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Therapeutic communities and group analysis

Jan Lees, Rex Haigh and Sarah Tucker

Abstract

Purpose – *The purpose of this paper is to highlight theoretical and clinical similarities between therapeutic communities (TCs) and group analysis (GA).*

Design/methodology/approach – *Literature review shows comparison of TC and group-analytic concepts with illustrative case material.*

Findings – *Findings reveal many similarities between TCs and GA, but also significant divergences, particularly in practice.*

Practical implications – *This paper provides theoretical basis for TC practice, and highlights the need for greater theorising of TC practice.*

Social implications – *This paper highlights the importance of group-based treatment approaches in mental health.*

Originality/value – *This is the first paper to review the relevant literature and compare theory and practice in TCs and GA, highlighting their common roots in the Northfields Experiments in the Second World War.*

Keywords *Therapeutic communities, Group analysis, Group approaches in mental health, Group psychotherapy, Milieu therapy, Psychologically informed therapeutic environments*

Paper type *Conceptual paper*

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Introduction

This paper will review the literature on democratic therapeutic communities and group analysis, and highlight the theoretical and clinical similarities between democratic therapeutic communities and group analysis. The paper will compare classic therapeutic community and group analytic concepts, with illustrative case material. There are many similarities between therapeutic communities and group analysis, but there are also significant divergences, particularly in practice. This paper provides an additional theoretical basis for therapeutic community practice, and highlights both the need for a greater theorising of therapeutic community practice, and the importance of group-based approaches in mental health. The paper is the first to review the relevant literature, and to compare theory and practice in therapeutic communities and group analysis, highlighting their common roots in the Northfields Experiments in World War II. Democratic therapeutic community (TC) practice and group analysis (GA) in the UK grew from the same roots in the war-time Northfields Experiments. "[…] from this hotbed of experimentation had come both group analysis and the idea of the therapeutic community," (Clark, 1987, p. 5). Pines stated that Foulkes began to practise GA in 1939 (Pines, 2009), although Mannheim (1939) was the first to use the term "group analysis", a fact which Foulkes himself acknowledged (Winship, 2003, p. 38). Harrison said that "During 1942, Foulkes elucidated the concept of group transference (Foulkes and Lewis, 1944)", while over the winter of 1942-43, Bion and Rickman developed what became known as the First Northfield Experiment (Bion and Rickman, 1943; Bion, 1946, 1961; Harrison, 2000, p. 13). According to Harrison, Bion and Rickman turned "psychiatry upside down" by "forging an alliance with the patients (sick soldiers) in order to defeat the problems of mental ill-health", and instigating daily group discussions for the whole ward in what was primarily a communal living environment; and that the two Northfield Experiments "implemented entirely new methods of group psychotherapy.

These included dealing with the reality of 'here-and-now', making the examination of members' interrelationship the centre of therapy, allowing the psychodynamics to reveal themselves, and working with the group transference. Leadership was another focus […]" (Harrison, 1999, pp. 19-20). Main also said that Northfield was where the concept of the TC was born (Main, 1983, p. 203). Even Lacan, who visited London for five weeks in 1945, and effusively detailed a long conversation he had with Bion and Rickman, described them as "pioneers" of a "revolution", and talked of Bion undertaking "to organise the situation so as to force the group to become aware of the difficulties of its existence as a group, and then to render it more and more transparent to itself, to the point where each of its members may be able to judge adequately the progress of the whole […]" (Lacan, 1947, p. 17).

Foulkes worked at, and was involved with, both developments at Northfield – the TC and GA, although he left TC work, and was no longer directly involved with in-patient psychotherapy, but concentrated on GA, and the Group Analytic Society. Foulkes acknowledged the links between the TC and GA in many of his writings, and described his development of small group therapy, and of working with the ward as a community, and later the whole hospital (Foulkes, 1983, 1984, 1986, 1990b; Foulkes and Anthony, 1965). De Maré talked of meeting Foulkes at Northfield in 1944, and stated that Foulkes was "the only person who witnessed the 'Northfield experiment' (2nd) throughout, from his instituting it in July 1943 to his demobilisation in December 1945" (De Maré, 1983, p. 218). However, according to De Maré, Foulkes did not become fully aware of the first experiment until Rickman revisited Northfield in 1944 (De Maré, 1983, p. 223). De Maré suggested that Foulkes approached the second experiment in "an entirely different and more circumspect manner", by regarding the total situation – the whole hospital, and all the hospital staff – as his frame of reference, and Phase B of the second experiment involved, initially, a whole ward as a community being conducted on small-group lines, and then all wards being conducted along group lines (De Maré, 1983, pp. 223-5). De Maré concluded that "it was this dialectic duality between relationship and context that constituted the basis for his *(Foulkes)* success, and particularly the application of what Foulkes called 'group analytic principles' to an entire context, which resulted in the 'large-scale transformation of a whole hospital' – the first therapeutic community' as described by Main" (De Maré, 1983, pp. 224, 226; Main, 1946, 1977).

TCs and GA also had common personnel initially – Foulkes, Bridger, De Maré at Northfield – and later, Clark at Fulbourn Hospital, Pines at the Cassel Hospital, Roberts at Ingrebourne Centre, Blake at Kensington and Chelsea Day Centres, Whiteley at Henderson Hospital, Kennard at Littlemore Hospital, Haigh at Winterbourne TC and, more recently, Pearce at Oxford Complex Needs Service (Pines, 1999). Of these, Whiteley has been the most prominent in linking TCs and GA. However, as Harrison noted, "Some therapeutic communities were inspired by Northfield; but the influence of Maxwell Jones (*Mill Hill Hospital, Belmont Hospital, Henderson Hospital and Dingleton Hospital*) tended to overshadow the earlier and more complex model" (Harrison, 1999, p. 29). Nevertheless, Hinshelwood observed that "The engagement in a group learning process has become a core feature of therapeutic communities. It is the group activity as much as the learning one which is crucial – although it seems that the group activity has to be of a learning kind" (Hinshelwood, 1999, p. 40).

History of TCs and GA

TCs

According to Bridger (1990), the idea of using all the relationships and activities of a residential psychiatric centre to aid the therapeutic task, which also entailed a radical change in staff-patient relations, was first put forward by Bion in 1940, in what became known as the Wharncliffe Memorandum, a paper to his former analyst, John Rickman. When Rickman tried to put Bion's ideas about groups into practice, he faced severe resistance from medical and administrative staff. However, both Bion and Rickman got the chance to try out the TC idea in 1942, on the training wing at Northfield Military Hospital, after they were posted there, and after psychiatrists had been asked to try out new forms of treatment, which would enable as many "neurotic" casualties as possible to be returned to military duties (Bion, 1946; Bion and Rickman, 1943). This experiment only lasted six weeks, even though it seemed to be working, because the wider hospital staff found it intolerable – this was known as the First Northfield Experiment.

Bridger said the scheme was revived in a new form about a year later, again on the training wing, with him in charge, and his remit was to understand the group and the organisational processes that were going on (Bridger, 1990, p. 75). This became the Second Northfield Experiment, which "for the first time embodied the therapeutic community idea in a whole organisation" and as a result of the success of the scheme, a "new paradigm was born" (Bridger, 1990, pp. 68-9). Main also argued that the second Northfield Experiment changed the role of psychiatrists in a TC, so that they became a "more sincere […] member in a real community […] responsible to the community as a whole". He added that "The psychiatrist has to tolerate disorder and tension up to the point when it is plain that the community itself must tackle these as problems of group life" (Main, 1946, p. 68).

GA

Pines observed that Foulkes assisted Kurt Goldstein, when, post First World War, he set up a "helping community" where patients and their families "were encouraged to aid each other in rehabilitation", and that Foulkes also later adapted Goldstein's teachings for his work in group psychotherapy and the TC (Pines, 1999, p. 25). Foulkes' first attempts to apply group therapy began in 1940, in his private practice in Exeter, which he described in a paper in 1944 (with Lewis), which acknowledged the importance of social conditions in affecting people's problems, mentioned group association as distinct from free association, stressed the importance of the group situation as the preferred frame of reference, and described specific group features such as socialisation, sharing, stimulation and exchange (Foulkes and Lewis, 1944; De Maré, 1983, p. 222).

Foulkes came to Northfield later, and began by using the small group setting as a way in which the problems of any one individual could be observed and reflected upon by other patients, so that an interactive group therapeutic process was created, and he and Bridger co-operated in working with activity groups, and particularly with anti-group dynamics. Foulkes took over Bridger's role of social therapist, and continued working with groups in the TC (Bridger, 1990, p. 84). Bridger went on to say that these experiences at Northfield played an important part in forming Foulkes' approach after the war, and led to the establishment of the Institute for Group Analysis (Bridger, 1990, p. 74). Foulkes himself said of his work at Northfield that "the following shifts of emphasis emerged:

From individual centred to leaving the lead to the group

From leader centred to group centred

From talking to acting and doing

From the still artificial setting of a group session to selected activities and to groups in life function

From content centred to behaviour in action

From the controlled and directed to the spontaneous

From the past to the present situation (Foulkes, 1984, p. 193).

According to De Maré, Foulkes turned "the whole direction of psychotherapy towards a new dimension" in "introducing the psycho-social level by an actual operative technique which could be simply applied […]" (De Maré, 1983, p. 218). However, Foulkes always acknowledged that Trigant Burrow first applied the word "group analysis" to group therapy, and said of Burrow that he was "the first person to put the group into the centre of this thinking […]" (De Maré, 1983, p. 221; Burrow, 1927, 1928). Foulkes concluded that "The widest view will look upon group therapy as an expression of a new attitude towards the study and improvement of human inter-relations in our time", "a new method of therapy, investigation, information and education" (Foulkes, 1975, p. 33).

Review of the literature

While much has been written separately about both TCs and GA, little has been written about the relationship and links between TC practice and GA, and what has been written tends to be more about what GA can contribute to TC practice, rather than vice versa, or what the relationship between the two might be (Blake, 1981; Clark, 1987; Kennard, 1982; Rawlinson, 1999; Whiteley, 1982).

Blake (1981) wrote a brief article about the place of GA in a TC, its process and the issues arising from such practice, but was more concerned with arguing for the place of group analytic understanding, and particularly the importance of small analytic groups, in the TC. Blake argued that, at that time, TCs in the UK were mainly based on a "re-educative model", which used the small analytic group for the working through of maladaptive behaviour revealed on the social level, which was the focus of the community group. Blake said that a process of "re-education" then took place – "what Foulkes called 'ego training in action'" (Blake, 1981, p. 215). However, Blake felt that another TC model – that of the "re-constructive analytic community" or "psychotherapeutic community" (Crockett, 1966) – was more suited for the group analytic experience. Here the focus was on the inner world and the small analytic group, and the aim was to translate the gains achieved by the primary reconstruction of personality on to the social, or community, level (Blake, 1981, p. 215).

Kennard (1982) and Whiteley (1982) both responded to Blake's article. Kennard commented that "[…] it is a pity Foulkes left the field of therapeutic communities when he did, at the end of the war", as later practitioner/authors, such as Jones and Main, tended to concentrate on the sociotherapeutic or social learning aspects of TCs, and therefore on the community meeting/ large group rather than the small group. Kennard said although Crocket at Ingrebourne was "more inclined towards an analytic model this was centred on the community as a whole rather than the small groups". Kennard concluded that although none of the TC pioneers placed the small group at the centre of the TC in the decades before 1982, interest and training in small group psychotherapy and GA had grown enormously among TC practitioners (Kennard, 1982, p. 49). According to Whiteley, "Small group therapy of the analytic kind shared common roots with the therapeutic community at Northfield", but also argued that the connections went further back to Lewin's ideas about the individual in his social field, and Burrow's ideas about illness as a sign of social discord (Whiteley, 1982, p. 48). Again, his arguments were about the place of the small group in the TC, about the relative weight given in TCs to psychotherapy and sociotherapy, and the difference in role for the group conductor in a residential, as compared to a day, TC. Whiteley concluded "Undoubtedly group analysis with its awareness of social forces has given much to the TC worker", but also stressed the need for sociological and social psychological approaches to group dynamics to be included in TC theory and practice as well (Whiteley, 1982, p. 49).

Clark gave the opening remarks as part of the large group discussion which formed the tenth S.H. Foulkes Annual Lecture, which was on GA and the TC. Clark commented that he learnt GA from Foulkes in the early 1950s, and TC practice from Jones in the late 1950s; that he saw GA and the TC as two methods of social therapy; and that he attempted to apply both in his clinical practice (Clark, 1987, pp. 3-4). However, Clark stated that the later development of the two were very different – that GA developed slowly and steadily, with a body of theory and practice, whereas the TC had a more "chequered" career – initially seen as the treatment of the future, and then waning in popularity, but also adapting and modifying. Clark went on to explain that, at that time, TCs were seen as more revolutionary but also more challenging to conventional hierarchies and authorities (Clark, 1987, pp. 6, 8).

Rawlinson alone attempted to demonstrate the relevance of some Foulkesian group analytic ideas to the clinical work of a TC, which he described as practising in a group analytic way (Rawlinson, 1999, p. 50). He described the group analytic concepts of: the basic law of group dynamics; the matrix; mirror reactions; the condenser phenomenon; socialisation; resonance; and exchange, and how these applied in his TC, with useful illustrative examples from clinical practice in the TC (Rawlinson, 1999, pp. 51-4, 59-61). It is the intention of this paper to extend Rawlinson's discussion of group analytic concepts and their application to TC practice. In addition, nothing has been written, or written recently, that extensively outlines the similarities and differences of the two therapies, in terms of their theoretical underpinnings and practices. This paper also aims to address this gap in the literature.

Common theoretical principles

TCs mostly operate as open systems (prison TCs less so), but they are always part of, and interacting with, the wider society. Moreover, TCs work through large, median and small groups, and with the community as a whole, and group analytic ideas apply in all of these. This application will be explored below.

The basic law of group dynamics

For Foulkes, the norms of behaviour and interaction in an analytic group reflect in microcosm the norms of the wider community and society – "[…] the community, of which (members of an analytic group) are a miniature edition, itself determines what is normal, socially accepted behaviour" (Foulkes, 1983, pp. 29-30) Foulkes went on to say that (the norms that) "[…] the community supports […] (are) determined by its life conditions, historical and present […] It calls it […]. 'Normal' […] (Foulkes, 1983, p. 31); that group norms are 'collective' and 'permeate' an individual member 'all through […] to his core" (Foulkes, 1983, pp. 29-30); and that group norms are shared at a deep, often unconscious level. Foulkes then articulated a basic law of group dynamics. First, Foulkes argued that "The deepest reason why […] patients […] can reinforce each other's normal reactions and wear down and correct each other's neurotic reactions, is that collectively they constitute the very Norm, from which, individually, they deviate" (Foulkes, 1983, p. 29), and that group members will work to weaken and remove support from each other's modes of exchange which are "neurotic" or abnormal, and will work to strengthen and support modes of exchange which are "normal", and that this is so precisely because group members together share group norms. Second, Foulkes said that "shared group norms act as an active ingredient in therapy groups because there is tendency for 'communication' to take place in the group-as-a-whole, and that the group is unconsciously 'forced to act in (the) direction' of the ever increased communication (because) […] it can only grow by what it can share, and only share what it can communicate, and only 'communicate' by what it has in 'common' – e.g., in language […]" (Foulkes, 1983, p. 31). However, one of the criticisms levelled at Foulkes has been that he is driven by an underlying optimism about social and group process, and that he has attended less to the more negative aspects of GA – these will be discussed later in this paper.

This basic law of group dynamics has been described by Rawlinson as the foundation stone of group analytic theory, and as summarising how individuals' deviation from social and cultural norms, together with those individuals' healthy elements, combine to promote movement from regressed and disorganised functioning towards progression and coherence, and he argued that, in TCs, there are many levels on which this can happen, and opportunities for it to do so. Rawlinson went on to give an example of this in practice from his own TC – "we often have patients who are at risk of 'acting-out' their distress in a dramatic manner e.g. cutting themselves, or losing their temper and throwing things". There are also patients who "act in", directing all their overwhelming rage inwards and presenting with severe depression, anxiety or psychosomatic symptoms. In a group setting, such extreme ways of coping will tend to move towards the norm, and become modified as patients learn from each other and articulate the underlying feelings in the "network of relationships". Foulkes comments on the process by which this is done: "working towards an ever more articulate form of communication is identical to the therapeutic process itself" (Foulkes, 1984; Rawlinson, 1999, pp. 52-3).

The role of the conductor

Foulkes had a different view of the role of the group conductor – one that is less interventive, less about leading and more about facilitating. Foulkes argued that the group conductor is responsible for the sort of culture that is promoted in an analytic group, and that the total atmosphere prevailing in a group, the mores and behaviour, is introduced and maintained in operation by the group conductor. This starts with selection, and dynamic administration during the setting up of the group, and then continues throughout the duration of the group (Foulkes, 1986, pp. 79, 95-6, 99-155).

According to Pines (1983), the tasks of the group conductor are putting the group as a whole in the centre of the conductor's attention, and letting the group speak in order to bring out agreement and disagreement, repressed tendencies and resistances. The group conductor also "activates and mobilizes what is latent in the group, and helps in the analysis and interpretation of the content and of interpersonal relationships. The group conductor encourages the active participation of the members of the group and uses the contribution of the members in preference to their own". The group conductor also "emphasises the 'here-and-now' aspect of the situation" and promotes "an attitude of tolerance and appreciation of individual differences". The group conductor "helps the members of the group to become active participants in the process of

group maturation through which individual change then takes place". Pines argued that Foulkes saw interpretation as "[…] a perceptive and creative act which arose from the receptive, passive attitude of the therapist. The conductor allows the interpretation to come to him from the contributions of his patients […]" (Pines, 1983, pp. 278-79). Pines said Foulkes differentiated three types of interpretative activities – interpretation which enables unconscious processes to become more conscious; interpretation of resistances and defence; and interpretation of transference reactions, which could be addressed to any particular individual, or could refer to any configuration or relationships within the group, between the group and the conductor, or could be concerned with the here-and-now, or could range over the whole history of the group. Pines added that Foulkes thought these interpretations should preferably be based upon the available experience of the moment, and on the level at which the emotion is most active (Pines, 1983, p. 279) Again, Pines claimed Foulkes advised the conductor to direct his interpretations towards ongoing group interactive processes; repetitive conflict situations; understanding of the past experiences which spring to the mind of the patient in association to the group situation; current experiences in the life of the patient both within and without the group; but in particular to what Foulkes called "boundary incidents", events taking place at the interface between the ongoing group and the outside life of the individuals comprising it (Pines, 1983, pp. 279-80).

Foulkes' style of group leadership is very congruent with TC practice, especially staying with the "here-and-now", and encouraging the active participation of community members in their own, and others, therapy. However, unless group analytic groups are a specific part of a TC programme, there is much less emphasis on the interpretative role of staff.

Dynamic administration

Dynamic administration is all the work the group analyst does to ensure the security of the setting in which the group takes place, and to maintain the boundaries. Dynamic administration emphasises the crucial relationship between the practical and the dynamic (Barnes *et al.*, 1999, p. 30). Pines (1983) described dynamic administration as "not only selection of patients and composition of the group as a whole but also consideration of the social situation of therapy itself". The group conductor is also "the responsible administrator and has to be aware of the interface between the group-therapy situation and the social situation in which it occurs […]". The group conductor "has to guard and define the external boundaries of the group situation itself. There are always powerful dynamic forces at the boundary of the therapeutic situation, with pressures that will both support and disrupt […] (the therapist) is concerned with such very basic factors as accommodation, that is having a room with the correct furniture, quietness and freedom from disturbance […]" (Pines, 1983, pp. 277-8). In a TC, much of the dynamic administration is the responsibility of the whole community, and not just the staff (Rawlinson, 1999, p. 54).

Conditions set and principles of conduct required

Following Foulkes, GA uses a number of conditions and principles for practice. These include trying to ensure that group members are strangers; that groups meet in the same place, at the same time, and on time, on a regular, pre-determined schedule; that the group sits in a circle; and that the number of group members is usually 6-12; that confidentiality, and respect for other group members is required, as is "abstinence" (for group analysts this means avoiding any tension-reducing action during a session – like smoking, eating or physical contact); that there should be no deliberate contact between group members outside of group time; and that group members are discouraged from making life decisions during treatment (Foulkes, 1986, pp. 79, 80-95). Foulkes argued that these conditions and principles are "[…] as the patient finds them. He has no influence upon them and is not consulted. He should have been prepared or at least informed about them before joining the group" (Foulkes, 1986, p. 79) In a TC, this is partly true, and varies between communities, but TC members do have some say in, and the ability to influence, the framework for treatment in the community.

The group-as-a-whole

For Foulkes, group analytic treatment involves "psychotherapy of the group, by the group, including the conductor" (Foulkes, 1975, p. 3). In a TC, it is psychotherapy of the community, by the

community, including staff members. Foulkes also state that "[…] what we experience in the first place is the *group as a whole*" (Foulkes, 1990a, b, p. 154), and GA emphasises "understanding all events in the group as being meaningful in the light of the total group matrix" (Foulkes, 1984, pp. 75-6). In TCs, this would be articulated as everything that happens in the community is part of the therapy.

The group matrix

Foulkes defined the group matrix as "[…] the hypothetical web of communication and relationship in a given group. It is the common ground which ultimately determines the meaning and significance of all events and upon which all communications, verbal and non-verbal, rest" (Foulkes, 1984, p. 292), and stated it is "[…] not merely interpersonal but could rightly be described as transpersonal and suprapersonal" (Foulkes, 1984, p. 70). Foulkes described two types of group matrix – the foundation matrix and the dynamic matrix. The foundation matrix is the "[…] pre-existing community or communion between the members […]" and is a "[…] pre-existing and relatively static part […]", and has "primary levels […] based on the biological properties of the species, but also on the culturally firmly embedded values and reactions". The dynamic matrix overlays the foundation matrix – "there are varying levels of communication which are increasingly dynamic […]" and it is "[…] a current, ever-moving, ever-developing *dynamic matrix*" (Foulkes, 1990a, b, pp. 212-3, 228).

Foulkes went on to argue that "[…] the group-analytic situation, while dealing intensively with the unconscious in the Freudian sense, brings into operation and perspective a totally different area of which the individual is equally unaware. Moreover, the individual is as much compelled and modelled by these colossal forces as by his own *id* and defends himself as strongly against their recognition without being aware of it, but in quite different ways and modes. One might speak of a social or interpersonal unconscious", "that of which we are completely ignorant because we are born into it" (Foulkes, 1984, p. 52; Pines, 2009, p. 8). Hopper adds that "we need a concept like the 'social unconscious' in order to discuss social, cultural and communicational constraints", and that people are "affected profoundly by social and cultural facts and forces, and such constraints are largely unconscious […]", and that "a person may be as unaware of external social facts as he is of internal psychic facts" (Hopper, 2002, pp. 131, 136).

These concepts of foundation and dynamic matrices, and the social unconscious, are fundamental to TC work. TCs work with the foundation matrices of community members, and particularly emphasise their social and cultural contexts, but they also work with the dynamic matrix of the community at conscious and unconscious levels, through emphasis on the here-and-now of relationships and interactions within the community.

Common factors in practice

Group specific therapeutic factors can be supportive or analytic. For Foulkes, these factors applied mainly to small GA (Foulkes and Anthony, 1965, pp. 149-50; Foulkes, 1964, pp. 33-4, 41, 43; 1990a, b, pp. 179-185), but many of them apply to TCs too.

Boundaries and containment

Two ideas which GA adopted from psychoanalytic studies of early mother-infant relationships, and applied to groups, are holding and containment, and the notion of providing a secure base – these ideas are taken from Bion, and Winnicott, and Bowlby's ideas about attachment. Attachment, as an experience of belonging, and containment, and as an experience of safe boundaries, has been described as the essential preverbal experience for healthy emotional development, and is a feature that is planned and incorporated into TC programmes (Haigh, 2013). Psychodynamic containment also means holding, and working with, splits and projections within the group. Boundaries provide both physical and psychological security to enable therapy to take place – "boundary breaking has a meaning which, if exposed and understood, can become part of the therapeutic experience" (Barnes *et al.*, 1999, p. 85):

> Terri is in her forties and has a history of failed relationships and being fired from several jobs for not attending work. She has been a member of the community for six months, but has started to give

illness-related reasons for missing therapy groups. She had missed the previous day's community meeting – and this was discussed in the community meeting the next day, which she did attend. When challenged about her absences, she was initially defensive but eventually admitted that she was finding therapy very difficult, and was thinking of leaving. The community expressed concern for her and said they valued her contribution and wanted her to stay. They also linked this to her previous patterns of behaviour, such as her inability to stay in relationships or work. Members who had been in the TC longer told Terri that they had these feelings at about the same stage in their time in the TC, but they had managed to stay and benefitted from "staying with it". She was asked to attend all the groups and told "it's when you're feeling worst that it's most important to be there". She asked if other members could help by reminding her and encouraging her to go to all the groups, so two other members agreed to do this. The whole community agreed to review the situation with Terri the following week.

The here-and-now

For Foulkes, "the 'here-and-now' is understood in terms of the total situation, not merely the patient-therapist relationship. It includes current reality, current experience and the current network. There is no active search for the past, but it comes dynamically into the situation and is then considered as important and fully accepted as part of the on-going analysis" (Foulkes, 1986, p. 124; Foulkes and Anthony, 1965, pp. 19, 40-1, 62). The "here-and-now" also involves regarding anything that happens in the group members' experience as relevant for the group. The group's experience includes all concerns and issues, not only in the institutions and organisations within which the groups are held, but also society's norms, values and conflicts. Rapoport, in his study of Henderson Hospital, described this as "working with the problem while it's hot" (Rapoport, 1960, p. 95). Again, the concept of the here-and-now has always been an important tenet of TC practice. However, there has been little description of this in the TC literature, until recently. Harrison suggested that "conceptualisations […] such as the 'here-and-now', have gained a familiarity that indicates a less formal route of transmission" (Harrison, 2000, p. 268):

> Sandra has been in the residential TC for six months. One day, she doesn't turn up for the morning community meeting. The day before she had been criticised for not doing her cleaning job properly, and it was due to be discussed in the community meeting. Two members volunteer to go and fetch her, but they come back, saying that she is refusing to come. The community discusses what to do about this and somebody suggests that the whole group takes the community meeting to Sandra. When everybody turns up at her bedroom door, Sandra decides that she will come down to the meeting. When she does so, she talks about her anger at being criticised by the community and also anger at herself for not doing the job properly. She was also able to link this to her experience of her critical father, and difficulties she had had at work with what she perceived to be critical managers.

Reduction of isolation

Learning that others have similar problems is a basic therapeutic factor in both GA and TC work. Foulkes argued that "The patient is brought out of his isolation into a social situation in which he can feel adequate […] he can feel understood, as well as show understanding for others […]. The patient's realization that other people have similar morbid ideas, anxieties or impulses, acts as a potent therapeutic agent, in particular relieving anxiety and guilt […] He is a fellow being on equal terms with the others" (Foulkes, 1984, p. 33). Pines stated that this happens through the process of sharing, and through the experience of group acceptance and belongingness (Pines, 1983, p. 274). Foulkes and Anthony added that "The cardinal lesson of social living is gradually learned – the reciprocal need to understand and be understood. With increasing socialization, the character of intercommunication changes. What was egocentric and leader-centred becomes altruistic and group-centred; references to 'I' and 'me' alter to 'we' and 'us'" (Foulkes and Anthony, 1965, p. 149).

More recently, Pearce and Pickard (2012) highlighted the importance of "belongingness" in TCs for reducing an individual's sense of isolation, and identified this sense of belongingness as linked to positive TC outcomes. It is associated with a reduction in feelings of isolation as well as reduced suicidality, deliberate self-harm, aggression and substance misuse, as well as an increase in feelings of well-being and promotion of hope. "[…] in so far as TCs promote prosocial

skills, they provide tools by which a person may in fact successfully change their social reality […]" (Pearce and Pickard, 2012, p. 641):

> Ravi is a thirty five year old first generation British Asian man, who lives alone in a white working class area. He had barely left his house for nearly ten years, and was referred by an Asian community worker who was a friend of the family. After being accepted into the community, he barely spoke for four weeks, although he did eat with the community. He started attending the gardening group, and this was a turning point for him. He began talking to others about the gardening and the various tasks, and soon started talking about himself in the community meetings. He is now an active and committed member of the community.

Active participation

Foulkes said that active participation is essential for "mutative" therapeutic experiences (Foulkes, 1983, p. 73). Active participation, both in therapy groups and in the day-to-day workings of the TC, is a necessary and integral part of TC treatment for both staff and community members. This involves participation in peer therapy, in shared decision making, in role and task allocation relating to the running of the TC, and in the overseeing of the execution of these tasks:

> Tracey had been rather shy and anxious in the groups for the first three months of her time in the community. She was reminded that she was now eligible to take on some community posts, and took on some minor jobs. At her nine month review, the community encouraged her to take on the role of chair of the community. At first she was terrified of the responsibility, but grew into the role - as a result she became much more involved in community life. She herself said how important this had been in building up her confidence and self-esteem, and the how the experience enabled her to talk about herself more in groups, and to challenge and support other members.

Occupation

According to Foulkes, one occupation of the group is "the analysis of the relationship of any individual to any other, of any individual to the group, or the group to any individual […]" (Foulkes, 1984, p. 51), but this should not monopolise the group. Foulkes felt the group should "have an occupation other than that of self-observation and self-reflection" and that the group occupation "can be used as a screen behind which to hide problems of more central significance. This is why the group is left to devise its own occupation" (Foulkes, 1984, p. 51), and group-analytic groups should have a "total absence of occupation" (Foulkes, 1984, p. 68). Foulkes and Anthony add that "[…] occupation may be of secondary importance therapeutically, whereas active participation in the group setting may be the essential therapeutic agency." "[…] thus the effects and dynamics of participation replace the group's occupation as the centre of interest" (Foulkes and Anthony, 1965, pp. 35-6).

In TCs, analysis of relationships is fundamental to the work, but equal emphasis is given to the therapeutic value of practical tasks, and work related activities, as well as the interplay of these two aspects. Jones *et al.* stressed the sociotherapeutic importance of work groups in TC treatment (Jones *et al.*, 1956), while Christian and Hinshelwood (1979) argued that "the work group was pivotal" in the TCs run at Northfields Hospital, and at Belmont Hospital (Christian and Hinshelwood, 1979, p. 173). Both Christian and Hinshelwood, and Lees and Manning, argued that work groups, or "social labour" in TCs, and the relationships in the work groups, often highlight the difficulties that have brought people to the TC in the first place, but they also argued that increasingly work groups have been sidelined by "the more fashionable preoccupation with psychodynamics", and internal "work" (Christian and Hinshelwood, 1979; Lees and Manning, 1984, p. 22). Work groups used to include maintenance, furniture repair, painting and decorating, gardening, tailoring, and magazine/newsletter production, but are more likely now to be gardening, sport or arts related activities. More recently, Paddock again stressed the importance of work groups, because the "experience of being unable or unwilling to "work" is open to enquiry by the rest of the group" and community (Paddock, 2004, p. 247). Paddock also argued that the focus on task encourages more intimate relationships amongst group and community members, but that these relationships are a by-product of the task, rather than being the primary focus (Paddock,

2004, p. 247), but that work groups also "provide a rich and varied source of therapeutic material, which is often difficult to examine by other means" (Paddock, 2004, p. 252):

> Juli and Marc were both in their twenties, lived alone, and had existed on microwave ready-meals, which they ate in front of the television. In the cooking group in the TC, when it came to their turn to prepare lunch for the whole community, they were anxious because they had never cooked before. Other members of the group gave each of them different advice about how to cook rice. They got into a fierce argument about what was the correct way, and a crisis meeting was called. Initially they continued arguing in the crisis meeting, but with help from other members were able to both acknowledge their anxiety about cooking – and to acknowledge and understand some underlying tensions in their relationships. At the end of their time in the community, both commented how helpful and important their experiences in the work groups had been. Marc said "arguments over the washing up can be just as important as deep discussions in the groups".

Communication

Communication is the key that helps people change in therapy groups. "[…] working towards an ever more articulate form of communication is however, identical to the therapeutic process itself" (Foulkes, 1983, p. 169). "Foulkes described the work towards greater communication as going parallel with the process of analysis" (Pines, 1983, p. 276) "Foulkes also described the therapeutic process 'from symptom to conflict' in terms of a growing capacity for communication. The therapist's role was seen by Foulkes as that of a person who facilitates the processes of communication in the group, that is the process of 'analysing' took precedence over that of 'interpretation'" (Pines, 1983, p. 276).

"The conductor strives to broaden and deepen the expressive range of all members, while at the same time increasing their understanding of the deeper unconscious levels. The zone of communication must include the experience of every member in such a way that it can be shared and understood by the others, on whatever level it is first conveyed. The process of communication has much in common with making the unconscious conscious and with the concepts of unconscious, pre-conscious, and conscious in topographical and dynamic sense" (Pines, 1983, p. 276).

Individual group members "symptoms" are forms of communication which cannot be put into words. These "symptoms" need to be translated into communicable shared language and this occurs via verbal exchanges and free-floating discussion in the group. "The language of the symptom, although already a form of communication, is autistic. It mumbles to itself secretly, hoping to be overheard; its equivalent meaning conveyed in words is social" (Foulkes and Anthony, 1965, pp. 259-60). Examples of this include translation from talking too much, to fear of intimacy, or from short sharp answers, to shame about vulnerability:

> Barry has been a member of the TC for 1 year. He has a childhood history of being abandoned or rejected by those closest to him in his family (through loss by death and abusive family relationships). He has struggled to form close friends hips or intimate relationships as an adult. He has recently been elected to take up the position of Chair of the TC, which involves a number of duties, including chairing the community meetings. He has a tendency to run the meetings very actively, using up most of the time talking himself. Over the last week, in his small therapy group other members of the community have begun to explore this tendency in a thoughtful if characteristically direct way. Barry starts talking ten to the dozen again, until Pete says "listen mate, shut the f*** up, I don't care what your words are saying […] what your voice is telling me is that you are s*** scared". After a short argumentative and rather defensive exchange between Barry and Pete, Barry stops and becomes quiet. Another group member Daz say, "Its alright you know […] to say that your scared […] with your childhood and that who wouldn't be". Over the next few weeks, Barry used his small therapy group to talk again, in more detail and very movingly, about his painful experiences of loss and abusive rejection and to begin to be able to acknowledge his fear of intimacy. He stopped controlling his social environment by talking too much and Chaired the community meetings allowing others to use the space, simply keeping to the agenda and keeping time.

Free-floating discussion, and the "chain" phenomenon

"The keynote in group-analytic sessions is informality and spontaneity of contributions, which leads to what I have described as a 'free-floating discussion'. The conductor gives a minimum of

instructions and there are no set topics, no planning" (Foulkes, 1984, p. 40). Foulkes characterised free-floating discussion or group association as:

- similar to free association in psychoanalysis – free group association but collective not individual (Foulkes, 1984, p. 117) and

- talk about anything that comes to your mind without selection (Foulkes, 1983, p. 71).

Foulkes added that:

- the conductor gives a minimum of instructions;

- there are no set topics and no planning;

- sparing intervention from the conductor; and

- informality and spontaneity of contributions in groups leads to free-floating discussions (Foulkes, 1984, p. 40).

while Barnes *et al.* included:
- "members communicating with each other and resonating to what each says" (Barnes *et al.*, 1999, p. 103).

According to Foulkes, "On occasion […] the group get near to its own characteristic 'free-floating' discussion. This may frequently, in a well-established group, show bursts of chain activity, each member contributing an essential and idiosyncratic link to the chain. The chain phenomenon makes it appearance at certain tense moments in the group, when some 'collective condenser' theme is released – for example, fear of being laughed at, of being neglected, of being victimised. Each member may cap an association with his own. The event can deepen the level of communication in the group and lead to dynamic group developments" (Foulkes and Anthony, 1965, p. 151):

> Des has been a community member for 2 years in a Prison TC. He cannot read. Brian has started teaching Des to read in the evenings. Des plucks up the courage to speak about this in the community as a form of "update" and also to formally thank Brian. After a short silence, he says how ashamed he feels of not being able to read and how he has hitherto gone to great lengths to hide the fact, and starts telling amusing but deeply moving stories about this. Des's humility and openness on this occasion seems to colour the whole atmosphere of the community meeting, taking attention off the formal agenda, and leading to an open resonant discussion in which Tony talks about his shame about not being very tall, Sean speaks about the shame he feels now for his index offence and before that, about his heroin addiction, and his psychotic mother coming to pick him up from school. Other members who don't speak in the meeting reflect later in the their small therapy groups on their own aspects of shame.

Translation and ego training in action

For Foulkes, translation is the move from "symptom to problem" (Foulkes, 1990a, b, p. 181), through the "[…] interpretation of the raw material presented by the patient in the form of free association […]" (Foulkes and Anthony, 1965, pp. 51-2). This also involves translating symptoms into their meaning and transforming "the driving forces which lay concealed behind them into emotions, desires and tendencies, experienced in person. While doing so, the members learn a new language, a language which had previously been spoken only unconsciously. In this way the capacity for insight and communication grows" (Foulkes, 1984, pp. 176-7). Translation also "promotes awareness in each individual of himself and the other person, as well as of the world of objects, and thus the capacity for (analytic) insight and integration in each individual ('Ego training in action')" (Foulkes, 1990a, b, p. 181). "For this we need the communication of material that would normally be censored, so that we can arrive, with the help of this material by steps and stages, at the repressed and unconscious meaning of the patient's communications. We want means of communication under reduced censorship" (Foulkes and Anthony, 1965, pp. 55-6). "Interpretation refers to a special contribution on the part of the psycho-analyst to this translation. The whole group participates in this process, which ranges from inarticulate symptom to verbal expression, understanding and insight,

from primary process to secondary process, from primitive to logical, rational expression" (Foulkes, 1984, p. 111):

> Simon has been in the prison TC for 2 years and is serving a sentence for armed robbery. Yesterday, he spoke to the Wing Therapist, telling him he had "taken" a ceramic pot from his office when doing cleaning duties, and is now using it for one of his plants in his cell. The therapist is encouraging to Simon for coming forward and, after some discussion, they both agree that Simon should bring the issue to the community meeting to explore, which he duly does. During discussions with others in the meeting, making clear connections between stealing the pot and his index offences, but also exploring the way in which Simon disclosed this to the therapist in private, members of the community work with Simon to begin to translate his offending behaviour in to a communication to others for acknowledgement and praise.

Exchange

Foulkes (1984) described exchange as a therapeutic factor specific to groups, which alters the emotional situation. Foulkes also commented how a patient is more likely to take in something, e.g. confrontation or challenge – said by a fellow group member than by the therapist – "just as children accept many things from each other which they would oppose if they came from their parents". This makes discussion more lively and full (Foulkes, 1984, p. 34). This is particularly important in TCs, where members may come with profound mistrust of professionals or those in authority. Early on in someone's time in a group, "they may well experience more "give and take" among their peers, and will be able to accept confrontation and challenge much more readily from fellow group members than from therapists" (Rawlinson, 1999, pp. 51-2).

According to Pines, "Not only do the members of the group often have a lively exchange with each other of information which leads to understanding both of oneself and of the meanings of emotional inter-resonance. Each member of the group will reverberate to a group event according to his currently displayed level of development. Thus, for example, if a theme evolves in a group that has to do with violence, one will see how some members withdraw into silence, others display a marked interest in the behaviour of the other persons, i.e. sharing the use of projection, others can be self-revelatory about their own fantasies. Themes that arise in the group that have to do with such issues as parting, loss, grief, mourning are rich sources of information as to the current fixation and developmental level of the members of the group" (Pines, 1983, p. 275):

> Tony is always 5 minutes late for the community meeting. Whenever anyone challenges him, saying for example, "why can't you get ready 5 minutes earlier and get here on time like the rest of us", Tony reacts defensively, saying that he can't believe people are talking about him being late when he has so many other more pressing traumatic and emotional issues to talk about and which no one seems to care about. This cycle of communication has been occurring in the community meeting for some weeks until Martin, another community member speaks gently, kindly and directly to Tony, explaining that he too used to turn up late to the small groups and, when every anyone spoke about it, he felt attacked and misunderstood. The generosity and kindness in the way Martin spoke to Tony appears to have a deep impact on Tony, whose expression then softened in gratitude to Martin. During the rest of the meeting Tony remained quiet but attentively reflective. He started turning up on time to meetings, and began the process of exploring how difficult he found it to feel he belonged. The exchange with Martin had been a turning point for him, as a peer to peer understanding grew.

Group analytic dynamics

Mirror phenomenon

For Foulkes, one of the primary functions of a group is to mirror the self. "The group situation has been likened to a 'hall of mirrors' where an individual is confronted with various aspects of his social, psychological, or body image [...] In the development of a baby, the so-called 'mirror reactions' help in the differentiation of the self from the not-self. The reflections of the self from the outside world lead to greater self-consciousness [...] The mirror reactions are, therefore, essential mechanisms in the resolution of [...] primary narcissism [...] It can be assumed that a member of any therapeutic group has had a disturbed emotional upbringing, and that a good deal of narcissism belonging to his infancy still continues to function in his adult life. The mirror

reactions in the group help to counteract this morbid self-reference" (Foulkes and Anthony, 1965, pp. 150-1). In addition, Foulkes argued that "*Mirror reactions* are characteristically brought out when a number of persons meet and interact" (Foulkes, 1984, p. 110), but also that it "is it easier to see the other person's problems than one's own" (Foulkes, 1983, p. 167). Foulkes said that, in a group, "an individual sees himself, or part of himself – often a repressed part of himself – reflected in the image, behaviours, problems and interactions of other group members. He sees them reacting in the way he does himself, or in contrast to his own behaviour. He also gets to know himself – and this is the fundamental process in ego development – by the effect he has upon others and the picture they form of him" (Foulkes, 1984, p. 110), but also "Repression and the repressed, for instance, can be recognised when pointed out to others […] The discussion, interpretation or analysis of such material is therefore effective in a number of people at the same time, even if they merely listen to it" (Foulkes, 1983, p. 167). Pines added that in this way, the individual "is enabled to confront various aspects of his social, psychological and body image through identification with and projection on to the other members of the group" (Pines, 1983, pp. 274-5).

Rawlinson argued that similar processes occur in TCs – "patients see parts of themselves in other group members. This happens through their sharing of thoughts, feelings and behaviour […] When it takes place, patients may then be able (or be helped) to recognise the qualities they see in others as aspects of themselves, and so re-own projected feelings. This leaves them more self-aware and less isolated and fearful" (Rawlinson, 1999, p. 51). Rapoport had already described a characteristic of Henderson Hospital practice as "All relationships in the system are to be verbally reciprocal – i.e., individuals are to hold up a mirror to others, and to confront them with a verbal reaction that makes clear the effects of their behaviour on others" (Rapoport, 1960, p. 103).

On the other hand, Zinkin (1983) pointed out that mirroring could produce an aversive reaction, leading to a hostile, persecutory relationship between the two people involved – "malignant mirroring", and this can also happen in TCs:

> Steve was a fifty year old ex-soldier, who had been discharged on mental health grounds. When the women in the group talked to him, he tended to dismiss what they said. After a few months in the community, other members noticed this behaviour and confronted him in a community meeting. Initially he denied it, but after several members fed back examples of him doing this, he looked shocked and upset. He started to see how his father was a very autocratic man, who always belittled the women in the family, and that he was behaving in the same way. Steve said that this realisation was painful, because he doesn't like his father or want to be like him. Although he struggled with this over the next few weeks, he did start to take on board what female members of the community said to him. Before he left, he said that life in the community was like "having twenty mirrors around me and no place to hide".

> Gill was about forty, a lone parent with grown-up children, who came in with a diagnosis of depression and self-harm. In her small group, another member was talking about how lonely she was, and how much she wanted a relationship. She began to realise that she "gave off vibes" that tended to put men off. Gill said "OMG, I've just realised that's exactly what I do, and I hadn't seen that my depression is actually about loneliness since the kids left".

Resonance

Resonance literally means "resounding" – a sound which creates another sound. In a group, each individual reacts in their own specific idiosyncratic way to issues that arise, enriching and deepening the emotional experience. Resonance refers to one's own unique response to the feelings of another group member or group issue. The things to which group members are prone to resonate are likely to relate to their early emotional experiences (Foulkes, 1990a, b, pp. 298-305; Foulkes and Anthony, 1965, p. 152).

Again Rawlinson, in relation to TC work, suggested that "having a forum where patients can feel less isolated by being heard and hearing others, at a level of some depth and often out of conscious awareness – can be of great therapeutic benefit. In powerful emotional moments in groups, several members may experience this sort of resonance simultaneously. E.g. where someone has decided to leave a group and is discussing it, which may put another member in

touch with painful feelings which are based on a loss of an important person when they are small which might never have been fully accepted or grieved for" (Rawlinson, 1999, p. 51):

> Joe, aged 28, had been in the community for nine months and had become quite emotionally articulate. In a morning community meeting, he announced that it was the first anniversary of his abuser's death, and that he had mixed and conflicted feelings about it. Part of him felt that he felt loved and wanted by his abuser, while another part hated him and was glad that he was dead. For several minutes, everybody in the community meeting went quiet. Gradually, various members began to relate to what Joe had said and recount similar feelings of their own. Although the meeting felt sad and heavy, people also said that they felt closer to each other as a result of sharing their experiences and emotions about their own abuse.

Location of disturbance

Foulkes argued that "[…] the most important source of the disturbance is not in the patient at all […]" (Foulkes, 1984, p. 21) but is rather between the figures of his past and present networks. Group members' problems/symptoms/disturbances are not localised in the individual in isolation but located in a social network. In order to change, group members need to understand that their disturbance exists between them and other people, not simply within them. So, any group members' disturbed mode of communication may have its roots in historical family modes of communication (Foulkes, 1983, pp. 127-8):

> Bernie, a 34 year old former IT consultant, has been in the TC for nearly a year: her struggle has been to get beyond her rationalising and intellectualising defences and own her feelings and disturbance. She can come over as somewhat patronising to people in earlier stages of the programme. Jaqui is 45 and has been in the TC for four months, and continues to struggle with being very disorganised and emotionally labile. In the morning meeting, Bernie criticizes Jacqui for always leaving the kitchen in a mess, and Jaqui flies off the handle and starts screaming at Bernie. Bernie calmly replies that it is Jaqui's problem, and the rest of the community remains quiet. A staff member questions what is going on, and what the two of them represent for the rest of the community. After a little while, other members begin to acknowledge that is it safer for them to let Jaqui hold the disturbance and identify with Bernie's "I am no longer disturbed" stance. General discussion followed about how frightening it is to be in touch with one's own "mad bits".

Amplification

Amplification describes the exaggeration of a set of responses within another group member and the group as a whole, and happens when emotions are often unexpectedly felt more strongly when in a group setting. For those who find it hard to access emotions, amplification can be liberating, but it also needs to be managed actively, especially in a new group (Klain, 2009):

> Jenny is usually a very quiet 45 year old member of a residential TC in the community for 12 people diagnosed with severe and enduring mental health problems. She spends most of her days inside, tidying up after others. She clearly resents the carelessness of other community members, sometimes muttering under her breath. However, she never speaks about her resentment and anger in the weekly community meetings. However, on this occasion, the community therapist manager comes in to the meeting 30 seconds after the start time and Jenny can't contain her fury. She uncharacteristically and unexpectedly starts a loud and long critical monologue. Her feelings of frustration towards the therapy manager are amplified by the community meeting setting, and reflect pent up anger and frustration over many months, which she has hitherto not been able to articulate openly to others.

Condenser phenomenon

"The term 'condenser' phenomenon is used to describe the sudden discharge of deep and primitive material following the pooling of associated ideas in the group. The interaction of members loosens up group resistances, and there is an accumulative activation at the deepest levels. It is as if the 'collective unconscious' acted as a condenser covertly storing up emotional charges generated by the group, and discharging them under the stimulus of some shared group event" (Foulkes and Anthony, 1965, p. 151). For Foulkes, "[…] in a group […] Many more themes are touched upon and it is easier to talk about them when they have been brought up by others. […] This was exemplified in particular in connection with dreams and symbolism, common

phobias and the like. In formations such as symbols which are productions of a collective unconscious, the pooling of associations in a group seems a particularly adequate means of throwing them into relief" (Foulkes, 1984, p. 34). These symbols, acting as condensers, and which appear as symptoms, dreams or phobias – what the group holds in common – can be more readily understood (Pines, 1983, p. 275):

> The community meeting in a residential TC in the community for 12 people diagnosed with severe and enduring mental health problems has, over the last few weeks, been focussed on the here and now concerning everyday business matters, shopping and cleaning rotas, what needs mending in the house, and so forth. There are dynamic challenges within the community group membership, for example, to those who have not been pulling their weight in their community jobs, but there is no talk of feelings or emotions. Rosemary is a woman in her early 60s with a long history of psychosis and early childhood sexual trauma, who tends to keep herself to herself, and usually says the minimum in the community meeting. On this occasion, she uncharacteristically opens the any other business section at the end of the meeting proclaiming she has had a dream about the therapy manager, in which the therapy manager is wearing high heels and looks like a prostitute. There is a ripple of hilarity across the community at this somewhat demeaning image of the therapy manager. Eventually, Rosemary has time to express how disturbed she feels, and troubled by an underlying worry about trusting the therapy manager, being reminded of early childhood experiences. This deep emotional work continues over the next few weeks, resonating on the theme of early experiences of untrustworthy authority figures across the community, so that the everyday business part of the meeting is dealt with swiftly, leaving more and more space for these explorations. The dream acted as a condenser releasing the possibility of exploring deeper emotional material in the community, which had hitherto felt too difficult and painful to speak about.

Analytic factors

Foulkes argued that the group-analytic situation is essentially a transference situation (Foulkes, 1984, p. 177), and that the concepts of transference and countertransference refer to the total group situation (Foulkes, 1990a, b, p. 180). He also said that "The transference reactions of the group as a whole are a different matter from the transference situations of the individuals concerned" (Foulkes, 1984, p. 24), and allow, for example, for the analysis of collective resistance, but also that the relationships between group members are to be treated as transferences, and so subjected to interpretation and analysis (Foulkes, 1984, p. 285). For Foulkes, "the phenomenon of transference is in itself the most powerful resistance and defense against change" (Foulkes, 1986, p. 117).

In TCs, transferences and countertransference's appear differently, because of multiple leadership, and having more than one group conductor, with TC members working in a varied range of group settings, which, therefore, provide more opportunities for splitting and projection, but also because these dynamics can be demonstrated much more clearly in the many groups involved in TC practice:

> Jon is a relatively new and inexperienced member staff who has come under criticism for the last few days, from several members of the community, who say that he is useless at his job. As a result he has become somewhat withdrawn and silent. A more experienced member of staff drew attention to this dynamic and the Community members began to recognise that Jon represented their critical fathers, and this was why they were attacking him. Jon acknowledged that he too had a critical father, and that his response was to become quiet and withdrawn. After the transference and countertransference had been recognised, community members began to relate to Jon differently.

Anti-group factors

More recently, Nitsun argued that Foulkes' basic law of group dynamics has "[…] underemphasised the extent to which groups mobilise aggressive and destructive impulses […] (and) as such […] it did not address the issue of group as opposed to individual pathology […]" (Nitsun, 1996, p. 272). Rawlinson, based on Nitsun, also stated that there is a "[…] destructive aspect of groups that threatens integrity and therapeutic development. It is present in all groups: sometimes it can be resolved with relative ease, but sometimes it fatally undermines the foundations. These are powerful and primitive forces arising from early mental mechanisms which include splitting, projection and projective identification" (Rawlinson, 1999, p. 53).

Nitsun went on to argue that processes and norms in a group are a miniature version of those in society, so just as there is war, conflict, corruption and violence in society, the same underlying forces and dynamics are present in groups. He also pointed out that unconscious processes occur in all types of groups, whether or not the group aims to explore and work with them. If these are not recognised and worked with, the group can potentially be anti-therapeutic and even damaging. This is what he calls the "anti-group", and it is a potential presence in any group, and a threat to its effective working.

Destructive processes in groups can include, for example, drop-outs, lateness and absence, monopolising, secrets, meetings outside the group, sub-groups, splitting, conductor's isolation and paralysis, irresolvable conflict, enactment of aggression, bullying, scapegoating, enactment of erotic feelings, stuckness, and malignant mirroring of disliked and hated attributes. In a TC, these processes can be particularly prominent.

According to Nitsun, the anti-group is a natural part of a group's development, but a destructive outcome will only ensue if the container function of the group breaks down. Furthermore, the anti-group can be harnessed for its creative potential. For this, group members need to be able to recognise their part in the formation of the anti-group, and take responsibility for the well-being and development of the group (Nitsun, 1996):

> Gary has been in the prison TC for 6 months, and has recently tested positive for cannabis in a routine drug test. The matter is bought, as a matter of course, as an agenda item in the next community meeting. Longer standing members of the community begin to explore with Gary what feelings he might have been avoiding by having a smoke. Gary laughs and avoids the question, going on to talk about the music he had been listening to, and some other members of the community chuckle quietly in response. Tom, a more senior member of the community, says he doesn't feel safe knowing there are drugs on the wing. Gary reacts quickly with a raised voice saying "Listen I'm not going to grass anyone up – have you got that yet?"[…] As Gary continues in this vein, the community members become quieter and quieter, and eventually there is a long silence. The strength of the cultural norm of secrecy and mistrust as opposed to being a "grass" takes hold of the community, and stifles the therapeutic culture of openness, communication and trust. A form of anti-group process is at work here, and staff needed to intervene actively to challenge this.

Divergences between GA and TCs

Selection

In GA, the group conductor takes full, sole, responsibility for the selection of members. In TCs, the community as a whole takes responsibility for the selection of members, although this task is usually delegated to a group of staff and TC members, agreed by the community as a whole.

Structure of groups

Group size. In group analytic practice, small groups tend to involve a minimum of three group members, with 6-9 seen as optimal, and 12 as the maximum number of members. Median groups usually have 15-40 group members, and large groups can be anywhere between 40 and several hundreds of group members. In TCs, small groups tend to be a similar size to those in GA, whereas large groups tend to be median group size.

It is interesting to note that, according to Pines, Foulkes "was not over-enthusiastic about the application of group-analytic theory to large groups (upwards of 25 persons), and he significantly influenced those persons who had begun to develop the large group as a significant therapeutic situation […] e.g. Pat De Maré". However, De Maré said that, in the large group, the individual can discover what it means to be a citizen (Pines, 1983, p. 283).

Frequency of groups. Foulkes initially felt once a week was sufficient, but later thought twice a week not only worked well, but was "much more satisfactory", and that "continuity is much enhanced" (Foulkes, 1986, p. 86). Although he is not always consistent in what he says, Foulkes concluded that the best workable time duration for small groups is 1.25-1.5 hours, based on his own clinical experience, although currently group analysts tend to run groups for 1.5 hours.

Foulkes also felt that intensive therapy groups would probably take two to three years to be effective, but with nine months minimum required (Foulkes and Anthony, 1965, pp. 67-8). TCs usually have small groups twice a week, usually for 1.5 hours. However, TCs are also intensive group treatment programmes, so they offer differing groups, and differing sizes of groups, offering different activities, throughout the day. Also, the time TC members are in treatment varies, with a maximum time of 1-1.5 years currently in community-based TC programmes, but significantly longer in prison-based TCs.

Number of conductors/therapists. Group analytic groups usually have only one group conductor, although sometimes two. In TCs, although some analytic small groups tend to have one, most have two or three conductors. Other groups usually have several conductors, particularly in larger groups such as community meetings.

No contact outside group. This refers to members meeting up outside the group and acting out inner states, rather than trying to find words for them within groups; it also refers to contact with the conductor, and includes post-treatment. Group analysts argue that the group analytic group is not there to provide outside relationships, but to widen members' options of how they relate to others, and that the whole group should not be involved in after-session activities, as the conductor is absent. Moreover, chance meetings should be reported back to the group (Barnes *et al.*, 1999, p. 88). This is based on Foulkes' argument that "The specific condition for treatment in an analytic group is that the patients are strangers to each other and have no relationship in life. Members could not feel free to talk to each other in the group if it could lead to consequences in real life. The desirable degree of free communication requires relaxation of the censorship which normally applies in social situations. The group situation must therefore be kept free from social implications, which in addition would stimulate acting out. Only thus is it possible for transference relationships to develop unhampered within the group and for them to be analysed" (Foulkes, 1986, pp. 93-4).

In TCs, however, all members meet in a range of settings and activities outside of small therapy groups, and sometimes have after-groups for client members and staff members, although any discussion is then taken back to the community group. There is an expectation that informal contact outside the groups will be fed back. Day TCs often have an out-of-TC-hours on-call system for members, and if there is contact through the rota system, this is to be fed back to the community in the next community meeting. TCs argue that the range of groups increases the number and range of transferences that occur, and also enables acting-out behaviour to be seen in the community, and seen more clearly. Social aspects of life in the community are regarded as part of the therapy – the living-learning experience (Jones, 1968a, b, 1982). Moreover, TC members often maintain contact with the TC, and with fellow members, after they have left the TC.

TC specific factors

There are some aspects of TC work which are very different, and would not apply in normal group analytic practice. TCs are more holistic in that members interact with each other in a wide range of social situations and settings, and a much wider range of emotions and behaviours is available to be included in the therapeutic process. It also means that every participant is seen as a gestalt, a more integrated whole person, where split-off parts cannot be hidden from the community's eyes.

In a TC, the community itself is the primary treatment tool, and specific therapies such as GA and sociotherapy are secondary to that. Sociotherapy is another distinctive feature of TCs which is not found in GA (Edelson, 1970): it would not be normal practice outside a TC for members and staff of a therapy group to eat, work, play, do therapy and sometimes live together. Indeed, many clinicians would not want to work in this way.

Democratic self-government is a fundamental aspect of TC treatment, and it is not found in regular group analytic treatment. It involves all community members taking some part in the day-to-day running and organisation of the TC, including some aspects of dynamic administration such as boundary maintenance, containment and member selection. Moreover, community

members vote each other into posts needed for the running of the community, and use this as part of the therapeutic process itself.

Another distinctive feature of TC practice is the prominence of therapeutic or positive risk taking. In this way, the community as a whole takes responsibility for managing risky behaviour amongst its members. TCs encourage people to be as much like their usual selves as possible, rather than proscribing or reporting dysfunctional behaviour – so it is not hidden, concealed or kept secret, but can be openly discussed. Through this discussion, behaviour can be worked with as part of the therapy. In this way, the community as a whole takes responsibility for managing risky behaviour, rather than being left with a single clinician.

TC treatment can also include a wide range of additional activities as part of the therapy programme. These can include arts and creative work, drama and psychodrama, social and therapeutic horticulture, looking after animals, cooking, sports and games, outings, parties, open days and other special events.

All of this links to another specific TC tenet – that of "living-learning situations" (Jones, 1968b, pp. 73-4, 105-12, 87-90) or "social learning" (Jones, 1968a, pp. 68-107), and applies to everyday living and problems related to this (Jones, 1968a, p. 87). Maxwell Jones stated that "Social learning as practiced in a therapeutic community implies two-way communication motivated by some inner need or stress leading to the overt expression of feeling and involving cognitive processes and learning". It also "describes the little understood process of change which may result from interpersonal interaction, when some conflict or crisis is analyzed in a group situation, using whatever psychodynamic skills are available" (Jones, 1968a, pp. 69-70). It involves "a willingness to become involved in an examination of one's own and other people's attitudes and behaviour, with a view to bringing about change […]" (Jones, 1968a, p. 87). This is reflected in the TC belief that all activities and interactions in the unit are available for comment, for analysis, for learning and for treatment (Whiteley and Gordon, 1979).

In addition to the above, TCs also offer a completely different experience specifically for staff. Working in a TC always involves working directly as a staff team, rather than as a lone therapist. Supervision arrangements vary, but, in most TCs, supervision and reflective practice happens throughout the day through pre-groups, after-groups, informal conversations, staff meetings, staff supervision groups, staff sensitivity groups, team away days and training days. Being part of a cohesive and close-knit therapy team is often cited by staff as one of the most significant experiences of working in a TC. This is essential for effective practice.

Because there are so many people in the therapeutic field, there is potential for a large range of relational dynamics. Because of this also, transferences are often split and members will be able to project different feelings onto different members at the same time, and this can be seen with particular clarity by other community members. Moreover, with a large staff team, a range and pooling of countertransference is possible, and can be effectively processed in the staff's reflective spaces. Peculiar to TCs is the related phenomenon whereby the staff group can be enacting a particular dynamic which is happening in the members' group, or vice versa. This is called parallel process, and can provide important therapeutic material once processed in supervision and staff sensitivity groups.

Conclusion

Democratic TCs emerged from the same roots as group analytic psychotherapy in the Second World War, although various experiments in therapeutic education in the nineteenth and early twentieth centuries could be seen as precursors to some aspects of TC work. The two Northfield Experiments in the 1940s provided the clinical and theoretical bases for GA and TCs.

This paper has examined the similarities in theory and clinical practice between TCs and GA, as well as the divergences. TCs can be viewed as a modified or applied form of GA, and since the 1940s they have both been modifying and developing their theory and practice. Until recently, TC practice has been under-theorised, and this paper is an attempt to highlight the group analytic principles that underlie much TC practice.

Although there are still some TCs and group analysts working in a classical way, both approaches have undergone extensive modifications to meet external constraints and societal changes. There has been a much greater diversification of TC practice which includes TCs which are community-based and non-residential (day TCs), programmes which run a mini-TC or a micro-TC model, and virtual or distributed communities. TCs are also developing programmes which includes additional models of psychotherapy, such as person-centred and humanistic, transactional analysis, and more recently dialectical behaviour therapy and mentalisation based therapy. Despite the inclusion of these other approaches, TC practice continues to be fundamentally group based.

Now TCs need a modern and inclusive exposition of current theory, practice and evidence. This would provide a coherent incorporation of the different approaches being used in an overarching framework. Pearce and Haigh (2017) provide an initial contribution to this body of literature.

Note: all clinical examples are composites, constructed from our combined clinical experience in therapeutic communities, and do not refer to any specific individuals.

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