and negative interactions with peers and staff, program demands, and boredom with the daily regime.

Treatment progress also can have unpredictable effects on motivation, readiness, and suitability. Rapid improvement in the early days of treatment, for example, could result in premature dropout. Paradoxically, a transient sense of well-being could lessen motivation or readiness to continue in treatment ("flight into health"). The resident may stop feeling bad, conclude that he or she can handle their problem on their own, and no longer perceives the necessity for treatment. Conversely, delayed or slow improvement may lead to demoralization, weaken readiness to continue, and result in early dropout, particularly in individuals who cannot delay gratification.

Ironically, important changes in perceived suitability for the TC occur *after* individuals actually encounter the demands of the community environment. For example, they may see themselves as different from others in terms of their drug use or their cultural and social background, or they may view the program negatively and its demands as too harsh or lacking in sufficient personal attention. Such *perceptions of mismatch* between the individual's needs and the program's approach can lead to premature dropout.

Much of the effort in TC programs is aimed at monitoring and modifying these perceptions, which shift continually throughout the resident's tenure in residence. Peers and staff attempt to sustain the individual's motivation and reaffirm the suitability of the TC by helping the individual reassess and minimize the importance of outside influences, by reminding them of the gains made and the problems that still need to be addressed, and why he or she needs to be in the TC.

## Critical Perceptions

Certain self-perceptions appear to be critical in the change process. These are reported as a distinct awareness of positive self-change *in contrast* with past self-perceptions. These contrasts simply may be residents seeing themselves as behaving, thinking, and feeling differently, usually in statements of self-efficacy and self-esteem. More dramatic contrasts may be a self-perceived change in identity, expressed in terms of being oneself, being real, or not being the person they once were.

Perceptual contrasts may occur in encounter groups or marathons as an element in the high-impact critical experience (i.e., therapeutic events referred to earlier). They also may arise in other special circumstances away from the program, such as day trips or weekend furloughs. These situations provide the individual with explicit opportunities for making comparative observations and confirming personal changes with respect to how they experience the old neighborhood, the proximity of drugs and users, or how they relate to friends, family, and children.

More often, the cues for contrasts are ordinary, emerging in the various roles and everyday activities of the community (e.g., seeing younger or newer residents who are earlier in the process, listening to a seminar, handling a stressful or provocative situation with peers or staff in a new constructive way, managing feelings differently, or simply noting the absence or reduced frequency of old thinking about drugs and related matters).

Although they are distinctive, contrasts usually represent the summation of smaller unperceived changes in behaviors, thinking, and feelings (i.e., "kindling"), which finally culminate in the individual's clear recognition and acceptance of self-change. Regardless of how and when they occur, however, perceptual contrasts are integral to the TC process. Behavioral and cognitive change is unstable if residents cannot discriminate; that is, perceive and authentically acknowledge *where they were, where they are,* and *where they want to be.*

## Classification of Essential Experiences

As with perceptions, a limited array of experiences are underscored which appear as necessary to the change process within the TC. These can be conceptualized under three themes—*healing experiences, subjective learning experiences,* and *critical experiences as therapeutic events*.

*Healing Experiences.* Healing refers to palliating or lessening feelings of emotional pain in its various forms. Fears, anger, guilt, hurt, confusion, despair, desperation, hopelessness, and aloneness are some of the pains common to residents in TCs. These are associated with specific circumstantial stress, pressures, and threats as well as longer term psychological injuries and personal and social isolation. The healing experiences can be organized under several themes that reflect the TC perspective: *nurturance-sustenance, physical and psychological safety,* and *social relatedness.*

*Nurturance-Sustenance.* These experiences include the basic provisions of daily maintenance: three meals, housing, clothing, cosmetic accessories, medical, dental, and social and legal advocacy services. These provisions are entitlements rather than privileges for which nothing is asked of the client except that they participate in the treatment regime. The nurturant experiences are primarily those of *relief* from circumstantial pressures, distress, and uncertainties.

*Physical Safety.* For those who have characteristically lived with fears and anxieties associated with their drug abuse lifestyle, street life, domestic violence, and sexual and interpersonal abuse, physical safety provides an essential healing experience. The TC community maintains strict adherence to cardinal rules against violence, threats of violence, stealing, sexual abuse and harassment, and drug or alcohol use. The security of the facility with respect to daily traffic and unauthorized intrusion is steadfastly maintained. Moreover, maintenance of the rules governing personal security is the responsibility of the residents as well as the staff. Thus, the code of the TC is collective security, which provides *relief* from common fears and anxieties associated with physical safety.

*Psychological Safety.* Although many individuals in TCs have lived precariously, rebelliously, or antisocially, they are psychologically fearful of facing themselves, other people, the demands of ordinary living, and of change itself. Facing these fears requires trusting others to support their psychological risk-taking. For most residents in the TC, the dissolution of mistrust is a profound healing experience that relieves covert, but long-standing intrapersonal and interpersonal fears. The essential experiences reflecting psychological safety are blind faith, trust, being understood, and being accepted by others.

*Social Relatedness.* The past social relationships of residents in TCs often are characterized by personal isolation or attachments with others

that are unhealthy or frankly self-destructive. Family histories tend to be marked by disturbance, abuse, and deprivation. Even among those from socially advantaged backgrounds and intact families, their loss of self-control and disordered lifestyle have alienated them from significant others. For many this alienation precedes their drug problems and they have marginal identification with any family or community and no real friendships. The essential social experiences that reflect their relationships with others include *identification, empathy,* and *bonding.*

*Subjective Learning Experiences.* Change in the TC occurs through trial and error learning. This involves behavioral changes followed by objective consequences (e.g., disciplines or rewards) as well as experiential or subjective *outcomes* associated with these consequences. Typically, these experiences involve self-evaluative perceptions, thoughts, and feelings. For example, when residents revert to undesirable behaviors leading to disciplinary actions and social disapproval, experiential consequences may occur on the theme of *self-rejection* (e.g., disappointment, worthlessness, failure, and guilt). When they engage in effective behaviors, positive subjective outcomes may occur on the theme of *self-efficacy* (e.g., confidence, satisfaction, mastery, and self-esteem).

When residents *feel,* as well as think about the effects of consequences, learning (or unlearning) is more stable. For example, the positive socialization rewards of privileges, job promotions, and peer recognition occur *only if* residents experience them as positive events. Similarly, disciplines, demotions, or bans are effective teaching consequences *if* they are experienced in a negative way by the resident. Subjective outcomes are viewed as essential in the change process, specifically for achieving *internalized learning;* that is, behavior change that is maintained by fewer external consequences and more self-control.

## Critical Experiences as Therapeutic Events

The change process is erratic, gradual, and incremental. However, the course is punctuated by distinctive moments of individual change that involve a total or *critical* experience involving related thoughts, perceptions, feelings, and understanding. Critical experiences mark *therapeutic events* because they are remembered occurrences that appear to singularly facilitate individual change in behavior (e.g., effective ways of coping and responding); insight (e.g., new understanding of the relationship between self and influences); and commitment (e.g.,

redecisions to continue in the process). Conversions, for example, are special cases of dramatic change that involve one or more therapeutic events.

Although these experiences appear to be sudden, they usually represent developing changes up to the point of their occurrence. Occasionally, however, they occur as isolated incidents of "personal breakthrough." These events often are unplanned and spontaneous, although programs attempt to induce them at appropriate clinical points. For example, intense group marathons, special retreats, or wilderness activities can promote dramatic bonding or self-efficacy experiences that can sustain individuals in the treatment process.

Therapeutic events or moments *link* previous learning with current learning, which in turn mediates new learning. For the individual, they often represent a point of reframing their problems, life options, and self-perceptions. Although they may involve painful feelings, they are reported as positive experiences that motivate the individual to continue in the process.

## Characteristics of the Essential Experiences

The essential experiences are *interdependent* and *interrelated* characteristics that illuminate how experiences contribute to the change process. A resident may first experience blind faith before fully experiencing trust. Without trust, there is no meaningful self-disclosure, which is the basis for experiencing understanding and acceptance.

There also is an interrelationship between behavioral learning and healing experiences. Residents who experience trust, understanding, acceptance, or bonding are more likely to remain in treatment and engage in the behaviors that lead to the subjective outcomes that facilitate internalized learning. Moreover, healing experiences are positive subjective outcomes that directly reinforce the social behaviors that result in these experiences. For example, residents who personally disclose to others obtain the positive experience of understanding and acceptance from others, and they learn that disclosure and similar behaviors evoke these healing experiences. By displaying understanding and acceptance behavior *to* others, they learn to facilitate healing experiences *in* others. In the argot of the TC, residents learn how to "reach out" for themselves and "give it away" to others.

## A PROCESS PARADIGM: SOME PRINCIPLES AND MECHANISMS OF CHANGE

Thus far, the main elements of the TC treatment process have been outlined in terms of the interventions, behavioral dimensions, and essential perceptions and experiences. This section briefly outlines a paradigm to illuminate how these elements are linked or related in the change process, which incorporates behavioral and social learning principles with essential experiences and perceptions as mechanisms in the process.

### The Learning Principles

Change in the TC is viewed from a behavioral orientation in terms of learning and training. Attitudes, feelings, roles, and awareness are regarded as valid behavioral data. For example, a resident's attitude on the job or in the morning meeting may evoke various responses in others. In conversations or groups, this attitude will be explicitly translated into observable behaviors (e.g., gestural, postural, or verbal) (De Leon 1991*a*). Thus, embedded in the community life of the TC are familiar behavioral training and social learning principles that underlie change in the four dimensions.

*Efficacy Training.* The general principle of trial and error learning is the basis for efficacy training in the TC. The resident must engage in the behavior that produces the mistakes as well as the correct positive outcomes. Indeed, errors highlight a subtle distinction between efficacy and self-efficacy that relates behavioral change with subjective outcomes. Efficacy is performing the behavior that works; *self-efficacy,* as a subjective outcome, is enhanced by *overcoming the errors* in performing the behavior that works.

*Social Role Training.* Although specific behaviors and attitudes are the primary observations, the focus of training is on *constellations* of related behaviors, skills, and attitudes that have labels indicating their social or psychological relevance. Thus, the resident jobs and positions in the work hierarchy, such as expediter, department head, and coordinator, are examples of roles learned in the TC. Socialization is a special type of role training that refers to classes of social behaviors and attitudes other than work roles. Typical labels for these behaviors are responsible, cooperative, and mature; role model behaviors are a broader class of

related behaviors and attitudes reflecting the values and expectations of the community.

*Vicarious Learning.* Individuals often initiate self-change through observation of and identification with others in the process of change. The sources of vicarious learning derive from the *context* of community life-its rules, norms, daily regime of activities, and informal interactions. For example, adherence to the explicit rules that prohibit drug use and all forms of antisocial behavior is mediated by peers and staff who act as role models for the appropriate behaviors and attitudes as normative expectations of the community.

Vicarious cues arise directly from the day-to-day social and interpersonal interaction with others. Hearing different life stories, witnessing subtle and dramatic examples of behavior change over time, and experiencing empathic exchanges with peers transmit covert but powerful emotional and perceptual signals toward change. Indirect vicarious cues come from information *about* others (e.g., the dispositions of dropouts, the successes of graduates, and the struggles of staff). All vicarious cues initiate some form of imitation, rehearsal, or trial and error attempts at change without explicit instruction.

*Conmunity as Trainer.* Although behavioral and social learning principles are evident in the TC, these are "naturalistically mediated" as an inherent characteristic of community as method. An explicit instruction by the community to the community is that peers and staff are the observers, monitors, and mediators of the messages of recovery and right living.

Indeed, the role of community member is a trained and mutually monitored role. Residents are expected to be attentive to both the physical and social environment of the facility; to offer specific instruction, feedback, and support for individual efforts to change; and to express their concerns or affirmation concerning the status of the community itself. Staff as community members guide the residents to be role models and peer trainers, and they monitor the fidelity and impact of the daily activities as interventions for individuals and the community.

## Perceptual and Experiential Mechanisms in the Process

In the TC perspective, changing the whole person involves not only observable behaviors but subjective perceptions and experiences. The

essential and critical perceptions and experiences can be viewed as *integral mechanisms* in the process that links interventions with behavioral change. For example, group acceptance of the individual is an intervention that induces a healing experience, which encourages the individual to engage in new behavioral efforts. Such efforts lead to consequential outcomes—both objective reinforcements (e.g., social approval, privileges, and change in community status) and subjective outcomes (e.g., personal efficacy and self-esteem). These changes result in internalized learning, perceptual contrasts, therapeutic events, and eventually changes in identity.

The subjective elements in the process may appear gradually in the daily regime of social interaction or as critical, striking occurrences. Nevertheless, either as consequences of interventions or correlates of behavioral change, the essential perceptions and experiences are necessary to stabilize new learning.

## Stages of Change in the TC

Stages and phases are definable points in the developmental process. These can be described from different but interrelated perspectives of change, program, and treatment stages. For example, the four dimensions of change relate to the individual's movement according to specific goals or expectations of the program. However, another stage perspective, treatment *process,* more closely captures client change *in relation* to the treatment activities program. Thus, there are two perspectives of stages of change—program stages and treatment process stages. However, this chapter outlines only the program and treatment process stages.[6]

## Program Stages

Three main program stages and several phases within each stage have been delineated for the traditional long-term TC. These stages are roughly correlated with time in program as follows: Stage 1, *induction,* corresponds to 1 to 60 days; Stage 2, *primary treatment, 2* to 12 months; and Stage 3, *reentry,* 13 to 24 months. For TCs with shorter durations of treatments, the length of each stage is shorter, but the goals remain the same.

In Stage 1, *induction,* the main goals are assessment and orientation to the TC. Clinical assessment of the individual continues during the first 2 months of residency to clarify specific treatment needs and overall

suitability for the long-term residential TC. The objective of orientation is to assimilate the individual into the community through full participation and involvement in all of its activities. Rapid assimilation is crucial at this point when clients are most ambivalent about the long tenure of residency. Thus, the new resident is immediately involved in the daily regime, which emphasizes role induction into the community.

Stage 2, *primary treatment,* focuses on the main social and psychological goals of the TC. This stage generally consists of three phases that roughly correlate with time in program (2 to 4 months, 5 to 8 months, and 9 to 12 months). These phases are defined by the member's status in the community (junior, intermediate, or senior resident) and are marked by plateaus of stable behavior that signal the need for further change. The daily therapeutic and educative regimen (i.e., meetings, groups, job functions, and peer and staff counseling) remains the same throughout the year of primary treatment.

Stage 3, *reentry,* consists of two phases: early (13 to 18 months) and late (18 to 24 months) reentry. In the early phase, the main goal is preparation for healthy separation from the community. Clients continue to live in the facility but may be attending school or holding full-time jobs, either within or outside the TC. However, they are expected to participate in house activities when possible and to carry some community responsibilities.

In late reentry, the main goal is to complete the separation from TC residency. Clients are on "live-out" status, involved in full-time jobs or education and maintain their own households, usually with live-out peers. They may attend aftercare services such as Alcoholics Anonymous or Narcotics Anonymous or take part in family or individual therapy. This phase is viewed as the end of residency but not the end of program participation.

*Stage Interventions.* Throughout all the stages, the main social and psychological goals of the TC are pursued in the daily regime, which consists of the community and individual interventions previously described. However, the interventions differ in accordance with stage-specific goals in terms of their frequency, duration, and intensity, and the use of special groups, meetings, seminars, and professional services. For example, the specific goals of assimilation and affiliation in the early stage require less emphasis on therapeutic demands for change and more emphasis on training and instruction in the TC perspective, approach, and

procedures. Similarly, the specific goals of the reentry stage emphasize acquisition of the skills and information needed for facilitating separation from the program and transition to independent living. Thus, emphasis is on individual planning and activities concerning educational and vocational needs, interpersonal and family relationships, and social and sexual behavior.

*Stage Profiles.* Although individual differences are the rule in terms of rate of change, typical resident profiles can be described for the various stages and phases of the program. These profiles reflect both the overall and stage-specific goals of the program in terms of the four dimensions of change described earlier (i.e., community member, socialization, developmental, and psychological). These profile descriptions are illustrated in other writings (De Leon 1994*a*, 1994*b*; De Leon and Rosenthal 1989).

## Treatment Stages of Internalization

Progress refers to the movement of the client along dimensions of behavioral and attitudinal changes with respect to the goals of the program stages. The treatment process refers to the interaction between client progress and the myriad of community and individual interventions. Thus, interaction can be viewed as an evolving relationship between the individual and the community that can be described as *internalization* that is evident in the stability, acceptance, and use of the behaviors, attitudes, values, and general teachings of the TC.

For TCs, the importance of internalization is especially salient because the power of its community method can readily modify observable behaviors and attitudes in the program setting. However, these changes may not endure once the individual separates from the omnipresent influence of the peer community. Practically all residents in TCs display drug-free behavior during their residential stay; that relapse occurs among a number of the dropouts and some of the graduates, however, underscores the relevance of internalization in the change process.

The mark of internalization is the *transfer* of the influences of new learning from external (objective) consequences to internal (subjective) outcome experiences of the individual. Internalized learning can be characterized as more consistent and more self-initiated (“inner directed”) than externally influenced learning. Notably, learning that is internalized

is generalizable to new situations both inside and outside of the program (De Leon, in press). In the TC, internalization does not occur all at once-it evolves over time. This evolution can be characterized in terms of four stages-compliance, *conformity, commitment,* and *integration.*

*Compliance.* In this stage, there is little evidence of internalization. The resident adheres to the norms, expectations, and teachings of the community primarily to avoid negative consequences such as disciplinary sanctions or undesirable alternatives such as discharge to the street, return to jail, homelessness, or an unwanted home situation.

*Conformity.* In this stage, the resident adheres to the program teachings primarily to maintain affiliation with the community, either to avoid threats to newly formed relationships or simply to enhance their acceptance by peers and staff. This stage reflects a high degree of program affiliation but a relatively low degree of internalization.

*Commitment.* In this stage, residents adhere to their own *personal resolve* to remain in the treatment process and complete the treatment program. Early phase commitment still reflects a considerable degree of conformity; the individual's resolve is largely influenced by the program, its goals of completion, graduation, and remaining on parity with peers. This phase is much like the commitment of college seniors to finish school with their class, graduate, and receive a degree. However, early stage commitment also reflects some degree of internalization, since the social value and psychological importance of completion are major teachings of the TC. This teaching is incrementally strengthened by the individual's experience in attaining the phase and stage goals leading to program graduation. Thus, residents who commit themselves to completing the program have internalized a valued program teaching.

In the *commitment to self* phase, the individual adheres to a personal resolve to remain in the change process beyond completion of the program. In this stage, the resident reveals a greater degree of internalization, since he or she has fully accepted the teaching that recovery and personal growth are continuing processes.

*Integration.* This is an evolving stage that begins in treatment but emerges mainly after separation from the program. The term "integration" underscores the interrelation between TC influences and broader life experiences. The values of right living and the recovery teachings of the program serve as general guidelines and tools for life

adjustment. The coping strategies, understanding, and insights of the previous stages are validated through *confirmatory experiences* and *generalized* to new life situations. Thus, the internalization of TC teachings is significant and stable. However, individuals gain perspective on the benefits, limits, and uses of these teachings in their personal growth or self-actualization.

In this stage, consolidating and advancing personal gains are primary goals, rather than recovery from chemical dependency. Sobriety (i.e., abstinence in behavior, thinking, and values) is *internalized.* The individual does not consciously think about maintaining abstinence, but he or she accepts this as a *prerequisite* for right living. The focus is on personal growth and psychological and existential issues for which the individual may utilize therapy or assistance. Their affiliation shifts from the program community to the wider social community of family, friends, work, and professional colleagues, and involvements are with mainstream activities and obligations (e.g., work, education, religion, and social and family roles).

*Identity Change.* A distinctive marker of the integration stage is a change in identity that is perceived by self and others. No single label describes how substance abusers view themselves; however, some of the more frequently stated labels that change during and following treatment are addict to nonaddict, social deviate to conventional person, baby to grown up, and antisocial to prosocial citizen. These labels reflect the general changes in lifestyle as well as the specific behaviors of deviance and substance use. The shift in identity is gradual since the elements of identity change are evident throughout all of the stages. However, it is the powerful mechanism of *perceptual contrast* that marks the main change in the integrative stage. Individuals retrospectively reframe and relabel who they were then and who they are now.

## SOME CONSIDERATIONS FOR RESEARCH

The theoretical formulation outlined in this chapter suggests a broad agenda for research in TCs. The major lines of inquiry are the validity and utility of the framework itself and the extent to which it is applicable to the current diversity of TC-oriented programs. This agenda is further addressed elsewhere in this mongraph. In the final section of this chapter, some implications for theory, research, and policy in TCs are briefly considered.

## Program Models

The extent to which the current diversity of TC-oriented programs is guided by the perspective and foster community as method is fundamentally an empirical issue that remains to be evaluated. In this regard, an initial effort is underway using a modalitywide survey to describe the range of TC-oriented programs based on many of the essential elements outlined here (Melnick and De Leon 1993). This research effort is described briefly in other chapters of this monograph.

## Process Framework

Research on treatment process in the TC presents a formidable challenge for investigators. The framework presented underscores the need for operational definitions of the elements as well as appropriate measures, particularly of the perceptual and experiential concepts. Feasible methods of data collection are needed, as are analytical models for capturing the effects of interventions in dynamic interaction with a changing client.

A recent advance in the measurement of essential perceptions has been the development of a multidimensional instrument assessing circumstances, motivation, readiness, and suitability (CMRS) for TC treatment. The CMRS reliably predicts short-term retention in TC treatment (De Leon and Jainchill 1986; De Leon et al. 1993, 1994; Schoket 1992), and it holds promise for differentiating subgroups of substance abusers with respect to their motivation and readiness for drug treatment in general.

*Treatment Stages and Planned Duration of Treatment.* The process stage formulation underscores the relationship between time in treatment and treatment process. Retention is the most stable predictor of positive treatment outcomes in TCs (Anglin and Hser 1991; De Leon 1985; Hubbard et al. 1989; Institute of Medicine 1990; Tims and Ludford 1984; Simpson and Sells 1982). Clinicians always have known that the treatment effects in the TC were *time correlated events*. In the present theoretical framework, these events reflect the stages of internalization. If a significant degree of internalization of the TC teachings is not attained, recovery is incomplete and the potential is greater for premature dropout, relapse, or recidivism after leaving treatment.

These treatment process considerations bear upon several intersecting issues—the differences among subgroups of substance abusers, the treatment setting (residential/nonresidential), and the planned duration of treatment (short, medium, or long). Research on these issues will have important implications for policy and treatment planning as well as science.

For example, clinical and research evidence has shown that the 18- to 24-month duration of treatment in long-term residential TCs has been the optimal time period to achieve some level of internalized change. However, increasing numbers of substance abusers who are homeless, violent, psychologically disturbed, and unhabilitated underscore the requirement for even *longer* periods of immersion in the TC recovery process, given the extensive habilitative and rehabilitative needs of these groups.

Even among the more socialized substance abuser, there is a need for a sufficient period of treatment involvement to ensure some degree of internalized change, regardless of treatment setting. Thus, the effectiveness of shorter term TC-oriented residential, day treatment, and outpatient programs will depend on appropriate matching of clients to these different settings from a *treatment and recovery stage perspective.* Research is needed to develop and evaluate the efficacy of assessment protocols that guide such matching strategies.

*Process and Design.* In the TC, the change process unfolds as a dynamic interaction between the community and the individual. In this process, a self-selection activity is ongoing as individuals continually make decisions about remaining in treatment based on their behavioral and subjective changes. Thus, from a self-help recovery perspective, self-selection *is not a problem, but a prerequisite* for the effectiveness of treatment. Treatment works *because* of client factors such as motivation, readiness, and perceived suitability of the treatment.

This view of client self-selection contains important implications for research designs in TCs, some of which have been discussed in other writings (De Leon 1993). New design paradigms are needed that accept a functional view of self-selection; namely, that treatment effectiveness *depends* upon the client's contribution to the process and outcomes. Controlling for self-selection and isolating the specific effects of treatment are less relevant than identifying the relative contribution of these factors to the change process.

*Treatment Process and Recovery.* The present formulation stressed the distinction between the process of treatment in the TC and the more general process of recovery. The former refers to client change in relation to the interventions, services, and activities of the TC. Recovery is a broader term, referring to a continuing process of individual change from active use or addiction to maintained sobriety. Many factors contribute to the recovery process in addition to treatment. These relate to the client (e.g., social and psychological resources); life circumstances (e.g., social-economic potency, personal relationships, friendships, and family); and specific events (e.g., health, personal, and material losses or gains).

Treatment in the TC can be viewed as one significant facilitator of the recovery process. Clients who achieve the social and psychological goals of the TC are viewed as better prepared to positively engage life and to continue in their recovery. In this sense, completion or graduation from the TC represents the end of treatment, but it is also a stage in the recovery process.

This distinction between treatment and recovery has important implications for research, particularly with respect to evaluation of the effectiveness of the TC. For example, shorter term success rates in the period proximal to separation from treatment are more directly correlated with the specific impact of the TC program. Longer term success rates, however, are subject to a variety of influences that may obscure the specific contribution of TC treatment. Of special relevance to these long-term outcomes, however, is the client's recovery stage, particularly the posttreatment integration stage described earlier. As noted in this stage, the individual incorporates their treatment-based learning into their general life experiences. From this stage perspective, fair and appropriate evaluation of the effectiveness of TC treatment must assess both its *indirect* and *direct* contributions to sustaining the individual's long-term recovery status.

## CONCLUSION

Several caveats must be emphasized with respect to the present theoretical formulation of the TC. First, it reflects the perspective of the author and does not necessarily represent a position of consensus among workers in TCs. Second, as noted, the essential elements are most characteristic of the traditional long-term residential TCs; their relevance

for other TC-oriented programs (short-term residential and nonresidential) remains to be empirically clarified. Third, a theoretical formulation of the TC has obvious implications for training, clinical practice, quality control, and funding. However, consistent with the theme of the present monograph, this discussion has highlighted the research considerations.

## NOTES

1. The terms "components" and "elements" are used differently; the former refers to the program model, while the latter refers to the significant features of the general theoretical framework.

2. As discussed elsewhere, the TC community has features that are common to other communities, such as schools, the prison, the military, and even some corporations. Although closer in form to extended families, villages, and some utopian communities, the TC remains unique in how it uses the community as a method to change, treat, or assist the individual (De Leon, in press).

3. A useful formulation of TC activities in terms of structure and setting is provided by Frankel (1989).

4. Although perceptions and experiences remain to be operationally defined, they are characterized elsewhere (De Leon, in press). In the present framework, perception refers to how residents understand or give meaning to what they see or hear. Experience refers to more complex subjective events that include feelings and perceptions as well as behavioral change. In the last analysis, however, subjective events such as perceptions and experiences are indicated behaviorally with certain words, deeds, and gestures.

5. Detailed descriptions of the program and process stages in the TC are contained elsewhere (De Leon, in press). A more fully elaborated recovery stage perspective drawn from the clinical and research experience with TC residents is described in De Leon (1994*b*).

6. The late reentry phase has been viewed by TCs as an aftercare stage, although these agencies have been under funded for providing the aftercare services of a fully developed continuance program.

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