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Themes in a Therapeutic Community

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Introduction

The therapeutic community method of treatment was developed by Maxwell Jones at Belmont Hospital (Jones *et al.*, 1952; Jones, 1954; Rapoport, 1960) for the treatment of psychopathic personalities. The method has been applied to an admission unit by Wilmer (1958) and to psychopathic personalities by Craft (1965). Clark (1964) has differentiated between 'the therapeutic community approach', of increased activity, freedom and responsibility for all patients in the hospital, and the 'therapeutic community proper', the small unit with face-to-face gatherings of all members, social analysis of events, opening of communications, flattening of the authority pyramid and blurring of roles.

Fulbourn Hospital, an 800-bed general psychiatric hospital, serving a catchment population of 450,000, had used the 'therapeutic community approach' since the mid 1950's. By 1958 all the ward doors were open; a sheltered workshop was established in 1956, and in 1959 a half-way house was opened (Clark and Cooper, 1960). As a result, the total number of people in the hospital declined, and it became a more pleasant place to live in.

However, Hooper (1962) found that making the women's 'disturbed ward' more pleasant to live in did not bring about any basic change in nurses' or patients' attitudes and behaviour. A more fundamental restructuring of the ward social system was needed if patients were to be released from the insidiously crippling effects of the institution, even though 'open door' and 'liberal'. In 1959, a detached villa with forty 'convalescent' women patients was re-organized as a 'therapeutic community proper', with good results. (Clark, Hooper and Oram, 1962).

During the period 1960–63 an attempt was made to apply some of these lessons to the women's 'disturbed ward'. Weekly community meetings began, attended by all patients and staff. Gradually, mutual understanding improved and residents began to take responsibility for one another. The 50-bed men's disturbed ward was unlocked in 1957 (Pattemore, 1957) and by 1963 had regular meetings attended by ward nurses, doctors and the consultant psychiatrist, with a patient as chairman. They were orderly gatherings, with formal motions and voting. These meetings, again, improved communication and understanding between staff and patients.

In 1963 both disturbed wards became the responsibility of one of us (D.H.C.). In February, 1964, the hospital took over a new admission unit, and the two disturbed wards were moved into the former admission villas.

This paper describes the development of the unit thus formed from February, 1964, to January, 1969, a period of five years. The aim of the experiment was to see how far the therapeutic community method could be applied to this rather special group of people.

Numbers

There were 60 beds (30 male, 30 female) in the unit. Seldom were all occupied. During 1965 the unit was occasionally full. In 1968 the average occupancy was 51.

In the period February, 1964, to January, 1969, there were 566 admissions and re-admissions to the Unit.

Table I

Admissions	M	F	T
Total patients	.. 136	131	267
Re-admissions	.. 158	141	299
Total admissions ..	.. 294	272	566

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TABLE II

Age on first entry to Hereward House

	M	F	T
15–25	42	38	80
26–35	30	40	70
36–45	37	29	66
46–55	17	13	30
56–65	10	10	20
66–	0	1	1
Total	136	131	267

TABLE III

Marital status on first entry to Hereward House

	M	F	T
Single	98	79	177
Married	24	47	71
Widowed	4	1	5
Divorced	8	2	10
Separated	2	2	4

All categories of psychiatric diagnosis were represented though the broad groups involved were as shown in Table IV.

TABLE IV

Diagnostic group	M	F	T
Schizophrenia	65	48	113
Personality disorder (including addictions and epilepsy) ..	50	58	108
Other psychiatric diagnoses (mostly affective disorders) ..	18	22	40
Subnormality	3	3	6

Development of the unit

During 1964 one meeting a week was held in each ward, attended by all the patients and staff and followed by a review session. Each ward dealt with its own problems, and there was little contact. Gradually, the patients began to associate, but the staff groups remained separate.

In 1966 the previously separate male and female nursing administrations of the hospital were united under a Principal Nursing Officer. This external event permitted rapid developments within the unit. A Nursing Administrator was appointed to help the two wards work together. Joint meetings were started, and in 1967 a Sister took charge of both wards. A joint office was set up and during 1968 all the main functions of the unit (dining room, dispensary, outside telephone) were centralized. Gradually a 'mixed unit' developed (Mungovan, 1968).

A sense of identity emerged slowly. At first the patients identified themselves with their wards, but during 1966 they began to see themselves as members of a unit. A Staff Christmas Party in 1966 produced the name 'Hereward House'. The title was apt, not only because Hereward the Wake is a famous local character and an archetypal Fenman, but because he seemed to typify the spirit of the residents—defeated again and again but always fighting back.

Flexibility and constant change are important characteristics of therapeutic communities. For this reason any description is soon out of date. The pattern of meetings and communications at the cut-off point of this paper, in February, 1969, can, however, be described.

There were community meetings, with a patient as chairman, each weekday morning, attended by all or most of the members, lasting an hour, and followed by a review session attended by all staff, any visitors and two elected patients. At midday there was a handover meeting attended by both shifts of staff. All these meetings started with 'feedback reports' from previous meetings and often had a general framework of business, with votes on some issues, but the discussion was unstructured and egalitarian. An evening 'workers' meeting' was held once a week for those out all day, and a relatives' meeting for a small group of interested family members on another evening. A 'crisis meeting' could be called at any time. These averaged about three a week. The accepted principles were that the community was the responsible body, making and implementing decisions, and that each situation had to be resolved with the human resources available, if possible by understanding what had happened and analysing the feelings aroused.

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Legal status and freedom

The ward door always remained open, though absconding remained a constant problem for the community. Erring members were placed in night clothes and dressing gown. At times they absconded thus dressed into the town, to everyone's dismay. Legal detention was at times necessary by use of Section 30 (para. 2) and Section 25 of the Mental Health Act, 1959. Most of the patients under long term legal detention in Fulbourn Hospital were in Hereward House. In October, 1968, of 52 patients (26 men, 26 women) 43 were informal, 7 detained under Section 26 and 2 detained under Section 60.

Entry to the community

The unit continued to provide 'disturbed ward' facilities for the rest of Fulbourn Hospital, and most residents came to the community because they had become intolerable elsewhere in the hospital. They came most frequently from the admission wards, sometimes because they were the focus of increasing disturbance, but usually because other forms of treatment had failed. (Table V).

TABLE V

	M	F	T
Resident in wards February, 1964	13	26	39
Referrals from within hospital:			
Admission wards	50	58	108
Habit training wards	8	4	12
Rehabilitation wards	26	14	40
Geriatric wards..	7	3	10
Direct admissions from outside of hospital	32	26	58
Total	136	131	267

Many had had several admissions (Table VI) and most, long experience of hospital treatment (Table VII).

TABLE VI

Admissions and re-admissions to Hereward House

No. of admissions	1	2	3	4	5	6	7	>7	T
No. of patients	175	44	23	11	4	2	4	4	267

TABLE VII

Total time in hospital in ten years before first entry to Hereward House

	M	F	T
Less than 1 month	4	2	6
1–3 months	8	7	15
3–6 months	16	16	32
6–12 months	15	21	36
12–24 months	27	29	56
More than 24 months	66	56	122

In the later years patients began to be recommended for admission for the treatment Hereward House could offer rather than because of the failure of treatment elsewhere. This caused a change in procedure. Candidates were invited to spend a day in the community and then to decide whether they wished to stay.

Treatment within the community

The major treatment was the community therapy, the constant examination and analysis of one's own and other people's actions, motivation and attitudes. Formal individual psychotherapy was not undertaken. Traditional methods of treatment were, however, also used. Schizophrenic patients received tranquillizers, epileptics were on anticonvulsants, six manic-depressives received lithium carbonate, and about one-third of the patients received nocturnal sedation. Electroplexy was used occasionally for severe depression and schizophrenic exacerbations. Its use gradually declined; 34 people received ECT in 1966, 23 in 1967, and 15 in 1968. Orbital undercutting was performed on four residents in five years for the relief of intolerable, intractable tension. All were much improved; one has left hospital, one is on another ward and two are still on the unit.

Exit from the community

When the hospital was re-organized in 1963 the intention was that patients in the unit who improved should be transferred to rehabilitation wards. Gradually, however, the House undertook its own rehabilitation. Community members found jobs in the town, went on protracted periods of leave and were dis-

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charged direct. Some were transferred to other wards within Fulbourn Hospital. There were 13 deaths; 7 from suicide, 6 of natural causes. (Table VIII).

TABLE VIII

Status in January, 1969	M	F	T
Still in Hereward House ..	27	32	59
Elsewhere, Fulbourn Hospital..	38	34	72
Out of hospital, not working ..	26	18	44
Out of hospital, working ..	25	37	62
Other hospital	6	2	8
Not known	3	1	4
Other (jail, etc.)	5	0	5
Died—natural causes	3	3	6
Died—suicide	3	4	7

Work in the community

Although the residents were by definition the most disturbed patients in Fulbourn Hospital, most of them were engaged in paid occupation off the ward for the greater part of each day. On 2 February, 1969, for example there were 56 patients on the books, occupied as in Table IX.

TABLE IX

Occupation of patients in Hereward House on 2 February 1969

In Hereward House all day	Not working	6
	Working on ward	7
Paid work elsewhere in hospital		23
Fully employed outside hospital		8
Full-time student (attending College classes)		1
On leave at home		11
Total		56

Staff

The number of nurses varied over the years, but averaged about 16 in three shifts, two by day and one by night. On an average week in 1968 the staff groups were:

Full-time: ward sister, 1 deputy charge nurse, 5 staff nurses (R.M.N.), 4 student nurses, 4 assistant nurses, 1 pupil nurse, ward orderly, registrar, occupational therapist.

Part-time: consultant psychiatrist, nursing administrator, social worker.

Staff recruitment, entry and departures were governed by differing rules. Some were assigned routinely—student nurses for a tour of up to three months; ward doctors, social workers, occupational therapists as part of their training programme. There was often also an element of volunteering for what was seen as an interesting and valuable experience. Staff nurses were selected for six month assignments; physically weak or psychologically insecure individuals were seldom assigned. In the later years a few people came specially to work in the unit—one overseas doctor for six months, a few trainee social workers for periods of a month at a time.

When a person joined the community there was a period of questioning and exploration. Sometimes the new staff member would show irritation and distress, especially when traditional assumptions about professional roles were challenged. At this period support and help both from the community and from supporting figures outside—the Nursing Tutor, the Principal Nursing Officer, the Head Occupational Therapist—were very necessary. Some individuals felt very challenged, and their deeply entrenched professionalized reaction formations were shaken as they experienced the turbulent, destructive and seductive currents of emotion within the unit and within themselves. On the other hand, staff in training, doctors, nurses and occupational therapists were anxious for the opportunity to work there. The prestige of the unit was high, and this was buttressed by the number of visitors who came to the hospital to visit it.

Themes

It seems valuable to record some of the prevailing themes that occurred in the discussions in Hereward House during the five years.

Rejection is a constant theme. It comes up in many ways: 'Our relatives don't want us home! Why do people dislike us? Why is it so hard to get a job? If people know you are from Fulbourn Hospital, they won't engage you!' etc. The staff members share these feelings. They believe that the work of the House, and they themselves are misunderstood by others. But there is also some defiance: 'This

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is how we are, rejected, despised, but fighting on. We are the Herewards!'

Violence and how to control it is another constantly recurring theme. Most of the residents had at one time or another been violent. There were still fights—at times staff, including doctors, were involved. Self-directed violence was common. Seven members of the community killed themselves, one by setting fire to herself, one from exposure after hiding in dense undergrowth, one by throwing himself under a train, and four from overdoses of tablets. Wrist slashings were too numerous to count. Windows were smashed 100 times in 1965, but since 1967 residents have been expected to pay for the damage they cause; the figure is now down to two a month. The community discussions about violence in the early days were concerned with how to stop, prevent or punish it. In more recent years the discussions have been directed to understanding why it occurred.

Sexuality

Always a lively subject, this became a matter of active discussion and concern when the two wards joined in 1966. The male nurses were greatly exercised about the danger from lascivious females, at times quoting the 'carnal knowledge clause' (Section 324 of the Old Lunacy Acts of 1890 and its successor Section 128 of the 1959 Mental Health Act). They were clearly very anxious about their own sexual feelings towards the female patients, an anxiety shared by some of the doctors. Other, more realistic, fears concerned the likelihood of pregnancy in younger female patients, and the effects that rumours of sexual licence might have on the 'image' of the ward and the hospital. The problems of sexuality have been nothing like so troublesome as has absconding in pyjamas and nightdresses—which still occurs and still causes anxiety, distress and shame to the unit. There is some sexual intercourse, but rather less than in other wards of the hospital and far less than in the community outside.

Staff divisions

There are, of course, divisions amongst the staff, and we rapidly learned that much time had to be given to examining these. They attracted the 'splitting' tendencies present in all members and could spread until the whole unit was lined up in the factions and every issue related to the split. The divisions could be seen as functional, personal, or 'arena disputes' (Strauss *et al.*, 1964).

The functional divisions—night staff versus day staff, senior nurses 'in the office' versus junior nurses 'giving out the pills', the 'educated' members (those with University degrees—doctors, social workers, visiting anthropologists) versus the 'experienced' members (nurses, senior administrators, leading patients)—were always present, but at times became the basis of misunderstanding, blocked communications, withdrawal and mounting exasperation, until someone, often a newcomer or a visitor, would comment and bring the matter into the open. Personal antipathies were rare, but if they involved senior members could be very difficult either to discuss or resolve. 'Arena disputes' were seen when members were striving not so much on their own behalf but because they were under pressure from other members of their own profession outside the community. A discussion whether the women nurses could dispense with uniforms lasted from 1964 to 1968 because of outside pressures and repercussions; the nurses within the community had resolved their discussion by 1966, but it was not until 1968 that the rest of the hospital could tolerate their coming out of uniform.

Dependence—independence

Another constantly recurring theme is the Dependence-Independence conflict. Some patients clamoured for their discharge; others complained bitterly that the staff—or the doctors—were trying to push them out. The problem of the person manifestly unfit to be at liberty is not so difficult. The correct decision is nearly always clear to the community; if not, a period of trial leave would often make it so. A greater problem were the people who appeared to be 'making themselves too much at home'. These patients, many times rejected, yearned for a secure permanent home, while the nurses' nurturant and maternal drives led them unconsciously or consciously to welcome the

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desire of the patients to be with them permanently, despite the hostility also aroused.

Relations with outside bodies

Within the hospital, common areas of concern were over relations with the nursing administrative office, with the hospital kitchen, with the admission units (which referred so many of the new members, often in stormy circumstances) and with the hospital employment office (responsible for attempting to find paid jobs for patients). Outside the hospital, those with whom relationships were matters for discussion included the social welfare agencies, police and press. A common pattern was an outburst of denunciation of an outside agency by an aggrieved resident during a community meeting. Sometimes people present at the meeting could put the viewpoint of the outside agency. Sometimes it was necessary for senior members of the unit to assume the 'spokesman function' (Clark, 1964) and go to the agency to explain the community's viewpoint. The best solution was when someone from the agency attended the community meeting. At various times the Principal Nursing Officer, the Employment Officer, the Hospital Catering Officer, several Mental Welfare Officers and even a Member of Parliament have attended the community meetings to hear the viewpoint of the House and to put their own.

These problems arose in the first Fulbourn Hospital therapeutic community and are discussed by Clark, Hooper and Oram (1962) and by Clark (1963). They are a constant preoccupation of all therapeutic communities. If antisocial activity is to be analysed and examined it must be discussed and to that extent condoned. But attention must constantly be paid to avoiding too great a shock to outside opinion, and information and explanation must be available to key people in the community at large on the aims and activities of the unit, especially to those who are sympathetic and protective towards it.

Discussion

This brief account describes the development of a viable therapeutic community within the old 'disturbed wards' of a psychiatric hospital. The community has functioned for five years and has evolved steadily, becoming a mixed unit, abandoning staff uniforms, developing a lively and vigorous culture, without being estranged from its host hospital. It has been successful in that it has taken all patients sent to it, has handled several hundred and discharged almost half of them to independent lives in the community.

The history of its development resembles other therapeutic communities which have been described, despite certain differences. There is nowhere worse to which residents can be sent; all other therapeutic communities described have had a method of disposal as an ultimate deterrent and relief. There is no limit of stay; in 1969 there were members of the community who had been there since 1964—far longer than most members of the staff group; most other therapeutic communities have had a time limit.

The development from two separate single-sex wards to one fully integrated ward was a notable achievement, and it is interesting that it followed a pattern similar to other therapeutic communities, despite the fact that the patients were more disturbed and that many of them were diagnosed as schizophrenic.

This experiment has shown that a therapeutic community can function successfully within a mental hospital while attempting to care for the most disturbed and disturbing patients in the hospital. Two of the questions it raises are whether similar results in terms of rehabilitation can be obtained in a traditional ward setting, and whether comparable clinical changes would occur. One of us (K.M.) is studying these questions.

Summary

A 60-bed therapeutic community in the male and female disturbed wards of an 800-bed general psychiatric hospital is described. From February, 1964, to February, 1969, there were 566 admissions of 267 persons. Characteristics and customs are analysed. Frequent themes of community preoccupation were: Rejection, Violence, Sexuality, Staff Divisions, Dependence—Independence and Relations with Outside Bodies.

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