Group Work Method in Therapeutic Communities for Drug Addicts

Yair Amram*

School of social work, Ashkelon Academic college and Hebrew, University of Jerusalem, Isreal

Abstract

The goal of Therapeutic Communities (TCs) for drug addicts is to help them change their life style. The therapy is often based on small-group settings. In Israel, there are two types of TCs that operate two types of small-group settings: “Confrontation Groups” (CGs), represented by the Syn-ilan therapeutic community; and “Therapeutic Groups” (TGs), represented by the Ther-mal therapeutic community. The paper presents the findings of a study that used the Group Climate Questionnaire [1] to compare the small group climate as perceived by members of CG and TG groups in Israel. Participants included 71 members of two therapeutic communities that operated the two types of small-group settings. The findings revealed significant differences between the two types of groups: More expression of anger, confrontation, and anxiety was found in the Syn-ilan (CG) group than in the Ther-mal (TG) group, which worked more on the “past and childhood”. Similarities were found with regard to the following parameters: Self-disclosure, self-understanding, involvement, and caring. The findings indicate that there are differences between the theoretical approaches guiding the two types of groups. Moreover, it can be concluded that the groups have the potential to effect positive change in the lives of the participants.

Keywords: Therapeutic communities; Self-disclosure; Self-understanding

Introduction

There are thousands of drug addicts in Israeli society who have lost control of their lives and cause harm to themselves, to their immediate environment, and to society at large. The therapeutic community is one type of setting that can generate change in the lifestyle of drug addicts. In Israel, two main types of therapeutic communities focus on therapeutic intervention in small groups: the Confrontation Group (CG), and the Therapeutic Group (TG). The article presents the results of an empirical study on the group climate in the two types of groups, as represented by the Syn-ilan and Ther-mal Therapeutic Communities. The study compared the small group climate in each type of therapeutic community, based on the perceptions of the participants.

Theoretical Framework

Study estimated the number and description of the condition of drug addicts in Israel showed that, living in Israel about 36,000 heroin addicts (0.4% of the population) and the most difficult situation [2]. In addition, there are various estimates of the number of alcoholics and addicts to cocaine and other abusers of psychoactive substances comes to hundreds of thousands [3]. In Israel there will be strengthened through the methadone program and N.A. program that hold approximately 3,500 participants each. Therapeutic communities for drug addicts are just one of the treatment programs that try to deal with the difficult problem [4]. Israel is still trying to find the best way to treat drug addicts for recovery and for maximum results.

Therapeutic Communities (TCs) for drug addicts combine components of self-help groups with those of total therapeutic institutions (Jones, 1953, 1984) [5,6]. The idea of self-help derives from groups that developed an ideology and techniques to enable addicts to receive assistance from other group members and adopt a drug-free life style [7]. The term “drug-addict” refers to people whose lives are controlled by drugs [8]. Therapeutic intervention seeks to enable these individuals to change their life-style and live a drug-free life in which they work and are not involved in crime.

The Therapeutic Community

The first therapeutic community for drug addicts was established in 1958 under the auspices of Synanon in California [9]. The TC model is general, and encompasses over 500 different programs throughout the world. Nonetheless, these settings share basic aspects in common, which justify the name Therapeutic Community [10]. The therapeutic communities have changed over time, and they have been subject to various influences, including different professional disciplines and psycho-dynamic groups [8,11,12].

Therapeutic intervention is based on examination of the drug addicts’ behavior, mentality, and emotions, as well as on the background that led to their addictive life-style. The therapeutic processes take place in numerous settings, including small groups [13]. The primary goal of the therapeutic community is to create a safe group climate, where the members feel they can share their personal problems and maintain confidentiality. This is a complex task, and in some situations the therapeutic groups generate high levels of anxiety, anger, aggression, hostility, and even isolation and withdrawal [14,15]. During the group sessions and as a result of the group processes, participants may engage in destructive acting out behavior [16,17]. In general, however, the communities seek to create a positive therapeutic climate that is conducive to change [18,19].

Characteristics of therapeutic communities in israel

In Israel there are two main therapeutic communities – Syn-ilan, which is close to the traditional ideas of Synanon; and Ther-mal, which is based on the Syn-ilan model but focuses on work with professionals, individual treatment, and therapeutic group work. Both therapeutic communities deal with the same population and use similar rules and criteria to select their members. Specifically, the groups are intended for heroin addicts and adults with no history of psychosomatic disorders.
to the intake meetings and request treatment. In addition, both types of TCs have a similar hierarchical structure of daily activity, which combines self-help methods with techniques used by professional and therapeutic staff members in institutional settings. However, the communities can be distinguished by their styles of treatment. The Syn-ilan groups base their ideology on self-help components, responsibility and assistance from other members who are recovered addicts, whereas the Ther-mal groups focus on sessions with professional practitioners. Israeli Addicts (Jews and Arabs), can ask to come to any T.C. they want. Usually, because they heard about a good experience from a friend – but, they don't know nothing about the system or about the difference between the two type of T.C.s.

**The difference between the small groups in therapeutic communities**

**Confrontation groups in Syn-ilan communities:** According to Jones et al. [18], confrontation groups are one condition for social learning, which is an important goal for work with drug addicts. Five aspects characterize confrontation groups:

**Occurrence:** The groups meet after a crisis in the therapeutic community. Meetings are attended by the key individuals involved in the crisis situation, who attempt to find a constructive solution to the problem. At the beginning of the session, the climate is emotionally charged and communication is usually difficult. Each participant describes the crisis from his or her own perspective, and an attempt is made to obtain a complete picture of the situation despite divergent points of view. The facilitator encourages participants to be as objective and accepting as possible in their perceptions.

**Timing:** The confrontation should take place as close as possible to the time of the crisis, as long as the emotional impact of the crisis is not too extreme.

**Skills required for facilitators:** Facilitators can be anyone familiar with the details of the crisis who can cope with the anxiety and difficulty that accompany these kinds of events. The ability to lead these groups depends on the facilitator's involvement in the crisis and on his or her relationship with the participants.

**Open, safe communication:** Because the interaction causes discomfort, confrontation groups can only be held if the participants feel safe and are able to express themselves freely without risking punishment or sanctions.

**Appropriate level of emotions:** Participants in confrontation groups can freely express their emotions (anxiety, fear, condemnation, or hostility following the crisis). This type of expression and interaction is essential for interpersonal learning. Following arousal of emotions, "personality modification" becomes possible [18].

These groups, which were initially based on the Synanon tradition, have developed in different ways even though all of them are based on a similar idea. For example, In day-top communities, which were developed by people who left Synanon, these groups are known as "encounter groups" and members are assigned roles such as "chairperson," "witness," "executor," "preacher," and "identifier." The roles are chosen in order to enable the community members to adopt behavior patterns that conform to the rules of the community and to understand how their actions contributed toward creating the social crisis [19].

In the Syn-ilan community, the confrontation groups meet three times a week. Members write "notes" with information about meetings. The notes describe the immediate problem faced by the community, and the members involved in the incident are invited to the meeting. Group members seek to identify the source of the conflict in order to resolve it. Conflict resolution affects the life of the community as well as the situation of its members and their prospects for successful functioning in the daily life of the community.

The groups are not permanent, their membership varies, and they do not hold regular meetings with the same facilitators. Rather, the groups are an integral part of the community dynamics, and are led jointly by professionals and former addicts.

**Therapeutic groups in Ther-mal**

The theoretical approach of the groups varies from one community to another, depending on the extent of professional knowledge and on the population of members [8]. Some therapeutic groups are based on a combination of concepts formulated by Yalom and Leszcz [20-26].

Flores [21] maintained that several therapeutic principles should be adopted for treatment of drug addicts, based on [20] approach:

1. The groups shall encourage sincerity and spontaneity.
2. The groups shall ensure active involvement of all group members.
3. The groups shall create a climate of mutual tolerance that enables "independent openness".
4. Every group member shall strive to achieve self awareness, with encouragement from the rest of the group.
5. The group shall accept all members as they are, with their limitations, failures, and unique attributes and shall not pass judgment.
6. Members shall be encouraged to express dissatisfaction about themselves, and the group shall provide an incentive for change.

Besides the above-mentioned aspects, several additional principles have been adapted to these groups. The group is viewed as a collective entity, and individual therapy is not provided. In addition, group processes are analyzed and evaluated by the entire group, including the leader [22].

In the Ther-mal community, therapeutic groups are based on a dynamic approach and facilitated by professionals. Each group meets three times a week, and from time to time new members join the group while others leave after completing the treatment process. The content of the sessions focuses on recovery, i.e., the issues and conflicts discussed in the group are clearly related to the group member's recovery and not necessarily to organizational or community needs.

The boundaries and framework are clearly defined in terms of the timing of meetings, facilitators, participants, location of meetings, and rules of the group. There are two professional facilitators, and the issues are raised freely according to the decision of the participants. No "sanctions" are imposed on participants. Both "support" and "confrontation" are used as therapeutic tools, with emphasis on attaining a balance between the two.

Based on the theoretical background, it is hypothesized that will be differences between the two types of groups. Moreover, the study used the GCQS questionnaire items to explore the concepts of group work and the implications of those concepts for group treatment in therapeutic communities.
Methods

The study describes the small group climate as perceived by the participants, based on comparison between Syn-ilan and Ther-mal Therapeutic Communities.

Sample

Questionnaires were distributed to participants in confrontation groups and therapeutic groups in Syn-ilan and Ther-mal TCs. All of the participants were residents of the TCs, who had been staying in the communities between 60 days and eight months. Questionnaires were completed by 75 residents. Of those, two were eliminated from the sample because the resident had been in the therapeutic community for less than 60 days; and two more were eliminated because they did not fit the sample and could not be matched. Thus, the final sample consisted of 71 participants -34 (50% of 68 residents in the TC) were in Syn-ilan; and 37 (56.1% of 66 residents in the TC) in Ther-mal.

Most of the therapeutic community members were men (84.5%) between the ages of 25 and 35 (M=30.5 years), who were born in Israel to immigrants of Asian-African background. Thirty-three of the participants (46.5%) were in out-of-home placement as children. Most of them were from large families (52% had 5-11 siblings, 7% had 4 siblings, and 2.8% had more than 11 siblings). Most of them began compulsory military service at the age of 18, but did not complete it. The vast majority had been convicted of various crimes, and 60% of them had served terms in prison. The participants entered the therapeutic communities after a period of 5-15 years of drug use, starting in late adolescence – 45% used heroin, and 55% were multi-drug addicts who used Heroin and other drugs such as hashish, pain killers, and other pills. Only 12% of the participants used drugs by injection. Most of them reported very few and short periods of drug-free functioning. The majority entered the TCs after failing in previous rehabilitation attempts.

Instrument

The instrument selected to examine the small group climate was MacKenzie's (1983) [1] Group Climate Questionnaire (GCQS). This instrument was chosen to compare the groups because of its content and clinical components, in addition to the fact that it can be distributed conveniently [27]. The questionnaire explores participants’ perceptions of the group climate, on the assumption that there is a relationship between the perceived climate and outcomes of treatment. The instrument has been used in several studies, including research on therapeutic communities. According to MacKenzie, the questionnaire reflects numerous and important clinical syndromes [1].

Initially, the questionnaire was divided into three dimensions, which were considered relevant and appropriate for evaluating the climate of the therapeutic community: commitment to the group, involvement and considerable time investment. These factors were not found in factor analysis conducted by Kahn et al. [28]. Consequently, they adapted the GCQS questionnaire for use in their study without using the subvariables. Braaten et al. [29] found that high scores on the GCQS are a good predictor of positive outcomes of group therapy. MacKenzie et al. [30] found that most of the participants in successful groups (67%) gave high scores, whereas a very small percentage of participants in the same groups (7%) gave low scores. Successful groups were described as more cohesive, less protective, and less inclined toward denial.

This evidence indicates that the questionnaire examines issues of relevance to the group climate, that it is appropriate for use in research on therapeutic communities, and that it is a good predictor of the outcomes of therapy. At the same time, however, the questionnaire lacks internal consistency with regard to the theoretical dimensions reported by this author.

For the purposes of the current study, the GCQS was translated into Hebrew and worded in a way that was clear to the members of the various TCs examined. The original questionnaire consisted of 12 items, and three items were added in order to learn more about the characteristics that distinguish between the two types of groups under investigation. The wording of the questionnaires was identical for both communities, except for references to type of group. Specifically, one questionnaire referred to the “confrontation group” (Syn-ilan) whereas the other referred to the “therapeutic group” (Ther-mal).

Results

Exploratory factor analysis aimed at examining the sub variables in the questionnaire was carried out among the same sample of 71 participants. The results revealed that all of the items together explained 63.6% of the variance in these responses. Thus, the questionnaire provided a good picture of the small group setting. Because the three dimensions, who reported by the author (MacKenzie, 1983) [1], were not found in factor analysis of the questionnaire, the current study used every item separately and did not use the dimensions presented in the research literature. Five variables correlated negatively with the rest of the items: avoidance, distance in the group, dependence on the facilitator, submission, and anxiety and tension. These items were perceived by participants as contradicting most of the other group climate components such as self-disclosure, self-understanding, involvement, caring, challenge and confrontation, and mutual trust.

No significant differences were found between the demographic characteristics of the participants in the two TCs: Age (M=30 in Ther-mal; M=31 and 3 months in Syn-ilan), Sex (16% males in Ther-mal, 14.7 in Syn-ilan). In the Ther-mal group, 83.8% of the participants were Israel-born, compared with 85.3% in Syn-ilan. Regarding father's origin, 28 (75.6%) were Asian-African in Ther-mal, compared with 25 (73.5%) in Syn-ilan. Similarities between the two groups were also found with respect to socioeconomic background, history of drug abuse, education level, criminal records, mental state, and length of stay in the TC.

ANOVA was conducted in order to determine whether the group climate differed among the groups in each type of community. The independent variable was type of therapeutic community (Syn-ilan versus Ther-mal), and the dependent variables were the items related to the climate of the therapeutic community.

Table 1 presents the research findings. Items are ranked and presented in descending order, as perceived by the participants. In addition, the table presents comparative data on the two types of groups.

ANOVA revealed a significant difference in the climate between the two types of groups in Syn-ilan and Ther-mal TCs. F(15, 55)=6.52, p<0.001. This finding suggests that there are basic differences between the CG and TG with respect to group climate.

Responses to some items appeared to be the same in both groups. Thus, the differences were highlighted by only a few items. Regarding the similarities, members of both groups believed that the group setting enables them to reveal sensitive issues (self-disclosure), and that it enhances self-understanding and caring. Moreover, members of both groups indicated that the therapeutic setting entails a high level of involvement and considerable time investment.

Regarding the differences, the Ther-mal groups deal more with the
past and emphasize childhood experiences. Syn-ilan groups, in contrast, create more challenges and confrontations, and cause participants to report anger, tension, and anxiety. Moreover, participants in the Syn-ilan groups reported a greater sense of distance.

Discussion and Conclusions

Significant differences were found between the Syn-ilan and Ther-mal groups with respect to the participants’ perceptions of the small group climate. In an attempt to identify the source of these differences, several background variables were compared. The comparative analysis based revealed no significant differences between the two groups. Rather, the differences that were found can be attributed to the substantive aspects of the group process.

Although the results suggest that there are differences between the groups, caution should be exercised in drawing conclusions based on the data analysis, owing to the ad-hoc nature of the group situation and the small number of participants. In order to highlight these aspects, the discussion will deal first with the similarities between the groups and then address the differences between them.

I have to be careful in drawing conclusions due to the small sample and lack of control group, with all the variables that could affect the outcome. Learning at the future may repeat this by experimental study, as a therapeutic community’s patient will receive different types of small communities.

<table>
<thead>
<tr>
<th>Description of Group Climate</th>
<th>SYN-ILAN (N=34)</th>
<th>THER-MAL (N=37)</th>
<th>GENERAL (N=71)</th>
<th>F</th>
<th>Sig.</th>
<th>d</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self disclosure</td>
<td>4.53</td>
<td>4.27</td>
<td>4.39</td>
<td>2.957</td>
<td>n.s.</td>
<td>0.0485</td>
</tr>
<tr>
<td>Self - understanding</td>
<td>4.38</td>
<td>4.24</td>
<td>4.31</td>
<td>0.552</td>
<td>n.s.</td>
<td>0.1765</td>
</tr>
<tr>
<td>Involvement</td>
<td>4.23</td>
<td>4.03</td>
<td>4.13</td>
<td>1.957</td>
<td>n.s.</td>
<td>0.3323</td>
</tr>
<tr>
<td>Dealing with past and</td>
<td>3.88</td>
<td>4.11</td>
<td>4.11</td>
<td>5.013</td>
<td>0.028</td>
<td>0.5319</td>
</tr>
<tr>
<td>Avoidance</td>
<td>4.01</td>
<td>3.81</td>
<td>3.93</td>
<td>1.183</td>
<td>n.s.</td>
<td>0.2584</td>
</tr>
<tr>
<td>Dealing with the therapeutic</td>
<td>4.09</td>
<td>4.38</td>
<td>4.38</td>
<td>2.411</td>
<td>n.s.</td>
<td>0.3689</td>
</tr>
<tr>
<td>Time and opportunities</td>
<td>3.71</td>
<td>4.08</td>
<td>3.90</td>
<td>3.198</td>
<td>n.s.</td>
<td>0.4248</td>
</tr>
<tr>
<td>Challenge and confrontation</td>
<td>4.32</td>
<td>3.49</td>
<td>3.89</td>
<td>18.348</td>
<td>0.001</td>
<td>1.0176</td>
</tr>
<tr>
<td>Friction and anger</td>
<td>4.15</td>
<td>3.62</td>
<td>3.87</td>
<td>7.186</td>
<td>0.009</td>
<td>0.6368</td>
</tr>
<tr>
<td>Mutual trust</td>
<td>3.79</td>
<td>3.43</td>
<td>3.61</td>
<td>2.927</td>
<td>n.s.</td>
<td>0.4064</td>
</tr>
<tr>
<td>Anxiety and tension</td>
<td>3.47</td>
<td>2.89</td>
<td>3.17</td>
<td>8.522</td>
<td>0.005</td>
<td>0.6935</td>
</tr>
<tr>
<td>Dependence on the</td>
<td>3.32</td>
<td>2.97</td>
<td>3.13</td>
<td>3.150</td>
<td>n.s.</td>
<td>0.4216</td>
</tr>
<tr>
<td>Submission to the group</td>
<td>2.74</td>
<td>2.92</td>
<td>2.83</td>
<td>0.533</td>
<td>n.s.</td>
<td>0.1734</td>
</tr>
<tr>
<td>Avoidance</td>
<td>2.41</td>
<td>2.22</td>
<td>2.31</td>
<td>0.799</td>
<td>n.s.</td>
<td>0.2124</td>
</tr>
<tr>
<td>Distance in the group</td>
<td>2.53</td>
<td>1.97</td>
<td>2.24</td>
<td>7.083</td>
<td>0.010</td>
<td>0.6323</td>
</tr>
</tbody>
</table>

N - Indicates that the item correlated negatively with the rest of the questionnaire in the factor analysis

The response was on a 5-point Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree).

Moreover, both communities followed social-psychological approaches that view denial and lack of awareness as major factors that underlie drug addiction [31,32]. In this regard [18], argue that the goal of the group is to create a setting where changes can take place. Furthermore, they claim that in order to achieve that goal, it is necessary to create a group climate characterized by openness and mutual trust. Therefore, members of both groups emphasize the basic components that enable affiliation, openness, and clarification of interpersonal relations. These components create a climate that leads them to change and development.

A few main components – involvement, caring, mutual trust, and lack of avoidance – reflect the ideas put forth various theoreticians regarding group cohesiveness. Thus, in both types of small groups, cohesiveness ranked high compared with the other components.

Can cohesiveness in itself guarantee the success of treatment?

Yalom and Leszcz [20] claims that cohesion is not just a therapeutic factor, but is a necessary precondition for effective therapy. Taking this argument a step further, Roark and Sharah (1989) [33] mentioned that leading theoreticians and scholars in the field of group therapy consider cohesion to be one of the most important factors in the therapeutic process. In addition, group cohesion correlated with empathy, openness, acceptance, and mutual trust [35].

At the same time, small groups can develop cohesion that does not generate a positive change in the situation of the participants. Hinshelwood [34] argued that in some cases, it is even possible to create an "anti-therapeutic" structure of cohesion. This structure develops when the entire group avoids coping with anxiety and facing reality. According to Hinshelwood, these kinds of groups follow stereotypical rules and principles. They are rigid, and the need to remain cohesive does not allow for real scrutiny of feelings and relationships in the group. Whitaker and Lieberman [35] argue that cohesion may be either constructive or destructive.

This elicits the following questions: In cohesive therapeutic groups, besides perceptions of cohesion, are there additional factors that facilitate treatment and recovery? Does cohesion allow for expression of anger and opposition? Does it allow issues to be raised that create
tension and anxiety? Or is cohesion a structure that “protects” the members from true self-examination and inhibits change?

**Differences between the groups**

These differences can be attributed mainly to challenge and confrontation, friction and expression of anger, anxiety and tension and perceived distance in the group. All of these components were found more in the Syn-ilan groups than in the Ther-mal groups. In addition, the Ther-mal groups worked more on the “past and childhood”.

It is easy to embrace the idea that expression of anger, challenge and confrontation are essential components of the therapeutic process. However, these aspects are the core of the confrontation group and fit the theory. In keeping with the theory espoused by these groups, members perceive these components as being related to self-disclosure, self-understanding, involvement, and caring. However, discussion of feelings such as distance in the confrontation group, anxiety and tension may displace the main goal of group work i.e., to provide support and create an atmosphere of security that will facilitate treatment based on candor and self-disclosure. Conversely, the expressions of distance, anxiety and tension are sincere emotions that may enable group members to articulate and face the reality of their situation. Such conditions are made possible by the climate of cohesion and security that prevails in the group.

**Where do the feelings of distance, anxiety and tension lead?**

The current findings touch on a well-known issue dealt with in the literature on therapeutic communities: “positive group pressure” and “negative group pressure”. In this regard, Lopez [36] maintained that negative group pressure is represented by infantile object relations and a compulsive struggle for immediate satisfaction. This is the expression of polarization between idealized and bad objects operating within the social structure of group interaction. Positive group pressure is represented by therapeutic techniques adopted by the therapeutic groups, such as: self-awareness, patience and attention, emphasis on honesty and responsibility, consistency, hierarchical gradience, learning with experience, time organization, reality testing, and leadership [36].

In a similar vein, Jones, McPherson, Whitaker, Sutherland, Walton, and Wolf (1971) [18] argued that members of confrontation groups can express anxiety, fear, condemnation, and hostility resulting from crisis. The expression of genuine feelings aroused by interaction is a vital element of interpersonal learning. Personality change is made possible by arousal of emotions.

Thus, positive pressure and expression of genuine feelings such as anxiety, fear, and hostility may be desirable in small group settings [37]. In addition, it may be appropriate to examine the behavior and emotions that accompany such feelings [13,38]. In contrast, anger, aggression, hostility, withdrawal, and distancing might destroy the group [14,15,39]. This situation elicits the following dilemma: do the relatively high levels of group pressure, anger, withdrawal, tension, and anxiety in the Syn-ilan community indicate that those settings are characterized by a sense of security that encourages open expression of feelings? [38] Or do those groups delay recovery due to lack of mutual support and destructive pressure on participants? Perhaps the climate of open confrontation and the opportunity to express anger in the Syn-ilan groups, in contrast to the Ther-mal groups, free the participants from the obligation to be “nice”. This enables them to experience catharsis, and gives them confidence to candidly examine their role in interpersonal relations.

Another aspect that distinguishes between the two communities is reflected in the finding that Ther-mal groups focus much more on the participants’ past life and childhood. This is a key aspect of group psychotherapy, and is considered an important step in the recovery process. The question is whether dealing with the past is more important than dealing with the present or with interpersonal relations and adjustment?

The findings described above lead to the conclusion that each type of community emphasizes components that conform to the theoretical approach that guides the activity of the group. In both types of communities, there is consistency with regard to creating a therapeutic climate that conforms to the group’s theoretical approach.

Group climate is an intervening variable necessary in order to attain effective therapeutic outcomes. Since this study does not deal with the issue of “effectiveness”, it is important to examine different types of short-term changes as well as long-term changes in areas such as self-esteem, persistence in therapy, and the process of change. Clearly, it is also important to examine the long-term outcomes of the process such as success in remaining drug-free, finding employment, keeping a job, and ability to avoid the life style led prior to drug addiction.

Since this study was conducted among a small sample and based on a one-time measure, the conclusions that can be drawn from the data analysis are limited. Thus, it would be worthwhile to replicate and compare group work in future studies among a larger sample of participants. Moreover, a qualitative methodology may be used to examine the implications of the findings and follow up on the changes and development that occur throughout the life cycle of group therapy.

**Summary**

The goal of therapeutic communities for a drug addict is to create a situation in which participants can work through their behavior, experience interpersonal relations, and change their life style. In Israel, there are two main types of therapeutic communities: Syn-ilan and Ther-mal. The Syn-ilan therapeutic communities are based on the traditional approach of Synanon, whereas the Ther-mal communities focus on work with professional practitioners. Moreover, the Syn-ilan communities represent confrontation groups, whereas the Ther-mal communities represent more dynamic therapy groups. No significant differences were found in the demographic characteristics of participants in the two groups. Therefore, the differences between the two groups may result from the distinct types of experiences in these group settings.

Despite the basic differences between the two TCs, the findings revealed some similarities. Both types of groups are characterized by high levels of cohesion, as well as by high levels of self-disclosure, self-understanding, involvement and caring. Concomitantly, the findings revealed low levels of dependence on the facilitator, submission and avoidance in both settings. It can thus be concluded that both types of groups represent positive therapeutic climates despite differences in their character.

The significant differences in other areas reflect the distinctive small group theories that guide each type of community. In the Syn-ilan groups, the findings revealed friction and expressions of anger, challenge and confrontation, as well as feelings of anxiety, tension and distance. Group pressure and confrontation are key elements of the activity and therapeutic approach of the confrontation groups. However, the feelings of anxiety, tension and distance in the confrontation groups, raise a question about the effectiveness of this kind of process. Ther-mal groups, in contrast, were characterized by less group pressure and
confrontation, and emphasized the participant’s ‘past experiences and childhood, in keeping with the psychodynamic approach.

In sum, the small group climate contributes toward effecting change among participants within these two therapeutic communities. However, each of the theories defines the concept of change on the basis of different components, which were described and observed in the current study.

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