Psychotherapy Guidebook

Therapeutic Community

Robert W. Siroka
Amy Schaffer

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Table of Contents

DEFINITION & HISTORY

APPLICATIONS

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DEFINITION AND HISTORY

The concept of a community intentionally designed to maximize the well-being of its members is an old one. This concept has found expression throughout the centuries in numerous religiously or politically inspired Utopian communities. The systematic application of this concept for the benefit of the mentally ill, however, did not appear, with few exceptions, until much more recently. One exception was the Belgian community Gheel, whose residents have "adopted" mental patients into their homes since the seventh century. Another was the "moral treatment approach" of the late eighteenth and nineteenth centuries, which treated mental patients by providing an optimally structured and humane social environment.

It was in the 1930s and 1940s that the scientific manipulation of an individual's social environment began to emerge as a treatment modality. Harry Stack Sullivan, observing in 1931 that schizophrenic patients behaved in a less psychotic manner when ward personnel were sympathetic, was an early contributor to this approach. The Menningers in 1960 carried his work further, prescribing interpersonal environments designed to maximize the

therapeutic progress of each patient. J.L. Moreno experimented with and recommended the regrouping of members of residential institutions on the basis of their sociometric connections. In the late 1940s Maxwell Jones began to experiment with redesigning the mental hospital social structure, attempting to create a social environment that would produce therapeutic change. Jones (1953) called this environment a “therapeutic community.” Although the term “therapeutic community” is usually attributed to T. F. Main, the concept is most closely linked with this pioneering work by Jones.

Although all therapeutic communities are different, most of those modeled on Jones’s work share a number of features. Most important, patients play an active role in their own treatment. The patients in the organization meet usually daily, in face-to-face meetings. The authority pyramid is flattened so that the traditional power hierarchy diminishes and all members of the community, both patients and staff, can contribute to ward administration. Thus, as patients assume more responsibility, roles become blurred and the communication process becomes an open one.

Since Jones’s early work, therapeutic communities have proliferated. Many applications of the concept, however, bear little resemblance to the method developed by Jones. To clarify the resulting conceptual confusion, Clark has offered the distinction between the “therapeutic community proper” and the therapeutic community approach. The therapeutic

community proper is the type of community described by Jones. The therapeutic community approach is a more general one that includes features such as encouragement of patient freedom and responsibility, wards with open doors, active rehabilitation, and increased community involvement.

APPLICATIONS

Therapeutic communities (and therapeutic community approaches) have been used in many settings with a variety of populations. Probably the most consistent application has been in the psychiatric hospitals — perhaps because the more traditional hospital organization has been increasingly seen as "anti-therapeutic." Sometimes an entire hospital is considered a therapeutic community, but more frequently a ward or group of wards is given that designation. Within hospital settings such communities have been established with many types of patient populations, including psychopaths, alcoholics, schizophrenics, and adolescents. (For an overview of therapeutic communities within institutions see Rossi and Filstead, 1973.)

Another widespread application of the concept has been in the treatment of drug abusers. Residential treatment centers, such as Synanon and Daytop Village, are therapeutic communities designed specifically for the rehabilitation of drug abusers. Features such as reward systems based on increasing member responsibility, "attack" groups, and the use of program

graduates, as staff members are characteristic of these communities.

Psychiatric hospitals and residential drug treatment centers are total institutions that serve individuals whose problems are so severe that removal from society into such institutions may be preferred. Jones (1968) has encouraged the extension of therapeutic community concepts out of such total institutions and into larger societies. Such programs do now exist. Day-hospital therapeutic community programs have become numerous. The application of therapeutic community concepts within a psychoanalytic private practice has been described (Freudenberger, 1972). A number of nonresidential therapeutic communities (see the Sociotherapy article) have been created. These are “part-time” communities for functioning members of society who use community activities and groups as laboratories in which they can study and change their own social behavior (e.g., Siroka and Siroka, 1971).

The growth of the therapeutic community has occurred within the context of the “third psychiatric revolution” in which social psychological explanations and treatments of psychopathology have prevailed. Corresponding with the emergence of the therapeutic community has been the proliferation of many related or overlapping group methods, such as family therapy, network therapy, milieu therapy, and sociotherapy. Like other new treatment methods, which are initially applied enthusiastically but

somewhat indiscriminately, the therapeutic community will benefit from systematic study and evaluation. Outcome studies performed to date are generally inconclusive. More productive have been a number of investigations of the processes of the therapeutic community (e.g., Rapoport, 1960; Almond, 1971), as well as theoretical analyses of these processes (e.g., Edelson, 1970). Future work in the field should include more systematic evaluations of therapeutic communities, further study of how they work, and continued application in new settings.