

The System Bites Back: Politics, Parallel Process, and the Notion of Change

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ABSTRACT: In this paper the author weaves together her personal experiences of creating a trauma-sensitive therapeutic milieu based on therapeutic community principles with the currents of social, political and economic tides that have exerted influence over and interacted with the mental health service delivery system of the US over the past four decades. She uses chaos theory and the insights of Maxwell Jones as a background for illuminating and explaining some of these influences as they affected the life and work of her colleagues and herself.

Background: first exposure

Social Psychiatry – includes all the social, psychological, anthropological, educational, theological, philosophical, and research factors that may modify psychiatric practice and society in the direction of increased mental health.

Maxwell Jones, *Beyond the Therapeutic Community* (1968: 134)

I first came into contact with the ideas surrounding the therapeutic community beginning as a 19-year old secretary, then psychiatric orderly, then medical student, and finally a psychiatric resident on an inner city hospital unit in Philadelphia in the 1960s. Social psychiatry was in its prime, connecting the world of mental health and mental illness with current social problems, and psychodynamic concepts were still the explanatory system for most of the emotional difficulties we encountered in our patients. The work of Maxwell Jones was well-established in clinical practice by that time, so embedded at the hospital where I trained that it was not until years later that I fully recognised where the ideas behind the ‘therapeutic milieu’ had originated. At the time I thought that it was just the way things were done.

My psychiatric mentor, Dr Roy Stern, had been influenced by the intellectual currents of social psychiatry, radical psychiatry and psychoanalysis that dominated our psychiatric department at the time. He taught me to always question authority, to take into account everyone’s point of view in order to understand a complex problem. For him, professional training and educational status was only as valuable as the common sense that served as the underpinning of that knowledge. And common sense, a relatively rare commodity, could be found in some people with little or no education and could be dishearteningly absent in those most highly educated. He taught me to look at people as complex

A version of this paper was presented at the Maxwell Jones Memorial Lecture 2002.

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adaptive, self-organising systems, though he never used those words exactly. Instead, he taught about complexity by illuminating the absurdity of simplistic solutions, by constantly challenging us as residents to push beyond our own fixed assumptions and beliefs, and by demonstrating the paradoxes of human existence as they presented in our patients. Even in the 1960s he was challenging the growing dogmatism of the Diagnostic and Statistical Manual, recognising psychiatric labels as only sketchy descriptions of an otherwise exceedingly complicated being. He and the people he assembled to work with him, people from different races, professional backgrounds and socioeconomic classes, created a therapeutic milieu that was an open, compassionate, healing environment for anyone who sought treatment there.

This was an acute care psychiatric inpatient unit in an inner city teaching hospital so the patients spanned the urban psychiatric universe of the time. In true democratic fashion, the homeless black man or woman received the same consideration and respect as the university graduate student or the wealthy matron admitted by her private practitioner. Although psychotic patients then as now were sometimes prone to violence and people were frequently admitted because they were suicidal or self-harming, our unit had an open-door policy and my mentor fervently defended our right as staff and the right of our patients not to live behind locked doors to which other people held the keys. As a result, I discovered that a propensity towards violence could be powerfully influenced by the social environment and that maintaining clear and strong social norms discouraged most forms of acting-out behaviours.

I learned what it meant to be part of a therapeutic milieu, about the importance of looking at the whole, about the subtle influence we have on each other as individuals and as groups, and the extraordinary opportunity for 'social learning' that was presented each day to the staff and the patients. It was abundantly clear that successful treatment of the patients in an inpatient setting was almost entirely dependent on the compassion, integrity, perseverance, patience, and wisdom of the staff and in this lesson I learned a great deal about leadership, moral intelligence, and the importance of managing the system as a whole. I learned about individual and group dynamics and how the two interacted with each other and how the group unconscious could collude to create a collective disturbance. At the same time I witnessed daily the power of group dialogue and the emergence of group consciousness, producing creative solutions to complex problems that far outstripped the capabilities of individuals. I was taught to be profoundly curious about symptoms and to read the meaning in the messages that bombarded us from our patients, their families, the other staff in the hospital, and each other. I was taught to be humble in the face of profound mystery. I learned that human beings were simultaneously very simple and very complex.

Politics and the profession

There is reason to believe that in the United States a counterculture, or a revolt against the values of a society dominated by economic considerations, competition, and a nationalistic aggression that condones war but ignores the needs of the underprivileged or the racial minorities is already leading to a new value system particularly apparent in the youth of America.

Maxwell Jones, *Maturation of the Therapeutic Community* (1976: 82)

Maxwell Jones and his colleagues – and then later, my teachers – rode in on the back of World War II, the Holocaust, and the atomic bomb. My generation represented the first

offspring of these monumental and socially traumatic events. By the 1970s, when I was in my psychiatric residency, my country was going through a fundamentally disruptive but profoundly creative period. Involved in an unpopular and arguably illegal war, conflict was apparent everywhere. Authority in all of its forms – civil, military, religious, educational, artistic – was being challenged. Race riots sparked by centuries of discrimination and segregation broke out in major cities. Protests erupted on virtually every college campus as young people and many of their teachers – raised on the idealistic patriotism of Mickey Mouse and John Wayne – encountered Richard Nixon, Vietnam, the segregated South, Watergate, the slaying of students at Kent State, and the triple assassinations of John F Kennedy, Robert Kennedy, and Martin Luther King. All these events, though almost forgotten by many people today, were traumatic for the country as a whole.

In the psychiatric department at Temple University Hospital where I worked and trained, psychiatrists joined in civil rights and anti-war protests, wrote letters that allowed women to get what were then otherwise illegal abortions and allowed men to avoid being sent to Vietnam. Some of these psychiatrists were in the forefront of practising a different kind of psychiatry – therapy that involved the family, therapy that listened to the meaning behind the schizophrenic's unique language, group, therapies of all sorts from psychodrama to Tavistock groups, therapy that was socially and politically engaged under the rubric of 'community mental health'. Many of them believed that, as Ullman wrote in 1969, "the mentally ill person is seen as a member of an oppressed group, a group deprived of adequate social solutions to the problem of individual growth and development" (Gray, Duhl & Rizzo, 1969: 263). I was taught, following Foucault, that mental illness was a social construct and therefore the possibility was strong that social forms of intervention could significantly change the outcome for those labelled as 'mentally ill'.

Change was in the air and, alongside of the anxiety associated with seemingly chaotic and sometimes violent change, there was a surging of hope and vision that was captured in a number of ways, through television shows like *Star Trek* a sci-fi series that offered what remains one of the only positive visions of the future for the human race; in communal settings where people of all stripes experimented with alternative living environments; and even in a mental health treatment climate that implied that mental illness – along with poverty, racism, sexism and economic inequality – could be abolished. The human rights movement took off, people of colour began to overcome 200 years of oppression, women surged into almost every occupational and educational setting and liberated themselves by taking control of their own capacity for reproduction. The long climb toward children's rights even gained momentum with the 'discovery' of child abuse and child sexual abuse and new efforts directed at child protection.

For those of us who delighted in the changes that had been happening throughout the 1960s and 1970s – those who in the US would 30 years later be spurned as 'liberals' – change was sure, change was certain, things would never go back again to what they had been. We had no language for it then, because chaos theory for the uninitiated had not yet been written, but we thought that we could create something entirely new, a system embedded within the mental health system, in which the past no longer would predict the future but would instead be discontinuous, with sudden unpredictable jumps and that we would continue to see sudden transitions resulting from dramatic reorganisation, a reorganisation that would lead to a better and brighter future (McClure, 1998). But we had not reckoned with the true nature of change.

Creating a counterculture

The psychiatric hospital can be seen as a microcosm of society outside, and its social structure and culture can be changed with relative ease, compared to the world outside.

Maxwell Jones, *Beyond the Therapeutic Community* (1968: xii)

When I left my residency, my method for joining, at least on the periphery, this river of change was to create my own psychiatric unit. David Kennard has pointed out the long history of moral treatment and its continuation in the therapeutic milieu in the United States as pursuing the idea that a community created in the 'reverse image' of a society at large could be therapeutic for the casualties of that society (Kennard, 1998). I had absorbed that idea and, after experiences in a number of different psychiatric centres, I decided that, to create such a 'reverse image' – and have it be a safe and meaningful place for myself and my staff as well as our patients, I would have to gather some colleagues together and we would need to create such an environment for ourselves.

In 1980, along with a psychiatric social worker and a clinical nurse specialist, I led the transformation of a medical-surgical unit in a general hospital in the far suburbs of Philadelphia into a general short-term psychiatric unit designed to be a therapeutic milieu. Initially, we ventured into this project under the auspices of one of the small, private psychiatric companies that had newly entered the mental health service delivery world. True to the traditions I had been exposed to, we insisted on operating a voluntary, unlocked unit and hired a diverse staff. We provided a rigorous programme of group, individual and family therapy all embedded in a milieu that we attended to regularly through our rounds, team meetings, and staff meetings. We developed an excellent reputation in our local area and treated adults and adolescents.

Our average length of stay was only about 13 days and we never kept people in the hospital longer than we believed clinically that they needed to be there. We were still young and thought that the excellent, dedicated and responsible care that we delivered to our patients and their families would keep us on safe and solid ground. Creating a humane, healing and liberating environment as an alternative to traditional psychiatric inpatient care was our primary motivation but we rapidly came into conflict with the motivations of the company for whom we were working. The fact that we were a valuable commodity to the administrator of the company, who saw a fortune for himself ahead in an expanding free-market economy, was initially irrelevant and I was still quite naïve about the Faustian bargain I had made with an increasingly omnivorous capitalist system that I knew very little about.

By 1983 I had exhausted attempts at working through the many conflicts that arose between me and the psychiatric management company. In parallel with the spirit of 'the entrepreneur' that was the preferred character prototype of the times, I negotiated a separate management contract with the hospital where our programme was located and 'went into business' for myself – a venture that nothing in my past background had prepared me for. I was riding the tidal forces of change that were driving my country. I knew nothing about things like health care benefits, profit-sharing plans, and corporate legal arrangements but survival of our programme depended on developing the business structures that could support it. I didn't enjoy doing any of it but for the next 12 years this arrangement adequately protected my programme, my staff and myself from the increasing degradation of mental health care delivery in the US. Because I had the management contract and the business structures that supported it, we were able to

develop our inpatient and outpatient services in the way that we thought they should be developed.

My colleagues and I had a thriving practice by 1985 and thought we were doing good work for the community and our patients without having to compromise our ethical and practice standards. We were consulting with the local schools, lecturing regularly at many different venues in the community about mental health issues, interacting with the local churches and other social service agencies. We were faced with few ethical compromises because there was adequate money in the system. We could make a fair living for our services, not have to compromise on the level of care we delivered to our patients, and have enough to accept the losses that inevitably accompanied treating the indigent because of increasing cuts in Federal funding for the poor. By 1985, mental health care in the US was still mainly covered by private insurance, many more people than today had insurance through the companies they worked for, our programme was set in a prosperous, middle-class community, and the community mental health system that had been developed beginning in the 1960s was still adequately funded to cover the mental health needs of the poor – at least in terms of what exists today. But the system was about to ‘bite back’.

Equilibrium-seeking resistance to change

We are left with a dilemma; frustrated, disillusioned, and unfulfilled individuals, who appear to be in the majority in most parts of the world, see the social unrest around them and seem to call for social change, while society seems to be unwilling to face the effort, distress, and insecurity that inevitably accompanies social change.

Maxwell Jones, *Maturation of the Therapeutic Community* (1976: 73)

When a complex system becomes stressed or ‘perturbed’, the system becomes unstable. The further the system gets from equilibrium or into ‘far-from-equilibrium’ conditions, the more unstable it becomes. Human beings and human organisations experience such a phenomenon as anxiety, fear, increased conflict and stress. If the system does not re-stabilise, the continued perturbation will propel movement towards a ‘bifurcation’ – a decision point, a critical choice – Robert Frost’s ‘two paths’ diverging in a wood. There may be many possible options at each fork in the road and the consequence is that the future becomes unpredictable, although not random. In fact, the possibilities of movement will be constrained by previous decisions that have led to this turning point, and by other aspects of both internal and external reality. As one psychologist has said, “history circumscribes the choices with which systems are presented” (McClure, 1998: 20). But when this is happening, from within the field of choice, it looks to the inside observer like anything can happen. And this is the point at which major change can occur, putting an individual, a family, a society on an entirely different trajectory.

However, in chaos theory, systems that are becoming unstable and entering far-from-equilibrium conditions that could lead to such major change invoke powerful equilibrium-seeking functions to return them to their previous stable state. The rebellions of the 1960s with all the talk of equality – of races, classes, genders – was a direct challenge to the status quo that included several hundred years of racial segregation, the oppression of women, a growing separation of socioeconomic classes, and white male supremacy. The cultural changes that followed pushed more conservative elements in the society into disequilibrium. By the end of the 1970s, the social and economic systems of the US

responded strongly to the perturbations of the previous two decades by invoking the powerful equilibrium-seeking devices of large systems, in this case American right-wing, authoritarian, religious, conservatism. The Presidency of Ronald Reagan beginning in 1980 marked a change in the climate of the United States that has swung progressively and radically away from the liberal agenda of prior decades ever since and that continues without abatement today.

Some believe that this movement was profoundly impacted by the break up of the Soviet empire. In this major change, the United States lost its most valuable unconscious ally – its enemy – and all the fear, unresolved conflict, and suppressed guilt for previous misdeeds flowed back into the country producing more, albeit less conscious, destabilisation. The Jungian analyst, Jerome Bernstein astutely predicted what could happen when he wrote before the Soviet break-up that, if the Soviets were to become less paranoid, the United States “will be confronted increasingly with its own paranoid process and its own negative shadow as Soviet hooks for paranoid projection are withdrawn. At that point it will either integrate shadow elements in a healthy way or it will seek a new nation or hook or issue/hook for its shadow projections” (Bernstein, 1989: 157). At the time, he saw aspects of the American pluralistic society that mitigated the paranoid processes he described including: intense dialogue at all levels of society, an open press, a vocal public opinion, a highly functional institutionalised system of checks and balances in government, and accountability of government at all levels to the people at large (Bernstein, 1989). At present, many commentators believe that all of these mitigating aspects have been eliminated and the shadow side of the US alternates between hooking its projections onto international terrorists and attacking the elements it assigns to deviant status within itself – racial minorities, the poor, women, children, criminals – especially drug addicts, and the mentally ill.

Parallel processes: the wolf protecting the henhouse

The more the deviant behaviour goes against the expressed values of the local community, the greater the likelihood of some definitive action.

Maxwell Jones, *Beyond the Therapeutic Community* (1968: 61)

Throughout the 1980s and 1990s it had been possible to see – and experience – parallel processes between the larger social and economic changes that were occurring at a national level and changes that we experienced working in health care and, particularly, mental health care. The treatment of the mentally ill has historically reflected changes in the larger environment. In a society, all who deviate from established social norms are a potentially destabilising threat to that society. If the society is relatively secure, then it can afford to deal with deviants with a rehabilitative, compassionate and positive attitude because there is little meaningful threat to order. But in a society that is destabilised, all deviants pose significant threats because the society itself is reaching far-from-equilibrium conditions and as a result anxiety is skyrocketing.

Foucault pointed out that, as society became increasingly structured and compartmentalised between the late 17th and the 19th centuries, there was a greater need to insist that people follow established norms so as not to upset the social order. The result of this was what Foucault called “the Great Confinement,” during which period all kinds of institutions proliferated to take care of problem children, criminals, the poor, and the mad (Foucault, 1965). Foucault and others have attributed this enormous social change to forces related to the economics of capitalism, industrialisation, and a market economy. In

the 1960s and 1970s, the communalism, concern for the inequities inherent in capitalism, the Civil Rights Movement, the rise of feminism, and increased global connection all became significant threats to the existing social order in the United States. Not surprisingly then, the reverberations of this threatened change would be felt in mental health.

After the post-World War II intensive social engagement and activism of social psychiatrists like Maxwell Jones and all those involved in the therapeutic community movement and the sharp critiques of radical psychiatrists, by the late 1970s psychiatry was taking a sharp right-turn back to its medical and conservative roots along with the rest of the country. As a major social institution and therefore supporter of the status quo, the psychiatric profession in the United States has always had an underlying conflict, forever arguing over the etiologic foundations of the disorders that come under its purview and itself, resisting the chaos of change by invoking similar equilibrium-seeking adjustments. As Jones pointed out, "We have found that the greatest stumbling block to such an approach [therapeutic community] is the threat this approach holds for authority figures. ... The approach advocated here demands that the professional be willing to become the subject when appropriate, and that his performance in crisis situations be subject to scrutiny" (Jones, 1968: 86).

Biological psychiatry was inexorably displacing psychodynamic forms of training in virtually all residency programmes across the country. Biological psychiatry depends upon the expertise of – and several layers of – established authority: physicians, pharmaceutical manufacturers, Federal Drug Administration. In contrast, psychodynamic forms of treatment – at their best – insist upon multiple layers of complexity and creativity. The individual is the expert about themselves – even if they don't know it yet. Those inclining towards biological fundamentalism have always been in conflict with those who place a stronger emphasis on social and environmental factors as the sources of psychiatric dysfunction. In the world of psychiatry in particular and in the mental health field generally, there has long been a tension between those who favour doing whatever it takes to simply stabilise a patient – drugs, restraint, punishment – and those who see strategic and creative possibilities within the chaos created by the onset of acute emotional problems.

Many psychodynamic psychotherapists would agree that the proper role for therapy is to be a safe container for the chaos of the patient's experience, validating the importance of letting change occur, despite the disruptions that may attend the process, alternating between provoking enough anxiety to propel the person, family, or group into the vortex of change while soothing anxiety that is threatening to overwhelm the system, forcing it into regressive solutions. But such a system of care is fundamentally anti-authoritarian when the patient, not the professional, becomes the expert and ultimate decision maker. Such an approach can be perceived as dangerous because, in a destabilised system, deviants must remain deviants. Deviance must be suppressed or at least held in check and it is the socially assigned task of institutionalised psychiatry to assist in this process.

At the same time inpatient treatment was taking on a new face. The public system had deteriorated to such an extent that a movement called 'deinstitutionalisation' had already begun to close down most of the state facilities and put the patients out into the community. A good idea on its face, it was already evident that the 'community' was not about to provide the kinds of services that these chronically impaired patients needed and they began showing up as the ubiquitous 'street people' in all of the major urban areas and represent a substantial portion of the mentally ill in prisons. On the other hand, general hospital psychiatry was expanding as a countermeasure to deinstitutionalisation

so that patients could be treated acutely in their own communities and because the hospitals saw opportunities for new sources of income.

The dominance of the market economy, the value of profit above all else was a movement that was well underway by the 1980s and I witnessed this transformation via the psychiatric health care system. Corporate America had discovered that there was a great deal of money to be made by treating the mentally ill in private facilities under the notion that 'The Market Rules!': wherever money was there to be made – there was an obligation to make it. Insurance companies of the day still provided coverage for inpatient treatment and often long-term coverage. So the private for-profit and not-for-profit sectors mushroomed and, as they grew, intense competition for patients developed between the various hospitals and hospital chains.

At first, this competition produced innovation and it was possible for people like us to provide high quality care without ethical compromise. But it was a system that bred corruption, particularly in the mental health sector, largely because there were insufficient checks and balances, promoted by a Republican philosophy of deregulation. This was my first organisational experience with how a healthy 'cell' can become a 'cancerous' one characterised by unchecked growth. In order to keep the flow of patients coming in, and therefore keep their stockholders happy, health care corporations began engaging in corrupt practices that included bribery, paying referral sources for patients, intense and not always truthful marketing practices, and the practice of keeping patients in hospitals much longer than they needed to be there. Because recovery from an emotional disturbance is often more difficult to define than recovery from a medical illness, the psychiatric field was particularly prone to these kinds of abuses.

No meaningful thought or action went into anticipating the results of turning professionals into entrepreneurs and money managers, of having them switch their ancient loyalties to patient care to loyalty to the financial stability of their institutions. The Clinton Administration proved to be a dismal failure at challenging the system and their health care reform movement completely fizzled out. In the entrance of Corporate America into medical care, the fox was invited into the henhouse and was voraciously hungry. To subdue the fox the draconian response was to poison the hens and bring in a wolf to guard them. The wolf is 'managed care'. I am speaking here, not of every individual person or company but of the 'managed care' system as a whole. As in any large system, some companies are fairer than others and have better trained staff, some are more committed to the wellbeing of patients than others, but by now the abuses of the system are well-documented in research studies, books, personal accounts, even movies.¹

Managed care for mental health is a system that has reduced mental health benefits that never had achieved parity with physical health care, reduced inpatient stays to only a few days, reduced the number of hospital beds, virtually eliminated specialty programmes, reduced coverage for outpatient treatment to a minimum, while placing physicians and other health care providers into what can be described as a constant state of ethical conflict. At its worst, unless a bureaucrat on the other end of the phone – who may or may not have credentials similar to your own – agrees with your treatment plan, you cannot give your patient the treatment you believe is the right thing to do. If you do so against the will of the company, it may become impossible for you to make a living or you may compromise the survival of the organisation who hires you.

¹ For more information, accounts, policy papers, and publications, see the website <http://www.nomanaagedcare.org/>

As summarised in an article for the Journal of the American Medical Association:

The current trend toward the invasion of commerce into medical care, an arena formerly under the exclusive purview of physicians, is seen ... as an epic clash of cultures between commercial and professional traditions in the United States. Both have contributed to US society for centuries; both have much to offer in strengthening medical care and reducing costs. At the same time, this invasion by commercialism of an arena formerly governed by professionalism poses severe hazards to the care of the sick and the welfare of communities: the health of the public and the public health.

(McArthur & Moore, 1997)

Even as the extent of mental illness in the population of children and adults was reported as increasing, expenditures on mental health care were plummeting while profits for managed care companies were soaring. As one consumer group has pointed out: "In mental health, managed care creates administration and profit expenses that consume over 50% of the money that was previously available for treatment" (Miller, 1998). In a system where the only meaningful shared value is financial gain, this is entirely acceptable.

Trauma as an opportunity for growth

It seems eminently reasonable to view the concept of the trauma itself as a potential opportunity for growth; we must seek to determine appropriate procedures as a function of the interaction between the subject, significant others in his social world, and socially skilled professional workers during the period of stress.

Maxwell Jones, *Beyond the Therapeutic Community* (1968: 86)

Five years into the Reagan administration, enormous change was looming from several fronts. In 1985 managed health care was just coming on the horizon in our state but had not yet taken over the entire industry and we watched as, little by little, our colleagues 'sold out' to promises of an improved service delivery system or more money – depending on what appealed to each particular person. However, for a while at least, we were protected from these market forces by our location, by the service we delivered, by the fact that we were in a general hospital, not a psychiatric hospital, and by luck. For me, creating and maintaining a democratic, self-organising therapeutic system was entirely consistent with the vision I naively embraced for my democratic, good-hearted, compassionate country. But I had not reckoned with the astonishingly powerful equilibrium-seeking behaviour of systems, the enormous power of raw human greed, nor with the constraints on imagination wrought by exposure to traumatic experience. However, before we would be changed by the changes in the overall health care environment we would be radically altered as a group by our 'discovery' of psychological trauma.

Around 1985, we began to recognise that most of the patients we were treating in our psychiatric unit had traumatic childhoods, frequently compounded by numerous traumatic experiences as adults. As we learned, a past history of trauma is a bivalent experience. On the one hand, it puts harsh constraints on possibility because the traumatic experience has so determined the initial conditions of childhood. On the other hand, the nuclear fission that has occurred deep within the psyche, manifesting through the split in verbal and non-

verbal experience at the time of the traumatic events releases a powerful energy that can push a traumatised person rapidly into far-from-equilibrium conditions, opening up the possibility of transformative change. For the trauma survivor, returning to the past means returning to trauma – there is nowhere to go but to leap into the unknown of a possible future. But the future has become unimaginable because the use of imagination is bound to horror, pain and loss. This knowledge changed our process of therapy. We found that there is much we can do to help people learn how to keep themselves safe, even with unpredictability, to manage their emotions sufficiently that they are not overpowered, to recognise and work through loss that appears insurmountable, and to relearn the use of imagination in order to envision a future that is worth surviving.²

My immersion in the social and political life of the 1960s and 1970s had prepared me for a natural inclination towards working within a therapeutic milieu, but little had prepared me for embracing the devastating magnitude of traumatic experience in my culture. It was about this time that I turned seriously to the actual written work of Maxwell Jones, looking for – and finding – support and indirect mentoring for the profound shifts in understanding that we were experiencing. It is not a coincidence that the therapeutic community was born out of the chaos of war. As Malcolm Pines has pointed out, the therapeutic community was the offspring of war (Pines, 1999). Maxwell Jones and others carved out new territory in treating combat veterans and then extended that work to the veterans of domestic wars, the chronically unemployed and the personality-disordered patients

By 1985, in contrast to 1965, there was a large and growing body of research about the profound impact of traumatic experience on the body, mind, and soul of the trauma survivor. The trauma field itself was born out of the clashing ideologies that were articulated in the 1960s and 1970s. “War crimes, war protests and war babies; child abuse, incest and women’s liberation; burning monks, burning draft cards and burning crosses; murdered college kids and show trials of accused radicals; kidnappings, terrorism and bombings; a citizenry betrayed by its government and mass protests in front of the Capitol in Washington” – all played a role in increasing awareness of the impact of violence (Bloom, 2000).

Studies on all of these survivor groups began entering the mental health environment in the 1970s and picked up momentum in the 1980s. At the time, in parallel with the other momentous social changes of the times, the full recognition of the impact of trauma on human functioning was just beginning to emerge in the US from the studies of Holocaust survivors, Vietnam veterans, battered women, abused children, disaster survivors, refugees, sexual assault and other crime victims, and torture survivors (Bloom, 2000). In 1980, the same year as the United States elected a Republican president with an increasingly conservative agenda, the American Psychiatric Society embodied the results of prolonged exposure to combat trauma in the diagnosis of Post-Traumatic Stress Disorder. We began wrestling with this knowledge on our unit, questioning ourselves and our patients about what exactly it means to be a trauma survivor. By 1991, we decided that we knew enough about the impact of trauma on our patients to establish a specialty unit that at that time we began calling ‘The Sanctuary®’ (Bloom, 1997).

The psychobiology of trauma, the body of research and clinical wisdom about the multigenerational impact of traumatic experience and its impact on attachment behaviour provided us with what we came to believe was a secure and scientific underpinning for the practice of the therapeutic community. It became clear to us that given the complex biological, psychological, social, and existential impacts of trauma no one therapeutic

² For more about the Sanctuary Model and treatment of trauma, see www.sanctuaryweb.com

approach could possibly hope to respond to this complexity. Rather, the therapeutic community provided an ideal context for organising and delivering a wide variety of therapeutic interventions. This context could be designed to – in and of itself – counteract the multiple influences of traumatic experience. In its emphasis on creating a culture of belonging, safety, openness, participation, and empowerment much of the fundamental damage done by exposure to chronic violence could be counteracted and, if not undone, then transformed (Haigh, 1999).

In the furnace of change, which is ideally the nature of the therapeutic environment, patients are pushed into ‘far-from-equilibrium’ conditions by the various forms of therapeutic intervention and the result is anxiety that we then try to channel into constructive and transformative change. The ‘initial conditions of childhood’ constrain the choices they can make, but nonetheless within the constraints the possibilities are immense. Our job is to push them – but not too hard and not in the wrong direction. Herein lies the heart and the art of therapeutic change – what is too hard and the wrong direction is almost infinitely variable and frequently extremely difficult to determine for the individual patient whose symptoms may appear bizarre, self-destructive, even intentional.

In working with survivors of childhood trauma, those whose ‘initial conditions of childhood’ had left them scarred and following exceedingly negative life trajectories, we came to see the planned therapeutic environment as an effective and powerful way of applying stress to their individual system, while watching that system attempt to restabilise itself using tried and true methods – also known as defences – only to become overwhelmed and enter a period of chaos out of which frequently came positive change and growth.

We came to believe that a therapeutic milieu that is truly working is one in which we could create enough turbulence to edge people towards change, towards that critical turning point, while providing a safe enough container so that their choices were somewhat constrained, deterring a deterioration into chaos. In our therapeutic milieu we promoted that turbulence through the work of psychotherapy, through group process, through the everyday friction of social interaction and social learning, and through planned interventions. In Maxwell Jones’s descriptions of social learning, we found explanations for how and why a planned social environment could powerfully enhance the process of change. In a planned therapeutic environment, we contain the turbulence by having a clear value system and coherent practice, based on democratic principles that we all agree to share as a way of life.

For us, the study of traumatic experience was also a political wakeup call. Here we were, comfortably ensconced in suburbia with a lucrative and successful practice and a healthy management contract to operate our programme designed to compassionately respond to the needs of the ‘mentally ill’. Having been immersed in the tenets of social psychiatry, we had never completely forgotten our roots, but our mores of the 1980s did not lend themselves to philosophical speculation about the sources of oppression that constituted our psychiatric care. But when we began to recognise that the evolution of the psychiatric problems in the majority of our patients – and these mostly middle-class Caucasians – began with exposure to violence in childhood, frequently exacerbated by exposure to more violence as adults, it became impossible to ignore the social and political forces around us.³ Dr Judith Herman, in her powerful book, *Trauma and Recovery*, noted that “to study psychological trauma is to come face to face both with human vulnerability in the natural world and with the capacity for evil in human nature

³ For a recent study on childhood exposure to adversity, see <http://www.acestudy.org>

... Those who bear witness are caught in the conflict between victim and perpetrator. It is morally impossible to remain neutral in this conflict. The bystander is forced to take sides" (Herman, 1992: 7).

We were forced to take sides and we came down solidly on the side of the victim while coming to understand the seemingly endless, circular and reverberating connection between victim and perpetrator. We came to recognise that our apparently isolated and protected world of the psychiatric unit was actually part of a potential social revolution in our understanding of what goes wrong in human behaviour – that it is the terrible things that happen to people and families, and whole societies that determines most of the psychopathology that we see – and that in fact most of it is *preventable*.

We were excited by the prospects of change that spread out before us, thrilled by the often seemingly miraculous responses of our patients. But at the same time, we began to see that our ability to be a part of what could become a truly human revolution was being eroded away by enormous destructive changes in mental health care delivery that would rip away from us any pretence of having a Sanctuary for ourselves or our patients. It also became evident that in our political beliefs as a result of this 'awakening', we were moving in ways diametrically opposed to the mainstream political agenda. At this point, failing to recognise neither the history of the study of trauma, nor the ways in which the system 'bites back' we were unprepared for the changes that were to follow.

The nineties

The more the hospital culture deviates from the traditional culture, the more it will tend to arouse resistances from the outside public and furnish material for rumor formation.

Maxwell Jones, *Beyond the Therapeutic Community* (1968: 58)

Between 1991 and 2001 we were compelled to move our programme four times in an effort to avoid the ravages of what is known as 'managed care' and the other powerful forces of suppression that were impacting mental health care. The incursion of managed care into health care meant that the patients were no longer the consumers that anyone had to please. Instead, concern shifted almost totally to cost-savings and the client became the insurance company and, behind them, the employer who funded the worker's insurance benefits, with the managed care company as the middle entity entirely determining the amount and type of treatment that individuals would receive and making profit from whatever money they saved the insurance companies. Because of my early exposure to the concepts of the therapeutic community and systems theory, I was always aware of the connections between the personal and the political, but had learned most about those interactions as played out between me, my staff, and our patients.

What became abundantly obvious was that we were far more willing to do the work entailed in 'creating Sanctuary' for our patients than anyone above us in the hierarchy was interested in providing a 'sanctuary' for us. It became clear to me that the limits of our growth and development were determined by the relative health or dysfunction of the systems within which we were embedded.

In fact, every system we moved to welcomed us with open arms, tasted us, and then systematically extruded us. The dominant culture, even in the microworld of the psychiatric hospital, was becoming increasingly authoritarian, coercive, secretive, deceptive, abusive, paranoid and violent. All around us, the use of seclusion and restraint was increasing along with rising levels of psychotropic medications and electroshock

treatments – we did not use seclusion, restraint, or ECT and the psychotropic medications we used were in collaboration with our patients. Staff injuries were on the rise as pressures were exerted upon staff to do more with less – but our staff members were rarely injured. As money was withdrawn from the hospital systems, hospitals resorted to cost-cutting methods that included staffing reductions below the level of safe management and moving staff around to such an extent that there was only the illusion of consistency left on the units. We dealt with these reductions by strengthening our social norms and enhancing staff morale through shared problem solving and joint decision making.

Wherever we went we were a counterculture preaching the importance of establishing an agreed upon set of values and the need for a coherent, trauma-informed framework. We were illustrating the importance of shared decision making, empowerment of patients, and more democratic processes as our country was becoming progressively less participatory, less concerned with civil rights, less democratic. We were advocating open communication, the exposure of secrets, and the importance of open debate as our country was silencing the press and eliminating investigative journalism. We eschewed the use of violence, restraints or coercion in favour of social learning and conflict resolution while systemic violence in our country mushroomed. We were talking endlessly about trauma – the trauma of combat, of domestic violence, of street violence, of child abuse – and the preventable nature of most psychiatric disorders as it became increasingly unfashionable to do so. The pressures on us to conform to the dominant culture were extremely powerful and every day was a constant battle to secure our own culture and maintain the sense of sanctuary that our patients so desperately needed.

Collective disturbance

In our competitive and insecure world it is hard to find a group climate where there is a sense of security without fear of reprisal. To achieve such a group climate requires a social structure where the sanctions are positive and there is no threat from the abuse of authority.

Maxwell Jones, Beyond the Therapeutic Community (1968: 73)

This was a profound lesson for me in the power of a collective social disturbance over which we had no control, a disturbance far beyond reason or rational influence. Performance did not matter. In every setting our programme was profitable, we had fewer critical incidents, received positive affirmation in the press, from families and patients, had shorter lengths of stay, and consequently produced far fewer management problems to the hospital administration. But our performance depended upon a distinct value system that challenged the dominant culture in a way that could not be tolerated. Judith Herman had predicted that this would happen. She had observed that:

the systematic study of psychological trauma ... depends on the support of a political movement. Indeed, whether such study can be pursued or discussed in public is itself a political question. The study of war trauma becomes legitimate only in a context that challenges the sacrifice of young men in war. The study of trauma in sexual and domestic life becomes legitimate only in a context that challenges the subordination of women and children. Advances in the field occur only when they are supported by a political movement powerful enough to legitimate an alliance between investigators and patients and to counteract the ordinary social processes of silencing and denial. In the

absence of strong political movements for human rights, the active process of bearing witness inevitably gives way to the active process of forgetting.

(Herman, 1992: 9)

Regardless of – or perhaps because of – the number of books and articles I had published, the television coverage we had, the acclaim our unit received – we had to be silenced. The systems we were embedded in could not deal with the stresses exerted on them demanding more profitable performance without exerting more control and this very stance contradicted our basic value system. Democracy cannot flourish in an autocracy, and in a system of diminishing resources the assumption was made that greater profits in health care could only be obtained through ever more constrictive control measures.

Did we create our own repetitive extrusion? No, but we certainly may have contributed to it. Conflicting ideologies typically and simplistically compete rather than find a way to integrate their views of reality. In retrospect, I think that we emerged from within our longest – and often tortured – 12-year experience with an ‘external enemy’ mentality that solidified our internal group while laying the groundwork for later systems of projection and projective identification. However, to the extent these mechanisms were operative there was no escaping the realities of the changes that were occurring in the mental health delivery system – and the political system – in the United States.

The challenges of changing systems

The psychiatric hospital can be seen as a microcosm of society outside, and its social structure and culture can be changed with relative ease, compared to the world outside.

Maxwell Jones, *Beyond the Therapeutic Community* (1968: xii)

We closed our programme in 2001, just two months before the events of September 11 would plunge my country into an era of fear, secrecy, corruption and unreason. I had sold the practice in 1995 to a large health care company because I knew by then that I no longer had the expertise to negotiate our way through the highly managed health care environment that had emerged. The sale helped to provide me with some financial stability as I transformed my own life from that of a practising psychiatrist to that of a consultant, trainer, and facilitator of system change. The merger with this health care company gave us six more years of existence and the time for me to make this personal and professional transition. But closing the programme, after having to reinvent ourselves four times, was as close as I will come to losing a child and all of us experienced a period of significant mourning after the final end.

Just before we closed our programme for adults, I became involved in two long-term projects that enabled me to apply what we had learned about creating environments to treat traumatised adults to the residential care of children. That work has thrived, has produced some positive research findings, and has led to the development of a Sanctuary Leadership Training Institute that is beginning to train other agencies this year.⁴

I also became involved in a number of other system change efforts, applying our trauma-informed, therapeutic community concepts to a number of private and public social service programmes – inpatient acute care settings, outpatient mental health

⁴ For more information, see http://www.andruschildren.org/Sanct_Lead_Dev_Inst.htm

settings, domestic violence programmes, homeless shelters, state hospital programmes, substance abuse programmes, child protection agencies, public and private schools, and community collaborative efforts to respond to family violence (Bloom, Bennington-Davis, Farragher *et al.*, 2003).

In all of these venues I have consistently observed that, in a parallel process way, the changes in the mental health and social service environment have destabilised the entire system and in doing so have created situations where our helping systems frequently but inadvertently recapitulate the very experiences that have proven to be so toxic for the people we are trying to treat. Regardless of what layer of the social service system, there is fragmentation of our understanding about the clients that are being served, the goals of the work that people are actually performing together, or the importance of consistent role modelling, of 'walking the talk'. There is astonishingly little understanding or practice of group dynamics, much less a knowledge of therapeutic milieu concepts. People who spend the most time with the clients and/or their families – and arguably therefore have the most influence – are the least trained, supervised, and supported. As a result, there are frequent mistakes in technique and gaps in knowledge. When mistakes are made by subordinates, the mistakes are often overlooked or ignored, subtly condoned, or harshly punished without a sharing of responsibility by the superiors who have not properly trained or supervised them. There is chronic short-staffing, particularly in mental health, and this causes a reverberating problem in every other part of the system when clients are unable to access adequate or appropriate mental health services.

In every aspect of the social system there is a desperate need for a coherent framework that integrates all of the different schools of thought, therapeutic theories, and controversies into a meaningful, effective, and practically usable whole. There is an equally desperate need for a shared language that can make sense to everyone – children and adults; professionals and clients. Trauma theory, combined with attachment theory, good psychodynamic practice, and therapeutic community principles, provides just such a coherent framework. But, once again, we come up against the current political climate. To be meaningful the framework has to reference highly charged political discourses about expanding economic disparities, deeply rooted racism and sexual discrimination, and conduct towards children – none of which is fashionable and, in some circles, permissible to discuss today. And everywhere there is a grave need for strong, committed, non-hierarchical, democratic leaders who can create group safety and who are not afraid to surface and resolve long-standing conflicts and tensions.

Where there is no vision the people perish

In the field of mental health, most attention has been given to psychotherapy, some to mental hygiene, but very little as yet, to the design of a whole culture which will foster healthy personalities.

Maxwell Jones, *Therapeutic Community* (1953: vii)

I wish I could conclude this article secure in the belief that Maxwell Jones's vision of designing a culture to foster healthy personalities was becoming a reality in America but, from my particular point of view, I cannot. In the public mental health sector in the US – at least for right now – there is a movement focusing on system transformation, the elimination of coercive forms of institutional behaviour, and the initiation of a trauma-

informed approach.⁵ But these efforts – though extremely important to the patients and staff involved – are minuscule compared to the enormous forces of social regression, repression, denial, and amnesia that are currently determined in the playing field of American social, economic and political life.

These efforts, our own system change endeavours, and those of the therapeutic community practitioners around the world, still constitute only what Maxwell Jones termed “a laboratory situation for experimentation with methods of productively resolving crisis situations” (Jones, 1968: 76). From all the years of research on the therapeutic community, we know that these are the best environments within which to treat people who have severely disturbed developmental experiences that have negatively impacted their life trajectories (Lees, Manning & Rawlings, 2004). From the research on the implementation of the Sanctuary Model, we learned some important guidelines for helping system transformation in the direction of trauma-informed, therapeutic community care (Rivard, Bloom, Abramovitz *et al.*, 2003; Rivard, Bloom, McCorkle *et al.*, 2005; Rivard, McCorkle, Duncan *et al.*, 2004). We would argue that this body of research has significant implications, not just for the personality disordered adults or conduct-disordered children but for all of us.

In the Sanctuary research, we learned that the staff found it very important to have a clear and coherent framework for understanding the work they do with a central focus on safety. Trauma theory and its impact on attachment helped them to reorient the services they delivered to children towards a path of recovery instead of simply order or stabilisation. Teamwork, universal participation and a sense of community were seen to be vital in creating a safer more coherent culture that provided a forum for practising how to deal with programme issues in a non-hierarchical, authoritarian manner. The staff consistently wanted to learn more, even though in many instances their leaders had behaved as if they were too unskilled to learn anything new. Leadership was a critical determinant of whether the model was consistently implemented and, when both leaders and staff had a better method for understanding and responding to their patients’ behaviour, they were able to be less punitive, more patient, and more instructive.

But, interestingly, what the Sanctuary staff who participated in the research project complained about was that they did not know what the ‘ideal’ environment would look like. Essentially they were saying that envisioning a truly different kind of environment was difficult to do without a model they could see, touch and experience. This is presently a universal problem – there is no real shared vision of what a healthier society would look like, much less a vision of how to get there. As Thomas Kuhn pointed out, for a true paradigm shift to occur, there has to be a new paradigm that more effectively solves existing problems than the old (Kuhn, 1970). In chaos theory language, as the change process is evolving, in order for transformative change to occur instead of a return to equilibrium conditions, there must be another, more powerful attractor that moves the system away from its previous stable point into a new and different kind of stability.

The therapeutic communities that exist are some of the only living examples of a better way of living and learning in a group setting. As we have discovered in the therapeutic community movement, democracy is the best structure to deal with complexity. That is its great strength – that it minimises the abusive use of power and creates a structure within which limited individual human beings can create the emergent group processes that allow for the solutions of very complicated, interactive, interdependent problems. But democracy does not bear up well under stress unless the anxiety and fear induced by this stress is contained. The United States presently bears

⁵ For more information, see http://www.nasmhp.org/position_statement.cfm

witness to the uncertainties and dangers of this kind of stress response every day and how easily the structures of democracy can be turned against themselves and even dismantled by fear (Bloom, 2004a; Bloom, 2004b; Bloom, 2005).

The therapeutic community contains the 'cellular' knowledge, the very basic technology for containing the overwhelming anxiety resulting from the vast process known as globalisation. I hope somebody out there is listening. The legacy of Maxwell's work is one of vision and hope. As he and many of his like-minded colleagues passed the baton to my generation, our role may be nothing more than to keep the hope alive and pass it on to the next.

Can we hope to move further along [a] continuum to explore such possibilities as restructuring society in an attempt to meet the problems of a technological age ...? Here the urgency and personal anxiety may be absent in a large section of society. People, in general have not learned to identify themselves with larger social units than perhaps the home or their own particular peer group ... To be a change agent in these wider problem areas is to court disaster. Who knows what directions society must take in order to protect itself from extinction? In any case these global problems are the concern of rational governments. Behind these valid rationalizations lurks the most basic problem of all – man's almost universal resistance to change as an ongoing process.

Maxwell Jones, *Maturation of the Therapeutic Community* (1976: xv)

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