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Community and Individuality:

A Therapeutic Philosophy

The term 'therapeutic community' has gone the way of all linguistic flesh. Whereas it was originally coined to describe a particular kind of approach to psychiatric treatment, and specifically in a hospital setting, it now applies to a wide variety of approaches to helping people come to terms with their problems - and in an equally wide variety of settings. Alcoholics, drug addicts, schizophrenics and anyone diagnosed by virtually any other psychiatric label can turn to therapeutic communities; equally can those who deny the very legitimacy of the term 'mental illness'. Some approaches deny medication, others accept it; some are in hospitals, others in the wider community; some are highly structured while others deny the need or even the ethics of such structures. Does all this mean that the term 'therapeutic community' has lost all meaningful content, that it is simply a general and negative cliche implying every kind of therapeutic approach which is not a 'classical' and impersonal ('Goffmanesque') mental hospital or psychiatric ward?

What follows is an attempt to articulate a therapeutic philosophy which tries to express and incorporate some fundamental principles which, it seems to me, are common to most therapeutic community policies. While I have said that 'therapeutic community' can refer to a great variety of settings I am chiefly concerned here with expressing the idea in the context of halfway houses, since it is in that area that I am myself most involved. Our starting point is the observation that while vast numbers of people are hospitalised as mentally ill, many are then 'released' from hospital as suddenly as they entered, yet frequently not able to cope with their problems much better than before. From this the question arises: can a framework be created which has intrinsic value as a community, can it relate to the mentally ill individuals in their own right and can it still help them come to terms with and cope with their problems - and all this without seeing them as somehow inferior or basically deficient or socially marginal?

1. The Nature of Mental Illness

In the community model proposed here there is no single explanation of the ultimate causes of mental illness - nor in fact need there be. No attempt need be made to ascribe all mental illness to, say, bio-chemical processes or arrested emotional development or the consequences of a capitalist economic system or the structure of the nuclear family or anything else. These may or may not be the causes of illness but arguments about them are not necessary to the community philosophy. What is important is that whatever the ultimate causes of illness the members of the community share certain problems, and since it is these which were the direct cause of their emotional breakdown it is these which need to be tackled.

In the context of therapeutic communities, the mentally ill share a few basic problems. These are a lack of identity, an inability to communicate fully, an inability to cope with stressful or even normal (by average standards)

situations, failure to relate constructively to others, and failure to be constructively aware of one's own states of mind. As such, the mentally ill person is not a satisfactorily functioning personality, neither in their own eyes nor in the eyes of others. This is precisely the opposite of the healthy individual. Satisfactorily functioning individuals are those who are familiar with and can understand their own emotional states and personality traits; can define more or less clearly their goals in life and choose the best means of attaining them - not as some abstract aim but as an extension of what they know they are capable and not capable of achieving; are responsible for and to themselves; can relate creatively to others; can cope with life generally and with particular problems that arise in it. In short the healthy person is one who has a general sense of purpose and satisfaction which, even though not fully attained, are somehow progressed towards; and even if obstacles and painful setbacks occur these are coped with and eventually overcome.

The mentally ill person is for removed from this situation. He or she cannot articulate their aims; they will not take responsibility for themselves (they wish others to do so for them); they cannot relate creatively to others or cope with many situations; they refuse to come to terms with his or her own traits or even simply to define them; they have no sense of purpose or satisfaction (though they may be wishing to have them) nor frequently even envisage's the possibility of attaining them.

The point of a therapeutic community is to create a framework wherein individuals, who are not so sick that they cannot see that they are, can overcome the above difficulties. This is a framework where the past - so confused, mystified and seemingly irrational, and so infused with shame and guilt - can be put into its proper and rational perspective. From this the future can be placed into an equally proper and rational perspective.

Just as there is no single model of the causes of illness, so is there no conception that there is only one way to treat it. The *values* of a therapeutic community are universal, but not the *means* of attaining them. In this case a certain type of milieu is aimed at. It is unrealistic to expect a sick individual to become healthy on their own. One is bound to go through the rest of one's life in a pattern of relation with others, hence learning to relate to them positively is a necessary part of learning to cope with life. At the same time, living in a community can be an exercise in learning responsibility, both towards oneself and towards others. This can refer to simple tasks such as learning to cook or keep oneself looking presentable, or to more complex and demanding tasks such as helping others through difficult situations. Nor is this simply a 'technical' education. From it people can learn that their environment, physical or human, is not something to be feared but something one can relate to constructively and can even, up to a point, control.

One needs to acquire both the desire to be a properly functioning individual, and the means to becoming one. The mental patient leaves hospital usually when the symptoms of breakdown have disappeared, yet this is a long way from being a healthy individual. Until he/she sees what health is and manages to define what it means for them personally and acquires the ability to move in that direction, their situation is delicate, to say the least. The perception of health and the movement towards it are slowly and frequently painfully acquired, and individuals require an environment which can help them and make demands on them yet care for and protect them during such an acquisition.

2. The Concept of Health

All this points to an important consideration, namely that illness is not to be construed simply as the absence of health nor, more important, does health follow simply from the absence of illness. We have contrasted the characteristics of the emotionally ill and healthy, but these are not the only possible situations: on the contrary, there is a vast, grey and murky area in between into which most of us are born and remain for the rest of our lives. It is an area in which we *do* indeed have goals - but these have been defined for us by others and are geared more to the satisfaction of social convention than of personal need and identity; we *can* cope with problems - but more by avoiding them and by denying their existence than by confronting them directly; we *are* in touch with our personalities -but not too much lest we discover aspects of it we may not like or may even have to fear; we *are* able to communicate with others - but largely in the direction of expressing our demands on them, without really wanting to know or understand their demands on us; we *do* have feelings, but are afraid to express them openly lest we be labelled as ill or abnormal; we *have* fears and anxieties but hope that we will manage life 'successfully' by refusing to recognise or come to terms with them;we *do* perhaps have a vague sense of satisfaction in our lives - but it is far removed from the depths of satisfaction we are capable of attaining. And perhaps most important of all not only does this situation exist but we are generally not prepared to admit that it exists.

To the extent that this therapeutic philosophy is linked to a critique of society, this is it. No attempt is made, even implicitly, to ascribe causes to this situation, to explain why the majority of us grow up in this area of non-illness and non-health. There is no religious, economic, historical, cultural or psychological reduction. It is a fact of life which all of us need to understand - and then contend with. Personal breakdown occurs when people hovering on the fringes of this psychiatric limbo step or are forced to step beyond it, so that not only are they not healthy, they become ill. So, to relate to such people as somehow inferior to the rest of us is absurd since all of us are in reality not very far removed from this situation.

It follows then that the aim of a therapeutic community cannot simply be to treat emotional illness. Treatment is a negative activity; it aims at the removal of the symptoms of a problem. This is what mental hospital does. But if this is what you aim at then all you are really achieving is to transport individuals from a state of illness to a state of non-illness, from which state they became ill in the first place, and are only too likely to become ill again. The aim of a therapeutic community must be to help people become healthy, to show people that they have choices in responding to situations; that they need not respond only in preconceived or stereotyped ways. They have choices too in life, and by choosing with responsible self-awareness they are attaining emotional freedom. Simply to act as you like is not freedom. To act in terms of your capacities, your relationships, the totality of your needs, and to accept responsibility not only for making choices but for their consequences too - that is freedom.

This means that individuals need to come to terms not only with themselves but also with their society, and to find a fruitful interaction between them. To come to terms only with one or the other is destructive; to have a creative

tension between the two is intrinsically satisfying and a sign of emotional health. The therapeutic community aims at helping the individual find a private and individual identity *through* a group, not to take on that *of* the group, even that of the community, however praisworthy its aim. If there is a grey area between the extremes of sickness and health, there is potentially a bright and satisfying one between total withdrawal and total immersion, since from the viewpoint of emotional health, they are both sterile.

There is no assumption here that all you need do is help people understand why they are ill, from which understanding a process of recovery automatically follows. To attain mental health is, quite literally, a matter of hard work. We need constantly to make a conscious and determined effort, constantly to strive to understand our relationships with others, our attitudes towards them, and the way they see us. Only on this basis can health be attained. It follows that this cannot be a purely private process nor, even if we are interacting with others, can it be a purely one-way process. Only in a dynamic community where all share this common aim can individuals, whether they have suffered breakdown or are merely in a state of non-illness, attain mental health. It is through constant interaction with others, in which an atmosphere of mutual good faith exists, and in which there is constant feedback, understanding and sympathy, that one can understand better who and what one is and how one relates to others. Criticism and anger are also legitimate since this is part of the problem of living with others. The question is whether these are expressed in an atmosphere of good faith and whether they can be used constructively to further the attainment of positive ends.

Frequently people come to the community with preconceived notions about themselves (e.g. they can only survive with heavy medication, or they are the ill people of society, or they have no worth); they may too hide behind the security of psychiatric labels while simultaneously fearing them; or they may bear the stigma of having been in mental hospital and are imbued with shame, guilt, fear and confusion. To remove this self-image at the very least, is the aim of the community.

There is no guarantee though, that the individual will attain emotional health; at any rate such a condition is hard to define in concrete terms. All that one can realistically strive for is that the individual should *want* to be healthy; should realise that health must be defined positively not negatively (it is not a state of non-illness); and should begin to work actively in that direction. They must learn to value themselves (frequently their biography is one of negative evaluation from others and hence the need for a community in which they are valued), and must learn to accept themselves for what they are and are not, can be and cannot be. Ultimately (in terms of life in the community) they will, if they have achieved such awareness and the basic 'tools' of maintaining it, have made the necessary breakthrough. It is this breakthrough which the community aims at. (It is not concerned to define for individuals what their private goals should be or how they should relate to others or how they should define a feeling of satisfaction in life or how they should cope with stress.)

So a therapeutic community is 'merely' concerned with helping members arrive at a situation where they can do all this for themselves and be able to lead a relatively independent life after their stay in the community -at the very least without suffering a recurring breakdown and hopefully with

the desire and ability to explore further personal growth. There is no conception here of 'cure' or 'success'. This is too much of a cut and dried approach, implying a clinical distinction between sick and healthy, and having misleading biological overtones. One could perhaps look for statistical criteria of success e.g. rates of rehospitalisation, entry into employment and so on. But the real criteria of cure and success are far more intangible. They lie in individual's ability to look at themselves squarely, to understand the nature of their wants and needs, actions and relations, to come to grips realistically with their problems as they arise. The question is not whether individuals will have difficulties in life but how they will respond to them as they do arise.

In all this there is one fundamental assumption without which the whole philosophy collapses, that is that all human beings are basically healthy (within the limits of their own capacities) or are capable of being so, and that good human relations are a *sine qua non* of this health. We all need good relations; the aim of a therapeutic community is to provide them in a style that some need more than others, but the fact that they need them is not a sign of some deficiency on their part, rather of their being normal. Yet while the 'style' of the community is concerned with emotional health, it is too a way of life based on inherently good values. It is frequently society's refusal to recognise this which has caused mental illness. To this extent mental illness is a sign of a sick society.

From these assumptions it follows that the individual member is to be treated as an adult, a mature person, one who has rights and needs. He or she may not feel that way about him or her self and society may well reinforce this negative evaluation (personal relations, difficulties in finding employment, family) and both may see them as playing the sick role. It is this entire range of problems which needs to be tackled.

3. The Community Culture

The foregoing can only be attained if a certain type of atmosphere prevails, an atmosphere characterised by open and honest communication; by an attitude of mutual caring (but not to the extent where this creates feelings of dependency on staff or on the community as a whole); in which individuals accept the need to take responsibility for themselves and others; in which they genuinely try to achieve the primary breakthrough mentioned above; and in which there is a feeling that over and above each individual's private need to be in the community a culture of togetherness and pleasure prevails.

Clearly then the community needs to be something more than an institution in which a number of people happen to be under one roof, each pursuing private ends unrelated to those of the others. Nor can it be a halfway house whose only purpose is to contain mental illness. The community though does not aim at becoming a substitute for the world at large, nor for families in it, even though it can and should have a family-like atmosphere. Nor is it trying to convince society to restructure itself on the community's own lines - although it very much wants society to adopt its *values*. In this respect there is a contradiction in its aims. To be therapeutically successful it needs to create the atmosphere and culture of a community - togetherness, sharing, caring, common aims, close friendship. But unlike other communities which share these qualities as permanent ends in themselves or as a means to attaining supra-individual goals the therapeutic community is a self-denying

community. It creates a community culture in order that its members should be able to live without such a culture. This is not to say that life outside the community is necessarily 'cruel, nasty, brutish and short', only that the values of the community are only marginally expressed in the ordinary daily situations the member is likely to encounter. The successful member of the community is paradoxically not one who commits himself to it but one who is able to deny it. Yet this is not as paradoxical as at first appears since while he is expected to be able to live without the specific community he matured in, he can be expected to carry the values and tools he acquired with him into the wider world.

4. The Role of Staff

Clearly only individuals with a commitment to these aims, with personalities suited to the type of interaction required with residents and other staff, and with the necessary professional skills can staff such communities. This is of course true of any occupation, especially where interaction with others is of the essence. But the significant difference here is that staff *are themselves integral to the creation of the community.* In other words, they are not only employees of the institution but also community members. This does not mean that there should be no difference between staff and residents. On the contrary, certain differences between them in roles, responsibility, demands on self and others are essential to the attainment of community goals. To try to remove totally these distinctions, with all the goodwill in the world, is likely to hinder rather than promote these goals. By recognising a fairly clear structure, residents and staff can know what the spheres of differential responsibility are; they can know on whom to lean and not to lean; they can test out themselves and others. Without any distinctions, confusion can arise as to what each is meant to be doing and in what ways they can or need to behave. Yet while it is necessary for staff to have a role, to know what that is, and to act accordingly, they should not hide behind that role. They must be prepared for confrontation to the same extent they demand it of residents.

The reason for this follows too from our earlier comments about the universal need for mental health. Staff cannot set themselves up as the arbiters of mental health nor as perfect models of it. On the contrary, members of staff should themselves, no less than residents, be seeking to attain mental health. They have a much firmer starting point than residents: They have perhaps not been mentally ill, or, if they have, have gained a perspective on it which enables them to help others. Through accepting the need in themselves to strive for mental health they are more likely to approach the problems of residents with the right amount of sympathy and understanding, and are more likely to be able to acquire the necessary skills to help other community members.

But staff should remember that because of the relations between themselves and residents the ways in which they (staff) behave will influence greatly the behaviour of the residents, and staff values will become residents' values. It is not so much what staff *say* about honesty, responsibility and so on, but how they *actually implement* them that will influence residents. So if staff cannot or will not implement them, not only will the residents not learn to do so too, but they (the residents) may become cynical and despairing about those values.

There is an important qualification to all this though. The community structure is to be democratic and egalitarian (below): this is both intrinsically good and therapeutically valuable. The same applies to the staff's own need to strive for emotional health: this need is both ends and means. But the ways in which they promote their own good health must not take precedence over their role as staff members in relation to residents. In a word - that staff should share the aims of residents is good and it is useful. Fortunately what is good and useful happen to coincide, but conflict can easily arise (and this may happen if a staff member wishes to satisfy private needs at the expense of the role as a staff member, or wishes to act out with residents what he is really acting out regarding himself) then the staff role must take precedence. Anyone who cannot resolve the conflict in that direction cannot be a staff member. Hence the structure of the house and the aims of staff help to facilitate the creation of a single community irrespective of roles. In this way a community atmosphere can be attained without jeopardising the *raison d'etre* of the community. This means though that staff have to maintain a delicate role. On the one hand they need to serve as a model for residents -someone who is strong, caring, able to help, and someone from whom criticism and unpleasant demands will be accepted. On the other hand they need to be ordinarily human too, and if staff members can demonstrate that in themselves they can cope with their problems, this can help to show the residents that they too are capable of doing so. Self-awareness and personal responsibility are ends in themselves; honesty, communication, sharing, caring, demanding are also ends in their own right and they are means to attaining self-awareness and emotional health.

5. A Normal Environment

The development of staff's and residents' self-awareness is very much linked not only with the culture of the community but also with its physical existence. One fundamental difference between a residential community and any other kind of therapeutic community is that life in it approximates fairly closely, from the viewpoint of daily living, to life in the outside world. One does all or almost all the things one would normally do - prepare food and eat it, have a room and look after it, pay rent, go out to work, relax with friends, work in the garden and so on. This means that unlike most other therapeutic settings one is engaged in a whole variety of activities and placed in a variety of settings, and one is constantly getting feedback on how one is acting and responding. In other words the aim is not simply the humanistic one of treating individuals as whole beings but of giving them a total and as far as possible a normal environment in which to learn about themselves, their goals, their needs, the ways in which they relate to people and respond to situations.

The difference between everyday living alone and everyday living in the community is that in the latter one has a degree of protection. One can ease oneself into the exigencies of daily living in gradual and controlled form, all the time getting feedback and having the opportunity to test oneself and others, to experiment. In a therapeutic community one has too the chance to practise daily living. However banal this may seem to the non-ill many members have simply to learn to cope with and even just to learn the technicalities of preparing a meal or paying rent. To throw an individual

directly into isolated everyday living straight from hospital where his needs are catered for, responsibility denied him and only a strictly limited range of stressful situation catered for, is to court disaster. By creating as nearly normal a situation as possible with the maximum range of situations, one can provide, quite literally, an education in living. At any rate, one needs to test oneself and to be tested in diverse ways, since one's capacities and responses will vary from situation to situation. This applies equally to staff both in their 'private' capacities and in their 'official' role.

6. Care and Protection

It will be quite clear from all this that while care and protection are fundamental to the community they are not absolutes. Potentially there is no limit to the extent to which one can provide care and protection or demand them from others. These are, like other aspects of the community, to be valued in their own right, but also they are instruments to help the residents in their path towards personal growth. Yet to be over-caring or over-protective is likely to damage more than help the resident. Anyone who wants only care and protection is too ill to be able to make proper use of the house and has no place in it. Equally, any staff member who can provide only care and protection and who cannot make demands on residents is not capable of helping them. A person who cannot or will not cope with the world is ill. There is every reason therefore to demand of residents that they get up in the mornings, help clean and cook, pay their rent, and so on. So in a therapeutic community caring and protection mean not necessarily doing things for others but relating to their inability to do these things with understanding, not treating it as deviance but as a problem to be worked through.

As residents progress in the community more can and will be demanded of them. The point is not to make the same demands of every resident but to demand of each to be as responsible as they can possibly be. The resident who has no desire to make attempts in this regard has no place in the community. In short, there must be a sympathetic adult-to-adult relationship, not an over-structured or over-caring one.

Yet, as we have seen, residents frequently do not want responsibility. Equally, staff may not want to give it to them, or may simply underestimate them. They (staff) may feel easier playing a parental role or they may want residents to be dependent on or to like them; or they may fear the consequences of giving residents responsibility - if they have misjudged the situation tragedy can follow, or the resident can begin to relate to them as an adult, and this may not be easy to accept. Staff need to be aware of these dangers and of the temptations to circumvent them. They must also not fear their use of authority: they may feel that to use authority is to be authoritarian, but this need not nor should not be the case, and they should be able to make the distinction.

7. Rules and Expectations

This raises the question of rules and expectations. Rules refer to formal demands made on members of the community; expectations refer to the personal goals of each member in joining the community. Rules then are universal and impersonal; expectations vary according to the individual.

Why should there be rules and expectations, and why should they take the form they do? There are a few main reasons:

(i) *Because the community is 'total' (at any particular time) it needs to perform certain basic tasks - cooking and cleaning, for example, or payment of wages and bills. Rules are needed to ensure that such needs are met and further rules are needed to say how they shall be met.*

(ii) *In all social groups there are further reasons why rules are necessary and it is easy to see how they apply to a therapeutic community.*

  (a) *People in the group need guidelines around which to pattern their behaviour.*

  (b) *People need to know what the limits to their behaviour must be so that their behaviour does not damage themselves permanently (emotionally or physically) or arouse serious anxiety in other residents or destroy basic group cohesion.*

  (c) *While the house is only loosely structured and while there is much flexibility in the application of rules, some structure and rules are necessary even if only in negative form, to canalise one's energy, thinking and behaviour, especially where there is difficulty in articulating goals and needs.*

(iii) *Normal living means abiding by many rules. The rules of a therapeutic community should not be arbitrary; they should at all times be therapeutically valuable, but there is no harm in residents getting used to the fact of having to live with rules.*

(iv) *Since the individual needs therapy, and since fundamental to this therapy is the ability to express one's emotions constructively and articulate one's goals, anti-social behaviour which negates constructive expression and articulation should not be encouraged because the individual will not be making any useful progress and will certainly be preventing others from doing so too.*

8. Sanctions

In the argument proposed here, the only formal sanction for breaking rules and expectations is expulsion. This is consonant with the loose and democratic-egalitarian nature of the house. To fine people or to lock them in their room for a day or to give them menial labour - surely this would create an atmosphere which is hardly consonant with its community-culture? More important, might people not live in the house with a fear of punishment, and might this not inhibit people from expressing themselves freely?

There is though another sanction in the house and that is public opinion. It is both informal and therapeutically useful. When a resident acts anti-socially, other residents, possible with the help of staff, will respond negatively. This may or may not deter someone from acting like that again. What is important though is that the response to the behaviour is not the cold application of an abstract rule but the involvement of the 'culprit' in the responses of the others to it - the questioning, the searching, the perception of what that behaviour has brought out in them. Equally, it helps the other residents

to examine their own responses and why these take the form they do. In a therapeutic community whose very existence is predicated on the assumption that interaction *per se* is a therapeutic process, the response to deviance must be based on human, in the sense of personalised, interaction.

Hence while anti-social behaviour is not to be welcomed, or even tolerated beyond certain limits, one must see it in its proper perspective and even attempt to put it to therapeutic advantage. For this reason staff will frequently avoid taking the 'you're a bad child' approach but will rather use the aberrant behaviour as a springboard from which to help the residents understand why they cannot express themselves in more constructive ways. However, there are limits even to this because of the stresses such behaviour places on staff and the response may well be to demand of the resident to conform or else, which too can be therapeutic since it is an education in reality acceptance.

The question of how to respond to rule-breaking helps to highlight one of the basic problems facing staff. *This is that no amount of rules and guidelines will be sufficient to guide one absolutely in one's work.* They can only provide a *framework* as to how to relate to residents and how to respond to their behaviour. Ultimately though staff need to develop the ability to assess situations rapidly, to choose the most beneficial response, to know when to be more caring or more demanding, more rule-bound or more permissive. This is not a question of steering a non-committal middle course: that offers not consistency but ambivalence and uncertainty. The only criterion of consistency is to respond in the most therapeutically valuable ways, and these ways may vary greatly. So staff need to know which are the most valuable ways and to have the confidence that they are doing the right thing. They also need to be aware of whether they are responding to residents according to their (staff's) own needs, individually or collectively, and whether they are rationalising such responses (e.g. taking a personal dislike to resident, over-responding to a resident's attempts at manipulation,choosing a non-response as the easy way out).

9. Democracy and Equality

All this is related to something we have implied but not discussed explicitly. I refer here to the community's relatively democratic and egalitarian nature.

It may help if we begin by comparing the conventional psychiatric ward which most residents have experienced and the therapeutic community. In hospital people are treated as patients, as sick individuals who require treatment. The treatment is active, the patient is passive. Moreover they are dependent, protected, treated as adolescents. On release they are expected to be adults, and if they fail (a frequent occurance) they are blamed for this inadequacy. The structure of the hospital is also significant. There is much emphasis on control, hierarchy, the gap between staff and patients, isolation and even a degree of dehumanisation. In contrast the community attempts to relate to residents as adults who are capable of change through their own efforts (and only through their own efforts) and who need to be gradually eased into a state of independence. The structure emphasizes democracy, permissiveness, equality and relating to others as human beings to be valued and respected in their own right. Staff, instead of being authority or parent figures, need to be guides, friends, leaders, helpers, examples.

One of the difficulties in discussing democracy in a therapeutic community is that it is another term which is hard to define. The community argument against the classical setting is that many rules in the latter are frequently oppressive, anti-therapeutic, unnecessarily custodial, based on the convenience of staff and imply a moral judgement about patients. In therapeutic communities the criterion of whether a rule is good or not is whether it meets the purposes for which the community exists or if it contributes to the basic functioning of the community.

The democratic argument is that adult, responsible people will know what they want and need and, at any rate, even if they err that is their privilege. For the community this means first that the number of rules is fairly minimal; that they are applied flexibly; and that they do not assume a model of what is morally good or not - they are primarily designed to help people become more responsible and more self-aware through acting in therapeutically valuable ways.

The main value of having a democratic structure is that it helps to strengthen those characteristics which go to make up the community atmosphere. If there is to be honesty than it must be a two-way process: residents must be as honest to staff as staff to them. If people are to learn responsibility then decisions must not be made for them: they must be encouraged to make decisions for themselves and to accept responsibility for the consequences of such decisions. If residents are to learn to share themselves with others then staff must be able to show them the way (without, as we have seen staff exploiting residents for their own ends). If there are to be, on the one hand, caring and protection, and on the other demands and expectations, then each can only exist because of the other (you are more likely to accept the challenge of expectations if you know that caring and protection will follow you in your difficulties - always provided your intentions are basically positive), and each can only exist if an atmosphere of good faith and genuine concern prevail in the community (as opposed to destructive over-concern or paternalism). The function of democracy and equality in the community is to promote the circumstances under which the development of responsibility, the readiness to share and to meet expectations, and the promotion of an atmosphere of good faith can emerge.

The success of the kind of therapeutic community we are discussing here depends, ironically, on its readiness *not* to implement the 'pure ideology' absolutely, that is, it uses the ideology as a *general goal* which provides guidance, direction and unity of purpose, yet is sufficiently flexible and compromising in its daily application. So the community aims at being democratic but not totally so; it aims at equality but not to the point of obliterating all role distinctions; it believes in honesty and free communication but recognises that at times speaking your mind or demanding that your needs be met exactly as you like can be disruptive and threatening; it accepts permissiveness but only within a loose framework of general rules. The point is that one cannot legislate these compromises and 'deviations', nor can one give them even a specific ideological rationale. 'All' that one can do is to create and sustain an atmosphere in which such contradictions are recognised as being necessary and inevitable, but where this recognition is not accompanied by cynicism or confusion. Where the general atmosphere of goodwill exists

compromises are not viewed as failures or as scheming manipulations but as part of the problems of sustaining a community and as necessities to be lived with or problems to be worked on. And whether the positive situation is to prevail or not depends on such intangibles as how people talk to each other, how they respond to each other's needs, how honest and caring they show themselves to be, how committed to the community they are. Only when the bulk of members 'click together' from that point of view will a positive atmosphere emerge, and only in such an atmosphere will the compromises necessary to continued functioning be accepted and sustained.

Put otherwise there are no formulas for how to relate to people and to respond to situations. With all the guidelines in the world, relations and responses will vary from person to person and time to time. As we have seen, the criterion of what is the correct response is to do whatever is therapeutically necessary. But what is therapeutically *necessary* will only become therapeutically *valuable* if the residents themselves accept it as necessary; and they will only accept it as necessary if (among other things) they have trust in the good faith and judgement of others. In such an atmosphere the ideology is not accepted as rigid but as a means and a framework for creating and sustaining a therapeutically beneficial culture - with all its weaknesses, problems and compromises.

In conclusion we may say that the crucial characteristic of the true community, and of *any* true community, is that there is no gross disjunction between goals, values, life-styles, occupations and activities, the community's structure and principles on which that structure is based. They are all integrated, and it is this integration which turns a group into a community. In context of a therapeutic community model, as expounded here, such integration exists since the value of the individual is upheld in all the dimensions of his life. Furthermore, when this is recognised by all concerned then even the formal distinctions which exists between community members do not appear to be based on power or careerism of self-gain but on common purpose. Only in such an atmosphere can the necessary tools for emotional health - honesty, communication and caring, coupled with mutual demands and expectations -be properly sustained.

Sue Hinton

Roads to Freedom Conference - One Person's Journey

Roads to Freedom. Congratulations to whoever thought up that title. From the magazine on the breakfast table, under the electricity bill, among the toast and marmalade, between "where are my shoes" and "hurry you'll be late - again", between Terry Wogan and the time checks, and the rain beating against the dark winter morning window, it reached out and called irrestibly to that part of me that knows that there are more things in heaven and earth. . .