

# Addiction, Treatment and the Evolution of Therapeutic Communities: The Legacy of Dr. David A. Deitch

By Liliane Drago, MA, Master CASAC, MAC, Vice President of Training Outreach Development Corporation

David A. Deitch, PhD, is one of the most influential figures in the modern history of addiction treatment. A clinical and social psychologist, he currently holds the title of Emeritus Professor of Clinical Psychiatry at the University of California, San Diego, where he founded the [Center for Criminality & Addiction Research, Training, and Application \(CCARTA\)](#). Through a career span of more than 45 years, Dr. Deitch has helped shape both policy and practice, working across academic, governmental, and nonprofit sectors to build systems of care for people with substance use disorders.

A co-founder of [Daytop Village](#) and former Senior Vice President and Chief Clinical Officer of [Phoenix House](#), Dr. Deitch played a key role in developing the therapeutic community (TC) model, one of the most influential and controversial approaches to addiction treatment in the 20th century. He has consulted for the United Nations, chaired national commissions under two U.S. Presidents, and authored foundational training materials still used across the field today.



Liliane Drago with Dr. David Deitch

I worked with David at Phoenix House, when he was its Chief Clinical Officer and I was the National Training Director. Together we worked on both preserving and updating the therapeutic community model.

This article brings together two in-depth explorations of therapeutic communities and addiction recovery, grounded in an ex-

tended conversation with Dr. Deitch. The first section delves into the nature of addiction and the second traces the origins, evolution, and philosophical tensions of the TC model through the lens of his lived and professional experience.

Together, these reflections offer insight into treatment practices that have shaped

the lives of countless individuals. They also raise critical questions about what we preserve, what we revise, and how we ensure that healing remains at the center of all our efforts.

The Enduring Puzzle of Addiction: Genetics, Trauma, and the Human Condition

As we continue to grapple with addiction in the U.S., it's easy to assume that advances in science and psychology have brought us closer to a solution. But for Dr. David Deitch, a lifelong observer and practitioner in the field, the hard truth remains, we may not be much closer than we were a century ago.

"I don't think there's any place in the world where we've reached a truly rational, problem-solving approach to addiction," Dr. Deitch reflects. "We still don't have a widely accepted or conclusive understanding of the roots of substance overuse. The same themes, circumstance, chemistry, and plain accident, have been with us for hundreds of years."

While today's practitioners may be more attuned to the nuances of substance use than in decades past, Dr. Deitch points to one enduring truth: the role of genetics. "There's a vulnerability that runs through

see Dr. David Deitch on page 45



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### Overdose Prevention from page 20

workforce requires more than training. It depends on leaders who model supportive communication, supervisors who create space for questions, and team cultures that normalize discussions about overdose risk. Providers build confidence through practice, reflection, and environ-

ments where uncertainty is expected rather than hidden. When staff feel grounded, connected, and supported by their organizations, prevention becomes a natural part of the workday instead of an additional burden.

My commitment to this field is shaped by personal loss and strengthened through my work in prevention. I believe in a behavior-

al health workforce that feels equipped and supported to recognize overdose risk early and integrate safety planning into routine care. When providers have clear frameworks and training pathways, prevention becomes manageable instead of overwhelming. This creates continuity across service settings, reduces crisis-driven responses, and strengthens recovery-oriented

environments. A community that can talk openly about overdose is a community that protects life, and I'm committed to advancing an upstream model that helps providers make that possible.

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### Dr. David Deitch from page 21

families, not just to one specific drug, but to excess itself. To a biology that can get captured by it." That vulnerability, he says, is deeply ingrained and not easily resolved through social policy or intervention.

In that light, addiction becomes less of a social anomaly and more of a human constant. "It's something we'll always be living with," he says. "When we look at children of alcoholics, for example, that's one of the clearest tools we have for understanding this condition."

#### Trauma and the Gene Bank

But the picture isn't purely genetic. Psychological trauma, especially childhood trauma, is often present in the lives of people with substance use disorders. While Dr. Deitch acknowledges this connection, he cautions against viewing it as a complete explanation. "We shouldn't pretend it's an accident, but we also shouldn't ignore that once a genetic vulnerability shows up in the gene bank, it becomes a constant danger for generations."

This dual lens—genetics and trauma—shapes how we should view prevention and treatment. "The interplay is real," says Dr. Deitch, "Abuse, neglect, dysfunctional families—all of it contributes. But even without a clear family history, people can still develop addiction. And when that happens, we must ask what other traits, impulsivity, self-neglect, acting out, may point to underlying vulnerability."

The challenge is that these traits don't operate in isolation. "It's hard to tease apart what's most significant. Often, it's not just one thing. And when these behaviors are left unchecked, they can become antisocial, and that tends to go hand in hand with substance misuse."

#### Implications for Solutions

What does all of this mean for preventing and treating addiction? Dr. Deitch believes it starts with early awareness. "That doesn't mean banning alcohol from someone's life, but it does mean recognizing the signs early and acting accordingly. For some, information is enough. For others, we need an action plan, something reparative."

He emphasizes that culture and environment shape how this work unfolds, but the core idea remains: identify risk early, and respond with empathy, not just control.

Addiction isn't something we'll "solve," but with humility, compassion, and a deeper understanding of both biology and environment, we may be able to better support those who struggle with it and perhaps even

change the course for the next generation.

Dr. Deitch's life spanned decades in and out of recovery spaces. He's witnessed the evolution of the therapeutic community model firsthand, from the raw, experimental days of Synanon to more professionalized iterations like Phoenix House. And he carries those stories not as a historian or academic, but as someone who lived them from the inside out.

"We were experimenting in real time," he told me. "No manuals, no metrics, no funding protocols, just human beings trying to figure out how to save each other."

But over time, the movement fractured. Some communities professionalized. Others veered into controlling, even cult-like behavior. And still others dissolved under the weight of financial or political pressures.

One of the most pressing questions today: *What parts of that original model are worth preserving? And what parts should we leave behind?*

#### The Early Days: Magic and Mayhem

Synanon, Daytop, and Phoenix House weren't just programs, they were counter-cultures. People came not only to get sober, but to remake their lives entirely.

"There was a specialness to it," Dr. Deitch said. "It felt magical. Painful, yes, but also transformative."

In those early years, everything was communal. Confrontation was the norm. You might be called out brutally in the morning but still have coffee with the same people that afternoon. Forgiveness came after penance. Suffering was a currency, and for many, the first sign that healing was even possible.

"We were turning the ugliness in our private lives into something communal. There was camaraderie. There was meaning."

But it didn't last. At least, not everywhere. "I watched the Netflix documentary," he said. "And I was disgusted with how impressionable I was. What I thought was brilliance, I see now as narcissism. But at the time? We believed. Wholeheartedly."

#### When the Dream Curled Inward

Dr. Deitch's disillusionment began in San Francisco, during a leadership transition. He was asked to run a facility, a rarity at the time for someone so newly in recovery. And then, two moments changed everything.

First, when he brought up a book he admired, Synanon founder Chuck Dederich replied, "I don't read other people's books. I write them."

Second, he was told to hustle a Cadillac for Chuck. *Not a Chevy. A Cadillac.*

"That was it," he said. "I started to see him clearly—not as a wise leader, but as a man who had lost touch with what we were doing."

Shortly after, Synanon abolished the second and third phases of treatment. The message was clear: once in, always in. There was no graduation, no reentry into society. What started as temporary healing became a permanent lifestyle.

#### Radical Shifts and Growth

Some of the program's changes veered into the bizarre. Same-sex couples were split up. Clothing and presentation were strictly policed. New romantic partnerships were assigned by leadership. What had once been framed as recovery now resembled social engineering.

"There were elements of insanity," Dr. Deitch said. "But at the same time, it was an incredible social experiment. For the first time, people with addiction were living without using drugs, working together, and creating something new."

Even as Synanon's model frayed, its legacy spread. Other therapeutic communities across the U.S. adopted parts of the approach—some more grounded, others harsher still.

"New York's version was more aggressive. California's had softness by comparison," he reflected. "But New York was also more racially tolerant. There were contradictions everywhere."

#### What Do We Keep?

So where does that leave us now?

"Disclosure," Dr. Deitch said. "That's the piece I'd fight for. The power of personal truth-telling—not to shame, but to shed shame."

He explained how early marathon groups invited people to move step by step—from guardedness to vulnerability, from secrecy to relief.

"By the end, people weren't just crying—they were rejoicing. They had been seen. And still accepted."

But he's clear that this process takes time.

"You can't expect someone to tell you about their deepest trauma on day one. You start with what they *can* say. And you build from there."

#### What Must Change?

And what should be left behind?

"The aggression. The humiliation. The idea that you must be broken to be healed."

At Phoenix House, we began shifting the model with "Care and Concern" groups,

structured forums for resolving conflicts and developing interpersonal insight. Borrowing from family therapy models, we taught clients constructive ways to voice struggles. We created a practitioner's manual and trained both staff and residents.

The results were mixed: many clients embraced the approach, while others clung to harshness as the only path to change. Perhaps, we concluded, this was more about familiarity than actual necessity.

As David often advised: "Admonish with love. Healing happens in safe communities, not punitive ones."

We trained staff in motivational interviewing, used positive reinforcement and incentives, and incorporated trauma-informed approaches. The storied 24-hour marathons, once the stage for processing trauma, were replaced with safer, more structured interventions.

#### The Evolution Ahead

Dr. Deitch sees ongoing value in therapeutic communities, if they continue to evolve, though shorter treatment stays threaten their efficacy. He questions the extent to which we can get good outcomes as the duration of treatment becomes shorter.

"The old model worked on multiple levels, emotional, cognitive, behavioral, and social. Most importantly, it gave people connection and community. We can still do that. But we need to bring back emotional depth. That's what's missing now."

He believes in integrating TC principles with contemporary approaches: blending CBT with small, emotionally focused process groups. "There's no real cognition without emotion, no transformation without vulnerability." Guided by that belief—and inspired by Kevin McEneaney, then COO of Phoenix House—we developed a manualized program called *Emotional Cartography*. Designed for both group facilitators and clients, the program applied principles of CBT to build emotional literacy, foster introspection, and encourage progressive self-disclosure and emotional processing. Through structured workbook exercises, clients labeled and mapped their emotions, identified personal triggers, and practiced strategies for managing their feelings, sharing insights and reflections with their peers in group sessions.

And the central lesson to this day, he says, remains clear: "People don't need to be hurt to grow. They need to be seen and valued. That's the heart of it."

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