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ADDICTION PROFESSIONAL

WHAT'S WORKING IN TREATMENT AND PREVENTION

Peter Provet says creative arts workshops have helped socially isolated residents express feelings.

Clues to the Future of the Therapeutic Community

A more caring, comprehensive approach to the TC may help residents flourish

EDITOR'S NOTE: *This article on the evolution of the therapeutic community (TC) group model in addiction treatment is an excerpt of an address by Peter Provet at a plenary session of the World Federation of Therapeutic Communities' 2006 conference, a September gathering of leaders from more than 50 countries in New York City. Provet is president of New York City-based Odyssey House, a multisite addiction treatment agency offering addiction treatment, medical care, and support services to more than 1,000 adults and children. He is a clinical psychologist with more than 20 years of experience in treatment and in managing programs for adolescents, adults, and families with substance abuse and mental health problems.*

by Peter Provet, PhD

As the central protagonist of group-based drug treatment, therapeutic communities (TCs) lead the way in harnessing the power of group dynamics to exert individual change. Evolution of the model calls for maximizing the clinical potency of the TC group methodology as we continue to integrate other clinical approaches into the treatment regimen.

Opportunities include utilizing time more efficiently by re-examining how clinical intervention takes place on a 24-hour, 7-day-a-week basis, and providing on-site/co-located services that ensure, for example, that teachers and medical personnel are knowledgeable of TC concepts and able to incorporate clinical directives in their interactions with residents.

Also key is the productive utilization of "group transference" where the group is identified as a benevolent force with an attractive identity, and confrontation is used in a strategic manner, with positive reinforcement far outweighing negative reinforcement and punishment. This is further enhanced by a redoubling of efforts to demonstrate core TC values of responsible love and concern, and by helping individuals in treatment fill the vacuum created when addiction and

concomitant behaviors are removed.

Additional efforts to maximize TC potency include: integrating traditional psychotherapy; fostering a more compassionate and transparent TC management style; and capitalizing on the synergetic partnership of counselors in recovery with those who are not. Clinical managers must also resist pressure from licensing and funding bodies to move away from a peer leadership model in favor of staff-led interventions, and must become promoters (and role models) of emotional sharing, healthy physical activity, and rigorous intellectual pursuits—a role that further extends to promoting treatment efficacy to funders, policy-makers, and referral sources.

Residents' intrinsic motivation

Fundamentally, clinical potency within the TC is maximized when its members achieve "intrinsic motivation."

In the U.S., entry into treatment has increasingly relied upon criminal justice referrals and mandates—"alternatives to incarceration." Depending on locality, such efforts have become quite systematic, with all relevant partners (e.g., judicial, prosecutorial, defense) working in concert. This movement has been essential as drug and alcohol abuse is now recognized more as a medical disease, rather than a moral failing or criminal enterprise. Solidifying this critical shift, however, will take many more years of research into the biological and genetic correlates of addiction, and ongoing public education.

Simultaneously, however, this shift has placed greater pressure on treatment programs to motivate clients to achieve sobriety and a meaningful recovery based on self-examination and self-awareness. Stimulating initially dormant "intrinsic motivation" is now more important than ever. If unsuccessful, the client simply "does his time" in the TC rather than jail and returns to the community largely unchanged, primed for relapse. As a result, most early treatment interventions can be best conceptualized around the goal of shifting the addict's motivation from that of extrinsic to intrinsic sources.

One unifying principle around which this effort can be based may be thought of as enhancing group transference. The individual enters the TC environment typically resistant to change, negative, and certainly impressionable. The group environment, represented by fellow peers, staff, the physical structure, operational guidelines, and all elements of daily implementation, must be logical, consistent, and attractive. The perceived potency of the group should be great—most importantly, however, in a benevolent form. For some residents, the experience of the TC as authoritarian and rigid is a contributing factor in early treatment dropout.

Of course, achieving initial behavioral compliance is essential. For the community that regularly, if not daily, accepts and integrates new members, "fresh off the street," individuals must comply. Too often, however, our treatment environments are perceived as hostile (conveniently reframed as "confrontational"), with far too little responsible love and concern. Shifting this environmental tone need not sacrifice the critical behavioral underpinning of the TC to offer both positive and negative feedback within the context of earned reinforcement.

Of course, "tough love" has its place in the TC. Through years of drug use and related addictive behavior, the addict's defenses—denial, projection, repression, grandiosity—dominate his personality and become rigid, often impermeable. A degree of breakthrough is essential if meaningful change is to occur. The issue is more one of timing and technique. When and how is it best to assist this complex process along?

Compassionate clinical management

A key to this particular evolution may be management style. Here, the primary function of role modeling in the TC may inadvertently limit this shift to a more embracing, more compassionate TC. Direct-line TC program managers and counselors, when queried on their rough, "in your face" clinical style, all too often respond, "I give it like I got it." Staff management style must model appropriate compassion, benevolence, fairness, and integrity if the TC environment is to embrace and welcome the addict and not just confront and belittle him.

While clearly not a democracy, the TC should incorporate certain democratic principles to enhance its clinical potency. At every level of TC management, decision-making should be carefully examined. From work schedules to encounter group membership, from weekend passes to seminar leadership, from menus to linen replacement—when handled openly, judiciously, representatively, decision-making processes can powerfully reinforce the clinical potency of the TC environment.

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A page from organizational psychology is instructive here. One of the most highly replicated findings in organizational psychology pertains to employee satisfaction. When asked, "What is the number one attribute that promotes job satisfaction?", the overwhelming response appears counter-intuitive. It is not salary, comfort, tenure, etc. Rather, it is being part of decision-making processes that are directly related to the individual's work functions. Or put another way, having a central role in shaping one's own destiny; having a voice and being heard. The work "structure" and job hierarchy at the core of all functional TCs

are natural platforms upon which to maximize this fundamental motivation of human behavior.

Filling the void

One particular decision that each recovering addict must make over the course of his recovery is how to fill the psychic and behavioral void that the cessation of drug use and its related lifestyle has by definition created. From the addict's perspective, so very much is taken away in the early phases of treatment. Throughout the course of treatment, he must be given a range of options on how to fill it—how to productively occupy time, maintain interest, fuel motivation, obtain enjoyment, pleasure, and satisfaction. As we know too well, boredom is the drug's ally. And I am speaking here, of course, outside of the critical life functions that must be addressed and stabilized—education, work, family, shelter, establishment of an ongoing recovery network, etc.

Art and exercise are two media through which I have seen individuals mobilize and find purpose. Creating art for art's sake—not as a way of interpreting and resolving unconscious conflicts in a therapeutic process—allows the individual to see beauty in the world and, perhaps, to begin to see beauty in the self.

At Odyssey House here in New York City, we have engaged clients—many with comorbid disorders (chronic addiction and schizophrenia or bipolar disorders)—in an active art program, and have recently mounted three art exhibits: two of paintings and one of sculptured masks. The process of creating art has in itself been highly therapeutic. Themes, such as self-portraits, bring structure to each project, but then clients are encouraged to make numerous decisions on how to fashion their personalized work. The art show itself becomes a vehicle of self-pride, as clients glow in the revelation of their powerful expressions. The art program engenders hope and possibility, bringing individuals closer to their own creative abilities and those in the cultural worlds in which they reside.

Exercise represents one of the most powerful antitheses to addiction. Building the body—stamina, strength, and improved appearance—becomes the antidote to the physical destruction of addiction. Exercise teaches discipline, patience, the delay of gratification, and most formidably increases self-esteem. A vigorous, consistent exercise routine serves as an inoculation against drug abuse. When great effort is daily (and sometimes painfully) exerted in the pursuit of a positive physical goal, the thought of abusing one's body—one's newfound sense of physical health, strength, and well-being—becomes dissonant. That dissonance only grows and may reinforce relapse prevention efforts.

Completion of the 26-mile New York City Marathon last November by 15 individuals in residential treatment at Odyssey House for heroin and cocaine addiction invigorated not only the athletes and their friends, coaches, and families, but the entire therapeutic community.

Engaging the intellect

Vigorously engaging the intellect can also be more strategically utilized in therapeutic communities. While high school education, college preparation, vocational training, and job placement are now common elements of a holistic treatment regimen, what I refer to as engaging the intellect is something wholly different.

Here I am speaking about reading classic works of literature and holding weekly book club sessions; engaging clients in chess tournaments, while having an expert teach a weekly strategy course; forming debate teams and then addressing issues that impact clients' lives (e.g., the legalization/decriminalization of drugs); holding a daily news events meeting with a daily reading of the nation's best newspapers. Such activities engage the individual, helping him see and feel his own worth while reinforcing his abilities to learn, communicate, and question. They also take the individual "out of himself"—dismantling the egocentric world view of the addict while giving powerful perspective to pain, challenge, and fortune.

Strengthening bond to the group

And now a final point. Attachment or transference to the group, while natural for some, is difficult for others. Premature dropout may often be attributed to the individual's difficulty in forming a bond to the group.

Individual psychotherapy in the earliest stages of treatment can be a useful tool in transitioning the individual from a largely careless, egocentric world to that of the functional group. The bond between the individual and psychotherapist may offer reassurance and stability where the group environment is experienced as overly demanding, pressured, and unkind. It is critical here, however, to view the psychotherapeutic relationship in the service of the group process—a place for the individual to discuss the challenges of group identity and bonding. As the latter takes hold, the former can be de-emphasized.

In comparison to other social, psychological, and medical interventions for human disturbance (e.g., psychoanalysis, behaviorism, family therapy), the therapeutic community may be presently conceived as transitioning out of adolescence and into early adulthood. While still strong-willed, confident, argumentative, with a hefty dose of hubris, the therapeutic community approach is no longer viewed as a rebellious reaction against convention (that is, the medical model), but rather as a legitimate, powerful, and cost-effective methodology for treating some of the most intractable human disorders. To maintain its vibrancy, and ultimately its relevance, we must strive to support and encourage its evolution. ■