

Short Communication

THE CHANGING RELATIONSHIP BETWEEN THERAPEUTIC COMMUNITIES AND 12-STEP PROGRAMS: A SURVEY

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Therapeutic communities (TCs) provide a vast and growing network of substance abuse treatment facilities within the United States. The static population of TCs associated with Therapeutic Communities of America (TCA) grew more than 100% from 1985 to 1992. In 1985 there were a reported 5,000 residential and 3,300 outpatient slots. By 1992 this grew to 10,250 beds and more than 9,800 outpatients (Kerr 1992, 1985). Concurrent with this growth has been an explosive surge in attendance at 12-Step self-help groups. Because these groups stress anonymity, estimates of membership vary widely; however, the total number of Alcoholics Anonymous (AA) groups in North America grew from 31,000 in 1982 to 55,700 in 1992 (Alcoholics Anonymous World Service Information Bureau 1992). Narcotics Anonymous (NA) grew even more dramatically, expanding from a United States total of 1,600 groups in 1982 to more than 20,000 in 1992 (Narcotics Anonymous World Service 1992). This rise, coupled with an even greater escalation in the number of hospital-based programs in recent years, serves to illustrate the dramatic growth in addiction treatment in general and the self-help approach in particular.

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While the roots and origins of the TC have been well explored, and the links between AA and the founder of the seminal American TC, Synanon, have been abundantly documented in the literature, most notably by Deitch (1973) and Glaser (1981, 1974), relatively little attention has been paid to the current relationship between 12-Step groups and TCs.

Superficially, the approaches seem radically opposed. Traditional TC graduates view themselves as "ex-addicts." TCs see addiction as a disorder of the whole person, affecting cognitive skills, values, and socialization. There are frequently vocational, educational, and emotional deficits involved in addiction. The rehabilitative regimen is shaped in terms of motivation, self-help, social learning, and the perception of treatment as an episode (De Leon 1986). The traditional TC believes that addicts can change themselves and assume responsibility for their lives. To treat ex-addicts as helpless deprives them of this opportunity and encourages manipulative and irresponsible behavior (Warner-Holland 1978).

This approach is contrasted by the precepts of 12-Step fellowships, whose members view themselves as in a constant state of "recovery." Typically they stress powerlessness, and offer a fatalistic prognosis of ever-increasing and degenerative substance abuse without the surrender of "our will and our lives" to a Higher Power. Abusers develop an "allergy," and can never use the abused substance in any form again (Alcoholics Anonymous 1976). NA fellowship members believe themselves to be "people in the grip of a continuing and progressive illness, whose ends are always the same: jails, institutions and death." Recovery must be approached one day at a time and addiction is a disease from which "we can never fully recover, no matter how long we stay clean" (Narcotics Anonymous 1986).

The present study was designed to investigate the current relationship between TCs and 12-Step fellowships, from the TC perspective.

METHODS

Subjects

Subjects were 67 TCs who are members of Therapeutic Communities of America, a professional association. Ninety-seven questionnaires were distributed, and of these, 67 were returned (69%). These programs are all residential, long-term (typically one year or longer) treatment

facilities for men and women. They range in size from 12 beds to several hundred beds. With the exception of three programs that were 12-Step oriented from inception, these programs are modeled after the first broadly accepted American TC, Synanon, which began in 1953. The responding programs reported beginning dates ranging from 1967 to 1991, with only four programs beginning after 1976.

Procedure

Questionnaires were sent to every affiliated program in the TCA association. It was requested that these questionnaires be filled out by a senior staff person familiar with the program's policy and the reasons for that policy, and be returned to the research team based at Walden House, a TC program in San Francisco. The questionnaire included general questions about the population, services, and length of treatment. It also included questions about the inclusion or exclusion of 12-Step program meetings and activities.

If 12-Step meetings were part of the program's activities, respondents were asked to provide details of the involvement, including what year the meetings were introduced to the program, the types of meetings, location of meetings, and whether the meetings were open to the public or closed. Additionally, the questionnaire requested open-ended responses to policy questions surrounding 12-Step meetings. These questions included asking for background to the process for including or excluding 12-Step meetings; asking about any changes that may have taken place in regard to this policy; asking what policy led meetings to be closed or open to the public; and asking how the proliferation of 12-Step programs had effected respondents' services. There was also a question about the percentage of staff at each level of responsibility who identified themselves as members of 12-Step programs, and a question that attempted to gauge the agency's attitude toward client participation in 12-Step fellowships. A follow-up phone contact with 49 programs included confirmation of the date that the program's services began.

RESULTS

Of this sample, 60 (90%) reported currently having 12-Step meetings on their premises. Of all 67 programs, 14 (21%) reported the inclusion of 12-Step meetings beginning in 1980 or before, 18 (27%) began including meetings between 1981 and 1985, and 25 (37.5%) began including meetings since 1986. Of the 49 respondents who were later contacted by phone interview, it was found that of 46 programs that were founded between 1959 and 1978, 25 (54.3%) introduced 12-Step meetings since 1982.

Of the 67 programs with 12-Step meetings, 51 (76%) have AA meetings, 44 (66%) have NA meetings, 12 (18%) have Cocaine Anonymous (CA) meetings, and 17 (25%) have other types of 12-Step meetings, such as Ala-teen,

AlAnon (for the significant others of alcoholics), Adult Children Of Alcoholics (ACOA), Sex and Love Addicts Anonymous (SLAA), and Gamblers Anonymous (GA).

Fourteen (21%) reported that their program's meetings were open to the public (i.e., open to individuals from the larger community who were involved in the 12-Step fellowships); 38 (57%) reported that their meetings were not open to the public; and 8 (12%) reported that they had both meetings open to the public and meetings closed to the public. Seven respondents (10%) did not answer the question.

Respondents reported on attitudes toward 12-Step programs at specific phases in the programs. Attitudes were rated on a four-point scale: strongly encourage, encourage, allow, and discourage. In the orientation phase, 31 (46%) reported that they strongly encourage participation; 8 (12%) reported that they encourage participation; 6 (9%) reported that they allow participation; and 9 (13%) reported that they discourage participation. Thirteen respondents (20%) did not answer the question.

In the primary TC phase, respondents reported as follows: 40 (60%) strongly encourage participation; 11 (16%) encourage participation; 2 (3%) allow participation; and 4 (6%) discourage participation. Ten (15%) did not answer the question.

In the reentry phase, 46 (69%) respondents strongly encouraged participation; 7 (10%) encouraged participation; and 2 (3%) allowed participation. There were no reports of discouraging participation. Twelve (18%) did not answer the question.

In the aftercare phase, 51 (76%) respondents reported that they strongly encourage participation, while 5 (7%) encourage participation. There were no responses in the "allow" or "discourage" categories. Eleven (17%) did not answer the question.

For the purposes of the survey, there were five distinct categories of TC personnel: senior managerial, administrative, managerial, line, and junior. It was assumed that senior managerial staff would have philosophical roots in the fundamental design of the program, and may count among their numbers actual founders or principal architects of many programs. Administrative staff were considered much more likely to have been hired for a particular skill or expertise, rather than knowledge of substance abuse issues and philosophy. Managerial staff were considered to be largely "home grown" middle managers with considerable experience in the field, and line staff were considered to be largely former substance abusers. The category of "junior staff" was meant to represent new program graduates, for whom the treatment program is often the employer of first resort. Survey responses, however, indicate that the last categorization was somewhat ambiguous, and many respondents did not use the classification. For this reason, the category was dropped from the report.

In estimates of the percentage of staff who identified themselves as members of 12-Step programs, it was found that 11 (16%) of the agencies had 50% or more of their senior managerial staff involved in the 12-Step programs; 12 (18%) had 50% or more of their administrative staff involved; 17 (25%) of the programs had over 50% of the managerial staff involved; and 35 (52%) of the programs had 50% or more of the line staff involved. The frequency of this data not being available was 33% of senior managerial staff, 33% of administrative staff, 33% of managerial staff, and 16% of line staff.

DISCUSSION

The above data suggest that in recent years there has been a trend toward use of 12-Step programs as an integral part of TC treatment. This may reflect the increasing size and influence of the 12-Step programs in the larger culture, the growing concern and action in regard to addiction as a social problem, and a change in the philosophies of individual TCs.

Many involved in TCs have noted a change in the knowledge about and experience with 12-Step programs of clients first coming into residential treatment. Today's clients have frequently been attending meetings, or they have had some contact with 12-Step programs and members, prior to their initiating residential treatment. Thus, there is a demand from the client level on TC programs to include this type of treatment along with the more traditional drug abuse treatment approaches. Furthermore, an increasing number of counselors, who were themselves clients both in and out of their particular treatment facility, have reported successful involvement in 12-Step programs.

A common experience leading to this change in the use of 12-Step programs within TC programs has been that of addicts who were unable to achieve prolonged abstinence from drugs by use of residential treatment alone or 12-Step treatment alone, but required a combination of both treatment programs before their recovery could be solidified.

Another factor relating to the acceptance of 12-Step fellowships by TCs is the use of the structure and support offered by the fellowships as de facto aftercare. As one respondent noted, the decision to have meetings was precipitated by the desire "to introduce clients to a network of positive support systems in order to maximize and sustain posttreatment abstinence." Several respondents made similar comments, and the supposition may be made that as pressure for shorter residential treatment periods has increased, so too has the acceptance of alternative support systems.

Within this growing tendency to support and make use of 12-Step programs, respondents expressed concerns about destructive influences that might accompany too much

interaction between recovering addicts in nonresidential, voluntary 12-Step programs, and those who were also participating and living in the TC. In particular, it was suggested that in some cases the residential treatment programs might not be supported by those outside, and that individuals might be encouraged to leave their inpatient programs, to violate rules and regulations of the programs, or permit themselves less comfortable alliance with their residential program. One reply stated, "In 1985 we had open meetings once a week. Client retention decreased due to the perception of some that 12-Step groups were easier than treatment. We 'closed' the meeting, and the situation was resolved."

Inpatient treatment programs necessarily are highly structured, and this has been shown to suit the needs of many residents. Those who are able to achieve stable abstinence without this structure in some instances may fail to understand its importance, and thus be unable to support recovering addicts within these programs. This concern was expressed by many agencies in their discussion of the problems of open versus closed meetings within the treatment facility, and continues to be discussed among TC policymakers.

An overwhelming percentage of respondents had closed meetings, most exclusively. While the explanations for this were varied, with some respondents expressing a fear of "contamination" and interference with programmatic goals by outsiders, others stressed the need for both confidentiality and facility security. More than one respondent admitted to tampering with the format of 12-Step meetings in order to "tailor the discussion to the specific needs of the population."

An alternative to both the open and closed meeting formats that surfaced during the survey was the use of "privilege cards," issued to members of the community who have been oriented to the norms of the TC. While several respondents reported using this technique, apparently successfully, it should be noted that an attempt to introduce a similar approach several years ago in San Francisco drew considerable antipathy from the local 12-Step community.

While the clients, and clients who become counselors, have been influencing TCs in the direction of accepting and making use of 12-Step programs as an integral part of the residential program, there have been a variety of responses and changes within the administrative levels of these programs. While it is impossible to be certain, given the basic precepts of anonymity among 12-Step membership, and confidentiality of clients and former clients of TCs, there may be some association between the extent of personal involvement in 12-Step programs on the part of senior management and administrators, and attitudes toward integrating these two treatment approaches within the residential treatment program. Because some of the founders of traditional TCs do not recognize the disease

model of addiction or perceive alcohol as one of many addictive drugs, senior administrators within these communities frequently do not personally endorse the treatment represented by AA and those modeled after it, and likewise do not embrace this influence within the TC.

However, even in cases where agencies do not encourage 12-Step involvement in the early phases of treatment, every program that permitted any 12-Step involvement at all encouraged or strongly encouraged 12-Step participation for clients in the final phases of treatment and aftercare. This appeared to be the case regardless of the personal 12-Step involvement of the staff at any level. Thus it may be concluded that TCs today are increasingly accepting 12-Step programs as a useful part of the therapy available for clients in recovery from drug addiction.

There can be no doubt that the proliferation of 12-Step fellowships has affected service delivery by some TCs. To quote directly from survey responses: "The greatest impact

has occurred on (the delivery of) outpatient and aftercare services in regard to 12-Step participation being at first an adjunct and ultimately an integral component." Also, "it has opened (the TC) to considerably more input from outside. The graduate rate is rising and more clients are staying clean. 'Controlled drinking' is no longer discussed as an option." And finally, a reply that neatly sums the overall impression given by many survey respondents: "12-Step programs have enhanced our services, providing a more structured and systematic approach from the clinical staff as well as broadening the client's useful tools in achieving abstinence."

The relationship between TCs and 12-Step fellowships is clearly evolving. While there is still resistance from a number of TC personnel and 12-Step adherents, it may well be that forces beyond either's control necessitate, if not a marriage, then at least an acknowledgment of each other's strengths and weaknesses.

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