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How Treatment is Constructed Among Graduates and Dropouts in a Prison Therapeutic Community for Women

Jill McCorkel [a] , Lana D. Harrison [b] & James A.
Inciardi [c]

[a] Department of Sociology and Criminal Justice ,
University of Delaware , USA

[b] University of Delaware Center for Drug & Alcohol
Studies at the University of Delaware , USA

[c] Department of Sociology and Criminal Justice ,
University of Delaware , USA
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How Treatment Is Constructed Among Graduates and Dropouts in a Prison Therapeutic Community for Women

JILL McCORKEL
University of Delaware

LANA D. HARRISON
University of Delaware

JAMES A. INCIARDI
University of Delaware

ABSTRACT This study explores the influence of client constructions of "drug treatment" on their expectations and participation in a prison-based therapeutic community program. Initial investigation into client attrition revealed that those clients who prematurely left the program frequently did so under the assumption that they had never received treatment. Indeed, clients who dropped out of the program overwhelming believed that "treatment" consists of a passive, hierarchical relationship with a counselor in which activities are tailored to respond to the uniqueness of the individual's life experiences. The therapeutic community modality de-emphasizes individually tailored treatment in favor of peer-group counseling and role modeling. In light of a treatment modality that deviated from their expectations, clients defined the program as "punishment" and dropped out. Of those clients who remained in the program to graduate, many maintained similar notions of an ideal type of treatment, but these changed to accommodate

the therapeutic community modality over time. This study explores the significance of constructions of treatment on residents' experiences in the program and examines the processes that lead some clients to reject the TC modality, while others are able to successfully embrace it. Suggestions for reducing client attrition in group therapy programs are drawn from the analysis. *[Article copies available for a fee from The Haworth Document Delivery Service: 1-800-342-9678. E-mail address: getinfo@haworthpressinc.com]*

The application of the social constructionist paradigm in studies of substance use and treatment has assumed increasing prominence over the course of the last few decades. The majority of this work has focused on the emergence of the disease concept (see Neuhaus, 1993; Conrad & Schneider, 1992; Poikolainen, 1982; Gusfield, 1963; Seeley, 1962) and the mechanisms (both institutional and interpersonal) through which substance use is defined and treated as "misuse," "abuse," and "addiction" (Wiseman, 1991; Sonnenstuhl & Trice, 1987; Schneider, 1978; Orcutt, 1975; Lindesmith, 1965). For example, McCorkel's 1998 study of a residential drug treatment program reveals that the organization's construction of the "addict" involves a complex interplay of therapeutic rhetoric, institutional social control, and ritualistic emphasis on interpersonal labeling. Residents were not passive recipients of the designation "addict." Instead, they frequently challenged the treatment program's definition of addiction and promoted their own sentiments regarding the types of behaviors, attitudes, and experiences that constituted the presence of "addiction." It is clear from this study as well as from other ethnographies of various types of rehabilitation programs that client participation in, and comprehension of, therapy is directly influenced by the ways in which staff and clients contest and negotiate the definitions of such things as "sickness," "recovery," "normalcy," and "deviance" (see Horowitz, 1995; Schaler, 1995; Snow & Anderson, 1993; Bloor, McKeganey, & Fonkert, 1988; Sugarman, 1974; Goffman, 1961).

Ironically, while there is a growing body of research that examines the influence of contested meanings and negotiated structures on treatment participation and success, considerably less effort has been focused on examining the impact of the preprogrammatic definitions clients maintain regarding "treatment" and "therapy" on their participation in treatment programs. Indeed, scholarly efforts to identify factors associated with success in treatment have been based largely on quantitative analyses of intake assessments and close-ended survey instruments. These studies have examined the influence of such variables as parental history (Caudill et al., 1994), self-esteem and other psychologically pertinent variables

(Anglin, 1994), treatment modality (Lanehart et al., 1994); socio-demographic indicators (Siddall & Conway, 1988); treatment history and time spent in program (Simpson, 1979), and forced versus voluntary admission (De Leon, 1988; Collins & Allison, 1983) on successful participation in treatment programs and success following program graduation [Note 1]. While informative, this type of study is problematic on at least two levels. First, many of these studies focus on variables that are unmodifiable such as socio-demographic characteristics and events occurring in the life histories of clients. While determining that certain socio-demographic indicators correlate with treatment success is useful in some regards, it does not alter the fact that substance users (and abusers) come from a variety of backgrounds and experiences. Second, these studies offer little in the way of suggestions for treating clients whose survey profiles are associated with failure in treatment. Indeed, among those hard-to-treat populations, these studies are often unable to account for those who actually succeed. Obviously, the long-term implications of such research are problematic–one can hardly justify the exclusion of large numbers of individuals from treatment programs on the basis of their membership in particular social categories. Instead, we must seek to modify treatment programs in ways that meet the varied needs of different sets of drug-using populations.

The central contribution of ethnographic studies of treatment programs is precisely in those areas where quantitative studies are at their weakest–prescribing alterations in program structure and content, and in revealing the influence of meaning and interaction on the *experience* of treatment itself. As mentioned previously, studies examining meaning construction and the labeling process in treatment programs have been tremendously useful in demonstrating how these experiences contribute to the quality, duration, and consequences of client participation in treatment programs. This study seeks to contribute to this literature by examining how clients define "treatment" and "therapy" prior to their entering a treatment program and the influence such definitions have on their experiences in the program. In this paper, we will argue that client constructions of "treatment" are a central conceptual device through which experiences in treatment are rendered meaningful and evaluated. Further, such constructions often serve as the basis on which decisions to prematurely leave the program are made.

DATA AND METHOD

This study is the outgrowth of a three-year process evaluation of BWCI Village, a prison-based, therapeutic community program for drug-involved, women inmates located in New Castle, Delaware. During the

program's second year of operation, it became necessary to interview women who had dropped out of the program due to a fairly substantial client attrition rate during the program's first twenty months of operation [Note 2]. During this two-year period, the program's dropout rate ranged considerably, although during the final nine months of the three year evaluation period it leveled off at approximately 50 percent. While a dropout rate of 50 percent is not unusual or particularly high for a residential treatment program, it does have some implications for intake and retention. For the BWCI Village program in particular, high attrition rates (e.g., 70% or greater) negatively impact the treatment progress of remaining residents. Further, when residents prematurely depart from the program they are frequently returned to the general prison population where they often criticize the program and actively intimidate other inmates who are considering entering the program. In light of these facts, interviews with program dropouts were undertaken with the goal of reducing attrition and improving the program's ability to comprehensively meet the treatment needs of a relatively understudied population.

Of the 43 women who had dropped out of the program during the first two years of operation, 32 agreed to be interviewed. Interviews were semi-structured and focused on client perceptions of treatment, relationships with staff and other residents, and the circumstances surrounding their premature departure. Interviews ranged from 60 to 120 minutes in length and were generally conducted in an interview room housed within the prison. Of the respondents who agreed to be interviewed, all remained incarcerated in correctional facility [Note 3]. With the permission of the respondent, interviews were taped and later transcribed by a member of the evaluation team.

Analysis of these interviews followed from a grounded theory framework (Glaser & Strauss, 1967). While we maintained an interest in several areas we hypothesized as being central to the treatment experience (e.g., relations with staff, involvement in group activity, and impressions of the program), we did not mine the data attempting to "test" certain hypotheses regarding departure. Instead, we analyzed the data according to categories that our respondents regarded as particularly salient or meaningful. These categories, then, became the basis for our analysis of the circumstances and perceptions that contribute to premature departure.

The category that assumed central relevance to our analysis involved perceptions of treatment. When asked to discuss their impressions of treatment in the program, the majority of respondents would counter with statements like "What treatment?" or "I never really got treatment, I only met with my counselor a few times a month." Further, it seemed that the

perception that they had never received treatment served to erode their motivation to stay in treatment. As evaluators who were regularly in the program doing fieldwork, we were confident that staff were doing their jobs and that various therapy groups and activities were indeed taking place. In fact, the problem was not that the staff were not doing their jobs; it seemed that the problem lay in how respondents defined treatment.

In light of the themes raised in interviews with program dropouts, we decided to conduct interviews with graduates of the program to further examine two areas: (1) the salience of client expectations of treatment on participation in the program and, (2) whether program graduates maintained similar conceptions of treatment compared with their peers who dropped out. Interviews with program graduates followed from the same format used with women who had dropped out of the program. The interview schedule was a revised version of the dropout schedule, with an additional section examining whether respondents ever felt like prematurely leaving the program and the ways in which these feelings were resolved. Also, detailed probes were added to the schedule that were designed to illicit information about core themes raised by the dropouts. Probes included queries about surveillance in the program, confrontation, relations with staff, privacy, and information conveyed to them by correctional administrators and program staff regarding sentence modification.

Of the 39 program graduates, a total of 18 women agreed to be interviewed. On the basis of intake statistics compiled by the program staff, those graduates who agreed to be interviewed are representative of the total population of graduates in terms of age, race, and time in the program. Graduates who were housed in an institutional setting (e.g., prison, work release center) at the time of the interview were considerably more likely to participate in the interview than graduates who were living on their own in the community. This diminished response rate is due primarily to problems locating graduates after they had been released from prison, and coordinating work and child care schedules. It is also possible that some of the graduates who were located and refused to be interviewed had relapsed on drugs (although this is an unconfirmed consideration).

THE FIELD SETTING: BWCI VILLAGE

The structure of BWCI Village follows from the therapeutic community modality, and like all therapeutic communities, the program rejects the traditional hierarchical relationship between client and professional therapist (see Pan et al., 1993; De Leon & Ziegenfuss, 1986). The program has a total of six counselors who are considered role models that support and

encourage the development of the client. In therapeutic communities (henceforth TCs), the client, working along with her peers, is largely responsible for her own treatment. The distance between professional therapist and client is minimized in the Village, although like other TCs, the program maintains a hierarchical residential structure (Yablonsky, 1989; De Leon, 1984). Typically, residents who have been in the program longest and/or residents who conform to program rules are given positions of authority over other community members.

The Village is a 42-bed unit located within Baylor Women's Correctional Institution in New Castle, Delaware. The program began accepting clients in January 1994 and since that time has handled over 250 inmates. Inmates either enter the program voluntarily or are sentenced to the program in accordance with the discretion of Delaware drug courts. Clients generally spend between six and eighteen months in the program before graduating. The unit in which the program is housed is completely separate from the rest of the prison facility and residents have only limited contact with other inmates and correctional officers.

The Village follows the traditional model of a hierarchically organized TC and is guided by the philosophy that behavior modification is most effectively accomplished through peer pressure and role modeling (Kooyman, 1993). As such, all residents are given the responsibility of monitoring and assisting in the development of their peers. Typically, staff designate residents who have been in the program the longest for the most prestigious jobs in the community. These jobs include such tasks as organizing the daily schedule, structuring therapy groups, and monitoring the work performance of other residents. Older residents and staff also serve as role models for incoming clients. Older residents may be responsible for teaching new clients the program's philosophy, providing them with information regarding community rules, and assisting with their transition into therapeutic community life. Counseling staff rely heavily on these experienced residents to serve as monitors of the community. Staff expect these residents to immediately report any trouble brewing among residents (e.g., sexual affairs, threats, bad attitudes, etc.) [Note 4]. Staff also expect that newer residents will be responsible enough to report other residents who engage in "negative behavior," rule violations, "contracting" and "dope-fiend" attitudes [Note 5]. A resident who is discovered to be engaging in any one of these behaviors will be informed of her misdeeds by another resident and may, depending on the seriousness of the violation, be called to the center of the treatment facility where other residents and staff will harshly critique her behavior.

The trademark treatment technique common to all TCs involves the use

of confrontation. Liberal use of confrontation is premised on the belief that residents cannot change their attitudes and behaviors if they do not recognize the ways in which these behaviors affect others (Sugarman, 1986). The confrontation process is often difficult for both donor and recipient because it typically violates the "no snitching" code that is central to inmate culture (Silberman, 1995). Additionally, the recipient of a confrontation is generally not allowed to respond to any indictments of her behavior with anything but "thank you." Finally, confrontation can often take severe forms, with a number of residents and staff members yelling at a client in front of the rest of the community for her "negative" behavior.

Several therapy groups that residents participate in on a bi-weekly basis are organized around confrontation therapy. Encounter groups ("EG") are the most popular and most attended of the therapy groups. In EG, residents sit in a circle with counselors who select which residents will indict one another for displays of negative behavior. All residents who formally complained about the same client are also allowed to indict her. The client being indicted can only respond with "thank you," or "what you said was valid, I'll take a look at that." The purpose of such groups is to teach residents how to manage and resolve their feelings toward others in appropriate ways. Rather than "stuffing" (i.e., repressing) their feelings, they are encouraged to express them and move on.

Clients also regularly participate in feelings groups and self-disclosure seminars, both of which allow clients to share private feelings, painful experiences, and concerns and fears they may have about the future. In addition, clients run their own Narcotics Anonymous/Alcoholics Anonymous meetings. Most of the therapy women receive in the program occurs in group settings–only rarely do they receive individual counseling and this tends to be done on an emergency basis.

COMPARING GRADUATES TO DROPOUTS

While dropouts and graduates are similar in terms of socio-demographic, sentence length, and various life history variables (see Table 1) there are two important differences between the groups that are worth mentioning here.

First, graduates spent an average of 9.5 months in the program prior to graduating and ranged from a low of 5 months in the program to a high of 19 months. Dropouts spent less time in the program than did graduates. Among the sample of dropouts interviewed, 81% spent between three and five months in the program. Since the program requires that residents remain in the treatment facility for a minimum of 30 days

	Graduates	Dropouts	X^2
☐ **Table 1: Sample Characteristics**			
Race/Ethnicity			.02
White	33.3 (6)	31.3 (10)	
Black	66.7 (12)	68.8 (22)	
Age			.16
20-29	66.7 (12)	71.9 (23)	
30-40	33.3 (6)	28.1 (9)	
Sentence Length			.28
6 months	5.6 (1)	6.3 (2)	
7-12 months	27.8 (5)	34.4 (11)	
13-18 months	44.4 (8)	40.6 (13)	
> 18 months	22.2 (4)	18.8 (6)	
Primary Drug of Choice			
crack-cocaine	77.8 (14)	71.9 (23)	.21
cocaine**	16.7 (3)	0 (0)	5.67
heroin*	0 (0)	15.6 (5)	3.12
marijuana	5.6 (1)	12.5 (4)	.62
Previous Drug Treatment	44.4 (8)	53.1 (17)	.34
Primary Motivator for Treatment***			14.06
reduction in sentence length	83.3 (15)	28.1 (9)	
treatment for drug problem	16.7 (3)	71.9 (23)	

Note: the chi-square test of significance may not be valid when there are cells with a frequency of zero
* p ≤ .10; ** p ≤ .05; *** p ≤ .005

before submitting a request to be transferred to the general prison population, none of the dropouts were in the program for less than a month. In addition, none of the dropouts stayed in the program longer than five months.

Second, graduates were significantly more likely than dropouts to report that their primary motivation in entering the program was to gain early release from prison (83% compared to 28%). The responses to the question "what was your primary motivation in entering the program?"

were unambiguous. Respondents entered the program with either a sincere interest in receiving drug treatment or with the practical intention of receiving a reduction in sentence length. Based on their responses to this question and related discussions of motivation for treatment, it does not appear that graduates are initially more motivated to receive treatment than are dropouts (in fact, the converse is true–dropouts are more likely to report that their primary reason for entering the program is rehabilitation).

CONSTRUCTING TREATMENT

As interviews with program dropouts were reviewed, it became increasingly clear that the source of their dissatisfaction lay in the program's inability to provide "treatment." While responses to the question "why did you leave" often involved a specific series of events or a problematic relationship with a member of the counseling staff, further discussion with respondents revealed that these women were unhappy and dissatisfied with the program long before events occurred that precipitated their departure. Indeed, it is their negative evaluation of the program and the contention that it is not "treatment" that most frequently causes residents to leave prematurely or to engage in behavior that results in their dismissal from the program [Note 6].

Prior to entering the program, dropouts had an image of what drug treatment would consist of, what experiences in therapy would be like, and how the therapy process would produce changes in themselves. It is through their construction of "treatment" and "therapy" that residents interpret the Village program and the activities offered therein. Throughout these interviews, respondents stated that they never or rarely received any kind of treatment at all. When questioned about this further, it became clear that residents equated treatment with private meetings with an individual counselor. Shawna, a resident who dropped out of the program after four weeks, notes:

> Treatment, shit, I didn't get no treatment. I got a bunch of noisy inmates running around trying to pretend like they's counselors. Where's the treatment in that? I only saw my counselor twice in the whole time I've been there–none of them inmates gives a shit what happened in my life, that's the counselors' job and they ain't doing it.

Because TCs embrace the philosophy that "treatment" can be virtually anything and everything within the residential structure, little emphasis is placed on individual counseling. Residents are expected to rely primarily on their peers–particularly senior peers–to help them progress through the

program and to assist them in developing the reflexivity necessary to analyze the ways in which their own attitudes and behaviors contributed to their misuse of alcohol and/or drugs (Lockwood and Inciardi, 1993). Dropouts did not regard any aspect, with the exception of individual sessions with counselors, as treatment. They had problems equating "therapy" with group meetings and peer interactions, and were generally cynical of the peer-based treatment environment.

So how did these women conceive of treatment? In general, conceptions of treatment among the dropouts are remarkably similar and follow from the popular stereotype of a passive, hierarchical relationship between a psychologist and a client. Consider the following answers offered by dropouts to the question "what is treatment?":

> What is treatment, you mean? I see it as someone just listening to me, not interrupting till I'm done. Listening to my story, you know, and then telling me where I need work. I would need help getting to remember stuff, admit stuff. They [counselor] would do that. But they would have some respect for me, believe me, cause I'm paying them, you know?
>
> Treatment to me is good advice from someone who knows what they hell they're doing. These women in here are just the same as me—ran the streets, the same streets as me, fucked the same men for some shit. They can't tell me nothing. They barely sober! I need someone to give me advice, to tell me where I went wrong. Some things you can't see for yourself—you need a doctor to do that and there ain't no doctors in here. Just a bunch of counselors and inmates!

Further, according to the dictates of program rhetoric, staff refer to the women who enter the program as "clients" or "residents." Use of the term "clients" reaffirms the dropouts' preconceptions of therapy. As Denise, a resident who remained in the program for two months before leaving, recalled:

> When they [staff] first called me "client" I thought to myself, "yeah, I'm really gonna heal this time. This is for real, it ain't some slappy shit some state of Delaware government gonna force on us that don't work anyway." I was excited about it 'cause I thought they ain't calling me "criminal" or "inmate" no more. I'm important, too. Shit, once I got in there you might as well as called me a dog. I think a dog got more rights than those women in that program. They can't decide shit, they can't say nothing 'bout what they need. . . .

Subsequently, while the dropouts believe that they ought to be subordinates in an essentially passive relationship with a counselor, their com-

ments do suggest that there is a certain level of power and autonomy embedded in this role. The concept of client implies that subordinates in the therapeutic relationship would have a level of control over the direction of that relationship. Further, it implies that they—the subordinates—have the power to terminate the relationship according to their own likes and dislikes. This is certainly inconsistent with their experiences in the treatment program where nearly half of the residents are sentenced to the program and all who desire to leave are subject to a series of significant impediments including solitary confinement and a potential increase in sentence length.

Following from their original conceptions of treatment, the women who dropped out of the program objected to a number of different aspects of the program which they associated with powerlessness, and by definition, the *absence* of therapeutic value. In general, the dropouts protested the degree to which they believed the program was overly invasive into personal lives. While respondents agreed that the function of treatment is to expose and solve problems that are largely of a personal nature, they objected to the frequent use of such techniques as surveillance, forceful probing, and public confrontation. Each of these factors appears to contribute to feelings of powerlessness, loss of autonomy, and cynicism regarding programmatic objectives.

Surveillance

Dropouts likened extensive levels of surveillance and the lack of personal autonomy in the program with their experiences as inmates in the general prison population. For them, surveillance was inconsistent with the notion of treatment and instead comparable to traditional incarceration practices. In fact, most of the dropouts tended to see the program as a more severe form of "punishment" because of restrictions in personal freedoms and constant surveillance. In the words of one dropout:

> I've got my jail time already. Eighteen months level 5 time [incarceration] is bad enough, now why should I come over here and get punished more? No TV, no radio, our commissary is blacked out [restricted]. I'm already in jail, I don't need to come to Hell! It's just more punishment is what it is. . . .

They reported that the constant monitoring of their behavior by both the staff and other residents made them feel "crazy," "stressed," "angry," and "frustrated." In general, they interpreted the use of surveillance to mean that they were not trusted to behave. One former resident noted,

"They's watching you all the time. It's like they just waiting for you to fuck up. I mean, I understand we addicts and stuff like that, but never to have privacy? That's fucked up. . . . They might as well be COs [correctional officers]." When they do violate program rules, disciplinary actions are taken which, in most cases, involve further erosions of personal autonomy thereby reinforcing the notion that they are "punished" not "treated."

Probing

The second form of program intrusiveness involves what respondents believe to be forceful probing for information. Many dropouts report leaving the program in conjunction with a staff member or group of residents probing too deeply for "personal" information. "Personal" information frequently involved highly traumatic and/or degrading events in their lives such as rape, molestation, child neglect, and sacrifices made for drugs. Again, dropouts suggest that the lack of control over personal information and past events in their lives is indicative of the extent to which the program is inconsistent with therapy and, instead, comparable to punishment. One respondent noted:

> . . . they expect you to just come out and put everything out on the floor, in front of total strangers, and it's hard to do. Regardless of how you are trying to get yourself together and all that, some things you just can't put out. Some people have trust issues. . . . Don't force a person to talk. Eventually, it will come out, but in some things you have to ease out, work away on it. I just don't like the forcefulness of it.

Dropouts suggested that they were forced to disclose such information in one of two ways. First, many reported disclosing a personal experience to a counselor who later insisted that such information be made public before a group of residents. Respondents believed that if they refused to make such information public, counselors would prevent them from progressing through the program in a timely manner. Second, several respondents believed that counselors "hinted" or "gossiped" about personal experiences to their peers, leaving them to disclose their experience to the group or else be the subject of endless speculation and scorn. It is clear that efforts to elicit information, and to render this information public, are inconsistent with the dropouts' belief that confidentiality and privacy are intrinsic features of the counselor/client relationship.

Public Confrontation

The third criticism of the treatment program advanced by dropouts involves public confrontation, which is intimately related to their concerns regarding forceful probing. Contrary to the speculations of counseling staff, most of the women that leave the program do *not* do so because they are troubled by the use of confrontation in theory or by all the yelling. Indeed, the majority of respondents reported that they enjoyed encounter groups and that the program's confrontation techniques taught them restraint, as well as how to avoid taking criticism personally. Instead, dropouts problematized confrontations which they believe "disrespected" or otherwise degraded the intended target. Disrespectful confrontations consisted of unfair accusations and/or personal attacks.

An unfair accusation of wrongdoing (referred to in the program as an "injust") is often undertaken purposefully by staff to teach residents patience and how to avoid taking critiques personally. Dropouts were generally unable to assign any therapeutic value to the use of injusts and noted the number of times they were used by other residents (rather than by staff) to advance personal interests. Since injust accusations were frequently followed by disciplinary actions (wherein the accused resident would be treated as if she had broken a rule when she had not), dropouts believed that this practice was comparable to "snitching" behavior in the general prison population. As one former resident recalled:

> Oh, Counselor [name withheld] was out to get me, yes she was. She just didn't like me from the start and she has her favorites. She had them [senior residents] on me from the time I got there to the time I left. They was always pulling me up [reporting and punishing for rule violations], accusing me of shit, and making fun of [me].

Personal attacks are associated with the practice of injusts in that each involves, according to the dropouts, the use of "therapy tools" to advance personal interests. In discovering the "personal" motivation behind a confrontation, respondents believe that they have discovered definitive "proof" that the program does not really provide treatment. Treatment would involve the application of therapy by a disinterested, objective "professional." When confrontations involve mean-spirited labels and make negative imputations to the target's character, dropouts suggest that any vestige of therapeutic value is forsaken. For example, when asked about the confrontational aspect of encounter group, Jenna noted:

> If I take you to group, I call you names, I say you a "dog." Cuss you out, 'cause that's the time you can cuss somebody out. Then you

> have, "Mother fucking this. Sit here, mother fucking, mopey-look-
> ing, ass," or something like that. The name calling–that's an issue
> for women . . . addicted women all their life have been cussed out,
> name called, and totally disrespected.

Another client commented on the staff's use of the word "family" to refer
to the residents and counselors that constituted the Village program:

> They just doing the same things my family did to me to get me here.
> I guess that's why they call themselves a family. They beat you up,
> call you names, spit on you just like a family. How much more
> breaking down [degradation] do I need? Shit, I've been broken down
> my whole life–what they's doing to me isn't going to help.

In summary, dropouts do not believe they receive "treatment" in the
Village program largely because the program's emphasis on group therapy
violates their conception of treatment as an individual relationship with a
counselor. Practices that occur within the program such as surveillance,
confrontation, and group sharing confirm their evaluation that the program
operates to punish rather than treat. For them, punishment involves loss of
personal discretion, powerlessness, surveillance, and discipline while
treatment implies levels of autonomy, privacy, and interpersonal respect.
Subsequently, their cynicism and suspicion regarding the "true" objec-
tives of the program quickly erodes their motivation to complete the pro-
gram and generally corrupts their relationships with counselors and other
clients. At this point, any hurtful or injust confrontation prompts them to
prematurely leave the program.

THE SUCCESSFUL TREATMENT EXPERIENCE

Upon analyzing the interviews with women who did not successfully
complete the program, we decided to interview women who had success-
fully graduated from the program to determine if their preconceptions of
treatment were a salient feature in their experiences and evaluations of the
program. Interestingly, we discovered that three-quarters (77%) of gradu-
ates suggested that they initially believed that "treatment" consisted of a
one-on-one, hierarchical, passive relationship with a counselor. However,
over the course of their participation in the program, they became more
flexible in their definition of what constituted treatment and acknowl-
edged that their experiences in the group setting generally qualified as
"therapeutic." Their willingness to depart from their original conception
of treatment is related, in part, to their acceptance of the program's philos-
ophy of addiction. They believed that their drug use was the result of a

disease that attacked basic features of their personality and led to negative behaviors and attitudes. Responses regarding the nature of addiction were fairly ambiguous. For the most part, graduates reiterated the philosophy of addiction that they learned in the Village and offered few criticisms of this philosophy.

Their reliance on the program's theory of addiction is quite distinct from the notions of addiction advanced by the dropouts. Dropouts conceptualized their addiction as part of a complex, causal framework—one that merged aspects of personality characteristics and various social and familial experiences. Most expected treatment to be individually tailored in order to address those unique aspects of personality and experience that contributed to addiction. Further, while the majority of dropouts referred to themselves as "addicts," many expressed doubts that all addicts are the same or that similar circumstances produce addiction in everyone. One dropout respondent summarized:

> Yes, we are all addicts in a way. We all have a problem with drugs, but they [staff] treat us like we was the same and we're not. I may have done this for this reason and some other one may have her own reasons. Don't treat us like we was the same person 'cause we're not. We might have similarities on this and this, but we have differences too. They treat everyone like they's the same to make it easier. They read in a book this and this is the addict—who she is. But we all different, we all individuals. You got to see that to give good treatment.

Graduates, on the other hand, often couldn't remember how they conceived of addiction prior to entering the program and did not engage in the extended discussions of the sources and varieties of addiction that the dropouts did. As a group, graduates were considerably more likely to emphasize the similarity of their addiction experiences with those of their peers. Overall, even graduates who held individual counseling as the ideal model for treatment were able to relatively quickly adapt to the peer-based therapy structure of the Village.

Despite their acceptance of the TC structure, graduates did express similar levels of discontent with the program's emphasis on surveillance. Graduates were more likely than dropouts to articulate the functionality of surveillance mechanisms in the treatment program, but they disliked them just the same. One graduate who grappled throughout the interview with whether surveillance was a good or bad feature of the program commented:

> Well, I can see why it's there, especially for the new residents 'cause they always just trying stuff. But as you go on, well even then, a lot

of it is personal. People just trying to trip you up or getting in your business. It becomes an excuse to gossip about–cause it's not evenly distributed. Some people are watched more than others and they don't deserve it all the time. And it gets to be too much, always being watched. There's a lot of rules, you'll probably do something wrong and not even mean it but with them watching, they can get you if they want. It's too much and gets too mean sometimes, you know?

Interestingly, when asked about their least favorite job positions, every graduate but one selected high-level jobs (i.e., those in the top of the resident hierarchy) that involved the greatest levels of supervision and direct responsibility for the behavior of residents below them. They disliked such jobs generally because they felt that both peers and counselors evaluated their job performance continually and were waiting for them to fail. Many graduates reported that even after achieving senior status in the program, they preferred such low visibility jobs as media coordinator, laundry, and service crew. Nonetheless, while graduates resented surveillance, they did not seem to feel that it was overly invasive. This was undoubtedly related to their success in the program and the duration of their participation which often meant that they engaged in surveillance rather than always being a target of it.

Graduates, like dropouts, were also critical of public confrontation. While they enjoyed confrontation when it was employed responsibly, they, like the dropouts, reported frequently being wrongly accused of a misdeed and/or finding themselves the target of personal attacks by other residents. The single most frequent complaint among graduates regarding confrontation involved the liberal use of "injusts." When asked if she found any parts of the program unhelpful, one graduate answered:

> A: Like I said, the injusts. It really, it can make a person real angry, you know? And I remember one time I did leave for two days because I was so sick of the injusts.
>
> Q: Was that for stuff you hadn't done?
>
> A: Yeah. Things that, you know, or I mean little mistakes that anybody would make. Something stupid. Or somebody has a problem with you and they want to see if they can fuck with you. Stuff like that. If you don't like that person and they say you did something you didn't do, it would make you real angry. Some girls left treatment because of it and that's a shame 'cause I don't believe they would have otherwise.

Graduates did not report feeling forced to divulge personal information. While they acknowledged experiencing discomfort the first time they

shared a personal trauma with the group, they believed the consequences of this admission were positive–they felt relieved, supported, and in control of those memories that had previously traumatized them. The fact that graduates did not feel forced to reveal personal information is the product of their remarkably close relationships with one or more members of the counseling staff. Indeed, it is the level of intimacy with a counselor that most clearly differentiates the graduates from the dropouts. While 72% of the dropouts reported "serious" problems with staff members, nearly 84% of the graduates identified a staff member as a crucial element of their success in the program. One graduate remarked:

> She [counselor] is probably one of the only people I could really trust in my life. I mean really trust–there's people I've said I trusted but I was always wrong about them in one such way or another. Counselor [X], I could trust Counselor [X]. I could trust, I could talk to all the counselors.

Indeed, it was often the close relationship with a staff member that served as the bedrock of graduates' motivation to remain in the program. These personal relations with a counselor served two major purposes. First, graduates were often willing to evaluate painful experiences and acknowledge personal responsibility for certain life choices with the help of a counselor. Nearly every woman (both graduates and dropouts) interviewed has reported that it was exceedingly difficult for her to reevaluate her life upon entry into the program. Graduates, however, were willing to explore new ways of thinking about their lives. They suggest that their capacity for doing so was largely based on the trust and respect they maintained for a counselor. When one client was asked how she came to terms with her precarious relationship with her children, she reported:

> At first I didn't want to deal with it. Who would? You don't want to think you hurt them [children], you don't see yourself that way, you know? You see yourself as good, but you's high when you make that evaluation, you know? You don't see the consequences of what you're really doing to them [children]. I finally listened to Counselor [X]. I knew in my heart she was the only one that could pinpoint me, exactly what was going on with me. And I know that if I came in saying some other stuff, she'd tell me exactly. . . .

Second, graduate respondents report that counselors frequently went out of their way to help them through particularly rough periods in their lives. This additional assistance took place when respondents were inside

the prison and following their release. For example, graduates, like drop-outs, report occasionally experiencing negative feelings toward the program and the desire to leave. In a few cases, graduate respondents did actually leave the program. In every one of these cases, a counselor visited the respondent and talked openly with her about her decision to leave. These women were touched by the effort counselors made in talking with them and each noted that the sincerity displayed by a given counselor was often more than they experienced in other personal relationships. It was their interpretation of this act as sincere which served to resolve resentment or negative feelings they had previously maintained toward the program. Counselors helped in numerous other ways as well. In several cases going the "extra mile" for clients involved personal time spent talking with lawyers, family members, social workers, and various service providers. These charitable acts did not go unrecognized by the respondents. Following such acts, every one of the respondents reported feeling a new sense of purpose which inspired them to participate more fully in the program. Close relationships with counselors formed a vital link between the client and the therapy program and were instrumental in helping clients through various rough spots that may otherwise have sabotaged their treatment.

CONCLUSION: "CONSTRUCTING" EFFECTIVE TREATMENT

Among both sets of interviewees, the conception of treatment as a passive, hierarchical, interpersonal relationship with a "professional" clinician was quite common. The salience of this construction for evaluating experiences in the Village program, however, varied considerably between the two groups. For dropouts, the program's departure from their ideal sparked a vicious cycle of suspicion, alienation, and hostility. The lack of emphasis on individual counseling generated resentment and hostility toward staff, which in turn, resulted in a series of demands for counselor time followed by a series of rejections. As dropouts became increasingly critical of the program, they ignored or violated rules and were subject to public confrontation and disciplinary mechanisms. This aggravated their hostility toward the program, the staff, and other residents, reinforced their belief that they were the subject of unfair and unnecessary punishment practices, and increased their isolation from their peers. Once this series of events was set in motion, few of the dropouts managed to remain in the program more than a week or two. All were adamant that they would never return.

Graduates, on the other hand, were less wedded to their earlier concep-

tions of treatment as a mechanism for evaluating their experiences in the program. Over time, they acknowledged peer-based groups as a valid form of therapy and embraced the program's discursive constructions of "addiction" and "rehabilitation." While graduates were similarly critical of the program's policies regarding surveillance and confrontation they retained one resource not available to program dropouts–a close relationship with a counselor. Their intimacy with the counseling staff not only facilitated trust and acceptance of this seemingly "deviant" form of therapy, it actually resulted in more time spent in individual counseling sessions. They were able to see their counselors more often because their motivation and investment in the program resulted in rewards for conformity. Rewards conferred often involved jobs and status positions that facilitated access to counselors. Subsequently, when graduates suffered from personal attacks or experienced frustration over levels of surveillance, they were able to work through their feelings with the counseling staff. Further, their positive performance in the program generated new levels of commitment and motivation for rehabilitation, as well as affording good relations with their peers.

Subsequently, the goal for this program and other programs that rely on peer-based therapy must be to stem the cycle of negativity that women like the dropouts experience from the minute they enter the program. It should be recalled that among dropouts, their primary motivation to enter the program was to receive treatment for their drug use. Among graduates, the primary motivation involved a reduction of sentence length. This suggests that dropouts were more invested in both the idea and the actual process of treatment–they desired recovery in a way that graduates initially did not. Given that many of the dropouts had so much riding on their success in the program, their expectations regarding the requisite elements of treatment assumed a salience in their perceptions of the program that was not shared by the graduates. When the program appeared not to provide these requisites, the dropouts withdrew, fearing another relapse following their release from prison. Women like the graduates are willing to remain in the program because they have little to lose. As their participation is positively reinforced, they acquire motivation to remain in the program and to achieve rehabilitation.

Group-based treatment programs must acknowledge the prevalence of certain stereotypical notions of treatment among drug-using clients and make efforts to educate incoming residents about the ways in which different treatment modalities can accomplish rehabilitative goals. In this study, the problem of client attrition seems easily remedied by efforts to acknowledge the salience of client's constructions of treatment on their

perceptions of the program and to educate clients about the ways in which the TC modality is an effective means of rehabilitation. As this study makes clear, the process and effects of meaning construction, and interactional dynamics in treatment programs, are critical elements of client success and failure.

NOTES

1. In most studies, "successful" participation involves program completion. Success following program participation is generally defined as remaining drug/alcohol free, refraining from criminal activity, and obtaining legal employment.

2. For the purposes of the analysis, "dropouts" are defined as residents who either requested to leave the program or who were expelled for disciplinary violations (women who were discharged for medical reasons were not included in the sample).

3. Seven of the women who had dropped out of the program had subsequently been released from prison and either refused to be interviewed or were unlocatable.

4. Staff provide clients with an orientation manual when they are first received into the program. The manual outlines five different phases that clients are expected to successfully complete before graduating from the program. Each phase outlines specific sets of client responsibilities.

5. "Negative behaviors" are acts that are reminiscent of things the client did during her days on the street to facilitate her drug use. This includes such things as lying, threatening others, avoidance behaviors, repressing feelings, refusal to participate in therapy groups, name calling, etc. "Contracting" refers to a situation in which two or more residents develop a strong friendship and/or spend time only with one another, excluding other residents. The formation of such friendships is strongly discouraged as the intimacy of a friendship relation often discourages residents from reporting one another for rule violations. "Dope fiend attitudes" are those attitudes and behaviors that clients used as a last resort to secure drugs. In many ways, residents see dope-fiend attitudes as an extension of negative behavior. Residents define a dope-fiend as, ". . . someone who got no morals—don't care 'bout nothing but that drug and would kill you, me, or Jesus Christ to get it." Attitudes falling within this category include failure to trust others, manipulation, lying, and conning.

6. The program maintains a list of "cardinal rules" which, if broken, guarantee expulsion from the program. These include violence or threats of violence, use of intoxicating substances, and sexual relationships with other inmates.

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AUTHORS' NOTES

Jill McCorkel is a PhD candidate in the Department of Sociology and Criminal Justice at the University of Delaware and a researcher in the Center for Drug & Alcohol Studies. Her current research interests include gender differences in drug use and treatment effectiveness, race and gender disparities in the sentencing of criminal offenders, and processes of identity construction.

Lana D. Harrison, PhD, is the Associate Director and a Senior Scientist in the Center for Drug & Alcohol Studies at the University of Delaware. She has worked on the three largest epidemiological drug surveys in the United States, the National Household Survey on Drug Abuse, the Monitoring the Future survey, and the Drug Use Forecasting program.

James A. Inciardi, PhD, is the Director of the Center for Drug & Alcohol Studies, a professor in the Department of Sociology and Criminal Justice at the University of Delaware, adjunct professor in the Department of Epidemiology and Public Health at the University of Miami School of Medicine, and a Distinguished Professor at the State University of Rio de Janeiro.

Address Correspondence to Jill McCorkel, Center for Drug & Alcohol Studies, University of Delaware, 77 East Main Street, Newark, DE 19716.