Retrospective Study of Similarities and Relations between the American drug-free and the European Therapeutic Communities for children and adults

Eric Broekaert, Ph.D.*; Wouter Vanderplasschen**; Ingrid Temmerman***; Donald J. Ottenberg****, M.D. & Charles Kaplan*****; Ph.D.

* Professor, Department of Orthopedagogics, University of Gent, Gent, Belgium.
** Assistant, Department of Orthopedagogics, University of Gent, Gent, Belgium.
*** Orthopedagogue, Royal Orthopedagogical Centre St.-Gregorius, Gentbrugge, Belgium.
**** Consultant and former director, Eagleville Hospital and Rehabilitation Center, Philadelphia, Pennsylvania, United States.
***** Professor, Department of Psychiatry & International Institute for Psychosocial and Socio-ecological Research, Maastricht University, Maastricht, the Netherlands.


Address for Correspondence: Prof. Dr. Eric Broekaert
University of Gent
Department of Orthopedagogics
Dunantlaan 2
B-9000 Gent
Belgium
Tel. 32-9-264 64 66
Fax. 32-9-264 64 91
E-mail: Eric.Broekaert@rug.ac.be
Abstract –

This article focuses on the similarities and relations between the European therapeutic community for children and adults on the one hand and the American drug-free ‘concept’ therapeutic community on the other. Both approaches are reviewed in a historical and comparative perspective with special attention for the critical issues ‘democracy’ vs. ‘hierarchy’, ‘self-help’ vs. ‘professionalism’, ‘psycho-analysis’ vs. ‘behaviorism’ and ‘concept’ vs. ‘social learning’. These two different TC-approaches can be considered as subdivisions of one modality, namely an environment for social learning in which living together in a group can be regarded as the primary agent of growth and human development. In recent years we have seen a tendency towards further integration of these two approaches.
INTRODUCTION: TWO THERAPEUTIC COMMUNITIES

Two major domains can be identified in the field of work based upon the therapeutic community (TC). They have enough in common to be viewed as subdivisions of the same modality, yet they are quite distinct in origin and historic development, diverse in methodology, and serve different populations of clients. The first of these branches – though not called therapeutic community when initially established – consists of community focused programs developed to help children and adults with various psychological, social, educational and psychiatric problems. We will refer to this approach, originated in Europe, as the therapeutic community for children and adults. The other branch, originated in America to serve primarily drug addicts and substance abusers, we call the drug-free therapeutic community. Although much has been written about each of these two types of TCs, very few studies have placed them in a comparative perspective.

Most substantial discussions on therapeutic communities are found back in gray literature (e.g. Congress proceedings of the World and European Federation of Therapeutic Communities) and in the International Journal of Therapeutic Communities and a variety of other journals. However, two current books - "Community as a method" (De Leon 1997) and "Therapeutic Communities: Past, Present and Future (Campling & Haigh 1999) - represent the two branches and demonstrate clearly a tendency towards integration. To better understand these postmodern challenges and to be prepared for the future, it becomes important to study more intensively the similarities and dissimilarities of these two approaches.

THE THERAPEUTIC COMMUNITY FOR CHILDREN AND ADULTS

The Therapeutic Community for Children

At the end of the 19th and beginning of the 20th century, there is a reaction against the principles of the traditional school. According to ‘renewal pedagogues’, such as Decroly, Claparède, Kohnstamm, Ferrière, Piaget, Montessori, Dewey, Freinet and Steiner, education must be based on the needs and interests of the child rather than on severe discipline and book learning. They question the academic overload and mental pressure, the educational structure, the moral training, unworldliness and individualism, as they search for a functional pedagogics of interest and activity (Broekaert 1993).
In the United Kingdom, these progressive initiatives are aimed mainly at ‘maladjusted’ children and they are jointly called ‘Therapeutic Education’. Bridgeland (1971) extensively describes these schools, which at first do not call themselves ‘therapeutic communities’.

Chronologically we can distinguish three waves in the advancement of ‘progressive’ facilities for ‘maladjusted’ children: before the first World War, the years 1930-40 and the years 1960-70. The pioneer period begins just before the first World War and ends with the second World War, by which time the new developments in pedagogics and psychology gain momentum, as the states’ role becomes prominent.

The pioneers

Before the first World War, these schools for the so-called unschoolable (delinquent and destitute youngsters) were developed by pioneers such as Mary Carpenter (1852), William Hunt (‘Wallingford Farm Training Colony’: 1911), Leila Rendel (‘Caldecott Community’: 1911), Homer Lane (‘Little Commonwealth’: 1913) and Russell Hoare (‘Sysonby House’: 1914). Bridgeland (1971) calls Homer Lane the archetype of the early pioneers: in the ‘Little Commonwealth’ (1913-1918) the principle of self-government for the treatment of delinquent adolescents is used seriously for the first time.

Despite their different backgrounds and training, these pioneers exhibit some common characteristics: a large willingness to experiment, an inspiring charismatic personality without a mutual ideology or religion, an unconditional respect for the individual, belief in individual freedom and regard for love and trust as the foundations of the treatment. They all consider emotional deprivation - which is possibly expressed in anti-social behaviour - as the cause of maladjustment. They think that the children have missed fundamental experiences. They situate the purpose of the treatment in personal, social or educational recovery and emphasize the therapeutic value of play and work, activity and creativity.

Otto Shaw and David Wills

During the interbellum period the number of new initiatives increases, also under the influence of the ‘new’ dynamic psychology, which reaches its peak in the twenties. Influenced by Freud, Jung, Adler and Reich, emotional deficiency is emphasized. Dr. Dodd (1920), Alexander Neill (‘Summerhill’:
Dr. Fitch (1935), Otto Shaw (‘Red Hill School’: 1934) and David Wills (‘Hawkspur Camp’: 1936; ‘Barns Hostel’: 1940) are the most noteworthy representatives of this period. Shaw emphasizes the importance of psycho-analysis, because «the academic work cannot be performed successfully when the underlying deficiency is not dealt with» (Bridgeland 1971:170). Wills stresses that the shared responsibility must grow spontaneously, the «having to discipline oneself instead of being disciplined by others is a burden» (Wills 1964:52).

Wills is regarded as «an outstanding example of a pioneer because he - often impulsively but always convinced - shows new roads which others will follow more cautiously» (Bridgeland 1971:193). His work becomes the first practical experiment in ‘Planned Environmental Therapy’.

In "What do we mean by Planned Environmental Therapy", Wills (1989) describes ‘maladjustment’ as the product of social factors or deeper emotional problems. The love one received as a child is the basis of a stable development. He wants to provide experiences which strengthen the Ego and remove defense mechanisms against pain, fear and guilt. The children live and work together and are offered the possibility to have specific therapeutic relations with stable adults. The responsibility is shared in an atmosphere open to therapy. The moral code grows from the acting together. His main collaborator, the psychiatrist Marjorie Franklin, pleads for «the use of the environment as a means of correcting asocial and other related character deficiencies» (Bridgeland 1971:266).

In 1951, Otto Shaw and David Wills found the ‘Association of Workers for Maladjusted Children’. For the pioneers this was an ideal platform to discuss their principles and practice within a national organization. Its growth is one of the many signals that the pioneer movement is becoming a national issue around 1950. In 1966, the ‘Planned Environmental Therapy Trust’ is founded.

D.W.W. Winnicott

The second World War will mark a turning point within therapeutic education. Because of the war and the mass-evacuation of children from the big cities to small villages, maladjustment becomes a national topic. The remarks of pioneers suddenly become a national issue. The work in evacuation hostels with children separated from their parents carried out by John Bowlby, Anna Freud, and especially the psycho-analytically inspired paediatrician D.W.W. Winnicott appears as an important addition to therapeutic education.
One of the main positions in Winnicott's work is that reliable and consistent motherly (or someone playing that role) care for a child – ‘good enough holding’ - leads to integration of the personality (Winnicott 1978; 1976). During the period before the integration the child gradually splits off from the mother and leaves the ‘potential space’ which belongs to both of them. Traces of this space remain and are found in the first affective possession of the child, the ‘transitional object’ (e.g. a teddy bear). This object is one of the bridges between the individual psyche and the external reality. In this transitional and potential space lies the origin of play, creativity and culture. An emotionally neglected child will not reach integration, because he or she lacks ‘good enough primary experience’ and did not develop basic trust. A therapeutic community may, according to Winnicott, function as a ‘good enough holding environment’ and offer the spontaneous healing qualities of a healthy family life.

Under certain conditions the group may be used as a therapeutic means. A group in itself is not a part of the inner experience of an individual nor is it a part of the reality of daily life. A group is something between ‘inside’ and ‘outside’, a ‘third space’. Winnicott calls this an ‘illusionary area’ a ‘transitional space’ (Winnicott 1990; Van der Linden 1988; Winnicott 1984).

Melvyn Rose and Richard Balbernie

While England recognizes more and more special groups of children within the state system (in the 1945 ‘Regulations for Handicapped Children’ maladjustment is described as a new category of handicap), the sixties and seventies gradually show a new wave of therapeutic communities as a result of transformation of some ‘Approved Schools’ (rigorous educational institutions for delinquent youngsters) into independent schools with less authoritarian regimes. The ‘Cotswold Community’ of Richard Balbernie (1966) and ‘The Peper Harow Community’ of Melvyn Rose (1990) are the main representatives of this trend. With Balbernie, the development of the schools is based especially on the theories of Winnicott and his pupil Barbara Dockar-Drysdale (1993; 1990; 1968), while Rose tends especially towards Erikson.

The Therapeutic Community for Adults

Joshua Bierer claims that the first ‘therapeutic social club’ started in 1938 (Bierer 1964). For this, he collaborated with Dr. R. Ström-Olsen in the Runwell Hospital for neurotic and psychotic patients at
Wickford, Essex (England). Bierer was influenced by the individual psychology of A. Adler, the psychology of the total approach - the in-dividere - or what cannot be divided. « The social club gave rise to the concept of the therapeutic community. However, an attempt to change the whole hospital into a therapeutic community was considered so revolutionary at the time that it could only be carried out in stages » (Bierer 1964:224).

Bierer emphasizes the importance of a total environment, a guided democracy and a network of PATient-THERapist-Relationships (PATHERN) (Bierer 1960).

Since the beginning of the second World War, two somewhat independent trends within the European therapeutic community for adults arise. They are represented by M. Jones on one hand and by W.R. Bion and H. Bridger (Northfield Experiments) on the other.

**Maxwell Jones**

In 1939 in the ‘Mill Hill Public School’, more precisely in the ‘Effort Syndrome Unit’, Maxwell Jones starts a reorganization of the hospital structures. His work with patients with psychosomatic complaints resulted in a « more open communication, less rigid hierarchy of doctors, nurses, patients, daily structured discussions of the whole unit and various subgroups » (Jones in: Manning 1945:271).

In 1946 Maxwell Jones extends his work in the Southern Hospital (Dartford) in the ex-prisoner-of-war unit. His pioneering work with psychopathic and personality disturbances between 1947 and 1959 in the Belmont Hospital and later from 1960 in the Henderson Hospital in The Belmont Industrial Neurosis Unit is well known. Rapoport (1970) describes him as an archetypal charismatic innovator.

From 1960 to 1963 Jones continues his work in Salem (Oregon) and from 1963 to 1970 in Dingleton Hospital (Melrose), now with a more outspoken psychiatric population. From 1970 Jones resides in Fort Logan and other places in the United States. He expresses his views in ”The Therapeutic Community” (Jones 1953), ”Beyond the Therapeutic Community” (Jones 1968) and later in ”The Maturation of the Therapeutic Community” (Jones 1976). His interest shifts more to educational questions, social learning and open systems.

**W.R. Bion and Harald Bridger**

Between 1942 and 1948 - during the war - the Northfield Experiments took place in the Hollymore Hospital in Northfield (Birmingham). To the first experiment are linked the names of J. Rickman and
W.R. Bion, to the second those of S. Foulkes, T. Main and H. Bridger. The experiments are related to efforts for relief of soldiers with psychological problems (Harrison & Clarke 1992).

During the first experiment, Bion was the head of the rehabilitation unit. He developed a form of group activity, in which he considered the group task and group result, as well as the group process. In this case he wanted to examine how the leader, appointed for his task, related to the group members who assumed their responsibilities in difficult circumstances. The experiment, inspired by a country at war and the dynamics of the decision-making process during army tasks, contributed largely to the further knowledge of group dynamics and the activities of the Tavistock Institute (Bion & Rickman 1943). After a short while, Bion was transferred because disciplinary problems in the hospital increased and he had underestimated the relationship involving his task, the unit and the whole clinic (Bridger 1984:77).

Bridger, who with Foulkes and Main carried out the second experiment, was a mathematics teacher and thus influenced by project learning. By starting ‘social clubs’, he correctly assessed the relations between the departments and the whole hospital. He considers the therapeutic community as a transitional community, in accordance with the notion of Winnicott. By installing an empty space, which became the social club, the longing for a link creates a therapeutic space (Broekaert et al. 1996).

During that period the name ‘therapeutic community’ is used for the first time. Tom Main mentions the name in 1946 in "The hospital as a therapeutic institution" (Main 1946)

In the seventies a dialogue will develop between the therapeutic community for children and the therapeutic community for adults. In 1972 a mutual discussion forum is developed in the form of the ‘Association of Therapeutic Communities’ (ATC) and still later, a specialist journal is published, namely ‘The International Journal of Therapeutic Communities’ (Farquharson 1991). Here, Kennard (1994) describes seven specific characteristics of the therapeutic community for children and adults:

- the community consists of a group of people who regularly live together or meet and who participate in a number of purposeful tasks, who experience confidential, informal, non-hierarchical relations. It is further characterised by sharing of information between all members of the group, a living learning
situation, a culture of inquiry, a psychodynamic conscience, clear determinations of time, place and role.

In 1987 the existing therapeutic communities unite in the Charterhouse Group of Therapeutic Communities and postulated their principles (Beedell 1993). In the 1996 directory (The Charterhouse Group 1996) the return to the family and the local community is added.

THE DRUG-FREE THERAPEUTIC COMMUNITY

The drug-free therapeutic community originates from the eternal struggle of man to find unity between feeling and knowledge, religion and science, knowing and believing (Broekaert & van der Straten 1997).

From the beginning of the Christian era some Jewish-Hellenistic communities strived for this unity. The members of these communities were called ‘therapeutae’, because they were experts in curing illnesses of the body and the mind (Philo 1971). Questions of guilt and the breaking of rules were discussed publicly. This practice of publicly uttering viewpoints and feelings (‘exomologesis’) is described by Mowrer as "a complete openness about one's life, past and present, to be followed by important personality changes, with the support and encouragement of the other members of the ‘congregation’" (Mowrer 1976:6). This ‘exomologesis’ was later adopted by the first Christian communities.

Many years later the Reformation strived for innovation and originality within the Catholic Church. Zwingli, founder of the Swiss Reformed Church and kindred to the Anabaptists, emphasized the original way of life of the first Christian communities (Glaser 1977). Buchmann (19th century) was closely linked to Zwingli in his views (Glaser 1977). In his ‘Oxford Groups’ he wanted to return to the old humanistic religious ideals.

Bob and Bill

Dr. Bob and Bill W., the legendary founders of the Alcoholics Anonymous (AA) movement, were clearly inspired by Buchmann’s ‘Oxford Groups’ (Bratter et al 1985; Mowrer 1976), when developing the philosophy and practices of AA. "The Oxford Group, independent from any church was God-oriented. Its members were taught to surrender totally to Christ and practiced a four-step program
which resembled the four absolutes of Alcoholics Anonymous” (Bratter et al. 1985:469). Once more life problems were discussed in public.

**Chuck Dederich**

Charles Dederich became sober in AA. In 1958 on the Californian coast, Dederich and a few alcoholics and drug addicts founded Synanon, a therapeutic living and working community based on the self-help notion (Yablonsky 1967). In Synanon one finds the origin of the current drug-free therapeutic community (Dederich 1978a; Dederich 1978b; Dederich 1977a; Dederich 1977b; Ferderber 1974; Maillet 1972; Endore 1968).

Synanon was regarded by its leader, Charles ‘Chuck’ Dederich, as a social and religious movement. Synanon aspired to an ideal society, in which values such as honesty, truth and creativity - frequently not adhered to sufficiently in American society - were given a chance.

Within Synanon so-called ‘games’ were a central element. These ‘games’ were a reflection of ‘exomologesis’ and are credited with resulting in the birth of ‘encounter’ groups in the drug-free TC. Garfield (1978: 8) describes these games as an « uninhibited conversation, the arena for the discussion of all human feelings, community issues and the relationships among people ». Finally, Synanon's world view and philosophy are best revealed in the idealistic transcendentalism of R.W. Emerson (Garfield 1978). His neo-romantic belief in human possibilities is carried by an all-embracing divine power : ‘the universal mind’ or ‘the over soul’. This power is the foundation for the self-actualization of man, finding its peak in personal integrity : « Nothing is at least as sacred as the integrity of your own mind » (Emerson 1955:115). For Emerson (1955:114) the creed of man is : « Trust thyself : every heart vibrates to that iron string ».

**W.B. O’Brien**

In the early sixties David Deitch had the assignment of founding a number of branches of Synanon on the East Coast of the US. He was helped by W.B. O'Brien, a catholic priest from New York, a proponent of the Synanon philosophy (O'Brien 1993). After an initial close collaboration, Dan Casriel, a psychiatrist, and O'Brien pulled away from Dederich and Synanon. That Synanon demanded lifelong membership without return to the outside community and rejected professional help, influenced the breakup, as did diminishing controls on Dederich’s authoritarian tendencies as his leadership grew
excessively charismatic. O'Brien started « Daytop » the first drug-free therapeutic community with the help of D. Deitch and a number of ex-addicts who had left Synanon (Sugerman 1974). "No mechanism remained by which the leader's judgement could be questioned" (Ottenberg 1982:163).

In New York, at about the same time (1966), the psychiatrists Ramirez and Rosenthal collaborated in the creation of the ‘Phoenix Houses’ (De Leon 1974). Also in New York, Dr. J. Densen-Gerber founded 'Odyssey House' (Densen-Gerber 1973). Eventually the utopian striving of Synanon would lead to its own ruin. « Chuck Dederich and Synanon would fall deep. They would become a confused and violent sect. » (O'Brien 1993:46).

From ‘Daytop Village’ and ‘Phoenix House’ ex-addicts spread the ‘concept’ of the drug-free TC and these two TCs served as models for most drug-free TCs in the United States and Europe (e.g. ‘Daytop Deutschland’ and ‘Phoenix House London’) and later also in Asia, South-America and Australia.

Several authors described the background and the working of the drug-free therapeutic community, among others De Leon (1995a and 1995b), Kooymen (1992) and Broekaert (1981). In view of the distinctive basic concept of the TC, the drug-free TC was also called the ‘concept therapeutic community’ (Sugerman 1974). Later, De Leon (1995b) called it the ‘TC for Addictions’.

A drug-free therapeutic community can be defined as « a drug-free environment in which people with addictive problems live together in an organized and structured way to promote change toward a drug-free life in the outside society » (Broekaert, Kooymen & Ottenberg 1998:595). During the nineties the drug-free therapeutic community had to face a lot of challenges in the uncertainty of post modernism. Until then drug abuse was seen as an absolute evil and laws and treatment approaches were clear in their aims. According to G. van der Straten (1997) new developments were taking place: tolerated use of cannabis, new designer and smart drugs with mass consumption of ecstasy, limited impact of repression, harm reduction- programmes, free market economy with sharp competition and loss of solidarity. Post modernism went together with loss of values and relativism. The complexity of information and possibilities required a value system based on flexibility.

In such times of incertitude, the drug-free therapeutic community reacted in 1991 with a renewed search for its basics. They addressed the question: "What cannot be changed in the drug-free
Therapeutic Community”. They arrived at the conclusion that self-help and mutual help, a sufficiently long treatment period, openness, competent staff members, international collaboration, possibility for change, ethical boundaries, structure, a shared value system and sincere involvement are the necessary essence of the TC (Broekaert, Kooyman & Ottenberg 1993). In the United States, George De Leon identified the essential TC-concepts (De Leon 1995a): the use of participant roles, membership feedback, members as role models, collective formats for guiding individual change, shared norms and values, definite structure and systems, open communication and the use of relationships.

**DISCUSSION : SIMILARITIES AND DISSIMILARITIES**

**Democracy vs. Hierarchy**

A democracy in practice is a form of government in which the entire population takes part in the leadership, exerting this rightful prerogative mostly through the election of representatives and leaders. Opposite to democracy stands not hierarchy but autocracy, a form of government based on absolute power. Thus not a ‘demos’ (people) ‘kratein’ (to lead), but an ‘autos’ (alone) ‘kratein’ (to lead).

By hierarchy mostly an order of rank, a positioning is meant. The notion stems from ‘ieros’ (holy) and ‘archein’ (to lead). So it means to guide through an order of rank. Opposite to an order of rank there is arbitrariness: behaviour without order or system.

Between democracy-autocracy on the one hand and hierarchy-arbitrariness on the other, we can of course make connections. Thus, in a democracy one may very well choose institutions with a hierarchical structure (e.g. the army) and an autocratic head of state may well take a series of arbitrary decisions (e.g. banning art).

For Maxwell Jones ‘democracy’ was an attempt to break through the order of rank and to achieve decisions which were made in consensus, but certainly not arbitrarily. In the ‘hierarchically’ structured TC, decisions are taken by order of rank and finally by a leader, democratically controlled, one hopes.

The opposition between the ‘hierarchical’ and ‘democratic’ TC has first of all to do with the way in which leadership is assumed and decisions are made: either within the order of rank or based on consensus. In both cases the decision makers can be regarded as equal. The notion ‘equal’ belongs to the ethics category.
Bridger (1984) rightly remarks that the order of rank is subordinate to the purpose of every TC to grow and develop and in that sense proposes to use the words (more or less) ‘open’ and ‘closed’. « The point I was trying to make is that there is another way of looking at any system, namely the degree to which ‘open’ and ‘closed’ helps us to perceive more possibilities and deeper potentialities » (Bridger 1984:110).

Bratter et al. (1985) warn us not to confuse the hierarchical structure and the leadership during treatment with an authoritative form of management. « Many critics of the self-help therapeutic community confuse the fundamental difference between the ‘authoritarian management’ of people and ‘authoritative management’. Politically authoritarian management would describe an authoritarian system of rule in which people are forced to obey by oppressive and repressive methods. Authoritative treatment implies a hierarchical structure of leadership » (Bratter et al. 1985: 492). Ottenberg (1982) indicated the dangers resulting from the combination of hierarchical structures and authoritative forms of government. One ‘charismatic’ leader may then take the most arbitrary decisions.

In the therapeutic communities for children, the residents were given certain responsibilities concerning the organization of the institution. At the beginning of the 20th century, Lane applies the principle of self-government for the first time very seriously with adolescent delinquents (Bridgeland 1971). Several authors remark that this ‘self-government’ had in the first place a pedagogical purpose. « Being given responsibility for some parts of the school organization or activities altered children's perception of themselves. It gave them a feeling of worth and this too contradicted previous feelings about themselves » (Laslett 1995:7). Yet it was evident that the staff took their own decisions when managing the school, since the « staff made no secret of the fact that they reserved some aspects of the school management for themselves, chiefly in matters which were regulated by law » (Laslett 1995:7).

At first sight Dederich adheres to a form of self-government. « It gives our people a chance to learn about political manoeuvering, elections and the like, but it has little to do with the major policy decisions » (Yablonsky 1967:78). Addicts are regarded by Dederich as children who have to go through an entire process of education. But Dederich is also the law.

Drug-free therapeutic communities have had to face the fact that « some elements of their organizational structure, methods of organization, and even stated purposes » may at first sight appear
to be similar to those of certain cults. The European TC for children and adults does not face this problem, since it is inherent to psycho-analysis to permanently question authority. It can be considered as an example of good practice if the community meets daily, in order the various residents can speak about their experiences and feelings. Nothing is wrong with singing together or physical activities. Significant events can be noted with special celebrations. In some cases, it can be reasonable to forbid residents to leave the community ground without permission. Another example of good practice is when older residents members function as role models for younger residents. However, in case one is expected to “act as if”, i.e. act as if one is fully convinced even though one’s conviction is still tentative, or to cope with learning experiences such as wearing signs, we should carefully examine the motives, objectives and practices and observe the limits, location and exercise of power. Only if the communities are open to permanent questioning, we will be able to distinguish between education and indoctrination, between cults and therapeutic communities and between charismatic and contained leadership. If residents are the protagonists of their own life, if older residents identify with the problems of younger residents in order to look for common answers and if staff members act as facilitators instead of conductors, we come close to profound solutions. The creation of standards and the adoption of ethical codes by the Therapeutic Communities of America (T.C.A.) and the World Federation of Therapeutic Communities (W.F.T.C.) is a promising evolution. They set limits to the authority and activities of leaders and assume practices, which respect the safety and basic rights of the individuals in treatment (Ottenberg, 1982: 152-170).

Self-help vs. Professionalism

The drug-free therapeutic community originated from the AA-movement and should thus firstly be considered as a self-help group (Mowrer 1976). The history of the TC for children shows that the pioneers had a variety of occupations, but they were mainly teachers. In many cases, the TC for children refers to a system of self-learning. The teacher can only be a facilitator, a counsellor helping during the process. To a certain extent one may regard the ‘Northfield Experiments’ as self-help groups. The army takes care of its soldiers and hopes they will become of use again. It was Bion’s intention « to recruit his
patients into the battle against neurosis, confident that once this enemy had been delegated they would take their own responsibilities with fresh vigour» (Harrison & Clarke 1992:699). Yet the counsellors are professionals (doctors, analysts such as Bion, sometimes also teachers such as H. Bridger), but they remain soldiers first.

Was the drug-free therapeutic community influenced by professionals? In the time of Synanon it probably was not, but in the development and operation of the drug-free TC, it certainly was. W.B. O’Brien (Daytop) was a priest, D. Casriel (Daytop) a psychiatrist with an analytical training, M. Rosenthal (Phoenix House) a psychiatrist and J. Densen-Gerber (Odyssey House) a psychiatrist and lawyer. When the drug-free TC originated in Europe, it was even more clearly developed by professionals. As a psychiatrist M. Kooyman (Emiliehoeve) was best suited to lead therapy groups actively. In Belgium the drug-free TC was set up by two orthopedagogues who were also actively involved in the therapy: E. Broekaert (De Kiem) and J. Maertens (De Sleutel).

When we look at the European drug-free TC now, we probably will find a majority of professionals (social workers, psychologists, pedagogues, etc.) in it. In the United States the drug-free TC has a less ‘professional’ character, but a lot of added therapies, such as psychodrama, family therapy, bonding therapy, etc. are included in the program. More and more the idea is growing that with ‘dual diagnosis’ of mental illness and drug dependence, a psychiatric assessment is necessary and that scientific research can offer therapeutic support.

**Psycho-analysis vs. Behaviourism**

The therapeutic community for children and adults is characterized by an outspoken influence of psycho-analysis. W.R. Bion, H. Bridger and M. Jones were analytically trained (cf. supra). Various pioneers like Lane, Shaw and Neill tried to practise the functions of psychotherapist and manager at the same time, but many experienced sooner or later that this did not work.

Some admitted outspokenly they belonged to a certain school. J. Bierer talks as follows about Adler: «I am eternally greatful to a very great man, whose greatness has never been properly acknowledged» (Bierer, 1977:3). Others wished in no way to belong to a certain school. Neill writes to Reich: «I was a friend who loved you, who recognized your genius and also the little man in you,
but I never was a Reichian who accepted all you said and did» (Neill 1983:24). Sometimes they questioned their own analysis, such as Maxwell Jones: «I had a very unsatisfactory analytic training with Melanie Klein who thought I was a lousy analysant» (Jones 1984b:115).

In 1988, the mutual viewpoint of 10 therapeutic communities for children was rendered in «A Healing Experience». They describe the long-term residential approach mainly as ‘psychodynamic’. «Its aim is to give children and youngsters insight, both individually and as a group, into how their early experience has taken control of their lives» (The Peper Harow Foundation 1988:10).

The drug-free therapeutic community reacts against this ‘insight’, «because ‘insight’ produces introspection but not necessarily behavioral change» (Bratter et al. 1985:478). «Rather than to accept the psycho-analytic orientation which attributes the causes of heroin addiction to early-life deprivations and unconscious factors, the therapeutic community assumes that drug-related behaviour is a function of choice» (Bratter et al. 1985:473). Now this choice is combined with taking responsibility within the concept, not with avoiding it through an experience during childhood which may lead to excuses.

The therapeutic community is then brought under the denominator ‘operant behavioral conditioning’.

This behavioural conditioning has, however, little to do with a Skinnerian-mechanistic view. According to Bratter et al. (1985:479), it rather has to be situated in the American humanistic tradition. The group therapy, the encounter and the Synanon games all want to be humane. «In this intense form of small group interaction, many ‘square’ friends of Synanon find they are better able to comprehend their ‘existence’ as a side effect of exploring facets of themselves, their relationships to others and their own human values in the Game» (Yablonsky 1967:V). D. Deitch (1984:22) postulates that «the humanistic psychology movement (Maslow, Pearls, Rogers, Moreno and disciples of the European Community Movement) found in it an embodiment of their ideals and aspirations».

The link between the TC and humanistic psychology is also shown in the similarity in thinking with A. Maslow. Maslow, the humanistic psychologist who developed the concepts of levels of personal needs and self-actualisation, describes the TC as an educational institution: «The lessons of Daytop are for education in the larger sense, of the learning to become a good adult human being» (O'Brien
1993:261). Maslow also regarded the direct emotional confrontation as a token of respect for being (Maslow 1967).

This American humanism and its relation to behaviour, is also found with D. Casriel, who played an important role in the development of Daytop and the American TC (Casriel 1976:4). « By its nature, Synanon consisted of nothing but character-disordered personalities ». « Character-disordered personalities become disconnected from their deepest-level emotions. Psycho-analysis invariably is unsuccessful with them, chiefly because transference cannot take place ». « My group process involves the re-education of what I call ‘Triangular Man’. The ABC’s are Man's Affect, Behaviour and Cognition » (Casriel 1976:5). Here Casriel adheres to the great tradition of humanistic psychology to be a third way, which next to analysis and behaviourism reaches out for man in his given situation, as he lives and experiences.

The behavioral approach which characterizes the drug-free TC is strongly opposed to the idea of punishment and mechanistic influencing. As the TC for children reacted against punishment, so are the ‘learning experiences’ and the hard encounters in the drug-free TC tokens of mutual ‘responsible concern’. « The American self-help therapeutic community is an integral part of the revolution against the punitive trend » (Bratter et al. 1985:493).

**Concept vs. Social learning**

From the beginning of the drug-free TC, the ‘concept’ of the TC which is closely linked to the ‘values’ of the community, has played an important role. In The Tunnel Back, Yablonsky (1967:56) already describes ‘the concept box’ : "On file in it were about three hundred concepts. Emerson, Freud, Thoreau, Nietzsche, Lao-Tse and Russell were some of the names I noticed".

Through the relation with the AA movement and the Oxford groups, the influence of the ‘Rearmament Movement’, with a return to fundamental Christian values, was of great importance (Broekaert & van der Straten 1997; Broekaert et al. 1996).

This philosophy was adopted to a certain extent by Daytop and has spread beyond. It is symbolized in a text by Richard Bauvais : « Those nineteen lines are about the closest thing we have at Daytop to a written manual for life » (O'Brien 1993:100).
Until now it is assumed that the accentuation of the TC values contains the revival of the TC. But in a therapeutic community, the expectations towards everyone go further than ‘do no harm’. They go back to the Maximal Value, Love, which is characterised by wanting the best for the other one. It thus concerns investing in the other one, being active within one’s growing process, being benevolent and solidary (van der Straten 1997:94).

In the TC for children the living and learning together will determine the moral formation (Bloch 1973).

Maxwell Jones emphasizes the social learning, which he describes as follows: «By the process of social learning I mean two-way communication in a group, motivated by some inner need or stress, leading to overt or covert expression of feelings, and involving cognitive processes and change» (Jones 1984a:33). Jones links the concept directly with the ‘Gestalt theory of learning’ of Ellis and emphasizes here the importance of psycho-analysis and ego psychology (Jones 1968). He does not attempt to teach values or concepts which are determined beforehand. They rather grow from the mutual learning and the mutual confrontation.

It is striking how many similarities exist with the description of R. Bracke of the current trends within the encounter of the drug-free TC. He states that the encounter becomes more and more a learning process between individuals: a two-way confrontation for the confronter as well as the person confronted. With the ‘two-way confrontation’, in which he who confronts is also emphasized, safety and acknowledgement of attitudes, behaviour as well as feelings, emerge. But most of all we should not underestimate the importance of the group which experiences this two-way confrontation, which is an adjustment of 'behaviour' as well as 'insight'.

CONCLUSION : THE “NEW” INTEGRATED THERAPEUTIC COMMUNITY?

Without question some marked differences have distinguished the two main branches in the TC. The first has been characterized as democratic, influenced by psycho-analysis, with emphasis on social learning and a large role for professionals and situated in a ‘planned environment’, which is also a therapeutic environment. The second type is hierarchical, conceptual and behaviouristic, emphasizing the self-help concept and basing much of the therapeutic intervention on the ‘encounter group’.
Venerable authors in this field have not hesitated to stress the differences: De Leon (1995a:16) writes that « although the name ‘therapeutic community’ evolved in these hospital settings, there is no clear evidence of any direct influences of the Jones’ TC on the origins and development of addiction TCs ». Bratter et al. (1985:466) add that « the American self-help residential therapeutic community, in contrast to Jones' professional model, is part of the self-help movement. ‘Therapeutic community’ refers to a residential program which not only utilizes recovered persons as the primary agents of change, but also subscribes to a specific philosophy that applies learning principles to the treatment process».

On the other hand, there are the prophetic words of Maxwell Jones (1984b) himself, who warns us not to over-emphasize many dissimilarities. « There is a growing tendency to view more objectively the differences between the ‘democratic’ model of therapeutic communities (TCs) and the ‘behavioral’ or ‘concept’ model of TCs as it applies to the treatment of drug and alcohol addiction. It may be that a more generic concept of TCs will emerge that integrates some of the characteristics of both models, and especially the concept of social learning » (Jones 1984b:29)

This growing tendency is no doubt in debt to American and European pioneers who brought the American drug-free therapeutic community to Europe in the early seventies. Even though the Europeans were eager to implement the American approach, it was clear that differences in culture and the background and tradition of treatment would require changes to the concept.

The Europeans never rejected psycho-analysis totally. They were afraid of hierarchical systems with their potential for uncontrolled charismatic leadership. And as well-trained, traditional professionals they found it hard to accept the hard confrontation techniques, like the shaving of heads, harsh 'learning experiences', the wearing of signs, etc.. Despite this, the overwhelming influence of the American culture and technology opened the way for network approaches and systemic thinking. This systemic approach created a kind of bridge between the traditional European TC for children and adults and the European drug-free TC closely linked to the American model. Both Jones and Bridger, important contributors in the development of the TC for children and adults, were attracted to systems theory: "If we had a really good basic training in behavioral sciences, and particularly systems theory, I think much of our confusion might be lessend" (Jones 1984b:115).
Bridger, as a member of the Tavistock Institute, always describes the TC in terms of systems. He sees the TC ‘as an open system’, but more outspokenly ‘as a living organism’ (Bridger 1984:56). Currently, R. Hinshelwood (1999:41) who researched the influence of psycho-analysis on today’s work in the European TC for adults confirms this tendency, "but most TCs explore the importance of systems theory". The same is true for the drug-free TC on the European continent: The traditional drug-free TC had to make way for a new, open TC (Broekaert, Kooyma & Ottenberg 1998). The drug-free TC is more and more part of multi-modal treatment centers, which provide various residential and ambulant programs. Currently, this is not only shown in the great importance of family therapy, but also in the development of treatment-networks. Here the accent lies on ambulant care and aftercare, even in close contact with other forms of relief, such as methadone prescription.

This tendency towards networking is accompanied by another interesting observation. Most drug-free TCs in America as well as in Europe expand their approach to new target groups: the drug-free TC extends its actions strongly towards children, psychiatric patients, prisoners, immigrants and homeless persons (De Leon 1997).

According to De Leon (1995a), the evolution of the TC is most clearly expressed in the adaptation of the model to specific target groups and in specific settings. This was the origin of TCs for adolescents, addicted mothers and their young children, incarcerated drug addicts, mentally retarded drug addicts, substance abusers with (other) psychiatric disorders, etc. (De Leon 1997). With any of these special groups, the basic values of the TC itself were unaltered. Brown et al. (1996) describe such a TC for addicted mothers and their children, which in fact is a comprehensive treatment program for the mothers and their children, based on TC principles (self-help, drug-free perspective, living in a community, participating in groups, etc.).

In the United States, the classic TC-model made way for a TC-modality which consists of "a wide range of programs serving a diversity of clients who use a variety of drugs and present complex social-psychological problems in addition to their substance abuse» (De Leon 1995a:6). At the same time, staying close to their tradition, the European TCs continued their work in specialist communities for chaotic personalities, schizophrenics, prisoners, children and adolescents (Campling & Haigh 1999).
All of this leads to a certain common knowledge: the first step for integration with respect to diversity.

In the editor's introduction to "Prison communities" (Woodward 1999:162) we read: "This chapter covers the development and structure of TCs within the British prison service, including the three new concept TCs for drug abusers". This type of hierarchical TC is much more common in America, where it is a mainstream treatment for drugs and alcohol. We can also notice convergences in the therapeutic approaches. Social learning is fully accepted in Europe as well as in the United States. The concept of dialogue and responsibility becomes of primary importance if we look at R. Haigh's (Haigh 1999) contribution on "The quintessence of a therapeutic environment" and concentrate on his 'Therapeutic community principles'. We notice reality confrontation as well as permissiveness and safety along with empowerment. It is one of the many examples of possible extensions of dialogue.

Abundant evidence shows that the TC created in Europe, which we have called the TC for children and adults, and the American-grown model - now adapted to European needs- which we designate the drug-free TC, are on converging pathways. We believe this reflects a growing -and insistent- need for flexibility required to keep pace with the rapidly changing world. Having access to strong features that have characterized and distinguished these two TC-models, offers the possibility of future combined models that may prove more useful than the differentiated approaches we have used up to now.

REFERENCES


