An Enhanced Understanding of Therapeutic Communities Worldwide

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Abstract.

Therapeutic communities posit favorable treatment outcomes by relying on the community as the healing agent (Deleon 2000). Active treatment participation and treatment tenure are two domains that are positive predictors of positive treatment outcomes over time. Some of the more important domains that remain to be thoroughly investigated in international research on therapeutic community (TC) treatment outcome studies are the underlying effects of culture on the treatment process. Cultural components play a significant role, as also reported by various TC participants over the years (such as the effects of health literacy on sustaining abstinence from drug use over the long term, Tiburcio 2008). In recent years, health literacy has taken on a significant role in order for individuals to readily understand their needs (Schillinger et al 2002; Jorm et al 1997); or as pertains to feeling shamed in the process (Parikh et al 1996). As these and other studies suggest, the cultural competence of the providers is equally important. To our knowledge the "*International TC Study*" and findings presented herein constitute one of only a few studies that have conducted investigations comparing therapeutic community treatment modifications internationally, from the perspective of the participants themselves and which consider cultural components of this process. One key advantage of the resulting Qualitative datasets and analyses is that it not only includes residents' perspectives, and staff experiential elements, but importantly, incorporates staff debriefings about their respective interactions at each of the international treatment modalities, presenting well rounded depictions of each of these milieus. To that end, the data examined here presents an enhanced portrait of the provider-patient treatment dynamic, and lends voice to the various aspects of treatment participation in light of these cultural issues, and from the perspective of providers, as well as the participants.

Methods

Grounded Theory

Qualitative analysis is a powerful method for understanding the complex relationships inherent to ongoing drug use, and presently, the changes occurring at the individual level when such use is curtailed. As such, these ethnographic interviews provide extensive information and in the main, the results suggest that the treatment process is *greatly enhanced* by peer support. The analysis of data that follows employs the logic of grounded theory. Grounded theory is employed where emergent ideas are explored, typologies are elaborated, categories developed and connections with other themes and experiences are identified (Charmaz 2000; Glaser and Strauss 1967). This inductive procedure provides a method for reading, coding, and rereading (and subsequently recoding at times) the extensive collection of transcripts and observations to achieve insight into the forces and processes that underlie the lived experiences of treatment seekers, engagers and providers within this study group. The guiding topics are the questions being asked and the responses provided by subjects.

The transcript data was grouped and reanalyzed by theme according to the country where each theme was first identified [1]. The grouped data was then disaggregated according to self reported use (and/or cessation) patterns. Although admittedly time consuming, this iterative process is useful for identifying "nuance," and later, for identifying commonalities between programs. Overall three overarching categories of "recovery" emerged from the data and these are examined below. But first we provide a brief discussion of the qualitative methodology, and how we reached consensus on these overarching themes.

Qualitative Interview Development

The project team constructed the qualitative interview guide as an open-ended inquiry into the personal experience of participants within the respective TC cultural milieus. We found it necessary to anticipate various difficulties that appear to be *culturally dependent*. For example, the concept of *shame* in China refers not only to an understanding of shame brought on by perceived stigma, (pursuant to various socially sanctioned behaviors, such as illicit drug use, criminal involvement, etc.) but also a cultural adaptation of shame that is familial in nature, and that in fact may result in nuclear family disintegration pursuant to continued drug use. In Malaysia, *religion* and *religiosity* takes on an even more important role, where spirituality although important, becomes secondary to religion. As pertains to this dynamic, the US programs were somewhere in the middle of these cultural opposites. These and similar concepts are discussed more at length in the results section of this manuscript.

Staff debriefings at each of the respective programs were conducted regularly. The Qualitative Information Director (QID - Tiburcio) was in regular contact with program staff at the each of the foreign programs on an as needed basis, but no less that once every two weeks when data collection efforts were ongoing. During the analytical phase, the communications consisted of staff debriefings about the entire Qualitative protocol. These entailed descriptions of any issues encountered during data collection efforts, suggestions as to how these might best be corrected, and follow through to see if these implementations were seen to fruition.

Protocol Overview

Those recruited for in-depth interviews were initially screened as persons who were both users of illicit drugs, were amenable to be interviewed, and who were ready willing and able to supply pieces of their individual stories. Those persons meeting screening criteria were invited to participate in the research. A discussion was held and informed consent was obtained from each subject prior to any involvement with the study. The lead writer (Tiburcio) chose codenames for individuals where names were inadvertently supplied and in no instance will actual names be used in this (or future publications) in order to maintain confidentiality. Data presented in this report represent detailed individual and focus group qualitative surveys, which took place at each of the facilities and which in most cases provide an in-depth portrait of the cultural nuances present within each of these countries' participating treatment programs. Their recorded words constitute the fundamental data elements of the qualitative research.

Qualitative Data Collection

The goal was to construct instruments that allowed for expansive commentary, yet touched on the various aspects of TC culture and therapeutic components (that is, *confrontation, elicitation, identification, empathy,* etc.). Overall recruitment was ongoing for the duration of the project. Qualitative interviews consisted of two separate sample "pools." The first pool of subjects across all programs (referred to

as**Round One)** consisted of a total of 64 qualitative interviews, broken down as follows: 30 individual resident and 28 staff interviews and 6 focus groups conducted at four facilities. The program breakdown:

Malaysia

10 client individual interviews, 2 client focus groups and 10 staff individual interviews

China

10 client individual interviews, 2 client focus groups and 8 staff individual interviews

Daytop Springwood

5 client individual interviews, 1 client focus group and 5 staff individual interviews

Daytop Swan Lake

5 client individual interviews, 1 client focus group and 5 staff individual interviews.

Round Two Qualitative data collection for this round began in January 2010 and concluded in April 2010. A total of 59 qualitative interviews were conducted. 25 resident individual interviews, 27 staff individual interviews and 7 focus groups were held during this phase of qualitative data collection. The breakdown is as follows:

Malaysia

10 client individual interviews (7 male and 3 female), 3 client focus groups and 10 staff individual interviews

China

7 client individual interviews, 2 client focus groups and 9 staff individual interviews

Daytop Springwood

4 client individual interviews, 1 client focus group and 4 staff individual interviews

Daytop Swan Lake

4 client individual interviews, 1 client focus group and 4 staff individual interviews.

Qualitative Methodology

After signing consent to participate in the study, residents in treatment for at least three months were asked if they wished to participate in focus group and/or individual interviews. (Program staff solicited participation in either focus groups or individual interviews and not both.) Although the primary goal was for a randomized selection of participants, we were only able to achieve such selection in the US programs. In China & Malaysia, with much smaller program census numbers, essentially everyone in the study at the time of each qualitative phase was asked to participate in the in-depth interviews and groups. Additionally, the programs in China demonstrated much higher attrition rates than all other study programs; there was essentially nobody that stayed in treatment for 3 months. In Malaysia, there were only a couple of women.

Instrument Design

Dr. Tiburcio, a qualitative researcher by training and an expert in therapeutic community modification, treatment and protocol, designed the qualitative Round Two data collection instruments and these were reviewed and approved by NDRI Executive Director Dr. Joann Sacks, Center for the Integration of Research and Practice (CIRP) Director Dr. Stan Sacks, and the International TC study PI, Dr. David Kressel. Subsequently, Dr. Tiburcio trained national data collection staff and oversaw training sessions with their international counterparts on the nuances and subtleties inherent to the open ended protocols. We (project management) also conducted special in–house training sessions focused on the qualitative data collection efforts. The first step entailed restructuring the Round One questionnaires to more accurately capture missing information. Some of the key questions we examined as a group dynamic: Were the questionnaires reflective of the issues present or developing at all TC programs? Were the Round Two data collection designs responsive to the Round One themes as represented in the client/staff/Focus Group transcripts? Did the Round Two data collection protocols accurately reflect staff consensus as to what may be "missing" vis-à-vis Round One data, TC staff debriefing and study specific aims? One difficulty the project team addressed immediately was to reach consensus on how we could best capture the needed information, yet also agree that this enterprise was reflective of the realities *across* all treatment sites, an ambitious undertaking.

We strived to ensure that the questions were not difficult to administer, could be readily understood by the participants (as well as the interviewers), yet 1) Capture/Disseminate missing or unclear information from Round One data collection efforts 2) Clarify and expand upon ambiguous concepts (not solely from Round One but reflecting TC theory and practice in general), 3) Verify missing or ambivalent information, and 4) Accurately reflect the study aims. Issues that would normally be very easy to clarify were at times exponentially more difficult, as even the debriefing sessions were hard to conduct because of the ever present language barriers. One way we overcame this issue was to readily place the onus of verification on ourselves, that is, "I did not understand the following…. can you clarify?" By debriefing the interviewers and staff at the various programs, we managed to overcome the language and distance barriers quite effectively.

Qualitative Procedures

The most salient characteristic of qualitative methods is that they give voice to the powerless and voiceless (Tellis, 1997). In order to be contextually grounded, data analysis should occur simultaneously with data collection, as also occurred in this study. The purpose of constant comparison is to clarify the meaning of each theme and category, to clearly articulate the meaning each is given by the study participants. This is an iterative process in which analysis begins with the first data collected, and the emerging constructs, themes and patterns direct the next phase of data collection (Tellis, 1997).

We used a constant comparative method for organizing, coding and analyzing the emerging themes and patterns from data collected throughout the study programs. The purpose of constant comparison is to*clarify* the meaning of each theme and category, to *compare* incidents applicable to each category, to*integrate* categories and their properties, to *modify* concepts and relationships between concepts and to clarify which categories are most important to the study (Glaser and Strauss, 1967; Hesse-Biber and Leavy 2005). Data was initially coded into themes generated from the data, which were then grouped according to the contexts in which they were reported by respondents. This methodology is considered a procedure whereby newly gathered data are continually compared with previously collected data in order to construct

categories that capture common elements or relevant characteristics (Strauss, 1987). As the analysis progresses, codes, themes and categories are refined and amended. It is through the iterative process and inductive coding of interviews and field notes that the constant comparative method lends insight into the concept-building orientation of qualitative research, to effectively reach data saturation (Tiburcio 2006; 2008; Hesse-Biber and Leavy 2005). Building on one or more incidents that might be applicable to each category, and later integrating categories and their properties, enables modifying concepts and established relationships. In this fashion the project team can reach consensus on which categories are most important to the study and project aims (Glaser and Strauss, 1967; Tiburcio 2008).

One approach that was used in the present study was to continue constant comparison until reaching "data saturation," the point at which no new data emerge relevant to an established theme, no new themes are necessary to account for the phenomena of interest, and the relationships among themes are well established (Glaser and Strauss, 1967; Hesse-Biber and Leavy 2005). Optimally, data can be collected up to and during the final analytical stages to allow for expansive commentary on agreed upon categories and if necessary to dispute or refute opposing categories. Because of the location of these programs, and the open ended nature of the data, we were able to include expansive commentary and reach saturation on various domains of inquiry.

Each participant was assigned an identification number and a pseudonym, (in this and subsequent manuscripts all participants are identified by these pseudonym/s in quotations). As on previous studies (Tiburcio 2008; Strauss et al 2010; Tiburcio et al 2009) voice files from the digitally recorded focus group and individual interview administrations were transcribed, and theme analyzed for coding and analysis. Following Strauss and Corbin's (1998) process for seeking a balance of sensitivity and objectivity in qualitative analysis, the team conducted analyses using both a priori and inductive approaches. This process requires a delicate balance of expertise, knowledge, review and tenacity, in order to saturate conceptual elements. Transcripts (initially solely from round one data collection efforts, but subsequently from both standpoints) were read and re-read. Team members initially reviewed transcript material independently, and later during project staff meetings the resulting themes were compared, re-grouped and final overarching themes were decided upon. A priori themes were generated by comparing data and concepts derived from therapeutic community treatment modalities and expectations (Deleon 2000), additional literature from the substance abuse treatment field measuring self and group reported experiences (see Tiburcio 2008 for more on *recovery oriented* themes), and the ensuing analyses from the Round One data collection efforts. In the latter case, we sought comparative responses but also sought elaboration as pertained to the principal study objectives and specific aims.

In order to initially uncover emergent themes, QID Tiburcio read the entire batch of transcript data and identified possible nuance by simply underlining these *in vivo*. The PI (Kressel) then conducted an independent analysis of his own. Again this analysis entailed an in-vivo thematic interpretation, where underlying themes were recorded for later interpretation. These were then discussed, initially among the first two reviewers and later among other members of the research team. Once the team defined and reached consensus about the meanings of these codes, these were applied to a set of remaining interview transcripts by the first author. These themes were then compared to the earlier Round One analysis for each respective program, and subsequent analysis to the agreed upon global themes (*across programs*). In this fashion, programmatic nuances can be identified and extracted *within* each respective program and later, comparisons can be made *between* sets of programs, and at two separate data administration points. Thus, interviews were subject to additional coding until the final list of codes was applied to the entire set

of transcripts, including the translated data from Malaysia and China. As mentioned earlier, staff debriefings conducted afterwards with directors from the international sites supported our findings.

The next step entailed a line by line coding of a small sample of transcripts for themes that described and exemplified unanticipated phenomena in the data (Bernard and Ryan 1998). This is a technique commonly referred to by grounded theorists as open coding (Hesse- Biber, and Leavy 2005). At times, we found that codes needed to be redefined, as unanticipated nuance appeared to contradict expectations or findings from the literature (a specific instance where this occurred is examined more in depth below). But as a general rule, we maintained an *emic* focus when interpreting the data, *our respondents were our guides*.

Interviewing

Our quality control measures were extensive. The interview protocols were translated, back translated, implemented, edited, fine tuned and then *translated a second time*. These quality control steps ensured that the meanings and nuances that were possible when asking open ended questions would at the very least capture similar information regardless of where the interview was conducted, or by whom. It proved to be the most effective manner to ensure reliable, sensitive, high quality data that was not only culturally significant, but that was comparable to our Round One data collection efforts.

Data collection itself was an iterative process. Staff members in all three countries were initially trained about the proper ways to conduct the interviews, including what *not* to do in particular circumstances. Again these training sessions proved quite effective in that interviewers reported enhanced comfortability when conducting all interviews. Additionally, staff members at each of the international programs, as well as Daytop USA, were also asked their opinions of the protocols during ongoing debriefing sessions. In all cases, the opinions were favorable, reporting that the interviews successfully tapped into each of the selected venues and specific domains of inquiry. Staff debriefing notes were incorporated into our overall analytical framework.

International Data Analysis

All interviews and fieldnotes were transcribed in the language in which they were recorded (English, Chinese, Malay). These were later transcribed in each of the respective countries and copies of translated transcripts forwarded to the PI. Once the Qualitative Director received copies of study transcripts, a grounded theory approach (Strauss and Corbin 1990; Charmaz, 2006) was used to inductively code and analyze all interviews and fieldnotes in vivo, and later with the aid of Atlas ti qualitative coding software (Muhr, 1991). Grounded theory involves an iterative process of inductively building theory. The coding software was useful for indexing, sorting and grouping large blocks of textual data.

Data analysis comprised the following steps:

1) An initial set of codes was compiled by the research team reflecting the study aims and research questions. These codes were based on therapeutic community theory and practice (Deleon 2000) and were focused towards addressing each of the study's specific aims, where applicable.

2) The Qualitative Information Director coded transcripts according to the initial set of analytic codes. Discrepancies in coding were analyzed and resolved during project meetings. The PI conducted independent review of these selected codes, with a goal of achieving consensus on their applicability and

utility. Subsequently these initial set of codes were revised and augmented as the coding and analytical process continued to reflect our growing understanding of the respective treatment dynamics, barriers, goals and nuances.

3) Memos were written to reflect the questions, concerns and analytical insights emerging from our analyses. These memos served a vital data-reduction and analytical function. As data was coded and analyzed, we utilized these memos to generate associations among themes grounded in the analysis. Although laborious, the coding enterprise was extremely useful towards effective data reduction.

Prior to receiving transcripts of the interview sessions, Dr. Tiburcio heard the Daytop USA recordings and later, when transcripts were available; these were also coded for themes and conceptual saturation. After each interview, he reviewed the taped session and prepared a summary and brief analysis note. He selected passages that were particularly relevant to the questions under investigation for verbatim transcription and then entered these passages into a database and coded them for further analysis using the coding software. Afterwards PI Kressel listened to a proportion of the interviews and independently selected passages for transcription, which, in most cases, were identical to the first coder's selection of emergent themes. During project meetings with various senior staff members from Daytop USA, the interviewer for those programs and senior NDRI staff, we established overall consensus on emergent themes.

Results

There appear to be three main categories of clients that are now being treated within the US therapeutic community treatment environment, and which participated in the US Qualitative data collection for this study. These include:

1) Formal treatment seekers (many admit to "hitting rock bottom),"

2) Mandated clients (may or may not admit/ or realize they have "hit rock bottom" but their primary goal is avoiding incarceration),

3) Veterans, some of which report acquiring or worsening their habits overseas, and finding themselves unable to cope once stateside. [2]

Domains

Across all programs, there were various domains that clearly stood out as having at least some relevance to residents across all facilities. These domains can be grouped as pertaining to overarching definitions' of recovery emerging from study transcripts and the perceived causes of each; type of drug used (heroin and methamphetamine – otherwise known as Syabu in Malaysia); the importance of honesty; the various forms and importance of social support; and the results of and difficulties experienced as a result of economic hardship.

Honesty and Recovery.

Above all else, the main theme expressed across programs was honesty. Here we present some of the quotes emanating from the data regarding this domain. One Daytop USA resident put it this way:

I can no longer be with you if you continue to get high…what's love got to do with it?...I have to love me before I love anyone else…

Another resident from the same facility elaborated:

…remember to thine own self be true….Honesty is imp to me cause u have to be honest about life, you have to go about things the honest way…the honest way is the best way

This concept of honesty is comprised of two important characteristics:

1) Honesty with self – knowing one's limitations, identifying triggers, acknowledging strengths. As such,*self validation* takes on an increasingly important role.

2) Honesty with others, at times brutal honesty, even when such honesty can create additional strife.

Many expressed how they now felt life had some kind of meaning, that they had found a renewed purpose. As intimated by one Daytop USA resident: *"I am no longer living on a whim….at 5:30 AM my feet are on the floor..."* Tiburcio also found a similar phenomenon as expressed by a long time abstainer and former heroin user that expressed her "new life" was now purposeful (2008).

Social Support and Recovery.

Social support has also been found by others to be instrumental towards success in the long term drug treatment and abstinence process (Tiburcio et al 2009; Broome et al 2002). Peer support, familial reintegration and the importance of friends encapsulated the definitions of social support as expressed in interview transcripts and were evident throughout all programs. Honesty and social support co-occurred as concepts in many cases, suggesting that one of the mainstays of social support is the ability to be and maintain honesty within interactions and relationships. Indeed a basic tenet of therapeutic community treatment, this finding was not surprising, given the importance of social responsibility within the therapeutic community paradigm (see for example Deleon 2000 for more information regarding TC process). One Daytop USA staff member expressed the various nuances of social support:

I have never been to any other treatment modalities, but I do notice here that there is a real feeling of family and a lot of love, and responsible concern. I think that is really important for the staff and the resident.

In China, staff accepted (welcomed) the responsibility and importance of social support and serving as role model/s for residents/other staff:

If the clients have any opinions to the staff, they can talk to the staff directly, or can encounter the staff in the encounter group. But generally the clients do respect the staff member, so from this viewpoint we can see that the staffs are the role models to the clients.

Residents also attributed responsibility and acceptance of the feelings created by enhanced self awareness to a group dynamic. One resident for example described three feelings that being in treatment created: anger, discomfort and appreciation:

There are a lot of behavior tools for the Treatment in the TC…I think the TC picked your fault with thesetools. I can not understand this at the very beginning, there was no need to enlarge the trivial matters, so I felt angry. For example littering, it's a trivial matter.

He went on to describe how the TC dynamic of breaking him down by picking at his faults caused him discomfort and later appreciation. He indicated that he could now appreciate that the TC (and subsequently close family members) were actually trying to help him, not hurt him. This feeling of closeness is one of the therapeutic community tenets that of a pseudo familial environment designed to foster positive change (Deleon 2000). Other research supports this contention (see for example Tiburcio 2006).

Similar sentiments were expressed in Malaysia:

…clients remind us of our self before. They are like a mirror to our behaviour. Sometimes we see ourselves better when we look at them. Some clients curse their parents I did that too before… So we have residents here as our role model. And all of this reminds me of how bad I was before.

Another Malaysian staff member expanded on this sentiment:

No matter an old member or new member makes mistakes, others in the community will care of them. There is zero distance between us. We treat each other as family members. It is our responsibility to help you. No matter how much I care of you, I will never let your mistakes exist, help you to correct the mistakes is the forgiveness.

Family, Social Support and Recovery.

The conceptual elements of family appear of critical importance in China. The therapeutic community presents a key building block towards reformulating old ties and bridges to family members. One respondent shared this view about adapting to the "TC family" dynamic:

Everybody concerned about one another, when I was alone, the former clients would come to talk to me. The first day I came here, I did not want to talk to anyone, just sitting in the corner, at that time, some clients came to talk to me, I thought they may have specific purpose, so I refused to talk with them. But soon after, I could definitely feel a sense of family and brotherhood. The highlight of TC is the sense of family care.

This individual even discussed how he recognized that although difficult the" TC tools" are designed to assist in the treatment process:

During treatment, I could think more about myself. I liked the groups in TC, for example, "confrontation", "encounter group" and morning meeting, etc. These activities could practice my ability of expression and thinking. As we said just now, it's clean without drug right here, the topics were not drug issues, we talked about how to stay clean and how to face our future and the society, I had learned a lot from here.

Another resident from China discussed how TC changed his viewpoints as regards the importance of family:

"Old brother" and "old sister." It could negate new comers' apprehension and fear. There would be someone in this family to tell you what should be done or what shouldn't be done. And if you want to discharge, other clients will come and talk to you, you can not find this situation in other places. In other places, it is your own affairs, nobody concerns about you.

Even some of the "old ties," behaviors and manifestations were evident when comparing "new family" to old family" as expressed by another resident from China:

At the beginning, I hated people in Daytop, just like my mother. Because they pointed out my mistake in the morning meeting, even in front of lots of people, which made me embarrassed. But let's think about this right now, only when they treated you as family member, they may directly point out your mistake, otherwise, there is no need to do it like that.

This type of social support was also evident in Malaysia:

…a responsible attitude is important to be successful. We work to help ourselves and others. And this can help in our recovery.

One Malaysian resident expressed how the support process worked for him:

Strength and will power. This strength comes from friends….

Peer Bonding.

The conceptual elements of the bonding experience and its various facets were also an important theme across programs. In Malaysia for example, one resident had this to say:

I believe TC is the best program that is effective to cure addiction especially to heroin…. I belief it's the same. For addiction is a problem related not only to drug but also involves behaviour and emotion. The way of thinking, emotion and behaviour is different from normal individual. If normal people wake-up in the morning and go to work, bit addict sleep in the morning and keep wake at night. Yes, TC can change people's behaviour. Addicts have no pity for others, whether they old, young, pregnant. They are not guilty conscious. Addict like to put blame on others.

Another resident discussed how these bonds might take shape:

The concepts of brotherhood, very straight forward, open, we can talk to anyone. We can pull-up anyone,… of course there is a way to do it. We get our confidence here. In other places it's hierarchical.

Residents of US programs also expressed the need to "get right" with the family and really attempt to build upon this concept not only within the actual confines of the TC, but importantly afterwards, when re-entering their respective communities:

…the family concept because people come here and feel like they're developing a family and I think that makes a big difference feeling a sense of belonging an you are connected to people and they care about you.

For many residents, the positive aspects of bonding and familial interaction were reinforced:

We do everything together. Everybody has their own job functions and we eat together, the guys sleep together in the dorms. They do family functions, they have their morning meeting. All of that is community generated

Another resident put it this way:

My family is not only my little community, but it is also my family because we have to take care of our home. We each have a responsibility to do so. It is a community and it is family oriented

Included in the "renewed persons" many of the Daytop residents were attempting to become was the strong spiritual component they sought and shared with others. As one resident expressed:

Religion in the program Daytop is into the spirituality aspect of things, personal beliefs do not enter into the mold, spirituality is what we seek…

Staff members are also supportive of the varying religious beliefs and denominations. As one staff member reflected:

We have a very questioning clientele that is very knowledgeable….Religious observances, we accept all the different religious modalities and we accept all denominations and try to make it a greater part of the overall treatment experience, with spirituality being the key word.

In Malasya treatment providers sought a subtle balance incorporating the religious with the spiritual:

I see that the TC program does not clash with any of our Islamic values…If one only use religious aspect, it is not enough, and thus one must have a program that they can do something else.

The spirituality from this dynamic extends to their daily interactions with the residents, such that learning and "role modelling" can take place:

No matter an old member or new member makes mistakes, others in the community will care of them. There is zero distance between us. We treat each other as family members. It is our responsibility to help you. No matter how much I care of you, I will never let your mistakes exist, help you to correct the mistakes is the forgiveness……

The goal is for the therapeutic treatment model of "community as method" to take effect (Deleon 2000):

…whenever there is anything of concern, we'll communicate, take care, and advice each other. Even though we are staffs, we still will learn from other's life on how to be free of drug and how we can do things better. So we remember the phrase "I've learn by myself day by day."

In Malaysia, as in the other programs that participated in this study, the community serving as the "healing agent," seems to be working. As expressed by one Malaysian TC resident:

We have love, caring, respect, reminding each other and putting importance of health on each other. I have personally experience all that. This makes me stronger to go for full recovery. My own brothers and sisters think that it is all very odd; they were surprised to see me wash dishes and cleaning up the house. Before this, I could not care less about these things.

In the US programs these conceptual elements of "community" were also clearly evident:

Daytop is the only place I ever came in my life where they asked me to stay instead of leave… Daytop was the first place I ever went where they were like yeah you got a lot of crap but deal with it.

Another resident expressed these sentiments:

…I think there's a lot of that that goes on here where people see we don't just say we're done with you. We really don't do that a lot. We don't really give up on people. We keep pushing. We keep trying. And I think that that is what family does.

Shame and Family.

Concepts of shame and how these affect the treatment process were very effectively described by one staff member from a Chinese TC:

The national policy can influence our program greatly. As I know, the TC programs in United States are more easily to get funding from government or other organizations compared to the TC in China. It is difficult for our program to apply for government fund. Talking about the culture difference, I feel American people are more open to express their feelings and opinions while Chinese people are relatively close themselves and do not want to expose themselves in front of others. Therefore the participation of residents in certain groups in our TC program is limited. For example, an encounter group with 10 residents can last more than 2 hours in United States while not many people are willing to participate in this group in China. So our staff has to use some strategies to encourage residents' participation. It seems that residents do not have many comments on the government policy as they just can choose few models to get treatment in Yunnan. Regarding the participation, Chinese residents may need more time to be used to the TC culture, or they may need more encouragement and peer pressure to take part in. Some of them were involved passively in the group instead of actively taking initiative to join, especially for the new members.

Economic Difficulties.

The key similarities that were evident across these programs pertained to economic viability and sustaining treatment effects over the long term, particularly in the re-entry setting. These phenomena were elaborated nicely by one staff member from China:

I think that national policy affects our TC program greatly. As I know, drug users in United States have the right to choose between going to TC and going to prison and the government will fund their treatment in TC. But people in China have to pay their treatment in this program and our TC community is not funded by the Chinese Government. Probably our government has lots of things to concern and deal with so they did not pay enough attention to the treatment for drug addicts, especially to the rehabilitation for these people. Drug users can accept the reality as they know that drug use is illegal in China. But these policies affect the choice of drug users. Though many people want to quit drugs, only some of them can afford the treatment in this program.

Financial strains towards employment and the difficult economic climate were also discussed poignantly, even for those who successfully completed the treatment experience:

These people may have to deal with the pressure of unemployment as many of them do not have job. When they return to their old location, they may encounter their 'drug friends' or they may meet some situation which reminds them about drug use. These are problems they need to deal with. Unfortunately, the work of our reentry community has stagnated and few people can complete a long treatment so the reentry preparation in this program is not so effective. We need experienced staff to run aftercare programs such as reentry community, half-way house and family association because these components are helping people to cope with possible difficulties when they leave here.

Re-entry Preparation.

Discharge planning begins upon entry and continues throughout treatment tenure. It appears these plans are closely tied to previous behaviors, in addition to existing economic worries. One Daytop USA staff member discussed the additional triggers reentering individuals must deal with daily:

We work on specific relapse prevention tools and triggers. People places and things, these are identified. Identify situations where these settings may compromise recovery.

Across programs, the key is to identify these respective triggers individually and how these might affect the global recovery paradigm (Tiburcio, 2008).

For the women in the Daytop US program, a staff counselor expressed:

Staff members have talked to women who have left here still because they know that they call us and say 'I need help because I'm thinking about relapsing or I have relapsed and I want to come back to treatment.' They know their counselor is still available to them.

Similar sentiments were expressed across treatment programs. In China, one staff member stated:

We would help them come up with an after-care plan, a relapse prevention plan, incorporate that into their latest treatment plan. Sober support.

Treatment officials from Malaysia discussed this phenomenon:

Actually we rely on how matured they are in terms of recovery before they are allowed into re-entry oraftercare. We will have evaluation. If the family pressures us to let them go early, then we have family therapy or family group with the client's family. Whatever plans we have, the most important things is family environment. So, their own family is the most important.

Discussion

The qualitative data from this study suggest that for many individuals the recovery process is cyclical. Engagement in criminal activities (or subsequent desistance from same) appear to also function in a cyclical fashion and often operate in tandem to periods of abstinence and relapse, but particularly as pertains to two major classes of drug use. Across all international programs in this study, residents reported heroin/opioid use as the major drug issue. In addition, many reported that criminal activity engagement/desistance was a function of their *continued* heroin/opioid use or *cessation* of use. Syabu, (used as a form of methamphetamine/speed - Malaysia) and amphetamine use in general, was the second most used drug across programs, but particularly in Malaysia, where some residents described having to deal with relapse to this substance on a near constant basis, *in spite of* quite severe sanctions for doing so. Unsuccessful abstinence attempts followed by "*finally getting it right*" and sustaining these over extended periods are also discussed elsewhere (Tiburcio 2006; 2008).

Transcript data also suggest that the stability or *"permanence"* of criminal desistance and abstinence is often predicated on the cumulative effectiveness of:

a) Counseling sessions,

b) Improved family dynamic – establishment or re-establishment of familial bonds

c) Learned and applied coping strategies, and social support, *"each one teach one"*

d) Sustained abstinence attempts*, "progress makes perfect,"* "*finally getting it right*"

e) Behavioral accountability as a function of the peer bonding enterprise *"I am my brother's keeper."*

Peer support within the TC, and how it is built and sustained, and how this phenomenon is experienced during community reimmersion is something that needs further investigation, particularly as experienced during the *reentry treatment* phase/s. The transcript data suggest that "truisms" and visible slogans may have long lasting effects. As expressed by one Daytop TC resident "*Those little things mean a lot…"* These truisms also demonstrate interconnectedness across programs: *"You are your brothers' keeper"* appears to have a direct relationship to the adage of "*Each one teach one*," both which lend credence to the strength of peer support and how these experiences might be sustained outside of the protective treatment environment.

The drug treatment field and public health arenas in general require a better understanding of how these phenomena play out in "real world settings," given the various public health and criminal justice concerns, exposure and related sequelae that result from continued drug use and relapse. Recidivism for example, appears to be the cumulative result of engaging in various independent "mini-relapse behaviors," ("*acting the drunk"), "being high without picking up the drug,"* leading to "Chipping," (episode of sporadic use after a period of sustained abstinence), "falling off the wagon," and other drug relapse conditions. These sporadic "chipping," intermittent and short lasting episodes become more and more connected, and interdependent as time goes on, and in many cases ultimately result in cases of full fledged relapse.

Study Findings / Dissemination

This manuscript is the first in a planned series describing Qualitative methods and findings from this study. Two presentations based on these findings were presented in the United States in September and October of 2010. A proposal extrapolating some of these findings to other countries from Latin America is also planned (September 2011 NIH submission cycle).

Extant presentations include:

Tiburcio, N.J. and Kressel, D. (2010 September - October). *Achieving an enhanced understanding of therapeutic communities (TC's) worldwide*. National Hispanic Science Network Tenth Annual Conference, New Orleans, LA. September 29 – October 1, 2010.

Tiburcio, N.J. and Kressel, D. (2010, October). *An enhanced understanding of therapeutic communities (TC's) worldwide.* Addiction Health Sciences Research Conference, Lexington, KY, October 25-27, 2010.

Summary and Implications

There were clear elements of a sustained recovery paradigm as a common treatment goal across these programs. Further analyses reveal three common elements internationally: 1) the connection between substance use abstinence and criminal desistance, 2) the importance of successfully mending familial ties and 3) the positive effects of peer bonding and the bonding process. We found the overarching domain of interest across these programs to be "the importance of peer bonding," particularly as experienced outside of the formal treatment milieu; and how importantly honesty relates to the bonding enterprise. Analyses

also suggest that there exist unique cultural differences across these programs that from a policy perspective need careful consideration when implementing the "*whole person*" TC treatment approach (Deleon 2000). Individual willingness to accept sanctions and not "*act out*" appear to be affected differently across countries as well as by gender, for example. Mandated clients in U.S. programs seem to accept having *"hit rock bottom"* more readily than their overseas counterparts. On the other hand, acceptance of the "*program as family*" concept of TC treatment appears more readily accepted in China and Malaysia, than in the U.S. this may in part be due to the vastly greater availability of treatment within the US, leading to a more impersonal dynamic for those that enter treatment, sometimes on a repeated basis.

The findings from the present study also highlight the importance of incorporating qualitative research within treatment outcome studies. Across programs these individuals collectively report heroin/opioids and methamphetamine use as being the most problematic to address. In terms of future directions, their successful abstinence strategies are of key significance. Although further research is needed at this point, preliminary results suggest that if implemented correctly and adjusting for potential differences internationally, improved treatment completion rates and ultimately, sustained abstinence is possible using the TC model as a mechanism of change. One important step in this direction is recording the "voice" of the various success stories.

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Recommendations:

1) Enhanced investigation of the Re-Entry phenomenon across all programs;

2) Continued examination of cultural components of the treatment experience, (what works in one setting may not work in others, depending on how adaptive the treatment milieu is to the culture);

3) Client retention is a serious issue in China; there is a clearly significant need to examine splitinterview data (where available) as well as the post treatment experience via treatment as usual (TAU) follow-up interviews to examine this phenomenon in depth;

4) Examine what other components work in tandem with culture to build upon these and enhance retention rates across programs.

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References

Bernard, H.R. & G. Ryan (1998). Qualitative and quantitative methods of text analysis. In *Handbook of Research Methods in Cultural Anthropology*. Walnut Creek: Altamira Press.

Broome, K., Simpson, D., & Joe, G. (2002). The role of social support following short-term inpatient treatment. *American Journal on Addictions, 11*(1): 57-65.

Charmaz, K. (2000) Grounded Theory: Objectivist and Constructivist Methods. In Denzin, N. & Lincoln, Y. (Eds.) *Handbook of Qualitative Research.* 2nd Ed. London: Sage.

Charmaz, K. (2006). *Constructing grounded theory,* 1st Ed. Thousand Oaks, CA: Sage Publications.

De Leon, G. (2000). *The therapeutic community: Theory, model, and method*. New York: Springer Publishing Co.

Glaser, B.G., & Strauss, A.L. (1967). *The Discovery of Grounded Theory: Strategies for Qualitative Research*, Chicago, Aldine Publishing Company

Hesse-Biber, S.N. & Leavy, P. (2005). *The Practice of Qualitative Research*. Thousand Oaks, CA: SAGE Publications.

Jorm, A.F., Korten, A.E., Jacomb, P.A., Christensen, H., Rodgers, B., and Pollitt, P. (1997). Mental health literacy: A survey of the public's ability to recognize mental disorders and their beliefs about the effectiveness of treatment. *Medical Journal of Australia,* 166: 182.

Muhr, T. (1991). Atlas/ti - A prototype for the support of text interpretation. *Qualitative Sociology 14*(4):349-371.

Parikh, N.S., Parker, R.M., Nurss, J.R., Baker, D., and Williams, M.V. (1996). Shame and health literacy: The unspoken connection. *Patient Education and Counseling,* 27(1): 33-39.

Schillinger, D., Grumbach, K., Piette, J., Wang, F., Osmond, D., Daher, C., Palacios, J., Diaz Sullivan, G., and Bindman, A.B. (2002). Association of Health Literacy with diabetes outcomes. *JAMA.* 288:475-482.

Strauss, A., and Corbin, J. (1990). *Basics of Qualitative Research: Grounded Theory Procedures and Techniques*. Newberry Park, CA: Sage.

Strauss, S.M., Tiburcio, N.J., Munoz-Plaza, C., Gwadz, M., Lunievicz, J., Osborne, A., Padilla, D., McCarty-Arias, M., & Norman, R. (2009). HIV care providers' implementation of routine alcohol reduction support for their patients. *AIDS Patient Care and STDs, 23* (3), 211-218. PMID: 19866539

Tellis, W. (1997) Introduction to Case Study. *The Qualitative Report*, *3* (2). Accessed from the WWW August 15, 2010. Available at: http://www.nova.edu/ssss/QR/QR3-2/tellis1.html.

Tiburcio, N. (2006). *Five Years After: The process of long term abstinence from heroin use among ex-offenders*. New York, NY: City University of New York Graduate Center.

Tiburcio, N. (2008). Long-Term Recovery from heroin use among female ex-offenders: Marisol's story.*Substance Use and Misuse, 43* (12-13): 1950-70.

Tiburcio, N.J. Twiggs, R., & Dunlap, E. (2009). Hurricane changes: Examining enhanced motivation to change drug using behaviors among Katrina evacuees. *Anuario de Investigación en Adicciones, 10 (1)*, 79-95.