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THE ART AND CHALLENGES OF LONG-TERM AND SHORT-TERM DEMOCRATIC THERAPEUTIC COMMUNITIES

Kingsley Norton, M.D., and Sandra L. Bloom, M.D.

This paper, cowritten by Kingsley Norton, since 1989 Director of Henderson Hospital (a therapeutic community founded by Maxwell Jones in 1947 in the United Kingdom), and Sandra Bloom, Founder of the Sanctuary Model in the United States, compares and contrasts the practice of the democratic therapeutic community (TC) as applied to the notion of long-term care (up to twelve months), to that of the democratic therapeutic milieu (TM) as applied to short-term care (up to one month).

KEY WORDS: therapeutic community; therapeutic milieu; Sanctuary Model; Henderson Hospital; Maxwell Jones.

Kingsley Norton, M.D., is Director, Henderson Hospital, Surrey, UK.
Sandra L. Bloom, M.D., is President, Community Works, Philadelphia, PA.
Address correspondence to Kingsley Norton, M.D., Clinical Director, Henderson Hospital, 2 Homeland Drive, Brighton Road, Surrey, SM2 5LT, United Kingdom; e-mail: kingsley.norton@swlstg-tr.nhs.uk.

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THE CHALLENGES

Psychotherapy and Sociotherapy

The democratic therapeutic community (TC) represents the pooling of available human resources to facilitate the psychosocial maturation of its resident members—the clients (1). To achieve this ambitious aim requires equal attention to both the formal therapy programme (the psychotherapy) and the time in between (the sociotherapy)—the "other twenty-three hours" (2). Ideally, psychotherapy and sociotherapy complement one another (3).

Functioning effectively with (up to) twenty-nine clients in therapy at any one time in Henderson Hospital's democratic TC requires the pooled resources—eyes, ears and noses—of clients as well as staff members. The challenge for staff is to set up good communication networks within the TC so that what goes on during psychotherapy and sociotherapy interconnects.

Drawing on the TC and its underpinning ideology (4,5), principles can be identified that can be applied to a variety of target populations including various kinds of longer-term residential treatment programs for adults, children, substance abusers, group homes, many homeless shelters and domestic violence shelters (6,7). Democratic therapeutic milieus (TM) refer to settings that are shorter-term and more acute and include inpatient psychiatric settings for children and adults, day hospitals, and intensive outpatient programs. In the service of maximising the therapeutic potential of any setting, we argue that wherever and whenever people gather together in groups long enough to develop relationships and a group identity, the basic principles that underscore the therapeutic community can—and arguably must—be applied.

Staff and Clients—Collaboration Versus Confrontation

Both the democratic TC and TM comprise two main subsystems—the clients and the staff. To be effective, these two systems need to engage and harmonise, in spite of their inherent differences. Staff attempt to dismantle or more accurately to "flatten" the conventional hierarchy between themselves, both within and between the different disciplines (1). On the client side the opposite applies, i.e. there is a deliberate structuring of the clients into a hierarchy that is stable and predictable but also changing regularly (monthly), according to fixed rules, democratically applied (8,9). Clients at the top of their hierarchy liaise directly with the staff subsystem on behalf of their peers. The aim is both to strengthen

the bonds between clients (to maximise the positive influence of peer support and pressure) and to provide clients with experiences of being alternately on both sides of the power divide.

In the TM, the staff hierarchy must be flattened but only as much as is practicable, safely, to maintain the function of the program. Usually embedded within the medical model, and subject to all of the legal and accreditation pressures of the modern hospital setting, the typical top-down, doctor-to-nurse-to-other staff pyramid is not structurally changed but is continually modified according to everyday fluctuations related to individual and collective risk management, so that it becomes safe for staff to challenge authority figures and mutually supervise each other. Because of the constantly changing nature of the client population and their inherently unstable psychosocial state as a subsystem, any naturally democratizing influence within the client community is reinforced by staff to promote peer support and the positive use of peer pressure (10,11). At the same time staff act to ameliorate clients' tendencies to scapegoat, especially those of their peers who inhabit the margins of society (12).

Delegating Power Safely

The TC model represents an attempt to erode the traditional hierarchy existing between clients and staff, replacing this with a more collaborative and power-sharing relationship. When successful, the effect is to produce a more "equal" and symmetrical state of affairs. Each of the parties knows where it stands in relation to the other, in terms of role expectations and, importantly, also the limits of these. Achieving this reciprocity comes via the delegation to the clients of much of the authority conventionally invested in the professional role. In practice, power and authority is never truly relinquished by staff but "loaned" to clients under particular circumstances and conditions. So, if a client commits a serious criminal act or is at risk of serious violence (to self, property or others), this could trigger the medical, nursing and social work staff to regain immediately their formal roles as dictated by wider society in relation to risk assessment and management.

In the democratic TM, by comparison, power is usually not as devolved because the time it takes to socialize clients into a different kind of normative community is not available and because the make-up of the community is altering far more rapidly that in a TC. Nonetheless, the pursuit of daily life within the TM provides multiple opportunities for clients and staff to engage in dialogue about the uses and abuses of power as these are inevitably enacted in the treatment setting. This

is extremely important since most of the clients who enter treatment in either the TC or TM will have been exposed to the routine abuse of power and will not have acquired the skills (especially verbal skills) to use their own power in constructive ways.

Balancing Rights and Responsibilities

One effect of being treated (or indeed working) within this democratic TC model is to have assumptions and values about the delivery of healthcare challenged. In its operation, the TC is often far from the "medical model," which at its most extreme can imply that caring is an activity done *by* professionals *to* patients. Clients in a TC can expect to be cared for, but with this "right" come "responsibilities." Repeated failures to deliver on the latter mean that the client's place in the TC is potentially forfeit, as the result of a democratic vote by all clients and staff. This democratised treatment paradigm was defined at Henderson Hospital in the 1950s by a visiting team of social anthropologists led by Robert Rapoport (4), who coined the term "Community as Doctor" to denote the dispersal of the doctor's traditional authority to the collective whole and noted, among others, ideological themes of "democratisation" and "communalism" within the staff team. All members, staff as well as clients, are thus required to yield to the over-arching authority of the treatment model.

In the democratic TM, a heavy burden is placed on the staff to balance the demands of the "medical model" with the promotion of a more democratic and power-sharing environment. Acute settings often must contend with frequent crises and the rapid escalation of situations that can lead to violence, since frequently they cannot exert much selective influence on who is admitted. A crisis-focused environment may result, which can become increasingly hierarchical, controlling and autocratic, unless deliberate steps are taken by leaders and staff to restore power and authority to the collective whole immediately after each crisis or threat to milieu integrity (13). As a result, the expected "community" norms of shared power and responsibilities must be clearly articulated through spoken and written communications, constantly repeated via community meetings, and non-verbally reinforced via community rituals, artwork and signs (7,10).

Real Tasks and Real Relationships

Ideally, all activity in the TC and the TM is carried out in the spirit of collaboration using teamwork—communalism—both within and between

the staff and client subsystems. Each day has a predictably structured timetable of domestic, administrative and clinical events that really are required for the effective making of this particular environment (14). Both client and staff members therefore need to know what is planned and why. This important information is not simply the preserve of the professional subsystem. (Clearly, new clients have a less sophisticated knowledge than those further along. Crucially, knowledge passes from senior to junior client so that there is a "fast-tracking" new members to achieve what is a steep learning curve regarding the TC—the "letter" is absorbed much more quickly than the "spirit").

Structure and teamwork are equally important in the TM. But the difference between "senior" and "junior" clients in the TM may span days instead of weeks or months. Nonetheless, the mechanism of knowledge transmission from one peer to another remains of great value even in very short-term situations.

Clients are to expect many of the conditions that prevail in outside life to exist on the inside of the democratic TC. This is so that "normal" interpersonal and social situations are encountered, thereby potentially evoking clients' habitual, often destructive or self-destructive, responses. Only by encountering "social reality" (as opposed to a highly artificial environment) can the real problems and conflicts that clients experience as difficult to contain and articulate in outside life be authentically communicated. The challenge facing the TC and TM therefore is to effect this communication as safely as possible, through close attention to risk assessment and management, and to speed the translation of any physical "acting out" into its verbal equivalent. There is a range of structural elements in the TC designed for this purpose.

The rules represent one element. These include the proscribing of violence to self, others or property and the forbidding of alcohol or unprescribed/illicit drugs being taken or indeed brought into the TC. Even minor transgressions of these are taken seriously and dealt with swiftly by the TC. Transgressors potentially forfeit their place in the community and may be discharged or referred to another treatment setting. There is a limited tolerance of maladaptive behaviour and attitudes ("permissiveness"—another ideological theme of Rapoport) but only if there is a collective sense, as judged by the TC membership, that a member is authentically engaged in a therapeutic process or, at least, struggling to be so.

In a TM, the structural elements of the program are critically important in establishing clear social norms, the limits and boundaries of expectable behaviour and the expectable consequences when these are overstepped. However, the involuntary nature of admissions to many

acute inpatient settings limits the responses (e.g. grounds for discharge) that the program staff can use to express intolerance for maladaptive behaviour. Because this is the case, programs may underestimate (hence underutilise) the powerful influence of group pressure, even among a group of involuntarily committed patients. In acute settings, twice-daily community meetings added on to a rigorous group therapy regimen can be used effectively to de-escalate and contain episodes of rising tension and the spread of contagious negative affect among other members of the community (7).

Responses to Rule-Breaking

Within the democratic TC model, rule-breaking activity, its serious threat and untoward personal or interpersonal distress all dictate the convening of an emergency meeting. Everyone who is present in the community at the time comes together, at very short notice, to attend to the business that has threatened the psychological or physical safety of any of its members. In both the TC and TM, self-harm and, much less frequently, physical violence would be reasons for bringing the whole community together in an emergency session, regardless of the time of day or night. The matter is explored in order to manage the immediate risk posed, through identifying and offering appropriate support to provide containment. The aim is to enable the issues to be further explored within the formal treatment programme, i.e. the matter is not usually examined in depth outside of the formal therapeutic program, since appropriate resources are not then available to enable this to be achieved safely. Overall, the challenge is to facilitate the understanding of destructive or aggressive attitudes and behaviour neither simply condoning nor condemning (15).

In a therapeutic community, unlike a short-term therapeutic milieu, the ultimate judges of premature discharge are (by virtue of their superior numbers), the client's peer group. Thus there is peer pressure to conform to the majority view. In a therapeutic milieu, by contrast, the rule-making and rule-breaking domain is managed largely by the staff. The entire community becomes involved in an episode, via community meetings, with the main goal of providing information, containment and a corrective emotional experience.

Validation and Internalisation

Those who, in their formative years, are unused to self-validating experiences, having been emotionally or physically neglected and abused,

find it hard to accept that they could be in a "new" (hence validating) relationship with others. They tend to deny or ignore the fact that these new others do take notice of them and are affected by their behaviour (positively and negatively). Such denial or ignorance thus tends to elicit both supportive and challenging responses. The latter can be harsh but the "other" is for the most part similar, i.e. similarly struggling with the same basic issues, hence there is also much accurate empathy (15). Repeated validating feedback, over the course of the year-long treatment, about the client's strengths as well as confrontation of weaknesses (often expressed via defensive and aggressive behaviour), can be internalised, leading to enduring change (16). Many clients find a place in such a system and a sense of belonging not previously experienced. As a result, leaving is hard to do. Therefore, just as there are separate structures to support joining there are those to support leaving, including attendance at a "transition group" which lasts for 6 months following discharge (17).

In a TM setting, the main form of validation is through an intensive psychoeducational experience that validates the client's past negative experiences and provides a conceptual framework for beginning to view themselves both as injured parties and also as parties who can participate actively in recovering from those injuries, rather than as solely "sick" or "bad" or "defective" individuals (10,11). Given the attenuated nature of the short-term stay, there is little time for the development of a mature therapeutic relationship. There is however time for an intensive and collaborative assessment of the client's situation, the development of short- and long-term treatment goals, and awareness of inhabiting a system (albeit temporarily) that provides a coherent and radically different cognitive framework for understanding what has happened to them and that might also imply a capacity for change (10,18).

Interaction, Exploration and Experimentation

Encountering the range of group meetings and real tasks that comprise the psycho- and sociotherapeutic programme of the TC entails the taking on and relinquishing of multiple roles, even throughout the course of a given day. In effect, this provides a relearning or resocialising opportunity—a "living-learning" experience (1). The aim is to focus attention both to current and past events in the client's life, in the service of delivering an improved adaptation in the future (19). This derives from an exploration (especially in the thrice-weekly small group) of the issues and problems, many of which were hitherto buried. A cycle of interaction (leading to the usual reactions emanating from the client's

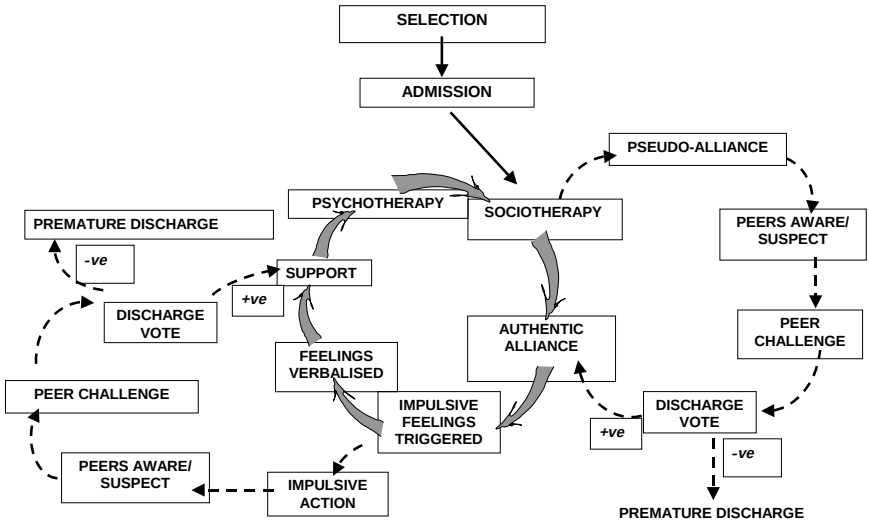

FIGURE 1. In-patient sociotherapeutic and psychotherapeutic processes.

past coping strategies and internal working models), exploration and experimentation (especially in psychodrama, art therapy, work groups and the social times in between groups) is set up (20) (Fig. 1).

In a TM, the pace of this interaction, exploration and experimentation may be significantly speeded up with two community meetings and several group therapy experiences each day, while the length of time that the person actually can stay in the setting may be only one week. It is not unusual, however, for patients to experience a number of inpatient admissions to the same setting and, with consistency of service delivery, the client can be enabled to build upon their social learning experience with every new admission.

Sustaining Countertransference Reactions

As Main has argued, the best patients are those whom the doctor has rescued from serious illness and who are grateful for such help (21). Departures from this straightforward type of clinical transaction increase the risk of personal disappointment and frustration for staff (22). This may be difficult to express openly, especially if there is a blaming of the patient for failing to recover (evoking guilt or shame in the professional) and/or a blaming culture of staff management. Clients diagnosed with personality disorders are renowned for their ambivalence about seeking

help and being helped and for their difficulties with engaging gratefully in relationships that might serve their healthy interests.

Dealing with disappointment with oneself or dislike of a client is a frequent and arduous part of TC work for staff involved with such clients. Staff members are often at odds with one another, for example, disagreeing about whether or not a given client is "doing well" or merits such labour-intensive treatment. Supporting these differences of opinions and their expression, during appropriate staff meetings, is a crucial aspect of the TC model. Facilitating such openness thus represents a key skill for those in senior clinical positions to acquire and exercise. Sustaining counter-transference reactions, often strong and usually negative, may be key to the success of the therapeutic process (23). Understanding the origins of these reactions, especially where they also find their complement in another member(s) of the staff team, can shed light on the internal world situation of the client (24). Overly positive countertransferences exist that can be equally as disabling professionally if not apprehended as such.

In the TC, to counteract any tendency to keep silent about such reactions, there is co-facilitation of therapy groups and "aftergroups," which follow each formal group meeting in the programme. This provides opportunities for dialogue about what has just occurred. In addition, there is formal weekly supervision. This, as with the weekly team awareness meeting that considers the impact of staff-staff relationships on treatment and vice versa, is convened by an external professional. Together, all of these structures help to maintain the staff team's objectivity, hence focus on appropriate clinical business. There is no individual therapy thereby minimising staff the possibility of isolation and potentially damaging "secrets."

The accelerated pace of a TM means that countertransference reactions will occur regularly but will often be conflated with the here-and-now pressures of the immediate situation. This necessitates the maintenance of a strong sense of teamwork, a network of mutual support and supervision, and frequent and open communication among staff members. Although group experiences are of primary importance in such a setting, individual attention is required at least at the level of case management, if not actual therapy, because discharge planning and dispositional challenges must be confronted from the time of admission.

Roles of Leaders

One of the TC leader's roles is to maintain the integrity, and preserve the meaning, of the above staff structures, to ensure that they do not

depart too far or too long from their intended purpose, for example, degenerating into interprofessional power struggles. This is easier said than done (25). Another role is to straddle the interface with the outside world, including those systems that fund and monitor the performance of the service. Janus-like qualities—a capacity of the Roman god to look forwards and backwards, inside and out, simultaneously—are important to acquire (26). More and more restrictive and risk-averse health service policies make democratic TC work harder to achieve and less rewarding for staff. Such policies are presented as being in the interests of the client—contributing to their safety and protection—but may be more about staff "covering their own backs."

These difficulties are especially relevant to the practice of the democratic TM and contribute significantly to the deterioration of many inpatient settings in the U.S. today. As leaders become pressured they tend to become more autocratic, sacrificing democratic decision-making for punitive control measures. Such reactions weigh heavily upon staff who frequently tend to vent their frustration on their clients (13). These pressures make it increasingly important for the leaders and staff to participate in democratic decision-making. As the level of complexity within any situation increases, the need for collaborative, calm, diverse and intelligent problem-solving logarithmically increases and can only be accomplished in an atmosphere that values mutual respect and open communication.

Outcomes

At any given moment, nobody ever knows for sure or can capture totally what is going on in the microcosm of society that is the TC or TM. Indeed, tolerating "not knowing" is a key skill for staff to acquire. However, evidence for this negatively-defined attribute is hard to gather reliably. "Not knowing" may be hard to distinguish from burnout and, behaviourally, indolence may masquerade as the required "masterly inactivity." In the absence of clear evidence on a daily basis that clinical progress is being achieved, knowing that staff activity and (masterly) inactivity is achieving its goals, it helps to have data regarding long-term benefits of treatment. Seventy per cent of those enduring the full course (approximately 50 per cent if those who leave prematurely are included) derive a variety of psychosocial gains (27–30). This TC programme has also been shown to be cost-beneficial (31). A thorough review of therapeutic community research is available in this issue (16).

There is some evidence that TM principles applied to the residential treatment of abused and neglected children using a trauma-sensitive

approach does have benefit, although much more research is required (32,33). In the application of TM principles to short-term treatment it is important to take a broader approach to the treatment of people with very complex problems. One short-term stay is unlikely to be sufficient and rehospitalization should not be labelled as "recidivism" or "treatment resistance" or "treatment failure." Instead, each admission should be viewed as a vital part of the continuum of care, particularly useful during times of crisis. The yardstick for measuring progress, rather than whether the person has needed treatment or not, should be whether the person has managed some improvement between admissions, improvement that can be built upon for the next step in recovery.

THE ART

So wherein lies the artistry? Well, there is a tendency for the hoped for harmony both between and within the two major subsystems of staff and clients to be lost or only briefly sustained. "Clashes" and other discordant outcomes appear on a daily basis. Some require little intervention from senior staff, while others need the combined might of all staff and clients to get the community back to singing from the same hymn sheet! The art of therapeutic containment lies in knowing when to intervene and when not. It is the skill of the "good enough" parent (34). It requires dedication and skill to deploy such sensitivity in the workplace to adult clients who suffer from personality disorders.

Too easily the "words" of the therapeutic model are remembered at the expense of the "tune" and this applies with equal relevance both to staff and clients. Too often, treatment programs claim to be using therapeutic community principles when they are failing to pay attention to the nature of the therapeutic culture. It is the culture, rather than the structure, which is decisive therapeutically (35). Those with leadership responsibilities within the TC thus must strive to remain attuned to the subtle shifts of tempo and pitch and to the multiple, at times competing and contradictory, voices within the TC and outside in the embedding systems' environment. Within a TM setting, artfulness is similarly practiced in the constantly changing harmonizing of staff and clients, a form of musical engagement more like jazz than a classical form. But regardless of the musical structure, all of the musicians—even when playing solos—must keep in mind their vital connection with the entire orchestra, that the whole is always greater than the sum of the parts (36).

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