The quintessence of a therapeutic environment

Rex Haigh

Rex Haigh is a consultant psychiatrist at Berkshire Healthcare NHS Foundation Trust, Bracknell, UK.

Abstract

Purpose – *The purpose of this paper is to describe the necessary primary emotional development experiences for healthy personality formation.*

Design/methodology/approach – *The paper is a critical synthesis of psychoanalytic theory.*

Findings – *Five experiences are judged necessary for health ''primary emotional development'': attachment, containment, communication, inclusion and agency. These can be deliberately recreated in therapeutic environments to form a structure for ''secondary emotional development''.*

Practical implications – *The ways in which these qualities of a psychosocial environment can be produced are described.*

Social implications – *Failure to recognise the importance of these qualities of an environment can cause unhealthy, or frankly toxic, psychosocial environments in various settings.*

Originality/value – *This is the author's original work, and has relevance for all psychosocial environments.*

Keywords *Psychosocial environment, Therapeutic environment, Therapeutic community, Milieu therapy, Organisational culture, Organisational development*

Paper type *Conceptual paper*

My first encounter with a therapeutic community was thirty-two years ago, when I was quizzically confronted by a large manic man as I nervously edged into a circle of about forty chairs on my first day in my psychiatry placement, as a medical student. I was looking forwards to my eight weeks on the Phoenix Unit, at Littlemore in Oxford, not least because I had previously spent a year as an undergraduate studying social sciences – including some antipsychiatry and psychoanalytic theory. But the practice was very different indeed from what I was expecting, and could not really have been adequately communicated without experiencing it. I learnt all the normal things a medical student is expected to learn in psychiatry, but I also ''learned'' something which puzzles me to this day, when I try to pin it down and describe it. It is something about a way of being – of relating to others – that feels far more authentic and creative than is ever described in the text book or the job description; the words that come to mind are freedom, safety and playfulness. I have been trying to describe and use this ''essence'' throughout my career since, and this version of this paper is the latest iteration of that process. I produced the first outline of it in 1995, as a theory essay needed for my qualification as a group analyst; a short version was published in the 1999 *Therapeutic Communities: Past Present and Future* book (Haigh, 1999). The quest also underlay the development of the ''Community of Communities'' quality network based at the Royal College of Psychiatrists, and more recently the ''Enabling Environments'' kite-mark. This version, now written after eighteen years as a consultant psychiatrist in various TCs, brings it up to date by adding new material and linking it to important British developments such as the innovation network of services for personality disorder.

Students and trainees rarely know anything about therapeutic communities nowadays, and if they do is generally just to be able to recite Rapoport's four themes, perhaps better called ''Articles of Faith'': democratisation, reality confrontation, communalism and permissiveness. Unfortunately, I have never been happy that they capture the essence of what happens in many TCs I have worked in or visited. Squeezing their practice into 1960s words like

''democratisation'' and ''permissiveness'' seems tokenistic, and it feels that those words cannot do justice to what happens. I do not want to imply that they were wrong: as I am sure they provide an excellent anthropological or ethnographic description of what was happening at the Henderson Hospital in the late 1950s, fuelling the blaze of radical social psychiatry. But they are not enough to link the whole purpose of therapeutic communities (transformative psychosocial change) to the experience of those who live in them.

Chomsky wrote about the underlying structure of language – how words we utter are connected to what we want them to mean. This is a parallel project about the ''deep structure'' of community – perhaps how emotions experienced in an environment are connected to meaning in our heads. It takes in some psychoanalytic concepts of object relations theory, uses the ideas of group analytic psychotherapy, and ends up in the realms of critical theory. Some see this as unhelpful postmodern perplexity – although elsewhere I argue that TCs are a thoroughly fit-for-purpose postmodern solution to some of the alienation caused by modernity and its consequences (Haigh, 2005, 2007).

But this contribution is primarily phenomenological: it is a journey through five experiences – five psychosocial concepts or ''principles'' which say something about the essential qualities of a therapeutic environment. The way they are arranged here is also a developmental progression – from the nakedness and vulnerability of attachment, through both motherly and fatherly aspects of containment (primary intersubjectivity) to the intercourse of communication (secondary intersubjectivity). Then the struggle of involvement and inclusion (perhaps ''adolescent''), and the adult, interdependent and empowered position of agency – finding a sense of self from which to deploy one's own power and effectiveness.

Each of these five principles has internal and external aspects, like an illusion and a reality, and this paper will aim to explain this with TC practice particularly in mind. The inside, or the illusion, is the emotional experience of what being there is like – perhaps the ''culture'' of a milieu. The outside, the visible facts of what is happening to enact the principle and carry the culture – and I am going to call that the ''structure'' of the environment. I am going to take each of the five principles in turn, look a some of their underlying theory, and try to understand what they mean for the members of our communities. Then, for each, I will try to see what we do – in terms of the nuts and bolts of the structure – to uphold, respect and maintain them.

As I have said, this is a developmental journey: much of it is my own journey through groups, and psychotherapy theory, and TCs. But I hope it is also a universal journey, and one that will find a resonance in all of us who work with people who are casualties of emotional development, and who use our own emotional processes in that work.

Attachment: a culture of belonging

> To a man utterly without a sense of belonging, mere life is all that matters. It is the only reality in an eternity of nothingness, and he clings to it with shameless despair (Hoffer, 2002).

Attached is how we all start: umbilically, within our mother and with her blood flowing right next to ours, separated by only a thin membrane. At birth, this physical and physiological attachment is suddenly and irreversibly severed: the smooth and fairly tranquil life of swooshing around in a warm ocean that is your whole world, without ever needing to eat and breathe, is over. It is the first separation and loss, and many more will certainly follow. The effortless existence is lost, and experience suddenly becomes discontinuous or bumpy: with good parts and bad parts, and if you are lucky, with people close enough to help you through it.

For the baby who is fortunate, the physical and physiological bond will be smoothly and seamlessly replaced with an emotional and nurturant one, which will grow and develop until various features of that too are invariably broken, lost and changed in the relentless inevitability of development. This secure early attachment gives the infant a coherent experience of existence, and protects against being later overwhelmed by life's vicissitudes. This places loss – of contact, of relationship, of security, of hope – centre stage in the process of individuation: attachment must take place so that loss can happen. It is through the successful endurance of loss that we all have to survive and change to live on (Bowlby, 1969, 1973, 1980).

For a less fortunate baby, born with greater needs, or for whom the process does not go so well, the emotional bond is not secure. Research in attachment theory shows that if the bond is not secure for the infant, nor is the adult who grows from it. When the failure or deficiency of emotional development is severe and incapacitating, psychiatrists will often come to a diagnosis of personality disorder when the person has reached adulthood, although many other diagnoses are also likely.

When disturbance is as fundamental as this, the first job of treatment is to establish a secure attachment, and then use that to bring about changes in deeply ingrained expectations of relationships, and patterns of behaviour. The culture in which this attachment needs to happen is one where community members can clearly feel a sense of belonging – where membership is valued and where members themselves are valued. This is harder than it sounds when people arrive with a lifelong history of unsatisfactory relationships – expecting rejection, hostility, abandonment, trauma or abuse.

Often, attachment is both strongly sought and fiercely feared (and resisted): the struggle between desperate neediness and angry rejection. Not enough stable ground has developed between, and the demands of reality almost always meet the emotional responses of pain, anger, humiliation and shame. When this is played out as the ambivalence to attach or not, it is often the very meat of the therapeutic process: can intimacy be tolerated, perhaps even used and enjoyed, or is it just too terrifying? Many never join, or drop out, because the fear and shame of letting others know them is just too great.

For those who fall into membership of a therapeutic community like a warm duvet, the natural course of development demands that their intrauterine-like experience soon becomes more complex. Members of any society who stay under the duvet all day will soon start having their responsibilities to themselves and others pointed out: conflicts will arise and need to be resolved. Various elements of the community will become invested with different and complex feelings – the stage is set for the rough and tumble: love, hate, anger, frustration, sadness, attack, defence, comfort and all the other ingredients of relationships. Facilitating the disillusion from the symbiotic fusion fantasy of the early attachment is about growing up and leaving home.

For those who start by fighting against it all, the destructive feelings can involve a wide range of ''primitive'' and pre-verbal defence mechanisms, such as denial, splitting, projection and projective identification. They can represent a deeply unconscious need to spoil, steal or envy what is good. For some, working with this can be the main therapeutic task: staying is an achievement, and any work to actually look at what that attachment means is a bonus.

The structural requirements for this mean we need to pay great heed to joining and leaving. The joining process is all about referral and assessment, and how prospective members of a community are dealt with. The very first contacts with people will have significant impact on how they feel about attaching to a community, and much of this will be in a complicated interplay with their deeply held expectations of relationships (and mental health services). However, a successful TC does need to believe in what it is doing and present itself, with hope and optimism, as a place worth belonging to. Being realistic about difficulties and doubts is necessary, but an early alienating experience in joining a TC can trigger persecutory feelings, defensive actions and premature departure.

The practicalities of leaving are just as important. It represents loss of a very important attachment, and the successful negotiation of it is a crucial part of the whole process. Leaving is usually the most significant loss a member will experience while having the full depth of therapeutic support available: it might be the first chance to ''do it well'' and be something learn and grow from. Communities often arrange it with rituals and gifts, but the real sense of sadness and loss need to be experienced, for it is by being fully aware of the pain of detachment that the intensity and meaning of the attachment before can be understood and ''taken inside''. It usually involves a mixture of anger, desolation, yearning and hope: the end of something very important, but also the beginning of the rest of life starting in a different place.

Containment: a culture of safety

> I mean Negative Capability, that is, when a man is capable of being in uncertainties, mysteries, doubts, without any irritable reaching after fact and reason (Keats, 1899).

One of the earliest things that ''grown-ups'' do for babies on their bumpy ride through infancy is to be there and accept their extreme feelings of primitive and boundless distress. This process is the template for containment, and for infants who get a satisfactory experience of it, it forms the basis of a safe world in which experience which feels intolerable can be survived.

Using the commonest family configuration, this could be characterised as a maternal element: safety and survival in the face of infantile pain, rage and despair. In a therapeutic community, these primitive feelings are often re-experienced, and survival without criticism or rejection may in itself be a mutative new experience for members, whose usual expectation will be to face hostility, rejection and isolation. Now they have the novel opportunity to have these powerful primitive feelings accepted and validated.

An aspect of safety which comes a little later for children could be called the paternal element: about limits, discipline and rules. This is the safety of knowing what is and is not possible and permitted – done through the task of enforcing boundaries. This is somewhat at odds with the view of permissiveness as a required quality of therapeutic communities: if the experience of containment is to be achieved through holding the boundaries as well as holding the distress, although the emotions may be boundless, the actions they precipitate are within agreed limits. It is therefore more fundamental for a place to feel safe than for anything to be allowed. And emotional safety is exactly what is experienced in the culture of a community when it is well-contained: it needs to tolerate severe disturbance so it can witness and then digest violent emotions, and still feel safe. However, the size of the stage on which the dramas are played is not limitless – and members need to know where its edges are so that they can feel that safety.

The continual and inescapable deep involvement and challenge causes a relentless regressive force on members, and will cause the community to act as a hothouse for feelings and the actions they precipitate, so the negotiation of ''disturbance'' will commonly be at the forefront of members and staff experience. The community needs to provide the structural stability to contain these primordial and overwhelming anxieties. Then, when the high emotion and incapacity to think and act rationally has subsided, can the digestion, understanding and healing happen.

The holding process also depends on the sensuous and nurturant qualities of the environment. These qualities will bridge the gap between the reality of holding and the experience of being held. It is the difference between ''containing'' and ''holding'' – one is mostly inside, and one is mostly outside (Symington, 1995). Both are weaker without the other: sympathetic and compassionate holding is unlikely to be usefully internalised without a deep and significant internal experience of containment of powerful emotion, and that containment at this intensity would be difficult and somewhat sterile without some grounding in the qualities of real relationships within a community.

In due course, a space arises between container and contained and it becomes safe enough to explore, and start seeking a sense of autonomous identity (Winnicott, 1965). It is in this ''transitional space'' that the infant plays with new behaviours, explorations, emotions, relationships and ideas. The therapeutic community can recreate this ''play space'' with a richness, intensity and variety which would be impossible to devise in other therapies. It will contain a large diversity of people with different experiences, attitudes, views and expectations. It is as if all human life is here – for relationships to be made with, to have fun with, and to get into trouble with: much as it is for a secure infant on its early explorations.

The structural features which embody the principle of containment, and make a therapeutic environment feel safe, are about support, rules and holding the boundaries. Support systems are important in providing a way in which disturbance is tolerated, distress is held and people are not left isolated and rejected when they are feeling desperate. But they also need to allow for the experience and tolerance of imperfection, which might make risk managers nervous in current times.

Rules need to clearly establish what is permitted and what is not: considerable efforts will often be spent on bending, stretching and interpreting the rules and boundaries. The process by which rules are invented, changed and discarded also deserves attention: the sense of safety will be compromised if the rules are not held and owned by the community.

Communication: a culture of openness

> Poetry, recording of the stripping of individual darkness must, inevitably, cast light on what has been hidden far too long, and, by so doing, make clean the naked exposure. Freud cast light on a little of the darkness he exposed. Benefiting by the sight of the light and the knowledge of the hidden nakedness, poetry must drag further into the clean nakedness of light even more of the hidden causes than Freud could realise (Thomas, 1934).

Once the primitive and turbulent preverbal work is in hand, a major developmental task is to make contact with others, enjoy mutual understanding of common problems and find meaning through this connection. For children, this starts in earnest once they begin to talk – although of course there is very deep and rich communication in the primary intersubjectivity which starts growing in the primary bond immediately after birth. However, it is by striving to put it into words that symmetrical contact is made through symbolic representation, that existence and identity is confirmed through mirroring – and that despair and distress can be articulated and made bearable.

For this to be possible for adults, particularly in large groups, requires a very specific and unusual culture. First, the attachment and containment need to be securely in place. Then, an intangible quality of safety needs to be present in the atmosphere so that people experience some certainty that the community will accept and digest what they have to say, rather than defend against, patronise or reject it. It is very different to their normal experience of being persecuted or isolated, where others are seen through two-tone glasses which colour them either wholly menacing and malign, or angelic and all-giving.

Communalism was one of the original TC themes (Rapoport, 1960), and was described as ''tight-knit, openly communicative and intimate sets of relationships – encouraged by sharing of amenities, general informality and an expectation of participation by all members''. Main (1989) described a culture of enquiry as a requirement of a therapeutic community, which indeed it is, and the expression has been much used in the field since. But perhaps enquiry is rather dry and inquisitorial, and calling the culture one of openness better concurs with the qualities of communalism, allows the opportunity for enquiry, as well as commentary and questioning, and conveys a subjective sense of freedom, movement and possibility of change – without implying undue formality or unwelcome scrutiny.

When this sort of openness is working well, it is difficult to feel paranoid: persecutory fantasies are immediately and deliberately reality-tested. If somebody – staff or community member – feels any anxiety about somebody or not knowing something, then there is a shared acceptance that it is reasonable to challenge others, and try to understand it through open communication and making contact. This openness is unusual in most adult situations: it refers to the exposure of interpersonal material which is usually left unspoken, maybe communicated non-verbally without full explanation, but normally well beyond where it is possible to allow detailed conversation or scrutiny. Amongst other things, it includes the questioning of motives, the relentless challenging of defences, and inquisitiveness about observable relationships. The defining characteristic is the expectation and demand that communication is more open, more profound and more honest than happens in everyday situations. Through it, relational connections are deepened and personal meaning is found through contact with others (Foulkes, 1964).

This openness is unremarkable for time-limited therapeutic sessions, but much of the time in a therapeutic community does not give that protection. For a therapist, it is reasonable and relatively easy to have a ''therapeutic demeanour'' in a group, but much harder to know just ''how to be'' when sitting together at lunch, or playing a game together. When the rough and tumble of this everyday milieu is avoided by staff, the openness gets undermined by ''us and them'' feelings, which although useful and workable with in a specific therapy space, need to be minimised in the overall experience. Expecting this degree of openness can be difficult

for staff, even those who have considerable therapeutic experience. Therapeutic boundaries here are much more complex than in once weekly therapy, and there are many strong pressures on them. Careful selection of staff, suitable training and reliable supervision are essential.

Within a community, this sort of communication also needs well-arranged structures in which to take place. Normally this means stable, dependable groups with clear membership, protected time and space, and mutual agreement of boundary issues such as confidentiality and expectation of attendance. Individual therapy sessions work against this, as they undermine openness within a community, and reduce the impact, cohesiveness and power of the groups.

Clarity about communication with professionals outside needs to be established. This can be done by copies of all letters and reports being given to members and openly discussed, or by all those documents being written collaboratively.

Some of the structures to promote openness are in keeping with contemporary expectations of transparency and accountability. Therapeutic communities need to be honest about what they are doing, and willing to communicate that to whoever is interested: including referrers, those who pay or commission such services, potential members and colleagues with overlapping interests. Inviting visitors into the community can be an important part of this. If this spirit of accessibility runs through the whole service, then openness is an expectation which people know about before they join.

Research and scrutiny should also be welcomed, and met with the same open mindedness as the clinical work requires. The quest for evidence is parallel to this: in a therapeutic community one is immersed in evidence of the power of relationships in promoting health, the harder task is to pin it down and communicate it openly.

Involvement and inclusion: a culture of participation and citizenship

> I was firmly convinced that we were on the threshold of an important new treatment model in mental health, but I didn't know at that time what direction it would take (Jones, 1991).

The three principles described so far – attachment, containment and communication – could apply to different forms of psychotherapy, in different measure. But the next two are more specific to therapeutic communities: perhaps they take the developmental sequence through adolescence into adulthood – and real life – in a way that other therapies do not. They also provide a radical challenge to the nature of managerial authority.

The term living-learning experience was an early description of therapeutic communities, and that is part of what this principle represents (Jones, 1968). Everything that happens in the community – from who makes the coffee, to the board games, to the requests for holiday – can be used to therapeutic effect. A disagreement in the kitchen can be more important than a therapeutic exchange in a group; it is as much part of the work of a junior doctor to play rounders with the community as it is for him to formally assess patients' mental states.

This goes beyond openness, in that it requires the sum of the experience of all the members all the time to come to bear in understanding ourselves in relation to the human environment. So the meaning of an individual's existence is as much in the minds of others as in the physiological or biochemical reality of an isolated person: we are mindful of others and they are mindful of us. One member of a community is held in mind by all the others, and they are all held in his mind. In a community where people are together for considerable time at considerable depth, and often with uncertain definition of where their edges are, this is an almost tangible realisation of how we are only meaningfully defined through a social process.

In the old residential therapeutic communities, this holding in mind was made utterly tangible: no longer a fantasy, but reality. For 24 h a day, all interaction and interpersonal business conducted by members of the community belonged to everybody. In day TC units, other ways are used to bridge the gaps and ensure that ''out of sight'' does not mean ''out of mind''. The expectation will be to use all aspects of interaction and understand it as part of the material of therapy. Not in isolation, but in the real and ''live'' context of interpersonal relationships all around.

In a normal therapy group, which might meet once a week, it is not normally possible to see so much of the context within which the individual is defined, but in a therapeutic community it is deliberately impossible to get away from it. Involvement of all aspects of a group member's experience is an indispensable part of the relevant material: ''everything here is part of the therapy'' is a commonly heard in therapeutic communities. This goes much further than the behavioural formulation of reality confrontation.

This discourse leads to a position where any separation of an individual from society or constitution from environment leaves the definitions empty and meaningless: the very opposite of an individualistic world-view. Social cohesion becomes the dominant aim; interdependence emerges through intersubjectivity and its perceived ethical responsibilities more than by demanding rights; fragmentation and alienation are reduced through finding meaning in relationship to others.

In some ways, we take this interdependence to the limit in therapeutic communities. Each has a different but vital contribution to make to the health of the whole. In the language of group analytic psychotherapy, the group constitutes the norm from which each member may individually deviate and the aggregate of all the individual elements produces a thing with its own qualities and a whole that amounts to more than the sum of its parts. This diversity, tension and energy which exists in the web of relationships between the members, with all the feelings and responsibilities that implies, is itself a creative and reparative force, when worked through.

To come back to practicalities, involvement and the continuous effort of looking at the context in which things are happening, is hard work. ''Dragging in'' much material which members would rather avoid will clearly meet resistance. Communities vary in how much structure they see as needed, how it is demanded, and how flexible that can be. This demand for involvement can be by peer pressure, by rules and procedures, or by staff intervention.

The community meetings – usually at the beginning and end of the day – are a vital part of this, for they are normally where the day's business is all brought together in everybody's mind. Their frequency, length, timing, structure and need for specific agenda items can all be arranged with this objective. In this way, everything that has happened within the day is part of the therapy – whether it has been discussed or not, interpreted or not, analysed or not. Often, it just needs to be acknowledged and held.

Agency – a culture of empowerment

> . . . they can demand responsibility because the demand comes from within a group of supportive peers: people who are all equal and people who all care (Pearce and Pickard, 2012).

In 1941 at Mill Hill Hospital, Maxwell Jones was running a unit for soldiers suffering from ''effort syndrome'' (probably called post-traumatic stress disorder nowadays) and he soon noticed that fellow-patients were more helpful than the staff at helping each other. At Northfield, Wilfred Bion was taken off his therapeutic rehabilitation wing after six weeks, probably because his experiment was unacceptable to the military hierarchy. These two locations were the start of therapeutic communities as we know them in mental health, and they both made fundamental challenges to the nature of authority. At that time, they probably seemed countercultural and somewhat subversive, but in may ways they were ahead of their time – and many subsequent social changes since have undermined our notion of traditional authority, and made us re-evaluate how it is now carried and administered. Although most psychiatric providers have moved from a traditional authoritarian model to a modernist managerial one, to provide an environment for the development of authentic personal agency demands a further move – to a world where a dazzling array of relationships and networks makes any sense of ''firm ground'' open to challenge. Perhaps it could be called a ''postmodern perplexity''.

But for therapeutic communities, this challenge to authority, and the primacy of the ''network of relationships'' over any social hierarchy, was there at the beginning. It also reiterates Jung's idea that the unconscious (of patient and analyst) know better where to guide the therapy than does the analyst's expertise, and the general belief that most therapeutic impact comes from work the

service user does, rather than the therapist. It also reflects the teachings of interpersonal theory and self psychology, where labelling and reification are seen as authoritarian, distancing and inimical to the establishment of a satisfactory therapeutic space. In group therapy terms, it is at odds with the models where therapists do individual work in the group, or only offer group-level interpretations. In both of these there is an underlying assumption that the therapist ''knows best'' or at least knows what is going on: information which the group members cannot know, or which is delivered to them under close control of the therapist.

In communities where members are afforded this sense of personal agency, things are different. An asymmetry and difference between therapist and patient is accepted, but an automatic assumption of authority is rejected: members acknowledge that anybody in the group might have something valuable to contribute to any other member. This is the essence of therapy by the group. Authority is fluid and questionable – not fixed but negotiated. The culture is one in which responsibility for all that happens within specified limits is shared: members are empowered to take whatever action is decided. However, a major part of the non-clinical work is to specify those limits and ensure that the space within them is kept free from authoritarian or managerial contamination.

Turning to the individual therapist, the role of doctor or therapist might often demands obedience or dependence, with a ''false-self'' quality where true affects concerning a relationship have little bearing on the conduct of both participants. In a therapeutic community this is very quickly subject to an uncomfortable scrutiny and deconstructed – for staff/service user relationships need to be grounded on something deeper than etiquette, seniority or custom. There are easy ways to do things, without thinking or feeling too much, which rely on ways of dealing with situations which have become almost automatic. It is much harder to think about what really needs to be done, and why (Main, 1990). This means struggling to understand each others' experiences and actions, and of avoiding standard responses, which might be dismissive or punitive, or using a stock phrase like ''what do you think?'' It also means respect must be earned as much through qualities of ''being with'' as of ''doing to''. Extrinsic authority and rank will come to mean much less than intrinsic authenticity and demeanour. Only through this process of experiencing parts of real relationships, beyond the transference, can a true sense of personal agency develop. Then action and feeling will have a clear connection to a true core self, and they are not held by a role or prescribed behaviour.

When members of a community take responsibility for each other as part of a live and intense process or relationship that really makes a difference, it is worth infinitely more than a risk assessment, or a procedure, policy or protocol (Cox, 1998). It demands that authority must always remain negotiable – authority is something that exists between people rather than in individuals or policies. Of course this is not anarchy or wholesale delegation of responsibility – or an unreal world with no outside references. In reality, we all work within a framework in which we are accountable for what we do. This may be where Bion's Northfield experiment fell down, for he challenged authority head-on, and those in power would not tolerate it. Bridger, Main and Foulkes challenged it by quietly demonstrating a way in which they could survive, and they went on to sow the seeds for radical re-evaluation of the nature of authority in therapy, and the development of a whole field of creative group relations.

The principle of agency in modern therapeutic communities follows this approach. With empowerment in human relations as the aim, it is in opposition to regimes based on biological determinism, the empty core of bureaucratically imposed policies, and the binary tyrrany of ticking boxes and unthinkingly following protocols. This goes much further than the original ''flattened hierarchy'' of democratisation (Rapoport, 1960). Rather than being a fashionable idea, or a policy which is imposed on a unit, it demands a deep recognition of the power within each individual, and particularly the multiplication of that power when a group acts coherently together. It is not a ''harmony theory'' or ''positive psychology'' that says we simply have to find this effectiveness within people or just work with the affirmative – for it necessarily includes powerfully destructive, envious and hateful dynamics which exist in all of us and are sometimes beyond reach. However, working towards establishing personal agency which is anchored in a solid sense of self does entail work needing a considerable degree of intimacy. It needs to be an intimacy which is safe, open and healing rather than abusive, dark and frightening.

The structures which support this type of culture are concerned with when votes are held, how decisions are made, and progression to positions of responsibility. Where the culture is developing, staff might often find themselves giving decisions back to the community to make – ''it's up to you'' or ''it's your community''. It can seem much easier to accept the projections of dependency and make the simple decisions, but then no power would be given back, and the staff would be the agents of action in the community. It is this process of refusing to accept members' individual or group dependency which makes them empowered – through having to search for their own sense of agency – both as a community and as individuals within it. Much of the time, it is uphill work – but there are plenty of occasions when the collective power of the community transcends what any one person could do. It is easy to forget what a radical and subversive idea it is to give real power to the people.

Primary and secondary emotional development

These five qualities can be seen as a simplified sequence of the fundamental requirements for reasonable emotional health in anybody – through the process of primary emotional development. Although we all start with slightly differing needs and have them met to various extents, it is something that goes seriously wrong with these five themes in a infant's or child's environment when it is abused, deprived, neglected, traumatised or suffers severe loss. And that results in a multitude of different consequences with possible symptoms and diagnoses, which all have a disturbed emotional development as the primary cause. This is of course closer to chaos or complexity theory, with ideas of ''sensitive dependence on initial conditions'' (as the butterfly effect is properly known) and the complexity of what is called ''deterministic nonperiodic flow'' (from which meteorologists first worked out the equations to define unpredictable events like hurricanes) than it is to biomedical models of linear causality which can be analysed by multivariate statistical analysis.

So secondary emotional development is what we try to facilitate by recreating these conditions in a therapeutic community. We are trying to provide a psychic space in which the things that went wrong or got stuck in primary emotional development can be re-experienced and re-worked in this artificially created setting. It might never have quite the impact as it could in childhood, but the experience can at least make a difference to expectations of relationships and the way in which care is sought of others thereafter.

Table I shows the five principles, their origins in human development, corresponding TC cultures and structures, and where the original therapeutic community themes fit.

Secondary emotional development is everybody's quest for what has been described with various names: positive mental health, wellness, happiness index, emotional maturity, emotional intelligence and well-being, as well as specific terms for those who have been through episodes of specific mental ill-health such as recovery, survival, escape, emancipation and transformation. Seven models defining ''Positive mental health'' have recently been described by Vaillant (2012).

Table I

Developmental need	*Origin in*	*Culture*	*Structures*	*Rapoport's themes*[a]	*Treatment phases*[b]
Attachment	Primary bond, losses as growth	Belonging	Referral, joining, leaving		Engagement
Containment	Maternal and paternal holding; intersubjectivity	Safety	Support, rules, boundaries	Permissiveness	Stabilisation
Communication	Play, speech, others as separate	Openness	Groups, ethos, correspondence	Communalism	Assessment, preparation, intensive therapy
Involvement	Finding place amongst others; interdependence	Living-learning	Community meeting agendas	Reality confrontation	Intensive therapy
Agency	Establishing self as seat of action; individuation	Empowerment	Votes, decisions, seniority	Democratisation	Recovery

Notes: [a]Original TC themes' were described by Rapoport (1960); [b]as described in Kennard and Haigh (2009)

The developmental sequence described here illustrates how this is not a consideration which is related to specific psychopathology, but is a general issue describing how we all develop to our full potential – or fail to do so.

References

Bowlby, J. (1969), *Attachment and Loss: Volume 1*, Attachment Hogarth Press, London.

Bowlby, J. (1973), *Attachment and Loss: Volume 2, Separation: Anxiety and Anger*, Basic Books, New York, NY.

Bowlby, J. (1980), *Attachment and Loss: Volume 3, Loss: Sadness and Depression*, Penguin Books, Harmondsworth.

Cox, J. (1998), ''Contemporary community psychiatry'', *Psychiatric Bulletin*, Vol. 22, pp. 249-253.

Foulkes, S.H. (1964), *Therapeutic Group Analysis*, Allen and Unwin, London.

Haigh, R. (1999), ''The quintessence of a therapeutic environment'', in Haigh, R. and Campling, P. (Eds), *Therapeutic Communities: Past, Present and Future*, Chapter 20, Jesssica Kingsley, London, pp. 246-257.

Haigh, R. (2005), ''Charismatic ideas: coming or going?'', *Therapeutic Communities*, Vol. 26 No. 4, pp. 367-382.

Haigh, R. (2007), ''Whose disorder, whose problem?'', presentation given to Limbus, Totnes, September, available at: www.limbus.org.uk/rex.pdf (accessed 24 August 2012).

Hoffer, E. (2002), *The True Believer: Thoughts on the Nature of Mass Movements*, Harper Perennial Modern Classics, New York, NY.

Jones, M. (1968), *Social Psychiatry in Practice*, Penguin, Harmondsworth.

Jones, M. (1991), *The Therapeutic Community: Dialogues with Maxwell Jones, M.D. Special Collections*, The Library of the University of California, San Francisco, CA (interviewed by Dennie Briggs).

Keats, J. (1899), *The Complete Poetical Works and Letters of John Keats*, Cambridge edition, Houghton, Mifflin and Company, Boston, MA, p. 277.

Kennard, D. and Haigh, R. (2009), ''Therapeutic communities'', in Gelder, M. (Ed.), *The New Oxford Textbook of Psychiatry*, 2nd ed., Chapter 6.3.9, Oxford University Press, Oxford, pp. 142-148.

Main, T.F. (1989), *The Ailment and Other Psychoanalytic Essays*, Free Association Press, London.

Main, T.F. (1990), ''Knowledge, learning and freedom from thought'', *Psychoanalytical Psychotherapy*, Vol. 5, pp. 59-78.

Pearce, S. and Pickard, H. (2012), ''How therapeutic communities work: specific factors related to positive outcome'', *International Journal of Social Psychiatry*, 20 July.

Rapoport, R.N. (1960), *Community as Doctor*, Tavistock, London.

Symington, J.N. (1995), ''Container/contained'', *The Clinical Thinking of Wilfred Bion*, Routledge, London.

Thomas, D. (1934), ''Political commentary'', *New Verse*, December, pp. 19-20.

Vaillant, G.E. (2012), ''Positive mental health: is there a cross-cultural definition?'', *World Psychiatry*, Vol. 11 No. 2, pp. 93-99.

Winnicott, D. (1965), ''The capacity to be alone'', *The Maturational Process and the Facilitating Environment*, Hogarth, London.

About the author

Rex Haigh is a consultant psychiatrist in the National Health Service who has set up several non-residential therapeutic communities. He was chair of the Association of Therapeutic Communities 1998-2004 and founder of the Community of Communities in 2002. Rex Haigh can be contacted at: rexhaigh@nhs.net