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Long essay outline

Title:

IN SEARCH OF THE ENABLING ENVIRONMENT

By Robin Johnson

A comparative study of therapeutic community models and structures, identifying some underlying modalities or dimensions of interaction.

Subject matter:

In this essay I hope to demonstrate that, despite the apparent diversity of approach between different models of therapeutic communities, they can be best understood as evolved variants, differing expressions in differing environments of a few central themes, or modalities.

This recognition then hints at some of the underlying links between psycho-dynamic processes and the social dynamics of institutions and communities. Making such links helps create a new conceptual framework to guide the development of new services in the future.

Materials:

Personal observations and experience of a number of communities, plus numerous articles and books by exponents of the therapeutic community principles; sociological theory (particularly of the functionalist and symbolic interactionist schools); systems theory; psychodynamic theory (particularly transactional analysis, Kleinian and group analytic concepts).

Structure:

1: Introduction: the diversity of practice and the search for a 'baseline' concept: proposing a comparative perspective on 'TC's.

2: Core concepts: the model, the moral and the modal conceptions: various possible baselines examined; Rappoport's four themes.

3: A brief outline of various community approaches

4: Common Threads:
- The dimensions of community
- The extent of community
- The emotional significance of community

5: Inconclusive Conclusion, and further avenues for investigation

now read on……….

IN SEARCH OF THE ENABLING ENVIRONMENT

A comparative study of the social structures underlying diverse therapeutic community models

PREFACE

This paper arose initially from my reflections as a participant on the short course "Free to Grow", held in Bristol in July 1979 and hosted jointly by the Planned Environment Therapy Trust and the Association of Therapeutic Communities. It builds however upon some eight years' previous working experience in therapeutic communities and comparable environments, and visits to many others.

The introduction, and the concluding section, have been revised somewhat in the light of developments in the policy and services context since the early 1980s. The substantive hands-on research, however, stands unchanged, as written. The methodology of first-hand observation might be described as participant observation. It is probably closer to what we now call embedded journalism.

These actual organisations, of course, will have changed and evolved substantially over this period. The descriptions given here may no longer reflect at all the day-to-day or general operations of the various particular units described. Equally, the use of the past tense for these descriptions is not intended to imply that these organisations no longer exist, or no longer operate in this way, but merely that they once did.

To that extent, this paper echoes the comments of Helen Spandler, in her recent re-exploration[1] of the Paddington Day Hospital:- "This book forms part of a process of historical recovery, contributing to a body of literature which documents innovation, debate and political struggles in psychiatry since the 196Os."

Nevertheless I would contend that the underlying issues, of which these snapshots of past units are taken to be historical examples, remain; and the dynamics or dimensions of interaction outlined here can be seen in many other environments in the present day. It is for their contemporary relevance, not their historical accuracy, that I now offer this material.

RJ
2/11/2OO6

[1] Spandler, H. [2OO5] *Asylum to Action: Paddington Day Hospital, Therapeutic Communities and Beyond.* London: Jessica Kingsley Publishers

PART ONE: INTRODUCTION

In the concluding article of the collection of essays “Therapeutic communities – reflections and progress “, Manning[i] suggests that a productive approach towards evaluating therapeutic communities, or “TCs”, might lie in comparing a large number of therapeutic communities in order to use natural variations to suggest relationships between constituent elements.

Yet in practice, the difficulties in doing so are daunting. When members, particularly more senior members, of the various TCs do meet, diplomatic niceties – not to mention other motivations - may all too often inhibit much real comment or cross-examination of each other’s cherished, but always tenuous, achievements. Yet in any average career, no one individual can be expected to actually work as a member of staff or as a researcher in more than a few communities, at most.

If I do attempt the task here, it is out of my personal conviction that the results are worth the risks. The reader, and not I, must ultimately be the judge here. But my “escape clause” is to state that all the material presented here refers to establishments and practices from over 20 years ago. No-one working in services of the same name today need feel that their existing service is mentioned at all.

Other than that, my credentials for the necessary temerity are that in six of the communities I shall describe in this paper I have myself actually worked – or have in some other fashion participated in depth, as several of them did not "employ" "staff". I have also visited, albeit briefly, the other two, and whilst I clearly cannot speak so confidently of my experience of them, I had discussed these issues with their senior staff, and seen enough to believe that their inclusion is necessary to any broadly comparative study.

But, in attempting this study, and this comparison, I must tread still more dangerous ground. In making this selection, I have not kept solely to establishments and practices that are comfortably and unequivocally “within the family” of accepted TCs. Indeed, some of my examples would perhaps be surprised to find themselves identified in the same company. I do so, because I do not assume that the TC principles, as I identify them here, are only to be seen in units that specifically identify themselves as therapeutic communities.

Rather, these underlying principles – as I see them - have a particular contribution to make to a wider debate that takes place between all those who are seeking to gather insights from all sources, in the interests of creating appropriate - what I propose to call *enabling environments* - for those entrusted to our care. This concern may be found in psychiatric hospitals, special units or day centres, but also in residential schools[ii] and children’s’ homes, in hostels, resettlement centres, in prisons or in any establishments where people come to live, to confront change and hopefully to grow as persons[iii].

If there is to be a debate between all those who are seeking to provide consciously appropriate, enabling environments, undeniably the TC movement has already played a large part in creating a vision of new ways to work. But all too often the debate has been conducted in terms of conceptions from the past which have tended to prematurely separate out TCs as quite different from other ways of working.

After a long period when the growth of the TC movement within psychiatric hospitals had slowed almost to nil, and yet when interest in these ideas is again spreading, both inside and outside of the N.H.S., albeit in a vague and often confused way, it is more than ever necessary to consider closely exactly what the experience of the TC movement has now to offer to the wider search.

In fact, it is this, I would argue, that is the ultimate responsibility of the TC, as a movement. All members of any community are expected to behave generally as responsible human beings. But the TC staff member is expected both to play out whatever roles are part of the formal staff structure of the establishment, and at the same time to be consciously examining and re-examining the implications of those roles and those structures, in order to change them wherever necessary. This culture of enquiry[iv] is at the heart of the TC project.

So let us then see what happens, when we do take a broader view.

PART TWO: CORE CONCEPTS

In their essay "Implementing ideals", Manning and Blake, writing in the mid-1970s[v], hinted at the possibility of a "paradigmatic revolution" in therapeutic community thinking – a dialectical resolution of the growing contradictions of a model, or a conception, that no longer comfortably or unambiguously reflects the reality "out there". My own belief is that an overview of different TCs does indeed lead to a re-think of the essential nature of the TC, and raises many questions as to the real contribution of the TC "movement". But to do so, involves tackling head on the notion that there is, or can be, a pure or proper model of a TC.

In this paper, I shall argue that there have tended to be three dominant accounts or discourses on the nature of the TC, three fundamental ways of thinking about the TC and the TC movement, and its contribution to the rest of the "caring professions"; three conceptions which I will call the model, the moral, and the modal.

In brief, the first conceives the TC as a model, a blueprint for us all to follow, if we are to "do it right". The second conceives the whole TC movement as offering a moral lead, an essentially values-based crusade that happens also to offer a better way in practice of running hospitals, schools etc. The third sees the TC as intrinsically fluid and variegated, as operating in a range of different modes - just as music may modulate through different keys - but united by a common theme or perspective, which is an awareness of social structures and processes as agents for help or hindrance.

It is my intention here initially to contrast these three different conceptions, and to explore briefly the contribution each conception has had to offer all those of us whose concern is to provide enabling environments for those for whom we care. I shall argue that the first two conceptions have had, and still have, their place and value, but it is the third which now offers the richest vein for new insights and new directions for the future. I will then go on to outline eight examples of establishments, projects, or approaches that, in my view, shed light on the phenomena of group process, bonding, community identity and personal growth.

But in order to do so, I must first pause, retrace a moment, and explain my use of the phrase “enabling environments”.

I choose the word “environment” to describe the wider frame, as it makes an obvious claim that the social context is relevant to good care, whilst avoiding the perhaps prematurely narrow claim that all such environments for care require a specific or an explicit “community” ethos. (It also allows the possibility that the material environment – architectural design, or the deliberate clustering of living units – may be an aspect of the model, although that is not a feature that we will be exploring in any depth in this paper.)

The extent to which any particular social and/or material environment may set out to foster a strong sense of community, and the nature of the community to be fostered, is then no longer a given, but can emerge as one of the variables to explore. Thus I would propose that we could regard the various therapeutic community models as particular examples, or as particular forms, of enabling environments:- those in which an explicit community dimension is an essential part of the model – for a reason.

In like vein, the concept of “enabling” avoids the assumptions and the self-imposed structures of either “therapeutic”, “teaching”, or even “learning”, as the core task of environments. Environments which wish to identify themselves with psychotherapy may well adopt then the term “TC”; but others may prefer other connotations. (In an ideal world, it would be the terminology or discourse of the intended service users, and not of the staff or the funding agency, which should determine the language adopted.)

The question I then wish to ask is whether in fact there is really something quite unique and different about the dynamics and the structures of those environments that we call therapeutic communities? Or do they have much more in common than might “meet the eye” with other establishments and other networks that have, as our common ground, the fact that they too have seriously attempted to re-examine and re-shape the social environment to suit their particular clientele and task?

THE MODEL

The concept of the “model TC” has of course much in common with David Clark’s concept of the “TC Proper”, which he contrasts with the “TC approach” – for less-than-fully realised TCs, constrained from “full” or proper development by limiting contexts[vi]. This paradigm is of course based squarely on the sociologist David Rappoport’s classic 1950s study[vii] of the Henderson hospital, incorporating the four key themes that he had then identified: - communalism, permissiveness, reality confrontation and democracy - and using, in practice, the same interlocking structure of community group, small psychotherapy group and work group.

So powerful is this “model” conception, that if some establishment comes close to this model, or scores high on these four themes, it is generally seen as a “real” TC, or “TC Proper”, *whatever its central task or clientele*. Sometimes it seems as if the original TC - the “Mach 1” - were like a new strain of cattle or of plant, discovered or developed in a particular place and time, but capable in principle of

being exported intact to any new location. Debate then centres on the purity of the line; whether or not hybrids and the products of local interbreeding are to be held as legitimate descendants, or as a degeneration of the pure thoroughbred stock.

This is one measure, certainly, of the TC model's apocalyptic dynamism. But this conception has its advantages and its drawbacks. The principal advantage is that by establishing one particular system as a blueprint of a successful TC, and by making it possible to refer to a tangible central example, it has served to give a focus both to the theoretical debates around good professional (psychiatric) practice, and to the more practical, political movement supporting budding TCs in various settings. After a time when the TC movement within the N.H.S. has been be on the defensive, and is only just now reviving, it is perhaps important not to water down such precision. Besides, in an age of evidence-based medicine, by what yardstick can we measure efficacy, if there are no simple defining parameters?

The model conception has, however, serious weaknesses, not least that it does not too well describe the range of services identified as TCs. A number of quite successful establishments, starting either from the model itself, or from first principles taken from the TCs inspiration, have subsequently developed in ways that quite contradict the model, whilst others that have attempted to import the model whole have found it wither and die on them, or even explode.

More careful examination also seems to suggest that the earliest blueprint for a model TC actually may not cater for all types of problem equally well. This requires us to question quite what it is about the model that suits certain people, and what variations would in fact be better suited for the needs of others - in order words, to abandon the concept of one model, and to reach back instead to the first principles underlying the approach.

I, therefore, would prefer to contrast the original, the classic or prototypical model "proper" TC, not with a concept of watered-down, less-than- proper TCs, but rather, with a concept of alternative, but equally legitimate, expressions of the same core thinking, applied – appropriately - in different contexts.

THE MORAL

A second candidate for the role of "essence" in the TC movement has been a set of principles which are essentially ethical. The TC, it has been said, stands for openness, egalitarianism, freedom and a respect for other's potential – and in particular, for the potential of patients to be something other than passive recipients of therapy, but to be active and knowing participants in their own programme.

Certainly this moral conception has some very powerful resonances. Traditionally in the TC's history it has seen itself as a movement - not a mere technique, but an approach with radical social and political implications, the successor perhaps to the great humanitarian mental health reforming movements, from the York Retreat to the Salpetriere.

One major drawback to this approach is that it has dated somewhat. These ideas were of course new, radical and powerful in the pre-war and post-war years; latterly they have become commonplace ideals in

some quarters of society - the keynote may remain the same, but the mood and meaning changes as the chords modulate around it.

Certainly the TC can reasonably claim to have spearheaded the movement towards user involvement and empowerment, which is now rapidly gaining ascendancy within mental health, as with many other client groups. But if the therapeutic community now offers the rest of the world a plea for listening to patients, and for open communications systems, it will find the world no longer quite so challenged. There must be something more to it than this.

I will not be the first to insist that the moral conception needs to show that it can also explain why, how and for whom the TC is actually effective[viii]. This is, of course, a gap that is obscured by the model and the moral concepts alike, both of which do assume that a particular practice will suit all circumstances, all types.

Nevertheless, where the model conception is ultimately misleading, the moral conception, essentially inspirational, is a necessary part of any approach, not just to a community setting, but to any kind of helping profession. We all need inspiration; it is necessary - but not sufficient. The problem with the moral conception is that it is too philosophical - it does not lead to immediate, practical guidelines. Any establishment wishing to embody this conception must derive its pragmatic base from elsewhere.

THE MODAL

If, then these first two approaches cannot take us much further, what other is there? As I have already implied, it involves a return to first principles - to the earliest and most abstract statements of the social psychiatric perspective - and an examination of how they have and can come to be applied in practice in different situations.

I contend that, if the TC movement is to develop, it must return to its stress, not on community groups and open discussion and self-governing structures, but on a recognition of the effect that social processes in any group will have, to enhance or impede the task of the establishment; and a freedom to challenge and change. Where an establishment dedicates itself to the fundamental re-thinking of the social milieu, to constantly bring out new possibilities of relationships fostered to match the needs and use the strengths of its particular group in its particular circumstances, whatever those unique strengths, needs or circumstances may be, there we have some kind of TC.

To then characterize the resulting forms that this approach may lead to, the term “modal” conveys hopefully the theme of recognising common patterns in variety – and, as a musical term, of harmonies resonating in disparate forms - which I wish to attempt here. For illustration of this approach and some of the interesting connections it may reveal, let us take a fresh look at some familiar models, and a look at some other examples of communities which could be identified as enabling environments. If this analysis of the essence of the TC seems helpful and valid, we might in future want identify such approaches as “modal therapeutic communities”.

PART THREE : VARIOUS COMMUNITY APPROACHES

THE HENDERSON HOSPITAL

The Henderson, as they say, needs no introduction. It has been internationally famous, recognised as one of, if not *the*, archetypal or model TCs. Largely for historical reasons, those who talk casually of "the therapeutic community" most frequently have in mind a version of the Henderson hospital. It was here that the concept that the community itself is therapeutic, with flattened hierarchies, the four key principles of democracy, communalism, permissiveness, reality confrontation, the interlocking group structures of the "model", was seen in its fullest expression.

The Henderson staff consistently avoided authority roles, and the perpetual authority conflicts so characteristic of "psychopaths" - or individuals with a personality disorder, as we would now term them - so that futile and repetitive/compulsive authority conflicts were turned aside; or turned back on the individual. Flattening of hierarchy here appeared as a deflating response to glib rebelliousness, and the easy collusions that rebellion can foster.

In this context the stress on permissiveness and communalism similarly meant an avoidance both of comforting rules and of the manipulable role conflicts that rules create, whilst fostering an expectation of active participation and responsibility upon a body of inveterate drop-outs, rebels etc.

Reality confrontation here meant a refusal to get too sucked in to an individual's inner emotional world, but a focus instead on the impact of an individual's actual behaviour on others. It also meant a constant vulnerability to exposure for those whose style is to keep up a front, constantly spinning to evade the consequences of their actions without, somehow, managing to inspire the allegiance of their fellows, outside of perhaps a small and temporarily collusive circle.

The complex structure of groups then helped to ensure that, even for the most vehemently alienated, there was likely to be some activity, somewhere, where the individual can, and does, actually get involved. Finally, within the self-policing, safely encompassing boundaries of a 24-hr community, group psychotherapy in a conventionally structured form was available to a group of people who would not normally be thought able to maintain such an exposure or commitment.

It was sometimes held that at the Henderson, transference was not to the therapist, but to the community itself. Perhaps so. But if so, this community was a complex, living, constantly shifting entity. It was not static and it was far from perfect. The community as an entity in its own right, as expressed by its daily "community meeting", was by turns inconsistent, contradictory, paradoxical, hypocritical, ambivalent, collusive etc. etc. and it was, thereby, susceptible to as many interpretations or projections as one could wish to put on it. This, indeed, was – as I see it - the real beauty of the place; it was the ideal object for a disrupted and vehemently ambivalent transference, in the psycho-analytic sense.

In the constant flux of the community's life a format had therefore evolved which seemed to allow their particular members - a largely young, highly selective group - the ideal arena for their particular patterns of behaviour to be displayed, contained, exposed to

comment. My point, in this brief description, is that this particular community structure and ethos was remarkably appropriate and tailored for the needs of a particular cross-section of "problem people" – those with a personality disorder - and it had, over time, come to specialise in treatment for just such people.

Yet much of this was unplanned, or rather, was the unintended consequence of other intentions - permissiveness and the democratic structure for example, were originally conceived not as avoiding facile and evasive authority conflicts for the manipulative, but as preventing dependence on authority for those heavily institutionalised by incarceration in war. And for further questions about the nature of environments that enable growth, it is to their latter-day counterparts, those heavily institutionalised in psychiatric care, that we must now turn.

DINGLETON HOSPITAL

Dingleton Hospital, at least at the time I was there, was, without doubt, a classic T.C. in its organisational structure. There was a multiplicity of groups for all staff, whose functions varied (indeed, glided effortlessly) from decision making to sensitivity training and back continuously, with, at the pinnacle, the quintessential T.C. structure of a daily meeting open to all, to share and re-assess problems and resources.

This was, I believe, a tremendous achievement, in a general psychiatric hospital; and it made possible two tremendous shifts. The first was the change from a progressive but otherwise conventional hospital to a T.C.; but it did not stop there. As the hospital freed up its decision-making structures into an open communications model, so decisions as to how to respond, on a day to day basis, to the crises thrown up by discharged patients, or the dilemmas over admission of new referrals, began to call for new ways of working[ix].

Bringing patients into – or back into - hospital environment in order to have their behaviour challenged by reality confrontations seemed somewhat perverse; it was the reality "out there" that was challenging – or in some cases, needed to be challenged. New models of family therapy were beginning to suggest that mental illness, embedded in family and social relations, should best be addressed by addressing the family and social relations themselves[x].

The second shift, therefore, was the switchover from a more inward-looking T.C.model, to a more outward-looking, resource centre model, a home base for a community psychiatry service. It was in fact precisely these open discussion channels that made it possible to ask what in fact was the most appropriate response to the catchment area hospital's task, and a move to this latter, more "community outside" based model; and simultaneously the daily meeting, opening up all traditional channels and structures made possible the drastic re-deployment of manpower required.

From this example, I think we can conclude that open discussion is a powerful thing - but it should perhaps not be too closely identified with providing the blueprint for a "model" therapeutic community.

THE TWEED ANNEXE

Meanwhile, as the main hospital's focus shifted from T.C. groupwork to "extra-mural" community psychiatry, some areas, and particularly the long stay and geriatric wards, became again backwaters, dominated by the pragmatic custodial and peace-keeping concerns of the nursing staff. The burnt-out and heavily institutionalised, those who had inwardly fled from the exposure and challenge of the full-blown T.C., sat on through group after group. The pace slowed.

There was, however during my time there, an experiment that interests me. Two young and largely untrained social therapists were given charge of a small work group of patients of Tweed, the long-stay ward, who began to meet regularly in work group time in an emptied corridor of broom cupboards and disused domestics' quarters, known as the Annexe. For convenience, they started taking their tea down there, and biscuits, which they kept down there; then taking their meals down there; and slowly, something unexpected happened. The group began to gel.

A small kitchen unit was installed, they began buying in some basic stocks, and soon, budgeting from a communal purse, and planning shopping lists for trips into town; the kitchen was done up and they planned the re-decoration of the former bedrooms, which had been cleared out; eventually all moved into their own private rooms. All within the protective canopy of the hospital building, these long stay patients gradually took on more and more self-management.

The programme, was, I stress, gradual and (at least ostensibly) practical, rather than confrontative and psychological. Here, within a hospital running on T.C. lines, was an area recognising and then developing a very effective use of social and milieu resources to respond to particular needs - drawing on the insights and philosophy of the T.C. milieu, but finding a very different approach in practice.

THE CASSEL

It was Dr Tom Main who first coined the term "therapeutic community" to describe the innovations in medical and ward organisation and thinking that had begun in the experimental war neurosis units at Northfield and Mill Hill[xi]. Upon his appointment as medical director of the Cassel, a hospital in which dynamic psychotherapy was already established as the primary treatment model, Main set out with the original therapeutic community precepts, but translated them in a unique way.

Main recognised that the day-to-day operation of the hospital must facilitate, not impede, the therapeutic goals and relationship, and that the orthodox hospital milieu distorted a patient's functioning perhaps just as much as their illness, until the two were impossible to disentangle. To avoid "anti-therapy", in particular the traps of invalidisation and institutional passivity, the hospital environment would need to be radically adapted, and patients would be encouraged to take an active part in managing their own daily lives.

Bu in contrast to the Henderson, this activity and interaction was not seen as particularly therapeutic in itself; the "community effect" helped alter outward behaviour, contained or avoided un-necessary

regression, but it was not decisive for fundamental change, which occurs only in psychotherapy. Daily experience may offer some supports, and some opportunities for improved social functioning to practice, but essentially, by throwing up the kinds of conflicts the patients typically meet and make for themselves in the world outside, it reveals material for psychotherapy.

In this context, the primary purpose of "opening the channels of communication" had become that of enabling the staff to share and understand their own feeling better, in order to recognise conflicts, splitting, collusions, projections and other manipulations. This better understanding helped in the daily management of disturbed patients, and in feeding in to that patient-doctor dialogue all possibly relevant information that might be useful for the better interpreting of the analysand, by the analyst[xii].

This "culture of enquiry" was maintained by very clear lines of communication and responsibility within the staff team. With the division of therapy and patient management retained and even accentuated, when the nursing staff moved away from their traditional roles, boundaries became for a time quite problematic; and it was found best to clarify roles more clearly. Staff roles at the Cassel had shifted, rather than blurred.

The hospital structure and operations might respond in group discussions to the day-to-day dealings of all involved, but the therapeutic relationship, which was seen as something separate, was immune to this flux. It thus offered a clear and ordered element of help, dovetailed into a form of normal living, in a way that outpatient analysis once a day or week cannot be.

I suggest that it may be this element of internal order within external flux that made the Cassel an appropriate and effective environment for the highly neurotic patient. This approach was thereby well suited to those patients whose emotional problems are indivisibly embedded and expressed in their family life, in particular, with children (who lived in the hospital with their parents).

Nevertheless, granted that, in this model, the essential therapy was taken to be, not the group analytic stance of Bion[xiii], Foulkes[xiv] et al, that underlies many other community approaches, but the more orthodox one-to-one psycho-therapeutic relationship, it can be seen from this description that the social structure of the hospital had still been carefully re-examined and radically adapted, in pursuit of personal growth, as it is defined here.

This development of the Cassel suggests that perhaps a very different community format may in fact be what is needed for the very neurotic personality. At least it is sometimes remarked that very neurotic patients in both traditional hospital and in "model" T.C. structured units often seem to be searching for just such a one-to-one relationship within the group structure.

In fully group-based community structures, such as the Model, this is then seen as pairing, manipulative, as something to be resisted. Yet the experience and structure of the Cassel suggests, by contrast, that for some patients at least, they may simply be seeking to create, in the wrong place, the kind of therapeutic community that they actually need.

Perhaps, in that case, even greater divergences from the traditional picture of a therapeutic community might be suited to other kinds of problem.

THE SYNANON MODEL COMMUNITIES

The Synanon Group were the self-proclaimed heretics within the T.C. movement. The Synanon approach had developed quite pragmatically as a treatment programme for the drug addicted in the United States. When later translated – as the Phoenix House group - to Europe, its exponents encountered and immediately recognised an affinity with TCs, and the four themes that Jones, Rappoport etc had seen as characteristic of the therapeutic community – democracy etc - but they insisted that they had, quite consciously and necessarily, inverted two of them, having, in their own words, replaced democracy and permissiveness with “hierarchism and control”.

The communities were run on a day-by-day basis through a chain of command with its senior residents at the top, using a strict discipline which more closely resembled the army than any hospital. Roles and responsibilities were clear-cut, mutual, demanding and fundamentally and rigidly hierarchical. New entrants started at the very bottom of the status ladder, and gained measures of status, discretion and responsibility (simultaneously) that came with the more senior roles, only when they were deemed by their seniors to be ready.

For any impropriety, any senior member could then be busted to the ranks - as indeed could any of the higher rankers (and impropriety could include for example, arrogance and abuse of power, or equally, any weakness in evasion of authority and responsibility). Members were required to inform on each other, or be jumped on for collusion.

The tasks of the “crews” were largely practical and behavioural, cooking, cleaning or administrative, and standards of work expected were meticulous - almost obsessionally so. “Reality”, in the sense of day-to-day domestic routine and practical tasks, was simply a back-drop to the interpersonal reality of discipline and reciprocal responsibility. Communalism here had come to mean an almost fanatical sense of responsibility to and for each other, and to the community as a whole.

These rigid and clear hierarchies were then, however, completely abandoned in a more or less daily communal encounter group session – “The Game”; here the members could let off steam and give vent to all the pent-up frustrations and rage that they carried, whether from the present, or from the long-distant past. Here, negative feeling were suddenly okay to express, and members might scream at their persecutory supervisors all the things that would have them instantly “carpeted” if even muttered outside the group.

In this way, the element of reality-confrontation in the Synanon/ Phoenix concept houses was dramatically polarised into behavioural confrontation in the hierarchical structure, and emotional exposure, in the accepting communalism of the group. This strange world was the complete opposite, on both counts, of the drug sub-culture from which the residents had come, with its constantly collusive, drug-focussed relationships, its erosion of personal or mutual responsibility in self-serving solipsism.

It is also a complete and total break insofar as, although the doors were not locked, new residents were allowed little or no contact with the world outside for their first months. All the social processes of the "total institution" as identified by Goffman[xv] were here deliberately used to strip off one identity and create a new one - this for a group who are notoriously vacillating in their professed wish to break the habit. (In the original houses, resident's heads were shorn on entry, to mark their new identity, and could be shorn again, as a mark of disapproval of inappropriate hair. Although shaven heads were a thing of the past by the 1970s, the process of stripping someone of their rank and privileges was still called "giving someone a haircut".)

It is my contention that this extraordinary social structure in some way responds to, corresponds to and meets the emotional needs of the drug-addicted; I suggest that there is a connection, somewhere in the themes of persecutory guilt, retribution and restitution, that links (and thus allows a transition between) self-destructive masochism, and self-abnegating discipline.

Just as Communism and Catholicism have some common features, so that one can frequently lead to the other, so there may be a kind of congruence between the all-embracing oblivion of hard drugs, and the all pervasive intrusion of the strict hierarchy. In more orthodox Freudian terminology, is there are an emotional "fit" between the all-consuming, demanding orality of addition, the equally demanding anal fixation on orderly cleanliness, and the demanding paternalism of authority? Is there a balance being struck here?

I could suggest, therefore, that this particular social climate may have evolved to "fit" the emotional valencies of addiction, whilst gradually shifting them towards a more healthy resolution.

Interestingly, this model had then been adopted within the "private sector" during the 1970s as a growth movement technique:- week-long residential "intensives" were offered during which the members were isolated in temporary enclosed communities, in which an almost identical structure is created.

For the sophisticated libertarians of the self-actualisation culture, it seems that clear roles, authority, and responsibility for each other were truly revolutionary. I have heard graduates of this experience describe it as immensely challenging, precisely because it so contradicts the norms and self-images of 1970's "me generation", culture. It was known to participants as "the therapeutic community method".

WODEHOUSE EAVES

But for my next example of an enabling environment, we must stray still further from the orthodoxy of the Rapport-model therapeutic community. Wodehouse Eaves was a hostel for adolescents under the wing of Social Services, situated in N. London. It catered for young adults of either sex over school-leaving age, who were thus facing, besides the multiple emotional turmoils of adolescence - leaving school, working, sexual development etc. - the purely legal but very real crisis of leaving council care at the age of 18.

The hostel took individuals, many – but by no means all – of whom had become institutionalised into a life in the social services residential care homes; others had come to care only later, as the result of family trauma or serious behaviour problems. The unit saw its task as being to imaginatively respond to the emotional demands of this disparate group, and particularly to prepare for independence by using, and if necessary even provoking, these very crises. The staff structure complemented and reflected this task.

Most of the residents, being in care, were deeply disillusioned with a string of social workers – but yet deeply dependent upon them - and the "house style" at Wodehouse Eaves became the conscious antithesis of social work, quite abrasive, deliberately unpredictable, demanding self-reliance rather than "good behaviour". To prepare their youngsters for the demands of survival in the tough outside social world, all rules at Wodehouse Eaves were applied or not entirely at the discretion of the responsible staff member on duty, the "AP" or "acting principal" – an entirely non-egalitarian role, that is nevertheless rotated throughout the whole staff group.

The authority of staff was impersonal, yet consciously autocratic, embodying the principle that life outside of care is "rule-lessness within the law". This delegated authority made possible an atmosphere in which considerable freedom could be given to individuals who were likely to abuse it, since the response could be fast, decisive and confrontative - usually in withdrawal of privileges.

There was no attempt to blur staff and client roles, nor to involve residents in the running of the home. The focus was not on participating in the home, but on moving on, to full independence outside. Wodehouse Eaves was about preparing for leaving, and a necessary part of leaving, of separation to independence, is making links and putting down roots that can then be safely left behind.

After a brief trial period, the new resident might be offered membership of what was seen as essentially a club, membership of which continued after residence ended, and after the age of 18, conferring essentially "a place to belong to", plus certain preferential access to the few material facilities the hostel offers. The non-resident members soon far out-numbered the residents, but were of equal status and importance to the life of the community. Although there was a very strong community ethos, the community that was created was deliberately <u>not</u> one based on residence.

The essential paradox here is that in order to create the right kind of community, it was necessary <u>not</u> to involve its members too much in the day-to-day running. A self-managing community of adolescents would be likely to develop and give preferred status to an "in group" of the most active and committed members - a centripetal dynamic that is in direct contradiction with the hostel's aims.

Further, a democratic community would deal with its troublemakers by group pressure, and ultimately expulsion (or, of course, with tough adolescents, violence and crude super ego victimisation). Since the staff held this responsibility and authority, and thus managed and carried the brunt of resentment and rebellion, the troubled and troublesome child was not, for social management's sake, cut off from the peer group acceptance from which his or her support, and eventually also social adjustment, comes. Despite often strong peer-group rejection, no member was ever expelled, though the autocratic

structure meant that temporary bans, suspensions, or other strict limits could be rapidly imposed – and equally rapidly withdrawn.

These young people, with varying backgrounds and lengths of time in care, whose families have typically either collapsed, or rejected them, sometimes many years before, could thus make what use they individually wished of the expertise, counsel or confrontation of the staff or the companionship of the residents - they did not need to be "eligible" - disturbed or "in need" - in order to still belong somewhere, but they could expect support, including short-term "crash padding" in case of real need. Wodehouse Eaves was careful to ensure that its stated task was the non-labelling one of independence training, so that "after care" consisted in still belonging, not still needing.

Within this unusual community structure, fairly "normal", traumatised but not fundamentally disturbed youngsters who merely needed the relative freedom and independence training of Wodehouse Eaves to grow up quickly with support, could do so – "treating the place like a hotel" was perfectly acceptable. But those more damaged individuals who, beneath the demand for independence, revealed by their behaviour a need for more intensive work on an emotional level, might bring this upon themselves, without any implication that to justify being there, they need to do so.

The hostel's more therapeutic aims were delicately and deliberately covert. Yet there was some serious psychodynamic thinking lurking – albeit heavily disguised – behind this stern "tough love" approach. The original Officer-in Charge came from a background in the planned environment therapy world, and referred, with conscious irony, to the need to be "a bad enough parent". Certainly the community that they set out to create could best be seen as a transitional space[xvi], creating containing safety, so that it could then be left behind[xvii].

THE COPE CRISIS CENTRE

Cope – the Community Organisation for Psychiatric Emergencies - was an organisation inspired by the anti-psychiatry thinking of the 1960's[xviii], working in the anarcho-bohemian ghetto of the Portobello area in W. London. Beginning in conversations in the foyer of the radical magazine IT's BIT "Underground Information Service", then developing into a volunteer-organised help-line offshoot, and then a drop-in centre in the basement, Cope as it gradually emerged espoused all the anti-authoritarian, anti-bourgeois, anti-structure stances of the local drop out community[xix].

What characterised the community that Cope became was a common fact of alienation - social, political, personal, often all three. What linked them were the T.C. ethics of permissiveness, communalism, egalitarianism, plus a conviction that orthodox bio-medical psychiatry was an intrinsic part of the institutional oppressive apparatus of the state, and a "frontline" for resistance[xx]. Some of the inner core of the COPE community had also been involved – whether as staff or as patients - in the Paddington Day Hospital, one of the TC experiments of the 1970s that did collapse.

The permissive chaos of this culture, without any funded task or any sovereign body to express the group's democratic ethic in the form of group decisions, replaced the reality-confrontation ingredient of

Rappoport's mixture with the radical non-interventionist ethic; giving "space" for the "freaked citizen" role, was a pervasive theme.

The Cope Crisis Centre, which grew from this grouping, was a rent-free short life house, in which lived a number of individuals heavily involved in the group, with spare rooms for "crisis people" - quite literally, space. Taking their inspiration form the unstructured community approach of R.D.Laing and his colleagues at Kingsley Hall[xxi], the role of the long-stay resident was emphatically not that of therapist or nurse; they were to be sympathetic "fellow searchers" - all were themselves involved in therapy, encounter[xxii], Gestalt[xxiii], Reichian body work[xxiv] or co-counselling (see below).

Short stay "crisis" people were not required or pressured to get into therapy themselves - though they might choose to follow the obvious examples - but there was nothing else offered, other than a culture that did not stigmatise emotional stress, doubt and confusion, but put a premium on "growth through openness to stress". Typically, short-stay people in fact stayed on, became the long-stay residents (like post grads), or moved out and settled nearby as "senior citizens", or they drifted off, or vanished, sometimes circling like comets.

There was a continuous turnover of faces; over two years, the household fragmented and re-stabilised as rapidly and readily as the psychic half lives of the individuals in it. Eventually came a time when the inhabitants were all women; the house proclaimed itself a feminist self-help commune, declared independence from the rest of the Cope and is lost to the annals of T.C. history. There were simply no rules to prevent it.

THE CO-COUNSELLING COMMUNITY

My final example takes the concept of an open-structured community in another direction entirely. Co-counselling, which is perhaps more a format than a technique, consists primarily of a contract between two people to meet and counsel with each other, usually on a regular basis. The essence of the relationship is that it is reciprocal; counsellor and client change places midway[xxv].

It is this deceptively simple formula which defines co-counselling; any actual techniques used are borrowed eclectically from other schools of psychotherapy. In practice, the style of counselling adopted within the co-counselling world was humanistic, being largely a blend of Rogerian positive regard with some Gestalt techniques. For most, an introduction to co-counselling would be via a short course, in which the format and some basic techniques were taught. There were also books for purchase, and any individual could go on seminars and workshops to learn more advanced techniques.

Through the essential reciprocity of the co-counselling format, any implication of superior knowledge, skill or theory of one partner, and thus any implication of treatment programme or patient role was entirely avoided. There was no prior assumption as to whether the root of any problem is individual or social, psychological or circumstantial. People simply had an emotionally supportive space in which to "talk things through".

This self-directing format allowed the partner playing "client" to slip easily from a basic assumption of personal failing to one of self-

actualisation, or of political struggle. Hence the technique was often popular amongst the “life-style politics” exponents of the New Left and of the feminist movement, since it allowed them to simply articulate, give vent to, and so perhaps transcend, the self contradictory and self-repressive ways of feeling and thinking in which the “normal” and “healthy” may find themselves, as readily as the “troubled”.

Although there are conferences and training events, the co-counselling “community” as such met only rarely, if at all; it consisted simply of a network of people, all of whom have some common training and experience of the techniques, and who were ready to co-counsel at times with each other - though most would have regular partners too. There was nothing untoward in having many partners – another feature that chimed with the world view of many on the New Left at that particular time.

The co-counselling community was arguably a community only in the sense that e.g.; the catholic community in England is; though it might not meet in a face-to-face sense, it was a significant form of self-identification that confirms an individual and personal world-view - in this case, a way of relating to personal problems. It also functioned as a reference point, and as a widening of options for partners, to ensure that the counselling relationship did not become submerged in the particular relationship between any two individuals, but remained a format which they each freely chose to adopt.

This is, I suggest, a model that many rehabilitation day centres might envy since (like the Wodehouse Eaves model) it neatly evades both the assumptions and requirements of need and pathology, and the centripetal tendencies of small group therapy. It is a form of self-help community that is well suited to adults without gross psychiatric disturbance (who are likely either to totally deny their problems or to feel them so great they could only be entrusted to specialist help and safe containment) but who, nevertheless, recognise a need for sporadic or regular support and counsel, on their own terms. It has perhaps a particular appeal and value to the “socially marginal” - those whose life crises are not safely accommodated within the conventional wisdom of their community.

The example of the co-counselling community takes us, I suggest, to the defining edge of the concept of “a community of therapy”; or, some might perhaps want to argue, it takes us over that edge. Certainly, beyond this, we have individuals meeting for counselling, with no evident community context at all.

PART FOUR : COMMON THREADS

What, then, do these very different communities have in common; and what can be learnt from the cross-cultural comparison? Only one conforms to the model conception of a TC (and that, only because it *is* the model), and several that claim the name of TC appear at least to depart markedly from the model - and even from the moral - conception.

It is certainly arguable as to whether the co-counselling community belongs within the family of therapeutic communities; the example is included here to highlight the issues, not to re-define the extent of

membership of the TCs club. And yet I would certainly want to argue that the Tweed Annexe, housed in a recognised TC but discovering a radically different approach to supporting its own clientele, was undoubtedly, if not a TC, then at least what I had earlier called an ”enabling environment” for its particular client group.

Nevertheless, it has to be acknowledged that the social processes inherent in a particular set of relationships have been, in each case, consciously harnessed to further the task of the group. It seems to me that each of these stories demonstrates the extent to which it is possible to construct or to rethink the social structure of group relationships, with a view to enhancing the potential for individual growth, and a sense of belonging, of being in their own place, for the individuals as a group.

This has, certainly, meant very different things to different groups and different tasks - as indeed it would. Within even this variety, however, certain common features, or modalities, do begin to emerge.

A: THE VARIETIES OF COMMUNITY ETHOS

Firstly, the four themes of the Rappoport's early study of the Henderson do seem to recur continuously as useful descriptive terms, even for the units which diverge dramatically from the model. Time and again we see the same underlying issues dominating community life and structure. Yet in some communities, we see one or more of the principles – though still central to the structure and ethos – adapted or even inverted, to reflect, it seems, the needs of the particular community clientele.

So, for example, communities may often be democratic (or more loosely egalitarian – that is to say, having no hierarchy of members but also no formal decision-making structure). But they may also be hierarchical, autocratic, or even divided in two-tiers with a negotiated, power-sharing relationship between groups. Democracy, in effect, is just one place on a spectrum of possible ways to manage decisions, with autocracy at one end, and anarchy at the other. Whatever the power and decision-making structure that is adopted, in an evolving community, it has to be the one which is actually experienced by members as legitimate to them, to create the right social climate to provide the interactions and experiences that any one group of people needs, to engage with, in order to develop and grow.

Similarly, on the axis of permissiveness, a community which aims to allow regression for the purpose of interpretation of behaviour might well be very permissive. But equally, that permission might lie in simply encouraging and enabling institutionalised individuals to live an ordinary life, where ordinary behaviour is acceptable; or it might lie in encouraging a challenging, even quite tempestous inter-relationship with other members, so that inner conflict may be made social, and explored openly, within the group. But a community that deals with the rehabilitation of very regressed individuals might need to be highly prescriptive and controlling; in each case, the community can develop a structure which will express and consolidate this ethos.

The dimension that Rappoport pinpoints at one extreme with the notion of reality confrontation, has at its opposite pole the notion of giving space, as in the Cope community, where an ethic of extreme tolerance and appreciation of all deviant behaviour as valid and

needing self expression also offers curious parallels with the old asylum model. (NB: the Arbours community households, another therapeutic community model with its roots in anti-psychiatry philosophy, also offers acceptance of all behaviour, but with attendant scrutiny from therapists; this community structure is analysed in another paper.)

The opportunity that domestic life presents to throw up, in the name of reality confrontation, interactions that provide material for therapeutic intervention is one that few communities forego. It is noticeable that many communities have done away with domestic staff, so that these tasks may be shared out and organised by the community members. At the Cassel, reality confrontation primarily took the form of re-establishing ordinary living tasks, replacing the institutional hospital regime, so that individuals are not spared the demands of daily life, and de-skilled into dependency.

At the Tweed annexe, by contrast, such low-key domestic reality is almost the cornerstone of therapy, being the practical framework around which the low-key accepting relationships between members becomes established. Making simple practical tasks do-able, and simple co-operative relationships safe, was the primary material and opportunity for re-building these internally chaotic individuals' social skills and self-respect.

But some go much further. Some communities seem to be deliberately fostering a conflict-ridden social structure, one that will exaggerate the world outside's demands, in order to examine how people then handle conflict. Even so, the confrontative end of the spectrum nevertheless comes in different styles, depending upon how it is moderated by other facets; at the Henderson, confrontation was focussed on the meaning of an individual's socially manipulative behaviour, and all confrontation, as with all behaviour and manipulation, calls for a group response; the purely behavioural confrontativeness of the Synanon model was dealt with in a strict hierarchy, sitting paradoxically alongside a highly accepting, permissive ethos for the encounter group.

Communalism, too, appears to operate as one principle on a spectrum that runs from one extreme – such as the Synanon models' almost totalitarian allegiance – through the highly participatory, such as the Henderson model, to the simple sharing of living space as at the Tweed, and the temporarily shared mutuality that links individuals in the Co-counselling community – within a broad identification with the project as a community.

As for the flattening of hierarchy and the blurring of roles between staff and between staff and users, there are again a variety of models and degrees, from strict hierarchy, through clear, though sometimes novel, staff/patient roles, to fully shared participation.

From this I would rather tentatively conclude that Rappoport's analysis of some, at least, of the essential issues and features of a community approach are confirmed - provided they are seen, not as fixed points, or as ideals to attain, but as variables on four axes, as dimensions, or as modalities of therapeutic living, reflecting the central issues which any community seems to have to settle for itself, in its own way. The Rappoport themes mark one particular community's configuration, on

a spectrum along which any one therapeutic task must be located, according to what is most appropriate to meet the needs of the group.

B: THE ROLE OF COMMUNITY ETHOS

The T.C. movement has shown that the tendency for any group to develop some kind of community dynamic must be anticipated and worked with, harnessed into a useful format, or there is the danger of it working against the task - as the patient and custodian cultures of the traditional mental hospital were shown to do, by so many studies in the 1950s[xxvi]. But it would appear that there are many ways in which this community dynamic can operate, and the deliberate fostering of a strong community ethos and a sense of belonging may not be the only way to bring people into consciously constructive social relationships.

In the formation of a community theme it may be sufficient to foster, not the immediate community of those meeting face-to-face and daily, but instead, as the example of the co-counselling community shows, a more notional community; or, as at Wodehouse Eaves, it may be more appropriate to create a community of those who still somehow belong, wherever they may actually be.

Similarly, the boundaries or boundaried-ness of any community - the "other-ness" of the world "outside" - reflect the intensity of the community spirit. Yet a great gulf between the intensive community and “the rest” may be appropriate for some, eg: the Synanon group, quite inappropriate for others, eg: the co-counselling community, and must be initially fostered in order to be later discarded and out-grown, as at Wodehouse Eaves or the Tweed Annexe.

Closely linked to the issues of boundaries is the question of where the inner core of membership, belonging and participation, is felt to lie. For some, only the large group, with its well-studied chaotic dynamics, is the real locus of the community, and of therapy; this seems to suit those for whom organisational structures are inherently problematic. For others, it is a one-to-one relationship, although in a community context of greater of lesser prominence. For others, it is simply a sense of belonging, at an emotionally managable scale. Most communities seem to offer a mixture of such relationships; some offer tiers of engagement. But the size or scale of what is seen as the core, pivotal therapeutic encounter seems to reflect the depth at which uncontainable chaos and conflict disable the individual’s life.

There is an intriguing link in the extent to which, and the ways in which, almost all these groups seem to cater for the development of some kind of therapeutic transference relationship somewhere in the social mix. The Henderson, for example, managed to create a structure in which the exposure of psychotherapy was tolerable, for those often thought unable to cope with such emotional demands, whilst working in such a way that the community itself became an object of transference; whilst the Synanon houses appeared to adopt a socio-therapy stance, eschewing psychotherapy and transference, yet created a community to which an almost fanatical allegiance and obeisance is demanded.

Meanwhile, the Cassel, dealing specifically with highly neurotic patients, had a clear staff structure, mirroring a clear traditional

analytic relationship; Wodehouse Eaves and the co-counselling communities were structured to interpret and deal with individual pathology and even transference, but did not assume that for their client group it necessarily must arise; and Tweed Annexe made no apparent attempt to use transference at all - nor to develop a community ethos as a major element.

The only examples where the community as transference object did not seem particularly relevant are those of the Tweed Annexe and the co-counselling community - which of all these groups, are in fact the ones where a pronounced community membership element appears the least relevant aspect of the therapeutic work.

In each community example, as well, there seem to be “culture carriers”, or leaders in and of the community; though how they are identified, and how they then lead, will vary from one community structure to another. In some, it is the staff; or particular staff, such as the medical director. In others, leadership from members is more encouraged, with the staff refusing the role: and in some, such as Tweed and COPE, leadership if any was very low key, as befits the nature of the growth process.

To be leaders, members must be still participants, still exposed to and living the process, whatever it may be. At the Henderson and the Synanon communities, leading members – the elected reps at the Henderson, those who have achieved authority and rank at the Synanon communities – had to be open to challenge. Staff at the Cassel were relatively protected from challenge by residents, but they were expected to be in therapy or psycho-dynamic supervision themselves:- participating, but separately. Culture carriers in the co-counselling community were still co-counselling themselves. Culture carriers at Wodehouse Eaves were the non-Resident Members, ex-residents choosing to return to visit, because it was where they wanted to be; and had the right to be.

C: <u>THE SIGNIFICANCE OF A COMMUNITY ETHOS</u>

Let us then assume that any self-identified network of people – any community of whatever degree – will have to come to some resolution of certain fundamental issues in social relations:- what is this community about? what is the primary tasks that binds? who is a member? who really belongs? is active participation to be valued and encouraged? who will do what? and in particular, who has a say in decisions? how necessary are rules? how strictly should they be enforced? and how will the community respond to whatever is seen as inappropriate behaviour? It is as if each viable community must somehow address these underlying issues for itself, even though it may locate itself anywhere on what is, in effect, a spectrum.

Where the primary task is therapy, the emotional locus where therapeutic engagement is most valued seems to depend on where the emotional disturbance is felt to lie, and where, therefore, the solution. For some communities and some therapies, growth is essentially personal, an inner process; for others it is essentially social, expressed and measured in relations with others. For some, the solution is exposure, confrontation and challenge; for others, it is self expression and facilitation; for most, it is some mixture of the two, but the balance varies.

A new avenue of exploration therefore now emerges, in comparing the social structures developed in various communities with the emotional needs, the personality structures of the particular clients around whom they have developed. For this, we can formulate a core hypothesis: that any community that manages to convene, and that is allowed to evolve to respond to the situations produced by a particular group of clients (and staff), will eventually come to reflect and express the emotional issues, patterns and conflicts, of that client group, in its social structure.

This, I suggest, will be true, whether the community in question's primary task is primarily economic – a farming or mining community – educational – a school or college – recreational – a holiday camp or pub – or therapeutic. In either case, a community that has survived and prospered will be one that has managed the emotional issues of belonging and relating that the task gives rise to. In most community settings, of course, that management consists in keeping the peace by reducing conflicts between members.

In therapy settings, we see a wide range of mental/personality disturbance, from highly neurotic, psychopathic, addiction-prone and psychotic patients, through to merely immature or turbulent adolescents, and emotionally healthy adults. In therapy – that is, in a problem-exploring culture rather than a problem-containing culture – these problems must be raised into consciousness and dealt with, and a wide range of community structures have evolved to manage these emotional in-puts and out-puts.

Hence each community specifically for therapy appears to set up, and often to exacerbate, by its very structure, particular personal or social conflicts; and then typically offers within the structure approved ways of dealing with these conflicts, whilst exposing to view other undesirable ways. Most commonly it is possible to see a connection between the issues typically aroused and the personality structures and flaws of particular groups.

It seems to me that from such cross-cultural observations of the ways that the needs of selected groups are mapped out in the social structures they develop, we might draw inferences not just as to the most appropriate environments for particular emotional needs, but also as to the underlying psycho-pathology and personality structure in particular groups.

It seems, then, that we should be asking ourselves a new and different question, relating to the effectiveness or otherwise of a community approach in therapy. Previously we have asked what it is about democracy etc that produces a therapeutic climate; and we bemoaned the constraints in practice that seem to thwart the realisation of a fully democratic, permissive, communal etc. regime.

Now perhaps, rather than asking ourselves how we may create a therapeutic community in such and such a situation, we should instead be asking what inner conflicts the individuals we typically deal with present with; and how they are manifest in the social relations – relations with staff and with peers – that we see in the communities that we have created. Then we can look to see if the conflicts in the community, and in its relationship to the staff[xxvii], are handled in such a way as to suppress or to enhance the individual's capacity to manage

those inner conflicts expressed outwardly, and to what extent the involvement of others is or can be made valuable.

In a paper of this length I cannot attempt to explore this theme much further; my intention was rather to suggest the kind of insights that may be stimulated from the comparison of different communities that could be seen as either as enabling environments, or indeed as therapeutic communities, if we can accept the wider definition of T.C.s that I have called the modal conception. Nevertheless, it is irresistibly tempting to look forward to future exploration of the ideas expressed here.

PART FIVE : INCONCLUSIVE CONCLUSION

Further avenues for investigation

Part One of this paper suggested that whilst it may be most helpful to compare a variety of therapeutic communities to gain from this a glimpse of an underlying theme, we may need to un-think first some restrictive notions of what constitutes a therapeutic community.

Part Two of this paper then consisted of a brief survey of a number of communities that have attempted to adapt their social structure in the light of the experience of participation that is felt to be appropriate to particular populations. In each case, a particular client group, a particular conception of therapy (or “growth”), and a particular approach to belonging interweave in the evolution of the modality of community that is then adopted.

Part Three then attempted to unravel some of this complex variability, and examine some broader issues that arise from the comparison. Some communities seem to be transforming, or translating, one kind of conflict into another, in an attempt to make the conflict expressible, but containable.

It could perhaps be instructive now to apply this analytical framework to some other kinds of communities where the peculiar stresses encountered might now perhaps be better understood by reference to their mechanisms and management of these underlying modalities, as described here. There are, for example, some attempted therapeutic community model services that then failed, and here it may be helpful to learn from the experience, and consider what in the nature or dynamics of their client group did not perhaps accord with, was not appropriate for, the model TC approach.

There are also many other establishments in which people with mental health problems may find themselves living, temporarily or for the longer term. Homeless persons hostels – both short- and long-stay units – group homes, “cluster” and “campus” housing such as warden-aided accommodation, all may find themselves addressing the problems of individuals with mental health needs, and are in need of some new thinking to help them identify how best to manage or respond to the lives and conflicts their residents bring with them.

But perhaps the most interesting avenue for further work would be to take this analysis into ordinary community settings. Since the 1950s, it has been increasingly argued[xxviii] that institutional living in any shape or form is inherently damaging; and there is a great conviction in many quarters that "an ordinary life" - ie: a life in ordinary or "normalised" housing - is the way forward.

Dingleton, Tweed, Wodehouse Eaves, COPE and the co-counselling community have all attempted, though in very different ways, to address the issue of making a community "beyond" the institutional community. As we move into a new era of home-based services, what scope may there yet be for a community ethos, to complement and counter-balance the individual, casework-centred focus of mainstream community mental health care? Perhaps some of the examples of reality confrontation and communalism described in this paper might throw up new insights into the nature of the "community in the community" that might now be appreciated, fostered and facilitated.

This paper, it seems, is barely the beginning.

Robin Johnson
Original research and analysis conducted 1972-8.
Analysis updated 1985 and 2006.

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