

ARTICLE

**Therapeutic Communities and
Mental Health System Reform**

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Topic: The contemporary relevance of therapeutic communities as a treatment modality in mental health is described. *Methods:* This paper builds upon on a qualitative study to provide a case illustration of a working therapeutic community for persons with serious mental illness. *Sources Used:* The data are seventeen interviews conducted with staff and residents and observations carried out during four days of field work by the research team. *Conclusions:* Studies are needed to determine whether therapeutic communities strengthen consumer capacity for social integration and thus contribute to empowerment and the larger recovery agenda.

Keywords: therapeutic communities, mental health system reform, community integration, recovery

Introduction

With more attention being focused on the quality of care provided to people with serious mental illness, different visions of quality are emerging. In recent years, consumers of mental health services and members of their families have increasingly made their voices heard (Corrigan & Phalen, 2004). Consumers have fought hard to replace the notion of serious mental illness as a chronic disability with language that is more in keeping with the experience of recovery, arguing that leading a full life that includes civic and social involvement in community is possible (Deegan, 2003). We propose that, as one specific path to this goal, the therapeutic community model be incorporated into residential programs and evaluated as to its use-

fulness in building a recovery-oriented system. This report makes explicit the themes of therapeutic communities that are consistent with a recovery-orientation and, more specifically, lead to social integration. We then illustrate their application in a case example.

Therapeutic Communities

Contemporary therapeutic communities evolved from the work of two English psychiatrists, Wilfred Bion and John Rickman, during World War II. Bion and Rickman were asked by the British government to set up a specialized unit within a mental hospital for the rehabilitation of psychologically traumatized soldiers. Their charge was to return the soldiers to the front lines as rapidly as possible. To accomplish

this, they set up a special inpatient service where rehabilitation took the form of engaging the soldiers in “soldierly activities,” for example, map reading, physical training and grenade practice (Bion & Rickman, 1943). In addition to these activities, Bion and Rickman held daily group discussions on the difficulties of the “here and now,” a term they coined to focus attention on the communal living situation. These group discussions, which were offered in place of conventional psychotherapy, were a form of behavioral feedback in the service of personal accountability. Accountability was seen as improving the cohesion of the group.

The lessons learned by Bion and Rickman about the therapeutic effects of communal living led to the establishment of therapeutic communities in post-war Britain for civilians with mental illnesses. One of these communities became the subject of an anthropological study by Robert Rapoport (1960). The title of Rapoport’s seminal book-length report on his research—*Community as Doctor*—sums up the fundamental premise of contemporary therapeutic communities: living in a community is healing. Based on his observations, Rapoport articulated five themes that characterized the structural organization of the English therapeutic community he studied and the culture it produced. He reported that these themes appeared to have no hierarchy and had “elastic boundaries” that were “flexible enough to provide rationales for various courses of action.” (p. 54) They have become the conceptual scaffolding for therapeutic communities today. The themes are summarized below.

Democratization. The theme of democratization refers to the sharing of power among members of a therapeutic community. Rigid hierarchical dis-

tinctions between staff and consumers are reduced through sharing living space, eating meals together, and jointly carrying out work projects. Everyone shares in community decision-making. At the individual level, consumers are presumed to be competent to set their own personal goals and to share in treatment decisions that will help them reach those goals.

Acceptance. Acceptance¹ refers to an emphasis on tolerating behaviors that may fall outside social norms, while at the same time managing the anxiety such behaviors may engender in others. Managing both acceptance of individual behavior and community anxiety about safety is accomplished through limit-setting. At least as important to the growth of the community are the rules members themselves make to support individual freedom within the community culture.

Communalism. In a culture that honors both the acceptance of individuals and limit-setting, communalism can take root. Communalism denotes the expectation that all members will work to ensure the community’s welfare. The sharing of everyday work experiences and events, or “living-learning,” yields situations that offer opportunities for personal growth. Work on behalf of the community also means contributing to the healing environment through creative contributions, and through mutual emotional and instrumental support. When all members share the goal of learning from experience, accountability is a primary therapeutic agent (Kennard, 1998). As members heal, expectations of contribution to the community increase.

Reality Confrontation. Reality confrontation is the theme closest to the theoretical center of community life. Bion and Rickman observed that communal living engenders experiential learning that in turn, leads to individ-

ual healing and change. In the “insistent intimacy” (DeLeon, 2000) of living and working together, community members are expected to be aware of and comment constructively on their own behavior and that of others. In so doing, they hold themselves and others accountable for the health of the community.

Reciprocal Relationships. Reciprocal relationships represent the community in action. Whether intimate or casual, reciprocal relationships are characterized by the respect and dignity accorded to each party. Rapoport (1960) described the ebb and flow of community life as predictable, not unlike the outside world (thus testifying to the rehabilitative value of communal life). He argued that the experience of resolving difficulties when they arise strengthens personal relationships and community bonds, providing individuals with experiences from which valuable social learning about relationships can take place.

Sources Used

The case to follow draws upon data collected during ethnographic visits to a therapeutic community that served as one data collection site for a study of social integration (Ware et al. 2007; Ware et al. 2008). The data are seventeen interviews conducted with staff and residents and observations carried out during four days of field work by the research team. These interviews, designed for a different purpose, presented an opportunity to illustrate the principles of therapeutic communities from one that is in operation. The interview excerpts give living examples of the concepts first put forth by Rapoport in 1960. The study was approved by the Committee on Human Studies at Harvard Medical School and by the Institutional Review Board at the Nathan S. Kline Institute for Psychiatric Research. Informed consent

was obtained from all study participants using an approved consent form. Participants received \$20 in return for their time and effort.

Illustrative Case: Spring Lake Ranch

Spring Lake Ranch, a working farm, is at any one time home to approximately thirty staff and thirty residents who live and work together. Typically, a resident arrives at the Ranch following a psychiatric inpatient stay. Each new arrival is assigned to housing shared with several other residents and a house advisor. New arrivals are expected to join any one of the several work crews. Work crews are made up of 5 or 6 residents and a crew leader, who may be a former resident or a house advisor. House advisors are young adults committed to living and working together with residents. House advisors typically leave after a year or two of employment; the core administrative and supervisory structure is provided by long-term senior staff. Senior staff are hired for their expertise in farming, gardening, cooking for large groups, maintaining buildings and grounds, carpentry, bookkeeping or administrative skills. Neither house advisors nor senior staff are clinically trained. Except for a nurse who oversees medication, professional medical and mental health services are accessed when needed in a nearby town.

Work crews are charged with carrying out the tasks needed to sustain the community—the theme of “communalism” in action. They cultivate gardens, make hay, care for farm animals, produce maple syrup, and sell Ranch-made products at the local farmer’s market. Consumer residents rotate through crews of their choosing each week. Everyone in the community, staff and residents alike, is expected to make a significant contribution. At the Ranch, work is the enactment of com-

munalism. It not only builds community, but also leads to personal growth. One resident explained:

For me, work builds up sort of an emotional bank account, kind of a confidence bank account. When I am working—doing something other than just doing nothing—that goes a long way in giving me sustenance in my life.

Staff report an emphasis on helping residents to understand that reciprocal relationships are based on trust and mutual regard. The development of these relationships cannot be one-sided; thus staff and residents are urged not to ignore uncomfortable situations when, inevitably, they arise. Reality confrontation—constructive feedback on the behavior of others—is used to enhance experiential learning.

The theme of acceptance is realized at the Ranch through decisions to maintain tolerance of a wide range of behaviors. Efforts are made to balance respect for self-determination with the need to keep community members safe. A recent example involves the setting of Ranch policy on illegal drugs. To protect the community from the presence of illegal drugs on the property while not infringing unduly upon individual privacy, members struggled with the question of whether to establish a stricter policy on personal searches or invest more heavily in trust. One staff member, leaning toward “trust,” characterized the dilemma this way:

We’re due to have a discussion next week [in community meeting]...and the discussion has to do with searches, with searching resident bags and rooms. I know it can sound irresponsible to think that we should cultivate relationships with people so that we can have trusting conversations with them, and that trusting conversation is going to get them to either not bring their dope or [to] hand it over. I still believe that what’s important [is] to really work

at having a relationship with people so that we can really talk about what we have to.

Democratic governance (democratization) is practiced at Spring Lake Ranch not as an ideal political model, but as a means of realizing community as mutual benefit. At Ranch meetings, each member of the community has one vote. A former Ranch Director has observed that at community meetings...

frequently, opinions are divided along other than staff/resident lines. For example, there may be conflict between men and women, old and young, conservative and liberal, all of which help lessen the often destructive dichotomy between staff and residents and when dealt with creatively, can help draw the community together. (Wells & Hussey, 1988).

Reducing the “destructive dichotomy between staff and residents” goes beyond voting in meetings. Working together also breaks down distinctions. The extent to which shared tasks can build a sense of commonality and connectedness for residents is aptly illustrated in the following comment by a study interviewee, who said:

When you get out there and start chopping wood, or making maple syrup with Sam and Ed, it’s like hanging out with the guys, you know, you’re working, you’re hanging out, you’re having a good time, and you’re just like everybody else.

The “Sam” referred to is the Ranch Director, but the speaker does not feel the need to identify roles in this report. His experience is “hanging out with the guys,” and feeling “just like everybody else.” This example illustrates how reciprocal relationships are embedded in the culture of communal daily activities, present in every encounter. As a quotidian reality, relationships are seldom ideal and often frustrating. However, it is the effort to acquire and maintain reciprocal rela-

tionships that builds competence.

In addition to creating experiences of connectedness, collaborating on work tasks also produces substantial practical benefits. The following interview excerpt from a work crew leader provides an example of how staff and residents succeeded collectively in solving a “transport” problem:

I thought that I could get a truck and put this portable thing in it, to carry chickens. We put the portable thing in it, and it was too big. It wouldn't fit into the truck. And I was like, “I don't know what to do now. I don't know how to transport these chickens.” And I had three people on my crew, and one of them said, “We could turn it upside down, and put a top on it.” And I was like, “Wow, we could do that!” Somebody else said, “We could get a different truck.” And I was like, “We could do that.” And somebody else said, “We could get those turkey top things that we use to transport the turkeys.” And I was like, “These are great! These are all great! These are so much better than my original plan, and so much nicer that we didn't have to stand here for 20 minutes while I tried to think of some new solution.” Ultimately, we used one of their solutions.

In sum, the goal of the Ranch is to move residents toward recovery and social connectedness as a result of their participation in Ranch life.

Discussion

How does this case illustrate services that are more consumer-driven and recovery oriented?

The case illustrates, in the words of therapeutic community members, how each of the themes of therapeutic communities contributes to the development of relationships and thus, to the strength of the community. The theme of *democratization* removes a major obstacle to the exercise of personal

authority. *Acceptance* reduces restrictions on individual action, even though it also entails communal limit-setting. This loosening of accustomed constraints creates room to maneuver – to experiment with participation in opportunities for productive work and involve oneself in the development of relationships with others. Greater involvement inevitably leads to consequences, such as experiences of success or failure, and to critical feedback (*reality confrontation*). As they develop, *reciprocal relationships* are maintained through accountability, reliability and other virtues that strengthen interpersonal ties and increase a sense of obligation to others with whom one lives in community (*communalism*). The opportunity to develop greater autonomy, stronger relationships and a supportive community are all consistent with the goals of consumer-driven recovery services.

What are the Implications for clinical practice?

Social integration, defined as interpersonal connectedness and active citizenship, is integral to recovery. Fostering social integration is a core function of the therapeutic community we studied (Ware et al., 2007). Proponents of therapeutic communities argue that the essence of community life lies not in the presumption of clinical effectiveness, but in relationships that embody human dignity. The interviews conducted at Spring Lake Ranch suggest that making new connections with others improves understanding of how to initiate and maintain relationships. In this way, growth within community may become the impetus for seeking involvement and active participation in the larger social world. This, we suggest, constitutes empowerment—achieved not as an end in itself, but in the service of social integration for persons margin-

alized by mental illness.

As clinical practice shifts to emphasize personal empowerment and social integration, mental health professionals will be challenged to find growth opportunities for consumers. If more therapeutic communities are developed, who stands to benefit most from this type of growth opportunity? Therapeutic communities are not for everyone. To benefit, one must participate. However, it is not always evident to prospective members, before the fact, exactly what being a member of a community entails. To reduce referrals that fail, the referring clinician must clearly understand the nature and goals of therapeutic communities and be able to convey the benefits (and expectations) to a prospective member.

A second challenge is determining the best time for a therapeutic community experience. Maximizing the benefits of such an experience requires practice that refers interested individuals at the optimal point in the course of their illness. Is this opportunity best suited to individuals who have just been discharged from an inpatient stay following an acute episode of psychosis? The optimal time for participation in a therapeutic community has yet to be established. However, supported employment advocates are likely to argue for involvement sooner rather than later following hospitalization. Recent research has shown that return to work as soon as possible reduces disability (Killackey, Jackson, & McGorry, 2007; Nuechterlein et al., 2005; Rinaldi et al., 2004).

Staffing presents a practical challenge for constructing therapeutic communities in the public mental health system. The power inequalities inherent in consumer-staff relationships in public mental health are inconsistent with the therapeutic community model. If the development of reciprocal relationships between staff and consumers is essen-

tial, then the challenge is to recruit and train staff in ways that allow the optimum balance of power to be struck. Prioritizing life experience over clinical experience in hiring staff is one way of identifying those likely to prove comfortable working in a therapeutic community framework. Michael Wells, former Spring Lake Ranch Director, has emphasized the importance of a hiring strategy that maximizes diversity. He writes:

...we look for people who are different from one another in ways that mean that they represent as broad a cross section of life as possible. There is even room for those who take a very jaundiced view of mental illness, those who may have experienced problems of their own and especially those who know little about the subject; their ignorance guarantees a fresh perspective to problems most of us insist there is only one way to view (Wells & Hussey, 1988).

Implications for further research

This paper is not an evaluation of Spring Lake Ranch nor is it an attempt to provide a complete description of its operation. The purpose of the paper is to illustrate, with living examples, the principles of therapeutic communities with the goal of encouraging adoption because of its potential value. That value appears to lie in the realm of social integration rather than clinical improvement, although neither proposition has yet been empirically tested. The available evidence on effectiveness of therapeutic communities suggests both social and clinical positive outcomes (Rapoport, 1960; Mosher, Menn, & Mathews, 1975; Davies & Campling, 2003; Lees, Manning, & Rawlings, 2004) which justify additional research. Future studies would do well to focus on the relationship between a therapeutic community experience and subsequent involvement in the social world outside treatment. Elucidating the path from community life to social integration will begin to answer the question of

whether growth within community becomes the impetus for seeking involvement and active participation in the larger social world.

Conclusion

It has been argued that in this country, with its commercialism, materialism, and individualism, the ideal of community has been crowded out (Putnam, 2000). A lack of community-mindedness in society at large does not, however, entirely explain why therapeutic communities for individuals with serious mental illness are rare. We have offered a case illustration of one therapeutic community serving persons with serious mental illness to start a discussion of how such communities might promote system transformation.

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FOOTNOTES

1 WE HAVE SUBSTITUTED THE TERM "ACCEPTANCE" FOR RAPOPORT'S "PERMISSIVENESS," SINCE IT APPEARS TO MORE CLOSELY MIRROR THE THEME THAT HE DESCRIBES.