**Why therapeutic communities work**

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It is for me a pleasure to be in this beautiful and interesting city and at this conference in a country with a long tradition in therapeutic communities for addiction. With one of the pioneers Dr. Skala I had long discussions at a WFTC Conference in San Francisco on his therapeutic communities where he treated whole families with an addiction problem.

I come from a country, The Netherlands, where everything has been tried to cope with the problem of drug addiction. There are programs to control the problem or reducing the harm to the users and society: distribution of methadone and even heroin, there are places where drug addicts can use their drug under observation by nurses, organizations where you can test the quality of the drugs and coffee shops where the sale of cannabis is tolerated in an unsuccessful attempt to separate the market of the so called soft and hard drugs. There are also treatment programmes: detoxifications units from which the addicts can be transferred to ambulatory treatment, day centres and drug free therapeutic communities. There are also programmes for addicted parents and children.

Many mistakes have been made in The Netherlands. The life long distribution of methadone to heroin addicts did not lead to a reduction in crime or overdoses. A special risk of the methadone distribution is the combination with alcohol abuse. In a ten year follow-up study of a harm reduction programme with methadone distribution in Maastricht was found that of the participants 25% had died within these ten years. The heroine distribution programme where heroin is given together with methadone did not totally reduce the related crime: the participants are using daily cocaine.

The coffee shops are now in the hands of organized crime. The THC, in the cannabis has increased so much that cannabis from the coffee shops can no longer be regarded as a soft drugs. The users are no longer recreational users together with friends, but solitary drop-outs, using cannabis to cope with stress and sleeplessness.

Therapeutic communities (TC’s) can be part of the solution. From thirty to fifty percent are no longer using drugs after their treatment. They are no longer involved in crime or in lifelong medical care.

Because of this the benefits of the treatment in therapeutic communities are far greater than the costs of this treatment (Kooyman, 2004, Pitts, 2010).

At the conference of the European Federation of Therapeutic Communities (EFTC) in The Hague four years ago, a professor of addiction research asked me: “Can you tell me what is the difference between a hospital and a therapeutic community and why drug addicts should be treated in a therapeutic community instead of in an outpatient programme? I was not able to explain this to him in a few minutes. In this presentation I shall try to explain this to you in this presentation.

I shall share with you what I learned since my involvement in on therapeutic communities.

In 1974 two years after I had started the first TC in The Netherlands, Emiliehoeve, I spent six weeks in America to visit TC’s. After arrival in New York, Msgr. William O’Brien, the President of Daytop Village, brought me straight from the airport to their TC Parksville, situated in a former hotel. When we arrived there were 50 residents sitting in a big hall waiting for my speech. My TC had ad 25 residents at that time. After I had spoken on The Netherlands and my TC Emiliehoeve, which had 25 residents at that time, I asked the Director of the TC, Tony Gelormino, how many staff he had. We have 7, he said. We used to have 5.
Three quarters of the graduates of this TC had recovered well from their addiction in this TC programme, as research had showed. I then understood, that there must be more than the input of the staff what made the TC work.

Apparently the self help and mutual help philosophy and the responsible concern worked for the members of the TC. All staff members were recovered addicts. Once a week there was a visit by a psychiatrist with the name Sid Lecker, who came with his private plane to see some of the residents.

There were clear rules: no drugs, no alcohol, no violence or threat of violence and no sexual acting out among residents.

In the weeks I spent in the program of Daytop and other TC’s in New York I saw the importance of the role models of older residents and ex-addict staff members.

The philosophy: ‘You alone can do it, but you can not do it alone’ came originally from Synanon, the innovative psycho-social experiment at the West Coast of America which became the model for the therapeutic communities for addicts.

After my stay in New York I went to visit Synanon. I had read the book of Daniel Casriel and was interested to see the place where it all began (Casriel, 1963). When I arrived at their large facility, Tomales Bay, where at that time 1600 persons were living, I asked to live in the Boot Camp, the house for newcomers. In the groups, which were called games, I learned the power of angry concern and humor.

After a few days I was shown around the premises by one of the residents.
When we were in ‘The Club” the building were Synanon residents could meet and for instance prepare a holiday in the United States, a big man entered.

It was the founder of Synanon, Chuck Dederich. He was apparently curious, to know who this psychiatrist from Holland was, who wanted to stay in the boot camp, the house for new residents.

When we sat down and talked he became interested in my story when I told him, that my TC started to become effective after we had introduced encounter groups, while Synanon had started with the groups before the community was established. He told me that, probably because there was no professional in the group, the AA meeting in his house turned into a game with heavy emotional confrontations.

In the facility Thomales Bay every Monday night there was a game of the elders, to be seen on a close TV circuit end heard on the radio in the other facilities of Synanon.

Dederich told me that it worried him that in these groups the only persons confronting him nowadays were his wife and his brother. We now know that Synanon ‘s downfall started after the death of Betty, Chucks wife.

Back in the Netherlands I realized how different TC’s are from the medical model.

I was trained as a doctor in the medical model in which the doctor is responsible for the treatment and the patient not responsible for his disease.

In TC’s the residents are seen as responsible for taking their drugs and are also made responsible for their treatment.

When you enter a TC you usually find residents welcoming you at the reception.

Staff members are parts of the community. They can also get confrontations in the groups.

George Deleon introduced the term ‘ownership’. Patients in a hospital do not have this feeling. In the Emiliehoeve TC the song “Our House” was popular among the residents (De Leon, 2000).
The characteristics of a TC are the following:

All activities in the TC including cleaning, cooking and administration are therapy.

The residents learn to help themselves with the help of others. There is no individual therapy

Conflicts are dealt with in encounter groups. The rule in the group is: “say what you feel and feel what you say”. Negative behaviour can be confronted emotionally in the group session by one or more participants. One of the participants can confront another participant in the encounter group by expressing his anger loudly: “It makes me angry that you were late this morning”. Another person agrees and says to the same person “You were also late yesterday. Do you think of leaving?” Other participants may join in the confrontation. Often a person confronts his own negative behaviour in the other person. Then a group member may ask to the person who started the confrontation: “Are you so angry at him because you think of leaving yourself?” It is important to find out in the group why a person is emotionally upset by the behaviour of another person. In these groups the participants learn to express their emotions in a direct way, they learn that anger can be a sign of concern, a reaction on the behaviour of a person and not a rejection of the total persons. At the end of the encounter group the participants can give feedback on what happened in the session.

Different from what usually occurs usually in psychiatric treatment guilt feelings are not seen as abnormal or as a symptom of a depression, but as a normal reaction on ones behavior which the person himself sees as negative. He can become caught in the guilt circle: after acting out in a negative way, the person can rationalize: it was not that bad, others do it too, he may compensate it by positive behavior or deny that he did something wrong. This may result in fear, distrust in themselves and others, depressive feelings with guilt which is no longer connected with the negative behavior. This may lead to negative acting out again.

In therapeutic communities the participants are invited in therapeutic sessions to speak of their guilt and to confess any behaviour they feel guilty of. At special occasions when there is a lot of negativity in the group long so-called “coping” sessions led by two staff members, usually one male and one female staff, can be held in which all residents are invited to share their guilt feeling. This leads to new commitments by the group members, who realize that the group does not reject them and a better atmosphere in the community.

At the first conference of the World Federation of Therapeutic Communities in 1976 in Norrköping Hobart Mowrer indicated that the first Christians also confessed their sins in the group. That was called exhomologesis. Only in later centuries the confession was made to a priest (Mowrer, 1980).

What works in the TC?

We know from research that the exposure to the therapeutic milieu of a TC has to be long enough to have success. The longer the time spent in the programme the greater will be the success (Kooymen, 1992, Vanderplasschen, 2013)

In the two year follow-up of the Emiliehoeve TC was found the following: The success (no use of hard drugs, no criminal behavior, no alcohol problems) two years after leaving the programme was the following:

Time spent in the programme (TIP) 1 month: 0%, TIP 1 month to 6 months: 10%, TIP 6 months to 1 year: 30%, more than one year: 70%. Completions (graduates: 82%). The research was repeated 10 years later with similar results.

The main determining factor for the success was the time spent in the TC programme. If parents had been involved in the therapy it was found that the residents had stayed stay longer in the TC and were therefore more successful (Kooymen, 1992).

So a resident has to stay long enough in the TC to benefit from the treatment (Vanderplasschen, 2013).
4.

We also know that many residents drop out during treatment and usually only onethird finishes the total planned stay until completion (including the re-entry, the aftercare programme of approximately one year.

**Why is that? Is it typical for drug addicts?**

At the 5th World Conference of Therapeutic Communities in The Netherlands the criminologist Alexander Bassin, one of the founders of Daytop, characterized addicts as follows: Addicts have a failure identity and are unable to sustain long lasting relationships (Bassin, 1980).

It was Bowlby who stressed the importance for the young child of a safe attachment to the caregivers to grow up well. The child internalizes the early experience of attachment and through this they see themselves as positive or negative and also the other as positive or negative (Bowlby, 1969).

The psychiatrist Daniel Casriel, who also was one of the founders of Daytop, stated that bonding, physical closeness and emotional openness, is a biological need, necessary for the young child to survive (Casriel, D., 1971, 1972).

Bonding and attachment stay a basic psychosocial need when we grow up, together with physical wellbeing, autonomy, identity, acknowledgement, and meaning and spirituality. When needs are not fulfilled or expected not to be fulfilled we feel fear, anger and pain. When they are fulfilled or expected to be fulfilled we feel pleasure and love. When we do not receive what we need, we develop negative attitudes towards our self and towards others, such as: I do not exist, I do not need, I am not lovable, I do not have the right, I am not good enough, I cannot change, I am not responsible for my own life, I am not equal.

When the child does not feel welcome in the family, not feels the love of the parents an attitude may develop: I am not good enough, I am bad. The child initially does not know why. It starts to behave naughty: their identity becomes “I am a bad person”, of course that is why they do not love me. They later may use drugs or become a criminal. They develop a low self-esteem and a fear of rejection. They show manipulative behaviour as a defense to avoid rejection. When they use drugs as a defense against the fear, anger or pain of rejection they can become addicted.

When they are addicted they deny their addition. They are unable to ask for help out of fear to be rejected. Rejection results in unbearable pain and evokes painful emotions of being rejected from their past (Kooymman, 1985)

This is what I saw treating drug addicts: They had a fear of closeness and rejection. Deep down in their personality they did not feel that they had the right to exist.

They had a low self-esteem. They were even losers as an addict. Addicts in the streets will never admit to this. Most addicts had in their childhood an unsafe attachment with a parent figure.

In the history of drug addicts we usually see emotional neglect as a child, physical and psychological trauma and sexual abuse (Glover, c.s., 1996, Kooymman, 2000). This leads to the attitude I am bad, I have no right to exist.

This negative attitude towards themselves and others can be changed in the Therapeutic Community.
5.

**What is therapeutic in a therapeutic community?**

When I wondered what are the therapeutic factors in a TC, I followed the advice of one of my professors. He said when you want to know something, write a book about it. I wrote a thesis on therapeutic communities and found that there were at least fifteen therapeutic factors in a therapeutic community (Kooyman, 1992).

These fifteen therapeutic factors are (Kooyman, 1992, 1993, 1996):

1. The substitute family.
   In this new family the resident can grow in a safe environment.

2. The consistent philosophy.
   The philosophy can easily be understood, explained and supported by all members.

3. The therapeutic structure.
   The structure offers a safe and secure environment with few but clear rules in which the resident can learn to seek responsibilities and to be able to deal with mistakes.

4. The balance between therapy, autonomy and democracy. Too much therapy can result in avoiding responsibility, too much democracy can make the environment anti-therapeutic (Kooyman, 1975); the autonomy of the individual is limited by being part of a group.

5. Social learning through social interaction.
   The resident learns to function in different roles. Through feed-back he gains insight into his own behaviour.

   Maturation can develop through a series of crises. Reintegration follows after the crisis situation has been mastered.

7. The therapeutic impact of all activities.
   Everything happening in the therapeutic community is therapy: the work, the different jobs, the different roles in the community.

8. Responsibility of the resident for his behaviour.
   The residents are told not to play the victim by blaming their failure to others or society. They have to learn that they need help, that they can ask for help and that they are able to help themselves as well as others.

   By overcoming the fear of failing step by step, by "acting as if" the resident becomes no longer afraid to fail. As a result the self-esteem of the resident is raised. The increased self-esteem in itself diminishes the fear of failure and rejection.

10. Internalisation of a positive value system.
    The resident learns to be honest, to confront and criticise negative and self-destructive behaviour and attitudes.

11. Confrontation of behaviour.
    The resident learns to verbalise his inner conflicts. He learns to confront the behaviour of others, the same behaviour that he does not like of himself. He learns that being confronted does not mean being rejected. He learns that it is not necessary to be perfect to be loved as he might have believed as a child. In fact he sees that the opposite may be the case. He learns that confrontation is not directed at the person but at the behaviour.

12. Positive peer pressure.
    In the same way, that peer pressure may have been a factor in starting to use drugs, positive peer pressure makes a person to abstain from drugs and develop positive behaviour.
13. Learning to understand and express emotions. In encounter groups and other therapy groups the resident learns to make contact with and express emotions. He learns to overcome his fear for expressing anger, fear and pain and finally to express positive emotions such as pleasure and love, which are usually still more difficult to express than negative ones. Painful memories of traumatic experiences in the past can be worked through in therapy groups.

14. Changing negative attitudes into positive ones. Most addicts have negative views of themselves in relation with others such as: "I am not lovable", "I am not good enough" and "I don't have the right to exist". That last attitude is very common among addicts, although they often only realize during therapy groups, that they have such an attitude. The negative attitudes developed in early childhood. It helped then to survive, but it became a great handicap when they grew older. Therapy groups such as bonding psychotherapy can help to overcome this negative self-fulfilling prophecy on life (Casriel, 1972).

15. Improvement of the relationship with the family of origin. In therapy groups "unfinished business" with parents can be worked through with parents symbolically present (empty chairs, role-played by staff members or other residents). Parents and other relatives are involved in group activities. The relationships with the relatives are renewed with the help of staff members after a period of no contact.

These fifteen therapeutic factors of a therapeutic community are all essential for the therapeutic process. If any of these are not present the treatment will be less effective.

Other important activities increasing the self-esteem are: job training and education.

In a study among residents of Daytop Village Vincent Biase found that the self-esteem of the residents, who had followed education classes in the Daytop Miniversity project, had increased more that of those who did not get this education (Biase, c.s. 1986).

Therapies can be added to increase the impact of the TC.

Bonding psychotherapy groups developed by Dan Casriel, psychodrama, pessomotor therapy, relapse prevention groups, family therapy and others (Kooyman, c.s. 2014). In bonding therapy groups participants can reinforces positive attitudes and the feeling to belong to the group with the help of the other participants.

There are several phases in the stay in the therapeutic communities (Kooyman, 1992). The first phase is the phase of the newcomer who needs to learn to adapt to a regular life in the TC to become part of the community. This is the phase where the resident needs to feel welcome and gets most attention from the staff.

The second phase is the phase in which the resident feels that he is part of the community. He can tell his life story to the group and look at his past. There can be a meeting with parents or other relatives with a staff member present. The resident can ask for privileges such as leaving the TC for a day together with an older resident.

In the third phase the resident learns how to engage in friendships and to overcome fears of intimacy (Höfler- Zimmer D. & Kooyman, M. 1996). He works in the TC in groups on his emotions in relation with other members of the TC.

In the fourth phase the resident feels responsible for what is going on in the community. The TC is his house.

In the fifth phase in the TC the resident prepares himself on the future and leaving the programme.

Rex Haigh describes five phases in the development of the individual in the therapeutic community in the International Journal of Therapeutic Communities. (Haigh, 2013).
7.

He describes five phases in the stay of the resident in the TC as follows:

Attachment, containment, communication, involvement and inclusion and agency.

After admission to a TC, a culture of belonging the resident needs to experience a safe attachment. He struggles internally with the strong desire to belong and the urge to resist or reject this. In the first phase the newcomer needs to feel heard and seen not only by an older resident, a brother or a sister (who may hate to see another person needing attention) but also by an experienced staff member, a parent figure.

Containment. There is a culture of safety. Strong emotions are tolerated and expressed in groups. There are clean rules and limits.

Communication. There is a culture of openness. There is honesty. There are no secrets. There are opportunities for questioning.

Involvement and inclusion. A culture of participation. All interactions belong to everybody. There is exchange in community meetings.

Agency. A culture of empowerment. There is interdependent finding of the real self.

There is active participation with responsibility for each other.

Conclusions.

The answer on the question “Why therapeutic Communities work” is:

The therapeutic community gives people with a failure identity a possibility to overcome their fear of closeness and rejection through corrective emotional experiences. The TC increases their self-esteem, enabling them to have stable relationships. They do no longer need drugs or alcohol to feel better.

The therapeutic community is therapeutic in itself. The community is the method.

The therapeutic community should remain therapeutic and not became a clinical institution in which professionals are taking the responsibility away of the residents.

The therapeutic community should not be replaced by a model that keeps the addict a dependent patient, not responsible for his or her treatment as is the case in an institution or in a medical model clinic.

Treatment programmes should not only be directed at the symptom: the abuse of drugs, but also at solving the causes of the addiction and at preparing the person for a drug free life.

In that view so-called “harm reduction” programmes can not be regarded as treatment.

In the TC the residents can find a sense of self from which they can use their own power in a positive way in a safe and stimulating environment promoting a healthy life style.
8.

Literature:


