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Simon Clarke, Gary Winship, Jenelle Clarke and Nick Manning

Simon Clarke

Simon Clarke is a Health and Care Professions-registered clinical psychologist. He has lived experience of psychosis and using psychiatric services. He was part of Christ Church Deal (CCD) therapeutic community from 2000-2010, first as a member and then as part of the community leadership team. Simon gained his Doctorate in Clinical Psychology (DClinPsy) from the Salomons Centre for Applied Psychology at Canterbury Christ Church University in 2009. He is currently working as an Academic Tutor on the Trent DClinPsy training programme and Senior Lecturer in the School of Psychology at the University of Lincoln. He is completing his PhD at the School of Education, University of Nottingham in the subjectivity of madness and therapeutic community approaches to recovery.

Gary Winship

Gary Winship is a registered psychotherapist and Associate Professor in the School of Education, University of Nottingham, UK. He started working as a cleaner at the Bethlem Royal Hospital at 15. He was Treasurer of the Association of Therapeutic Communities (ATC) 2001–2007, and a full member of the Association of Psychoanalytic Psychotherapy in the NHS.

Jenelle Clarke

Jenelle Clarke is Research Fellow in the Business School at the University of Nottingham, UK. She was part of Christ Church Deal (CCD) therapeutic community from 2005-2011. She has

BAs in history and writing/literature and an MA in social research. Jenelle recently completed an ESRC funded PhD in the School of Sociology and Social Policy that explored how times outside of structured therapy in therapeutic communities contributed to the process of personal change.

Nick Manning

Nick Manning is currently Professor of Sociology at King's College London, and was the founding director of the Nottingham University Institute of Mental Health, 2007-2014. As a child, he spent 10 years in English Boarding Schools, where he learned about both the power and creativity of intense community living. He is currently working on research projects on mental health in Shanghai, on global mental health, and on the Japanese approaches to dementia.

Learning Outcomes

By the end of this chapter we hope that you will be able to:

1. Understand some of the core principles underlying Therapeutic Communities (TCs)
2. Identify the historic roots behind TCs in terms of providing an alternative therapeutic modality to conventional biological psychiatry, including the role of nurses in developing the core approach
3. Demonstrate an understanding of how TCs may support recovery from severe mental health difficulties through the personal account of a former TC member
4. Understand TCs in relation to recovery approaches in mental health
5. Appreciate TCs continuing relevance to the NHS, mental health nursing and current mental health services

Summary of key points:

- TCs are planned social environments that involve both staff and service users in the therapeutic process
- Despite considerable diversity across service setting, TCs share a common ethos and philosophy
- Core values and principles underlying TCs include: Attachment, Containment, Communication, Respect, Interdependence, Relationships, Participation, Process, Balance and Responsibility
- TCs in their current format emerged from post-Second World therapeutic experiments with traumatised war veterans at three hospitals across the UK, and then during the radical critique of psychiatry in the 1960s and 1970s
- TC principles became, to a lesser or greater extent, part of the fabric of organised healthcare, especially in terms of social psychiatric attempts to reform community mental healthcare

- Despite a relative decline in the latter decades of the Twentieth Century and first decade of the Twenty-First Century, TCs are still at the forefront of developing alternative psychiatric practices in mainstream healthcare

Introduction

This chapter provides an introduction to therapeutic communities (TCs). The chapter begins with a brief illustration of the core principles underlying TCs, before exploring the development of TCs in their historical context. The foundations of mental health nursing, through the work of Hildegard Peplau and Annie Altschul especially, are shown to be coterminous with the emergence of the TC method. The narrative is also interspersed with a service user's account of his experiences in a TC. With its emphasis from the start on social inclusion and user involvement, it is argued that TC methods continue to promise radically and politically informed mental health practice, compensating the anti-therapeutic tendencies inherent in modern psychiatry. This relationship is further highlighted in the chapter through a discussion of TCs version of 'recovery' compared to mainstream psychiatric care and by illustrating TCs' unique craft of caring.

What is a Therapeutic Community? Core Principles and Standards

TCs are planned social environments that utilise the whole community – both staff and service users – in the therapeutic process [1]. Although TCs were formed largely within hospital institutions, they have evolved into many different types of organisations in a variety of settings. TCs focus on a range of issues including personality disorders, eating disorders, alcoholism, gambling addiction, psychosis, drug addiction and a range of other personal and mental health related issues [2]. Despite the diversity of TCs across various sectors, they all share common ethos and philosophy [3]. Mechanisms and principles of TCs are rooted in a sociological/anthropological perspective beginning with Rapoport, whereby he identified four main principles: democratisation, permissiveness, reality confrontation and communalism [4]. Haigh most recently writes that participants of TCs should

experience ‘attachment, containment, communication, inclusion and agency’ within the environment of the community [5]. These qualities, refined by a consultation group in 2014, are defined as Attachment, Containment, Communication, Respect, Interdependence, Relationships, Participation, Process, Balance and Responsibility [2].

Attachment	Healthy attachment is a developmental requirement for all human beings, and should be seen as a basic human right.
Containment	A safe and supportive environment is required for an individual to develop, to grow, or to change.
Respect	People need to feel respected and valued by others to be healthy. Everybody is unique and nobody should be defined or described by their problems alone.
Communication	All behaviour has meaning and represents communication which deserves understanding.
Interdependence	Personal well-being arises from one's ability to develop relationships which recognise mutual need.
Relationships	Understanding how you relate to others and how others relate to you leads to better intimate, family, social and working relationships.
Participation	Ability to influence one's environment and relationships is necessary for personal well-being. Being involved in decision-making is required for shared participation, responsibility, and ownership.
Process	There is not always a right answer and it is often useful for individuals, groups and larger organisations to reflect rather than act immediately.
Balance	Positive and negative experiences are necessary for healthy development of individuals, groups and the community.
Responsibility	Each individual has responsibility to the group, and the group in turn has collective responsibility to all individuals in it.

Whilst the Core Values do emphasise the individual's role in the TC, they clearly outline that the process of personal change is a social, rather than individual, pursuit [6]. Both the community and the individual share a responsibility to one another in order for the TC to function as a therapeutic mechanism of transformation [2]. Interestingly, aside from 'attachment' and 'containment', the Values do not distinguish between social and psychodynamic processes. Rather, they are fused together, inseparable, and any one of these Values apply equally to both structured and unstructured forms of therapy in TCs.

REFLECTION POINT

How are the core principles of TCs similar/different to other social movements in mental health (e.g. Recovery)?

History of Therapeutic Communities

A new concept of cooperative psychiatric therapy, the third revolution as Rapoport eventually called it [4], emerged against the backdrop of deep social change during the Second World War [1]. Three UK psychiatric hospitals, Northfield in Birmingham, Mill Hill in London and the 312th Military Hospital in Stafford, were involved. These wartime experiments generated ideas of social participation. 'Talking therapy' and 'patient empowerment' came into sharp focus and formed the basis of social psychiatry, which remains a frame for community-based therapy today. At the time of these early experiments, however, psychiatry was mostly characterized by the use of drugs such as sodium amytol, used alongside deep insulin therapy, continuous narcosis and electroconvulsion therapy (ECT). Many soldier patients were unable to return to active service and those that returned to 'civvy street' had problems with unemployment and social disability. There was also a steady trickle of suicides.

As a result of taking drugs in my late teens, my mental health began to deteriorate. I began hallucinating and I became more isolated from my friends and family. One night my mind completely unravelled and the next morning I was hospitalised after setting fire to myself and slicing my arm with a knife. The next morning, I was taken to the psychiatric hospital by my parents and admitted as a voluntary inpatient. The experience of being an inpatient was deeply traumatic and humiliating. The unit was a chaotic and confusing place to be. Staff did not have much time (or inclination) to engage with patients on any human level. I made various attempts to run away and was eventually sectioned under the 1983 Mental Health Act. At various times during my inpatient stay I received medication (sometimes forced), seclusion and, finally, Electroconvulsive Therapy (ECT). At some point I made a decision to “play sane” even though I was still incessantly paranoid and anxious. I would eventually be discharged with a diagnosis of Paranoid Schizophrenia. I left the hospital under the supervision of a Community Mental Health Team (CMHT). At the age of 21, I had no qualifications to speak of; I was working as a kitchen porter in a local restaurant, still never having had an intimate relationship. I desperately wanted to go to university and make something of myself, but I could never seem to translate these aspirations into a plan of action. Also, as a result of my stay in hospital I had gained considerable weight (going from 12 to 16 stone in less than 3 months), which reinforced my low self-esteem and negative self-image.

A general sense of dissatisfaction with conventional biological treatments in psychiatry abounded, and there was the impetus to develop some of the new talking therapies expounded by Freud and his colleagues. At Northfield Army Hospital in Birmingham, Wilfred Bion, a psychiatrist and trainee psychoanalyst took charge of a rehabilitation ward of soldiers with his colleague John Rickman. Group meetings were established on a daily basis and there were discussions held in which the analysis of conflict ‘in the here and now’ was examined. Bion took to strolling around the ward having discussions with patients in the corridors and kitchen. This innovative approach brought about, at the very least, modest improvements and some reports have even suggested that the ward became the cleanest and most disciplined unit in the hospital. The Northfield experiment continued when Bion and Rickman were replaced by Michael Foulkes, a psychoanalyst, and it was his junior colleague Tom Main who coined the term ‘Therapeutic Community’ as a way of describing the method in which all elements of life in the hospital community could be seen as therapeutically intentioned [1,3,5-7].

Through a friend I made contact with a Therapeutic Community (TC) in Kent, eventually relocating to Kent to be part of the community. The community provided an accelerated form of 'living learning' in social relationships. The practice of living together in 'community houses', whereby a number of members would be rent a large property together in order to use the experience as a form of relational learning, was one example of this process. This form of 'communalism' was a core value of the community process. However, it was often in the daily life of community that such experiences were reinforced: meeting someone in the street and going for an impromptu coffee; going up the pub with a group of friends; the conversations over dinner with other members. It was through these more informal meetings that the therapeutic potential of the community was really distilled.

Coinciding with the experiments at Northfield, at another military hospital, this time the 312th in Staffordshire, a young newly qualified nurse called Hildegard Peplau began her work with soldier patients. Peplau had just graduated from Bennington College in the United States in 1943 with a BA in Interpersonal Psychology. At the 312th she began to put into practice what she had learned from her prior experiences at Chestnut Lodge, a hospital which at that time was well on its way to defining milieu therapy, gaining a considerable reputation as one of the most radical treatment environments yet seen in psychiatry. The psychoanalytic work of Harry Stack Sullivan, among others, had been particularly influential at Chestnut Lodge and had shaped Peplau's early expectations and capacities. At the 312th, the shell-shocked soldier patients under Peplau's care were both depressed and anxious. She took it on herself to implement formal and informal group therapy sessions with soldier casualties, facilitating discussions over breakfast and in other everyday social situations taking the opportunity to engage her patients in normalizing activities as part of a community programme. At the same time in London, Mill Hill was the site for evacuated patients and staff from the Maudsley. Here, a young medical psychiatrist called Maxwell Jones was experimenting with groups too. It is here that our other mental health nurse protagonist, Annie Altschul, enters the frame. Annie Altschul (personal communication) worked as nurse in the Mill Hill team and she was taken with the bristling of a 'democratic ethos' in the treatment milieu both at Mill Hill and then later at Dingleton, Scotland, where she worked with Jones in the 1970s. Altschul's early contact with the idea of democratic community therapy was interwoven with her training in Vienna in the 1920s, where she had attended lectures with Alfred Adler, finding his

ideas about socialism to be inspiring for her own political persuasions. Altschul later developed a renowned theory of nursing systems, theory that seemed to be well fitted to therapeutic community practice [1,8-11].

REFLECTION POINT

How do you think these formative experiences influenced the careers of Annie Altschul and Hildegard Peplau?

In ways not dissimilar to the cooperative efforts of therapy at Northfield and the 312th, Jones found mutual learning to be beneficial in the treatment of shell-shocked soldiers at Mill Hill. Jones's approach differed from Northfield and the 312th insofar as he was not, ostensibly, working psychoanalytically, although Jones was far from analytically illiterate having been under the guiding influence of Aubrey Lewis, his mentor and lead physician at the Maudsley. Certainly at Mill Hill, Jones seems to have made good use of Freud's concept of conversion hysteria when, during the treatment of one soldier who was suffering from paralysis of his arm, Jones noted that the patient described the death of his friend as 'like losing your right arm'. When the conscious connection between the loss and the paralysis was articulated there was subsequent progress made in the patient's condition [9].

The second crucial dynamic for me was the community's prioritising of emotions. I realised that much of my emotional life had become entirely mentalised, divorced from embodied, relational reality. Coming to a community in which the focus was on emotional expression forced a reversal in my habitual patterns of behaviour. Instead of avoiding and mistrusting my emotions, I was encouraged to allow them to surface and engage them through the process of cathartic release. This 'permissiveness' to experiment gave me both the freedom to express these emotions and the means by which my emotional distress could be contained within the relational structures of community living.

The Department of Health and Labour (DoHL) was satisfied by the outcome of the rehabilitation of the POWs and asked Jones to repeat the treatment with 100 homeless men suffering with concurrent mental infirmity. This formed the basis of the Belmont Social Rehabilitation unit in Sutton, which was established in 1947, later to become known as the Henderson Hospital. Belmont, and later Henderson, gradually deepened the use of democratic ideas, and the emphasis on these social democratic aspects of therapy culminated in a seminal book *Social psychiatry* published in 1952 by Jones and colleagues. Thus, the democratization and the urge towards egalitarianism emanated in its earliest articulated form from the Henderson during these years. The role of staff, such as Eileen Skellern, who went on to be an important figure in the mental health nursing profession, has often been underestimated and may have had far greater influence on the development of therapeutic democracy than is usually credited [9,12-14].

This community value of responsibility was reflected in the therapeutic community values of involvement, democratisation and empowerment. Thus, community members were expected to take an active role in serving in the various community functions, vote on issues such as electing the new leadership team, be available to new members if necessary and contribute to the day-to-day running of the community. As a community staffed entirely by volunteers, this ethos was the glue that held the community together in a web of mutual accountability. It was also the basis by which many of us acquired the valuable life skills of managing projects, organising events and learning to put other people's needs first.

Between 1962 and 1969 Maxwell Jones returned to work in the UK as chief superintendent at Dingleton Hospital in Scotland. By then TCs following the Mill Hill lineage rather than the more analytic TCs following the hierarchical approaches of Northfield (i.e. the Cassel Hospital, the Charles Hood Unit at the Maudsley) had forged a reputation synonymous with radical social psychiatry. The intersection between therapeutic communities and the urgency towards a more liberated psychiatry was easily blended; George McDonald Bell had established Dingleton Hospital as the first 'open door' hospital in 1948 followed shortly by TP Rees at Warlingham Park Hospital in the early 1950s. David Clark likewise opened all but two of the locked psychiatric wards at Fulbourn, describing this as an

‘experiment in freedom’, which naturally paved the way towards the concept of patient self-government [1,10,12,13,15].

The value of taking responsibility could have a dark side, in which people could be dismissed as “not taking responsibility” for themselves when they genuinely did not have the skills or capacity to do so. Sometimes people found it impossible to accept this value and quickly left the community. For me, it was the basis by which I began recovering agency and empowerment, a sense of myself as the seat of action. As a psychiatric patient, the loss of agency is common: you quickly become a passive recipient of the system, learning very quickly that “it’s not your fault – it’s your illness”. Of course, there were times when this explanation would be applicable. However, there were also times when I used my mental health problems as an excuse to avoid doing things that were difficult or challenging. Even though I had spent many years resisting it, the label became a core part of my identity. When I first told someone in CCD I was bi-polar, they shrugged and said, “aren’t we all mate?” Another member of the community remarked, “I’m not – I take responsibility for my mood swings”. This form of ‘reality confrontation’ may seem harsh to an outsider but it really helped challenge me to become more active in my recovery.

The concept of a ‘therapeutic community’ became synonymous with the idea of progressive psychiatry and between the late 1960s and mid-late 1970s. The challenge for the organized second generation of TCs was to maintain the radical edge of progress towards egalitarianism arising out of the creative chaos of a fermenting ideology while balancing the need for authoritative professional governance via standardization and statutory responsibilities. It appeared to be the challenge of applying a concept of a flattened hierarchy, as opposed to no hierarchy, where a vertical rather than horizontal system was preferred. Although during the 1970s TCs became peripherally associated with the counter-culture movement through the anti-psychiatry work of David Cooper and Ronnie Laing, who established Kingsley Hall as a therapeutic community and later the Arbour Crisis Centre, many of the cornerstone principles of TC practice were adopted by an ever-increasing number of psychiatric hospitals who saw *Social Psychiatry* as a progressive alternative psychiatric orthodoxy [1,3,5,10,12].

REFLECTION POINT:

What do you understand to be the key ingredients that linked therapeutic community practice with social psychiatry from the 1960s onwards?

The acceptance of the TC ideology in the very hierarchical establishment of the NHS seemed something of an anathema of its radical anti-establishment roots. Anti-psychiatry itself became a dominant culture and there was fresh impetus to close the old asylums and reintegrate the mentally ill in the community under an agenda of social inclusion. TCs, which had been a sturdy haven for the interface of psychoanalysis, sociology and psychiatry, had produced a set of treatment ideologies which became embedded, to greater or lesser degrees, in all psychiatric treatments. But this 'established' place for TCs in the network of NHS provision was found to be precariously tallied to winds of political whim; when the idea of social therapy came under fire from new advances in pharmacology and behaviourism, the social method of TCs went out of favour. During the 1980s, the closure of the old hospital asylums, where many TCs had been rooted, saw many renowned TCs close. This drift away towards the anti-social inclinations of behaviour therapy and new biological theories saw further threats to the social type of approaches expounded by the TC method [1,6,10,16-18].

Therapeutic Communities and the Recovery Movement

In recent years we have seen the emergence of a new approach to the principles of mental health under what has been called 'recovery' [19]. This approach seeks to diminish the role of the expert and proposes that education rather than therapy is central to the process of recovery [20]. However, this 'New Recovery' [21] approach - coined for the purpose of debate here - is a specific addition to other well-established traditions in recovery. For example, New Recovery can be compared and contrasted with the progress of the TC movement that, over the last 60 years, has also been committed to changing the role of expert, user-involvement and theoretical co-construction [22]. Of course TCs did not invent

recovery, but there is a good case to be made that TCs have evolved some exacting methods of socially inclusive co-operative therapy that are the vanguard of achievements in the progress towards efficacious humanitarian intervention in the field of mental health [23].

The history of progressive approaches in mental health care are not limited to TCs however. Recovery in the field of substance misuse dates back to the 1950s and has been the backbone of organisations such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA). There are a whole range of recovery programmes in the substance misuse and eating disorders field, such as concept houses in the UK, Twelve-Step or Minnesota Model rehabs, as well as a large network of correctional institutions in the US closely allied to milieu therapy and TCs [24].

Another new recent Recovery method is the Mutual Recovery programme [25] that has been funded to the tune of £1.5 million pounds by the Arts & Humanities Research Council (AHRC). Mutual Recovery, while owing some of its impetus to the New Recovery movement, is distinguished by the fact that the process of recovery is arts based rather than educative. The array of arts based interventions for the Mutual Recovery programme includes music, clay and creative writing, and the interventions are led by artists and practitioners but not therapists per se. In an off-shoot from the AHRC research there are some other innovative workshop based creative activities such as drumming, Capoeira, music and comedy workshops [25].

The fourth and final defining arena of recovery we can consider in terms of a more general model of psychosocial health recovery that covers an array of recovery facing therapies, which are established traditions in psychiatric and mental health services. For example, social rehabilitation, occupational therapies and psychological interventions that are geared towards general principles of health recovery informed literature from the allied field of social psychiatry, psychiatric rehabilitation [21]. Taken together, these domains of recovery can be represented as a quadrant (see figure 3 below) that graphically offers Meta-Recovery model or framework.

Figure 3: Meta-Recovery Quadrant

<p>NEW RECOVERY</p> <p>Organisation: NHS, Recovery Colleges, non-residential.</p> <p>Theoretical orientation: Education focused, Recent history</p> <p>Where: UK, NZ, Australia</p>	<p>TRADITIONAL ADDICTIONS RECOVERY</p> <p>Organisations: NHS, 3rd sector, private, AA, NA, TCs, Correctional Institutions, residential, non-residential, clinics, day programmes.</p> <p>Theoretical orientation: 12-Step, Milieu Therapy, Minnesota Model, Concept House approach</p> <p>Where: Global</p>
<p>MUTAL RECOVERY</p> <p>Organisations: AHRC Funded Research, 3rd sector, independent, non-residential, arts centres, libraries.</p> <p>Theoretical orientation: Arts focused</p> <p>Workshop based, led by artists, TC informed</p> <p>Where: UK, USA, China</p>	<p>PSYCHIATRIC RECOVERY</p> <p>Organisations: NHS, private, residential, day hospitals, day programmes.</p> <p>Theoretical orientation: Psychiatric rehabilitation, prisons, TCs (principles & proper), social psychiatry, anti-psychiatry, PIPEs, enabling environments</p> <p>Where: Global</p>

In the New Recovery movement the concept of self-help and self-organisation replaces the role of professionals [20]. The TC approach, on the other hand, while being committed to co-operative efforts that seek to engage with the concept hierarchy in order to diminish it, can be seen as rooted in approaches inclined to collectivist ideologies [23]. While the recovery approach has been strong on the rhetoric of service user-involvement, TCs have developed the means to put principles into action in the deployment of formal democratic structures and quality and quality checks, including service audit and review [22].

Perhaps the most significant difference between the New Recovery approach and the way in which TCs operate might be considered in terms of what we might think of as ‘soft’ versus

‘tough’ recovery. New Recovery begins with a pre-supposition of client co-operation [20]. Whilst TCs and New Recovery entirely agree that peer support is essential in building resilience in recovery, TCs begin with the notion that social inclusion is not a given. Social isolation lies at the root of many mental health problems and there are any number of steps which precede a client being able to be engaged with peers. TCs are therefore particularly able to help clients work through resistance and engage with conflict in a way that seems remote in the approach of New Recovery.

REFLECTION POINT:

What are the similarities and differences with TCs compared to other approaches in modern mental healthcare in the UK?

Therapeutic Process in Therapeutic Communities

This willingness and capacity to engage in the dynamics of conflict would be characteristics of a ‘tough recovery’ particular to TCs. TCs can sometimes get the reputation of being harsh and challenging places to be and clients can initially find the experience hard and unsettling. Here is a brief illustrative extract from some field study notes drawn from in-depth observations of therapeutic community processes [25]. In this brief extract from Clarke’s research [26], the client Anna, who is new to the TC where she is residing, is talking about an experience of being in a community group where another client has been distressed:

“And then we sit in a meeting and we’re asking her all these questions and like, I don’t know, I kind of wanted to say just leave her the fuck alone, she can’t think straight. Like what you doing? You’re asking people these really important questions when they’re clearly not in a place where they can answer it. And I don’t know, there’s something really about it, struck me as quite cruel in a way. Um, but within 10 minutes, she was sat in the bay of the

window with her headphones on, still upset but contained and able to be safe. And I just thought, God, this is really weird. Because all through the meeting I was just thinking, what the hell? And then you're like oh, I don't really get it but it does seem to work somehow. Um, and that was really strange... I really connected with [her] um right from the off. And I think it was that sense of nobody can help me. I think that's what I got from her, the fact that...she couldn't imagine there would be anyway that anybody could ever help..."

Perhaps Anna, in the vignette above, might have initially felt that the approach of the staff and fellow was rather haranguing the distressed client. However, within a short period of time Anna has witnessed that compassion can come in many forms and sometimes people may need a different approach at different times. In this case for example, compassion has been tough rather than tender, but appears to afford benefits to clients that may not have been possible through other forms of care.

The reputation of TCs being rather tough places might point to one of the distinctive therapeutic imperatives of TC recovery approaches which is the idea of 'reality confrontation', a phrase coined by Rappaport [4] based on his observation of work at the later Henderson. In the early 1980s places like Phoenix House and Alpha House, Promis in Canterbury, and several other TC minded services for addiction and eating disorder recovery, set up by Griffith Edwards in the 1960s along the lines of the DayTop Recovery Milieu therapy model in the USA, very much had the reputation of being tough places [24]. 'Tough Love' was a catch phrase for recovery TCs and milieus. Some of the approaches would seem out of place today such as 'Mirror Therapy', which involved a client sitting in front of a mirror for several hours taking a good look at themselves, or marathon large groups, for example spending between 8 and twenty-four hours in the same room. Many clients would, when faced with the choice of going to a TC or going prison, would chose the latter.

Reality confrontation has never been a soft option. Today, the quintessential elements of TCs [5] such as containment and agency are the preferred descriptors for TC practice.

However, the idea of reality confrontation in TCs has never been entirely dispatched. Reality confrontation is an interesting notion of course, and one that could be rather more unpicked. The clue is in the word ‘confrontation’. One might also trace this harder edge back to the roots of TC in the Army experiments at Mill Hill, Northfield and Staffordshire, where discipline and boundaries were extant [7]. And then there was something of the 1960s encounter group culture where emotional confrontation was the order of the day [6].

REFLECTION POINT:

What do you think of reality confrontation as a therapeutic technique and how does it compare with other psychotherapeutic approaches?

Therapeutic Communities and The Craft of Caring

Reality confrontation as a therapeutic endeavour suggests that somehow, the client a client needs reality. It might seem like a pejorative notion and the public image of TCs as a ‘tough recovery choice’ has perhaps not played out well over time, and perhaps there could be some clearer articulation of the way in reality confrontation is a staged process. However, New Recovery and TCs would seem to overlap on a shared interest in ensuring that engaging in the real world is an outcome of recovery. Whilst New Recovery is ambitious about client’s developing an aptitude for work and civic membership, TCs are equally ambitious about developing the client’s ability to consider how their attitudes and behaviour impact upon other people [21].

TCs have therefore pioneered a version of the craft of caring that is somewhat unique in comparison to other psychiatric healthcare approaches [21]. However, this ‘tough love’ approach is also counterbalanced by innovate strategies to engage all clients in the process of caring for one another that go beyond merely ‘telling it how it is’. This next excerpt from Clarke’s [26] research illustrates this process more clearly in terms how reality confrontation and intrinsic care can work together in terms of confronting suicidality in clients:

Last night's Crisis Text was from Abby who is slumped very low in her chair, her head just poking up. Her fringe nearly covers her eyes and when they don't, her hand does. Abby says she was feeling very low over the weekend and is tired of her thoughts as they are "not budging". She continues to work on them but feels they are not getting better. She wanted to overdose over the weekend but only had antibiotics on her, "which would just make me throw up again" (so not worth it?). However she did not self-harm, even though she really wanted to, and she says the texts she got from the clients were very helpful - especially Brian's. Brian had told her that she would be letting not only herself down but others too if she self-harmed, meaning that he and the others would be disappointed if she did. Abby said this was a helpful reminder and she worries about when she goes and knows that no one will tell her that she'll be "letting' people down".

As this scene shows, another client member confronts Abby with the consequences of her actions to other people: that other members in the community cared her for and her self-harm affects the whole group. Yet this idea was brought home to Abby in a way that was both confrontational *and* caring. While TCs might have a reputation for reality as a confrontation, it should also be stressed that reality for clients in TC recovery is not always an immediate big dose of reality, rather it is more usual that reality is staggered. The model of reality confrontation in TCs is more like Winnicott's idea that good enough maturational environments are characterised by reality in small doses [26]. In TCs new clients have much less responsibility than the more senior members who have been in treatment longer.

Despite their reputation for toughness and sometimes-brutal honesty therefore, TCs have also pioneered the use of peer support in often novel and creative ways. The participation of all community members in every aspect of the therapeutic programme is not just an afterthought or optional add-on, either in terms of cost-benefit (as we may find in some aspects of New Recovery) or as a top-down imperative of 'patient involvement' (such as is often found in the NHS). Rather, client members learning to care for each other is an

intrinsic part of the TC model from Ghent, The Retreat York and the post-war Northfield Park experiments. As this final excerpt from Clarke's research shows [26], this process can mean clients become especially attuned to one another's needs:

It is nearly 9pm and I join some of the clients in the lounge. Julie, who is sitting with Anna on the sofa, is sobbing. Julie is explaining that she wants to leave the unit but her mum will not come get her. Erica is colouring but clearly listening to the conversation. I feel strange just staring so I whip out a magazine, open it and alternate between looking down at it and watching Julie and Anna. Julie says that the only time her mum really seemed "bothered" about her is when she jumped off the roof. For the first time I am very concerned. Will Julie try something drastic to prove to her mother that she should be worried about her? Erica asks Julie about her urges and Julie says she does not feel safe and that is why she is in the lounge. Margaret (nurse) then comes in and joins the conversation. Talk revolves around Julie's eating disorder. Anna at times pats Julie's leg, and tells her she will get to the point where she can picture life without the disorder. She reminds Julie that the eating disorder is not her friend and does not help or protect her - it will kill her. Julie is crying and loudly sniffing. After a while the conversation moves on but every now and again someone will either gently pat Julie's shoulder or quickly check in with her.

REFLECTION POINT:

How do you think reality confrontation and care are balanced in the TC approach? How does it compare with peer support initiatives?

The history of TC and milieu therapy movements usually features accounts of the key male psychiatrist figure heads, such as Harry Stack Sullivan, Dexter Bullard, Maxwell Jones, Michael Foulkes, Wilfred Bion, Tom Main and Ronnie Laing, among others. Suffice it to say, reports specific to nursing practice in the history of the therapeutic community tradition have been limited to a handful of accounts. In reappraising the history of TCs we can glimpse the influence of some of the most eminent founders of mental health nursing with TC evolution. Mental health nursing and TC practice emerge concurrently with the progressive traditions of user involvement and social psychiatry. So what place is there for TC practice today?

Although the recent era of modernised healthcare has resulted in the closure of some of the pioneering early communities [17], TCs continue to thrive in a number of service settings including: mental health in the NHS, independent/voluntary communities, prisons, children's homes and day centres, learning disabled communities, and faith communities [28]. Personality disorder (PD) remains a challenging condition for most mainstream psychiatric services yet TCs have emerged as a particularly well-adapted treatment modality for the difficulties encountered in this client group [29]. The evidence for TCs in PD are generally positive [30], albeit limited [31], although the first major randomized clinical trial for TCs in PD is currently underway [32].

We know at present that acute psychiatric inpatient units are particularly difficult environments, which stretch the resources of even the most capable individuals. The *Audit of violence* [33] drew attention to the wide array of problems encountered by staff including the unsafe atmosphere of acute wards compounded by inadequate staffing with high vacancies and inexperienced leadership. The report characterized treatments as coercive and chronic staff demoralization with 78 per cent of nurses, 41 per cent of clinical staff and 36 per cent of service users reporting that they had been personally attacked, threatened or made to feel unsafe [33]. *Acute Care* [34] also noted high levels of boredom and inactivity reported among patients. In the aftermath of the Bennett Inquiry [35], and more recently the problems identified in the Francis Report on Stafford Hospital [36], it is timely to review some of the theoretical underpinnings of ward management by mental health nurses.

Over time, I became an established and senior member of the community. In many ways, responsibility is learned through a process of helping other people. This 'living learning' approach provided me with many of the skills that I had lost through my recurrent bouts of mental distress. Through involvement with the community's various programmes, I began to learn how to support others in their therapeutic journeys. I eventually decided to retrain as a mental health professional and qualified as a clinical psychologist in 2009. I now work as a practitioner in a multidisciplinary team in the NHS.

There is some emerging evidence that TC group-based therapy, emerging from the traditions of TC and user involvement, is effective in producing a safe milieu [18]. There is also some persuasive evidence, albeit limited, that democratic administration and collective rule-setting in the milieu might have a positive impact on reducing levels of aggression, violence, seclusion and staff sickness and increasing staff morale [37]. It is perhaps through principles of TC practice that the transformative potential of mental health nursing practice might counter anti-therapeutic milieus [16]. A revitalized agenda for psychosocial mental health nursing might also produce more active service user engagement, a renewed focus on compassionate but reflective healthcare delivery and an increased emphasis on recovery and relational self-determination. All these aspirations are familiar givens in TC practice.

REFLECTION POINT

What role do you think there is for therapeutic community philosophy and practice in the future?

Suggested Reading

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Haigh, R., *The quintessence of a therapeutic community*, in *Therapeutic Communities: Past, Present and Future*, P. Campling and R. Haigh, Editors. 1999, Jessica Kingsley: London. p. 246–257.

Manning, N., *The Therapeutic Community Movement: Charisma and Routinization*. 1989, London: Routledge.

Royal College of Psychiatrists, *Service Standards for Therapeutic Communities 8th Edition*. 2014, Royal College of Psychiatrists: London.

Useful Websites

The Community of Communities Project at the Royal College of Psychiatrists is the quality improvement and accreditation programmes for TCs:

<http://www.rcpsych.ac.uk/workinpsychiatry/qualityimprovement/qualityandaccreditation/therapeuticcommunities/communityofcommunities.aspx>

The Consortium for Therapeutic Communities (TCTC) is the organisation that represents TCs across the UK:

<http://www.therapeuticcommunities.org>

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