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CREATING A THERAPEUTIC MILIEU WITHIN INPATIENT AND OUTPATIENT SETTINGS

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I. INTRODUCTION.

Puente de Vida treatment is based on the therapeutic milieu perspective that every interaction between a patient and a staff member has therapeutic potential for personal discovery and learning new ways of interacting and negotiating with other in a healthy way.

One of the main foundations of the milieu therapy setting is the belief that clients' difficulties arise out of, and are expressed within, their relationships with other people. (Karlyn Pleasants, Psy.D. "The Bridge of Life Newsletter, November 2004).

I should like to find out, not only what milieu is and how it operates, but also how we can describe it, how we influence it, and by what actions of all involved it is, in turn, created or molded. At the moment I am convinced of only one thing for sure—we all have quite a way to go to achieve either of these tasks. (Redl, Fritz. 1966. "When We Deal With Children." New York: Free Press, p.64).

II. PURPOSE. To explicate the traditional residential concept of a *therapeutic milieu*, discuss basis elements and offer application strategies for both residential and outpatient chemical dependency treatment settings.

III. DEFINITIONS.

A. Milieu. (French) environment; especially a social or cultural setting.
Etymology: middle-place.

B. Therapeutic Milieu. 'Healing Environment'. This concept was first used in the early 20th century by August Aichom in his work with Austrian youth, and has been a mainstay of youth residential treatment since its application in England during the 1940's. Research has shown it to be an effective component in achieving positive behavior change for both adults and youth. (Medlar, 2007).
...the physical and interpersonal environment manipulated in a systemic manner for therapeutic purposes. For example, for the promotion of optimal functioning in activities in daily living, or for the improvement of interpersonal skills. (Peterneli-Taylor, 1997).

B. Therapeutic Community. . . treatment philosophy involves all the resources of the institution. The treatment evolves from continual interaction between the inmates themselves and the staff. (Bluegrass, 1977, p. 54).

C. Guided Group Interaction (Positive Peer Culture). This intervention process is designed to restructure peer interactions in order to create a prosocial group climate, group controls on antisocial behavior, and supports for conventional attitudes and behaviors. Widely used in schools and institutional settings with mixed results among youth programs.

IV. PROGRAM MODELS.

A. *Therapeutic Community*. This systematic treatment approach is traditionally long-term, and employs the therapist and *'the community itself'* as the primary teachers. (Documented Effectiveness: 1991—Anglin & Hser; 1989—Hubbard, et. al.; and 1985—DeLeon).

1. Basic Concepts:

- Disorders are of the “whole person”—psychological & social.
Disturbances of cognition, mood, behavior, values and beliefs generate problems in socialization; cognitive and emotional skills and overall psychological development; immaturity; poor self-concept/esteem; disordered conduct.
 - * Social Deficits require *Habilitation*.
 - * Psychological Deficits require *Rehabilitation*.
- Right Living requires “Here and Now” focus with peers—past only to be understood within the context of today. Truth and honesty in word and deed is absolute.
- Recovery is a change from negative patterns of believing, thinking and feeling that predispose an individual to drug use.
 - * Developmental Process—stages of incremental learning.
 - * Motivation—positive and negative pressures to change with rehabilitation being the interaction between the individual and the environment.
 - * Self Help and Mutual Self Help.
 - * Social learning—how to get along with other; vocational focus.
- Community-As-Method
 - * Use of membership feedback.
 - * Use of membership as role models.
 - * Use of collective formats for individual change (each T/C develops their own).
 - * Use of structure and systems.
 - * Use of open communication (all personal disclosures are eventually shared).
 - * Use of relationships.

B. *Therapeutic Milieu*. (California Department of Mental Health Definition, 2003)

- * Provides the foundation for the provision of day treatment intensive and day rehabilitation and differentiates these services from other specialty mental health services.
- * Includes a therapeutic program that is structured by well-defined service components with specific activities being performed by identified staff.
- * Takes place for the continuous scheduled hours of operation for the program (more than four hours for a full-day program and a minimum of three hours for a half-day program).
- * Creates a supportive and nurturing interpersonal environment that teaches, models, and reinforces constructive interaction.
- * Supports peer/staff feedback to clients on strategies for symptom reduction, increasing adaptive behaviors, and reducing subjective distress.

- * Empowers clients through involvement in the overall program (such as the opportunity to lead community meetings and to provide feedback to peers) and the opportunity for risk taking in a supportive environment.
- * Supports behavior management interventions that focus on teaching self-management skills that children, youth, adults and older adults may use to control their own lives, to deal effectively with present and future problems, and to function well with minimal or no additional therapeutic intervention.

C. Milieu Therapy. “. . .Milieu therapy does not constitute a specific technique itself, in the sense that a drug or behavioral program does. . . can thus be defined as a method of organizing a community treatment environment so that all effective therapeutic techniques and contexts may be utilized by each patient in a consistent way to control his symptomatic behaviors and promote his social learning.” (Abrams, 1981).

Abrams identifies four mechanisms that are important contributors to developing such a milieu: 1) Morning Meeting attended by all clients and staff reviewing the previous 24 hours; 2) Staffing Meetings that are interdisciplinary and include all the clients on a therapists case load (6-8 in the setting he describes); 3) Team Planning Meeting that is operational in nature as opposed to clinical; and 4) Staff Sensitivity to resolve staff interpersonal conflicts that impact professional performance and do not morph into group therapy.

V. SOCIAL LEARNING THEORY. (Social Cognitive Theory—1990’s) Albert Bandura, PhD

A. Principles.

1. First organizing and rehearsing the modeled behavior symbolically, and then enacting it overtly allows an individual to achieve the highest level of observational learning. Coding modeled behavior into words, labels or images results in better retention than simply observing.
2. Individuals are more likely to adopt a modeled behavior if it results in valued outcomes.
3. Individuals are more likely to adopt a modeled behavior if the model is similar to the observer, has admired status, and the behavior has functional value.

B. Modeling Processes. (Amanda Moore, 1999)

1. **Attention**. Learning anything requires paying attention. Anything that puts a damper on attention is going to decrease learning, including observational learning. If distracted by competing stimuli, being sleepy, groggy, drugged, sick, nervous, or “hyper,” we will learn less well. If the model is colorful and dramatic, attractive, or prestigious, or appears to be particularly competent, then we pay more attention. And if the model seems more like ourselves (rapport), we pay more attention.
2. **Retention**. Retaining and remembering what we have paid attention to is essential. Through imagery and language we store what we have seen the model doing so we can later “bring up” or recover mental images or verbal descriptions that facilitate reproduction with our own behavior.

3. **Reproduction.** Just sitting and daydreaming isn't enough to translate images or descriptions into actual behavior. An individual must have to have the ability to reproduce the behavior in the first place. Observing Olympic ice skaters all day long does not lead to reproducing their jumps, if the observer can't ice skate at all. On the other hand, if the observer can skate, their performance would in fact improve if they watch skaters who are better. The ability to imitate improves with practice of the behaviors involved, and abilities can improve even when just imagining performing!
4. **Motivation.** Attention, retention, and especially, reproduction require motivation to imitate. An individual must have some reason for doing it.
 - Past reinforcement—traditional behaviorism.
 - Promised reinforcements—(incentives) that we can imagine.
 - Vicarious reinforcement—seeing and recalling the model being reinforced.
 - Past punishment.
 - Promised punishment (threats).
 - Vicarious punishment.

Note: Like most traditional behaviorists, Bandura says that punishment in whatever form does not work as well as reinforcement and, in fact, has a tendency to “backfire” on us.

C. Behavior Control—Self-Regulation.

1. **Self-observation.** We look at ourselves, our behavior, and keep tabs on it.
2. **Judgment.** We compare our performance with a standard. The standard may be traditional, such as “rules of etiquette,” or we can create an arbitrary one, like “I’ll read a book a week.” We can also use competition with others, or with ourselves.
3. **Self-response.** If we perform well in comparison with our standard, we give ourselves rewarding self-responses. A poor performance results in punishing self-responses. These self-responses can range from the obvious (treating myself to a sundae or working late) to the more covert (feelings of pride or shame). Bandura sees three likely results of excessive self-punishment:
 - a. Compensation—a superiority complex, e.g., delusions of grandeur.
 - b. Inactivity—apathy, boredom, depression.
 - c. Escape—drugs and alcohol, television fantasies, or even the ultimate escape, suicide.
4. **Poor Self-concept.** Bandura’s recommendations to those who suffer from a poor self-concept come from three steps of self-regulation:
 - a. Regarding self-observation—know thyself! Make sure you have an accurate picture of your behavior.
 - b. Regarding standards—make sure your standards aren’t set too high. Don’t set yourself up for failure! Standards that are too low, on the other hand, are meaningless.
 - c. Regarding self-response—use self-rewards, not self-punishments. Celebrate your victories; don’t dwell on your failures.

VI. APPLICATION CONSIDERATIONS.

- A. Use of Group.
 - 1. Empower the clients: give at least one important decision to the group.
 - 2. Require individual modeling during group through role-play, rehearsal, or re-enactment.
 - 3. Teach Self-control Therapy during group.
 - *Behavior diaries to be shared during group—clients report relapse triggers and individual coping responses whether functional or not.
 - *Environmental Planning—clients share actual applications from diaries.
 - *Self-contracting—clients share personal rewards for success and lack thereof during group.
- B. Create and maintain a respectful and supportive, non-toxic atmosphere.
 - *Reduce or eliminate gossip—Use Thumper’s Dad’s Communication Rule.
 - *Positive feedback ala the One Minute Manager—catch clients and staff being successful and point it out consistently.
 - *Watch the Language! Demand respectful speech from everyone!
- C. Staff—Give up the *Need To Be Right* and model enthusiasm.
- D. Don’t take anything personally—client success or failure.
- E. Check out ALL of your assumptions!
- F. Teach clients Social Learning Theory!