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Review Article

The Therapeutic Community

By D. H. CLARK

Introduction

It is thirty years since Main's original article (1946) launched the phrase 'Therapeutic Community' on its career. Main's was one of a series of articles commissioned for the *Bulletin of the Menninger Clinic* in which British psychiatrists described for their American colleagues some of the exciting new directions that had developed at Northfield Military Hospital (Birmingham), in the later years of World War II. Young psychiatrists and psychoanalysts, working with demoralized soldiers awaiting medical discharge from the Army, had developed a number of techniques which used social influences and the milieu in treatment in a new way. In memorable phrases Main pointed out how much harm was done to the hospitalized psychoneurotics by the traditional attitudes of doctors and nurses, and called for a 'therapeutic community' of which he said 'Ideally it has been conceived as a therapeutic setting with a spontaneous and emotionally structured (rather than a medically dictated) organization in which all staff and patients engaged.' We have spent the last thirty years trying to put this concept into practice and finding it remarkably difficult.

The main features of the story of therapeutic communities (and social psychiatry) during the first twenty years are well known and have been reviewed often. The main developer of the therapeutic community as a technique was Maxwell Jones working at Belmont Hospital during the 1950s. The unit (renamed Henderson Hospital in 1960) was a mecca for all interested in the new ideas of social psychiatry and social therapy. A number of hospitals attempted to develop therapeutic communities and described the process. A review in 1964 (Clark) described the position then and the status of the idea at that time.

The years from 1960 to 1976 have seen interesting developments in the practice and standing of the therapeutic community. The main purpose of this article is to describe and analyse these trends, to review the literature and to consider the position in 1976.

Definitions

It is perhaps desirable to say a little about the meanings attached to words, particularly those of the title. Many have complained of confusion of terms in this field. Some in the field of social psychiatry have taken Humpty Dumpty's attitude ('When I use a word it means what I want it to mean') and have scorned definitions. The term therapeutic community—perhaps because it is so laden with desirable values—has been much used and misused. This criticism cannot fairly be levelled at Maxwell Jones himself, who has always been careful to clarify and explain his use of terms. This review article, however, may be more helpful if we clarify the terms we shall be using. In this we follow Rossi and Filstead (1973) who, in the introduction to their useful compendium, have put forward a clarification which has merits. They speak of Milieu Therapy (in Britain usually Social Therapy), Therapeutic Milieus and the Therapeutic Community.

Social Therapy (R. & F. 'Milieu Therapy') is the idea, the concept, of the use of the milieu as a mode of treatment. The phrase encompasses theory and practice, activities and analysis, results and criticism.

A Therapeutic Milieu (plural milieus or milieux depending on one's need to display gallic

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sophistication) is a setting designed for the practice of social therapy—an environment consciously structured to produce desired change in those who enter it. There are many therapeutic milieus—sheltered workshops, hospital wards, halfway houses, Synanon houses, etc—with differing social structures.

A Therapeutic Community is a specific kind of Therapeutic Milieu, developed by Maxwell Jones in the 1950s at Belmont and further developed and varied by his pupils and colleagues in many countries since; it evolved within psychiatric institutions and bears the marks of this. Its characteristics are discussed below, but a few can be noted. It is 'permissive, egalitarian, democratic and communalistic' (Rapoport, 1960). It is a small face-to-face residential community using social analysis as its main tool. The phrase 'therapeutic community proper' (Clark, 1964) corresponds to this.

Developments 1960–76

In 1960 Belmont's therapeutic community was well established but few others were known: Martin was developing such a community at Claybury Hospital (Forest Lodge) and Crockett was doing the same in his unit at Romford. During the 1960s a number of other therapeutic communities were started, including well known ones at Fulbourn Hospital, Cambridge, Littlemore Hospital, Oxford, Dingleton Hospital, Melrose and Bethlem Hospital as well as many others in Britain less publicized. In the United States communities were started in the Fort Logan Mental Health Centre, Colorado, the Massachusetts Mental Health Centre, Boston, Austin Riggs Hospital, New Haven, Salem Hospital, Oregon, the Stanford Medical Centre, California and many other places.

Maxwell Jones himself left Belmont in 1959: he worked from 1960 to 1963 in Salem, Oregon, from 1963 to 1970 at Dingleton Hospital, Melrose, and from 1970 at Fort Logan and other US Centres.

In Britain therapeutic communities continue to be started within mental hospital wards and in a few of the new psychiatric units in general hospitals. A growing number of units outside hospitals such as halfway houses and residential units for the handicapped, call themselves therapeutic communities and use modifications of the method, as do some day hospitals. In 1971 a number of people who identified themselves as therapeutic community workers began to hold occasional meetings, and in 1972 they formed an Association of Therapeutic Communities. By 1976 this had 90 individual members, 15 group subscriptions from hospitals and units, and 15 overseas members. One characteristic of the membership was that many people joined each year and then failed to renew membership the next. In some cases this was due to disappointment, but with many it was because they moved on to other work.

Since its founding in 1972 the ATC has had three or four meetings yearly and has produced eighteen issues of a Bulletin. The meetings, held at different units, have always been lively and often stormy. There have been two longer conferences arranged with MIND, and there is an active Research Group. The Bulletin contains many announcements, advertisements and ephemeral pieces, but also a few contributions of enduring value; it also provides a reminder of many stirring and exciting occasions.

A number of residential units outside hospitals which had begun to apply therapeutic community ideas to their work became members of the ATC. Notable amongst these were the houses of the Richmond Fellowship but there were many other such experiments. Of the group memberships of the ATC in 1976 about half were not within hospitals. Discussions show that such units have freedoms denied to hospital units, but are also more vulnerable. They do not suffer the constant pressure that comes from the host organization onto units within hospitals—the demands of the nursing administration for tidiness, uniforms and seemly behaviour, the demands of the General Nursing Council, which produce regular routinized disruption of therapeutic interpersonal relationships, the pressures for academic and professional conforming and accountability. They are, however, more vulnerable to pressure from neighbours, police and others, and may be closed down by the indifference or hostility of the local authorities on whom they rely for funds, either for individual residents or for formal support.

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Other forms of residential institutions devoted to change have developed in the period. The Synanon movement—a network of houses for severe drug addicts—is such a phenomenon. Started by an ex-pugilist in Southern California in the 1950s, they have been very successful in creating a viable and enduring style of life for addicts, who stay off drugs while in the house but relapse and often die if they try to live outside. They are communities and they are therapeutic, but they do not pretend to be therapeutic communities as described by Maxwell Jones. They have an authoritarian structure, with punishments and degradations, harsher than could be tolerated in any organization run by doctors and nurses.

In other parts of the world the position differs. In the United States in the 1950s there was great enthusiasm, and many papers were produced. But other enthusiasms have come since—community mental health centres, transactional analysis, encounter groups, radical therapy collectives, Synanon houses. The enthusiasts moved on; many programmes collapsed, particularly after the withdrawal of the Federal funding of the 1960s. For many in the USA 'the therapeutic community' is last generation's fad, the fashion of the 1950s, gone like the hula-hoop, Camelot, the Apollo missions and the snows of yesteryear.

Maxwell Jones' ideas spread very widely, and in many lands there are a few units using the notion. There are therapeutic communities in Peru and in Poland, in Japan and in Australia. In some countries, such as Norway, they are an accepted part of psychiatric practice; in other lands they collect the revolutionaries and activists and are seen as dangerous. In Germany the Director of a 'therapeutic community' was imprisoned for providing his patients with a base for their bank robberies! Therapeutic communities do not usually start in a country if psychiatric services are primitive and impoverished and do not last long if the political regime is authoritarian, but even where the political climate is favourable their development is seldom widespread; it is the work of a few pioneers who are regarded with reservations by their professional colleagues. There are therapeutic communities all over the world, but always they are the work of a few enthusiasts who are seen by other professionals as deviant, anything from pleasantly eccentric to dangerously revolutionary.

By 1960 the therapeutic community appeared to be a relatively defined technique though not widely practised, but since then workers in social psychiatry have moved in different directions.

Maxwell Jones at Dingleton Hospital, Melrose, (1963–70) became involved in the development of psychiatric services in the catchment area of the hospital, and in *Beyond the Therapeutic Community* (1968) he described these highly successful ideas which almost eliminated the need for in-patient facilities for acute mental breakdown. In *Maturation of the Therapeutic Community* (1976) he developed his increasing interest in educational issues.

Ronald Laing, in developing his ideas on the aetiology and treatment of schizophrenia, used modifications of the therapeutic community. His original 'rumpus room' project at Gartnavel created a special milieu for very regressed psychotics. At the 'Villa 21' unit at Shenley Hospital, Cooper demonstrated that family therapy methods seemed to be as effective in promoting recovery in young schizophrenics as traditional methods; the unit had begun by using Jones' therapeutic community method, but it rapidly abandoned the formalized roles, structured ward meetings and feedbacks which had worked so well at Belmont with psychopathic personalities (Laing *et al*, 1965). Laing has continued to develop the use of the milieu as a way of allowing people to change or to live with their madness, and the Philadelphia Houses with which he is associated are leaders amongst the self-help communes which provide refuges for psychotically disordered people amongst others. His own books and their presentation remain a major influence in social therapy and help to draw into the field many able recruits.

Other developments from the common basis of social psychiatry have had an important influence. Berne's Transactional Analysis (1961) and Perls' Gestalt Therapy (1973) both make a fusion of the ideas of traditional psychoanalysis and the new insights of the social

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scientists and the practice and ideas of both these kinds of psychotherapy are congenial and helpful to those working in therapeutic communities.

Finally, the political dimension must be mentioned. The 'sixties were the period of the revolts of youth, the Paris 1968 riots and the subsequent world-wide student unrest, the anti-Vietnam-war agitation and the confrontations over drug usage. Many of these issues appealed to those who found therapeutic communities interesting, and there was a constant flow of people and ideas from one field to the other. Sometimes these contacts were immensely fruitful. Ken Kesey's experience of the misuse of therapeutic community ideas fused with his drug experiments to produce the masterpiece *One Flew Over the Cuckoo's Nest* (1962), recently made into a brilliant film.

During this period there were other developments in allied fields of social psychiatry and in theory which cross-fertilized therapeutic community practice. Among these were the liberalization of the custodial mental hospitals, the open door movement, which revived aspects of the 'moral treatment' of the early nineteenth century, sheltered workshops, halfway houses and the idea of psychiatric rehabilitation. As the 'sixties proceeded, this movement gathered great acclaim and strength because of its manifest success. The patients who had been incarcerated for so long were glad to get out of the impoverished institutions, the staff enjoyed their work more as the hospitals became less crowded, less tense, less squalid and more hopeful. Governments, national and local, were delighted to be able to save money on building.

Group methods of treatment, especially group analytic psychotherapy, which had developed at Northfield, spread from the Maudsley Hospital and the Tavistock Clinic and became a popular method of treatment in out-patient clinics. Many psychiatrists and psychologists learned to operate effectively in group situations. Theorists in London—Foulkes, Bion and Ezriel —explored new techniques and wrote convincingly about them.

Theoretical work progressed, but more slowly. The social scientists had published their revealing studies of the social characteristics of mental hospitals and the things that the organization forced people (staff) to do to other people (patients). Notable were the studies of Belknap (1956), Dunham and Weinberg (1966), Stanton and Schwartz (1954), Caudill (1958) and above all Goffman (1961). The influence of these writings, especially Goffman's brilliant *Asylums*, slowly penetrated practice, forcing people in hospitals to review many of their time-honoured rituals. A theoretical formulation of the principles of psychosocial treatment was, however, longer in coming; the Cummings' *Ego and Milieu* (1962) remained for long the only enduring formulation of a coherent approach to the process by which social forces change people.

Publications

First, there are the books describing the therapeutic community, the idea and its practice; they remain exciting classics. Maxwell Jones' first book (1952) was a joint publication, with articles by Baker, Skellern and others who have become prominent in other spheres, describing the exciting things they were doing at Belmont. Wilmer (1958) gave a vivid account of his therapeutic community in the Oakland Naval Receiving Ward. Rapoport's (1960) study made a sociological analysis of the Belmont unit, which contains the most detailed account of what actually happened in that unit in the late 1950s. Rather later, but still valuable as a descriptive text, is Clark and Yeomans' (1969) study of Fraser House, their unit in Sydney, Australia. These books give a permanent account of what the early therapeutic communities were like.

Other books also illuminated the process of change from the traditional medical setting to a therapeutic milieu, though not explicitly describing therapeutic communities in action. Martin (1962) described how Claybury Hospital changed itself in the 1950s, and Shoenberg's (1972) collection of essays takes the story a decade further. Barnes' (1968) collection of essays from the Cassel Hospital includes Main's original article and other studies which arose from it. Several American volumes contain the report of conferences, illuminate the process of change, and describe some individual experi-

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ments—the first Boston Book (Greenblatt, York and Brown, 1955), the 1954 Boston Symposium report (Greenblatt, Levinson and Williams, 1957), the 1957 Walter Reed Symposium (1958) and the 1959 New York Conference (Denber, 1960). They, of course, contain many ephemeral pieces but also a few permanent contributions, such as Hamburg's account of his work in Chicago, Goffman's early papers on the 'total institution', Artis' discussion of his Washington project and the Cummings' early writings from Saskatchewan. They capture the heady excitement of the 1950s when many felt that an entirely new way of organizing the life of hospital patients was coming to us.

Jones' four later books have extended his ideas steadily. His 1959 Stanford lectures (Jones, 1962) were re-edited for the Pelican book (Jones, 1968) to which he added a most illuminating preface describing the development of his ideas from Mill Hill through Dartford to Belmont and on through Oregon to Dingleton. *Beyond the Therapeutic Community* (Jones, 1968) contained reflections based on his experiences in the USA 1960–63 and at Dingleton from 1963. Unfortunately, his account of his important seven years at Dingleton Hospital (1963–70) has not been published. After his twenty years at Belmont, Oregon and Dingleton (1948–70) in which he set up and developed differing psychiatric therapeutic communities, he has moved into wider fields, especially education. He says he would now rather be called a social ecologist than a psychiatrist. In extending activities outside a defined institution he has had to seek wider frames of reference and has found these in Systems Thinking. In his latest book *The Maturation of the Therapeutic Community* (Jones, 1976) he develops these and the advantages for any organization—but particularly for one allegedly organized for the benefit and growth of its clients, such as a hospital or a school—in moving from a closed to an open system of organization.

Other medical writers have touched on therapeutic community practice. Clark's two books (1964, 1974) discussed other topics primarily, but also expounded many of the tenets of therapeutic community practice. Kreeger and his colleagues in *The Large Group* (1975) discuss many problems arising in therapeutic communities. In an autobiographical book which was a popular best-seller in Holland, Foudraine (1974) describes his progress through psychiatry and psycho-analysis to therapeutic communities and social therapy. The value of the book is enhanced by his meticulous discussion of his wide and scholarly reading.

During the thirty years we are reviewing there have of course been many articles in medical journals about therapeutic communities. They can be found extensively listed in the bibliographies of Ph.D. and M.D. Theses and other publications. Many of these were only of temporary interest. Some are the ecstatic accounts of how a unit changed after restructuring. Others are heated attacks, especially by senior psychiatrists, calling for a return to good order.

There have been a number of attempts over the years to assess the results of therapeutic community treatment or even to 'prove scientifically that it works'. Naturally many of these have failed, as have attempts to assess the efficacy of ECT or psycho-analysis. The strict comparative methods that can be used in assessing the efficacy of two drugs of similar action—double-blind cross-over controlled trials, etc—cannot be applied in examining a procedure catering for heterogeneous people over a period of time where any kind of 'placebo' or control trial is impossible. However, a certain amount of information has been published.

Jones' (1952) first book and Rapoport's book contained some follow-up material from Belmont, but too many clients were untraceable to make the findings statistically impressive. Whiteley (1970) has done further follow-ups; of a 1964–65 sample of 122 Belmont patients, 50 had had a good outcome and 72 a poor one in respect of reconvictions and readmissions to hospital—a marked improvement on their previous records. Clark and Yeomans (1969), Madew *et al* (1966) and Laing *et al* (1965) made assessments of their satisfactory results.

There have been several attempts to carry out controls of prospectively assessed clients. Caine and Smail (1969) compared the results from Forest Lodge at Claybury Hospital (for hospitalized psychoneurotics) with the results from

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other London hospitals and found them better. Letemendia and Harris (1967) compared results in two contrasting halves of Littlemore Hospital and could find no measurable difference in outcome. Craft (1965) compared two regimes for mentally subnormal youths and found that a firmly structured regime did rather better, while Miles (1967) in a study of regimes for subnormal psychopaths found that open regimes produced rather better results. Myers and Clark (1972) compared the results of two regimes for disturbed psychotic long-term male patients, and found that though the immediate results showed little difference far more of those in the therapeutic community regime left hospital in the following year.

Others have chosen to make their comments on the therapeutic community in different media, perhaps more in tune with the communications style of the twentieth century. Therapeutic communities fascinate film-makers and many have attempted to capture their essence. Some have succeeded; many have foundered on the formidable technical difficulties of catching the essence of the interactions of a large group of people. Wilmer's film *People Need People*, based on the play made from his book was one of the first. *The House on the Beach* described the original Synanon House. Television programmes of Dingleton Hospital were made by Swedish Television and by BBC 'Horizon'. The most famous film was *One Flew Over the Cuckoo's Nest*. Ken Kesey's original satirical masterpiece (1962) was based on his experiences in Californian hospitals that paid lip service to Maxwell Jones' ideas, which were quoted and appallingly misapplied by 'The Big Nurse'. Milos Forman's brilliant film preserved some of this, in particular the scene in which Nurse Ratched uses a group meeting to humiliate and degrade the male patients one after another. Laing, after his unsuccessful attempt to convince the psychiatric establishment of the effectiveness of the Shenley experiment, stopped writing 'doctor language' and spoke directly to the sufferers and their friends, as did Cooper and Esterson. Ken Loach's film *Family Life* is a brilliant and heart-rending account of a young girl's descent to schizophrenic mutism through a series of medical settings (including a therapeutic community) and was based on Laing's ideas. *Asylums*, a depiction of life in one of Laing's houses in 1973, was made with his direct cooperation and is introduced by an interview with him.

The Therapeutic Community Today

What does the phrase 'therapeutic community' mean in 1977? What is the 'definition of a therapeutic community'? Can there be such a definition?

Clark (1964) pointed out that 'the therapeutic community', at first an attractive phrase, had been 'an attitude and a method, a system of treatment and a battle-cry, a charm and a password', and went on to distinguish between the 'therapeutic community approach', which might involve a hospital and hundreds, even thousands, of people and the 'therapeutic community proper', the small face-to-face intensive unit.

In the last twelve years this distinction has become less important. Few people nowadays apply the phrase 'the therapeutic community' to whole organizations; it is now used mostly for small face-to-face units. This is probably partly due to a clearer understanding of the meaning of the phrase, but may also be due to the fact that it is no longer so fashionable or desirable, and so there is less temptation for people, such as administrators, to apply it inappropriately to a large institution.

The phrase, therefore, is now applied to small defined units, small enough for all members to meet face to face, which use some, if not all, the methods developed by Maxwell Jones at Belmont in the 1950s and described by Rapoport (1960).

Nevertheless, there have been constant debates within the Association of Therapeutic Communities around questions such as 'What are the essential features of a therapeutic community?' or 'Is this particular unit a *true* therapeutic community?' The debates were never conclusive, nor has any list of essential criteria been drawn up, so we shall not attempt it here, but merely indicate certain contemporary parameters.

It might almost be enough to say that in the 1970s, when the title is no longer modish, any

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place which calls itself a therapeutic community is one; that any unit which claims the name and attempts to base its functioning on Maxwell Jones' original ideas can fairly be allowed the title. However, we can identify a few characteristics.

It will be a community—a group of people living and working together—with the prime function of therapy—facilitating change in the people who are in it. In this it is different from communities with other prime aims—such as agricultural communes where food production is a prime aim, or religious communities, Zen monasteries or ashrams where the service of God or the search for Enlightenment are the prime aims. In these places if there is therapy it is secondary.

Most therapeutic communities are residential, but the method has also been used successfully in day centres where people are together by day but go to their homes at night. All places calling themselves therapeutic communities use some of Maxwell Jones' Belmont methods. Jones once said that 'a therapeutic community is distinctive amongst other comparable treatment centres in the way the institution's total resources, both staff and patients, are self-consciously pooled in furthering treatment'. This still remains a major difference between a therapeutic community and a traditional medical model psychiatric unit. In a therapeutic community the patients are active agents of therapy; in a traditional unit they are the passive recipients of treatment and active planning, diagnosing and treating are the exclusive functions of the paid staff, especially the doctors.

Rapoport stated that the Belmont ideology had four principal themes—democratization, permissiveness, communalism and reality confrontation. All these tend to be characteristics of most therapeutic communities today, but communalism—the belief that everyone should have equal shares of everything including treatment—does not seem to be so strongly held. Permissiveness—the tolerance of disturbed behaviour and 'acting out' (in order to understand it), reality confrontation—the regular, realistic and even brutal feedback to individuals of the results of what they have done—and democratization—the abolition of marks of difference between people (uniform, titles, etc)—remain essential parts of all therapeutic communities.

The structure of the community's day varies a good deal, but community meetings which all attend are frequent, often daily. There is constant attention to communications, so that all are informed of what has been happening. A major tool is social analysis—the analysis of happenings in the attempt to see how they arose in the hope that those involved can learn better strategies for another time, what Jones has called the 'living-learning' situation. This can occur at formal meetings but even more often in crisis meetings where methods of confrontation and crisis intervention are used.

The only way to learn about therapeutic communities is to work in one, or at least to visit several. This description may, however, convey something of their flavour.

'A visitor to a therapeutic community may often get a bad first impression. The door is open, to be sure, but there is no one about. The place is rather grubby and does not seem to have been swept recently. There are people about, but there is no way of telling who or what they are as they are all wearing casual clothes and are all addressed by first names. When he does succeed in identifying himself to someone who will respond, there will still be only limited interest in showing the visitor round; he is more likely to be swept into an informal group which is grappling with some painful personal problem.

If the visitor stays for some hours, or a day or two, he is soon drawn into the life of the community and involved in the current crisis. Apart from the many informal and crisis gatherings, he will be taken into community meetings, which have a fairly formal structure, with a chairman, feedbacks and minutes, and he will be called on to identify and explain himself and his interest. He may be vigorously quizzed about his work or challenged about his motives for visiting the unit. Soon he will find himself accepted by the community, given tasks to do, asked his opinion—and criticized trenchantly for giving it. It will stir him up and within one day he will find himself exhilarated, infuriated, puzzled, challenged and perplexed.

He will gradually sort the people out, identifying doctors, social workers, nurses, patients, though he will see that the barriers between the roles are slight and that leadership may pass to anyone in the group at any time. Often the most articulate, constructive and persuasive member of the group turns out to be

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a patient going through a phase of identification with one of the professional roles, and one of the most angry and disturbed people a staff member working through a personal crisis.

When he does get round the building he will find it like a large, casually run boarding house. Bedrooms contain piles of clothing, posters on the walls and radios playing unattended; some beds are made, others are in an untidy tangle. The kitchen is often a social centre, untidy, even unhygienic, but there is always a cup of coffee available, and the "office" is usually full of people holding a crisis meeting while the telephone rings unanswered.

There will be workshops, art classes and project work going on, but the main business is talk and interaction; it soon becomes clear that many of the residents are deeply disturbed people with many suicidal attempts, breakdown and hospital admissions behind them, and tempestuous emotions often explosively break surface.

One characteristic of a therapeutic community is that no standard reaction emerges. Some staff are converts, messianic in their desire to reshape the world to fit this pattern; others are full of criticism and complaint. Patients too look back on the experience and express mixed feelings: "It was like being in a pressure cooker—emotions, crisis, all the time—there was no peace. But it did force me to face some things in myself which I didn't like and I am certainly managing better now. I often visit them, but I hope I never have to go in again."

(Clark, 1974)

Few therapeutic communities are self-supporting; their money and trained staff have to come from outside sources. Many of the early therapeutic communities were in wards of hospitals, and a number still are; they received their support—food, staff wages, accommodation—from the National Health Service, which tends to put on them institutional pressures for conformity as part of the price of this support. A number nowadays are independent organizations, such as the Richmond Fellowship, Philadelphia Houses, etc. They raise capital money from charitable sources, but their income comes from the local authority and social security funds paid for each resident's keep. If they cannot attract enough residents or if the local authorities withdraw the grants, they will founder.

To summarize this section we can attempt a definition for the present time. A therapeutic community is a group of people living and working together with the prime aim of therapy—i.e. producing change in the members. It may be a ward in a hospital or an independent unit. It is small enough for frequent face-to-face meetings of the whole group. The contributions of all members are welcomed (and required), whether they came originally as clients or experts, as patients or as paid staff. A major aim for all, residents and staff, is learning, personal growth and change. The main themes of the approach are tolerance of deviant behaviour with a view to understanding it by social analysis and reality confrontation, aimed towards rehabilitation to an effective and tolerable life role.

The Therapeutic Community as a Phenomenon of our Time

The discussion so far has been mostly about publications by doctors for other doctors. A review of the therapeutic community in the last thirty years would, however, be incomplete if we did not also move outside the limited medical psychiatric sphere and look at the idea in the wider context of the intellectual influences and currents of our time.

During the between-wars period in Britain (1918–39) there was limited public interest in madness or its management, but since World War II the interest has been intense and continuous. The setting up of a Welfare State and a National Health Service exposed the pitiful state of the chronic psychotics, legally imprisoned in the antiquated dilapidated asylums. The concern of artists, visual and dramatic, with disordered thought brought interest onto figures like Dadd, Wain and de Sade. Some psychiatric writings appealed greatly to radicals and revolutionaries, as they appeared to support their call to restructure society. In these thirty years of intellectual turmoil the idea of the therapeutic community played a vigorous though transient part.

The idea of the therapeutic community, born in 1946, was a child of that period. It was a time of enthusiasm for new solutions based on social restructuring and social engineering. There was also a hope that psychological and social methods of government, could change

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British industry. There was also a growing tendency to challenge and modify many paternal authoritarian roles persisting from high Victorian days—policeman, doctor, school teacher, prison warder, asylum medical superintendent. All were to become more approachable, less mysterious, less rigid, less formalistic. There was great enthusiasm for new methods of education, for progressive schools.

To people thinking along such lines it was welcome news that a new way of organizing mental institutions was emerging, and many went to Belmont to see this exciting unit where doctors dressed like patients and were hailed by their first names, where the patients governed the community and apparently brought about cures. Enthusiastic articles appeared in left-wing journals; Maxwell Jones was appointed C.B.E. The open door movement in mental hospitals gained great acclaim, and those who advised caution were divided. The Percy Commission Report (1957) and the Mental Health Act, 1959 swept away a century of custodial legislation, aroused great hopes that the vast institutions for the mentally ill would soon vanish and fuelled a long public debate in Parliament and media about the best way for Britain of the 1960s to care for its mentally disordered. Similar ideas in the USA in the euphoric Kennedy era (Action for Mental Health, 1961) caused massive Federal Funds to be pumped into Community Mental Health Centres which were to replace the ancient State Hospitals.

After 1960 other developments kept radical interest focused on insanity. Laing's poetic descriptions of schizophrenic alienation made sense to thousands of unhappy young as they surged towards the student uprisings, the sit-ins, the protests and the anti-Vietnam-war marches. Plays like *Marat-Sade* and *The Caretaker* linked mental illness and the theatrical avant-garde. Psychiatric experiments still featured in the Sunday supplements.

In the 1970s, however, things have been different. Euphoria has departed. Economic recession presses. Mental disorder, grief, suffering and the pain of being human are still with us. New signs of mental turmoil—hard drug addiction and suicidal overdosing—are increasing. There is a feeling that mental illness has not gone away for ever and that somehow the psychiatrists have failed to deliver. Within public institutions too there is a swing away from the liberal atmosphere of the 1950s. The Mountbatten report made British prisons more secure and stopped much rehabilitation. In education the Black Book group presses for more formal education. The Butler Report presses for Regional secure units throughout the land and implicitly deplores the open door policy. Among psychiatrists themselves there is a strong swing back to the traditional limited medical role and rising interest in neurological psychiatry and treatment by drugs.

In such a climate there has been generally a loss of interest in the idea of the therapeutic community. There are few articles and no new television documentaries. Newspaper interest focuses more on scandals in mental hospitals and demands more rules and regulations to prevent further mishap. In the British psychiatric service of the 1970s any experiment as radical as Belmont was in 1950 would be stopped at once.

Manning, a social scientist who worked at Henderson Hospital during the 1970s, has recently (1975, 1976) discussed the therapeutic community as a 'social movement'—rather than as a medical technical innovation. He said that 'social movements' have a three-stage life:

> 'an early stage of unrest, perhaps with certain surrounding social strains or tensions; an enthusiastic mobilization or popular appeal, when the movement takes off; and a final stage of institutionalization when there is often goal displacement and stagnation.'

He concludes that the therapeutic community movement is entering the third stage. In 'What Happened to the Therapeutic Community?' he has set out a historical account of the development of the idea and practice of the therapeutic community in Britain and discusses its present position and future. He starts by saying flatly 'The influence of the therapeutic community has declined steadily since the late 1950s', and he concludes:

> 'As with many psychiatric innovations, early partisans felt that the therapeutic community was a panacea. Now it has more limited but more realistic

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aims: providing therapeutic resources for certain problems; gaining experience in organization development, in close association with a tolerance for self-criticism and research. The therapeutic community is coming in from the cold and will continue to play a modest role in the field of residential institutions through its special experience of individual and social process.'

Conclusion

What then is the position of 'the therapeutic community' thirty years after the phrase was first coined?

The first thing to say is that it has proved far harder than most of us realized to produce the 'therapeutic setting with a spontaneous and emotionally structured (rather than a medically dictated) organization in which all staff and patients engage' which Main called for in 1946. The strain on staff, especially the leaders in the communities, is very great. The therapeutic community method is hard and painful work—often more painful and certainly less well supported than individual psychotherapy.

It is clear that the 'idea of the therapeutic community' as a revolutionary concept in psychiatry, in medicine and in intellectual and political thinking, has passed. Born with a rhetorical flourish in the later years of the war when the new world of social engineering was dawning, it was the name given to a new form of treatment, but it was also an affirmation of attachment to an ideal—an ideal of a perfect psychiatric institution and, beyond that, glimmerings of a perfect social order. As a slogan it suffered the fate of all the slogans of mankind's crusades—it was inflated, distorted, perverted and discredited. By the 1970s most psychiatrists were able to snuggle back into their nineteenth century identities and dismiss the therapeutic community as 'a fad that has passed'. Its days as a slogan and trail-breaking concept were over.

The treatment method, the therapeutic community of Maxwell Jones, as developed at Belmont, as described by Rapoport, as copied and developed in many lands, remains. It is a valuable way of organizing a residential institution concerned with change and growth in its residents. It works well, especially with those patients who do things to other people, who act out and who are sufficiently integrated to handle concepts and learn from experiences, though it also works for other groups. It is a particular kind of therapeutic milieu; there are others, such as Philadelphia houses, Synanon houses or token economies, organized on different principles for different groups of people.

The method produces striking results where a group of patients, with marked disorders of behaviour, interact over a considerable period with devoted and sophisticated staff. The method puts great strain on the staff; it does not work well if there are too few staff, or if they are not adequately trained or supported by sophisticated colleagues with psychodynamic expertise; it does not work well if either patients or staff or both are changing so often that there is little chance for either therapeutic relationships or learning by experience to occur. It arouses anxiety in administrators who desire tidiness and conformity—nursing administrators, lay administrators, and managing committees afraid of bad publicity, who may be driven to use any crisis as an excuse for limiting the experimentation, unless an eloquent spokesman for the community can justify its method. The method challenges certain important characteristics of a bureaucracy—it challenges static role definitions, it threatens security, it threatens (or promises) change. It is, therefore, always liable to be suppressed unless it is clearly the most effective way of operating.

It has produced a number of valuable offshoots. Every therapeutic milieu—from patient workshops to Synanon houses and self-help communes—has used some parts of therapeutic community technique, though they have later developed toward quite different ways of operating. At the present time the most exciting developments in therapeutic milieus are going into new patterns—authoritarian units run by ex-patients and using punitive procedures unacceptable for doctors and nurses (Synanon houses), self-help communes based on family therapy ideas (Philadelphia and Arbour houses) more structured units with clearly accepted adult role definition (adolescent units). Some of the most interesting developments today are

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in communities not attached to hospitals (such as local authority halfway houses) or in non-residential institutions like day hospitals. Experiments are still going on in developing applications of the technique in other fields—such as acute admission wards, psychiatric units in general hospitals, rehabilitation wards and alcoholism units and we may see valuable developments and informative publications from these projects.

A number of components of the therapeutic community method have become part of standard psychiatric practice. The majority of psychiatric staff, even in general hospitals, do not now wear uniform. A style of openness, first-naming and decision-making by consensus is widely used. Although 'patient government' is not so widely used, ward meetings for the sharing of news and the planning of activities are very widespread. Group therapy, sociodrama and psychodrama, conducted by others than doctors and professional psychotherapists, is now quite common, and the number of professional staff experienced in group work is steadily rising.

The therapeutic community made a major contribution to the development of social therapy—the use of the environment as a means of promoting desired change in clients. This is a large field, covering concepts, theory, techniques and their application, studies and results. Many of the developments—such as the open door movement, the transitional facilities (halfway houses, sheltered workshops, etc) have a life and validity of their own. But the therapeutic community was for long the crucible from which many of the best ideas of social therapy in the 1950s and 1960s emerged and is still a most valuable arena for experiment.

The major need for social therapy at the present time is for more theoretical formulations. Since the Cummings' *Ego and Milieu* (1962) there has been little that links theories of man's inner psychology with the attempts to make therapeutic change in his environment. It is to be hoped that some of the self-questioning shown in *The Large Group* (1975), a series of essays by leading group analysts about the problems of using their skills within therapeutic communities, may lead to further insights.

In our theoretical thinking we have, as Maxwell Jones told us ten years ago, to move 'beyond the therapeutic community'. We have to explore which of the insights we gained within the therapeutic community can be applied to other situations—the development of psychiatric services, the development of education and possibly even the organization of neighbourhood communities.

The social scientists who helped psychiatry so much in the 1950s with their observations on the bizarre inner life of the custodial asylums (Goffman, Belknap, Dunham and Weinberg; Caudill, etc) have given us a new tool—systems thinking (Emery, 1969; Argyris, 1970) which may enable us to take a look at all our psychiatric institutions in a new way and thus improve our practice.

There are many new and exciting lines of development opening up. Although the therapeutic community itself has now reached Manning's third stage of acceptance, incorporation and institutionalization, the impetus which it gave to social therapy still persists and there is much for us to do and learn.

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