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THE THERAPEUTIC COMMUNITY AS AN ADAPTABLE TREATMENT MODALITY ACROSS DIFFERENT SETTINGS

David Kennard

Simple core statements of the therapeutic community as a treatment modality are given, including a "living-learning situation" and "culture of enquiry." Applications are described in work with children and adolescents, chronic and acute psychoses, offenders, and learning disabilities. In each area the evolution of different therapeutic community models is outlined. In work with young people the work of Homer Lane and David Wills is highlighted. For long term psychosis services, the early influence of "moral treatment" is linked to the revitalisation of asylums and the creation of community based facilities; acute psychosis services have been have been run as therapeutic communities in both hospital wards and as alternatives to hospitalisation. Applications in prison are illustrated through an account of Grendon prison. The paper also outlines the geographical spread of therapeutic communities across many countries.

KEY WORDS: therapeutic communities; children; psychosis; prison; learning disability.

The author is Head of Psychological Services, The Retreat, York, England. Address correspondence to David Kennard, The Retreat, York, YO10 5BN, United Kingdom; e-mail: dkennard@ntlworld.com.

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This is a paper about different adaptations of the basic therapeutic community idea. A detailed account of the principles and practice of therapeutic communities associated with the work of Maxwell Jones (1) and Tom Main (2) is given elsewhere. For our purpose it may help to have in mind a few simple core statements that mark out the common ground of this treatment modality, but which allow for the variations found in applications in different settings and with different populations.

- "What distinguishes a therapeutic community from other comparable treatment centres is the way in which the institution's total resources, staff, patients, and their relatives, are self-consciously pooled in furthering treatment. That implies, above all, a change in the usual status of patients" (1, pp. 85–86).
- The therapeutic community is a "living-learning situation" where everything that happens between members (staff and patients) in the course of living and working together, in particular when a crisis occurs, is used as a learning opportunity.
- Permissiveness is one of the four principles identified by Rapoport (3) and is perhaps the most central of the four: that all members should tolerate from one another a wide degree of behaviour that might be distressing or seem deviant by ordinary standards.
- There is a "culture of enquiry," a phrase that highlights the need not only for efficient structures but for a basic culture among the staff of "honest enquiry into difficulty," and a conscious effort to identify and challenge dogmatic assertions or accepted wisdoms.
- The basic mechanism of change can be described as this: the therapeutic community provides a wide range of life-like situations in which the difficulties a member has experienced in their relations with others outside are reexperienced and reenacted, with regular opportunities—in groups, community meetings, everyday relationships and, in some communities, individual psychotherapy—to examine and learn from these difficulties. The daily life of the therapeutic community provides opportunities to try out new learning about ways of dealing with difficulties.

CHILDREN AND ADOLESCENTS

Therapeutic communities for children and young people go back at least 90 years, to the founding of the Little Commonwealth by Homer Lane in 1913. Lane was an American who had experience as an educator at the George Junior Republic, a reformatory system developed in the

United States, and was invited to advise on the setting up of a home for delinquent adolescents in Dorset in south west England. For 5 years the Little Commonwealth housed around 50 youngsters, mostly aged 14–19, who participated in a carefully structured system of shared responsibility. Lane wrote that

> the chief point of difference between the Commonwealth and other reformatories and schools is that in the Commonwealth there are no rules and regulations except those made by the boys and girls themselves. All those who are fourteen years of age and over are citizens, having joint responsibility for the regulation of their lives by the laws and judicial machinery organized and developed by themselves. The adult element studiously avoids any assumption of authority in the community, except in connection with their duties as teachers or as supervisors of labour. (The individual and the whole community are free) to make mistakes, to test for themselves the value of every law and the necessity for every restraint imposed on them (4).

This remarkable venture ran for 5 years but came to a premature end after two young female "citizens" claimed that Lane, who had become an enthusiastic proponent of psychoanalysis and was attempting to apply it in the community, had immoral relations with them. However his innovative work inspired the educational pioneer A S Neill who founded Summerhill, and who in turn influenced the whole progressive school movement.

The term therapeutic community was not applied directly to residential work with children until the 1960s. However from the 1920s onwards a number of residential schools and projects for seriously disturbed or "unschoolable" children, which had many of the key features of therapeutic communities, were created by charismatic figures. These included Leila Rendell (Caldecott Community), George Lyward (Finchden Manor), Otto Shaw (Red Hill School), John Aitkenhead (Kilquhanity School), and the hugely influential Marjorie Franklin and David Wills, whose 1930s Hawkspur Camp laid the foundation for Planned Environment Therapy, described by Kasinski (5) as "probably the first unified model for the therapeutic community work with young people."

In his recent review of the history of therapeutic communities for young people, Kasinski (5) writes that "Planned Environment Therapy proposed that the child's social needs could be addressed through the experience of shared responsibility within the community; their emotional needs through attention to relationships with staff members and through individual psychotherapy; and their educational needs through measures designed to increase motivation for learning such as voluntary lesions and an emphasis on creative work."

Wills shared Lane's belief in the therapeutic value of love combined with shared responsibility. Love in this context meant that no matter how repelling a child's appearance, habits or disposition he or she was seen as basically worthy of esteem and affection, and punishment was never to be used to inflict hurt or humiliation. Unlike Lane, Wills separated the environmental and the psychoanalytic aspects of the therapeutic work, thereby creating a more contained and sustainable way of working. For many establishments this became the accepted model, while others developed a model that used the relationships within the large group as the therapeutic focus

Therapeutic communities today can draw on the full range of knowledge and theories available about emotionally deprived and abused children from Winnicott, Rutter, Alvarez, Bowlby and Bettelheim, as well as the models for adult therapeutic communities. They have developed ways of working that aim to provide the vital balance between the need for care and the need for control, between offering love and affection and setting limits. A recent issue of the journal *Therapeutic Communities* was devoted to papers on this topic. Rollinson, director of the Mulberry Bush School, described this as "*real living* and learning in the therapeutic community (where) so much of the work is in the "living alongside" the children, focussing on helping individuals and groups to learn to live with themselves and increasingly with one another" (6). The publication in 2003 of *Therapeutic Communities for Children and Adolescents* (7) provides further indication of the current conceptual and practical activity in this field in the UK, where The Charterhouse Group of Therapeutic Communities also has an informative website at www.charterhousegroup.org.uk.

THE THERAPEUTIC COMMUNITY APPROACH FOR PEOPLE WITH LONG-TERM PSYCHOSIS

The application of therapeutic community principles to work with the chronic mentally ill is in many ways the closest version of the therapeutic community modality to one of its most important predecessors, Moral Treatment. This was the term used to describe a model of care first developed in 1796 by the Quaker William Tuke at The Retreat in York. In keeping with Quaker ideology, the mentally ill were accorded the status of equal human beings to be treated with gentleness, humanity and respect. This was quite revolutionary at the time, and The Retreat also gave priority to the value of personal relationships as a healing

influence, to the importance of useful occupation, and to the quality of the physical environment (8,9). Much of this early vision of a humane treatment for mental illness was lost as the 19th century progressed and the mentally ill were housed in increasingly large and impersonal asylums. Although the first half of the 20th century saw some attempts to humanize these institutions, it was not until the 1950s that the zeitgeist for the mentally ill began to change. Factors which can be seen to have contributed to this included the founding of the English National Health Service, the emergence of sociological studies of the toxic nature of large institutions, and the (re)discovery of a humane and egalitarian model of care in the shape of the therapeutic community experiments during and following the second world war.

Right from its early days Maxwell Jones' experiment at Belmont Hospital, just outside London, attracted the interest of psychiatrists in England and around the world. This way of running a hospital that gave equal status to the views of staff and patients, that encouraged patients to take the decisions about things that affect their daily lives, that gave responsibility to patients for many aspects of ward activities, appealed to psychiatrists faced with large hospitals filled with people living totally dependent, featureless lives in drab, overcrowded wards. Jones inspired them to think that when Boston psychiatrist Bockoven described "the heavy atmosphere of hundreds of people doing nothing and showing interest in nothing" in American hospital wards in the 1950s (10), it did not have to be this way. The concepts of "institutional neurosis" (11) and "total institution" (12) were emerging, and Europe and America were ready for a revitalization of the institutions that formed the core of mental health provision. One of the things noted elsewhere (13) is that the therapeutic community approach often seems to be embraced when a county is going through democratising changes: England at the time of the NHS forming, Israel in its formative years, Cuba in the early years of the revolution, Italy in the years following its heroic hospital closure legislation. It isn't easy to overcome the inertia Bockoven found. It takes a charismatic and determined leader, and the following wind of a culture change.

In its early days the therapeutic community approach was very much about changing organizations in the way vividly described by Clark (14,15). Staff who for decades had managed patients with a mixture of control and protectiveness, and sometimes abuse, and who had run the institution in ways that suited their own convenience, were suddenly asked to give patients responsibility, to consider the social and personal needs of patients and how these could be met, and to adjust their work

patterns to meet the needs of the patients. Anyone who has tried this knows the time and tenacity and politicking it requires, but also if they see it through, the satisfaction of seeing institutionalised patients gradually blossom and in many cases leave hospital for independent or sheltered accommodation and a life in society. These were often the patients who were no longer ill or could now have their symptoms controlled by the newer medications, and whose continued hospitalisation was due at least partly to a loss of the skills and confidence to manage their own lives. However as these patients left hospital, those who remained were those whom today are sometimes referred to as the "difficult to place," whose combination of treatment resistant symptoms and difficult personalities keep them in need of 24-hour care. Thus although the crusading aspect of the therapeutic community approach to chronic mental illness is relevant where total institutions are still found, today there are other important applications in community-based housing projects for the long term mentally ill, and the work of community mental health teams.

Small domestic households of between 5 and 12 residents live with staff support (either 24 hour or office hours depending on the level of need). For people with more integrated or recovered psychoses there are regular community meetings, service users help to draw up and review their own care plans and those of their fellow residents, and help in running the household. Where an individual's symptoms prevent him or her from being actively involved, staff adopt a psychoanalytically informed style of "working alongside" the resident, carefully facilitating a degree of involvement through the relationship, seeking to avoid the twin defaults of leaving the resident isolated or doing things "for" the resident. (16)

For the difficult to place patient Shepherd (17) has described the concept of the "ward in a house," which is closer to the original model of Moral Treatment, and aims to combine the best features of hospital care and community-based residential care (18).

Although the therapeutic community is primarily a modality of residential or daytime living environments, it has also been identified as an appropriate perspective for all community-based services. The emphasis on respect for the individual, the recognition that service users have therapeutic skills, the importance of a containing environment and awareness of the potential for splitting within teams and organizations have been noted as some of the contributions that the therapeutic community approach can make to the work of community mental health teams (19,20).

ACUTE MENTAL HEALTH PROBLEMS

Although therapeutic communities grew out of work with people with long term problems in their patterns of behaviour and relationships, they have also been developed in a number of countries for people suffering from acute or first onset psychoses, including England, Switzerland, Finland and the United States. These have included both hospital admission wards and alternatives to conventional psychiatric services.

In England a small number of psychiatrists used the opportunities created by the National Health Service to make over whole mental hospitals, including their admission wards. These included Fulbourn Hospital in Cambridge, where Pullen developed a therapeutic community admission ward with an average length of stay of 17 days (21) and Littlemore Hospital in Oxford where Mandelbrote developed the Phoenix Unit as its acute admission ward (22). These and similar units adapted the core values of shared responsibility and democratised decision making to meet the needs and capacities of this client group, but maintained the practice of open communication, information sharing, informal relationships and, most importantly, staff self-examination within a culture of enquiry.

In an acute psychiatric ward the therapeutic community is not the primary agent of change but creates a structure and atmosphere which can greatly enhance the quality of care in a number of ways:

- In a busy ward some patients may get overlooked. Daily community meetings ensure that every patient is noticed and given some thought, even if they don't attend, because someone will ask where they are.
- The community meeting encourages patients to be aware of and taken an interest in others, with mutual sharing of experiences and giving and receiving information and feedback.
- There can also be groups to help with particular needs e.g. coping with positive and negative symptoms of psychosis; assertiveness and confidence building; cognitive therapy for depression; relaxation training.

The general ethos of the therapeutic community promotes a sense of empowerment—patients are given information about the effects of treatment, can question staff decisions, are consulted about aspects of the daily life of the ward, are encourage to take useful roles within the ward such as chairing meetings, showing round new patients, and

sometimes simple domestic tasks. The increased involvement can boost patients' morale and increase their willingness to engage with specific treatments such as medication and behavioural programmes. Working in an acute service can be extremely stressful for staff, and the therapeutic community model ensures that the concerns and anxieties of the staff are given serious attention—for example in a regular staff group with an outside facilitator.

A different version of the therapeutic community has been used to treat young people with first onset schizophrenia in noninstitutional settings without the use of medication. The best-known example is Soteria House, developed by Loren Mosher in San Jose, California, inspired by the ideas of R D Laing. It operated from 1971–83, in a controlled research programme comparing it with good quality hospital based treatment. Soteria House had places for 6 patients (smaller than the usual therapeutic community) and two sleeping in staff. The emphasis was on interpersonal support in a normal homely environment by staff that were tolerant and enthusiastic, who had no formal professional training but did have good and regular supervision for their work. No medication was prescribed in the first six weeks but it was used after this if required. The study found that Soteria was as effective as neuroleptics in reducing the acute symptoms of psychosis in the first six weeks, and that longer term therapeutic outcomes were as good or better than those of hospital treated control subjects in terms of independence, autonomy and peer based social networks. Mosher also noted that 80% of the experimental group had little or no risk of tardive dyskinesia as they used little or no antipsychotic medication over the follow up period (23,24). Surprisingly the success of this experiment has not spawned a host of replicas, pointing up the conservatism of the professional establishment, the reluctance to use the natural healing properties of normal relationships, and the hold that the drug industry still has over treatment models.

OFFENDERS

The hierarchical (concept house) therapeutic community is the type most widely used in prisons, mainly for offenders with histories of addiction, and prison may seem an unlikely setting for a treatment model based on democratic decision making. Yet democratic therapeutic communities have been run in prisons since the 1960s with positive results, and today there is an increasing number within the English prison system. The first and best known of these is Grendon Prison, 30 miles west

of London, which opened in 1962 and takes long-term male prisoners towards the end of their sentence. Violence, sex offences and robbery are the most common types of offence. Prisoners are referred from other prisons by prison medical officers and have often requested the transfer themselves. In a majority of cases they have had previous psychiatric treatment at some stage.

On arrival inmates live in the Assessment Unit for up to three months to assess their motivation to change, degree of psychological mindedness, their intellectual ability to deal with group psychotherapy, and personality problems that would benefit from therapeutic community methods. Once accepted a prisoner moves to one of 5 wings of 40 men, each run as a separate therapeutic community, where he may stay for up to 2 years. Extensive reconviction studies have found that length of stay at Grendon is correlated with reduced reconviction rates (25,26). Given the obvious limitations of running a therapeutic community in prison, considerable thought is given to how the key therapeutic principles can be adapted (27). A range of significant decision making opportunities is available, from allocating members to community jobs such as cooking and gardening, to voting a member out of therapy for a serious rule violation. Although there are limitations, the learning principle involved—to share responsibility for decisions and their consequences—are still operative. It is also accepted that prisoners must be allowed to behave as they normally behave rather than as model prisoners, so creating the possibility of "offence paralleling" behaviour which can provide the material for group therapy. As in all therapeutic communities prisoners can act as auxiliary therapists for one another, giving feedback on the impact of each others' attitudes and behaviour and confronting one another on the basis of their own experience and self knowledge. This can be particularly valuable in cutting through rationalisations or denials of the offence and its consequences.

In the experience of the author and other experienced practitioners in both the USA (28) and Europe (29) therapeutic communities in prisons can be surprisingly effective in creating a culture of openness and exploration of personal issues, in direct contrast to the conventional prison culture, and also in reducing the incidence of violent disturbances. Perhaps the major limitation is the acceptability of the model to prison staff and administrators. For some staff the relaxation of the "them and us" polarisation of officers and inmates provides a welcome opportunity to do something worthwhile, for others it is seen as a threat to their authority and control. Small therapeutic communities within larger prisons are particularly vulnerable to a sudden all round tightening of security when there is a security alert.

PEOPLE WITH LEARNING DISABILITIES

As in other forms of therapy that rely on verbal understanding, therapeutic communities generally require their members to have at least average intellectual ability. There are however many communities for those with learning disabilities which follow similar principles. Many of these are run by organizations in the voluntary sector. One of the largest, with a hundred centres worldwide, is Camphill Communities, which promote the ideal of a community life where each person contributes what they can towards the well-being of their fellows. These communities, which are in the tradition of Christian mission and philanthropy, focus more on the practical work tasks available rather than on verbal exchange, but as in other therapeutic communities emphasize the equal status of all members and the healing value of everyday relationships and activities. In some ways these reflect the original priorities of moral treatment with little use of the therapeutic community's potential for analytic understanding or social learning. However Schneider and Schneider (30) have described a modified therapeutic community for learning disabled adolescents that uses a psychodynamic developmental model, and in a rare example of a randomly controlled trial in this field Miles (31) found that young males with behaviour problems and borderline intellectual functioning changed from identifying with the trouble makers in the group to a more accepting attitude towards authority over 12 months in a therapeutic community ward, with no such change in the conventional ward.

THE GEOGRAPHICAL SPREAD OF THERAPEUTIC COMMUNITIES

The idea of a community as a place of healing for the troubled mind is probably universal and as old as society itself. One of the earliest recorded intentional uses of a community in this way was Geel in Belgium, which became a place of pilgrimage for "lunatics" in the fourteenth century. With more roots, as we have seen, in the Quaker Retreat at York and in schools for maladjusted children, the modern therapeutic community is generally recognised to have emerged from the work of a group of psychoanalysts, psychiatrists and social psychologists in England during the 1939–45 war and immediately afterwards. What seemed to happen at this moment in history was that a particular constellation of humanitarian ideology, wartime necessity, psychoanalytic insights and open minded pragmatism came together and coalesced

into a new form of treatment. Following the war, the flagship for this new approach was Maxwell Jones' unit at Belmont Hospital, later Henderson Hospital, which was visited by numerous psychiatrists in the 1950s and 60's (and still is). In 1998 I was able to identify 11 out of 15 member countries of the European Union that had developed therapeutic communities of the democratic type for mental disorders. These included.

- Holland, where from the 1970's to 90s therapeutic communities formed a major part of mainstream psychiatric provision.
- Finland, where thanks in particular to the work of Isohanni (32) therapeutic community principles were brought into acute psychiatric care, prisons, and even the care of the elderly.
- Norway, where a network of psychiatric day hospitals for personality disorders has been developed and evaluated (33).
- Germany, where residential psychotherapy has been a central part of health provision (34), and where various applications of therapeutic community principles have been made, including sheltered flats for former psychiatric patients and social-therapeutic prisons.
- Italy, where a law passed in 1978 required the closure of all the country's mental hospitals and their replacement with a range of community based facilities, many of which have turned to the therapeutic community for an appropriate model of care.
- Greece where Tsegos (35) and others have developed a comprehensive range of therapeutic services and professional training programmes based on therapeutic community and group analytic principles.

It is difficult to estimate how many therapeutic communities there are worldwide. One guide may be the source of papers published in the journal *Therapeutic Communities*. During my own seven-year period of editorship (1992–98) only 5% pf published papers came from outside Europe or the UK. However a recent bibliography of all papers published between 1986 and 2001 throws an interesting new light by placing papers into various categories. Of 41 papers published in the category "Models, innovations and developments in therapeutic community practice" 44% came form the UK, 34% from mainland Europe, and 22% from other countries, namely the USA, Canada, India, Nigeria and Malawi. This could be read to suggest that although the volume of therapeutic community activity is relatively small outside Europe, it may be more pioneering and innovative.

CONCLUSION

The therapeutic community is a surprisingly hardy plant that can be cultivated in a wide range of terrains. Elsewhere I have written of the "therapeutic community impulse" (36) as something that flows through many forms of institutional care, including hospitals, schools, prisons and other settings created by societies for their ill, disabled or troublesome members (and sometimes for their brightest too). This impulse comprises a tolerance of the expression of conflict, a desire to enable people to take responsibility for their lives, a natural sense of democracy (not necessarily of the one vote per person variety) where everyone has the right to information and to contribute to decisions that affect them, and "a kind of shirt-sleeves informality about the business of helping people." I believe it is a hardy plant because once experienced, the capacity to work with people in this way becomes an inner benchmark of the most humane and effective way of delivering mental health care.

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