Beyond the “black box” of the Therapeutic Community: A qualitative psychoanalytic study

Virginie Debaere

Promotor: Prof. dr. Stijn Vanheule

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General introduction

This general introduction outlines some basics of the Therapeutic Community (TC), in particular, how this long-term community approach has come into being in response to shortcomings in addiction treatment and mental health care. The main findings and shortcomings of past TC research are presented and the subsequent need for qualitative process research in order to teach the principle of this insufficiently understood treatment model is explained. In the second part of this introduction, we emphasize the importance of studying the interrelation between the TC approach and TC residents' process by means of a qualitative psychoanalytic approach. Finally we present the research questions addressed in this dissertation and give an outline of the chapters included.

The Therapeutic Community: An outcast in today's (mental) health care field

A *Therapeutic Community* or a *TC* is a place where a long-term residential group-approach is organized to address people that suffer from severe conditions, such as substance addiction, generalized personality dysfunction, psychosis as well as difficult and disturbed children (e.g. De Leon, 2000; Fees, 1998; Haigh & Lees, 2008; Hinshelwood, 2001; Werbart, 1992). Typically, in TCs interpersonal relations and group dynamics that arise in a purposefully designed social environment are used as a tool for social and psychological change (Bion & Rickman, 1943). Therefore, a TC is also called a "24 hour living/learning milieu" (Whiteley & Collis, 1987, p. 21), whereby "the community is the method" (De Leon, 2000). Unlike group therapies where individuals come together for a number of group sessions or activities, in a TC the time in between the more formal meetings is equally important to the therapeutic project. In other words: the TC community is both *the setting* as well as *the method* that facilitates change (De Leon, 2000).

While TCs for different target groups apply slightly different approaches and technical language, they obviously share a certain fundamental philosophy (e.g. Haigh & Lees, 2008; Vandevelde & Broekaert, 2003). In all TCs, residents follow a long-term community based approach, which means that residents live together in a home-like environment and share the responsibility for both their treatment process and the entire household (De Leon, 2000; Glaser, 1981). TCs do not comply with a disease-oriented view on presenting problems; mental suffering is not understood as a medical condition that should be diagnosed and cured according to an organic conception of health and disease. The administration of medication such as psychotropic drugs or opioid substitutes is not considered as a treatment for the problem at stake (e.g. De Leon, 2013; Nye, 2003). On the contrary, TCs encompass the social and interpersonal aspects of human life, psychopathology *and* treatment: "Service models such as the therapeutic community (…) were formulated largely with an understanding of the therapeutic potential of social interaction" (Priebe, Burns, & Craig, 2013, p. 320). However, in different TCs, the component of social interaction is differently organized and the way in which this leads to change is quite differently understood.

In this dissertation we focus on the *drug-free*[1] TC model. In these TCs, approximately 25[2] detoxified individuals live together 24/7 in a structured way in order to promote identity change and a drug-free life (Broekaert, Vandevelde, Soyez, Yates, & Slater, 2006; De Leon, 2000). While the prevailing disease-oriented view considers substance addiction as a *chronic relapsing brain disease* and the addicted person as a victim unable to control his or her actions (Leshner, 1997, 2001; Uusitalo, Salmela & Nikkinen, 2013), TCs adhere to a *person oriented view* where addiction is considered as being a consequence of psychological and interpersonal problems that the person has to deal with (De Leon, 2000). In the TC, the residents' main activity is their job function in a rotating[3] hierarchical structure: for instance, they work as kitchen assistants, leaders of the kitchen or cleaning crew, or even coordinator of the TC. Staff members in the drug-free TC mostly supervise the functioning of the self-governing peer group, but they do not initiate the therapeutic process. The immediate accountability of TC residents contrasts sharply with the way patients are approached in the mainstream health care system, what De Leon (2013) has described as "the management of the disease by means of medication." TC residents' responsibilities/privileges not only concern their job in the TC, but also to the progress in their therapeutic process of change. Apart from their job-related activities, residents attend therapeutic groups, eat together, and spend the little spare time they have together as well. The way TC residents are supposed to interact with each other is largely guided by a number of values and norms (e.g. no drugs, no violence, honesty, help each other, etc…). This steering of the residents' (inter)personal behavior is often explained in terms of the 'right living': residents must 'act as if' they already abide to the 'right living' - a changed drug-free lifestyle - with the older residents being the 'role models' (De Leon, 2000). When residents fail to follow all values and norms, they are confronted by fellow residents. The approach and process has been defined in several ways, as a developmental process or a behavioristic approach (De Leon, 2000; Perfas, 1994). Most descriptions remain very general, such as "the TC treatment consists of all interactions among staff members and clients that comprise the social environment" (Paddock, Edelen, Wenzel, Ebener, & Mandell, 2007, pp. 537-538), or "the TC model has emphasized a

[1] The drug-free TCs are also called 'concept-based,' 'hierarchical,' 'behavioral,' 'programmatic,' 'addiction' or TCs for substance abusers (Haigh & Lees, 2008; Goethals, 2013).

[2] This average stems from the European TCs; in the US, the number of residents can be much bigger (Vanderplasschen, Vandevelde, & Broekaert, 2014).

[3] In this rotating hierarchical TC structure, the TC residents successively occupy several positions (one can start, for instance, as a kitchen assistant, but after several weeks, when the hierarchical structure changes, he/she can become the person in charge of the cleaning team).

reliance on confrontational group therapy, treatment phases, and a hierarchy based on tenure in the program and community roles" (Dye, Ducharme, Johnson, Knudsen, & Roman, 2009, p. 275).

The other major TC type, the *democratic*[4] TC, addresses people with severe personality dysfunction without addiction. In these TCs, people do not function in an exigent structured hierarchy, instead group life evolves in a more spontaneous way. Next to the 'democratization' principle, which means that all members are given equal power in decision making affairs, the 'permissiveness' in a democratic TC basically means that all the group members should tolerate from one another a wide range of behaviors that might seem deviant from ordinary standards (Rapoport, 1960). The way in which social interaction leads to change in these TCs is differently explained. It is assumed that living together in the community will lead to social situations where the person experiences problems that are parallel to his or her everyday difficulties outside the TC. "Other patients and staff become players in a person's internal dramas. From the individual psychoanalytic perspective, this is sometimes called a displaced transference" (Parish, 2012, p. 332). The transference-like phenomenon is distributed across several people or even towards the institution itself.

The roots of the TC: In search for an answer to an unsatisfying treatment offer

These drug-free and democratic TCs came into being independently of each other in different places across the world in order to provide an answer to shortcomings in existing treatment approaches (e.g. Glaser, 1981; Haigh & Lees, 2008; Mills & Harrison, 2008).

Many TC publications tell the story of the rise (and fall) of Synanon, the cradle of *the drug-free TC,* which was located in Santa Monica, California (e.g. Casriel, 1963; De Leon, 2000; Goethals, Yates, Vandevelde, Broekaert, & Soyez, 2011). The Synanon-experiment was launched in 1958 by a recovered former member of Alcoholics Anonymous, Charles 'Chuck' Dederich. As the story goes, Dederich believed that in the AA-principles certain elements were missing, and that, for instance, in order to be able to recover, drug addicted people had to be confronted with the way they tended to rationalize their own behavior. In his living room, Dederich started weekly "free association groups" (De Leon, 2000, p. 17). Furthermore, he integrated a structured work program into the therapeutic system. After all, most addicted individuals had no regular

[4] These democratic TCs are sometimes known as 'Maxwell Jones' Model,' 'mental health,' 'psychiatric' or 'flattened hierarchy' (Haigh & Lees, 2008).

work experience (Goethals et al., 2011). Within a year, the weekly meetings expanded to become the first residential community in an old waterfront hotel in Santa Monica (De Leon, 2000; Goethals et al., 2011). In 1959, the organization was officially founded in order to treat substance abusers, regardless of their drug of choice (De Leon, 2000). Despite of the decline of the Synanon movement and its closure in 1991 due to the growing autocratic and aberrant leadership of Dederich (some said he became paranoiac (Goethals et al., 2011)) the basics of this experiment were successfully transferred into the establishment of TCs all over the world (www.wftc.org). Former TC residents typically stood at the cradle of the new TCs, and for decades the transfer of TC customs to new staff members has largely been taking place through word of mouth. This is also how the early European drug-free TCs descended from their American ancestors (Broekaert et al., 2006). It was not until 2000, that Georges De Leon comprehensively documented all aspects of the physical and social organization of the drug-free TC. Since then, his 'red book' is considered the reference text for drug-free TCs.
An important driving force of the drug-free TC movement was that addicted individuals *really* wanted to live a drug-free life and even free from substitute medication, such as methadone. Apparently, this goal was impossible to reach within the existing treatment paradigm in the US in the 1960s: "traditional methods, such as addiction clinics and psychiatric wards, did not cure the drug problems" (Ravndal, 2003, p. 229).

The fact that "TC treatment programs have developed outside of the medical, mental health, and scientific mainstream in response to unmet needs" (De Leon & Wexler, 2009) is also partly true for the inception of the so called *democratic TCs*. Their roots are situated in the UK during the Second World War. This was not down to a plea from the suffering individuals themselves: a limited number of psychiatrists and psychoanalysts felt forced to find new ways of dealing with the amount of soldiers that suffered nervous breakdowns. Instead of seeing these patients for individual therapy, they were put into groups where they were given a limited number of rules and tasks and where decision making became a democratic process (Mills & Harrison, 2007). Several psychoanalysts, such as Wilfred Bion, John Rickman and S.H. Foulkes (who became the founder of psychoanalytic group therapy) were at the foundation of this model in the Northfield Experiments (Bion & Rickman, 1943; Harrison & Clarke, 1992). After spending one day in London with the pioneers of the first Northfield Experiment, Bion and Rickman, the French psychoanalyst Jacques Lacan wrote about his admiration for this innovative method: "I found there the impression of the miracles of the first Freudian steps: to find in a dead end

situation itself the lifeblood of the intervention"[5] (Lacan, 2001 [1947], p. 108). Maxell Jones, a psychiatrist who was unhappy about the biological approach to human suffering has become known as the pioneer of this community based treatment approach (Vandevelde & Broekaert, 2009). To-date, anthropologist Rapoport's (1960) seminal text *Community as a Doctor* is generally referred to in order to explain the method in this TC model. Together with five members of his team, he spent four years working with staff at the Henderson Hospital in Belmont, under Maxwell Jones. Based on this qualitative research experience, Rapoport deduced four principles that make up the heart of the TC life: *democratization*, *communalism, permissiveness* and *reality confrontation.* These principles are explained and further commented in Chapter 4 of this dissertation. In sum, independently of each other and at two different places in the world, therapeutic group mechanisms were invented/discovered to help psychically suffering and addicted individuals.

The TCs' growing need for qualitative process research

Despite of their spontaneous restraint from scientific investigation "Ours is not to wonder why, but to do or die" (van der Straten & Broekaert, 2012, p. 83) in the early days, drug-free TCs had to convince the authorities in the drug treatment field of the usefulness and the effectiveness of their approach: "pressure has been put on the rehabilitation programs – particularly those financed through public funding – to show how many drug abusers in and/or following treatment have ceased to use drugs and commit illegal acts" (Collier & Hijazi, 1974, p. 806). Since the 1980s, European TCs have started to replicate the US outcome studies. The major finding of these studies is that TC residents who have completed the whole TC program show significant improvement in terms of *abstinence/decreased drug use, less illegal involvement* and *increased employment rates* (e.g. De Leon, 1999,2010; Holland, 1983; Vanderplasschen, Vandevelde, & Broekaert, 2014). Remarkable is that only one consistent predictor for success has been found, *'time in program' (TIP)*, what means that the longer a person remains in treatment, "the better the outcome, with treatment completion as the best predictor for success at follow up (e.g. Condelli & Hubbart, 1994; Malivert, Fatseas, Denis, Langlois, & Auriacombe, 2012; Perfas, 2004 ; Vanderplasschen et al., 2013). For instance, up to 90% of the former

[5] "J'y retrouve l'impression du miracle des premières démarches freudiennes: trouver dans l'impasse même d'une situation la force vive de l'intervention".

residents remain clean at a 15-month follow-up measurement after their departure from the community (Dekel, Benbenishty, & Amram, 2004). Nevertheless, TCs typically suffer from a considerable *drop-out rate,* especially within the first 30 days after admission (Goethals, 2013; Gossop, Marsden, Stewart & Treacy, 2002; Kooyman, 1993; Ravndal & Vaglum, 1994). The other remarkable finding is that *no client characteristics* (e.g. gender, age, nature of co-existing pathology, …) have been found that consistently contribute to successful outcome (e.g. Ravndal, 2003).

Thus, while "multiple field effectiveness studies have demonstrated the relationship between retention in TC treatment and positive treatment outcome" (Vanderplasschen, Vandevelde, & Broekaert, 2014, p. 42), the TC model has come under attack in many countries in the northwest of Europe. A general trend towards limiting funding for intensive long-term treatment programs has resulted in the closure and/or imposed length reduction of TC programs (Vanderplasschen, Vandevelde, & Broekaert, 2014). Literature provides several arguments that might have contributed to this precarious situation for the TC model. Next to the ***internal drop-out issue***, which is often used as an indicator of treatment (in)effectiveness, "TCs are overall less effective than other interventions with respect to treatment retention" (Vanderplasschen, Vandevelde, & Broekaert, 2014, p. 10), the TC approach has been challenged by several ***changes in society***. While TCs dominated the addiction treatment field for over 20 years, other treatment approaches have made their presence felt. Medical treatments, such as the prescription of methadone, have taken over the central role in the addiction treatment field (e.g. Fischer, Rehm, Kim, & Kirst, 2005). An alarming evolution has evolved with respect to the harm reduction initiatives that came into being in the 1980s to control the damage posed when the HIV epidemic caused a dramatic number of heroin deaths. In the last years, several countries, including Belgium, have begun to experiment with the daily administration of heroin to individuals addicted to heroin (e.g. Fischer et al., 2002; Metrebian et al., 2001; VAD, 2006). The idea was prompted by the idea that controlled heroin-assisted treatment might be a better option for addicted individuals who are 'resistant' to methadone maintenance treatment, i.e., "because of disappointing results of methadone maintenance treatment" (VAD, 2006). We consider this evolution alarming. For us, these initiatives do not seem to function as 'harm reduction' that offers individuals a way of working on intra- and interpersonal problems, but as treatment finality. The administration of medicine or heroine is in line with the disease-oriented view of addiction that has gained momentum since the 1990s; 'the decade of the brain'

(Courtwright, 2010; Leshner, 1997). As mentioned before, this paradigm disregards the drug-user's responsibility and ability to overcome their dependency, but, on the contrary, it emphasizes a certain immanent fate: "Opiod dependence is considered as a chronic relapsing disorder that leads to increased morbidity and mortality" (Garcia-Portia, Bobes-Bascaran, Bascaran, Saiz, & Bobes, 2014, p. 272). Such a view contrasts sharply the TC's view, which emphasizes the person's ability to tackle intra- and interpersonal problems with the help of others and move on to a sustained drug-free life.

The particular status that *science* has attained as representative of the ultimate truth and thus worthy of vast funding has proven to be another adverse evolution for the TC model. Policymakers emphasize the need to implement evidence-based treatments (EBT) in order to guarantee the success of a given treatment (Autrique, Vanderplasschen, Broekaert, & Sabbe, 2008; Broekaert, Autrique, Vanderplasschen, & Colpaert, 2010). Of course, the founding principle of EBT is acceptable: it aims to integrate research evidence with clinical expertise and human values (Chiesa, 2010). However, the way in which diverse research methods have been ranked into a 'hierarchy of evidence' in terms of the validity of the obtained findings, with higher ranking methods considered to be superior when it comes to evaluating effectiveness, has proven problematic in the context of (mental) health care interventions (e.g. Evans, 2003). As a matter of fact, what is considered 'best' evidence is evidence provided by the so-called 'randomized-controlled trial' (RCT), a research design that came into being to study the effectiveness of pharmacological interventions (Westen, Novotny, & Thompson-Brenner, 2004). Several researchers have pointed to the inappropriateness of this design to study the effectiveness of long-term and complex (psycho)therapy approaches (e.g. Desmet, 2013; Seligman, 1995; Westen, Novotly, & Thompson-Brenner, 2004). Next to their criticisms (such as the ethical objection to assigning people at random to diverse treatment conditions, the impossibility of the double-blind administration of a therapy or control condition, the favor for short-term treatments with mono-symptomatic patients and disfavor for long-term treatments with representative patients) we highlight a further problem related to investigating the effectiveness of *community* treatments with this design. How could one investigate the TC's method, being the '24/7 community life,' the 'living/learning milieu' by means of an experimental design? This led De Leon to remark that "evidence of 40 years observation of change in people through TC treatment is dismissed since it is not of the 'gold standard'" ("Oxford Science Meeting," 2008, p. 15). This difficulty of situating the TC model into the RCT-

design and thus to prove its effectiveness with this highest ranking method is reflected in TC review studies, which frequently conclude that firm conclusions on effectiveness cannot be drawn (e.g. Malivert et al., 2012; Smith, Gates, & Foxcroft, 2006; Vanderplasschen et al., 2013). Such conclusions with regard to the effectiveness of TCs seem to be a consequence of the fact that the way in which knowledge is produced is often more important than the knowledge itself (Parker, 2005).

The final difficulty inherent in the TC approach, and one which intensifies the above mentioned challenges, is the difficulty to ***explain and justify*** the TC approach. TC program characteristics, such as the job hierarchy; the self- and mutual-help principle; the close-knit group life that is for the most part isolated from the outside world; the custom of having one's voice heard in group sessions and so on, can obviously incite TC outsiders to comprehend this treatment as old-fashioned, unprofessional and humiliating or even as a 'boot camp' or sect (Broekaert, Kooyman, & Ottenberg, 1998; Debaere & Stofs, 2012; Yates, De Leon, Mullen, & Arbiter, 2010). The difficulty in understanding what makes up the heart of the TC approach has even become an issue for TC insiders. Since they have been changing TCs to include a broader population of adolescent drug abusers, mothers with children and incarcerated drug-users (De Leon & Wexler, 2009; Gideon, Shoham, & Weisburd, 2010) questions have been raised as to how the TC program can be changed without affecting its effectiveness (Broekaert, Kooyman, & Ottenberg, 1993, 1998). Following De Leon, who states that "Although much is known about *whether* TCs work in terms of successful outcomes, less is understood as to why and *how* TCs work" (De Leon, 2000, p. 5), a demand to explain the 'black box' of the TC by means of qualitative process research has been made by numerous researchers (e.g. Broekaert, 2006; Broekaert, Raes, Kaplan, & Coletti, 1999; De Leon, 1999, 2000, 2010; De Leon & Wexler, 2009; Nielsen & Scarpitti, 1997; "Oxford Science Meeting," 2008; Paddock, Edelen, Wenzel, Ebener, & Mandell, 2007; Ravndal, 2003; van der Straten & Broekaert, 2012). "The need for more qualitative phenomenological research to complement the existing quantitative approach" (Broekaert et al., 1999, p. 21) was one of the main conclusions drawn from a review study that investigated the state of art of European TC research, a conclusion that was reiterated in subsequent review study some years later:

> In process evaluations the main question is what is going on during the treatment process itself, and how the treatment organization and/or atmosphere affects the

> clients. Qualitative data and participant observation are used in an attempt to describe the interaction between client characteristics, treatment interventions, ideology and treatment organization. This kind of approach has often been called 'black box' research because in traditional treatment research what is actually going on is seldom explored (Ravndal, 2003, p. 234).[6]

Qualitative research takes a naturalistic and interpretive approach to investigate an insufficiently understood social reality by maintaining the specificity and complexity of the situation (Denzin & Lincoln, 2011). In this dissertation, we have investigated the insufficiently understood TC change processes using various qualitative research methods in a number of TCs. In line with Ravndal (2003), we highlight the importance of understanding the interaction between the treatment approach (i.e. what Ravndal calls the organization, ideology and intervention) and client characteristics. Additionally, we study clients' process of change. In doing so we mainly rely on Lacanian psychoanalytic theory as an interpretative framework. Within this conceptual framework, the process of identity formation and change is explicitly thought of as related to the way in which drive regulation and gratification are organized. In our view, these are most relevant entries for studying the life-style change the drug-free TC program aims towards.

A qualitative psychoanalytic study

It may seem strange to rely on psychoanalytic theory to study the 'black box' of the drug-free TC, a "therapy [that] differs in many ways from the *traditional* analytic therapy" (Kooyman, 2003, p. 49, italics added). Nevertheless, these drug-free TCs have influenced and have been influenced by psychoanalysts, such as American clinician Casriel (who was for 7.5 years in analysis with Kardiner, a former analysand of Freud). After visiting Synanon, Casriel founded a TC and also began to work with TC-like group sessions in his private practice (Casriel, 1963). Before further explaining our interest in studying how and why TCs work (from a psychoanalytic point of

[6] It is remarkable that this call for 'black box' research was also raised by the democratic TCs: "To a considerable extent the pursuit of the current research agenda is contingent upon the scientific elaboration of the 'black box' of treatment process in the therapeutic community. If links cannot be established explicitly between programme interventions, the course of client change and eventual outcomes, the effectiveness of the therapeutic community-oriented model remains unclear, much less proven. Similarly, understanding the treatment process is critical to retain the integrity of the therapeutic treatment approach in its various adaptations" (Lees, Manning, Menzies, & Morant, 2004, p. 105).

view), we will outline some difficulties in the conceptualization and treatment of substance addiction from a traditional psychoanalytic perspective.

Psychoanalysts' long-lasting struggle with addiction

Substance addiction has been a challenge for psychoanalytic theory and practice for decades (e.g. Aucremanne, 1990; Catteeuw, 2002; Geberovich, 2003; Gottdiener, 2008). The difficulty in actually *conceptualizing* addiction was once even referred to as "disorder in search for a paradigm" (Morgenstern & Leeds, 1993, p. 2). For instance, Le Poulichet (1987) reproaches the hasty way in which addiction has often been equated with existing structures such as: "'the addict is …'a pervert, a psychopath, a melancholic'" (p. 9). A contrasting idea is that the addiction actually makes the subjective structure unclear (e.g. Pirlot, 2009; Dodes, 2004; Geberovich, 2003): "the particularity of addiction should not be looked after at the level of the personality (traits or structure) but at the level of a common psychic functioning ('phobia of thinking') that is in a significant way connected to the addictive behaviors"[7] (Catteeuw, 2002, p. 317). Next to these difficulties in conceptualizing addiction, there are the difficulties in *treating* it from a traditional psychoanalytic approach. Freud was pessimistic about the possibility of helping addicted individuals by means of psychoanalytic techniques as he saw the administration of chemical substances (i.e. drugs) as the most effective solution to avoid suffering and to find satisfaction: "the most interesting methods of averting suffering are those which seek to influence our own organism (…) The crudest, but also the most effective among these methods of influence is the chemical one – intoxication (…) [they] directly cause pleasurable sensations ; and they also alter the conditions governing our sensibility that we become incapable of receiving unpleasurable impulses" (Freud, 1961 [1929], p. 78). More recent writings underscore Freud's early idea: "Psychoanalysts and addicted individuals mismatch because of the fact that they seldom meet" (Aucremanne, 1990, p. 27, our translation). When an addicted individual does meet a psychoanalyst, treatment problems are mostly related to the question for help and the expected course of treatment. Addicted individuals don't tend to ask for help, and when they do, it is usually to denounce the failure of the hitherto 'successful solution' and/or because

[7] "La particularité de l'addiction ne serait pas à rechercher au niveau de la personnalité (traits ou structures) mais au niveau d'un mode de fonctionnement psychique commun ('phobie du penser'), associé de façon significative aux conduites addictives."

of its serious consequences: debts, complaints from family members, physical deterioration, potential imprisonment …

Mental suffering or questions related to the motives for taking drugs are usually not formulated by addicted individuals themselves (e.g. Debaere & Stofs, 2012; Le Poulichet, 1987): "With addicts, there is avoidance of language"[8] (Magoudi, 1986). Indeed, addicted individuals don't tend to speak, a feature that has been characterized with the terms "a-diction," "de-verbalization," "absence of mentalization" and so on (e.g. Catteeuw, 2002; Hopson, 1993; Jeammet, 1995; Loose, 2002). These descriptions indicate an inhibition in or avoidance from the psychic/emotional life and language (Catteeuw, 2002). This of course runs counter the principle of free speech in traditional psychoanalysis, which hinders the development of a transference relation – also referred to as "toxic narcosis, narcosis of the transference"[9] (Decourt, 2004) – and to a problematic treatment course (e.g. Debaere, 2014; Jeammet, 2000; van den Hoven, 2008).

Despite the above mentioned controversy to grasp addiction within psychoanalytic thinking, in the next part, I will discuss how substance addiction has been conceptualized within Lacanian psychoanalytic theory on identity formation and drive regulation.

Why Lacanian theory?

As indicated above, in our view, it is most relevant to study the functioning of TCs starting from Lacanian psychoanalytic theory. In contrast with the disease-oriented view, both the TC perspective and psychoanalytic theory see addiction as a *symptom* of other problems:

> New admissions to the TC will commonly be asked by others "What is your problem?" Their usual reply "Dope, I shoot dope" is invariably countered with "That is your symptom, not your problem" (De Leon, 2000, p. 39).

Both frameworks also share the *ethical position* that the person is responsible for his/her acts and also emphasize practitioners' own therapeutic journey: all practicing psychoanalysts are supposed to have been through their own personal analysis, and the staff members of all drug-free TCs generally comprise ex-users who have completed a TC program themselves. A further point in common is the topic of *identity change*, which is - along with the drug-free lifestyle – the

[8] "Chez les toxicomanes il y a évitement du langage."
[9] "Narcose toxique, narcose du transfer."

main objective of a TC treatment (De Leon, 2000). Lacanian theory is first of all a conceptualization of identity formation and change in the context of the way drive regulation and gratification is organized (e.g. Lacan, 2001 [1947]; Verhaeghe, 2004; Vanheule & Verhaeghe, 2009).

Identity formation and drive regulation: not without the Other

At the beginning of life, no humans have an inborn identity, they are born in a helpless state due to a lack of motor coordination and the primitive organization of their libidinal life. This "premature" state necessitates the intervention of others to survive, to regulate inner drives and to develop an idea of who we are. Figure 2 shows the way Verhaeghe (2004) presents the fundamentals of this process. The starting point is a not-yet-thinkable *too much – experience* that is situated at the level of the body, that is unpleasurable, and that is referred to as the *need, arousal* or *drive,* represented here as (a).

The expression of this meaningless somatic need (e.g. by screaming) necessitates the intervention of the Other, represented as $\mathbb{A}$ (from the French word 'Autre'). In its conceptualization, the Other is multiple and simultaneously refers to (1) significant others (i.e., *persons*), (2) the symbolic order of *language* that lays the foundations of one's being (through the words of primary caretakers), and (3) a *symbolic law* that bridles immediate drive gratification. A paradigmatic example is that the early caregiver not only *undoes the need* by offering food and cradling the crying child, but that he/she at the same time mirrors the child's experience *by offering words* (e.g. "our little honey is so hungry today...!").

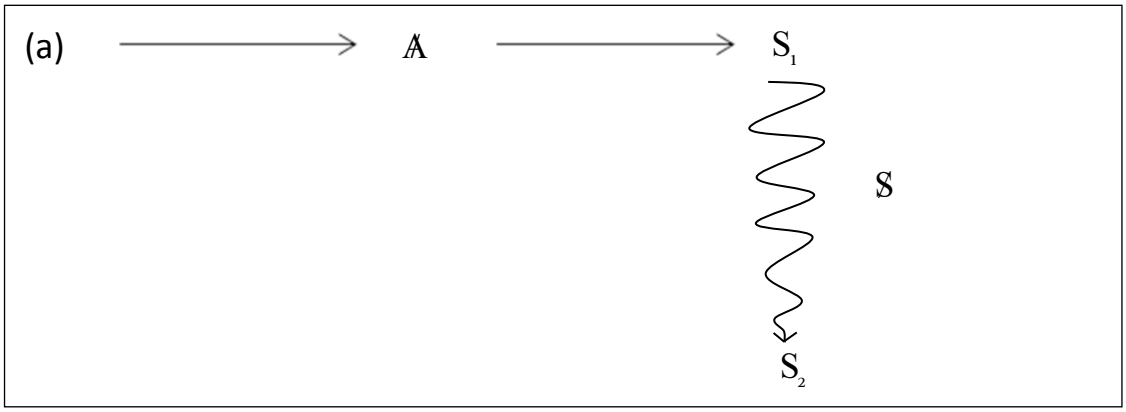

Figure 2. The interrelatedness of identity formation and drive regulation based on Verhaeghe (2004).

A further step is that children learn that the environment *does not always satisfy or permit the immediate satisfaction of needs*. Yet, through the obtained psychic, symbolic framework people become capable of regulating inner drives by themselves. In Lacanian theory, it is said that *identity formation* and *drive regulation* are two sides of the same coin that both come into being in relation to *the Other* (Verhaeghe, 2004). The ongoing process of identity formation is presented by the movement from S_1 to S_2, which represent signifiers or language components that are the building blocks of our identity. Quite similarly, in mentalization theory, it is said that *mentalizing* internal experiences enables us to *regulate affect and distress* (Choi-Kain & Gunderson, 2008; Fonagy, Gergerly, Jurist, & Target, 2002).

Although man's dependency on the Other is indispensable, at the same time, it also makes up the structural drama of humankind. The 'response' of the Other necessarily falls short because of the incommensurability of both systems involved: the drive can never be fully captured within a narratively structured reality, it is said that 'the Other is lacking,' which is represented by the bar through the $\mathbb{A}$. The price we pay is the experience of *lack*[10]*,* that is structural to our self-experience and that is represented as the divided subject, $\mathbb{S}$. Put differently: a primordial *somatic experience of excess* becomes experienced as a *lack in interpersonal relations* because of the indispensable detour via the Other**.**

Substance addiction as a 'successful' disconnection from the Other

While the Lacanian structures 'neurosis,' 'psychosis' and 'perversion' are understood as different manners of *dealing with* the lack in relation to the Other, substance addiction is understood as *annihilating* the lack or as *dis-connecting from* the lack in the Other (e.g Fernandez, 2010; Freud, 1961 [1929]; Le Poulichet, 1987; Loose, 2002; Magoudi, 1986; McDougall, 2004). Addicted individuals "erase in action the category itself of the boundary"[11] (Ginestet-Delbreil, 2004, p. 361). Drug use is a complete different way of regulating drives, i.e. by an immediate relation to the real product: "Drugs comes in the 'tear' encountered in the relation to the Other, or in the Other"[12] (Aucremanne, 1995, p. 50). Demand and desire are short-circuited, lack does not function (anymore) as motor of desire. The administration of chemical

[10] This structural lack of humankind is beautifully told in the children's books of Shel Silverstein *The missing piece* (1976) and *The missing piece meets the Big O* (1981).
[11] "effacer en acte, la catégorie même de la limite"
[12] " La drogue vient dans la 'déchirure' rencontrée d'avec l'Autre , ou dans l'Autre"

substances annihilates whatever tension or lack, which led le Poulichet to conclude that actually "addiction *is* a substitutive treatment" (Le Poulichet, 2011, italics added). In contrast to neurotic symptoms that represent (in a disfigured way) a conflict from within the social bond, by which this conflict is kept at a distance, substance addiction offers the possibility of functioning outside that social bond. Eventually, this simply leads to side-lining the Other, as Oury explained:

> It is as if the drug has replaced the other in an artificial way, the big Other with a capital O as well as the other, (…) as if the drug has come to occupy this privileged place in order to condense in itself the whole dimension of the Other, of the other persons (…) (cited in Magoudi, 1986, pp. 8-9, our translation).[13]

Freud had already pointed to that possible independence from others as the most dangerous aspect of using chemical substances: "We owe to such media not merely the immediate yield of pleasure, but also a greatly desired degree of independence from the external world (Freud, 1961 [1929], p. 78). In Figure 3, we present this disconnection from the Other by putting the Other, and hence, the whole process of identity- and symptom formation, between brackets, which illustrates the far reaching consequences to the human's life. In addiction, the Other is not so much radically lacking, but put between brackets; the Other is 'anesthetized.'

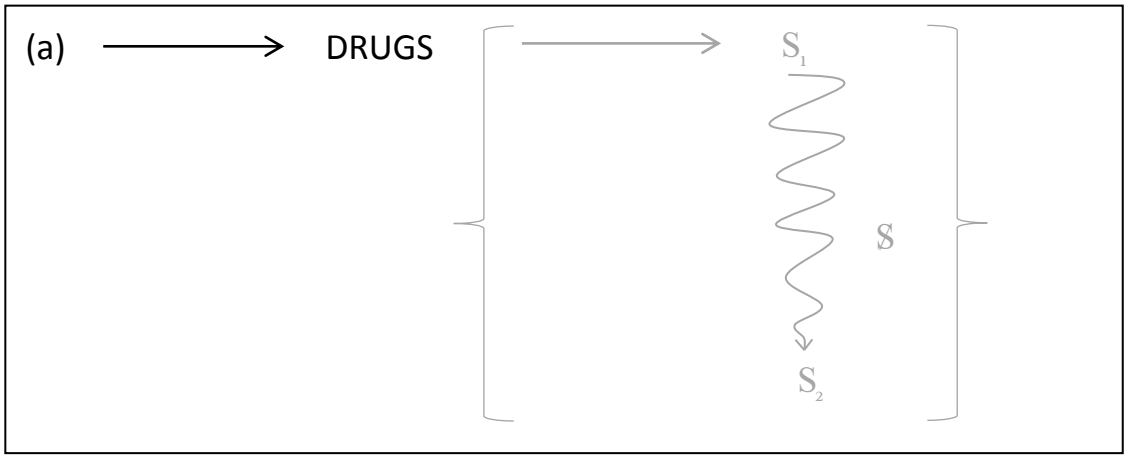

Figure 3. The consequences to people's identity and drive regulation process when they are addicted to substances.

[13] "C'est comme si la drogue remplaçait d'une façon artificielle l'autre, aussi bien le grand Autre avec un grand A que l'autre, l'alter … comme si la drogue venait prendre cette place privilégiée de condenser en elle-même toute la dimension de l'Autre, d'Autrui, des autres. "

As a result, these individuals' way of functioning falls back to a simple process: every psychic appeal is transformed into a somatic need (McDougall, 2004). The rise of meaningless somatic arousal - the (a) - becomes (once again) the heart of the problem that is time and again annihilated by consuming. They have become 'slaves of a quantity': "Sometimes, I don't know whether I am sad or angry, whether I am hungry and whether I want to make love; that's when I start to drink." (McDougall, 2004, p. 513). This condition is also reflected in people's detached way of using language (which we commented on above) and in the growing dis-connection between the individual and the internalized law. The consequences of the 'bankrupt' Other are illustrated in the famous story of the thirteen year old *Christiane F* (2001), who became a full blown heroin addict in the 1970s in Berlin. The next two fragments illustrate how interpersonal relations and interest in life in general had fallen into decline:

> To look up people out of friendship, that's not a thing to do for a junkie. First of all, because he cannot feel that much for someone else. But especially because he is all day on his way to find money and dope, having no time for something like that. [14] (p. 137)

> At a given moment, it is true that a junkie is interested in nothing else. Then he no longer belongs to a group. [15] (p. 147)

Along with the fading out of social life comes the down-grading of the (internalized) law:

> Old junks (…) those people really didn't have a shred of morals or ethics left. They beat their inject fellow down with a stone against his head when they were ill and when they needed a shot. [16] (p. 147)

Thus, starting from the idea that substance addiction is chiefly characterized by a disconnection from the Other, several psychoanalysts have suggested adapting the traditional psychoanalytic

[14] "Mensen opzoeken uit vriendschap, dat zit er voor een spuiter niet in. In de eerste plaats omdat hij niet zoveel gevoel voor een ander kan opbrengen. Maar vooral omdat hij de hele dag op pad is om geld en dope the versieren en echt geen tijd heeft voor zoiets."
[15] "Op een gegeven moment is het zo dat een junkie zich nergens meer voor interesseert. Dan hoort hij ook niet meer bij een groep."
[16] "Oude junks (…) Die lui hadden echt geen greintje moraal of geweten meer over. Die sloegen hun spuitmaat gewoon met een steen tegen zijn kop als ze ziek waren en een shot wilden."

treatment approach to work with addicted individuals (e.g. Catteeuw, 2002; Geberovich, 2003; Jeammet, 2000). Yet, our objective is to look from this perspective at an already existing treatment reality, that of the drug-free TCs, and in a second step, to compare these findings with the democratic TC approach.

Research question

This dissertation aims to investigate the ' black box' of the process of change in the TC by means of several qualitative research designs carried out in three different settings. Starting from people's lived TC experience and by relying on a Lacanian psychoanalytic framework, we aim to gain further insight into TC residents' process of change and its interrelatedness with the treatment approach.

Overview of the next chapters

Chapter Two presents a *participant observation study* in the drug-free TC *Trempoline*. The researcher fully immersed herself in the TC peer group for three weeks with the status of resident. Such full participation is considered being one of the best methods to understand the complexity of an insufficiently understood social reality (Howitt, 2013). Apart from the observational data, the "hands on" experience provides an extra type of knowledge that cannot not be obtained through mere observation and/or questioning people.

Chapter Three reports on the TC residents' process of change by means of two systematic single-case studies (McLeod, 2011). In order to study the process that residents go through during their TC stay, we followed all incoming TC residents in the drug-free TC *De Sleutel* for one calendar year. The data gathered for this in-treatment follow up consisted of *multiple individual interviews* and of the administration of the *Inventory of Interpersonal Problems* (IIP-32) (Horowitz, Alden, Wiggins, & Pincus, 2000) at four moments. From the subgroup of participants who had remained in the TC until moving on to the re-entry house, we selected the cases of Simon and Andrew: Simon had been offering rich material from the first interview onwards and Andrew's evolution showed profound changes, such that we could finally interpret his process as an example of a successful process of change.

In Chapters Four and Five, the process of change and the outcome was investigated by questioning former TC residents by means of *focus group interviews* and *individual interviews*. In Chapter Four, former residents of a democratic TC, *de evenaar*, were questioned. The study presented in Chapter Five addresses former residents of the drug-free TC *Trempoline* – i.e. persons who had been part of the TC peer group that the researcher also belonged to for the participant observation study. The focus group interviews and semi-structured individual interviews started from two main questions: (1) “Did you change because of the TC treatment? If so, in what way?” and (2) “How did your stay in the TC contribute to this change?”

Finally, Chapter Six comprises a general discussion in which the findings of the different studies are integrated. Clinical, theoretical and policy relevance is discussed as well as limitations of the included studies and directions for future research.

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2

Beyond the “black box” of the Therapeutic Community for substance abusers: A participant observation study on the treatment process

Therapeutic Communities (TCs) for substance abusers are an effective recovery oriented treatment for residents who finish the program. Over the years, the TC approach has been challenged by changes in society and by new perspectives on treatment. Moreover, the therapeutic process that takes place in TCs is barely understood or documented, often referred to as the ‘‘black box’’ of TCs. In order to gain insight into this process, there is a growing demand for qualitative research. This chapter presents the findings from a participant observation study in a Belgian TC. The researcher fully immersed herself amongst the residents of a TC peer group for three weeks. By interpreting naturalistic participant observation data through psychoanalytic theory on addiction and mentalization, the process of change is discussed. It is argued that the TC program challenges former substance abusers in terms of problems they have with affect regulation. This process is understood in terms of a growing ability to manage disturbing affective experiences in a more mentalized way. The frustrating and holding TC environment together with the TC tools provide the condition and techniques to make this process manifest. Limitations of the study and suggestions for future research are discussed.

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Introduction

Therapeutic Communities (TCs) for substance abusers are drug-free home-like environments where people with addiction live together in a structured way in order to promote identity change and enhance the possibility of a drug-free life in society (Broekaert, Vandevelde, Soyez, Yates, & Slater, 2006; De Leon, 2000). In response to more traditional mental health care settings, such long-term group programs emerged in the late 1950s in the US as self-help groups run by ex-addicts for ex-addicts (Glaser, 1981; De Leon, 2000; De Leon & Wexler, 2009; Rosenthal, 1989). Today, TCs can be found all over the world (http://www.wftc.org). Whereas the prevailing perspective on addiction considers it as a chronic brain disease, and the addicted person as a victim unable to control his or her actions (Leshner, 1997, 2001; Uusitalo, Salmela & Nikkinen, 2013), TCs distance themselves from such a *disease oriented* view. Instead, they adhere to a *person oriented view* and consider addiction to be a consequence of psychological and interpersonal problems that the person has to deal with (De Leon, 2000).

In the TC, physically detoxified individuals live together 24/7 in a rotating hierarchical structure[1], where they occupy one of many job functions, such as kitchen assistant, maintenance crew, crew leader, department head or even coordinator of the TC itself. The position residents occupy depends on their progress in the treatment; they are considered a 'new,' 'older' or 'old' resident. These positions also determine their respective responsibilities and privileges. Apart from their job functions, TC residents attend therapeutic groups, eat together, and spend the little free time they have together as well. The way in which they interact with each other is regulated by explicit expectations (e.g. no violence, honesty, help each other, etc…). While staff members in the TC supervise the functioning of the community, they do not initiate the therapeutic process (De Leon, 2000).

In the early 1980s, independent studies began to investigate the TCs' treatment outcomes. Since that time, it has been demonstrated that former TC residents show less drug abuse and antisocial behavior, and that their employment rates increase (e.g. Holland, 1983; Lees, Manning, & Rawlings, 2004; Yates, De Leon, Mullen, & Arbiter, 2010). More recent studies have also indicated positive outcomes, such as improvement in psychological functioning and well-being (e.g. Polimeni, Moore & Gruenert, 2010; Vanderplasschen et al., 2013). Remarkably,

[1] George De Leon's *The Therapeutic Community: Theory, model and method* (2000) is seen as the definitive reference text for drug-free TCs, where all aspects regarding the physical and social organization of a drug-free TC are described in a comprehensive way.

until now only one factor has been found to actually predict success at the end of the treatment, namely, 'time in program.' The longer residents stay, the better the outcome. Treatment completion is therefore the most predictive factor for success at follow up (e.g. Malivert, Fatseas, Denis, Langlois, & Auriacombe, 2012; Vanderplasschen et al., 2013). However, early drop-out is one of the main problems reported in TCs.

Next to this internal TC problem, over the last few decades, the TC research agenda has been challenged by changes in society and by new perspectives on treatment. To meet the demands of a changing population, such as adolescent drug abusers, mothers with children and incarcerated drug abusers, TCs have started to adapt their programs (De Leon, 2000; De Leon & Wexler, 2009; Gideon, Shoham, & Weisburd, 2010). These changes have brought forth questions concerning the extent to which the program could be modified without affecting its efficiency (Dye, Ducharme, Johnson, Knudsen & Roman, 2009) and safeguard its formula for success (Broekaert, Kooyman, & Ottenberg, 1993, 1998), thus prompting TC managers to operationalize and describe the essential elements of the TC from the point of view of the staff (Melnick & De Leon, 1999). Nevertheless, descriptions of such essential elements do not sufficiently explain the therapeutic process that takes place in the TC to outsiders and to agents of other treatment modalities. Moreover, this complex treatment approach is hard to explain in terms of the contemporary discourse on mental health treatment. Indeed, in the latest conference of the World Federation of Therapeutic Communities, Kurth (2012) remarked: "TCs have no counselors, TCs have no clients: how can you get funded when the subsidizing bodies talk in terms of counseling hours for clients?"

There is a pressing demand to explain the TC community approach in a more detailed way. De Leon states that "[a]lthough much is known about *whether* TCs work in terms of successful outcomes, less is understood as to why and *how* TCs work" (2000, p. 5). This lack of understanding has been referred to as the 'black box' of the TC (Broekaert, 2006; De Leon, 1999, 2000; Lees, Manning, & Rawlings, 2004; Nielsen & Scarpitti, 1997; Paddock, Edelen, Wenzel, Ebener, & Mandell, 2007; Ravndal, 2003). In order to explain the treatment process, various theoretical[2] frameworks have been put forward, the one gaining most popularity being social learning theory (e.g. De Leon, 2000; Jones, 1968). However, crucial aspects of the TC approach, such as the absence of all drugs, the separation from the world outside during the first few months of the treatment, the intense daily schedule and the many TC tools (Broekaert et al.,

[2] For an overview of other theoretical explanations, see De Leon (2000).

1993, 1998; Dye et al., 2009; Melnick & De Leon, 1999) are not taken into consideration within this theoretical framework.

The need to gather further insight on the so-called 'black box' of the TC has prompted a growing need for qualitative research on *all* aspects of the TC method. (Broekaert et al., 1999; De Leon & Wexler, 2009; Lees, et al., 2004; Ravndal, 2003; van der Straten & Broekaert, 2008). In this respect, naturalistic data could provide useful information about the interaction between the treatment program, the residents' process of change, and the outcome, based on the assumption that a meaningful connection between those parameters exists (e.g. Werbart, 1997). While, Scandinavian researchers have pioneered qualitative process studies in TCs, the majority of this work has only been published in their local language. For this reason, their findings have rarely been considered important in international research (Ravndal, 2003).

This paper presents the results of a participant observation study carried out by the first author, VD, who fully immersed herself in a Belgian TC with the status of resident. This in-depth experience revealed a relation between the atmosphere in the TC environment, the application of TC tools and the residents' process of change. The data indicate that a TC succeeds in tackling the disruptive affect-regulation of addicted people by triggering their mentalizing capacity. Below we outline the theoretical framework that inspired the data analysis of this study, which draws from psychodynamic literature on mentalization.

Mentalization points to "the way humans make sense of their social world by imagining the mental states (i.e., beliefs, motives, emotions, desires and needs) that underpin their own and others' behaviors in interpersonal interactions" (Choi-Kain & Gunderson, 2008, p. 1127). The starting point of this seemingly self-evident ability goes back to early infancy: "By mirroring the internal states of the child (…) the caretaker helps the child to solidify an understanding of an internal experience that he is only dimly aware of initially" (Choi-Khan & Gunderson, 2008, p. 1129). Children learn that the environment does not always permit the immediate satisfaction of their needs and learn to bear the frustrating absence of the primary caregiver, as they can *imagine* and *think* that she will come back. Thus, mentalizing internal experiences enables us *to regulate affect and distress* (Choi-Khan & Gunderson, 2008; Fonagy, Gergerly, Jurist, & Target, 2002).

However, this ability appears to be problematic in contemporary clinical pictures. The problem has surfaced in psychotherapy literature where patients are depicted as dealing with tension in a non-mentalized immediate way (e.g. De Wachter, 2012; Fonagy et al., 2002;

Verhaeghe, 2004). They attack their own body to soothe themselves (e.g. drug use, self-harm, starvation etc…) or they act out overwhelming affect in an aggressive way. Clinicians that work with people with addiction have noted similar problems. Their overwhelming affective experiences have also been attributed to difficulties in labeling and symbolizing feelings, referred to as their 'a-diction,' 'de-verbalisation,' 'hypo-symbolisation,' or, in other words, their problems in mentalization (Freda, 1992; Hopson, 1993; Loose, 2002 ; McDougall, 2004; Olievenstein, 1989; Wurmser, 1974).

Method

Participant observation in a TC

In order to gain further insight into the black box of the TC, the first author, VD, fully immersed herself in the peer group of a TC called *Trempoline*, a highly respected TC in the French speaking part of Belgium that is often used as a trainee post for staff members from other TCs (http://www.trempoline.be). VD is a female who was aged 32 during her stay in the TC. She is a clinical psychologist, trained as a psychoanalytic therapist and she is currently completing a PhD on how TCs work. She has never personally suffered from addiction.

The director of the TC suggested that the author live amongst the TC peer group for three weeks, nonstop, and then come back for two more weeks as a staff member. At her arrival, all residents were informed that she was a researcher who wanted to be part of the group to learn more about how a TC works.

Following Howitt (2013), direct participation in a misunderstood social situation is one of the best ways to understand its complexity. Immersion in a culture transforms the researcher into an instrument of data collection, which facilitates the discovery of in-depth data. Apart from collecting observational data, further knowledge can be acquired through 'hands on' experience (Madill & Gough, 2008; Stiles, 1993). Numerous participant observation studies have been carried out in TCs in the past, where researchers have observed and interviewed residents and staff. However, to the authors' knowledge, researchers have rarely subjected themselves to the program itself (e.g. Foster, Nathan & Ferry, 2010; Mello, Pechansky, Inciardi, & Surrat, 1997; Nielsen & Scarpitti, 1997; Ravndal & Vaglum, 1994).

In the TC used for this study, group life is based on *explicit expectations* on how to interact and how to verbalize inner feelings and thoughts. This expectation had far-reaching implications for

the participating author: as a new resident, VD was never left alone and from the very first day she was accepted as part of the group. This experience contrasts sharply with what is usually noted as an obstacle in participant observation studies, i.e., difficulty integrating into the group due to numerous taken-for-granted assumptions that are unknown to the researcher (Jorgensen, 1989).

The analytic process

The all-embracing nature of the TC program had further implications for the analytic process (Howitt, 2011; Jorgensen, 1989). VD's recording equipment was taken from her upon her arrival and she was permitted very little free time to take notes due to the exigent daily schedule. The data set thus included field notes on personal experiences, thoughts and feelings, observations and discussions with fellow residents, reflective notes and pieces of writing that were part of the actual treatment (e.g. Encounter Slips and Talking To Notes, discussed below in the results section). When the author returned home, all of the written notes were transcribed onto 50 A4 pages.

The analytic process started inductively, as the researcher did not know in advance what she was going to observe during her stay in the TC. Step by step, the experiences in the TC directed her attention to theory on mentalization and affect regulation (e.g. Fonagy et al., 2002; Lecours & Bouchard, 1997; McDougall, 2004). The analytic process proceeded by moving back and forth between data and theory within a constructivist approach, by formulating tentative analytic ideas, re-examining the data in the light of those ideas, and so forth (Guba & Lincoln, 2005; Howitt, 2013). This process was regularly discussed with both co-authors, who are clinical psychologists and trained psychoanalysts. During this process, the researcher discerned *a difference between the new and the older residents.* Comparing the observations of both groups revealed TC residents' growing ability to deal with disruptive affective experiences in a more mentalized way as the common theme of their process. In order to find out how and why this process manifests in the TC, other types of data were examined. *The researcher's lived experience* revealed particular aspects of the TC atmosphere that could explain why this process can begin in a TC. Moreover, the numerous *pieces of writing and group sessions (i.e., the TC tools)* were seen as ways to facilitate residents' ability to verbalize affective experiences, that is, as techniques that activate the mentalization process. After presenting the preliminary findings of this study at the 13th conference of the European Federation of Therapeutic Communities

(EFTC) in September 2011, several TC managers[3] and TC residents expressed their agreement with this analysis. Below we report the findings of this study. For reasons of confidentiality, the names of the TC residents have been changed and the date that the participant observation took place is not mentioned.

Findings

As shown in Figure 1, three steps in the process of residents' growing ability to mentalize affective experiences were identified. The first step; *Addicted people don't feel* (1), points to the drowned emotional life of people who have recently become clean. The second step; *their drowned emotional life awakens* (2) by living in the TC environment. Finally, the third step; *their mentalizing ability develops* (3) by making use of the TC tools. In order to grasp why this process starts to happen in the TC, the TC environment and the TC tools were taken into consideration. It appears that to revive the residents' drowned emotional life, the TC is first and foremost a *frustrating environment*, as well as a *holding* environment (A). The latter is in place to ensure that residents can sustain the frustration aroused and remain in the TC. In order to verbalize their affective experiences instead of acting them out, residents are encouraged to make use of the *TC tools* (B). The three steps of the TC process (1, 2, and 3), and the dimensions of the TC environment and the TC tools (A and B) are further illustrated below with accompanying data.

'Addicted people don't feel' (1)

Several residents talked about their drowned emotional life at the beginning of their stay. Melvin explained his difficulties recognizing his experiences in terms of affects as follows: "When I arrived in the TC and someone asked me how I felt, I was looking dazed ... I didn't have a clue! I knew the words 'anger' or 'sadness,' but I couldn't distinguish between those feelings within myself." Another resident, Jacob, commented: "When I arrived here, I didn't feel anything." This is how Fabian explained the emotional life of addicted individuals and his hope to make this known to a broader audience: "You'll probably be able to teach the outside world

[3] E.g. Steve Walker (director of The Ley Community, Oxford), Stuart Plant (department coordinator of Phoenix Futures, Oxford), Krysztof Krysta, (Secretary of the Federation of Therapeutic Communities of Central and Eastern Europe), Daniel De Angelis (director of Una Nueva Oportunidad, Argentina), Holly Robinson (staff member of the Royal College of Psychiatrists' Centre for Quality Improvement, London) and Chris Lemaitre (responsible of TC De Kiem, Belgium).

something more about 'us,' that we're just normal people who are sad, but who have pushed it away because it was too hard to bear."

The anaesthetized emotional state of new residents seems to underlie the reasoning behind the frustrating nature of the TC environment, that is, to revive the residents' dead emotional life.

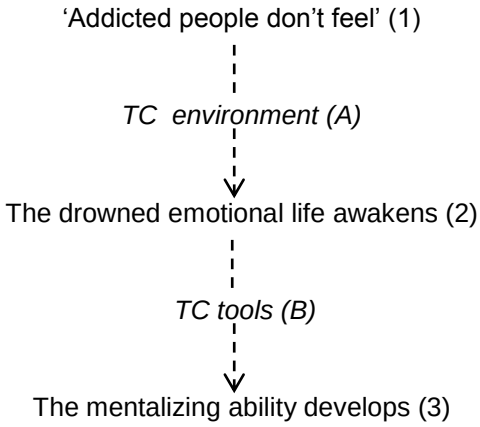

Figure 1. The figure illustrates three steps in the TC residents' growing ability to mentalize affective experiences (1–3) by taking into consideration the function of the TC environment (A) and the TC tools (B).

The TC is both a frustrating and a holding environment (A)

Frustrating environment

TC life deprives the residents of their habitual modes of satisfaction and their habitual modes of dealing with problems, which was a striking experience for the researcher:

> *I wasn't allowed to read a book, I couldn't text friends. I was tired of getting up at 6.15 a.m. and working all day, but I couldn't go to bed before 10.30 p.m. – in a small bedroom that I shared with three female residents. I couldn't listen to music, surf the internet or watch television as I wished. I missed my chocolate bars and a hot bath, there was no tea, only coffee, I couldn't spend private time in the bathroom to relax: I had 15 minutes to take a shower and get ready!*

Next to the absence of all drugs and alcohol, TC life is organized in such a way that it causes more frustration, as exemplified with this daily schedule based on the personal notes of VD:

> *As an assistant of the kitchen, I get up at 6.15 a.m. to start in the kitchen at 6.30 a.m. I share the responsibility of feeding the community - 35 persons - with three fellow residents. We reside in the kitchen from 6.30 till 7.30 a.m. and after breakfast, from 8.00 till 12.15 a.m. After a short 'cigarette break', we have dinner from 12.30 till 13.00 p.m. After a 30 minutes break, we do the dishes. From 14.00 until 15.30 p.m. we have an Encounter Group and then another 30 minutes break to recover from the emotions … At 16.00 p.m. we return to our kitchen till 18.15 p.m. After a ten-minute cigarette break, we gather together at 18.25 p.m. to have supper at 18.30 p.m. We wash the dishes from 19.10 till 19.30 p.m., then Evening Reunion until 20.45 p.m., take a shower in 15 minutes and finally we do the evening routines in the house (watering the plants, feeding the cat, emptying the ashtrays, …). At 21.40 p.m. we gather together to have some free time from 21.45 till 22.30 p.m. and then go to our bedrooms where the lights go out at 23.00 p.m.*

One remarkable finding was that the researcher rarely observed situations where residents actually *gave expression* to their frustration. However, this fits with the expectation that TC residents refrain from venting their frustration and deal with it by means of the TC tools only (see below). Nevertheless, at one moment Diana got fed up with the 'frustrating' TC regime. She had come to this Belgian TC from a foreign country some months earlier and suffered homesickness, wanting to phone her family as much as possible. However, in the TC you cannot make phone calls whenever you want to; as with any wish, it must be negotiated and approved by fellow residents (who are temporarily placed in a higher rank in the hierarchical TC structure). Moreover, it takes several days to get response to your request. Diana was pleased because she had been able to schedule a phone call to her parents from 22.00 until 22.10 p.m. Unfortunately her parents did not answer the phone within this ten-minute window and Diana was upset because it would require the whole process to begin again, and thus take several days to be able to call again.

These examples show that the TC is a frustrating environment that triggers affective experiences. However, there is also a certain risk in doing this with the target group, since their

habitual way of dealing with overwhelming affect was to take drugs, as Benny explained: “Previously, when I wasn’t well, I would run into the street to stop a car to get enough money for drugs!” Thus, to make sure that the residents *stay* in this frustrating environment, the TC is simultaneously a safe and caring place where they feel at home.

Holding environment

As mentioned above, VD felt part of the peer group from the beginning of her stay. She noticed that many residents got along with each other in a pleasant way. They referred to the TC as their 'home'. Similarly, older residents who came back from a weekend outside the TC, talked in terms of 'coming home'. Besides the fact that the TC is a very homely setting, the atmosphere of *physical and psychological safety* is a decisive factor in making people stay and feeling at home. We distinguish three aspects necessary to create this safety: the absence of stimulants, being cut-off from the outside world and the clear-cut rules of conduct.

The absence of stimulants. Many precautions are taken to guarantee the absence of all stimulants: contact with drug-using friends and/or family members is forbidden and incoming residents and their luggage are meticulously inspected:

> *A new resident, Tom, has arrived. My peers think he is drugged and up to smuggling drugs into the house. It creates a very tense atmosphere. When asked about it, Tom denies the accusation. In order to attain clarity, staff members inspect his luggage and bedroom, while Tom is kept alone in a room, away from the group. He eventually admits that he brought drugs into the house and is ordered to leave the TC immediately.*

The residents themselves are resolute on the necessity of this rule in order to deal with distressing experiences in a different way.

Being cut-off from the outside world. TC residents are isolated from the world outside during the first months of their stay, as VD found out the day she arrived in the TC:

> *I was asked to hand over my money, bankcard, cell phone and car keys till the end of my stay. I was body searched by a female staff member. Then she went through my luggage: recording equipment was put behind bars. For goodness’ sake … how will I be able to gather research data?!*

The residents experience this isolation as helpful. Many have been involved in illegal activities and have made enemies. This made them nervous about acts of vengeance in the outside world, as Anton explained. Most of the residents have lived on the streets or entered the TC from jail. Indeed, Jerome told the researcher that he actually started consuming drugs in jail, where they were provided by prison guards. Inside the TC, residents are kept away from drug users and are temporarily relieved from difficult family situations. There is no need to fear for their life they have easy access to food, shelter and clothing. All this helps them to focus on themselves, the peer group, and the demands of the TC program, a condition for a therapeutic process to commence.

The clear-cut rules of conduct. Before coming to the TC, many of the residents would have done anything to get money to buy drugs, as Anton explained: "To be addicted? That's the only thing that counts. We lie, we cheat, we swear on the head of our child to get the money to buy drugs. Anyway, anyhow." Entering a TC puts a full stop to this erratic lifestyle: residents commit to taking care of themselves, their peers and their house, they are expected to be honest and to disclose things about their intimate self; they bear responsibility for their own treatment and that of their peers. New residents learn these rules from their peers, as VD did: "On my very first day, after getting up from the table, a peer asked me to put my chair under the table; later that day I was asked to close the door behind me."

These explicit expectations are experienced as an external reference system to attune residents' attitude and interpersonal interactions. It makes the conduct of others predictable and makes it possible to live together peacefully. If someone violates a rule[4], other residents fall back on this system to reprimand the person. It is important to note that the TC law is employed in a *democratic manner*: residents as well as staff members are subject to the same rules and all are allowed to reprimand offenders (see TC tools (B)).

[4] Violation of rules is also *expected* in the TC: it provides the material for the residents' therapeutic work. There is zero tolerance, however, for transgressing the cardinal rules, as this is considered a direct threat to the physical or psychological safety of the community. Such cardinal rules include "(1) no physical violence, threats of physical violence or intimidation against any person, (2) no drugs, alcohol or related paraphernalia, and (3) no sexual acting out, including romantic or sexual physical contact" (De Leon, 2000, p. 224).

The drowned emotional life awakens (2)

One day, when VD was finishing a request to obtain a free hour to take notes, Jacob speculated that her request was going to be rejected: “They do everything to make you feel frustrated, angry or sad - until you can’t do otherwise but start talking or deal with it in group.” Jacob hit the nail on the head, one cannot remain unaffected in a TC, as VD felt:

> *Diana remarked in a determined way that my bed wasn’t made up properly and as a result of that nobody was going to be allowed to take a cigarette break. And the day before I was putting my clothes in the closet at 10.45 p.m. when Emily asked me to stop doing that since lights go out at 11.00 p.m. and that I still needed a shower. She was wrong, I already took my shower**… !** I felt angry and alone.*

Moreover, you cannot hide your discomfort from the others. At first, VD was ashamed when she discovered that her private confessions had been shared with the others:

> *I had written on my evaluation form (a piece of daily writing addressed to James, my TC brother) that I had felt agitated in the kitchen because the music was so loud and I disliked the songs. But ... I wasn’t aware that my inner life was going to be passed on through the TC structure to our coordinator Owan. During the Evening Reunion, he addressed me on that subject; I felt embarrassed! But it was not meant to make fun of me: all residents have issues with each other, but they are supposed to speak up at once, and to address the other in a well-mannered way.*

Although TC life causes discomfort and interpersonal conflict, TC residents are *not* allowed to take drugs, to shout or fight, to chat on the internet or retire to their bedroom. In other words, they are *not* allowed to run away from their discomfort or to apply defenses that bypass social relationships. Nor are they supposed to bear the tension endlessly, but expected to address the other in a respectful way and to talk it over. Since this is not an easy thing to do, they learn to make use of the TC tools to deal with displeasing experiences in another way.

TC tools to transform affective tension into words (B)

TC residents use specific TC tools to translate affective experiences into spoken words and writing. We will illustrate the most frequently used ones: the Emotions Board, Encounter Slips, Talking To Notes and the Encounter Group.

From her first day, VD was invited to put her nameplate in the most appropriate box of the Emotions Board as illustrated in Figure 2. Her TC sister Emily explained the purpose of this tool: "to visualize our state of mind and the dynamics of the group, and to be attentive to each other".

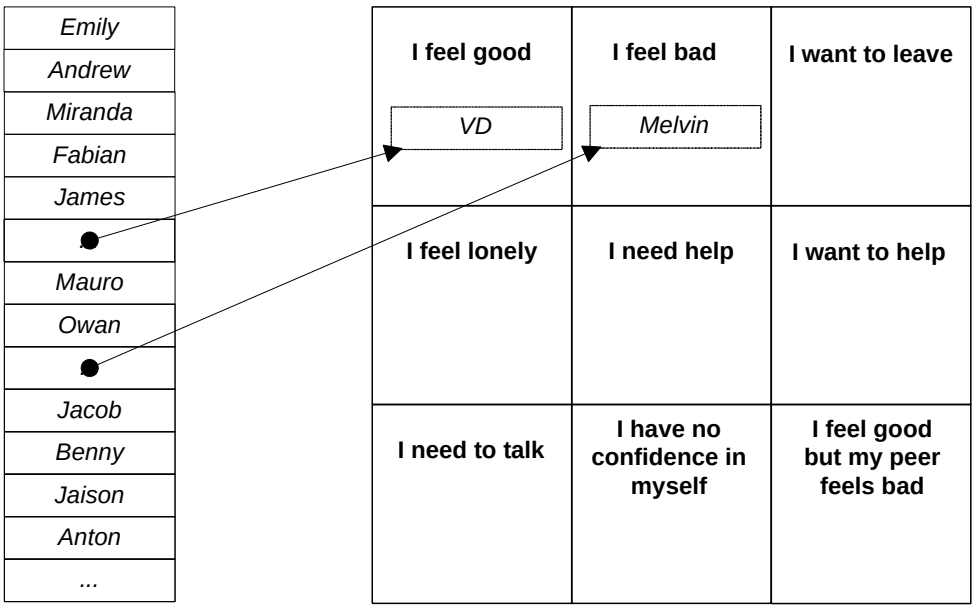

Figure 2. The emotions' board is a tool to visualize the TC residents' state of mind.

We assume that it is the interaction between the explicit expectations and the application of the TC tools that determines the therapeutic strength of the TC, as illustrated by the interplay between the Emotions Board and the explicit expectation to help each other: "Melvin had put his nameplate in the box that says 'I feel bad.' During dinner, I notice that Mauro, an older resident, sat down next to Melvin to talk to his younger peer."

Another tool is the Encounter Slip. VD was told to use this tool when she was struck by an emotional experience, to take distance from it by putting it into words. These tools are used

to word specific or more global moods, to address a single person, yourself or the entire group, as shown in Figure 3:

Date	06 / 11 / xxxx	ENCOUNTER SLIP
From	Jorge	
To	Mauro	
Situation	When we play football, and you don't want to listen to what I am telling you, … I don't feel heard by you !!!	
Feeling	anger	

Date	08 / 11 / xxxx	ENCOUNTER SLIP
From	James	
To	Jorge	
Situation	When I see that you are close with Mauro, it makes me sad.	
Feeling	sadness	

Date	09 / 11 / xxxx	ENCOUNTER SLIP
From	James	
To	the group and the members of staff	
Situation	When I have to stay here and tolerate all of you just because I can't limit myself while consuming: it frustrates me!!	
Feeling	frustration	

Figure 3. Examples of Encounter Slips.

Using this tool prevents the immediate discharge of tension by being aggressive or running away, and so on. Moreover, TC residents are not free to decide whether or not they make use of these tools, they are *required* to do so, as VD observed: *"*Emily is not writing enough Encounter Slips. A staff member gets angry with her because she stays on the surface of things. She is therefore obliged to write five Encounter Slips today, otherwise she won't get her cigarettes."

The next tool, the Talking To Note, aims at helping *the other* instead of yourself. When a fellow resident is not behaving according to the TC values and norms, one can write a Talking To Note, as illustrated in Figure 4. Next, the note is discussed with a member of staff to make sure

that the purpose is justified. Then, the offender is confronted with three fellow residents. One of them explains the observed situation, the second one confronts the person by expressing anger or disappointment, and the third one offers support by referring to the TC values and norms.

Date	01 / 11 / xxxx, 9.45 a.m.	TALKING TO NOTE
From	Daniel, Jorge, Andrew	
To	Christopher	
Situation	You get up late, you don't attend the meeting.	
Aim	to respect the daily schedule	

Date	01 / 11 / xxxx	TALKING TO NOTE
From	Miranda, Andrew, James	
To	Daniel	
Situation	You spit on the floor, you have been confronted before but you continue.	
Aim	to respect the others and your environment	

Date	05 / 11 / xxxx	TALKING TO NOTE
From	Tyler, Jacob, Jorge	
To	Andrew	
Situation	You continue to threaten Daniel, it gets worse.	
Aim	to control yourself	

Figure 4. Examples of Talking to Notes.

On her second day, VD was the object of a confrontation. According to a fellow resident, she remained at too much of a distance instead of sharing personal experiences with her peers. Since she was not allowed to talk about it for one hour after the confrontation, she became fully aware of the difficulty of enduring an affective tension. Besides the typical acting out behaviors, people have many more subtle ways of avoiding uncomfortable tension, for instance by playing the victim, by rationalizing, or – as she was inclined to do – by trying to justify their actions. However, since she had to keep quiet for an hour instead of explaining things immediately, she

was in great distress. Afterwards, fellow residents came to her and she was able to talk about her personal life, which helped her become part of the peer group.

However, Encounter *Slips* are not the definitive solution for very distressing situations; as explained by Emily, Encounter *Groups* are set up to "offer an emotional space to confront one another which enables us to discover our own difficulties through the relation with the other." When someone wants to work in the Encounter Group, he/she starts by describing the event that upset him/her (anxious, angry, sad, …) after which he/she tries to feel[5] the emotion again as well as possible. From then on, a staff member stimulates the resident to *put into words* everything that comes to mind, as is illustrated in the fragment below:

> *Mike sits in front of one staff member that he wants to confront and takes off: "When I arrived, you told me to change my personal bank account into a bank account at this TC, because that's the way things are done here[6]. I do not want to do this!" Mike didn't want to cancel his personal account; the request to do so made him go berserk. He felt inclined to leave the TC. Then, he expresses his anger towards a staff member. Next to that, the other staff member assists Mike in exploring the meaning of that particular situation:*
>
> *staff:* *Why is giving up your account so terrible for you?*
>
> *Mike:* *Not to be able to have a safety exit!*
>
> *staff:* *Has this happened to you at other times in your life?*
>
> *Mike:* *Yes!*
>
> *staff:* *What has been so terrible about it?*
>
> *Mike:* *To be faced with inescapable facts, to be taken just like that.*

By attending the Encounter Groups, VD became aware of the fact that the day-to-day situations that trigger the most emotionally charged feelings and conflicts are those that are related to

[5] In other group sessions, such as the bio-energetic group, residents attempt to trigger their own emotions by first expressing vehemently the words of the emotion, for instance: "I am angry! I am angry!! I am angry!!!" as if the triggering of an emotion by expressing it in a particular way actually realizes the emotion.

[6] The reason why new residents are asked to change their bank account has to be understood as another aid to recovery, by diminishing easy access to money to buy drugs. When residents are having a hard time during the treatment, they have more chance of staying and continuing their process when they do not have easy access to money.

marked situations in the resident's personal life. Underlying feelings such as anger, indignation or sadness are transferred to a new person if the external circumstances are fitting. Therefore, the Encounter Group can be thought of as the place in which these conflicts and transferences are explored and worked through.

The mentalizing ability develops (3)

With step (1), we illustrated how TC residents described their drowned emotional life at the beginning of their stay. For example, Melvin remarked: "When I arrived in the TC and someone asked me how I felt, ... I didn't have a clue! (…)." Yet this statement is part of a longer comment in which he explained how he became increasingly aware of different emotions and, later on, of his ability to connect these emotions to meaningful situations:

> *(…) I knew the words 'anger' or 'sadness,' but I couldn't distinguish between those two feelings within myself. I was able to after a while, but then I still didn't have a clue about the reasons for feeling that way, which took more time to find out.*

VD, the researcher, also experienced the program as a challenge to her ability to mentalize affective experiences. This was most striking when she experienced personally difficult moments, or when peers confronted her with something of which she had been unaware. For instance, on one occasion VD was criticized by other residents of being too distant, which was something she felt uncomfortable with because she *knew* that she was supposed to share her personal experiences. After becoming emotional because of this confrontation, she started to think about the reasons why it had been so hard to take the first step and linked this experience to former situations in her life. A second example started with an evening reunion, during which Jacob remarked that VD worked very hard in the kitchen, and suggested that it was her way to release tension. At first, this interpretation made her angry because she did not agree. Yet, it kept her busy. Because of the rules of the TC she was not supposed to respond and start explaining things right away, but to think about it. Consequently, she started to reflect on the reasons *why* she had been working so hard in the kitchen, and to make connections with other domains where she had been doing her best and from where this came.

Discussion

In order to gain insight into the so-called 'black box' of the TC, the first author of this study fully immersed herself in a TC peer group. By interpreting the naturalistic data collected through psychoanalytic theory on addiction and mentalization, light is shed on the interaction between the problems with affect regulation in addicted individuals, the TC environment and its tools, and the residents' process of change. This process of change is understood in terms of a growing ability to deal with affective experiences in a more mentalized way. The frustrating and holding TC environment and the TC tools stand out as the conditions and techniques that facilitate this process. We believe that our analysis makes the TC program more transparent to the agents of other treatment modalities, to psychotherapists, and to the TC residents themselves.

Problems with affect regulation in people suffering from addiction have been discussed in psychoanalytic literature in the past decades (e.g. McDougall, 1984; Rado, 1933; Wurmser, 1974). Substance abuse is interpreted as a way of coping with difficult affective states, and as a means of 'self-medication' (e.g. Khantzian, 1997). Substance abusers experience affect in an undifferentiated and somatic way. They are unable to articulate feelings and have a tendency to act out, hence the characterization of their problem as 'hypo-symbolization,' 'a-diction' or 'pathology of the act' (Geberovich, 2003; Loose, 2002; Wurmser, 1974).

As mentioned above, disruptive affect regulation has been studied thoroughly in psychoanalytic literature. Yet the role of affect dysregulation and the lack of mentalization in addiction have only surfaced in recent research (e.g. Cheetham, Allen, Yucel, & Lubman, 2010; Soderstrom & Skarderud, 2009). Our study is a further contribution to this new research domain, as our findings reveal that a drug-free TC explicitly works with residents' problems with mentalization, though it has not been theorized that way. This is best illustrated with Melvin's explanation of his process. His numbed emotional life at the beginning of his stay developed towards a growing awareness of affective experiences that he was at first unable to differentiate. Later he became more aware of different emotions that he was at first not able to link to personal experiences, which was the next step in his process. The way Melvin explained this process is illustrative of his growing "mentalization as referring to a general class of mental operations (…) which specifically lead to a transformation and elaboration of drive-affect

experiences into increasingly organized mental phenomena and structures" (Lecours & Bouchard, 1997, p. 858).

Two TC dimensions are of vital importance in making this process happen. First, the TC is a *frustrating* environment where residents are deprived of their habitual ways of gaining satisfaction and discharging tension. This reminds us of a fundamental principle in all upbringing and of a working principle in psychotherapy. To become a social being, we distance ourselves from the immediate satisfaction of basic needs. This educational achievement of the TC program has also been noted by former residents, who "often refer to their program as the place where they 'grew up' rather than where they recovered from addiction" (De Leon, 2000, p. 28). In a psychotherapeutic process, the individual's creation of substitute satisfactions delays psychic labor and allows him/her to stay away from problematic/traumatic issues that need to be worked through. The frustration required to make therapy work has been conceptualized by Freud as the 'abstinence principle' (1919). Clinicians after him extended its application by forbidding patients to undertake pleasant activities during therapy, which resulted in a faster progress (e.g. Ferenczi, 1919).

However, such intense sensations are precisely what made people relapse (e.g. Hopson, 1993). The reason why TC residents choose to *stay* in this drug-free environment is because it is a *holding environment*; it is a safe and caring place where they feel at home. The term holding environment stems from infant psychology and refers to the full environmental provision of safety and trust by early mothering. It offers the helpless infant an experience of continuity so that the transition towards more independence becomes possible (Winnicott, 1960). This environmental atmosphere is the condition for the birth of psychic life and symbolic functioning. Interpreting the TC as a holding environment where residents develop 'a sense of belongingness' (Pearce & Pickard, 2012) is in line with empirical findings that highlight a secure attachment in the acquisition of mentalizing language (e.g. Lemche, Klann-Delius, Koch, & Joraschky, 2004). Within this line of reasoning, we consider addicted people who are deprived of narcotics as similar to infants in terms of their psychological helplessness and dependency on others. Recently, the importance of creating a holding environment for *therapeutic aims* with people suffering from trauma and early deprivation has been put forward: "The Winnicottian holding environment might thus be understood as the establishment of a form of social order that can serve to open up the horizon of the symbolic" (Gorney, 2011, p. 52). In other words, the pre-requisite for successful recovery or development of mentalization is a relational experience of

safety (Fonagy et al., 2011). Another reason why residents stay in the TC is because they learn to deal with overwhelming experiences in a more functional way by means of the *TC tools*. While these tools vary in complexity, they join forces to transform affective experiences into spoken words and writing.

Two more principal requirements with regard to the development of mentalization (Fonagy, 2002) were also present in the TC. It is not merely a cognitive process, but commences with the discovery of affects; the process is not innate but starts from the outside-in. This was recognized in the role that fellow residents take up in offering words to their buddies and in how they act as 'talking mirrors.'

The fact that 'time in program' has been found as the only predictor of success (e.g. Vanderplasschen et al., 2013) can be further understood from our findings. The development of the mentalizing ability is a process that takes time; the longer residents stay, the better they are able to regulate affect in a functional way. Within this line of thinking, we consider the behavioral changes noted in most outcome studies (less drug use and criminality and higher employment rates) as consequences of an intra- and interpersonal change, a change in the regulation of affective experiences.

A major problem with TCs is the low retention rate. Dropouts usually occur within the first three months and are highest within the first 30 days (Goethals, 2013). Based on this immersive experience, the importance of the environmental atmosphere to enhance retention should be stressed. The extent to which the holding environment is actually experienced as such by the residents is crucial. In spite of the exigent program, VD was recognized as a valuable person, cared for and included in the group. The non-stop attentiveness and honest concern of fellow residents ensured that she was never left alone if she was having a difficult time. The reasons for drop-out in mutual-help groups in the addiction treatment field, such as in TCs, have rarely been studied in a systematic way (Kelly, Kahler, & Humphreys, 2010). This is an important issue to address through qualitative research. When VD found out that being part of a TC peer group differs enormously from being part of any other group[7], the importance of 'going native' became obvious. Although it is thinkable that the residents' process and the role of the TC tools could have been discerned through other methods, the important role of the environment as a treatment condition would not have been discerned without the full immersion. This subjective

[7] Whether it is an informal naturalistic group (e.g. a family) or a more formal group that is created because of a common goal (e.g. a school class, a team of colleagues).

experience has been crucial to collecting the data in a meaningful way and creating an interpretive theory as a product of this participant observation study (Jorgensen, 1989).

While several aspects of the TC program are grasped within this analysis, other aspects need further investigation. For instance, TC residents are approached as responsible agents who need to work to recover (De Leon, 2000, 2012). This vision (which is also shared by *democratic* TCs that address other target groups (e.g. Campling & Haigh, 1999)) contrasts sharply with mainstream mental health care, where problems are medicalized and care systems 'manage the disease' (e.g. De Leon, 2012). It would be interesting to investigate the role of the person's accountability for his/her process of change. A further limitation of this study is that the results are based on just one time period of observation by just one researcher in one TC. Future research could replicate this exploratory study in other TCs to refine the presented model and study differences between TCs. It would also be interesting to conduct periodical interviews with TC residents to explore their point of view regarding the process and to verify whether their ability to deal with affective experiences in a more mentalized way increases.

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3

Joining others on the rocky road towards a sustained drug-free life: A study on the process of change in a drug-free Therapeutic Community by means of two empirical single cases

The majority of drug addicted individuals strive for full abstinence when they go in treatment. A widespread approach that traditionally adheres to this goal is the Therapeutic Community (TC). In the TC's perspective, a sustained drug-free life is only possible when an "identity change" takes place. Yet, the process that TC residents go through to reach that change is barely understood. To explore this process, we set up two empirical single case studies. Throughout their stay in a Belgian TC, two residents were interviewed multiple times and the Inventory of Interpersonal Problems (IIP-32) was administered at four moments. The interview data have been interpreted with Lacanian psychoanalytic theory. This theory provides several concepts to help us understand the TC treatment process, such as "identity" formation and change, the role of "others" and "language," and the function of "addiction." The process of change was conceptualized in three steps: 1) "The Other is 'dead'" indicates participants' disconnection from people and from their own mental and emotional life when they entered the TC; 2) "The Other 'awakens'" explains how participants started to be affected again by everyday difficulties in the TC while a growing feeling of belonging also came into being; and finally, 3) "The subject 'awakens'" illustrates how subject-related trouble and pain was drawn out and how it was processed in one case more than the other. These steps were explored alongside the IIP-findings. Limitations of the study and recommendations for further research are discussed.

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Introduction

More than half of drug addicted individuals strive for full abstinence when they commit to treatment. This is the striking conclusion of a study that investigated 1007 addicted individuals entering diverse treatment programs (Mckegany, Morris, Neale, & Robertson, 2004). Although harm reduction and substitute 'treatments' are widespread, in the end, most addicted individuals want a drug-free life.

A treatment approach that has adhered to this abstinence goal for decades is the drug-free *Therapeutic Community* or *TC* (De Leon, 2000; Glaser, 1981; www.eftc-europe.com; www.wftc.org). In TCs, people are in treatment "24/7": they occupy job functions, attend group sessions, have meals together, and at all times, they are expected to relate to each other according to many rules which we will call the "TC law." There three cardinal rules - no drugs/alcohol, no aggression and no sex between residents. Transgression of these rules leads to immediate exclusion, as they are considered a crucial safety condition for treatment. Other main cohabitation rules include: respect and take care of yourself, your peers and your house; be honest and disclose thoughts about your intimate self; and bear responsibility for your own treatment and for that of your peers. In order to comply with this law, the residents are supposed to make use of the *TC tools,* such as participating in Encounter groups or using "paper slips" to write about any overwhelming situations and thus take some distance (e.g. Debaere, Vanheule & Inslegers, 2013).

In the TC's perspective, a sustained drug-free life only becomes possible when "identity change" has taken place, because the addiction is considered a symptom of intra- and interpersonal problems. To engender these changes, a group of *detoxified* individuals live together in a drug-free environment and follow this program. This seemingly paradoxical enterprise (i.e., one has to *be abstinent* to start a treatment that *aims at abstinence*) shows that the step from being physically detoxified towards living a drug-free life is not self-evident. The complex process that TC residents go through to reach this goal is barely understood and has been referred to as the 'black box' of the TC (e.g. Dekel, Benbenishty, & Amram, 2004; Ravndal, 2003).

In the early days, TCs were recalcitrant to academic involvement as they believed that the proper functioning of a TC was due to a belief system that was difficult to objectify (Van der Straten & Broekaert, 2008). The first TC outcome study was therefore done by staff members.

Since the early 1980s, it has been regularly demonstrated that former TC residents show less drug abuse and antisocial behavior and that their employment rates increase (e.g. Yates, De Leon, Mullen, & Arbiter, 2010). This early TC research had not yet studied the processes taking place in a TC or translated clinical techniques into theory. However, various challenges that the TC has been faced with in recent years has compelled it to justify its approach. For instance, review studies reveal methodological shortcomings in most TC outcome studies such that stable conclusions on their effectiveness cannot be drawn (e.g. Bale, 1979; Malivert, Fatseas, Denis, Langlois, & Auriacombe, 2012; Smith, Gates, & Foxcroft, 2006; Vanderplasschen et al., 2013). Furthermore, the adaptation of TC programs for new populations, such as drug using adolescents, mothers with children and incarcerated people (De Leon & Wexler, 2009; Gideon, Shoham, & Weisburd, 2010), has prompted questions concerning the extent to which such adaptations can be made without affecting the original TC's efficiency (Dye, Ducharme, Johnson, Knudsen, & Roman, 2009).

These questions have provoked a growing call for qualitative process research to investigate *how* and *why* the movement towards sustained abstinence, and the concomitant modifications at other levels of psychical and social functioning, are effectuated (e.g. Broekaert et al., 1999; De Leon, 2013; De Leon & Wexler, 2009; Lees, Manning, & Rawlings, 2004; Ravndal, 2003). Qualitative research is well-suited for this enterprise because it implies a naturalistic and interpretive approach to the investigation of an insufficiently understood social reality (Denzin & Lincoln, 2011). Qualitative methodologies aim to maintain the specificity and complexity of the therapeutic setting and process, and by approaching the data in a systematic way, it avoids the pitfalls of traditional single case reports (Midgley, 2004). Recent research has started to investigate the TC process by making use of naturalistic data (e.g. Kelemen, Erdos, & Madacsy, 2007). In previous research, we interpreted data obtained by means of a full participation study in a TC peer group through psychoanalytic theory on addiction and mentalization. The TC process was explained in terms of the residents' growing ability to manage disturbing affective experiences in a more mentalized way (Debaere, Vanheule, & Inslegers, 2014). Moreover, both the TC environment and tools were explained in terms of the conditions and techniques available to facilitate that process (Ibid.).

In this study, to explore the nature of the process of change in more detail, we set up empirical single case studies of two individuals during their stay at a TC (McLeod, 2011). Data was gathered through individual interviews and the administration of the *Inventory of*

Interpersonal Problems, a self-report instrument that taps into difficulties that people experience in interpersonal relations (IIP-32; Horowitz, Alden, Wiggins, & Pincus, 2000; Vanheule, Desmet, & Rosseel, 2006). The narrative data were interpreted using Lacanian psychoanalytic theory (Lacan, 1953-54, 1954-55; Loose, 2002). Lacanian psychoanalysis offers a conceptual framework that connects the process of identity formation and change with the manner in which drive regulation and gratification are organized. Moreover, given that the role of 'others' and 'language' is considered central to this process, it provides us with a unique position to investigate the hypothesized interrelations between a sustained drug-free life (which indicates a restructuring of the libidinal economy) and the purported necessary identity change.

Lacanian Theory

In order to clarify the Lacanian perspective on the function of addiction, we first discuss some basic ideas of his theory on the formation and development of the subject (e.g. Fink, 1997; Lacan, 1954-1955; Vanheule & Verhaeghe, 2009). Here, the fundamental idea is that drive regulation and identity formation are two sides of the same coin, and that both come into being in relation to the Other (Verhaeghe, 2004). This means that we only get to know *what we feel* (and how to deal with it) and *who we are* through the Other. This concept of 'the Other' has several meanings: it simultaneously refers to (1) significant others (i.e., *persons*), (2) the symbolic order of *language* that lays the foundations of one's being (through the words of primary caretakers), and (3) a *symbolic law* that bridles immediate drive gratification. In other words, newborn baby only becomes capable of handling its inner drive arousal through the Other. Moreover, in the wake of this process identity takes shape. The Other thus structures and determines any possible relation of the human being towards reality, themselves, and others qua interpersonal figure (Vanheule, 2011). The passage through the Other is indispensable for the process of becoming a subject: it is only thanks to the interventions of others that the drives become organized and manageable.

However, this fundamental dependency on the Other simultaneously makes up the structural drama of humankind. The response of the Other necessarily falls short because of the incommensurability of both systems involved: drive tension can never be fully captured within the narratively constructed reality that the Other offers as a solution. In other words: the price

we pay for being socialized is an experience of lack[1] that accounts for our never-ending quest to get 'it' from the Other (e.g. love, fame, …) and their tendency to blame the Other for not achieving it. This dynamic demonstrates that a primordial experience of *excess* in terms of a real bodily drive or tension requires the intervention of the Other to become 'human', but that this detour via the Other is at the same time not fully satisfying, the satisfaction is not lasting and experienced as a *lack* in interpersonal relations.

In general, people do not want to know about the anxiety-provoking nature of this inescapable lack. They tend to cover up this unbearable truth, for instance, by identifying with an image (e.g. "I'm a nice person," "I'm a player." Although this mechanism of ego- or imaginary identification offers temporary refuge from the experience of lack (as it promotes a sense of coherence), Lacan stressed that such self-images constitute a defensive armor that keeps an array of dissonant feelings and thoughts at bay. However, such repressed elements are not easily silenced, and 'return' to disturb and disrupt this short-lived experience of coherence. According to Lacan, disavowed thoughts and experiences form the heart of a person's subjectivity. It is essential that a psychoanalytic treatment engages the individual in a process of exploring and articulating these warded-off elements, as they have marked the subject but never been put into words. Such forms of treatment aim to move beyond alienated self-images and towards assuming lack and taking responsibility for one's own life. This is also referred to as a process of 'subjectivization' (Fink, 1997).

A Lacanian perspective on substance addiction

Within this perspective, addiction can be seen as a subjective strategy that completely abandons the detour via others and language as a means of dealing with the insistence of drives and the experience of lack. The substance is seen as a total solution to "anesthetize" drive tension and subjective discord: "The act of the addict (…) attempts to mask, to short-circuit, by means of the real and/or the imaginary, that what the subject does not want or cannot view (…) of his subjective position" (Magoudi, 1986, p. 30, our translation) (Le Poulichet, 1987; Loose, 2002). However, and this is the drama at the heart of toxicomania, the *solution* turns out to be a double-edged sword: it introduces a new problem (i.e. the physical deterioration as a

[1] This structural lack of humankind is beautifully told in the children's books of Shel Silverstein "The missing piece" (1976) and "The missing piece meets the Big O" (1981).

consequence of the substance misuse) while it endorses an already existing one, i.e., the growing detachment from the Other:

> It is as if the drug has replaced the other in an artificial way, the big Other with a capital O as well as the other, (…) as if the drug has come to occupy this privileged place in order to condense in itself the whole dimension of the Other, of the other persons (…) (Magoudi, 1986, p. 8-9, our translation).

This detachment from the Other is reflected in the breaking up of interpersonal relations and symbolic positions (e.g., job function, role as a son or daughter, partner, …) and in "the avoidance of language in addicted individuals" (Magoudi, 1986, p. 9, our translation). The wasting away of symbolic regulation might be a way to understand the overwhelming affective experiences and unrestrained behavioral patterns often observed in the clinical field of addiction. This tallies with De Leon's characterization of the behavior of new TC residents:

> The behavioral-attitudinal and emotional characteristics that define the disorder are evident in all residents. (…) Typically these include domestic violence, unsafe sexual practices, criminality, suicide attempts, violence towards others, involvement in vehicular and other accidents, child neglect and abuse, and neglect of health (De Leon, 2000, p. 39).

This disconnection from the Other coincides with a dominance of imaginary identifications, reflected in the fact that addicted individuals tend to identify themselves with global images – e.g. "I am an addict," "I am an outlaw" - which cover up the question of subjectivity, while simultaneously offer an explanation for experiences that stem from drive perturbation (e.g., Josson, 2012; Magoudi, 1986).

Lacanian theory will serve as a framework for studying the data, as it allows us to understand the TC treatment in terms of re-installing the dimension of the Other and of lack. The case material illustrates how this enables participants to get in touch with and process subject-related inner discord.

Method

Participants

The cases of Simon and Andrew were selected from a total of 21 individuals that commenced treatment in a Belgian TC[2] during the course of one calendar year. The entire group was studied as part of a broader PhD project. Simon and Andrew belonged to the subgroup of 8 people that stayed in the program until the re-entry house[3] (the other 13 people dropped-out or were sent away by staff). Simon was selected because he was a talkative person who offered rich material during the interviews. While Andrew was rather reticent at first, his evolution during the interview process reflected the change that he was undergoing. Thus his case was selected to illustrate what could be considered a successful process of change. Making use of two cases instead of only one additionally allowed us to study whether TC residents go through a *person-specific* process of change (while the TC law is the same for all). This also allowed us to address the issue of outcome as a different level of success in the two cases. Both participants gave informed consent and the study was approved by the Research Ethics Committee of Ghent University.

Data-gathering

Andrew and Simon spent approximately 17 months in the TC and during that period, data were gathered by means of qualitative and quantitative methods. Before coming to the TC, Simon had written *his life story* in the detox-center and this text was used to supplement our data during the analytic process. In the TC, every two to three weeks, *individual interviews* were conducted by the first author (VD) resulting in 26 audio taped interviews with Simon and 20 with Andrew. Each interview lasted an average of 20 to 30 minutes. VD is a clinical psychologist and psychotherapist who was not a member of the TC staff. To begin with, the *Clinical Diagnostic Interview* (CDI) was administered (Westen, 2006). This semi-structured interview gathered information on various life domains, such as relationships, childhood and school experiences, job experiences and symptoms. In general, the other interviews largely explored how participants were getting on in the TC by means of the following questions: “What keeps you busy? What is

[2] We do not go into detail of this TC for reasons of confidentiality.
[3] The re-entry house is the final stage of the TC program, where residents live on their own prior to reintegrating into society.

difficult in the TC? What do you like about it? How is your relationship with peers / staff members / your family? How do you think about taking drugs right now?" These questions were deliberately broad, so that respondents could talk about anything that was on their minds. The IIP-32 was administered at four moments: at the beginning of their stay (T1), at two TC stage transition moments (T2, T3), and after moving to the re-entry house (T4). At each occasion, participants were asked to fill in three versions of the IIP-32: 1) people in general, 2) mother, and 3) father. The instrument contains 8 subscales that are correlated in the pattern of a circumplex (see Figure 1). Each subscale consists of four items that are scored on a 5-point Likert scale, from *not at all* (0) to *extremely* (4). The subscales measure the following aspects of interpersonal problems: 1) 'domineering/controlling'; 2) 'vindictive/self-centered'; 3) 'cold/distant'; 4) 'socially inhibited'; 5) 'non-assertive'; 6) 'overly accommodating'; 7) 'self-sacrificing'; and 8) 'intrusive/needy.'

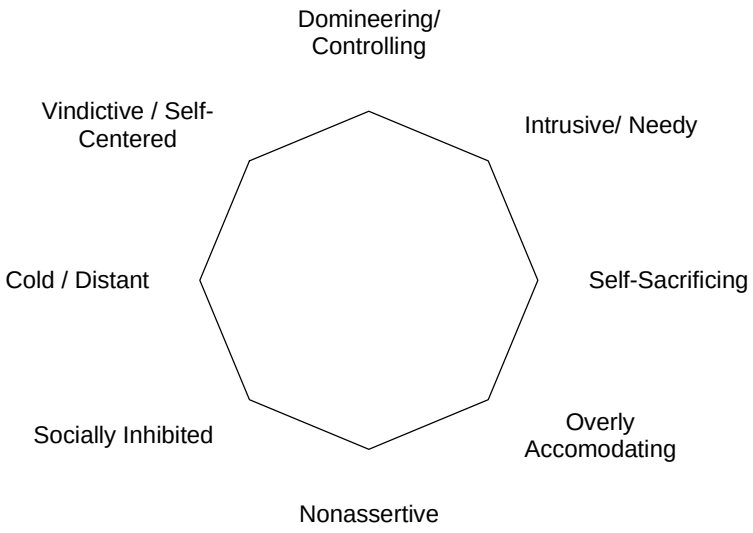

Figure 1. The circumplex pattern of the IIP-32 subscales

Psychometric research on this instrument in Dutch speaking populations have demonstrated its validity (stability of the circumplex structure and of correlations with convergent measures) and reliability (good internal consistency and test-retest reliability) (Vanheule et al., 2006; Inslegers, Vanheule, Meganck, Debaere, Trenson, & Desmet, 2012). The IIP is a clinically useful method for evaluating therapeutic processes, as it assesses the *nature* of interpersonal issues (reflected in

the *shape* of the IIP-profile) as well as the *seriousness* (reflected in the *size* of the profile: the larger the profile, the greater the problems).

Data-analysis

Taking our cue from the hypothesis that a TC treatment affects the residents' intra- and interpersonal functioning, we began by summarizing Simon's transcribed interviews, paying attention to the following themes: mental representations of self, others and relations; emotional well-being; drive regulation strategies; and the use of TC tools. Starting from this overview, the same procedure was followed with Andrew's interviews. In a next step, the Lacanian psychoanalytic framework was used to interpret the data. During this process interpretations of the data were regularly discussed with all co-authors. The IIP-data are presented in Figure 2. Each separate figure shows the four successive IIP-profiles (at T1, T2, T3 and T4, each depicted in a different color) for Andrew and Simon on one of the three IIP–versions (difficulties with other people in general; difficulties with the mother; difficulties with the father). Further credibility checks were obtained by discussing the preliminary results with all co-authors and with the members of VD's PhD guidance committee. Their remarks were taken into consideration.

Before presenting the findings, we briefly describe the background of both participants.

Case descriptions

Simon

Simon is a 20 year old male who came to the TC to recover from severe poly drug addiction. Because of his traumatic childhood, an extensive history of drug abuse and many stints in juvenile institutions, a staff member characterized Simon as "an out-of place stray dog." Simon's dad left his mother before he was born. Since his mother worked 24/7 to manage, Simon was sent to boarding school. During the weekends, he either went to stay with his grandmother or remained at the boarding school. At irregular moments, he saw his alcoholic father with whom he spent time sitting in pubs. When Simon was 8, his mom gave birth to his half-brother, Irvin. Instead of coming back home during the weekends, Simon preferred to stay at boarding school because of the many fights between his mother and his violent step-father.

At the age of 12 Simon started drinking and found discovered cannabis with his classmates. A history of excessive drug use and many stays in residential programs and penitentiary community institutions commenced. On his 18th birthday – being an adult - he was released. However, living on his own did not work out well, and he increasingly began to inject heroin and cocaine. He became homeless and was sent to prison for robbery. During his final admission into a detox center, where he had been previously excluded due to problematic behavior, he decided to enter a TC program. His provisional prison sentence was probably a decisive factor in making this decision.

Andrew

Andrew is a 29 year old male. He had been in prison five times for dealing drugs and for theft and suffered from severe addiction. During his fifth imprisonment, the Justice Department proposed that he enter a TC program as a condition of his released. He entered the TC after a final prison stay of two years. Andrew's parents divorced when he was 3 years old. Concerning his mother, he explained: "My mother left me because I was a bad child, she couldn't handle me, I hate her." He did not see his mother after this, apart from one time, many years later, when he was an adolescent. Sadly, this reunion quickly developed into a verbal sword-play. Andrew has no other childhood memories. Shortly after his parents' divorce, his father met a new woman, Andrew's step-mother, whom he considered his real mother. When Andrew was 7 years old, his half-sister Luka was born. This was hard to bear for Andrew, as his younger sister received all the attention. He linked this lack of attention to his descending into trouble when he became an adolescent: "I also needed some attention … well … I went astray." He rarely attended classes at high school, preferring to hang around in pubs. His drug use began at a party, when someone gave him speed to get over his drunkenness. He started to consume drugs in the weekends and worked during the week. When he found out that he could earn far more money by dealing drugs, he stopped working altogether. Andrew had two long-lasting relationships and has a daughter and a son.

Findings

The qualitative analyses of the interview data resulted in a three-step conceptualization of the process of change. The starting point, *The Other is "dead",* points to the participants'

disconnection from people and from their own mental and emotional life. *The Other "awakens"* explains how being subjected to the TC law brought about a double effect: Instead of being 'internally dead,' the interpellation of the demanding TC law introduced and resuscitated a range of troublesome emotions and feelings, and, at the same time, produced a growing feeling of belonging that sustained their efforts to adhere to the demanding therapy program. Finally, *the subject "awakens",* illustrates how another kind of difficulties, related to the participants' subjectivity, were slowly drawn out, and how this inner turmoil was differentially processed and symbolized. These three steps are illustrated with interview fragments and IIP-profiles.

The Other is "dead"

This starting point designates Simon's and Andrew's disconnection from the Other. This severed state is reflected in the absence of meaningful interpersonal relations and of an active mental life, which is a typical consequence of a year-long drug dependency. In Simon's written life story, sequences of behavior are described with no sense of why he does what he does or why other people do what they do. He articulated an array of historical events that appear to be independent of human intentionality and do not seem to trigger emotions, as is illustrated with this fragment:

> *In 2nd grade I was kicked out boarding school for smoking cannabis. Then I went to school in M. and there it went wrong. I started smoking and skipping class on a daily basis. Then, at the age of 14 I started using HEROIN (sic). I didn't attend school anymore when I was 16 years old, I was confined by the juvenile court judge to a short-term residential program for adolescent drug users. But because I presented with junkie-behavior and ran away all the time, I was kicked out after 7 months. Then I was confined to the penitentiary community institution in R. I was there for 9 months so in total I have been in placements for 16 months. (…) The first time, after 10 months, I was allowed to leave the institution for a day. I left at 8 a.m. in the morning and had to be back at 8 p.m.. By 10 a.m. I was already using heroin (…)*

The CDI with Andrew showed a similar detachment, reflected in his bland way of using language. Andrew delivered his story in a rather trivial way: "I'm Andrew, I'm 29 years old, I come from X and I have been in prison for 2 years. Now I'm here." Other people are also

portrayed in a one-dimensional way. For instance, he says that he *hates* his biological mother and never wants to see her again. By contrast, his step-mom is "a *very good* and a *very sympathetic* woman." He has never had any problem with her. He never mentions the names of his children or of former girlfriends: "Then I met a girl, she was my first girlfriend, we lived together and I have a child with her." He stated that he did not have any friends while he was on drugs and that human beings were only valued in terms of the possibility of getting drug.

As mentioned above, TC residents are supposed to relate to each other according to the TC law. The goal is usually explained in terms of learning the 'right living' (e.g. De Leon, 2000). The restriction of immediate drive gratification and the need to comply with a shared values-and-norms system (e.g. respect, mutual help, …). Here, connecting to the Other is what makes up the basis for social life. However, we propose that the way in which the law is applied in the TC goes beyond the mere goal of re-education by also encompassing a *psycho-therapeutic* goal. Each TC resident cannot but transgress the TC law, but he or she does so in a person-specific way, and thus the particular 'failure' provides the valuable (and difficult to obtain) material for the person-specific element of the psychotherapeutic process. This is outlined below with the cases of Simon and Andrew.

The Other "awakens"

Instead of remaining numbed and unhindered, Andrew and Simon started to become affected (again), due to the interpellation of the (avatars of the) TC law. Simon, for instance, was the object of numerous confrontations (e.g., avoiding his job duties and making fun of others). One example of the consequences of this behavior in the TC is that he was frequently made sit on a bench in silence, in order to give things a moment's thought. In the first two interviews he explained how he tried to circumvent the emotional impact of these consequences, by talking his a way out of it, acting silly or discharging tension in non-verbal ways. However, staff members and fellow residents saw through these primitive mechanisms of defense and he was called up on his behavior over and over again.

Both participants experienced the imposed involvement with the Other as difficult *in a different way*. The playful Simon had a hard time behaving respectfully without playing games, while Andrew had difficulties expressing his discontent towards people. The efforts of his peers

to make Simon obey the rules were at first felt as personal attacks: "This place is all work and no play… People are constantly on top of you as soon as you make a mistake, BAM! Really, I can't handle this … I'm fed up with this. (…) They are all overachievers in here, real assholes (…) just bastards, I have no other word for it" (S2)[4]. By contrast, Andrew did his very best to behave according to the TC law: "[I do my very best] to make sure that I do nothing wrong. I have to watch out, I have to pay attention to the way I put things into words (…)" (A1). The obedient Andrew did not receive much confrontation for transgressing behavior, which was precisely what bothered him, as it made him feel different from most residents. Andrew also felt very uncomfortable addressing others in the Encounter groups: "I'm so nervous in the days that precede the group, I can't stop thinking about the way I'm supposed to act" (A3). Thus, while the TC law is the *same for all*, Simon and Andrew experienced *difficulties that were particular to them*, i.e., concerning the specific manner in which they related to the law and to others. A certain aspect of the TC law proved impossible to comply with and triggered a person-specific way of "failing" for each participant.

Next to the renewed experience of troubling affects, they also became attached to peers and affiliated with the TC program. This global evolution towards experiencing friendship and a feeling of belonging to the community fed a desire to stay in the TC, as illustrated with quotes from the 1st, 5th and 11th interview with Andrew:

Interview 1: *VD: You want to be here [in the TC]?*

Andrew: I have to be here. Well … , I mean, …

Interview 5: *Andrew: If you had told me, years ago, that I would be living in a TC for up to several months, well .. I wouldn't have believed it! [laughs out loud]. To start with, I had NO faith in the TC. Now, it really feels good! In the beginning of my stay (…) I was looking at the older residents, seeing those close bonds, it was great. I missed .. well, I wanted to have that too (…). Now I start to feel that too …that is a good thing, you know, it is very pleasant.*

[4] S1, S2, S3, … refers to the first, second, third, .. interview with Simon; A1, A2 … with Andrew.

Interview 11: *VD: Would there be any chance of you leaving the program? Andrew: No, leaving the program, no. You'll never ever get me out of here! No matter how hard it is.*

This growing attachment to people is also reflected in the changing IIP-profiles with regard to other people in general, as can be seen in the upper profiles in Figure 2. From T1 to T2 (i.e., from the red to the green shape), the emphasis of both participants' profiles moved from the top-left corner towards the bottom-right corner, from "Self-centered" problems towards more "Self-sacrificing" and "Accommodating" problems. The scores on the items that examine the tendency to be "Self-centered" decreased[5], while the scores on the items that examine the tendency to be "Overly Accommodating" increased[6]. As they had been in the TC for about six months by that time, it is obvious that the interpersonal situations that they referred to were those with fellow residents and staff members. Taken together, this change in the IIP-profiles reflect both participants' tendency to become less self-centered and more concerned with and dependent on people, that is, re-connected with the Other. This increased dependence on people likely substituted their dependence on narcotics: in the drug-free environment, they cannot fall back on their drug-use as a solution, as Andrew explained: "When there is a difficult situation in the house, I sometimes think: 'I wish I had something [drugs] to fix the problem immediately'. But in here, you are supposed to face the situation" (A6).

The subject "awakens"

During the treatment, cracks began to appear in participants' defensive ego-armor and they became capable of articulating subjective discord. For instance, Simon was *in conflict* about his wish to contact his father: "My father drinks a lot and when I saw him, we drank together. When I was in the detox center, he said to me 'I found a job for you and you can live with me when you leave this place!' Well, that might make me want to go outside" (S3). He also started to feel *guilty* about how he had acted towards his mother and half-brother while on drugs: "It

[5] For instance, the score on item 17 "It is hard for me to put someone else's needs before my own" decreased from 3 to 2 for both participants, and the score on item 16 "It is hard for me to really care about other people's problems" decreased from 3 to 2 for Simon and from 2 to 1 for Andrew.

[6] For instance, the score on item 1 "It is hard for me to say no to other people' increased from score 2 to 3 for Simon and from 1 to 3 for Andrew. And the score on item 20 "'It is hard for me to be assertive without worrying about hurting one's feelings" even increased from a 0 to a 4 for Andrew.

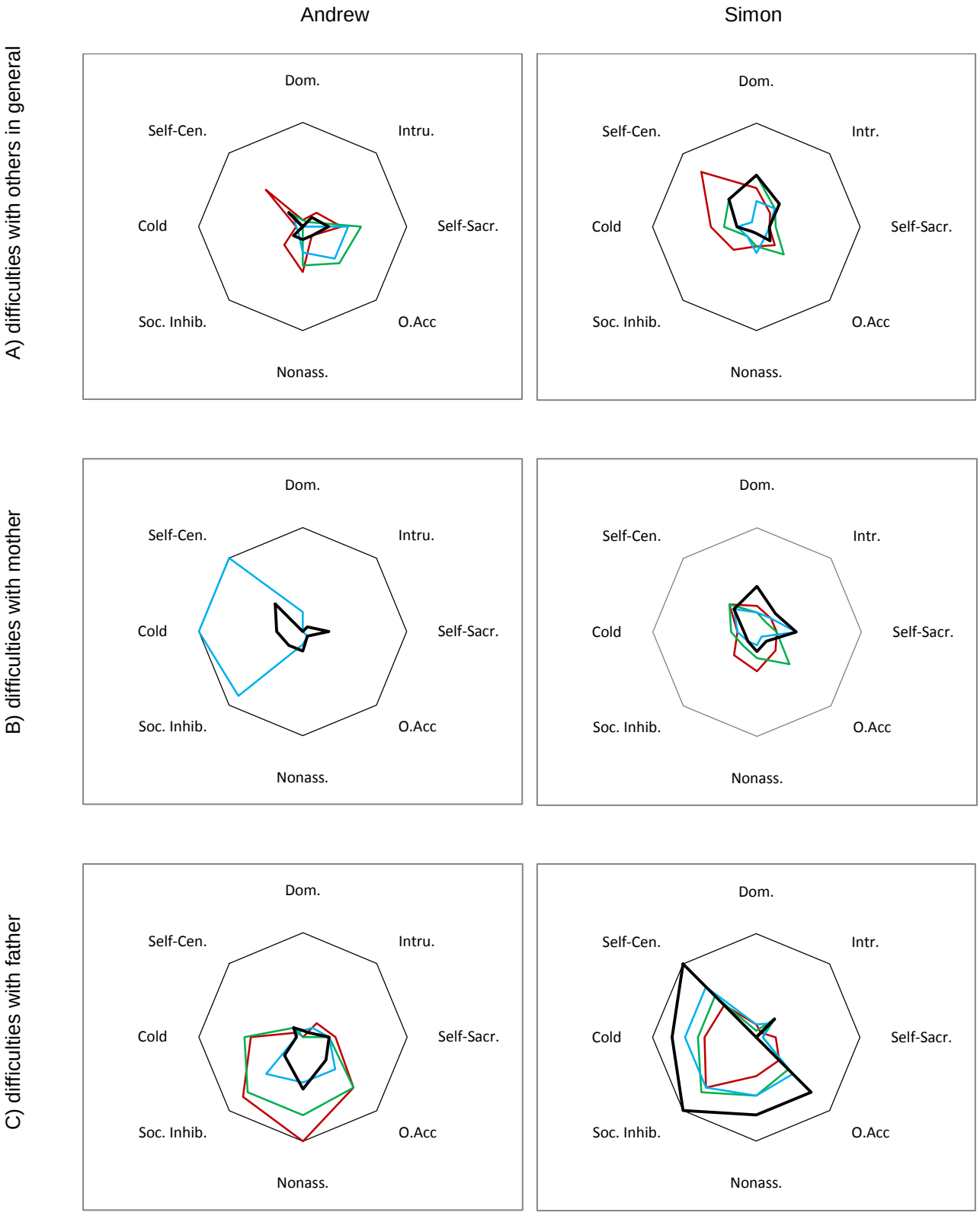

*Figure 2. Andrew's and Simon's changing IIP-profiles throughout their TC-stay (T1, T2, T3, **T4**) with regard to interpersonal difficulties with A) other people in general, B) mother*, and C) father. *As can be noticed in the second figure in the left column, at T1 and T2, Andrew had refused to complete the IIP-profiles related to his mother by arguing that he "didn't have a biological mother anymore."*

was out of proportion, really, (…) when my mother left for work (…), I just arrived from a night at a club, I sat down on the stairs, completely wasted, making fun of her“ (S4).

As participants became increasingly capable of bearing and articulating inner conflict, they were also affected by traumatic experiences from their past. From a Lacanian perspective, trauma refers to experiences that have not been represented in mental life, as the scaffolding that people use to symbolize and make them meaningful was lacking. Such unprocessed tension, however, keeps affecting the individual at the core of his or her subjectivity (e.g. Fink, 1995; Kirshner, 2007), 'requiring' a process of exploring it and putting it into words. Below, we take a look at Andrew's case to see how past trauma was triggered during TC life and how integrating it into his identity was realized. After that, we return to Simon.

While **Andrew** was initially rather reticent during the interviews, on two occasions, this façade dissipated. In the 4th interview, he said that he was not feeling well at all. A situation with Michael, his best TC friend, had triggered this affective disturbance. Michael's girlfriend, who was doing a similar program in a TC for mothers and children, had left the TC with her son and nobody knew where she had gone. Andrew: "Michael shared his sadness with the group but he couldn't hold back his tears. I couldn't handle that image, I also started crying!!" It is as if the situation with Michael activated a situation from Andrew's own past: "There is also a lot of sadness inside of me that I didn't even know it was there!" Later, he tried to explain why he had been so affected: "I also have children, if I had no clue about their whereabouts, I would go mad!" (At this point, he did not yet relate this situation to his own subjectivity, to how he had also felt abandoned as a child).

The second time that Andrew showed up in such an affected state was in interview 7, after telling the story of his life to students. Since he had been talking about his biological mother, things kept tossing and turning in his head. "Once I start talking about her, it's like an engine firing away, trrrrrr, I can't stop it anymore!" Andrew had been struck by his own speech, suddenly and unexpectedly, leaving him in a disoriented state, wearing him out: "I barely sleep at night." It is as if a hitherto isolated part of his subjectivity was suddenly released: "I have been crying for the first time; I used to be angry - I still am! – but there is also so much grief behind it." It scares him: "I'd rather not touch upon it, but that's impossible in here." Thus, Andrew decided to start talking with a staff member about what he was experiencing with regards to his biological mother, and to share this with his peers afterwards.

For about six months, we could follow Andrew's subjectivization process. At first, he was wrestling with contradictions related to the image he had created of his mother and the re-surfaced un-integrated affect that counteracted it. The fixed phrasings ("I never want to see her again / I'm finished with her (A7)") became more and more nuanced ("I do not respect her, even though I'd like to / I don't know her side of the story" (A7-A9)). After a while, he decided that he *did* want to meet her - to ask why she had left him (A9). In between interview 12 and 13, he called his mother for the first time. This important decision, however, did not bring to a halt the difficult process that he was going through, the relentless succession of ups and downs that accompanied this transition. Andrew was excited that his mother also wanted to see him, yet, at other moments (A13), he was destabilized by her story about the difficult divorce, which differed from his image: "It is as if something has broken down inside of me. She didn't forget about me, she has fought for me. It hurts to hear that. It's all such a mess!"

Andrew's process of rewriting the story of his life went along with many intra- and interpersonal changes. For instance, a remarkable change in his speaking was noticed: while he used to talk about his step-mom as "my mother" and about his mom as "my biological mother" (interviews A1 until A7), he started to wrestle with these nominations, and from interview A13 onwards, he consistently uses the terms "my mother" for his biological mother and "my step-mother" for his step-mother. Little by little, Andrew, showed a growing involvement in his life. For instance, shortly after meeting his mother, she expressed her wish to meet Andrew's children, her grandchildren. "But," Andrew said, "she must realize that it is not that simple" (A14). Andrew had started to consider his own needs and those of his children. "First I have to explain it to Angie: 'Look sweetheart, I do have another mummy, you have another granny …!' She is 9, she has always thought that my parents are my real father and mother - I'm concerned about the way she will react if I tell her, maybe she'll think that I'm a liar. I don't know what is going on in her head, you know. Or she might become hostile towards my parents. The situation is stable now and I don't want to mess that up. I'll first talk about it to Cindy, the mother of Angie, to get her opinion." Towards the end, he became much more open and relaxed during the interviews and his growing control in life was also reflected in the 18th interview, as Andrew himself ended the interview after an elaborate narrative.

Moving on to the case of **Simon**, during the interviews, he occasionally expressed his wish to contact his father. Below we outline the context in which this issue was raised and how the therapeutic work related to this theme stagnated in the TC.

Halfway through the TC program, Simon had developed a big sense of responsibility for what was going on in "his" house. He also had started to gain pleasure in helping new residents: "I'm glad that people look up to me and that I am able to support them" (S13). Yet, his devotion to the TC program turned out to be a new defense to stay away from subjective trouble: "I forget about myself somehow, I could start addressing some personal issues, but I don't." One of those issues concerned his father, with whom he had planned a reunion in the TC. Unfortunately, his father did not show up, which Simon mentioned only by coincidence in interview 14:

VD:	*Do you think you need to address subject-related issues?*
Simon:	*Yes, like my father, he's supposed to come today.*
VD:	*Ah, your father is coming.*
Simon:	*Yes.*
VD:	*How does it affect you?*
Simon:	*Well he was supposed to come last week but he didn't … so, well, euh, that's disappointing, yes. I ho .. hope that he comes today.*
VD:	*Hm hm. Does it make you nervous?*
Simon:	*Well … not really, I try not to get my hopes up that he will come, yes … yes (quietly)*

While Simon was usually a very talkative person, he was silent and sad-looking during this interview and he said almost nothing about the missed appointment. Instead of that, he continued to complain about investing too much energy in the TC, which had clearly become a new defense: "For 8 months I have been putting all my energy into the community and now I'm empty."

A staff briefing two weeks later revealed that Simon took another blow: for the second time, his father did not show up. Another message was that Simon had been separated from the group as a TC consequence.

In interview 15, Simon explained what had happened. In a meeting with staff member Steven, Simon wanted to apologize for having been disrespectful, yet, he explained how he did not manage to listen to Steven's reply: "I looked furiously at Steven, I was really really angry with him, I was really angry with him! I was just really angry with him!!" As Simon was so agitated and talking so quickly, VD asked him why he had become so upset: "Because he had put me on the

bench and I didn't know why, or, actually, *I did* understand why, but *I didn't want to* understand (…)." Simon's inability to adequately explain why he had been so furious with Steven suggests that his affected state was driven by unconscious motives.

In interview 21, Simon was very agitated again. His father had been calling his mother: "Since my mother told me this, it keeps tossing and turning in my head. But I cannot say much about it, I don't know how to start talking about it." Simon is clearly struggling with this father-issue without being able to name what disturbs him: "It's torn open again! I told [my peers] about it, but well, you can't say much about it." He continued the interview by talking in an agitated way about an unreliable OCMW-employee. A problem had occurred with the payment of his wages and the woman had told him that he was going to receive an advance on Monday. But he didn't. Simon was furious: "This is absolutely unacceptable (…) arrangements have been made and they're not kept! (…) I am going to tell her in person: 'what you do to people is unhuman!!'" The contrast between his affectless way of experiencing his father's failure and the extreme anger towards both Steven and the OCMW-employee was remarkable. It suggests that the un-integrated affect related to his father was displaced onto others because something in the relation with these people was 'transferrable': Steven was about the same age as Simon's father and functioned as a 'father figure' for Simon, the OCMW-employee had failed to honor a commitment, just as Simon's father had. In terms of realizing practical TC goals (e.g. he found a sports club, had a job perspective and a financial plan), Simon had come to the end of the residential program. However, instead of being relaxed and looking forward towards the re-entry house, he mentioned in the last interview that he was scared to go.

Andrew and Simon's different levels of processing trauma is also reflected in the different course of their IIP-profiles. As can be seen in the middle-left profile of Figure 2, at T1 and T2, Andrew had refused to fill in the questionnaire about his mother by explaining that he "did not have a biological mother anymore." At T3, when he was in the middle of re-writing his story, he did fill in the questionnaire. This struggle through inner conflict is reflected in the extreme pathological scores at that time (blue line). Five months later, at T4, the experienced difficulties were almost all gone (black line). As represented in the bottom-right profile of Figure 2, Simon's process with regard to his father shows a different evolution. From T1 until T4, the experienced interpersonal problems with his father were *growing worse* without reaching any relief. It is clear that this young man had become more aware of, and was struggling with, a huge amount of inner conflict when he moved on to the re-entry house. In one of the last interviews

he remarked that an eventual (unforeseen) encounter with his father "could lead to [his] relapse."

Discussion

This study offers a three-step conceptualization of the process of change in a drug-free TC, based on a follow-up procedure of two residents during their stay in a Belgian TC. The narrative data are interpreted from a Lacanian psychoanalytic perspective. The three-step conceptualization implies that two processes take place. The first transfer illustrates the *inversion of a process of dis-connection*. From being detached from people and their own mental and emotional life (1. The Other is "dead"), a renewed involvement with a shared discourse, people, and the participants' own mental and emotional life came into being (2. The Other "awakens"). We attribute this change to the application of the TC law that prohibits immediate drive gratification and requires a connection with the Other (i.e., respect, taking care of and helping your peers, verbalizing thoughts, …). Moreover, we presume that the TC law only becomes operative because the TC residents *themselves* are responsible for supervising whether their peers "talk the talk and walk the walk" and for confronting them when they fail to do so. The inversion became visible in the interviews by two major changes in the participants' intra- and interpersonal functioning. First, they became troubled and emotional instead of being 'internally dead,' and second, they began to internalize the law and develop a sense of belonging. This second aspect has been noted in previous research in terms of "social affiliation with the drug-free peer community" (Dermatis, Salke, Galanter, & Bunt, 2001, p. 105), reflected in the claim that "attachment to and identification with co-residents, staff, and the treatment program, are corner stones in the ideology of the hierarchical therapeutic community model" (Ravndal & Vaglum, 1994, p. 4). The evolution in the participants' general IIP-profiles from T1 to T2 reflected precisely this re-installed dependence on people, more precisely, on the Other.

Research regarding the nature of the identity change at the end of treatment is scarce and the findings are rather ambiguous. It is mostly presented as the full internalization of the TC law: "individuals fully immerse themselves in the community and *internalize its teachings*" (De Leon, 2000, p. 355, our italics), "[the goal is the] construct [of] a *new sense of self* according to *institutional parameters*" (Paik, 2006, p. 213, our italics). Such explanations suggest that all TC

residents adopt the *same* identity in the end. Based on such readings, TCs have been criticized[7] by Lacanian clinicians, for whom the *particularity* of each person's solution in dealing with subjective inner discord and in assuming lack is a crucial ethical principle. However, a more person-specific interpretation of the outcome can also be found in TC literature: "internalization of these changes is viewed as *more complete* when role modeling shifts from meeting community expectations to a personal mode of living based upon the *individual's own experiences* in this role" (De Leon, 2000, p. 355-356, our italics).

The fact that the process of change involves a person-specific component is precisely what caught our attention in the data. An early indicator that highlighted the importance of the singularity involved was that each participant experienced the TC law as difficult *in a different way*. As the participants were continually confronted with their ego-defenses, subject-related discord came to the surface. This refers to the second transfer in the process of change where participants got in touch with inner conflict and un-integrated experiences from the past that were no longer related to TC expectations (3. The subject "awakens").

At this point, we noticed a difference in Andrew's and Simon's process. The case of Andrew illustrated the time-consuming process of verbalizing past experiences into meaningful representations. This process resembles what is defined in Lacanian psychoanalysis as the "subjectivization of the foreign causes that brought a person into being" (Fink, 1995, p. 25). It can be understood as the hardest part of therapy that involves symbolizing experiences (i.e., becoming aware of and feeling the pain) that have had a profound effect, but occurred before the person was able to "think about them, speak of them, or formulate them in any way at all" (p. 25). This demanding therapeutic process led to intra- and interpersonal relief which was also reflected in Andrew's more conflict-free IIP-profiles at T4. The case of Simon, on the other hand, illustrated how such a subjectivization process concerning the relation with his father was not realized to a similar extent. Simon had "bad luck" for having a father who was not cooperative in reality. Yet, from a psychotherapeutic or psychoanalytic point of view, we are convinced that further therapy was needed. This could also be seen in the more pathological IIP-profile at T4 which reflects the major internal conflict in relation to his father.

[7] "Therapeutic communities are based on a master discourse. In that sense, it is possible to say that they form a barrier against the unconscious" (Loose, 2002, p. 276), or "they unite the law with the object that leaves no room for the subject" (Loose, 2002, p. 282). "[the TCs] erase particularity and may even shut down an encounter with the conditions that delimit the subject" (Goldman Baldwin, Malone, & Svolos, 2011, p. xx).

Our study suggests that in the best case scenario, TC residents accomplish a double process, both *identification* and *subjectivization*. The need to incorporate both dimensions in the treatment of addiction has been expressed by psychoanalytic clinicians outside the TC world (e.g. Geberovich, 2003; Snoy, 1993). For instance, Snoy (1993) applies Leonardo da Vinci's description of the two major arts, "per via di porre" (the art of painting) and "per via di levare" (sculpture), to metaphorically depict the way both processes are needed in the treatment of addiction: "We should be able to 'install' several elements in order to be able to 'remove' others so that a dialectical process takes off, a cycle of exchanges, choices and rejections that allow the suffering subject to find himself back" (Snoy, 1993, p. 38, our translation). The fact that such person-specific subjectivization processes can take place in a TC has almost never been addressed in TC literature. Yet in line with Vos (1984, 1989), we emphasize its importance. Typifying the TC process in terms of identification and subjectivization might offer a way out of the polemic that often arises at TC-conferences and that comes down at the following question "Are we dealing with an educational or a therapeutic process?" (e.g. De Leon, 2013). In our interpretation, we believe that it is both, and more precisely, that the person-specific therapeutic process would not be possible if these individuals remained dis-connected from the Other, i.e., if they were not 're-educated' in terms of becoming subjected to a shared, consistent and respectful law.

A limitation of this study is that we stopped interviewing the participants after they had moved to the re-entry house. However, approximately one year after the final interviews, we had a follow-up phone call with the clinical coordinator. Her report confirmed, unfortunately, what we might have predicted from our findings. Andrew successfully finished the TC program and continued to live a drug-free life with his new girlfriend and his two children, while Simon had left the re-entry house, fighting a relapse process as he had started to drink alcohol again. The staff member commented: "Probably after having a first drink with his father in a pub." This confirms our hypothesis that a further process of putting inner discord related to his father into words was needed. Another limitation of this study is that many issues raised in the interviews have not been addressed here due space restrictions. Nevertheless, we believe that this qualitative study opens up a new way of investigating the 'black box' of the drug-free TC.

Several suggestions for future research can be made. The opinion of staff members and former residents of different TCs with regard to the characterization of the TC process (particularly in terms of identification and subjectivization) could be further examined. Former

TC residents could be interviewed on how they have changed through the TC process and on whether or how the change has influenced their urge to consume drugs or alcohol. Another theme that should be further studied through a qualitative research design is drop-out in TCs. For instance, our analysis of Simon's case contradicts the premise of Ravndal and Vaglum (1994) that drop-out can be related to problems with the identification process. Simon clearly became 'plugged in' (Perfas, 2004), yet his departure from the re-entry house had seemingly more to do with unprocessed trauma in relation to his father. It might be interesting to interview residents who leave the TC prematurely concerning the reasons for doing so.

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4

Changing encounters with the Other: A focus group study on the process of change in a Therapeutic Community

Democratic Therapeutic Communities (TCs) are long-term group programs that address severely ingrained clinical populations. These psychodynamically informed social environments can facilitate improvement in people suffering from personality pathology. However, the TCs' working principle is not well documented, which threatens its continued existence. To gain further insight into how TCs work, this study explores former TC residents' perspectives on their treatment, its outcome, and the process of change they underwent. Four steps that might explain this process were identified through focus group interviews (using qualitative analyses) with 24 former residents of a Belgian democratic TC: (1) I encounter a safe, caring and challenging Other, (2) I unfold my particular way of interacting with the Other, (3) I am confronted with the Otherness in me, and (4) I live an Other life. This fourth step refers to the reported treatment outcome that consists of three main changes: (a) residents became more resilient and capable of coping with their problems, (b) residents became more involved in pleasant social relations, and (c) residents developed the capacity to make choices in their own lives. We recommend a reappraisal of social psychiatry, emphasizing the social aspect of human life, psychopathology and its treatment. Limitations of the study and suggestions for further research are discussed.

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Introduction

Democratic Therapeutic Communities (TCs) address severely ingrained clinical populations, such as people suffering from personality pathology (Lees, Manning, & Rawlings, 1999, 2004). They are defined as "psychodynamically informed planned social environments, which are based on the notion that types of psychological distress or destructive behavior are caused by the social network in which an individual is embedded and can be treated by a more healthy and constructive social network" (Boyling, 2010, p. 152). By interpreting disorders in human behavior and their treatment as essentially social or interpersonal, TCs represent one of the most significant innovations in the history of psychiatry (e.g. Hinshelwood, 2001; Mills & Harrison, 2007; Parish, 2012; Whitely, 2004).

Given the length of a TC stay and the complexity of the treatment approach, there are no RCT studies to prove the effectiveness of this longstanding clinical tradition. In times of Evidence Based Practice (EBP), this is threatening the TCs' continued existence. The closure of the Henderson Hospital in the United Kingdom in 2008, cited as "the flagship of the TCs for over 60 years," is illustrative in this respect (e.g. Parish, 2012; Whitely & Collis, 1987). Another complicating factor is the difficulty in explaining the TC approach in terms of contemporary discourse on mental health treatment: "TCs have no counselors, TCs have no clients: how can you get funded when the subsidizing bodies talk in terms of counseling hours for clients?" (Kurth, 2012). It is indeed unusual to consider complex interpersonal processes that occur in *all* residential facilities as a primary medium of treatment (Schimmel, 1996).

Yet, the RCT approach is only one strand of EBP, and problems in fitting a certain treatment strategy into the RCT framework does not prove that it is therefore not an effective treatment. In this context, effectiveness and efficacy studies have demonstrated the impact of the TC approach. In a meta-analysis of 29 outcome studies in TCs for 'people with personality disorders and mentally disordered offenders' strong evidence was found for their effectiveness (Lees, Manning, & Rawlings, 1999, p. 89). While that study focused on reconviction rates, other studies have examined global and psychological improvement. For example, a recent study which examined 56 individuals with severe personality pathology at intake, termination, and 2-year follow up (Werbart, Forsstrom, & Jeanneau, 2012) found significant improvements on outcome measures (the Symptom Checklist-90-R, the Global Assessment of Functioning, the Strauss Carpenter Outcome Scale, and the Integration/Sealing-over Scale), with high effect sizes

and the Reliable Change Index providing evidence for good outcome for 92% of the sample. Next to the studies that focused on intra- and interpersonal changes, cost-offset studies showed significant decreases in cost-price by comparing the (mental) health care utilization costs in the years before and after the TC treatment (e.g. Chiesa, Iacoponi, & Morris, 1996; Dolan, Warren, Menzies, & Norton, 1996). For instance, Dolan et al. (1996) concluded that a treatment in the former Henderson Hospital would pay for itself in just two years.

Thus, although "there is accumulating evidence (…) of the effectiveness and *particular suitability* of the therapeutic community model to the treatment of personality disorder and particularly *severe personality disorder*" (Lees et al., 1999, p. 9, italics added), the crucial question "How does a TC work?" remains unanswered. Rapoport (1960) was the first qualitative researcher to investigate the treatment process in the Henderson Hospital. In *Community as a Doctor* he outlines four principles of democratic TCs: (1) *democratization*, which means that all community members are given equal power in matters of decision making; (2) *communalism,* referring to the tight-knit, intimate sets of relationships characterized by free communication; (3) *permissiveness*, which means that all members should tolerate from one another a wide range of behavior that might seem deviant by ordinary standards; and (4) *reality confrontation,* which means that residents are confronted with interpretations about their behavior, as it is seen by others.

However, some researchers have criticized these principles as being too "ideological" (e.g. Whitely & Collis, 1987, p. 23) since they are highly valued by the members of staff without considering the residents' point of view. Moreover, Rapoport (1960) does not sufficiently explain *why* or how these principles are effective for that particular target group. In other words, the process by which a TC becomes effective still needs to be studied in more detail: "If links cannot be established explicitly between *programme interventions*, the *course of client change* and eventual *outcomes*, the effectiveness of any therapeutic community-oriented model remains unclear, much less proven" (Lees, Manning, Menzies, & Morant, p. 2004, p. 105).

In this study, we present the results of a systematic study of first-person perspectives given by individuals who completed a TC treatment. By using focus group interviews, we investigate the change experienced and reported by former residents and how they believe this change was realized.

Method

Setting and sample characteristics

For this study we worked with a TC known as *de evenaar*, the only democratic TC in the Dutch speaking region of Belgium (http://www.tg-de-evenaar.be). The TC consists of two houses in the center of Antwerp, each house providing accommodation for nine residents. The TC residents live together in a small-scale homely environment. The target group are adults suffering from "serious neuroses, borderline and narcissistic personality disorders, psychoses in remission and serious developmental disorders" (de evenaar, p. 4). The treatment program is psychodynamic and consists of several group sessions and two sessions of individual therapy per week. All residents share responsibility for the maintenance of the living space and the daily routines.

All individuals that had stayed in *de evenaar* for at least six months during 2006-2011 were selected as potential participants. The research project was approved by the Institutional Review Board of *Emmaüs*, the social profit organization to which *de evenaar* belongs. Of the 52 selected persons, ten declined to participate, 11 did not respond to e-mail and telephone invitations, one declined due to physical illness, five agreed to participate but were unable to schedule a time, and 1 agreed but did not show up. A total of 24 persons participated in this study, 14 women and ten men; their average age was 27 years (range: 19 to 45; SD: 6.6). They had stayed in *de evenaar* for an average of 12.3 months (range: 7 to 18 months; SD: 2.1). All but one had a history of mental health care that had lasted between 2 weeks and 20 years. All participants signed an informed consent form.

Focus group data collection and qualitative analyses

The 24 participants were randomly assigned to one of seven focus groups that took place between October 2011 and February 2012. Focus groups examine people's understandings of their experiences, with the group context facilitating personal disclosures (Farquhar, 1999; Howitt, 2013). The focus group interviews were conducted by the first author and started from two open questions to investigate the participants' treatment outcome and their process: *(1) Did you change because of the TC treatment? If so, in what way?* and *(2) How did your stay in the TC*

contribute to this change? The interviews lasted approximately one hour and 40 minutes and were digitally recorded. Participants were compensated 15 euros.

The recordings were transcribed verbatim. The first author started by identifying all accounts that were related to the *outcome* on the one hand (e.g. "Since the TC, I have started to …") and to the *process* on the other hand (fragments related to how it was in the TC, what they did etc., …). Next, a coding procedure was set up for both groups of data.

To analyze the **treatment outcome** data, we followed a procedure designed by Braun and Clarke (2006) to identify themes in the data. Since participants explained their outcome by making past-present comparisons, as a first coding level, we created time codes to indicate whether an account was related to their functioning *before* the treatment, *after* it or whether it was about an *unchanged characteristic*. Following this, content codes were created to differentiate between aspects of the participants' functioning. We remained close to the data and the emerging codes were regularly discussed between the first five authors of this study. This resulted in the identification of four specific themes that point to different aspects of the participants' functioning. By importing the final coding scheme into Nvivo10 (Mortelmans, 2011), we detected the codes that were most frequently associated with participants' functioning before and after the treatment, and noted examples for each of them. This analysis revealed that certain themes frequently emerged in the narratives of several participants for accounts regarding *the past* (I got overwhelmed; I dramatized; I withdrew from the other), while others themes were used for accounts regarding *the present* (I reflect; I have good social contacts; I choose). By comparing both groups of codes, 'treatment outcome' was identified by means of three major changes in the persons' functioning: a) participants had become more resilient and able to cope with their problems in a mentalized way, b) they report having more pleasant social relations, and c) they are more capable of making choices in their lives. This treatment outcome is illustrated in the findings section as the fourth and last step in the process of change, entitled 'I live an Other life.'

Next to the treatment outcome, the **process of change** was also investigated by identifying themes in the data. The participants' accounts of why they had changed could be grouped into three themes: the *TC context*, the *TC techniques*, and *their own approach*. Following this, we used interpretative analysis to explore the data in greater detail (Creswell, 2007). In this context, we examined a subgroup of 'successful' participants. This subgroup was identified on the basis of two criteria: participants that characterized themselves as successful

(e.g., “I’ve become much more positive in life,” “My whole life has changed,” …) and whether or not the three outcome changes outlined above could be located in their narratives. This resulted in a subgroup of 18 ‘successful’ participants. In the accounts of these participants, common patterns regarding their process of change could be identified. These patterns were discussed in a workshop with all researchers of the research group to which the first five authors belong. As a result, *three steps* in the ‘successful process of change’ were discerned and ‘treatment outcome’ was also added as a fourth step.

In order to define these steps, the concept of *the Other* seemed to be appropriate as a common theme throughout the four identified steps (see Figure 1). This concept stems from Lacanian psychoanalysis and has several meanings: it is used to refer to the symbolic order, language, significant others, as well as the unconscious (Vanheule, 2011). In Lacan’s view, all human relations are mediated by what he calls the *symbolic order* (Lacan, 1988 [1953-1954]): given the fact that we use *language* (i.e., words such as ‘mother,’ ‘friend,’ or ‘client’ to refer to others) and live in a cultural context (i.e., with cultural laws and customs that define what a ‘mother,’ ‘friend,’ or ‘client’ should and should not do), we thus always relate to people by means of the symbolic positions that they occupy. In other words, Lacan’s concept of the Other refers to the other to the extent that he/she is determined by the symbolic order. Indeed, the way that the Other takes shape unconsciously for people is influenced by social and cultural norms and, more particularly, by people’s personal/developmental history through their interaction with primary caretakers. Moreover, Lacan suggests that the putting in place of the Other has a reciprocal effect on our *subject position*. In other words, by being socialized (in relation to the Other), we embrace certain modes of relating to one another and this not only shapes the way we enter social relations but also influences the way we view ourselves. Interestingly, Lacan suggests that our symbolically determined subjectivity does not make up a smooth unity, but is ‘scattered,’ which explains people’s affective experience of not being *one*. ‘The subject is divided,’ says Lacan (2013, [1958-1959]). Our self-image or ego, in its turn, comes into being as a reaction against the experience of being divided (Lacan, 1966 [1949]). By identifying with a self-image, I defend myself against subjective division: some aspects of my subject position are acknowledged, while other aspects are warded off. Thus, these warded-off components constitute the unconscious, or put differently, the *Otherness* in me. In Lacan’s view, psychopathology is related to man’s rigid adherence to his ego, that is, to “the subject as fixated, as symptom, as a repetitive symptomatic way of ‘getting off’” (Fink, 1995, p. xii). The goal of

therapy from a Lacanian perspective consists of bringing about 'subjectivization,' meaning that elements of Otherness (in subjective functioning) are recognized as part of oneself, such that in a next step, different ways of positioning oneself in relation to the Other might be explored (Fink, 1995).

To provide further credibility checks, preliminary results were presented to all parties involved: the study participants, the members of staff and of the scientific committee of *de evenaar* and the board of *Emmaüs*. Their remarks have been taken into consideration.

Findings

As mentioned above, four steps in a successful process of change were discerned in the focus group data (see Figure 1). The first step, *I encounter a safe, caring and challenging Other,* points to how the participants experienced other individuals in the TC; the second step, *I unfold my particular way of interacting with the Other* illustrates how they have started to repeat their habitual 'maladaptive' way of interacting with people; the third, *I am confronted with the Otherness in me,* throws light on how they have become aware of their 'maladaptive' interpersonal style, and how this has been a way of defending themselves against unpleasurable thoughts and feelings; the fourth step, *I live an Other life,* illustrates the treatment outcome.

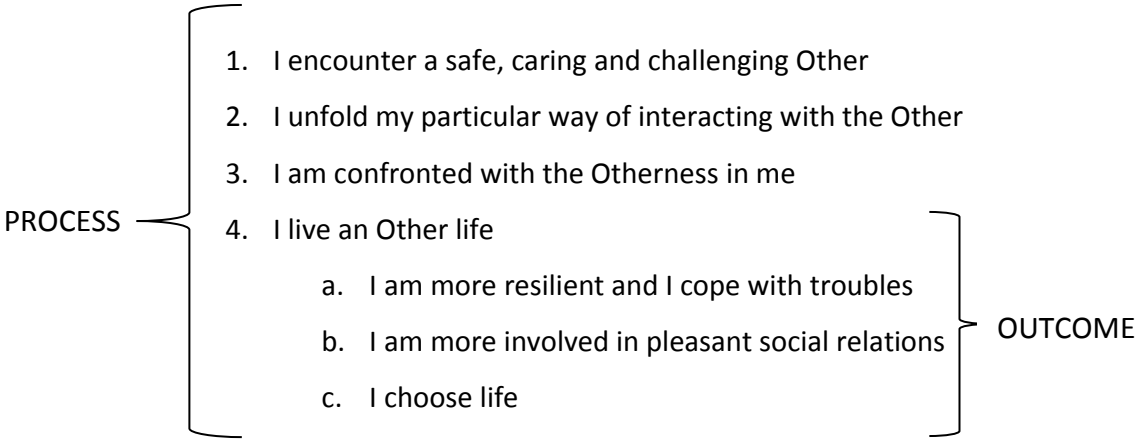

Figure 1. Four steps in the process of a change of successful TC residents

1. I encounter a safe, caring and challenging Other

Participants experienced the TC as an environment that is safe and caring on the one hand and challenging and demanding on the other. Staff members were described as authentic, patient, engaged and on an equal footing with the group, as illustrated by Angie: “they laugh with us at lunch, they play along.” The residents also started to feel at home and to be part of something bigger than themselves, as explained by Ida: “The feeling that you exist was pretty new to me, to belong to something (…) Being able to tell someone what you have experienced during the day ... It was great.” By starting to express themselves and help each other at difficult times, a peer group was created, as explained by Sylver: “Getting to know people when they are at their worst and when they feel good creates close bonds.” The integrity and continuous availability of this caring Other was stressed by several participants: “[in other mental health services] they don’t try as hard as they do in here to get to know you (…). They are available 24/7” (Nathalia). At the same time, TC residents are not supposed to rest on their laurels: “I always felt - not only by the group, but also by the sociotherapists - that you are expected to take part in all activities” (Annie). Even more so, residents are encouraged to take responsibility for their process: “They expect that you make your own therapy. Nobody is going to tell you that you have to do this or that; looking back, it’s up to you to make the choices” (Bastian).

It was remarkable that many participants compared the TC approach to how they had experienced others in their families; relatives were often experienced as either *too absent* or *too present* in a physical or an emotional way. For example, Doreen had been placed in institutions for many years, yet, when she was home again, she never felt encouraged to do anything, and her parents did not show any interest in her. On the day she had decided to admit herself, Angie discovered that her relatives had noticed but ignored her suffering: “I told them, look, I’ve been feeling bad for years, now I want to deal with it. And then, they said that they had known this for years." Many bore witness of how crucial aspects of their subjectivity had been excluded from everyday discourse: “Emotions just didn’t exist at my place, there was no such thing as ‘to feel’” (Ida). In contrast with such a taboo atmosphere, all emotional experiences have the right to exist in the TC: “At my place, anger was not allowed (…) So I was surprised to find out that it was OK to be angry [in the TC]. One day, I had a conflict with Mabel [a staff member], and she said to me ‘It’s OK that you’re angry with me, you have hurt me, and when you are hurt in return, it means that we have a relationship.’ It opened a whole new perspective for me!” (Elisabeth).

2. I unfold my particular way of interacting with the Other

This benevolent and challenging microcosm made it possible for the participants to repeat their habitual 'maladaptive' way of interacting with others. Many were able to briefly describe what was typical of their former interpersonal style:

Tim: *I used to be the joke of the wing, I fought with the staff to challenge their boundaries … I used to be the tough guy.*

Kim: *I was so impolite with everyone, I didn't respond, I was rude, I shut people out, but I didn't realize that I did so.*

Louise: *I used to be a hot-headed person and I felt offended by anything … become angry quite rapidly.*

Hank: *I used to be very well-behaved, I was amiable, (…) I was a nodder (…) I bottled up everything and in the end I always saw myself as the scapegoat.*

These particular ways of interacting are allowed to be expressed in the TC. By studying the participants' accounts in detail, we learned that their interpersonal style had been a way *to defend* themselves against negative thoughts and feelings. This was explained by Tim, for instance, a young man whose coping mechanism was to be a very rational/thinking person and to play mind games with people, proud to silence others with closing arguments:

> *I was so convinced that whatever I said was underpinned by rationality; I had conclusive arguments (…). Yet, they [the mind games] were ridiculous, but they had been my only support, and they were a way to fend off others around me - rather than saying that* I *felt worthless, it came down to saying that* you *are worthless.*

Later in the discussion, Tim made more explicit what he had been escaping from: "My anger, my being misunderstood, my troubles and being unable to tolerate emotions." Bastian used to keep himself busy with other people's problems: "One day [in the TC], someone told me to pay less attention to other people's problems and to start looking at myself instead. (…) It somehow distracted me from the things I needed to work through … not willing to face things." Kim's defense had allowed her to disavow a painful reality: "My mother died thirteen years ago and I always acted as if she was still alive."

3. I am confronted with the Otherness in me

As the TC format encourages residents to unfold their interpersonal style, it also makes them become aware of how they deal with people. In the end, interactions with others are no longer seen as things that just happen, but as events in which they play an active role. To put this differently: they become aware of the Otherness in themselves "as that which is alien or foreign" (Fink, 1995, p. xi). We will illustrate how this process was set in motion. Tim, the rational thinking person, believed firmly in the principles he lived by, for instance that he was a respectful person and that everyone is equal in the eyes of the law. Yet, his rock-solid convictions were challenged by residents and by members of staff, as illustrated with these two examples:

> *I wanted to ask something in the morning reunion: 'Would the person that takes the last cup of coffee be so kind as to make a new pot of coffee?' (…) Someone said 'No - I drink one cup of coffee a day and you have maybe twenty; I don't think I'm going to make coffee for you over and over again.' I freaked out!*
> *I loved rules, they at least make things clear (…) Woe betide if someone broke the rules, it was a 'lack of respect.' I couldn't bear if someone was allowed to do something while the other person wasn't. 'Everyone is equal in the eyes of the law' was a typical sentence of mine. One day, Steven [a staff member] answered: 'Seven persons, seven laws. Everyone is different and everyone is treated in another way.' I couldn't understand it, I got angry!*

TC residents also get feedback from staff by means of enigmatic sentences. Kim - the young woman who had been denying her mother's death – remembered this feedback clearly: "The period for drinking milk is over; it's time for coffee." When Emily requested a week off to help a friend demolish an old house, the staff said to her that they would prefer if she would start to *build* things in here instead of demolishing them out there.

The 'other message' that lies within such interpretations is mostly hard to hear straight away by the person it is meant for. Yet, when residents are able to accept it, such confrontations activate a process that is experienced as both *hard to bear* yet *good* in the long run. By facing their own share in their dysfunctional interpersonal style, people get in touch with the part of themselves that they had been escaping from. The anecdotes below illustrate this painful change in perspective. Louise identified a kitchen incident as a turning point: "The other girl … she was such a 'know-it-all.' She made me so furious that I smashed the cooking-pots from the fire! Well,

… It had frightened me a lot, my own behavior." At night, Louise has been able to start talking about "why I always reacted that way and how I felt about it." The next example describes a situation that initiated the process of change for Tim:

> *I had a light moped but no driving license and I was always saying that I'd like to get my motor driving license and buy a Vespa. One day, Steven [a staff member] said to me 'Come on, put on your coat!' and on our bike we jumped, to the Vespa store. I thought 'Man, why are you doing this to me, it's painful!' But it made me realize, 'Man, you're always sitting in your chair with your crosswords, quarreling, and explaining how things are supposed be, but when it comes to action, you don't do shit.'*

As a matter of fact, it is the residents *themselves* that discover this Otherness: "If they just explain it to you over and over again, well, that doesn't work. It's up to you to discover things little by little (…) Then it becomes less possible to run away from it, to act as if it isn't there … your reality" (Emilie). Working through their blind spot was painful labor to most: "I didn't know I had so many emotions, that so much could arise in terms of emotions. There are even moments that I don't remember because I felt so bad (…) in pain, sad. (…). The positive surplus only came up at the end of my stay" (Louise).

4. I live an Other life

As mentioned above, the treatment outcome can be described in terms of three major changes in the persons' functioning: they had changed their way of dealing with troubles and with people, and developed the ability to make their own choices.

a. I am more resilient and I cope with troubles in a mentalized way

Before coming to the TC, most participants got easily overwhelmed. This is illustrated by two young women, who explained how they would be totally destroyed by being let down in love or by critical remarks: "I crashed completely, I stayed in bed, I didn't take care of myself anymore" (Nathalia), "When someone criticized me, it ruined the whole day, the whole week ... the whole year" (Elisabeth). Some explained how their minds got excessively invested without coming to terms, as Sylver did "For anything that was wrong, I blamed myself severely and I

dramatized the situation," while others (e.g. Tim and Kim) had been able to strip the emotional impact of painful experiences.

As a result of the TC treatment, residents started to become more resilient: "Even when bad things happen, when someone hurts my feelings, I can deal with it" (Nathalia). Almost all participants explained how they have become more able to use their minds in a helpful way, to 'mentalize,' instead of *'freaking out'*: "I reflect, I can situate whatever happens; I have become much more conscious … in an unconscious way [laughs]" (Doreen); "There are things that happen automatically nowadays, for example, to reflect about a difficult situation" (Bastian).

b. I am more involved in pleasant social relationships

Before the TC stay, most participants had little or no social contacts and the few interpersonal interactions they had were very problematic; this changed a lot during their treatment. Former residents no longer withdraw from others by cancelling appointments or by ignoring engagements, by not reacting, recoiling or running away in challenging situations, as they were used to do: "When someone said something to me or laughed at me, I never responded, I always piped down" (Severin); "When someone commented on my school grades, I got enraged, but I couldn't speak a word" (Elisabeth). Many had ended up in desperate isolation, they stayed in bed and had no friends. Despite being emotionally bankrupt, many explained how they 'wore a mask,' how they pretended that everything was fine in social situations: "You stay strong on the outside, I didn't want to let it show. I kept it very hidden, nobody knew about it" (Nathalia). Sometimes they showed in a radical way that they weren't doing well at all by hurting themselves or by suicide attempts: "This was behind it: when you don't recognize my inner pain and when you don't try to help me, then I'll show it to you in a physical way to make things clear!" (Nathalia). A striking treatment result is that the participants have become more involved in pleasant social relations: "I have found an apartment and I have got to know several new friends. A whole new world has opened up!" (Hank), "At school, with colleagues, in the sports club ... I talk much more with people" (Nathalia).

c. I choose life

A further change was observed in residents' general attitude to life; they began to make their own choices. Before, the participants were seemingly in the grip of a paralyzing

indecisiveness: “I did not know what to do with my life, I did many little jobs … I was so stuck” and they felt as if their lives were entirely determined by others: “It was kind of like, *I am lived by* (the other) … everything was decided *for* me” (Darian). Others had been unable to pursue their own goals, to start studying for instance, due to being overwhelmed by anxiety: “When things started to be real, I cancelled everything and let it go because I was too scared” (Nathalia). As a treatment result, the participants have become more able to act upon their path in life. Some explained how they started to get to know themselves and to give expression to their desires: “I really discovered myself as a person” (Doreen); “I have started to accept my homosexuality, for myself and for the outside world” (Bastian). Nathalia and Doreen explained how they have been able to start and carry on with their studies. Others stressed that they made new choices in life according to their needs and desires, as Walter did, for example, who became a sailor: “I get up, I go to my job and two weeks later I come home for a week where I can do whatever I like. It suits me.” Still others explained how they started to stand up for themselves, as Louise did: “I used to do anything that was the best for my foster family … I never took care of myself (…) Now I stand up, I say things like: ‘No, that’s enough.’ (…) They see for themselves how much I have changed. (…) Now, it’s my life.”

Discussion

In order to investigate the treatment outcome and the process of change that takes place in a democratic TC, we examined first-person perspectives by conducting focus group interviews with 24 former residents of the TC known as *De Evenaar*. First, we analyzed the participants’ accounts regarding their **treatment outcome** and found three features characteristic for ‘successful’ cases. These people have become (a) more resilient and able to cope with troubles in a mentalized way, (b) they are more involved in positive social relations, and (c) they are more capable of making their own choices in life. These findings corroborate findings from qualitative research on recovery from severe mental health difficulties, which shows that individuals who characterize themselves as ‘recovered’ precisely emphasize the coming into being of *empowerment*, *connectedness with people* and a *meaningful life* (e.g. Farkas, 2007; Tew, Ramon, Slade, Bird, Menton, & Le Boutillier, 2012).

Next, we discerned three steps in the successful **processes of change**. While Rapoport's principles (1960) can be recognized within these steps[1], by explaining how a TC works in terms of the residents' *process*, members of the staff and the scientific committee noted the resemblance with successful treatment processes in other therapies. It came to the fore that TC residents are allowed to express their dysfunctional way of behaving in the TC. This is an important step in therapy that was first noted by Freud, who described that the patient "repeats everything that has already made its way from the sources of the repressed into his manifest personality – his inhibitions and unserviceable attitudes and his character-traits" (1975 [1914], p. 151). The next step showed that a TC enables the participants to see and work through this repetition compulsion with the help of confrontations or interpretations. These interventions help the person to start verbalizing his or her unconscious desire or *Otherness*. Putting into words this insisting Otherness has been described by Lacan as the main goal of an interpretation[2]: "What's important is to teach the subject to name, to articulate, to bring the desire into existence, the desire which, quite literally, is on this side of existence, which is why it insists" (Lacan, 1991 [1954-1955], p. 228). Although becoming aware of this alien but most intimate part of themselves was hard to bear for most participants, they stayed in the TC because they were held in the group, pointing to a sense of belonging that had come into being. This brings us back to the first step of the process: "I encounter a safe, caring and challenging Other" that stresses the impact of the TC atmosphere and thus of staff members' attitude. This atmosphere has often been described as 'a transitional space,' 'a holding structure,' 'a container' or 'a good-enough mother' (e.g. Schimmel, 1997; Whiteley, 1994). These concepts echo the relational experience of safety and care (holding) and the other's ability to bear and return in a digestible symbolic form the unbearable contents from the suffering person (containment). The importance of this first step in the process of change supports the above-mentioned finding by Pearce and Pickard (2012): promoting a sense of belongingness and the capacity for responsibility are the crucial nonspecific treatment methods in TCs. We see this environmental provision as a condition for therapy in this deeply hurt population.

[1] By comparing our steps with Rapoport's principles (1960), we could say that *democratization* and *communalism* are conditions for the residents to encounter another Other in the TC and to start taking responsibility. *Permissiveness* makes sure that participants are allowed to unfold their interpersonal style and *reality confrontation* points to the fact that they are confronted with it.

[2] Our study revealed several ways in which interpretations are administered in the TC: by fellow residents as well as by staff members, accidently or pointedly, in a direct way or in a more subtle way.

While we believe that our interpretation of the focus group data is fruitful and sheds light on the process of change in a TC, our interpretation is not unique. Alternatively, aspects of the process of change might also be interpreted from the perspective of attachment theory, particularly in terms of its connection with mentalization (Fonagy, Gergely, Jurist & Target, 2002; Fonagy, Bateman, & Bateman, 2011). Our results highlight the crucial role played by the *relational experience of safety*, which functions as a condition that facilitates a process of change whereby mental states are examined and named, and whereby reflection on the other's mind-state takes shape. In terms of metacognitive theory (Dimaggio et al., 2009), it could be argued that residents' self-reflection takes shape during their stay in the TC. Increased self-reflection entails better emotional awareness and helps residents' better comprehend different states of mind (i.e., between themselves and others).

We conclude that a TC can make a process of change possible for persons with deeply ingrained dysfunctional behavior patterns. In some other therapeutic approaches, these persons are often described as obstructing the treatment process because of immature defenses related to a problematic attachment (e.g. Cramer, 2000; Joel, 1998). Thus, while the dysfunctional interpersonal style is often seen as an *obstacle* for therapy, it is the main *focus* of therapy in TCs. The participants' accounts support the idea that their maladaptive patterns had come into being as defenses. Interpreting personality pathology in terms of defenses stresses its reversibility: immature defenses come into being as adaptive, yet, evolve to be pathological, and although they are often "the hallmarks of psychiatric syndromes, defenses are reversible" (Vaillant, 2012, p. 885). Indeed, what a sustained stay in a TC generates is a change in subjective identity through which interpersonal relations are increasingly seen as factors that enable affect regulations (Vanheule & Verhaeghe, 2009; Vanheule, Verhaeghe, & Desmet, 2011).

Our findings emphasize the 'nonspecific' or social treatment methods in a TC (e.g. Bracken et al., 2012; Pearce & Pickard, 2012; Whitely, 2004). Participants did not refer to formal sessions in general to explain why they had changed (e.g. creative therapy, group therapy, …), but to less graspable features such as person characteristics (authentic, engaged, …) and to the impact of interpersonal interactions. Even more so, our study showed that these nonspecific treatment *methods* are analogues with the treatment *results*. As a main result, former residents are more able to cope with troubles and they feel more connected with people. At the same time, these features are precisely encouraged during the TC treatment (e.g. supra: "it's up to you to make the choices," "getting to know people when they are at their worst and when they feel

good creates close bonds") and have also been described as the main treatment factors in TCs (Pearce & Pickard, 2012).

The first limitation of this study is that we focused solely on retrospective qualitative data and did not make use of standardized instruments that assess the process of change during therapy. The second limitation is that our analysis only involved participants that qualified their stay in the TC as successful, and did not study the narratives of participants that were not successful in terms of the two criteria that we put forth[3]. However, this does not imply that these residents' stay in the TC was characterized by therapeutic failure. In general, we observed that these residents tended to focus on material changes (e.g. I live in a nice apartment now) or on the practical skills that they had acquired (e.g. I can now live on my own, I have learned to cook, etc …). However, what they did not refer to was whether they had grown in terms of their involvement in enjoyable social relations, the ability to make choices for themselves, and stand up for themselves. Instead, they bore witness of the fact that they were still struggling to gain freedom from the domination of others (e.g. "When my mother visits me, the first thing she does is start cleaning up my apartment. I say 'no, I'll do it myself' but she doesn't listen (…)". The criticism that these participants expressed towards the TC program was mainly related to problems they experienced in individual psychotherapy. The main three complaints concerned the fact that they felt no rapport with the psychotherapist, that the therapist was too reticent, or that they wanted more than two individual sessions per week. For example, one young female participant indicated that she needed more support and more positive feedback. Another young woman complained that she was made stop taking her anti-depressant medication, which, in her view, was a bad intervention.

Interestingly, even the individuals that evaluated the process as successful pointed to certain negative aspects of their experience in the TC. These included the way group therapy sessions were run, the overall composition of the group staying at the TC, and the lack of an aftercare program. Some participants complained that group therapy sessions were occasionally not as constructive as they had hoped. For example, sometimes nobody spoke for over a half an hour and the therapist remained silent as well. This was not experienced as helpful but rather, as nontherapeutic. Some participants remarked that these tense group sessions actually led to a situation that undermined the therapeutic work: residents would use each other as informal

[3] These two criteria were the characterization of themselves as successful, and the localization of all three main changes with regard to outcome in the participant's narrative.

therapists such that certain problems or conflicts were often left undisclosed to the group as a whole. The actual therapists did not seem to manage this situation and thus the actual therapeutic work was somewhat interfered with. Another complaint was that occasionally group sessions were dedicated to a conflict between two or three residents and this theme would proceed for several weeks. This left little space for other residents to speak about their concerns. Finally, a shortcoming that was stressed by most participants was the lack of an ambulant or semi-residential aftercare program. This TC does not have a re-entry house, and therapists cannot be consulted any longer when residents leave the program. A number of participants experienced the abrupt transition to independent living as very tough and they felt abandoned. While some mentioned that they obtained advice for aftercare, the referral was not always experienced as helpful. For instance, one participant had been advised to continue psychotherapy with an ambulant working clinical psychologist, but that he would have to source such a psychologist by himself. This was experienced as an extra obstacle.

An interesting way of adding to this study would be to conduct follow-up interviews with the participants in the next few years to explore whether they sustain their process of change and to analyze the quantitative pre- and post-measures that were also gathered in this TC.

To conclude, we want to make a strong case for the reappraisal of social psychiatry that encompasses the social nature of human life, psychopathology and treatment (e.g. Bracken et al., 2012; Priebe, Burns, & Craig, 2013). “Service models such as the therapeutic community and day care were formulated largely with an understanding of the therapeutic potential of social interaction” (Priebe, Burns, & Craig, 2013, p. 320). These models have been in decline since psychopathology has started to be interpreted as detached from a social context and as merely determined by neurobiological processes.

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5

Identity change in a drug-free Therapeutic Community: A qualitative study with former residents

In drug-free Therapeutic Communities (TCs), people with addiction live together in order to achieve recovery in terms of a drug-free modified lifestyle. While TCs assume that this shift is only achievable when "identity change" has taken place, this has rarely been addressed in TC research. Further insight into the nature and realization of this so-called identity change might help us understand how this community approach contributes to long-term recovery. The present qualitative study explores the perspectives of ten former TC residents on treatment, outcome and the process of change. To organize and code the interview data, Lacanian psychoanalytic theory on the interrelatedness of drive regulation and identity formation/change is used. The findings illustrate how the participants have been bound to process drive regulation and identity problems (previously solved through addiction) through of their engagement with the TC law, and how this has led to a changed relation to themselves, others and life in general. These findings highlight the value of inventive qualitative research designs to address the many challenges to addiction treatment research.

This chapter is based on Debaere, V., & Vanheule, S. (under review). Identity change in a drug-free Therapeutic Community: A qualitative study with former residents. *Drugs: Education, Prevention, & Policy (special Issue "From the drug users' point of view").*

Introduction

"Treatment research has been asking the wrong questions in the wrong way" (Orford, 2008, p. 875). This is the sobering conclusion of a study investigating the way research is being carried out in the field of addiction treatment. According to Orford (2008), the way in which treatment effects are studied and interventions conceptualized have not been helpful to treatment planners or therapists: Therapeutic relations have been neglected in favor of techniques, and the service users' points of view have been largely ignored (Orford, 2008).

Research on one of the most widespread treatment approaches - the drug-free *Therapeutic Community* (TC) - suffers from comparable shortcomings. TCs are drug-free environments where people with addictions live together to promote recovery in terms of an identity change and a lifestyle modification (De Leon, 2000). In TCs, addiction is mainly seen as a symptom of intra- and interpersonal problems, i.e., "how individuals behave, think, manage emotions, interact, and communicate with others, and how they perceive and experience themselves and the world" (p. 49). Low self-esteem and difficulties in managing feelings are the typically emerging problems. The TC program therefore aims at "changing the whole person (…) [comprising] emotional, cognitive and behavioral changes" (p. 346).

However, the way these changes are realized in a TC is not sufficiently understood. This shortcoming, formulated by De Leon as "little is understood in terms of why and *how* TCs work" (De Leon, 2000, p. 5), has led to a growing call for qualitative process research. De Leon describes the TC process as follows: "lifestyle and identity changes reflect an *integration* of behaviors, experiences, and perceptions (…) Individuals must actively *engage in behaviors* to be changed, they must *feel the feelings* associated with this engagement, and they must *understand the meaning or value* of the change in order to see themselves, others and the world differently" (p. 321, italics added). Although many illustrations of such experiences and perceptions are given (pp. 322-346), they do not *explain* the process. To study this process, we start from Verhaeghe's thesis on the necessary interrelatedness of diagnosis and treatment of psychopathology (2004). Relying on Lacanian psychoanalysis, Verhaeghe's central thesis is that psychic identity is acquired in relation to the Other (i.e. other people, language, the symbolic law) and that psychopathology should therefore be understood within this relation. This way one can acquire the handles for therapy and the therapeutic relation. To explain how and why an already existing treatment works, it is important to investigate the supposedly meaningful connection between the

individual's identity and drive regulation, the treatment program, the process of change, and the outcome. This partly corresponds to the suggestion of De Leon for further TC research: "the link between treatment elements, treatment experiences, and treatment outcomes must be established to firmly substantiate the specific contribution of the TC to long-term recoveries" (p. 5). However, what is missing from this list is the participants' modes of identity and drive regulation. Indeed, this is also missing in the rising field of TC process research in which experts' and residents' opinions on crucial TC elements have been studied, without taking into consideration their eventual interaction with the residents' core problem (e.g. Melnick & De Leon, 1999; Goethals, Soyez, Melnick, De Leon, & Broekaert, 2011).

This study investigates outcome and process as it is reported by former TC residents. To interpret the data, we applied Lacanian psychoanalytic theory on the interrelatedness of identity formation and drive regulation in relation to substance (mis)use.

Method

Sampling

The ten participants included in this study belonged to a TC group from *Trempoline* four years prior to this study. The researcher had also been part of that group for three weeks during a participant observation study (Debaere, Vanheule, & Inslegers, 2014). At that time, the peer group consisted of 26 residents. All ten individuals who successfully finished the program voluntarily participated in this study. After being informed of the study objective, all participants gave informed consent. They received no incentive payment.

Study participants

Participants included seven men and three women with an average age of 31.5 years (range: 27 - 42) when they had started the TC program. Two women entered the TC with their child (of 2 months and 1.5 years old). All had a history of previous admissions in detox centers and/or in residential addiction or psychiatric facilities. Prior to entering the TC, they had been using drugs for approximately 17 years (range: 5 - 23); some said that they had been addicted to hard drugs from the very start. The participants' average stay in all phases of the TC program (i.e. induction stage, TC stage and re-entry house) was 20 months (range: 16 – 24). At the time of the

interviews, seven participants were employed, one had just finished higher education and the two others had already worked but were currently looking for a new job. Pseudonyms are used to protect anonymity.

Data collection

We initially aimed to organize three focus group interviews (Howitt, 2013), but for practical reasons, we instead organized two focus group interviews (with 2 and 4 participants) and four individual interviews. The first author conducted these semi-structured interviews starting from two main questions to investigate the participants' perspective on outcome and process: (1) *Did you change because of the TC treatment? If so, in what way?* and (2) *How did your stay in the TC contribute to this change?* Narrative storytelling was encouraged. The audio-taped focus groups lasted approximately 90 minutes and the individual interviews lasted approximately 38 minutes.

Qualitative data-analysis

The transcribed audio-recordings were studied using thematic analysis (Braun & Clarke, 2006) and Lacanian psychoanalytic theory as the interpretative framework. The fundamental idea of this theory is that *identity formation* and *drive regulation* are two sides of the same coin and that both come into being in relation to *other persons, language* and *a symbolic law* (Verhaeghe, 2004). Within this perspective, being addicted means that the common use of people, language and the law to manage affective experiences and represent oneself is abandoned and replaced by drug consumption, which "anesthetizes" all tension (e.g. Le Poulichet, 1987). This 'solution,' however, becomes problematic, not only because of biological consequences, but also because of a growing detachment from people and language.

A two-step coding procedure was administered. We started from a coding scheme that had been constructed for a study in which former residents of a so-called *democratic* TC were questioned on treatment outcome and process (Debaere, Vanheule, Van Roy, Meganck, Inslegers, & Mol, in press). We adapted this coding scheme because of the nature of the addiction in the present study and the differences between a drug-free TC and a democratic TC. To start coding, we indicated whether each fragment was related to the participants' functioning 'before,' 'during'

or 'after' the TC stay. Next, the fragments were coded for content, as presented in Figure 1. An overview of the study findings are presented in Figure 2 and illustrated below.

before the TC

- a.1 general problems resulting from being addicted
- a.2 person-specific problems existing prior to the addiction
  - a.2.1 drive regulation problems
  - a.2.2 identity problems

during the TC

- b.1 'preliminary' treatment by being subjected to the TC law
  - b.1.1 loss-experiences (-)
  - b.1.2 gain-experiences (+)
- b.2 'actual' treatment of person-specific problems
- b.3 preparation for life in society (in the re-entry house)

after the TC

- c.1 what has changed
  - c.1.1 drive regulation
  - c.1.2 perspectives (on self, others, life in general)
  - c.1.3 relations (to self, others, life in general)
- c.2 what didn't change
- c.3 perspective on (future) drug use

Figure 1. Coding scheme

Findings

Life before the TC

I had ended up in an additive cycle

Being stoned also 'solved' person-specific problems

Life in the TC

I have been recognized for who I am

I have been bound to process my person-specific problems

I have prepared for life in society

Life after the TC

I changed 100% …

But I'm still the same as when I was a kid

Figure 2. Overview of the study findings

Life before the TC

I had ended up in an addictive cycle

All participants indicate that upon entering the TC they had ended up in a disastrous 'addictive cycle,' as Anne explained: "The 10 years that I have been a heroin addict … you are in a spiral, and whether you are on methadone or … you remain in that spiral." They felt withdrawn from everything that is typically human: "Normal society, life, didn't exist anymore (…) me and my product, nothing else mattered" (Anne). Personal relations were of no importance and every thought was consumed with one aim: getting high. They had become completely alienated to the drugged mode of getting satisfaction and the junky identity: "Being a drug addict is being a thief, a liar, a manipulator (…) I wasn't raised like that, but at a given moment, you must become that way, otherwise you won't have your product… you're sick and it's hell!" (Maurice). The terrorizing impact of a full-blown addiction was strikingly phrased by Gerard: "The product

imprisons you (…) everything you do is as a function of that (…) it's the Alcatraz of all psychological prisons."

Being drugged also 'solved' person-specific problems

While the participants had at first been struck by the total satisfaction[1] offered by drugs, consuming drugs was also a means to 'solve' problems. Two participants spoke of having been previously overwhelmed by affective experiences: "I'm a very sensitive person, I'm easily hurt. Before, such things were *un-manageable*. From the moment something happened, I needed something [drugs] (…) Things were happening in here [in my body] that were uncontrollable, anxieties" (Emile). However, most participants situated their main problem in how they used to be extremely determined by the imagined expectations of others. Danielle: "To me, the gaze of others, or rather, how I thought the other had to see me was very important." She perceived herself as being "too small," imagining that she had to be "on top and beautiful" all the time. Such inner dialogue with a disapproving other put much pressure on participants' interpersonal functioning. Consuming had helped Danielle to overcome her perceived shortcomings: "I was too small, so I 'made' me like this [='larger'] (…) you can grow beyond yourself." Testifying to a similar alienation, "I felt the need to be how they wanted me to be (…) well-dressed, charming, sexy, always agreeing," Elise expressed the underlying reason for presenting such an image: "I always thought that I was the problem, that I had to model something of me for the other (…) I had no self-esteem at all."

Participants tended to perceive other people's attitude as disapproving. From a Lacanian perspective, such *interpersonal recognition* is vital to acquire a solid position in life, as humans cannot rely on an 'inborn' identity. To find recognition, these individuals tried to model themselves into presumed expected images, and getting high helped to sooth the tension stemming from being 'masked.'

[1] Most participants had not begun to consume drugs for one specific reason, but "out of curiosity" or "out of boredom." At first, the effects had been nothing but satisfaction: "It was love at first sight," "you're calm," "it gives so much energy," "you forget all the bad things," "you don't feel illness or fatigue anymore" "everything is fun"…

Life in the TC

I have been recognized for who I am

Participants discussed their TC experiences in terms of several 'loss-' and 'gain-' experiences that can be related to the group's subjection to the 'TC law.' In our interpretation, everything that is expected from TC residents can be understood as their needful engagement with some kind of law; the TC law. It implies *prohibitions* reflected by the cardinal TC rules, i.e. no drugs, no aggression, no sex, and *expectations* such as asking for help and helping each other, being honest by talking about your feelings and thoughts, bearing frustration by writing things down and by working these problems in a regulated way in relation to the other in group sessions, …

While some participants mentioned how tough it had been to be restricted from the drug-life, most elaborated on the gains, as having felt truly *recognized*: "I was recognized and appreciated for who I was (…) for your efforts and for the fact that you're still there" (Adrien). The justice in the system and in the staffs' attitude were crucial: "I felt honesty, lots of honesty" (Elise); "We were all put at the same level (…) some came from prison (…) some had worked, some had money, whereas others didn't, some had studied, others hadn't" (James). Moreover, they felt *valorized*, which was beautifully worded by Elise: "I felt that we were all on the same pedestal." She emphasized the importance of the rigorous surveillance of the TC law: "For instance, when you argue with someone by using a vulgar vocabulary ... it didn't escape [the others' attention] (…) I said to myself 'they look at me!' (…) I couldn't escape [the law] (…) It's weird! Because it irritated me (…) and simultaneously, I needed it (…) [that they were] attentive to me and that I was taken seriously." By all being bound by this transparent and respectful TC law, people's behavior had become safe and understandable, leading to a pleasant *feeling of belonging*: "You have 'a family' (…) affection" (Bob); "I have been loved for who I am" (Adrien).

These gain-experiences, which seemed strengthened by an *identification process* with staff (ex-users) and by an atmosphere of *hope* in the house, were crucial for participants to bear the loss and frustration fundamental to the recovery process. Nigel's concise explication, i.e., "the fact that you live through frustrations is what helps," is elaborated below.

I have been bound to process person-specific problems

By being involved in the TC program, participants felt bound to process their problems. They were challenged to put into words what they used to act out. Elise: "Most important to me has been the *management of my emotions*. I had to respect the limits that were imposed (…) it took me 6 to 7 months not to explode anymore." She also situated the role of TC interventions in this process: "Sometimes, for a silly thing (…) I exploded! Afterwards, for one to two days, I found myself without having any social contact, cleaning the whole day. (...) In the beginning, I wanted to leave all the time ... but something kept me there (…) So, I started to let go, I said to myself 'I'm tired of being like that and I started to reflect on my ways. I stopped saying 'It's his fault! It's the staff who are disgusting!' (…) and I started to think about how I could behave to avoid going through all that."

Along with finding words for their suffering, participants began to *process identity-related problems*, as the nonstop program gradually confronted them with the fundaments of their intra- and interpersonal problems. James: "The goal is to frustrate you; this exteriorizes a maximum (…) and according to your own difficulties, you'll always be confronted with the same things." Danielle explained that, in retrospect, she could see how her resistance during the first Encounter group had already been determined by her imagined expectations of others:

Danielle: *[After seeing] the first group, I said to myself: 'I will not take part in these groups! You all look ugly when you express yourselves! (…) That's not a thing to do.*

Interviewer: *You wanted to be ...*

Danielle: *Yes! [Me], all beautiful and all! And they all looked so ugly when they got angry!*

Participants started to *see their own investment* in the repetition of problematic situations. Their blind spots were directly 'mirrored' by fellow residents: "People tell you all the time what is not working for you" (Adrien). They also became aware of this investment by their particular way of handling TC tools. For instance, James related his stubborn way of working very hard in

Encounter groups and job functions as a way of getting recognition: "I always wanted to do well, and then do even better and to get recognized *because of that*!."

Beyond seeing how they were implicated in the difficulties they ran into, participants were also challenged to *let go*. This was a painful process as their symptomatic way of relating to others had actually come into being as a way to be someone in the eyes of the other, or more literally, to defend themselves against a violating other. The fragment below illustrates how Bob's way of holding on to "not bending" had developed in response to traumatic events in childhood and why it was painful to let go:

Bob: *I realized that* Trempoline *is stronger than me and that I could not bullshit them, that I had to, between brackets, bend … That's how it is, when you want to get out, that's the way it is.*

Interviewer *Why was it so difficult to* bend*?*

Bob: *To me, it had to do with the touching, because I once had to bend for an adult, I didn't want to, yet, I didn't have the strength to say "no" (…). One day I said to Hugo [staff]: "I have the impression that you still want me to lower my pants."*

For several participants, only a 'dive down'[2] experience made it possible to let go and move on. By holding on to a fixed belief of how things had to be done, Ann had become stuck in her process: "I had been thinking '*I will do everything*, so that it's over, so that I can go home with my child.'" Ann had been a nice and very cooperative girl in the TC, yet, for 6 months she had been losing weight: "Before the dive down, I weighed 47 or 48, now I weigh 64 kilo, imagine that." The weight loss had made the staff members realize that all was not well, that she was probably not genuinely engaged but sitting it out to the end. This is how Anne explained the dive down (that lasted two weeks): "They wear you out. No more contact with my child, no more contact with anyone. Everything I asked for, for instance, to work outside in the sun, was 'no.'

[2] The so-called 'dive down' is an intervention where the resident remains physically in the TC, but can no longer take part in group life. He/she has to accomplish practical tasks for days and is led by a fellow resident in this process. The TC director called it "a surgical tool," which emphasizes the radical changes that can be realized, but also the staff members' clinical know-how to implement and supervise this experience in a justified way.

They wanted me to 'explode.' They want to 'pull out' who you really are (…) they have been able to break something open that was so stuck (…)."

While their "mask was falling down" (Elise), participants were constantly encouraged to 'speak out' as an alternative way to move on: "You learn to say what you have to say to people" (Maurice)…. "(…) you have to be able to ask what you want and to say what you feel - I wasn't able to do that anymore" (Ann). Finally, some kind of transition took place: "It's a click (…) and it comes from inside yourself" (Elise) "that you do the things for yourself" (Danielle).

I have prepared for life in society

Most participants also mentioned the vital role of the re-entry house. Next to appreciating the practical help they received (e.g. looking for a job, apartment), they emphasized its usefulness in terms of reintegrating into life outside the TC: "It's as if you have been on an island [in the TC] where you cannot do what you want when you want, and then you return to society where you [*can*]. It's too different" (James). The re-entry house served "to construct life (…) to forge links with the outside world" (Emile). Remarkably, and in contrast with how they had 'unlocked' their affective life in the TC, they learned that "in everyday life, one has to hide a bit," "everyone plays some comedy ... and I learned: yes, you can!" (James).

Life after the TC

I changed 100% …

Compared to how they had arrived in the TC, *all participants* emphasized the all-embracing impact of the change: "The change is e.n.o.r.m.o.u.s" (Maurice), "I didn't change 90%, I changed 100%" (Anne).

Through the obtained narrative framework on who they are and what they live(d) through, they were able to *cope with affective experiences* via speech: "When I have a problem with her [girlfriend], we'll talk about it ... it will not always come out appropriately, but it comes out and after that, it decreases" (Emile). Interestingly, Anne stressed the importance of speaking honestly to prevent relapse: "When something is bothering me because of you, and I tell you in a correct way: it's off my chest. When I bottle up … I could relapse."

Next to this new ability to regulate affect, most participants emphasized their *changed perception of themselves* in relation to others. Their earlier distorted view, "I thought that I had a good view (…) of myself, of what others wanted from me … It wasn't true," turned into a more realistic view of themselves; "I know myself much better, I know my weaknesses and strengths" (Elise), and of others: "[No longer wanting] the love of everyone, that's probably what has changed" (Danielle); "'To do good' (…) that doesn't mean anything. (…) Life and people (…) they don't expect anything special from me."

This occurred alongside a *changed relation* to themselves and others; "I'm more gentle with myself … I have the right to make mistakes" (Danielle), is accompanied by a growing self-acceptance and self-worth, "I am my-self, I accept who I am (…) proud to be me" (Maurice); "I don't see myself as a waste anymore, I respect myself. I have my place" (Elise). For all participants, family relations improved: "It's much easier when I see my father (…) I'm happy to see them – before, I was never happy to see them" (James), and meaningful relations have come into being: "I have friends now, people that I can call when I don't feel well and who can also call me" (Adrien).

Moreover, a new desire for life has emerged; "I *want* to live" (Maurice). "I don't function as a victim anymore" is how Elise formulated the proactive change that resulted into a responsible agency: "I do what needs to be done to acquire what I want" (Gerard), "I have an apartment, I pay the bills, I work, I started going to school again." Their new stance in life resulted in a "normal well-being" (Bob), summarized by Ann as follows: "I live alone, but I have my child, my job, I live well, I have my family ..., I can't wish for anything more!"

… but I'm still the same as when I was a kid

Finally, these changes were experienced as having become more *themselves*, more authentic: "I am the same person as when I was a child" (Anne); "now, I'm my-self" (…) I'm Maurice since I was born, but I was anesthetized (…) but, all my shortcomings that these people know so well [group members laugh] ... I'm more profoundly me now than since I was 8 years old."

Discussion

This study examined 'identity change' by questioning ten individuals four years after they successfully finished a TC program. Using Lacanian theory, we related identity and problems with drive regulation and discussed this in the context of the TC program, with the processes of change and outcome therein. We differentiated between the addiction and participants' *pre-existing* problems at the level of identity and drive regulation. The TC process is understood as the participants' ongoing (i.e., 'non-stop') management of these pre-existing problems. While some mentioned their new ability to regulate affective experiences as an important outcome, most emphasized the *changed relation to themselves* in relation to a changed perception of and relation to other people (and life in general).

This 'inner change' is described as having become more themselves, more authentic (e.g. I am my-self now; I really feel that I am authentic in relation to the other). The meaning of such statements is clarified by looking at the way the participants' problems have been tackled in the program. Participants' excessive dependence on the imagined expectation of others (to find recognition) was challenged: in the TC, they felt recognized and loved for who they are, *not* for an image. At the same time, they have been challenged to move beyond that masked way of being. This finding contrasts sharply with how the meant change is sometimes described, i.e. as the *adaptation* to an external norm: "Participants are expected to construct a new sense of self according to institutional parameters" (Paik, 2006, p. 213). In our study, participants stressed that they did not adapt themselves to the TC lifestyle: "the way of functioning we learned there … you cannot function that way (…) you would go crazy!" (Adrien); "I don't think that cleaning the same thing non-stop has a specific goal" (James).

Interpreting the meant change as an 'adaptation' probably stems from confusing the terms treatment *process* and *outcome*. The importance of the residents' adaptation for the treatment *process* has been highlighted in theory and research: Incoming residents must "act as if" they already abide to the prescribed "right living" (De Leon, 2000), which results in "identification processes" (Ravndal & Vaglum, 1994) or "social cohesion" (Dermatis, Salke, Galanter, & Bunt, 2001).

However, by triangulating our findings with an earlier resident experience and the psychoanalytic framework, we understand the TC expectations as the residents' required subjection to the TC law. By stressing the need to become regulated (again) by a shared law that

prohibits immediate drive gratification/discharge *and* that expects participants to rely on others and language to regulate affect, find pleasure in the social bond and define oneself, the interrelatedness between the residents' problems and the treatment program becomes more understandable. The installment of the law reverses the addiction cycle by re-installing a connection to people, language and the symbolic law. Moreover, our findings demonstrate that successful treatment is not based on the residents' ever increasing application of that law, but in the processing of person-specific problems that have only surfaced because of their non-stop involvement with that law. This is how Elise put it: "although from the outside, the program looks similar to all, you don't all experience things in the same way (…) a program is always personalized!" In other words, what is put in place to organize group life in a TC (such as the hierarchical structure and the *act as if* principle) should be understood as tools that enable the residents person-specific therapeutic work and not as having an intrinsic, face-value. Danielle phrased this as follows: "the result is not where you expect it (…) the program is not a recipe for success." This is in line with Kooyman's characterization of the TC structure: "structure in a therapeutic community is a *tool* and *not an ideology* (…)" (Kooyman, 1993, p. 20, italics added).

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6

General discussion

The aim of this dissertation was to investigate the "black box" of the process of change in a TC by means of several qualitative studies. This final chapter summarizes the main findings from our studies and the way they are related to one another. We compare a successful treatment process in a TC with the way a process of change is understood from a Lacanian psychoanalytic perspective. We explain that the therapeutic value of these communities is related to the way they make use of interpersonal relations and speech, and that their approach fits the needs of their target populations, characterized by a disconnection from people and their own mental life. We further pointed to the confusion that stems from the way the several types of TCs have been labeled (e.g., 'drug-free' or 'hierarchic' TCs versus 'democratic' TCs) and we relate our findings to former TC research topics (e.g. drop-out, time in program). Finally, limitations of the dissertation and suggestions for future research are discussed.

Main study findings

This dissertation aimed at investigating the process of change that residents in a Therapeutic Community (TC) go through. Until today, the reason as to how and why people change throughout their stay in such long-term community based programs is still considered a "black box". By making use of several qualitative research methodologies, we studied the interrelatedness of the treatment approach with the process of change in three settings through a (Lacanian) psychoanalytic interpretative framework.

Chapter 2 presents a participant observation study. In this study the researcher joined a drug-free TC with the status of resident in order to experience the treatment approach from a first person perspective. In contrast with former participant observation studies where researchers do not fully immerse themselves in the system (e.g. Frankel, 1989; Foster, Nathan, & Ferry, 2010; Mello, Pechansky, Inciardi, & Surrat, 1997; Nielsen & Scarpitti, 1997; Ravndal & Vaglum, 1994), the researcher's intensive experience brought to light characteristics of the TC tools and treatment environment that might have otherwise remained unnoticed. What was characteristic of this TC was the atmosphere of a 'frustrating' and 'holding' environment. With the term 'frustrating' we refer to the experience of being deprived of the usual ways of finding satisfaction and acting out, such that numbed emotions come to life again. At the same time, the environment is 'holding', in the sense described by Winnicott (1960), which allowed us to understand the rationale of staying in the TC environment. In that paper we discuss the relation between this atmosphere and the process of change by focusing on the function of the TC tools. In order to handle the awakening affective life, residents must make use of different TC tools to translate or transpose their intense affective experiences into spoken words and writing. To our knowledge, the crucial role of these verbalizing, symbolizing or mentalizing tools has not yet been highlighted in TC research. Figure 1 summarizes the process of change in terms of residents' growing ability to manage disturbing affective experiences in a more mentalized way.

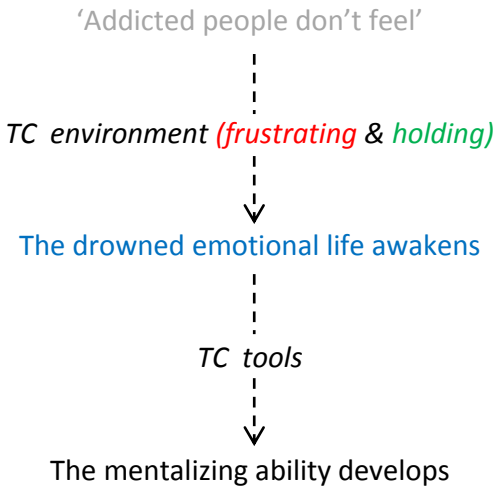

Figure 1. Main findings from Chapter 2

In order to refine the findings from Chapter 2, Chapter 3 addresses the process of change in two individuals during their entire period of stay in a TC by means of multiple interviews and the administration of the IIP-32 at four time periods. As presented in Figure 2, the process was divided into three logical steps. By making use of the Lacanian concept of the *Other*, we emphasized the extent to which the residents started from a position of disconnection. When Simon and Andrew entered the TC, they were not only emotionally anesthetized, but their 'a-diction' was blatant and their disconnection from meaningful social relations attracted our attention, as did their impoverished mental life and their lack of a (internalized) law. In a second step, we marked the reversal of this process of disconnection, which we inferred from two psychodynamic changes: in the TC they were becoming emotionally affected again and a growing feeling of belonging came into being. The third step that we discerned concerns the change in their affective life: both participants became increasingly affected by inner conflict and by un-integrated (traumatic) experiences. This means that they started to become affected by unprocessed experiences *from their own past* and not merely due of the (many) rules associated with the TC law. In this chapter, we discussed how both cases differed in term of the extent to which subject-related mental suffering was processed.

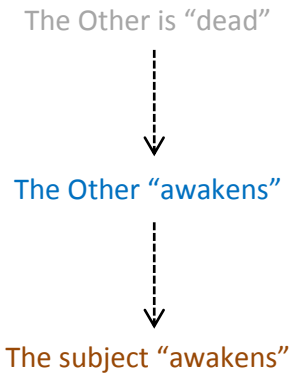

Figure 2. Main findings from Chapter 3

In Chapters 4 and 5 we investigated former TC residents’ perspectives of the treatment process that they lived through as well as on the outcome they experienced. We used focus group interviews and individual interviews; the participants in Chapter 4 were 24 former residents of a *democratic* TC, and in Chapter 5, 10 former residents of a *drug-free* TC.

In Chapter 4, the treatment process in the democratic TC was discussed in terms of four logical steps that residents made, with treatment outcome being the last step (see Figure 3). Again, the importance of the double atmosphere came to the fore: in the TC, the participants had experienced a *safe and caring* Other that had also been *challenging and demanding* (first step). The second step concerns the way these people began to repeat their habitual ‘maladaptive’ interpersonal style in the TC. The third step refers to their growing awareness of internal *Otherness*: they were confronted with the most intimate part of who they are, which they had not been experiencing as their own, but as alienated or foreign (Fink, 1995). We highlighted how participants’ growing painful awareness of this Otherness – and thus, of the active role they had been playing in the misery they usually ended up in – came into being because of a combination of confronting/interpretative experiences and interventions. The fourth step of our model concerns the treatment outcome: an improvement in intra- and interpersonal functioning, consisting of functional drive regulation strategies; a growing involvement in pleasant social relations; and the ability to act on their life path.

1. I encounter a safe, caring and challenging Other
2. I unfold my particular way of interacting with the Other
3. I am confronted with the Otherness in me
4. I live an Other life
    a. I am more resilient and I cope with troubles
    b. I am more involved in pleasant social relations
    c. I choose life

Figure 3. Main findings from Chapter 4

In Chapter 5, the process of change in the drug-free TC was presented as the middle step, in between life before and after the stay in the TC (see Figure 4). While the participants' life before their stay in the TC had been dominated by drug addiction - "the Alcatraz of all psychological prisons" (p. 118) - drug use had also been 'solving' person-specific problems, just as it regulated drives and problems related to identity. Crucial to the participants' experience of living in the drug-free TC had been the recognition of who they are, with the honest application of the TC law, and the perceived justice in staff members' attitude being determinative factors. Because of their non-stop involvement with the TC law, participants felt bound to process the person-specific problems that surfaced in the TC. The vital role of the re-entry house to reintegrate into life in society life was also highlighted. Finally, the all-embracing impact of the participants' change was illustrated. The change not only comprised the development of novel drive regulation strategies (e.g. speech, mentalization), but also an identity transformation that was explained as a changed relation to themselves in relation to others. As this process of transformation took place they experienced themselves as more 'true' and authentic.

1. Life before the TC

I had ended up in an additive cycle

Being stoned also 'solved' person-specific problems

2. Life in the TC

2.1 I have been recognized for who I am

2.2 I have been bound to process my person-specific problems

2.3 I have prepared for life in society

3. Life after the TC

I changed 100% …

But I'm still the same as when I was a kid

Figure 4. Main findings from Chapter 5

Interrelatedness of the main study findings

In order to acquire a more global insight into successful processes of change in a TC, we will now relate the findings from the different studies to one another. As can be noticed in the previous part, the different steps discerned in each figure are presented in different colors. These colors return in the four figures, and indicate steps that we consider as similar across the different studies.

Disconnection from the Other

The grey color that returns in all three drug-free TC studies refers to the intra- and interpersonal functioning of addicted individuals and of those who are only just physically clean: 'addicted people don't feel' (Figure 1); 'the Other is dead '(Figure 2) ; 'I had ended up in an addictive cycle' (Figure 4). These characterizations correspond to how, in our introductory chapter, we conceptualized addiction as a disconnection from the Other (e.g. Fernandez, 2010; Freud, 1961 [1929], Le Poulichet, 1987, Magoudi, 1986, Verhaeghe, 2004). What is interesting to note is that this condition persists even when the addicted individual is physically detoxified. This

is particularly apparent in the studies discussed in Chapters 2 and 3, where we encountered individuals at the beginning of their TC stay. In the democratic TC study, we did not report a separate first step to characterize the participants' way of functioning before entering treatment. Still, by looking back at their narratives, similarities with the condition of addicted individuals can be seen. It is as if these people had somehow 'encapsulated' themselves: in a mental way they had been detaching from meaningful relations, which we summarized as follows: "Before the TC stay, most participants had little or no social contacts" (p. 99), "many had ended up in a desperate isolation" (p. 99).

The TC embodies the mother and father function

Both the red and green colors return in 3 out of 4 figures. These refer to the interpersonal atmosphere experienced in the TC, which consists of two dimensions that we described in the different studies as 'the frustrating and holding TC environment' (Figure 1); 'I encounter a safe, caring and challenging Other '(Figure 3); and 'I have been recognized for who I am / I have been bound to … ' (Figure 4). TC staff members and other researchers have already pointed to both dimensions in terms of the contrasting concept pairs 'humane' and 'tough' (Perfas, 2004) or 'caring' and 'strict' (Infante, 2012). Based on Rapoport's (1960) 'permissiveness' principle, which means that all residents should tolerate a wide range of behaviors from each other, it could be assumed that only the presence of the holding dimension characterizes the atmosphere in a democratic TC. However, this did not prove to be the case. We observed that both dimensions were present in our democratic TC study, which corresponds with the characterization of democratic TCs in other empirical studies, including a recent Swedish study where the TC was described as having a "safe, home-like and relationship-intensive atmosphere with firm structure and clear rules" (Werbart, Forsström, & Jeanneau, 2012, p. 368).

Some psychoanalysts (from outside the TC world) also point to the necessity of such a double dimension in the treatment of addicted individuals. For example, Geberovich explains how "a motherly and fatherly axis is needed" (2004, p. 148), and in Chapter 3, we referred to Snoy's suggestion that "elements should be installed to remove others"[1] (1993, p. 38). Remarkably, both TC dimensions resemble dimensions that are crucial to all upbringing: love and safety on the one hand (the 'mother' function) and structure/laws on the other hand (the

[1] "(…) een aantal elementen 'aan te brengen' teneinde weer andere elementen te kunnen 'weghalen'".

'father' function). The combination of both enables the mental processes of alienation and separation (e.g. Verhaeghe, 2004).

The key question here is *why* such an interpersonal atmosphere is so important to the TC. In this respect, our immersion in the TC peer group was most informative. As explained across the studies, in the drug-free TC residents are *at all times* expected to tolerate many explicit values and norms, which we called the *TC law*. This is not just a senseless rule, but an explicit and transparent law with special characteristics with regard to content and with regard to how it is implemented. In terms of content, the prohibitions[2] and expectations[3] can be read as the *prohibition of immediate drive gratification* and *the expectation to connect to the Other.* The involvement with this law aims at the realization of a social life without drugs. Equally important is that new TC residents learn the do's and don'ts of the TC law by being socialized by their fellow residents. More than that, residents are expected to bear responsibility for their own process of change and for that of their peers. This means that they need to apply the TC law themselves and have to keep an eye on how fellow residents apply it. In other words: the TC peer group *and* staff members' involvement with the TC law (as they supervise the functioning of this self-governing system) realizes the 'mother' and 'father' function in the TC.

While we did not immerse ourselves in a democratic TC, we conclude from literature and from the interviews described in Chapter 4 that group-life in such a TC is not organized by this kind of stringent law. The difference between the *highly structured* drug-free TC and the *less structured* democratic TC is probably a direct effect of their work with different target populations. The inability of addicted individuals who are only just physically clean to regulate inner tension by means of their mental apparatus implies a total dependency on others, comparable to the "prematurity" or elementary "Hiflosigkeit" of the newborn child (Freud, 1961 [1929]; Lacan, 2006 [1949]). This was described by TC insiders as "a 'baby' in a man's body" (Perfas, 2004, p. xv). Apparently, the drug-free TC approach adapts to this condition of helplessness by offering a total environment to pull these people into the symbolic order, thus, into social bonds and life. We understand the function of the total TC environment as similar to the function of the Other to answer the somatic need of the newborn, that is, as the $\mathbb{A}$ in the

[2] The cardinal rules are 'no drugs', 'no aggression' and 'no sex between residents'

[3] e.g. respect, take care of and help your peers, be honest and verbalize thoughts about yourself, no withdrawal from the group, make use of the TC tools to transform affective experiences into language, …

figure that presents the interrelatedness of identity formation and drive regulation in our introductory chapter (p. 15).

The fact that residents in the drug-free TC need to be busy all day can also be understood by the fact that they experience the absence of their substance as overall *emptiness*, and not (yet) as *lack* that functions as the motor force of desire (e.g. Audibert, 2011). Many aspects of the TC law are crucial in order to keep narcotics outside, and to offer them a fair chance to rebuild another life by reinstalling confidence in people and the spoken word. In other words: in the drug-free TC abstinence is not merely a treatment *objective* but also a crucial treatment *tool*. In the next part, we refer to the psychodynamic changes that are triggered by living in this TC environment.

Re-connection to the Other … and to the Otherness

The step depicted in blue returns in 3 out of 4 figures. It refers to the fact that, characteristically, people do not remain un-affected as they start living in a TC, which we interpreted as an expression of their growing re-connection to the Other. Again, the participant observation study has been most informative in terms of this psychodynamic change in TC residents. In that study we referred to this as 'The drowned emotional life awakens' (Figure 1). Similarly, the in-treatment follow-up of Simon and Andrew showed how both of them began to be affected again by everyday TC difficulties, which we described in that study as 'The Other awakens' (Figure 2). While the appearance of their troubled affective state was the first change to draw our attention, another important initial change was that these residents started to enjoy the growing attachment to and friendship with peers. What we can conclude with regard to the process of change at this point corresponds to what the psychoanalyst Geberovich (2004) describes as the goal of the installment of the mother- and father function, i.e. binding and identification. This crucial aspect of the process of change in a TC has already been described in terms of a "social affiliation with the drug-free peer community" (Dermatis, Salke, Galanter, & Bunt, 2001, p. 105), or an "attachment to and identification with co-residents, staff, and the treatment program" (Ravndal & Vaglum, 1994, p. 4).

A further step concerning the development of transference relations: participants started to repeat their habitual way of interacting with people and thus started to become aware of what was typical, persistent and symptomatic about their own mode of social interaction. In the democratic TC study, we referred to this step as 'I unfold my particular way of interacting with

the Other'[4] (Figure 3). Typical for the drug-free TC approach, was that this symptomatic behavior especially became manifest in the residents' *particular way* of transgressing the TC law[5]. Indeed, also in the drug-free TCs the process of change was very personalized, which is illustrated in Chapters 3 and 5. We believe that by describing this step we developed a crucial insight into the process of change in these TCs. After all, this step is not explicitly discussed in existent literature on drug-free TC research. Therefore we concluded that the TC approach goes beyond the mere re-connection to the Other – which has also been described as 'education' (e.g. Broekaert, 2013) - and encompasses a *psycho*-therapeutic goal as well.

The subsequent step within this process – illustrated in brown in the figures 2, 3 and 4 – refers to what happened when 'cracks' started to appear in the residents' symptomatic interpersonal style, which we also called their defensive ego-armor[6]. In the addiction treatment field, this step is often referred to as 'hitting bottom': "The idea of facing a serious crisis or 'hitting bottom' is emphasized as being a common condition to change. In psychodynamic terms one could translate this as a crashing of defenses, a breaking down of omnipotence (…) a process of 'ego-reduction'" (Weegman, 2009, p. 97). The participants were confronted with parts of themselves that they had never been able to put into words and they started to assume them as part of their own being. We referred to this alienated part of oneself, which is also most intimate, with the concepts 'subject' (Figure 2) and 'Otherness' (Figure 3). Patricia de Martelaere (1997, p. 57) illustrated what this is about in one of her novels:

> The otherness does not start with others
> We are alien to ourselves

[4] see the examples on p. 96

[5] For instance: "The playful Simon had a hard time behaving respectfully without playing games, while Andrew had difficulties expressing his discontent towards people" (p. 69)

[6] Lacan states that the ego is structured like a symptom and that "the fundamental absurdity of interhuman behavior can only be comprehended in the light of this system – (…) – called the human ego, namely the set of defenses, of denials, of dams, of inhibitions of fundamental fantasies which orient and direct the subject" (Lacan, 1988 [1953-1954], p. 17). By following the TC residents' process of change in detail, we noticed how different functions of the ego were addressed throughout the interviews. For instance, in interview 1, Simon presented *his identity* as follows: "That I play a lot and that I am fond of laughing is typical about me". In interview 4, the *defensive function* became more to the surface: "It is always the same thing in here [his TC job function as member of the maintenance crew], it is boring; but I still enjoy myself, I can laugh a lot". And the next quote from interview 3 shows that it is because of their ego-functioning that residents collide with the TC law. This is how Simon explained that he got confronted "because I approach everyone to laugh with, but not to talk and not to share".

> We are to ourselves
> an other – or, even worse: many others
> Sartre is right when he says: l'enfer c'est les autres
> It just, the others are also in ourselves. Therefore, hell is everywhere[7]

One can deduce from this fragment the direction for the subsequent step in the process of change: they have to come to terms with who they are by starting to put into words and symbolize their subject-related discord. This has profound effects, which Lacan explained with his concept of "full speech"[8] (Lacan, 2006 [1956]), commenting that "speech is an act (…) [that] adds the dimension of flattening"[9] (Lacan, 1974-1975), that "speech rescues"[10] (Lacan, 1976-1977). This refers to the fact that unprocessed tension or trauma plagues the individual until it is transformed by 'true' speech. This *necessity* of exploring, putting into words and integrating this Otherness in order to move on was strikingly formulated by Naya Arbiter (2011) with the words of Jung: "One does not become enlightened by imaging figures of light, but by making the darkness conscious". In our studies, the importance of the peer group was often highlighted as a necessary support to go through this painful process. Such a process was described in some detail in Chapter 3 with the case of Andrew, but was also brought up in Chapters 4 and 5. In Lacanian psychoanalysis the therapeutic process that aims at moving beyond the alienated self-images, at assuming Otherness and lack, and at taking responsibility for one's own life is often referred to as a process of 'subjectivization' (Fink, 1997). The way Snoy continues the citation on the installment and removal of elements for the treatment of people with addiction corresponds to the way we understand the latest step in the process, that is "to allow the suffering subject to find back himself"[11] (1993, p. 38, our translation).

Within psychoanalytic circles, the intended treatment direction for people who are in a "situation of social abandonment" [12] or no longer connected to the Other, has been defined in similar way as how we have understood the treatment process of these people in TCs. For instance, this is how psychoanalysts of *Le Champ Freudien* (Miller, 2007) formulate the intended

[7] "De vreemdheid begint niet met de anderen. Wij zijn vreemd voor onszelf. Wij zijn voor onszelf een ander, of, veel erger nog: vele anderen. Sartre heeft gelijk wanneer hij zegt: l'enfer c'est les autres. Alleen zitten de anderen ook in onszelf. De hel is zodoende overal."
[8] "parole plaine".
[9] "Le dire est un acte (…) [ça] ajoute la dimension de la mise à plat".
[10] "dire secourt".
[11] "die het lijdend subject toelaten om zichzelf terug te vinden en te bevragen".
[12] "une situation de déprise sociale".

treatment direction: “A connecting, even briefly, to the supposed knowledge – that we call hypothetically ‘unconscious’[13] – reveals oneself in the rule by a reconnection to what we traditionally call the discourse of the Other (…) [or] to the social reality”. These intended two movements correspond to the way we have interpreted the process of change in TCs: on the one hand there is a reconnection to the Other, and on the other hand a re-connection to the Otherness. Yet, instead of trying to install these processes of re-connection at the mental level only, in a TC, it is explicitly organized in terms of how the group functions.

In our participant observation study, we formulated the process of change in terms of a *mentalization process* (Figure 1). Yet, by following residents during their whole stay, we have concluded that Lacanian theory provided us with a better framework for discerning the logical steps in the process of change. Also, during this participant observation study, we were struck by the crucial role of the *TC tools* (Figure 1) for translating or transposing affect into spoken or written language. As we further studied the TC approach, we started to see how the use of the TC tools was a fundamental ingredient of the TC law.

Living an Other life

Considering the treatment outcome - the purple part in figures 3 and 4 – all study participants[14] in Chapters 4 and 5 bore witness of an all-embracing change. While we addressed outcome by starting from an open question – *“Did you change because of your stay in the TC? If so, in what way?”* – it was interesting to note that they did not answer the question by referring to the acquisition of practical skills, for instance. Instead, they all explained that the crux of the process of change concerns altered intra- and interpersonal functioning. Not only did they refer to the development of more functional drive regulation strategies (e.g. mentalization, talking to others, …); they stressed that they acquired a changed perspective of themselves - in relation to others – as well as of relations with others. One remarkable change that we observed has also been described by Pearce and Pickard (2013) in terms of the coming into being of “the capacity of responsible agency”. Instead of chiefly undergoing life in a passive way – what Maurice described as “I used to be a mussel”, Adrien as “I used to be a plant” (participants study 5), or

[13] The ‘unconscious’ in this phrase is what we referred to with the ‘subject’ or the ‘Otherness’.

[14] While we did not consider all former residents of the democratic TC that took part in the focus group study of Chapter 4, we here refer to the 18 out of the 24 persons that we did consider ‘successful’ (based on the criteria we decided on in that study) and that we implied in the analytic process of that study.

Darian as “everything was decided for me” (participants study 3) - throughout the process of change they reclaimed their own life: while at first the Other used to pull the strings, now they have come into being as individuals that make up their own cause, and that rewrite their psychic destiny (Ruti, 2008).

We conclude that our qualitative psychoanalytic study of the “black box” of the TC process led to clinically meaningful findings. We clarified the interrelation between the TC treatment approach, residents’ onset of drive regulation and problems related to identity, and the TC process with its characteristic outcomes. We believe that a good conceptualization of TC residents’ basic problem is of utmost importance to clarify the rationale of the treatment approach, which is usually missing in other process research that has surfaced in the past years (e.g. Melnick & De Leon, 1999). What our study participants highlighted as essential to their process was not formulated in terms of specific group sessions or techniques, but in terms of intra- and interpersonal experiences and processes (that were realized, of course, because of the way the program is put in place). We fully agree with the way Schimmel (1996) conceives of complex interpersonal processes (occurring in all residential facilities) as the *primary medium of treatment* in TCs. The importance of these ‘nonspecific’ or social treatment processes in TCs is exactly what our findings emphasize (e.g. Bracken et al., 2012; Pearce & Pickard, 2012; Whitely, 2004).

While this research project was not set up to compare both types of TCs[15], based on our findings, we can highlight some aspects of difference. In our opinion the existing descriptive overviews that compare drug-free TCs with democratic TCs do not clarify the process of change taking place in both settings (e.g. Vanderplasschen, Vandevelde, & Broekaert, 2014; Vandevelde & Broekaert, 2003). For instance, defining drug-free TCs in terms of ‘self-help’ and ‘hierarchy’ and democratic TCs in terms of ‘professionalism’ and ‘democratization’ does not help us understand the process. Both types of TCs are based on self-help principles - they assign the responsibility of the process to the resident and function in a professional way (whether or not with former TC residents in the staff crew). The fact that TC residents in a drug-free TC function in a rotating hierarchical (job) structure, does not mean that the decisions made in this TC are

[15] The study with the democratic TC *de evenaar* was set up at the request of *de evenaar* when our research project on drug-free TCs had started already.

less democratic. This is also the way Rex Haigh felt about Rapoport's principles to define the democratic TC (i.e. democratization, communalism, permissiveness and reality confrontation): "It feels that those words cannot do justice to what happens" (p. 7). We believe that our studies shed light on the differences between both types of TCs. We consider it more interesting to think of the differences in terms of the effort that is needed to sideline the total drug solution and to re-install the law in order to re-install a connection to the Other in the drug-free TCs. Therefore, we suggest that it is more relevant to differentiate between *highly structured* (drug-free) and *less structured* (democratic) TCs. What is interesting in this context is the history of two of the first European drug-free TCs – *Choisis* in Belgium and the *Emiliehoeve* in The Netherlands. Both started as democratic TCs, with lots of freedom and the expectation that all residents are equally responsible for taking the initiative from the start. This is how it was during the first months in *Choisis*: "staff members asked the residents to participate in the meetings, in the groups, … Yet, they resigned (…) 'We found out that drugs were circulating in our TC since weeks' " (Delatte, 2004, pp. 15-16). This is how it was in the *Emiliehoeve*: "During the first months of its existence, decisions at the Emiliehoeve therapeutic community were made by staff and residents together in consensus or by one-man-one-vote system. In making up plans for the day, the votings usually resulted into going to the beach, to a coffee shop, or staying in bed, but generally not in going to work or having group therapy" (Kooyman, 1993, pp. 17-18).

Our findings also confirm that an 'identity change' can take place in (drug-free) TCs (De Leon, 2000). Yet, as already discussed, we do not think of this outcome in terms of an adaptation to - what some researchers have called – the TC's institutional parameters (e.g. Paik, 2006). In the end, the change was not about a further conformation to external parameters or images, but chiefly originated in the changed relation *to oneself*. As we pointed out in Chapter 5, interpreting change as 'adaptation' or 'conformation' might stem from confusing treatment process and outcome.

Our interpretation of the TC approach and the process of change, especially in drug-free TCs, differs from the way some psychoanalysts interpreted the TCs' approach. This is how Olievenstein understands the goal of treatment in TCs: "therapeutic communities, where one not only had to heal, but also to punish, to normalize, to suppress, to condition"[16] (1989, p. 102). An assumption that we often came across in psychoanalytic writings is that a drug-free TC only

[16] "des communautés thérapeutiques, où il fallait non seulement guérir, mais également punir, normaliser, réprimer, conditionner".

realizes an identification process: "therapeutic communities are based on a master discourse. In that sense, it is possible to say that they form a *barrier against the unconscious*" (Loose, 2002, p. 276, our italics), "they unite the law with the object that *leaves no room for the subject*" (p. 282, our italics), or "[the TCs] *erase particularity* and may even shut down an encounter with the conditions that delimit the subject" (Goldman, Baldwin, Malone, & Svolos, 2011, p. xx, our italics). We do not agree with these explanations. It became clear to us that a structured treatment program that joins forces to pull people into the symbolic order and that aims at reconnecting to the Other, is *not* the same as ignoring the unconscious and the subject, but on the contrary might open the door to addressing Otherness.

While we disagree with the above characterizations of the TC approach, we are well aware of the fact that everything that is put in place in the drug-free TC model (e.g. the rotating hierarchical structure, the TC law, …) might be mis-used (e.g. Kooyman, 1993, Nadeau, 1985). We consider the optimal functioning of a TC a difficult task depending on many factors, such as staff members' attitude, clinical know-how and personal functioning in the program; aspects that have barely been addressed in TC research. In line with this, and paradoxical as it seems, we understand why some authors distrust the growing 'professionalism' in drug-free TCs (e.g. van der Linden, 1982). Reference is made to the danger of untrained and inexperienced staff, whom in their eagerness to help residents, may undermine the concept of self-help, for instance. We think that the clinical training and supervision/intervention of staff is of utmost importance for the wholesome functioning of a TC, so that the 'total' approach does not degenerate into a 'totalitarian' approach (Debaere & Stofs, 2012). Based on our study findings, we underscore the crucial role of former addicted individuals in the organization and clinical work of drug-free TCs, a principle that is in line with psychoanalytic ethics and practice.

The (un?)usefulness of (TC) research

The straightjacket of the RCT design

While TC researchers often discuss whether, when and in what way they should start doing RCT studies to prove *once and for all* the effectiveness of TCs (e.g. Vanderplasschen, Vandevelde, & Broekaert, 2014; "Oxford Science Meeting," 2008), as we already discussed in the introductory chapter, we do not think that using RCTs is the best way to strengthen the position of the TC model in the field of addiction treatment and mental health care. First, the TC method does not fit the RCT design. Decontextualizing aspects of the TC model to fit a design no longer implies that one is investigating in the TC approach. As we already pointed at in a lecture at the 11th EFTC conference (Debaere & Stofs, 2009), the objectives brought forward in evidence-based research and practice are still rather vague and complicated: "There is no agreement regarding the standards of evidence for evidence-based practices (e.g., is one controlled trial enough or should we require two randomized trials by independent investigators?), which specific therapies and practices have achieved various evidence thresholds, or which agency or organization is responsible for making these determinations" (McLellan, 2007, p. 334). Another reason why we are skeptical about the eventual impact of this type of research is related to the TIP-finding, discussed below.

The crucial role of TIP

As mentioned in the introductory chapter, 'time in program' (TIP) in TCs has been found as the only factor that predicts success at follow-up (e.g. Vanderplasschen et al., 2013), a finding we fully underscore from our qualitative studies. Yet, despite this robust TIP-factor, "In recent years, a general European trend towards the limitation of funding for intensive long-term treatment has resulted in the closure of a number of TC programmes and also in a reduction in programme length and the number of client places provided" (Vanderplasschen, Vandevelde, & Broekaert, 2014, p. 9). People's general unwillingness to accept that the treatment time is related to the seriousness of the problem had already been noted by Freud a century ago in relation to his work with neurotic patients: "No one would expect a man to lift a heavy table with two fingers as if it were a light stool, or to build a large house in the time it would take to put up a wooden hut; but as soon as it becomes a question of the neuroses – which do not seem

so far to have found a proper place in human thought – even intelligent people forget that a necessary proportion must be observed between time, work and success" (Freud, 1958 [1913], pp. 128-129). So, despite this clinical wisdom and the empirically sound TIP-factor, TCs have been closed due to treatment duration and some have been forced to limit program length in a drastic way. At this time, the drug-free TC *Emiliehoeve* in the Netherlands is struggling to survive. The *Emiliehoeve* was the first drug-free TC founded on the European continent in 1972 and has been a well-established TC ever since (Kooyman, 1993). Today, plans circulate to reduce the maximum treatment duration to *three months* (F. Watson, personal communication, Mai 12, 2014). It would be ironic if it was not tragic: in TC literature, a TC stay of *three months* has been referred to as 'treatment threshold': the time needed for treatment influences to *commence*.

"TCs are overall less effective than other interventions with respect to treatment retention" (Vanderplasschen, Vandevelde, & Broekaert, 2014, p. 10)

Another recurring topic in TC research is the high drop-out rates (e.g. Kooyman, 2003). First, we do not agree with the assumption that drop-out rates are - by definition - an indicator of treatment *effectiveness* (e.g. McKeganey, 2011). Who concludes that an academic teaching program is not effective (enough) based on a high percentage of students that fails in the first year at the university? Instead of drawing this kind of conclusion, we believe that some students were not ready or motivated for such exigent study, or that some simply didn't want to do it. Of course, those responsible for a teaching program can make efforts (e.g. ameliorate didactics, give information, …) so that *as many students as possible* can succeed if they are willing to. This is also what TCs have been doing in practice: efforts to raise retention. In the annual report of 2012 of the Belgian TC *De Kiem*, for instance, we can see that up to 60% of all TC residents complete the program, which is a high percentage in relation figures in international literature (De Kiem, 2012). In the first years of this TC, the retention rate was approximately 20% or less (D. Vandevelde, personal communication, Mai 21, 2014). To our knowledge, these successful efforts in practice are not (yet) translated into academic research literature.

Some TCs also have an adjusted/shortened program to recover residents who are dropping out and/or relapsing at a late stage of their program. This kind of absconding is often connected to person-specific issues that they have tried to ignore (Zambito, 2013). Two participants of the study in Chapter 5 followed the extra Horus-program of *Trempoline* after a relapse during the

treatment (http://www.trempoline.be/index.php?content=&page_id=25&act=2). In the interviews, it was interesting how they explained their relapse.

Another important footnote that is mostly omitted when drop-out figures are used to judge or criticize TC effectiveness is that some TC residents who leave the program untimely, but after a stay of a least 3 months, do well afterwards (e.g. Kooyman, 2003; Ravndal, 2003).

Another unfortunate consequence of judging TC effectiveness in terms of drop-out figures is the forced conversion of TCs into other services. This happened to a European pioneer TC, *Phoenix House Veksthuset* in Norway. Between 2009 and 2010 this TC was turned into an addiction treatment clinic where pharmacological treatment has been reintroduced together with loose rules with the main goal "to reduce drop-out" (K. Arctander, personal communication, Mai 14, 2014).

To end this sidestep on the oversimplified or thoughtless use of drop-out figures to discuss effectiveness in the addiction treatment field, we refer to the VAD[17]-file on heroin-assisted treatment (VAD, 2006). In that file, information is given on experiments in several countries with daily heroin-administration to users who did not 'benefit' from the methadone[18] maintenance treatment. Apart from the fact that it is tacitly assumed that substitutive treatment is the mainstream treatment for heroin addiction, the value of the administration of heroin over other treatment programs is supported through its low drop-out figures: "The retention of 89% after 6 months and 69% after 18 months appeared to be above the average of other treatment programs for problematic heroin users" [19] (p. 13). From a psychotherapeutic point of view, this is clearly comparing apples and oranges. What our findings revealed is that the process in a TC is a

[17] The VAD is a non-profit association for alcohol and other drug problems, that coordinates most of the Flemish organizations that deal with the issues of alcohol, illegal drugs, psychoactive medication, and gambling (www.vad.be).

[18] "It is clear from literature that a number of heroin users improve insufficiently or do not stabilize from methadone treatment or they do not benefit from the treatment (Centrale Commissie Behandeling Heroineverslaafden (CCBH), 2002; Metrebian et al., 2001; Uchtenhagen et al., 1995; Fischer & Rehm, 1997; Fischer et al., 2002). The question whether controlled heroin administration could offer the solution, emerges more and more and is being discussed" (VAD, 2006, p. 12, our translation).

"Uit de literatuur blijkt dat er bij een aantal heroïnegebruikers onvoldoende sprake is van verbetering of stabilisatie bij een methadonbehandeling of dat ze er geen baat bij lijken te hebben (Centrale Commissie Behandeling Heroineverslaafden (CCBH), 2002; Metrebian et al., 2001; Uchtenhagen et al., 1995; Fischer & Rehm, 1997; Fischer et al., 2002). De vraag of gecontroleerde heroïneverstrekking hier een oplossing kan bieden, duikt steeds vaker op en staat ter discussie" (VAD, 2006, p. 12).

[19] "De retentie van 89% na 6 maanden en 69% na 18 maanden bleek toch boven het gemiddelde te zijn van andere behandelingsprogramma's voor problematische gebruikers van heroïne."

tough therapeutic journey that should not be compared to medicalized treatments or heroin-assisted treatment. TCs actually came into being as a *reaction against* the medical model of addiction (Vanderplasschen, Vandevelde, & Broekaert, 2014). Several participants in the study from Chapter 5 also used methadone and/or psychotropic drugs in the last stage of their addiction. “It’s all the same” was the way Gerard, Nigel and Adrien described such medication. To them, these were all substances they became addicted to. Drugs, substitutive treatment and psychotropic drugs are about suppressing suffering, affect, thoughts and a life in general, while a TC program is about working on these painful issues in relation to people, to get “life in one’s life again”.

Limitations and directions for future research

This dissertation has a number of limitations that can inform future research. An interesting way of elaborating the present study would be to investigate drop-out through qualitative research. As mentioned above, the single cases from Chapter 3 were taken from a sample of 21 residents. While the in-treatment follow-up of these individuals helped us to shape our ideas towards the three-step conceptualization formulated in Chapter 3, we did not further make use of the other information in this dissertation. It might be interesting to investigate the data from the drop-out cases. Investigating the reasons for drop-out in new research might offer valuable information for the TC programs.

Chapter 3 showed the added value of combining qualitative and quantitative research in order to acquire clinically meaningful information on treatment and outcome. For instance, Andrew’s refusal to fill out the mother version of the IIP-32 questionnaire at the first two time moments, would have been interpreted as ‘missing cases’ in a group design, while this was useful information from a process of change perspective. As a complement to Chapter 4, we intend to analyze several questionnaires that have been administered in that democratic TC several years, after the beginning of treatment and at multiple follow up moments (e.g. a symptom checklist, a questionnaire that investigates defense styles, coping, personality pathology, …).

In Chapter 5, the crucial role of the re-entry house was emphasized by the former residents of the drug-free TC *Trempoline*. Unfortunately, our participant observation study did not involve a stay in the re-entry house. Therefore, we could not compare living in the TC with

living in the re-entry house. In retrospect, we also consider the discontinuation of the in-treatment follow-up of Andrew and Simon after they had moved on to the re-entry house as a shortcoming.

An overall limitation of our qualitative research project is that not all studies were presented to third parties to provide further credibility checks, such as the findings of Chapter 3. While Chapter 5 has now been sent to staff members of *Trempoline* and to one study participant (James) for feedback their comments have not yet been integrated in the present dissertation. An interesting way of adding to our studies would be to present the findings in focus groups to staff members from several other TCs in order to explore their opinions and integrate their feedback.

While we are convinced of the importance of investigating the perspective of (former) service users on treatment outcome and process in TCs (as well as other forms of treatment), caution is warranted. Service users have often been involved in treatment research by means of questionnaire administration in order to measure satisfaction with the service (Trujols, Iraurgi, Oviedo-Joekes, & Guàrdia-Olmos, 2014). However, questioning the level of satisfaction in relation to treatment services (i.e., investigating the quality of therapy or the therapeutic process of change from the 'Customer is King' perspective), is beside the point. What clinicians know and what our studies illustrate is that profound therapeutic processes of change, which prove to be successful or satisfying in the end, are not satisfying during the process itself.

Conclusion

We conclude that the TC-model is a sophisticated treatment approach, which, because of the way it makes use of interpersonal relations and speech, may fit the therapeutic needs of deeply wounded populations characterized by a disconnection from others and their own mental life. We assume that until now, many aspects of our research findings, like the two-sided function of the treatment context or the interpersonal processes as medium of treatment, have remained underexposed in previous research. It is likely that the prevailing one-sided focus on experimental research designs leaves insufficient room for exploring these so-called 'non-specific' or social treatment factors (e.g. Bracken et al., 2012; Broekaert, Autrique, Vanderplasschen, & Colpaert, 2010). Therefore, in order to study the complexity of the TC treatment approach and process we support the idea of using naturalistic and qualitative

research in (addiction) treatment research (e.g. Babor, 2008; Broekaert et Al. 2010; Orford, 2008). These can take into account meaning making processes and shed light on fundamental differences underlying diverse treatment approaches (e.g. TC treatment versus heroin-assisted treatment).

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NEDERLANDSE SAMENVATTING

Aan gene zijde van de “black box” van de Therapeutische Gemeenschap: Een kwalitatief psychoanalytisch onderzoek

In dit doctoraatsonderzoek hebben we het veranderingsproces van bewoners in *Therapeutische Gemeenschappen (TG's)* onder de loep genomen. TG's zijn langdurige groepsbehandelprogramma's die zich richten tot mensen met ernstige problemen zoals drugsverslaving of wat men 'persoonlijkheidspathologie' noemt (De Leon, 2000; Haigh & Lees, 2008; Werbart, 1992). De verschillende types TG's ontstonden ruim een halve eeuw geleden als reactie op tekorten in de verslavingszorg en de geestelijke gezondheidszorg. Hoewel de verschillende types TG's enigszins anders functioneren, hebben alle TG's bepaalde eigenschappen gemeen. Zo leven TG-bewoners samen in een huiselijke omgeving waarin ze niet alleen de verantwoordelijkheid dragen voor hun behandelproces maar ook voor het ganse reilen en zeilen in de TG. Binnen de TG-visie wordt verslaving of psychisch leed niet begrepen vanuit een ziekteperspectief waarbij de persoon een willoos slachtoffer is en medicatie de voorkeursbehandeling is (e.g. De Leon, 2000, 2013), maar als een problematiek die begrepen moet worden binnen het intra- en interpersoonlijk functioneren waarvoor de persoon de verantwoordelijkheid kan opnemen om ermee aan de slag te gaan, bijvoorbeeld in een TG.

Hoewel de effectiviteit van dit groepsbehandelmodel in de laatste decennia werd aangetoond (De Leon, 1999,2010; Holland, 1983; Vanderplasschen, Vandevelde, & Broekaert, 2014), is het tot op vandaag onvoldoende begrepen waarom mensen tijdens hun verblijf in een TG veranderen en hoe dat veranderingsproces in mekaar zit. Dit gebrek aan inzicht in het veranderingsproces wordt in de TG-literatuur ook wel omschreven als de **'black box'** van de TG's (Broekaert, 2006; Broekaert, Raes, Kaplan, & Coletti, 1999; De Leon, 1999, 2000, 2010; De Leon & Wexler, 2009; "Oxford Science Meeting," 2008; Paddock, Edelen, Wenzel, Ebener, & Mandell, 2007; Ravndal, 2003; van der Straten & Broekaert, 2012). De moeilijkheid om de TG-aanpak uit te leggen en het veranderingsproces van de bewoners te begrijpen leidt tot steeds meer moeilijkheden om de TG-werking te verantwoorden ten aanzien van externe en interne uitdagingen. Zo werden er in verschillende Europese landen al heel wat TG's gesloten of omgevormd omwille van de lange behandelduur en/of de hoge drop-out cijfers. De opmars van medische behandelingen en de 'harm reduction' initiatieven, die schade als gevolg van het druggebruik beogen te beperken, zijn ook een bedreiging geworden voor de langdurige en intensieve drugsvrije TG-programma. De Leon formuleerde de moeilijkheid als volgt: "Terwijl het ruim bekend is *dat* TG's werkzaam zijn in termen van succesvolle resultaten, is het minder

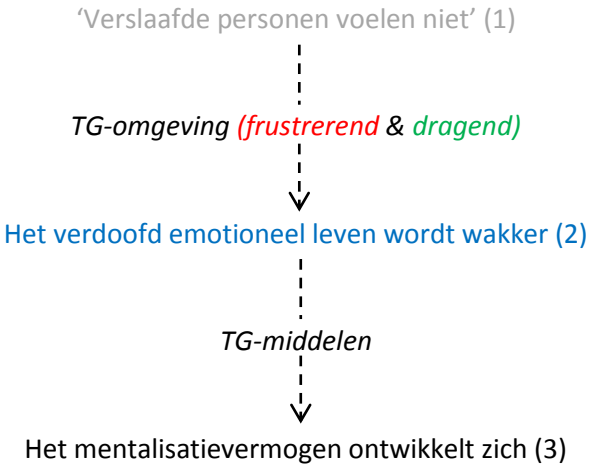
begrepen waarom en *hoe* TG's werken"[1] (2000, p. 5). Als gevolg werd er meermaals een oproep gedaan om de 'black box' van de TG te bestuderen aan de hand van kwalitatief procesonderzoek (e.g. Broekaert, 2006; Broekaert, Raes, Kaplan, & Coletti, 1999; De Leon, 1999, 2000, 2010; De Leon & Wexler, 2009; Nielsen & Scarpitti, 1997; "Oxford Science Meeting," 2008; Paddock, Edelen, Wenzel, Ebener, & Mandell, 2007; Ravndal, 2003; van der Straten & Broekaert, 2012). Kwalitatief onderzoek is een naturalistische en interpretatieve benadering om een onvoldoende begrepen sociale realiteit te bestuderen waarbij dus zowel de specificiteit als de complexiteit van die realiteit behouden blijft (Denzin & Lincoln, 2011).

In dit doctoraatsonderzoek hebben we aan de hand van verschillende kwalitatieve methoden en in verschillende TG's de samenhang tussen de behandelaanpak en het veranderingsproces van TG-bewoners bestudeerd. Als interpretatief kader hebben we gebruik gemaakt van de Lacaniaanse psychoanalyse. We hebben deze keuze verantwoord op basis van overeenkomsten met de TG-benadering wat betreft de visie op verslaving, de verslaafde persoon en de weg naar verandering. Zo begrijpen beide kaders verslaving als een symptoom dat een fundamentele intra- en interpersoonlijke problematiek afdekt en benaderen ze de persoon als verantwoordelijke voor zijn/haar daden (De Leon, 2000; Verhaeghe, 2004). Ook speelt 'identiteitsverandering' een cruciale rol in beide kaders. De drugsvrije TG's zien een identiteitsverandering als hoofddoelstelling van het behandelproces, terwijl de Lacaniaanse psychoanalyse net een conceptualisering biedt van identiteitsvorming en –verandering in relatie tot de wijze waarop driftregulering georganiseerd wordt (Verhaeghe, 2004; Vanheule & Verhaeghe, 2009). Binnen dit kader hebben we de problematiek van de middelenverslaving begrepen als *een ontkoppeling uit de band met de Ander* (zie Figuur 3 p. 16). Waar dus de (Lacaniaanse) psychoanalyse vooral een verklaring biedt voor wat middelenverslaving is en hoe een behandelaanpak zou moeten georganiseerd worden, is de drugsvrije TG een concrete behandelaanpak die vraagt naar een verdere conceptualisering.

Hoofdstuk 2 presenteert een participerende observatiestudie. Voor deze studie heeft de onderzoeker gedurende drie weken meegeleefd in een drugsvrije TG om niet alleen de behandeling van dichtbij te bestuderen maar ook om alle aspecten van de behandeling zelf te ervaren. Deze ingrijpende ervaring heeft de aandacht gericht naar specifieke kenmerken van de TG-omgeving en -middelen. Typisch voor de TG-omgeving is de sfeer die er heerst en die we

[1] "Although much is known about *whether* TCs work in terms of successful outcomes, less is understood as to why and *how* TCs work"

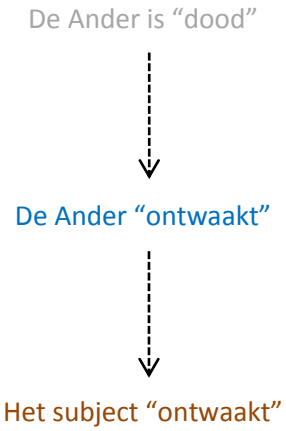
omschreven hebben als zowel ‘frustrerend’ en ‘dragend’. Met ‘frustrerend’ wijzen we op de ervaring van het zich verstoken voelen van gebruikelijke wijzen van genieten of ageren, waardoor het ‘verdoofd’ emotionele leven weer aangewakkerd wordt. Tegelijk wordt de TG-omgeving ervaren als ‘dragend’, of, zoals omschreven door Winnicott (1960), als ‘holding’. Dit kenmerk van de TG-omgeving biedt een verklaring voor het feit dat bewoners in de TG blijven ondanks de (emotionele) last die ze ervaren. De relatie tussen deze beide omgevingsdimensies en het veranderingsproces van de bewoners hebben we belicht vanuit de rol van de TG-middelen. Om te kunnen omgaan met gevoelens en conflicten wordt er van TG-bewoners verwacht dat ze gebruik maken van verschillende TG-middelen om affectieve ervaringen te vertalen of om te zetten in gesproken of geschreven taal. De cruciale rol van deze middelen om te verbaliseren, symboliseren of mentaliseren werd volgens ons nooit belicht in de TG-literatuur. Zoals voorgesteld in Figuur 1 hebben we het veranderingsproces van TG-bewoners samengevat als hun groeiende mogelijkheid om affect en emotioneel overweldigende ervaringen te mentaliseren.



Figuur 1. Deze figuur illustreert drie stappen in het zich ontwikkelende mentalisatievermogen van TG-bewoners en benadrukt daarbij de rol van de TG-omgeving en -middelen.

Om de bevindingen van Hoofdstuk 2 te verfijnen hebben we in Hoofdstuk 3 het veranderingsproces bestudeerd van twee bewoners in een andere drugsvrije TG en dat gedurende hun ganse verblijf. Daarvoor hebben we beide personen op regelmatige tijdstippen

geïnterviewd en de IIP-32 (Horowitz, Alden, Wiggins, & Pincus, 2000) afgenomen op vier momenten. Zoals voorgesteld in Figuur 2, hebben we het proces opgedeeld in drie logische stappen. Door gebruik te maken van het Lacaniaans concept van *de Ander* konden we de mate van onthechting of loskoppeling beter benadrukken. Bij hun aankomst in de TG waren Simon en Andrew niet alleen emotioneel 'verdoofd', maar viel ook hun leeg spreken op – wat ook wel benoemd wordt als 'a-dictie' – de afwezigheid van sociale relaties, een ledig mentaal leven en de afwezigheid van een (geïnternaliseerde) wet. De volgende stap in het proces gaf de ommekeer in dit ontkoppelingsproces weer: in de TG werden Simon en Andrew opnieuw emotioneel geaffecteerd en kwam er een gevoel van samenhorigheid met medebewoners tot stand. Om tot een derde stap te besluiten baseerden we ons op veranderingen in de aard van het opduikend affect. Doorheen het proces werden beide participanten steeds meer geaffecteerd door innerlijk conflict en onverwerkte (traumatische) ervaringen uit hun verleden, en niet enkel omwille van de vele vereisten van de TG-wet. Tot slot bespraken we de verschillen tussen beide casussen wat betreft de mate waarin subjectief lijden verwerkt werd tijdens het TG-programma.



Figuur 2. Deze figuur illustreert het veranderingsproces van bewoners in een drugsvrije TG in drie stappen.

In de Hoofdstukken 4 en 5 onderzochten we het perspectief van vroegere TG-bewoners op hun behandelproces en het resultaat van hun behandeling. In Hoofdstuk 4 hebben we ex-bewoners van een democratische TG bevraagd, en in Hoofdstuk 5, van een drugsvrije TG.

In Hoofdstuk 4 interviewden we 24 ex-bewoners van een democratische TG door middel van focusgroepen. Een succesvol behandelproces in die TG hebben we voorgesteld aan de hand van vier logische stappen, met als laatste stap het resultaat van de behandeling (zie Figuur 3). Opnieuw kwam het belang van de dubbele TG-atmosfeer op de voorgrond dewelke we in deze studie omschreven hebben als het ervaren van een *veilige en zorgzame Ander* die tegelijk *uitdagend en eisend* is (stap 1). Met de tweede stap hebben we beschreven hoe de participanten in deze TG-context hun gebruikelijke 'onaangepaste' manier van functioneren zijn beginnen herhalen. De derde stap wijst op hun groeiende bewustwording van een interne vreemdheid of 'Anders-zijn': tijdens hun proces werden de bewoners geconfronteerd met een intiem aspect van wie ze zijn, wat ze tot dan toe evenwel ervaren hadden als vreemd (Fink, 1995). Verder hebben we toegelicht hoe hun groeiende confrontatie met dit Anders-zijn – en dus tegelijk ook met de actieve rol die ze speelden in de totstandkoming van hun eigen misère – mogelijk werd door confronterende ervaringen, interventies en interpretaties door stafleden en medebewoners. De vierde stap betrof de behandeluitkomst die weerspiegeld werd in een verbetering op het vlak van intra- en interpersoonlijk functioneren: de participanten getuigden over een meer functionele driftregulering, een groeiende betrokkenheid in aangename sociale relaties alsook over de wijze waarop ze veel meer actor van hun eigen leven waren geworden.

1. Ik ontmoet een veilige, zorgzame en uitdagende Ander
2. Ik herhaal mijn particuliere manier van omgaan met de Ander
3. Ik word geconfronteerd met mijn 'Anders-zijn'
4. Ik leef een Ander leven
    a. Ik ben veerkrachtiger en kan problemen de baas
    b. Ik heb meer aangename sociale contacten
    c. Ik kies voor het leven

Figuur 3. Vier stappen in een succesvol veranderingsproces van bewoners in een democratische TG.

In Hoofdstuk 5 hebben we 10 ex-bewoners van een drugsvrije TG geïnterviewd via focusgroepen en individuele interviews. In deze studie hebben we hun veranderingsproces gepresenteerd in drie tijden: hun leven vóór, tijdens en na het TG-verblijf (zie Figuur 4). Terwijl hun leven voorheen volledige bepaald werd door hun drugsverslaving - wat door een participant

treffend omschreven werd als “het Alcatraz van alle mogelijke psychische gevangenissen” (p. 118) – had dit druggebruik ook een probleemoplossende functie, zowel op het valk van driftregulering als identiteit. Tijdens hun TG-verblijf zijn de participanten vooral getroffen geweest door de wijze waarop ze zich erkend gevoeld hebben, waarbij de consequente toepassing van de TG-wet en de rechtvaardigheid van de stafleden doorslaggevend waren. De participanten gaven aan zich genoodzaakt gevoeld te hebben hun particuliere problemen onder ogen te zien en ermee aan de slag te gaan. Verder belichtten ze de cruciale rol van het tussenhuis om de stap te zetten naar een leven in de maatschappij. Hun leven na de TG werd gekenmerkt door een alomvattende verandering die niet alleen bestaat uit een meer functionele driftregulering (praten, mentaliseren, …), maar ook uit een identiteitsverandering die vooral uitgelegd werd als een veranderde relatie tot zichzelf in verhouding tot anderen. Omwille van het ingrijpende veranderingsproces dat deze personen doormaakten in de TG, voelden ze zich vooral ‘echter’, meer authentiek.

1. Het leven voor de TG
    - Ik was terechtgekomen in een verslavingsspiraal
    - Onder invloed zijn loste ook particuliere problemen op
2. Het leven in de TG
    - 2.4 Ik werd erkend omwille van wie ik ben
    - 2.5 Ik voelde mij genoodzaakt mijn particuliere problemen aan het pakken
    - 2.6 Ik heb mij voorbereid op het leven buiten de TG
3. Het leven na de TG
    - Ik ben 100% veranderd …
    - Maar ik ben nog steeds dezelfde als toen ik een kind was

Figuur 4. Het veranderingsproces van bewoners in een drugsvrije TG wordt gepresenteerd door het proces in de TG in verband te brengen met hun leven voor en na het TG-verblijf.

In de discussie van het doctoraat hebben we verbanden tussen de vier studies besproken en aangetoond hoe de TG-behandelaanpak en het veranderingsproces van de bewoners aansluit bij de wijze waarop een therapeutisch proces vanuit de Lacaniaanse psychoanalyse begrepen wordt. Zo hebben we beide TG-dimensies besproken als de herinstallatie van de moeder- en

vaderfunctie (de groene en rode kleur in de figuren) waarbij zowel de connectie met de Ander weer gerealiseerd wordt (de blauwe kleur), maar ook met het onbewuste (de bruine kleur). We hebben aangetoond hoe het TG-proces van elke bewoner een particulier proces is van doorwerken, vergelijkbaar met een zogenaamd 'subjectiveringsproces' (Fink, 1995) dat leidt tot een identiteitsverandering in de zin dat de persoon 'authentieker' of meer zichzelf geworden is (de paarse kleur in de figuren).

Verder hebben we overeenkomsten en verschillen tussen de zogenaamde *drugsvrije* en *democratische* TG's belicht en erop gewezen hoe de bestaande naamgevingen verwarring scheppen. Zo zijn de drugsvrije TG's niet minder democratisch, maar hanteren ze meer en andere therapeutische middelen precies omwille van de druggerelateerde problematiek. Verder hebben we o.a. de (on?)zinvolheid van wetenschappelijk onderzoek besproken en de wijze waarop bevindingen geïnterpreteerd worden en al dan niet gereflecteerd worden in het werkveld. Tot slot hebben we enkele tekortkomingen van onze studies belicht en ideeën voor toekomstige onderzoek gesuggereerd.

We hebben besloten dat het TG-model, omwille van de manier waarop interpersoonlijke relaties en taal gehanteerd worden, een geschikte behandelaanpak is voor deze gekwetste populaties die gekenmerkt worden door een ontkoppeling uit de sociale band en hun eigen psychisch leven. We veronderstellen dat verschillende aspecten van onze bevindingen, zoals de dubbele functie van de TG-context en de wijze waarop interpersoonlijke processen als behandelmiddel gebruikt worden, onderbelicht zijn bleven in vroeger empirisch onderzoek. Een mogelijke reden hiervoor is dat de bijna expliciete focus op experimentele onderzoeksopzetten onvoldoende ruimte laat om deze zogenaamde 'niet-specifieke' of sociale behandelfactoren te exploreren (Bracken et al., 2012; Broekaert, Autrique, Vanderplasschen, & Colpaert, 2010). Vandaar dat wij het belang van naturalistisch kwalitatief onderzoek willen benadrukken om de complexiteit van het TG-programma en de behandelprocessen verder te bestuderen (e.g. Babor, 2008; Broekaert et al., 2010; Orford, 2008). Door de cruciale rol van betekenisverlening in dergelijk onderzoek kunnen ook fundamentele verschillen die onderliggend zijn aan verschillende behandelingen (zoals TG-behandeling versus heroïnebehandeling) bestudeerd en belicht worden.

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TC Philosophy[1]

I am here because there is no refuge,
finally from myself.
Until I confront myself in the eyes
and hearts of others, I am running.
Until I suffer them to know my secrets,
I have no safety from them.
Afraid to be known,
I can know neither myself nor any other,
I will be alone.

Where else but in our common ground,
can I find such a mirror?
Here, together, I can at last appear clearly to myself,
not as a giant of my dreams, nor the dwarf of my fears,
but as a person, part of the whole,
with my share in its purpose.
In this ground I can take root and grow,
not alone any more, as in death,
but alive to myself and to others.

[1] This 'TC Philosophy' was written in 1965 by Richard Beauvais while he was a resident in the original Daytop TC. The text has been recited in drug-free TCs since that time.
(retrieved June 20, 2014, from http://www.daytop.org/philosophy.html)