I processi di responsabilizzazione dei curanti e degli ospiti nelle Comunita Terapeutiche e nei servizi per la salute mentale

Balancing rights and responsibilities in therapeutic institutions:

Therapeutic change via participation in ‘real tasks’ and ‘real relationships’

Saturday 8th November 08

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Definition of a Therapeutic Community

- "… a socio-cultural envelope (within which) therapeutic opportunities are concentrated and fostered (by the) distinctive forms of social interaction that occur therein" (Hunt, 1983).

- The TC is deliberately organised as a small society, within which goes on ***the trading of certain (therapeutic) rights in exchange for the fulfilling of specific responsibilities.***

Therapeutic Rights

- Getting help with attachment, separation and loss
- Experiencing agency
- Encountering intimacy safely
- Finding support for respectful closeness with others
- Developing a meaningful interpersonal existence- sense of belonging
- (NB The above form the essence of Main's **'real relationships'**- they reflect the patients' core difficulties).

Responsibilities

- Activities and interactions that centre on a range and hierarchy of specific tasks
- These tasks are essential for the functioning of the TC
- There are observable consequences if the task is not or only poorly done

(NB An accurate matching is required of tasks to patients' capabilities overall and for the differing stages of therapy; senior patients are expected to be more capable- **real tasks).**

Culture versus structure?

- For Tom Main, who coined the term ‘therapeutic community’ (Main, 1946), the ‘culture’ rather than the structure made the TC not only distinctive but effective (Main, 1983).
- Main wrote about the ease with which a TC could function as if in a sate of ‘freedom from thought’, doing things thoughtlessly by rote memory (Main, 1967)

A culture of enquiry

- Sincerity and genuineness were at the heart of Main's TC ideology- the therapeutic potential is realized by the degree to which it is successful in achieving authenticity, i.e. delivering 'real tasks' and 'real relationships' (Main, 1983)
- Unlike the TC's 'structure', its 'culture' is easily lost; the latter depends on the vigilance of staff to identify early signs of this and take steps to maintain the spirit of 'enquiry' (Norton, 1992a)

Problems of conventional psychiatric inpatient settings

- The typical patient is passively engaged in a range of tasks, mostly imposed by the hospital ward 'system'
- Many tasks do not have any clear therapeutic purpose that is understood by the patient
- Carrying out (or not carrying out) task-related activities does not have clear or predictable consequences for the patient
- There are few if any aspects for which the patient is held responsible
- Beyond symptom loss, expectations of the patient's mental health and thoughtfulness are low
- (N.B. Such experiences for Borderline PD patients recapitulate those of their early lives, hence are harmful).

Solutions to be provided in therapeutic institutions

- Creating an environment that is intelligible both to staff and patients
- Considering the environment ‘as a whole’
- Conveying information (to all) about how the structural ‘parts’ relate to the ‘whole’
- Sharing with patients information about therapy aims and the means to achieve them
- Communicating rights and responsibilities of staff and patients and means to assess performance
- All collaborating to deliver the therapy safely.

Obstacles to achieving therapeutic ambition

- Inadequate delegation of managerial authority from higher levels to frontline staff
- Staff who do not understand how the programme works- parts/whole
- Staff who cannot convey to patients how the programme works and/or embody it
- Characteristic attitudes and behaviours of the patient group, etc, etc.

Obstacles to therapy imposed by Borderline PD patients

- Anti-authority attitudes/ basic mistrust of others
- Lack of sense of agency- ability to influence
- Ambivalence about intimacy- wanting/fearing it
- Difficulty asking for help- feelings of shame, stigma, vulnerability and lack of entitlement
- Fears of abandonment/infantile dependence
- Hypersensitivity to separations and losses
- Resorting to destructive actions under stress
- (NB These are the aspects of psychopathology which govern the TC's structure and culture).

TC responses to borderline PD patients' challenge

- Avoidance of pitfalls of conventional inpatient setting- passivity and absence of predictable consequences- "Do no harm!"
- Acknowledgement of areas of patients' relatively healthy functioning
- Expectation of patients' active engagement in treatment
- Predominance of a negotiating style of interaction with patients
- Setting of clear limits and methods to contain violent behaviour.

Therapeutic ‘contract’

- Patients’ knowledge of and agreement with TC aims and collective methods to achieve them
- Understanding of the need for rules of membership to safeguard therapeutic aim
- Understanding what can be tolerated (and what not) and WHY- ***responsibility to abide by rules***
- Understanding what support/therapy can be provided (and what not) and WHY- ***right to new experiences in relation to self and others***
- In summary, undertaking to participate actively in the TC while observing its rules.

Reciprocal responsibilities

- Existing members, patients and staff of the TC, to provide structures for safe delivery of therapeutic programme, mechanism for dealing with emergencies- risk-related- and also routine ‘domestic’ matters- food, hygiene, social
- New TC patients to accept role in actively being part of programme both (formal) group-based therapy programme and in the (informal) daily life of the institution, while striving to live within the TC’s rules.

Henderson's TC rules

- No violence to self, others or property
- No illicit drug use at all nor alcohol to be consumed on hospital premises
- No starving, purging or self-induced vomiting
- No tampering with electrics or fire equipment
- No trespassing on railway line
- (NB Sexual relationships between patients within therapy are strongly advised against).

Fixed consequences of rule-breaking

- Tampering with electrics or fire equipment = instant discharge- (re-application 6/12)
- Trespassing on railway line = instant discharge- (re-application 6/12)
- Violence to self, others or property = symbolic discharge (vote to ‘return’)
- Starving, purging or self-induced vomiting = symbolic discharge (vote to ‘return’)
- Taking of illicit drugs/consuming alcohol on premises = subject to views of TC as to whether their membership is retained- but not directly (or even symbolically) discharged

Assessing and managing risk

- Assessing and managing risk are carried out (other than in emergencies that require police, fire, ambulance) ***via the calling of an emergency community meeting*** at any time of day or night- **takes priority over formal therapy**
- Responses to emergencies (where external services not required) to define problem, identify risks; and manage, via interpersonal means rather than sedation, seclusion or 'sectioning'
- (NB Record of meeting taken and reported in next day's community meeting for digestion, reflection and (democratic) action).

Function of Henderson's community meetings

- Forum for all staff (on duty) and all patients
- To establish who is present and note absentees
- To collect and disseminate relevant 'news' of the community- positives and negatives ***(re tasks)***
- To review the previous 24 hours, including untoward/other events requiring emergency meetings- 'culture of enquiry' ***(re relationships)***
- To anticipate the following day in light of the lessons of the previous day- 'living-learning'
- To make decisions about 'discharges'- **voting**.

Some patient tasks/roles

- **Top Three (Chair community meetings/ emergency meetings)-** 3 months or more
- **General Secretary (Record above meetings)-** 3 months or more
- **Selection representatives (Attend selection interview of new patients)-** 3 months or more
- **Treasurer**- 3 months or more
- **Teller (Count votes)**- any patient
- **Washing up rota-** any patient
- **Cleaning**- all patients (sometimes staff)

Q: How can ***we*** operate rules with rule-breaking ***patients*** who are easily 'injured'?

- Needs collaboration- 'You' cannot but 'we' can!
- Knowledge of rules and understanding of their rationale
- Rules structure TC society, breaking them gives patients chances to learn- staff might welcome (some) breakages!
- Rules will be broken because hard to ask others for help
- Opportunities to develop self-esteem and agency offset negative impact of consequences so lessening injury felt
- Understandable, predictable and respectful environment over time is internalised by the patient

Q: What helps/ *hinders* patients' assumption of responsibility?

- Simple rules, clearly stated with a convincing rationale/ *absence*
- Set of clear consequences, reliably and consistently applied/ *absence of same*
- Statement of rules couched in terms of therapeutic aims of TC/ *disciplinary culture*
- (NB Authentic 'responsibilization' of patients cannot be imposed).

Q: What helps/ *hinders* operating rules and enforcing consequences of rule-breaking?

- Maximal delegation of staff authority/ *lack of this*
- Collaboration of patients/ *absence of this*
- The more senior patients (ideally the majority) own and embody respect for rules/ *lack (or minority)*
- Patients' experience of authentic agency (via **real tasks**) and meaningful membership (via **real relationships**) in TC- belonging/ *lack of this.*
- Authentic culture of enquiry to support structures thereby improving TC functioning and improving self-esteem/*lack*

Thank you. Further questions or comments please?