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**A new therapeutic community: Development of a Compassion Focused and Contextual Behavioural Environment**

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### **Abstract**

Social relationships and communities provide the context and impetus for a range of psychological developments, from genetic expression to the development of core self-identities. This suggests a need to think about the therapeutic changes and processes that occur within a community context and how communities can enable therapeutic change. However, the ‘therapeutic communities’ that have developed since the Second World War have been under-researched. We suggest that the concept of community, as a change process, should be revisited within mainstream scientific research. This paper briefly reviews the historical development of therapeutic communities and critically evaluate their current theory, practice and outcomes in a systematic review. Attention is drawn to recent research on the nature of evolved emotion regulation systems, the way these are entrained by social relationships, the importance of affiliative emotions in the regulation of threat, and the role of fear of affiliative emotions in psychopathology. We draw on concepts from Compassion Focused Therapy, Social Learning Theory, and Functional Analytical Psychotherapy to consider how members of therapeutic community can be aware of each other’s acts of courage and respond using compassion. Living in structured and affiliative orientated communities, that are guided by scientific models of affect and self-regulation, offers potential therapeutic advantages over individual outpatient therapy for certain client groups. This conclusion should be investigated further.

**Key Practitioner Message:**

- Current therapeutic community practice is not sufficiently evidence-based and may not be maximising the potential therapeutic value of a community.
- Compassion Focused Therapy and Social Learning Theory offer new approaches for a therapeutic environment, involving an understanding of the role, nature and complexities of compassionate and affiliative relationships from staff and members, behavioural change guided by learning theory, a clear formulation based on threat-derived safety strategies, goal setting and positive reinforcement.

**Key words:** therapeutic community, attachment, compassion, affiliative emotions, learning theory, reinforcement, systematic review

## Introduction

Like other mammals, humans evolved and live within communities, family and kin groups. Indeed, the social dynamics of group living have been fundamental to the evolution of a number of human competencies such as self-awareness, cooperation, social sharing and capacities for mentalizing, empathy and affect regulation (Baumeister, & Leary, 1995; Dunbar & Barrett, 2007). The evolutionary pressures that gave rise to these competencies are often referred to collectively as the *Social Brain Hypothesis* (Dunbar, 2007, 2010). There is increasing evidence that individuals adapt their behaviour and experience of the self according to the social context in which they operate – for good or ill (Cacioppo & Patrick, 2008). Different ecologies give rise to different values, senses of self and strategies involving trust and loyalty (Li, 2003). Gilmore, (1990) offers many examples of how self-identities are created within community contexts, such that male identity and behaviours can become aggressive and violent in some social contexts yet are benign in others. Group pressure and the desire to conform can lead to all kinds of immoral behaviours that are destructive, such as committing atrocities in war or youths getting caught up with criminal gangs (Gilbert, 2005, 2009; Kelman & Hamilton, 1989; Zimbardo, 2008). Even when people appear to be behaving according to the requirements of the group, it is not always clear whether this is submissive behaviour or even cynical compliance rather than an internalised valued system.

Social relationships and social context, especially affiliative and caring ones, play major roles in physical health (Cacioppo & Patrick, 2008; Holt-Lunstad, Smith, & Layton, 2010) profoundly influence neurophysiology (Cozolino, 2007) and genetic expression (Belsky & Pluess, 2009). There is even evidence that gene expression is influenced by a change in the dynamics of group living, such as social status changes

(Tung et al., 2012). We offer these preliminary concerns to indicate the power social relationships and communities can wield over their members, which has been put to therapeutic use in what are called therapeutic communities (TCs). (When using the term ‘member’ we refer to both the clients or residents and the staff.) We will argue that current TCs have operated largely outside mainstream psychological research since the Second World War and that a new generation of TCs, informed by such research and guided by a compassion focused and contextual behavioural environment, offers potential. However, this approach obviously requires further conceptual and outcome research. In this article, we will describe:

- (1) The history of the therapeutic communities to understand the context,
- (2) The theory behind contemporary therapeutic communities,
- (3) A critical evaluation of the processes in therapeutic communities,
- (4) A systematic review of outcomes of therapeutic communities,
- (5) An evolutionary and compassion focussed approach for a new approach to a therapeutic community
- (6) The contribution of Social Learning theory and Functional Analytical Psychotherapy to a new therapeutic community
- (7) The need for structured activity, goals and values in a new therapeutic community
- (8) The new therapeutic community in action

### **(1) The history of the therapeutic communities**

Psychodynamic therapists have defined a therapeutic community as “a consciously-designed social environment and program within a residential or day unit in which the social and group process is harnessed with therapeutic intent. In the therapeutic community, the community is the primary therapeutic instrument” (Roberts, 1997). Membership is clearly defined and staff has a facilitative role in operating the

community as mediators of change. The members have significant involvement in decision-making and the practicalities of running the unit. Their life together is configured to help members develop personal responsibility, build an understanding of themselves, and change their ability to regulate both emotions and behaviour (Kennard, 1998). The process is one of dynamic, reciprocal interactions where individuals receive feedback and support in the change process. They are engaged in a range of activities including community meetings, group psychodynamic therapy, social interaction and communal living. Some communities may include individual psychotherapy but it is the relationships between members and the community that are regarded as the mediators of change. The term “therapeutic community” does not therefore refer simply to a place for healing – it is used to describe a community where the relationships between the members (including staff) and with the community are reflected upon in group therapy.

TCs were traditionally residential. Economic considerations have meant that the large majority of adult TCs are now day centres for which the members usually attend 3 to 5 days a week, for between 6 and 24 months. TCs exist in various settings, including adolescent, adult mental health, and learning disability units and prisons. Populations served include those with severe personality disorder, and alcohol or substance abuse.

Previous literature (Borthwick et al., 2001; Kennard, 1998; Whiteley, 2004) has described the history and evolution of the first generation of TCs, beginning with Tuke’s “moral therapy” at the York Retreat in 1796. This involved the minimum use of restraint, early forms of behaviour therapy (including activity scheduling), and a humane and caring environment. The medical historian Roy Porter (2002) says that William Tuke, a tea merchant, modelled the retreat on bourgeois family life. Patients and staff lived, worked, and dined together in an environment where recovery was encouraged through praise and rewards rather than punishment, the goal being the restoration of self-control. Tuke’s grandson Samuel noted that medical therapies had

initially been tried there with little success; “the Retreat had then abandoned ‘medical’ for ‘moral’ means, kindness, mildness, reason and humanity all within a family atmosphere - with excellent results” (Porter, 2002, p.104).

The basic psychology was a form of benevolent paternalism guided by Quaker beliefs for those who had “lost their reason” (Borthwick et al., 2001). ‘Compassion and kindness’ was the basis of this movement (Ballatt & Campling, 2011). This focus was something of an innovation, although in keeping with the times that saw a resurgence in concerns of compassion and social justice throughout Europe, with notable figures such as Philippe Pinel (1745-1826) also attempting to introduce more humane care in various asylums in France (Porter, 2002). This was to change with the Second World War. A second wave of TCs was configured for soldiers needing to share the experience of war trauma in all its forms. Now the focus moved from helping people who had “lost their reason” experience a compassionate family environment, towards enabling traumatised soldiers to come to terms with their experiences and return to fighting. The capacity to get on with others was stressed because soldiers need this attribute in order to remain effective. The importance of this legacy derives from the original focus - working with the angry, frightened and traumatised soldier to try to (re)build his sense of responsibility to others and his ability to deal with feelings of aggression to others who may well be comrades. Groups needed members who were affiliative and corporative within the group, but killers without.

## **(2) The theory behind contemporary therapeutic communities**

After the war, a second generation of TCs began to take shape. Individuals from more diverse backgrounds with different types of problem were considered potential candidates for TCs. This work progressed at the Cassel Hospital in London and then at the Henderson Hospital in Surrey (Jones, 1956), still guided by psychoanalytical group



therapy fashioned from war experiences (Main, 1946). By 1960, Rapoport identified a number of defining features of a TC at the Henderson Hospital, which were updated by Haigh (1999). The first characteristic of TCs is “permissiveness”, meaning that members were expected to tolerate a high level of expressed emotion. For example, members may be encouraged to verbally express their anger and to be ‘authentic’ in their emotions. The rationale was of catharsis and to allow members to acknowledge their ‘true’ feelings. TCs are structured as communal living experiences with clear boundaries and rules, support for members expressing emotion, and frequent group meetings. This is linked to the theoretical principle of “containment” and the developmental stage of “being held” by one’s parents when one is distressed.

A second characteristic was “communalism” and group living: close relationships, sharing of facilities (e.g. a dining room) and free communication were encouraged, in order to enable members to learn from one another in groups and everyday life. Everything may be brought to the group so that any out of hours contact or communication between members is available for discussion in the community meeting to avoid “splitting” between members (whereby some individuals develop polarized views of another member because they have had very different interactions with the member). This is linked to the developmental stage of play, speech and developing a sense of self as separate.

A third characteristic was “reality confrontation”, whereby members confront each other’s behaviour and its consequences in the “here and now”. The culture in the community is of “living-learning” whereby members learn about themselves by reflecting on daily life events. Typically there are daily community meetings, after which the staff debrief, provide interpretations and reflect on the relationships between themselves and the members. This is linked to the developmental stage of finding a place among others.

The fourth feature was democracy and de-institutionalisation. A TC was equitable, non-hierarchical and members were actively involved in decision making for their own and others' care. This is now known as a "culture of empowerment" (Campling & Haigh, 1999). The theory is that sharing in decision-making helps to build self-confidence and a sense of responsibility. Note that this is not the same as a 'family environment', the focus of the earlier efforts of the Tukes, but a stage of establishing one's self as a seat of action. Some TCs were subsequently recognized as fully democratic, requiring voting procedures for all community affairs (including the admission, care and discharge plans of members). Those that were regarded as modified TCs were not fully democratic.

### **(3) A critical evaluation of the processes within TCs**

The practice of second generation TCs is guided by whether they achieve agreed standards obtained by expert opinion and consensus of members rather than by process based research. TCs thus try to raise standards by peer accreditation according to the defined values (Royal College of Psychiatrists, 2010). Many of the processes are strongly shaped by group psychodynamic theory reaching back to the War experience rather than the original Tuke Retreat or evidence from current psychology. We discuss below our concerns that some TC practice draws upon processes of group belonging without sufficient consideration of when such processes may be unhelpful.

In this section we critically evaluate the processes within second generation TCs - we identify some of the processes that are consistent with promoting the principle of feeling 'safe'. We will argue that this is one of the most important outcomes for a member of a TC, and that it is safeness, the provision of 'a secure base and safe haven' that opens attention and capacities for encouraging exploration but also regulation of difficult emotions – as originally envisioned by Bowlby (1969, 1973; Mikulincer &

Shaver, 2007). For most animals, humans (and we suggest members of a TC), safeness is best achieved by reducing the signals of interpersonal threat and increasing affiliative signals and capacities (Depue, & Morrone-Strupinsky, 2005; Porges, 2007; Taylor, 2006). We will discuss how a major way humans do this is by sharing and cultivating compassion (e.g., with caring interest and empathic engagement with distress) to self and others (Gilbert, 2010).

### **Attachment**

Attachment theory has now been integrated into many psychotherapeutic approaches (Danquah, & Berry, 2013; Wallin, 2007). The model behind TCs is of also attachment theory. Attachment theory stresses attachment to a reliable and powerful dominant other, usually a mother figure, possibly a father or ‘significant other’ (Bowlby, 1969, 1973, 1980; Mikulincer & Shaver, 2007). Bowlby was particularly concerned with the behavioural aspects of care. The first is a tendency for the infant to *seek proximity* to a caring other. Second is the ability of the caring other to act as a *safe haven* who regulates threat exposure for the infant, keeping the infant out of harms way, chasing off predators or picking up the infant and bringing it back to stay close; being soothing of the infant’s distress (all protective functions). Third, was acting as a *safe/secure base*, from which the child gains the confidence to go out explore and develop independence. Fenney and Thrush (2010) suggests a secure base operates in adult relationships with the functions of encouraging exploratory behaviour, facilitating confidence and self-development and is best developed in the context of safeness. For these functions Fenney and Thrush (2010) suggest that caring others should be available, non-interfering and encourage and reward efforts.

The importance of an accessible and available benevolent ‘authority’, who is the source of those functions is crucial in attachment theory, and indeed a hierarchy can

have a very containing and protective function. Family-based attachment was at the centre of Tuke's therapeutic communities.

Many theorists believe that early trauma can disrupt the smooth integration and operation of the attachment systems and in consequence produce a whole range of potentially maladaptive defences to threat (Van der Hart et al. 2006). A helpful description of this process is given by Liotti and Gumley (2008):

“Attachment theory explains the origins of disorganized attachment behaviour in terms of conflict between two different inborn systems, the attachment system and the fight–flight (i.e. defence) system. The attachment and defence systems normally operate in harmony (i.e. flight from the source of fear to find refuge near the attachment figure). They, however, clash in infant–caregiver interactions where the caregiver is at the same time the *source of*, and the *solution for*, the infant's fear... Being exposed to frequent interactions with a helplessly *frightened, hostile and frightening*, or *confused* caregiver, infants are caught in a relational trap: their defence system motivates them to flee from the frightened and/or frightening caregivers, while at the same time their attachment system motivates them, under the influence of separation fear, to approach them. Thus, the disorganized infant is bound to the experience of ‘*fright without solution*’... This experience may be understood as a type of early relational trauma, which exerts an adverse influence on the development of the stress-coping system in the infant's brain”,(Liotti & Gumley, 2008, p.118).

Early close attachment experiences influence interpersonal styles of relating, and when they function poorly, can create individuals who may be avoidant, demanding, distrustful or exploitative of others (Mikulincer & Shaver 2007; Wallin, 2007). The

theory is that these responses will gradually be corrected by self-observation and feedback from other members of a TC, and in a TC members can be motivated to engage in these processes through a desire for sense of belonging to the community. TCs make the assumption that the community will act as the ‘attachment object’, where individuals will seek proximity to the group rather than avoidance, and will be able to use a group as a safe haven and a secure base. However, there is an additional element, which is not particularly related to attachment theory. In current TCs, there is a focus on a sense of belonging to the group and peer-group attachments, which may be better regarded as affiliative psychology. Baumeister and Leary (1995) note that for interpersonal relationships to be successful there is a need for frequent, affectively pleasant interactions with a few other people, and second, these interactions must take place in the context of a temporally stable and enduring framework of affective concern for each other’s welfare.

It is the desire to obtain the security from belonging to a group that encourages individuals to change their behaviour in order to conform and feel part of the group and avoid rejection and sanction from not doing so. However, it is important not to mix functions of the provision of safeness and confidence with the issue of social conformity. For example, these social processes can be used for good or ill. They are prominently used in cults that make belonging core to their process (Zimbardo, 2008). People can do immoral things for such reasons, and indeed conformity does not always stem from feeling safe and attached in groups but rather feeling threatened (Kelman & Hamilton, 1989).

As in cults and religious communities members in a TC are expected to care for and emotionally support one another and to be “held” in mind by other members. There is a culture of belonging within the community with formal structures for referrals, joining and leaving (Haigh, 1999). Formal structures for referral, joining and leaving a

TC will encourage a sense of belonging to a community, and make it easier to tolerate the distress of loss and encourage the maximum degree of responsibility. These formal structures are in our view helpful processes in modelling for people who have had inconsistent and chaotic interpersonal relationships.

Pearce and Pickard (2013) suggest that the role of belongingness is central to how therapeutic communities work. They recognize however that it is not a requirement that the environment of TCs is “affectively pleasant” (Baumeister & Leary, 1995) but that mutual concern is an aspiration of all TCs. We think that a better term for belongingness is “connectedness to others” and that connectedness needs to be encouraged to occur to other members rather than attachment to the community. Attachment to a community will depend on shared values and tasks and is not the same as feeling connected to other members. We also suggest that affiliative and caring for others should not just be focused on group members but cultivated as a process for the relationship to one’s self and to others in general (outside the community). We will discuss later how the feeling of connectedness can be best cultivated using a compassion focused and social learning model.

### **Creating the community**

In a TC the focus is on relationships between members and the responsibilities to the community as a whole, which is regarded as the ‘attachment’ object. Although attachment theory has been incorporated into ways of thinking about TCs, the older themes of interpersonal relationships, developing affiliations between individuals, and learning how to deal with aggression and anger, are as much the key textures of TCs now as they were 60 years ago. What started as a wartime effort to get soldiers back to the front, guided by early psychodynamic concepts, gradually evolved and progressed into a complex array of approaches guided by different theories and philosophies

(Campling & Haigh, 1999). Indeed, some are guided by general philosophical orientations to life rather than research into the psychological processes of change, with ideas that everybody will benefit from the same kind of “caring behaviours” (Tucker, 1999) and democracy.

Democracy, participation and de-institutionalisation, now known as a “culture of empowerment” is one of the characteristics of psychodynamic TCs. TCs were thus pioneers in the principle of user involvement and taking responsibility. The principle of shared decision-making and user involvement now occurs in all health care in varying degrees of dilution. The ability to influence one’s environment is likely to influence the quality of a member’s experience of a community and is especially important if a member will be around for a year or more. The rationale is that it allows healthy parts of the personality to emerge. We agree that taking responsibility is very important, but there is no evidence that democracy or lack of hierarchy is a powerful *mediator* of change for everyone. We would question the ‘broad brush’ approach to democratic processes: we believe that there should be consideration of an individual’s formulation, including predictions on how an individual interacts with others in a community. This should be shared in the community so that others can provide feedback, and provide opportunities to explore and shape behaviours that are less developed. For example, an avoidant and unassertive member might benefit from taking a more active leader-like role in running the community. A member who finds it easy to use (or possibly abuse) power should be participating less in running the community and be more other and helper focused (i.e. positions should be given to those who would *benefit* most from them). Pearce and Pickard, (2013) also emphasise that TCs work by the unique combination of belongingness with *responsible agency*. Bizarrely they suggest that Cognitive Behaviour Therapy (CBT) is cautious about introducing the language of responsibility and is careful to preserve a non-judgemental attitude. This appears to be a

straw dog argument that we would strongly disagree with. We shall discuss a model that is both non-judgemental and promotes the outcome of responsible agency by the process of promoting acts of courage by positive reinforcement and compassion.

Another characteristic of TCs was of “permissiveness” and “reality confrontation”, in which members may have a high degree of expressed emotion. As noted above, the issue of aggressiveness was central to the early therapist working with war-traumatised soldiers. Therefore some individuals who are avoidant of emotion learnt they could express themselves safely and this is very helpful. However, there is no evidence that activating the threat system is helpful for other members in a TC. Indeed, facilitating open expression of anger could, for some patients, simply be a rerun of family scenes of anger (e.g. from a parent) that generated fear in them, when in actual fact what the child actually needed were parents who were emotionally controlled or someone who would protect them from ‘the anger’. Indeed, as noted above protector functions are very important for children and, we suggest, for some individuals in certain states of mind. So, open expression of anger could actually create the conditions for disorganised attachment in individuals who attachment systems are very fragile. Unfortunately there is very little research here in including how members in a TC actually experience these encounters with other members who are threatening.

Another concern is that some people with borderline personality disorder may have an *under*-regulation of emotion. The problem here is that anger may not be an authentic feeling as such but rather defensive and/or a cover for authentic feelings. Aggression can be a cover for avoidance of traumatic memories, fear or intense grief and yearning. Encouraging, or at least not discouraging anger (as affect) regulation may simply encourage experiential avoidance (for example of hurt or grief). So while it is true that people who are fearful of emotions be it anger, anxiety or grief, will need to learn to tolerate it via exposure, the way in which exposure is conducted and in



particular the audience on whom it impacts, needs careful thought. Experienced therapists know this of course, but it is poorly researched and articulated in the literature. Different people fear different emotions: for example, depressed people can be fearful of anger; yet for others this is not so and it is sadness, anxiety, yearning for love, or even guilt/remorse that are blocked. For many who are quite comfortable with anger as a defensive first-line response, it is a powerful form of avoidance. It is important to identify in a formulation the pattern of emotions and behaviours that are over-used defensively and those that are avoided, and to respond to the latter with behavioural experiments. This is, no different in principle to the behavioural experiments or exposure that is now standard for anxiety interventions.

Interestingly, research into mentalizing focuses on these kinds of processes where individuals are not able to understand or reflect on their emotions, or understand that one emotion can be a function of attempting to achieve safety from another (Allen & Fonagy, 2007). If reflective function is one of the aims of therapy then we need to understand that the psychology which facilitates it is most effectively delivered in a relatively safe environment, not a highly charged one (Liotti & Gilbert, 2011). The lack of an individualised formulation might lead to a general assumption in staff that any expression of strong emotion by a patient is to be encouraged, but this does not take into account the function of the emotion. Thus adaptive expression of any emotion may be regarded as important regardless of function.

Thus, a key concern is that an environment of high emotional expression within a TC may undermine other members' feelings of safeness, especially if they come from emotionally charged families who generated a lot of fear in them (Liotti & Gumley, 2008). Staff may *believe* that an instance of high emotional expression is contained within the boundaries of the community, and indeed report this in staff meetings. However, they do not formally evaluate containment, safeness or connectedness to

others. A TC may be merely reproducing the high level emotional expression that members or staff are used to during childhood and do little to enhance connectedness. The question should always be “does this intervention increase connectedness and safeness for a member and facilitate the maturation process associated with safeness?” It is safeness and ‘a secure base’ that opens attention and capacities for encouraging acts of courage in exploration or connectedness but also regulation of difficult emotions – as originally envisioned by Bowlby (1969). For most animals, humans and members of a TC, safeness is best achieved by reducing the signals of threat and increasing affiliative signals and capacities. One major way humans do this is by sharing and cultivating compassion (e.g., empathic engagement with distress, with caring interest) to self and others (Gilbert, 2010) and by the use of positive reinforcement when members act towards their goals with courage.

## **Boundaries**

An important aspect of creating safeness is to have boundaries. Some institutions emphasise boundaries without focussing on the motivation behind them. The motivation seen in some settings can be for obedience to authority in which members have to know that certain behaviours are unacceptable even if the authority is the so-called group. This type of obedience can be seriously problematic (Kelman & Hamilton, 1989). However TCs have rightly highlighted how boundaries are important if members are to feel safe and contained. A loving parent puts down boundaries to help and protect the child, whereas the authoritarian uses boundaries to be respected and maintain a sense of authority and power. It is important for a TC to be especially psychologically minded for members to understand the difference, especially given the likely abusive backgrounds of many members. Hence, clarity on the motivation and function behind boundaries needs to be part of the process of setting boundaries. The

non-verbal behaviour in these contexts is likely to be crucial and staff will need to be trained in this. It may be too easy for staff's anxieties and (unconscious) authoritarian traits to be stimulated in these contexts (Zimbardo, 2008). Again there is little research on user experiences to say how common this may or may not be within a TC or the degree of influence that the clients have in setting boundaries.

The concept of the therapeutic community evolved in the context of help for substance and alcohol misusers (De Leon, 2000). Phoenix House and Daytop communities originally developed in the USA and overlap to some degree with adult TCs. Concept TCs are not democratic but have a hierarchical structure in which an individual works to obtain privileges and responsibility. There is greater stress on members acknowledging their addiction and being able to identify with others with the same problem. Such groups are more likely to use confrontation and shame, which we discuss further below.

The combination of high expressed emotion and "reality confrontation" means there may be a sense of edginess and tension within a TC. Outbursts of anger are not viewed negatively: the community is judged both on how it contains the anger safely and how it provides a safe place to be angry. The risk is that members may be confronted for their disruptive behaviour can be criticised or shamed, with others in the community expressing their annoyance, upset, disappointment or anger. Unfortunately, 'shaming and blaming' may mirror the early experiences of anger and disappointment familiar to that individual and do not enhance a feeling of safeness and connectedness to others. This is especially true if staff don't understand the distinctions between shame and guilt (Gilbert, 2007; Tangney & Dearing, 2002; Gilbert, 2011). Guilt and the ability to experience remorse is indeed very important in developing prosocial relationships, and is very different to shame. The responses of staff and members may therefore be experienced by the individual as invalidating and may be seen as evidence to confirm

their negative self-beliefs. Being confronted by other members or staff in group about problematic behaviour may place too much ‘heat’ on the individual, with the result that they feel overwhelmed by intense emotion, particularly shame, that might actually make it harder for them to reflect on their behaviour. Opportunities for more protected reflection time, which may facilitate insight in ‘harms caused’, and remorse, sadness and guilt may be more helpful, and here one could take a leaf out of the work on restorative justice procedures. (e.g. Zehr, 2002)

There is a risk that shame (rather than guilt) may be used in an attempt ‘to make’ members more aware of the impact of their actions on the community as a whole and regarded as a therapeutic process. This occurs particularly in concept TCs and prisons, where it is believed that shame alters moral behaviour despite all the evidence that shame, in contrast to guilt, does not (Dearing & Tangney, 2002). Most researchers now recognise shame as a highly self-focused emotion that stimulates threat and defensive manoeuvres. These manoeuvres can vary from anxiety, submissive behaviour, through to denial and avoidance, and onto aggressive counter-attacks (Gilbert, 2007; Tangney, Wagner, Hill-Barlow, Marschall, & Gramzow, 1996). Guilt, in complete contrast, requires a very different process of engagement. It is focused more on reparative behaviour rather than an evaluation of a global sense of self (Tangney & Dearing, 2002), on the ability to be empathic to the harm that we do, and be in touch with sadness and sorrow. If we cannot deal with *our own* sadness and sorrow, possibly arising from the hurts we have experienced, then we may find it very difficult to deal with the sadness and sorrow that arises when we hurt others (Gilbert, 2009, 2010). We know of no data that emotional expression groups are always the best way to deal with “reality confrontation”. We suspect it is easy for vulnerable members to confuse conformity with genuine moral development. Reparation efforts based on guilt are quite different to reparations based on shame and in some ways this links to research into

retributive (shame focused) and restorative (guilt focused) justice (Gilbert, 2009, 2011). It may be better to use very small groups with only members involved in a conflict to discuss the issues compassionately and reduce the risk of shame; that is borrowing insights from the restorative justice movement (e.g. <http://www.restorativesolutions.org.uk>) rather than involving the whole community. This needs to be tested empirically in terms of the outcome of safeness and connectedness to others.

After each community meeting or group therapy in a psychodynamic TC, staff will debrief, provide interpretations and reflect on the relationships between themselves and members. This can be costly in terms of staff time. The process of psychodynamic reflection after each group has not to our knowledge ever been evaluated as a means of promoting safeness and connectedness between members. Whilst it is important that staff spend time in supervision or reflection to understand behaviour of members, it may be more clinically and cost effective to spend the bulk of the time face-to-face with members – providing a safe haven, modelling and responding in the moment and shaping acts of courage in achieving their goals. Again this could be tested empirically to determine which strategy is more effective.

#### **(4) Effectiveness of TCs: A systematic review**

Taken as a whole, the effectiveness of TCs has a thin evidence base for a range of problems. For example, TCs are not recommended in treatment guidelines for Borderline Personality Disorder (National Institute for Health and Clinical Excellence, 2009). To identify relevant past systematic reviews, a search was conducted on the database PSYCHINFO that yielded 19 results. Lees, Manning, and Rawlings (2004) study was the most up-to-date research that involved a range of clinical populations and psychological symptomatology outcome measures. They located 8 RCTs and 21 other studies using a control group, which had clear outcome criteria, raw data that were

reported, and a clear specification of the original sample before attrition. These 29 studies were included in the present review. A new systematic review was then conducted to try to identify additional, particularly more recent, studies that searched on “Therapeutic Community” or “Therapeutic Communities” and “randomized controlled trials” or “RCT”. This yielded 8 results on Psycinfo and 82 on Medline. From these results, studies were selected that (i) were comprised of a matched-control or randomized control trial and (ii) compared therapeutic community to a different type of treatment (rather than no-treatment, or early discharge from the therapeutic community). These criteria are more stringent than the ones used by Lees et al., (2004) who permitted matched-control trials comparing drop-outs and completers from the same TC; thus we do report below on some such studies that were identified by Lees et al., (2004). We did, however, include studies where the control condition was standard incarceration, or treatment that was less frequent than the TC program; yet such studies also have clear methodological limitations since it is possible that a non-TC treatment of similar frequency could produce equal or better outcomes. Where other systematic reviews of relevant RCTs and matched-control studies were identified, their results were also included. The 90 identified results were checked against our inclusion and exclusion criteria as outlined by Figure 1, resulting in 7 to be analysed alongside the 29 identified by Lees et al., (2004).

----- FIGURE 1 ABOUT HERE-----

The vast majority of the identified studies relate to substance misuse and/or forensic services; including six of the eight RCTs identified by Lees et al., (2004). There is some (limited) evidence for secure TCs being superior to standard prison services (in terms of reducing risk of future offending behaviour); and very little

evidence for therapeutic communities being superior to standard treatment for substance abuse. Furthermore, the evidence that does exist comes from studies with serious methodological limitations: *all* studies of forensic or substance misuse TCs included in this review either used no-treatment control groups or control treatments that differed considerably on intensity, length, and other factors. For example, Sacks, McKendrick, and Hamilton (2012) compared a prison therapeutic community program (20 hours per week for 6 months) and a cognitive-behavioural intervention (6-8 hours per week for 16 weeks). Several authors of systematic reviews have drawn the same conclusions (Fiestas & Ponce, 2012; Perry et al., 2009; Smith, Gates, & Foxcroft, 2006). This evidence base, of course, has limited applicability to the treatment of clients with personality disorders in non-forensic settings, given the differences in both client group and in environment (e.g. security issues in forensic settings necessitate some hierarchy between staff and prisoners). Thus there is a very poor evidence base for TCs that do not focus on forensic or substance-use populations. The majority that exist compare completers of TC treatment programs with dropouts of the same programs or no-treatment controls, which predictably find that TC treatment is better than no treatment, and that longer durations of treatment (9 to 12 months and above) were superior to shorter durations.

Only three RCTs were located involving non-forensic or substance-misuse services, and results overall did not support the superiority of TC treatment over other treatments. Lehman and Ritzler (1976) compared psychiatric in-patients admitted to either a TC or a service implementing a medical model, and found the former to have higher patient satisfaction but *greater* readmission rates (26% versus 19%). Hansen and Slevin (1996) compared a standard psychiatric ward to a ward informed by therapeutic community values (including greater patient involvement in treatment, group therapy focused on emotional expression, and regular community meetings). The wards were

matched on patient number, treatment duration and patient diagnoses (primarily schizophrenia). The TC-style ward was found to be significantly higher in patient involvement, support, and practical orientation; however no comparison was made in terms of symptomatology or outcome. Finally, Craft, Stephenson, and Granger (1964) compared male delinquents in two non-secure settings; one a TC and the other an authoritarian disciplinary programme with individual treatment. In a direct challenge to the effectiveness of TC treatment, the traditional unit produced significantly lower rates of reconviction and significantly lower numbers of clients still needing institutional care.

In summary, the evidence base does not support the claim that TCs are superior to other interventions. There is a paucity of evidence for mental health and personality disorder populations. The evidence-base for forensic and substance-abuse populations is minimal, and the studies that have been conducted consistently have significant methodological limitations. Typically the control condition is standard incarceration or involves treatment of lower frequency than that delivered by the TC. Furthermore, TCs are complex interventions and crucially there are no studies on the supposed *mediating* factors in a TC. There is no basic science to determine, for example, whether permissiveness or reality confrontation increases safeness or belongingness or responsibility for change. TCs are however still being commissioned by purchasers for a range of care. Current TCs are relatively expensive to deliver and there are no studies on cost effectiveness.

We will now argue for a new approach to the theory and practice of the TC, by focusing on recent research in the area of affect regulation, affiliative relating and the neurophysiology underpinning these. This area of rapid research development indicates new ways in which we can create opportunities for people to progress through



relationships and potentially make radical changes in how our minds work (Davidson & McEwen, 2012).

### **(5) Evolutionary approaches to ‘therapeutic’ communities**

Rather than approach therapy from a particular model, an alternative is to derive interventions from scientific studies of core psychological processes, and in particular from an understanding of the evolved systems of emotional processing and their regulation. Here we describe a theoretical model for a third generation TC that builds on the 2nd generation. It is derived from research in child and social development and the neuroscience of affect regulation which views evolved, affiliative motivation as core to affect regulation. This facilitates the maturation of social cognitive abilities such as mentalizing and maintaining a competent sense of self, especially when occurring within in a contextual behavioural approach. The reason to start with the power of affiliative processes as core to therapeutic endeavours is that considerable research shows that loving and caring environments play major roles in the maturation of a whole range of emotional and cognitive abilities (Cozolino, 2007; Davidson & McEwen, 2012) and even genetic expression (Belsky & Pluess, 2009). The importance of the attachment relationship for subsequent developments of emotion regulation and social relationship was one of the crucial insights of John Bowlby (Bowlby, 1969, 1973, 1980).

As noted above Bowlby argued that the early environment should offer two types of safeness: a *safe haven* which enables the child to return to a source of comfort and support in the face of distress and uncertainty; and a *safe base* that provides the security and safeness to go and explore both inner and outer worlds, thus developing insight, understanding and skills necessary for social living. Any therapy that is rooted in attachment theory must focus on these two provisions. Thus, to follow this approach,

we need to understand the mechanisms by which threat and safeness operate. We contrast *safeness* and *safety* by suggesting that *safety* is threat focused and involves stopping or getting away from threats - as in *safety seeking*. Even when 'out of harm', one's attention may still be vigilant to the possible return of threat. *Safeness*, however, depicts an open explorative attention and is focused on slowing but also growing and developing. In safe environments (Bowlby's safe base) people take risks, can engage with potential frightening things and try new things; in threatening environments people monitor both threat and their safety and are less creative and open (Gilbert, 1993).

### **The evolutionary function analysis of emotion systems**

Evolved social mentalities (e.g., attachment) are underpinned with evolved functional emotion systems. Recent research into the evolution of emotion suggests it is now possible to identify at least three evolved types of emotion regulation system each with a different function and triggered in different contexts (Depue & Morrone-Strupinsky, 2005). Stated briefly, these are:

**(1) Threat and self-protection-focused system** – this enables detection, attention processing, and response to threats. There is a menu of threat-based emotions such as anger, anxiety and disgust, and a menu of defensive behaviours such as fight, flight, submission, freeze.

**(2) Drive, seeking and acquisition-focused system** – this enables the individual to pay attention to advantageous resources. An experience of pleasure and achievement is associated with pursuing and securing them.

**(3) Contentment, soothing and affiliative-focused system** – this is associated with a distinct positive affect of parasympathetic slowing. It is experienced as contentment, openness and peaceful well-being. It occurs when individuals are no

longer threat-focused or seeking resources but are satisfied. These three systems are depicted in Figure 2.

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FIGURE 2 ABOUT HERE

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A key to mental health is an ability to tolerate, blend balance and flexibly integrate the function of these systems. Mental health difficulties are often linked to people's *direct effort to regulate threat* by avoidance or engaging in safety seeking behaviours (Gilbert, 1993). Many forms of anxiety disorder operate such that the short-term relief given by a safety seeking behaviour (e.g., escape or compulsive washing) becomes reinforcing of the behaviour. Moreover, as noted above, one defensive-safety emotion (e.g., anger) or behaviour (e.g. rumination) can be a cover for avoiding another emotion (e.g. sadness). Sometimes the drive system is used to regulate threat emotions e.g. a need to do, have or achieve to feel secure from rejection which can be unhelpful: excessive perfectionism, anorexia, gambling, and workaholism, are examples. The person's positive sense of self is contingent on frequent achievements.

However, all mammalian young are soothed by affiliation and comfort from (m)others. Operating through oxytocin and the parasympathetic autonomic nervous system (ANS) and other systems, caring behaviour is well known to have soothing and threat-regulating effects on recipients (Depue & Morrone-Strupinsky, 2005). Indeed, for most people, caring and affiliative relationships are the most important sources of threat regulation (Cacioppo & Patrick, 2008). For the most part, threat and drive emotions stimulate the sympathetic nervous system, whereas soothing calming and feeling safe are linked to the parasympathetic system, which in turn has a vast array of physiological and psychological effects (Porges, 2007). There is growing evidence that feeling socially safe, which is linked to parasympathetic activity, is a better predictor of vulnerability to psychopathology than 'excitement based' positive emotion (Gilbert et

al., 2008) and a better predictor than general positive or negative affect and social support (Kelly, Zuroff, Leybman, & Gilbert, 2012).

So the evolution of ‘caring’ is one evolved root for compassion (Gilbert & Choden, 2013). Compassion is commonly defined as “a sensitivity to the suffering of self and others with a deep commitment to try to relieve and prevent it” (Gilbert & Choden, 2013, p.94). This kind of definition highlights two different but integrated mental sets or psychologies. The first is the ability to ‘pay attention’ to distress and difficulties, to notice them as they arise, to turn towards and be able to tolerate them, along with being able to empathise (mentalize) and make sense of them, in contrast to turning away, closing down, avoiding, blocking off, dissociating, denying and so forth. The second psychology is more action focused and is concerned with acquiring and practicing the skills necessary to address difficulties, which is partly linked to wisdom (Germer & Siegel, 2012). So, for example, a client can become aware that part of their anger and mistrust is rooted in trauma memories. So using a compassionate approach they first work on creating a sense of secure base and safe haven from which they can then they begin to work with engaging with those memories (first psychology) and acquiring the skills and wisdom is to be able to transform or re-script those memories (second psychology). Therapeutic benefits training people in compassion has received increasing attention over the last decade. Indeed there is now a range of compassion focused training approaches with increasing evidence of the value of compassion training (Hoffmann, Grossman, & Hinton, 2011).

Compassion can permeate the relationship to one’s self as well as to others. Not only does affiliation and access to caring others facilitate soothing in the context of stress, but Bowlby also outlined how it enables courage to engage with acts that are frightening. Perhaps one of the clearest demonstrations of this is the visual cliff where infants are encouraged to cross the cliff even though they are clearly frightened:

parental encouragement and a secure attachment enables them to cross. Hence courage is influenced by access to affiliative others.

This perspective therefore suggests that TCs should first and foremost focus on creating safe and affiliative environments that facilitate courage and exploration (safe/secure base). Physiologically, the community would constantly try to shift from sympathetic dominant to parasympathetic engagement (Porges, 2007). We predict that stimulation of the parasympathetic autonomic nervous system within social contexts requires discouragement of high expressed emotion and shaming experiences. We do not mean this in a sense of avoidance because obviously learning to tolerate higher levels of emotional arousal is important for some individuals, but that it should not be encouraged as something that is necessarily good. This is particularly important since individuals with mental health problems have highly sensitized threat systems, and increased sympathetic tone with difficulties in calming down. They may find it difficult to avail themselves of affiliative relationships and utilise parasympathetic soothing systems. If a person is unable to use affiliative feelings, then they may be too reliant on trying to regulate the threat system with solutions from the threat or drive system. When individuals lack a secure base and safe haven, and access to soothing others, regulation of threat-based emotion becomes very difficult. Such individuals can become preoccupied with their own internal world and intrapersonal process, cut off from the potential corrective input of empathic and compassionate others. Therapeutic interventions that focus only on teaching personal coping skills may inadvertently be reinforcing the idea that emotion regulation is something that goes on purely in one's own head - when in fact evolutionary mechanisms for affect regulation are very much interpersonal and social (Cacioppo & Patrick, 2008).

### **The affiliative-cooperative environment**

Developing positive feelings is not just about being the recipient of care (which can be helpful), but also about feeling that the care we offer to others can be appreciated. To feel that we can be helpful and rewarding to others, and make a contribution that is valuable and appreciated by others, is core to developing a sense of self-value and well-being (Heard & Lake, 1986) and a sense of belonging (Baumeister & Leary, 1995). Gilbert (1984) suggested that part of the depressed person's experience of worthlessness is that they feel they don't matter to others, that they have little others value or appreciate. Understanding other's goals and needs, followed by altruistic helping, has been detected in chimpanzees and young children and is rewarding in its own right (Warneken & Tomasello, 2009). Developing an empathic concern for others and taking pleasure in *their* improvement is an important aspect of social relating (Krill & Platek, 2012). Indeed, as Yalom (1995) has highlighted many times one of the therapeutic benefits of a group is that it provides opportunities to be validated and supported by others but also opportunities to be valuing and supporting *of others* and in that way develop a sense of one's value to others. This process of reciprocity can be central to a sense of belonging, affiliation and change. Bates (2005) wrote of the value of mutually shared compassion in group work with severe socially anxiety clients, noting how it contributed to a sense of being able to contribute and be helpful to others:

“We have observed, both in our inpatient and outpatient groups that feedback, like mercy, is twice blessed. It is as much a gift for the giver as for the recipient. The experience of a group member having something to give another counters a pervasive sense of being no value to others”. (Bates, 2005, p. 376)

Hence, creating opportunities for clients to help each other and form affiliative relationships on the basis of mutual helping is possibly one of the most important

opportunities for learning new ways of relating and regulating emotions that a TC can provide. Indeed, while research into emotion regulation has typically looked at intrapersonal factors (personal cognitions, beliefs and ruminative processes) recent research is focusing on interpersonal process and style. For example, Niven, MacDonald, & Holman, (2012) found that interpersonal styles linked to high anxious attachment, low empathic concern, and low perspective taking, were associated with poor social relationships and lower positive mood. Crocker and Canevello (2008) found that compassionate self goals (such as wanting to be supportive of others) predicts feelings of closeness and connectedness, and increased social support and trust; whereas self-image goals (such as trying to convince others that you are right and avoiding shame) predicts conflict, loneliness, and feelings of fear and confusion. In a development of attachment theory approaches to psychotherapy, Fonagy and his colleagues have indicated the importance of mentalizing and the abilities of individuals to think about, be interested in and relate to the minds of others (Allen & Fonagy, 2007). These key qualities are more likely to arise if someone feels safe and the compassion system is stimulated.

Many individuals who have complex psychological problems have come from backgrounds in which others were more likely to have been threats than sources of help (Liotti & Gumley, 2008). Parents can send conflicting messages of safeness and threat creating a complex confusion of approach-avoidance conflicts when it comes to giving help and being helped (Liotti & Gilbert, 2011; Liotti, & Gumley, 2008). Under these conditions the need to become self-sufficient and self-regulating becomes part of self-absorption and preoccupation.

The ability to contribute to others' improvement and their lives shifts attention out of self-focus. Sharing in common experiences of suffering and having a real desire to avoid shaming others can have important effects on oneself. Therefore, it is important to

be open to the suffering of others, respond to them compassionately, offer help and develop empathic connectedness to other members of a community. Equally it is important to develop and practise skills of self-compassion. We stress that affiliative relating is not a one-way street.

In summary, we have argued that in order for a TC to develop an environment of safeness and connectedness to others we can turn to evolutionary, social and developmental psychology, and neurophysiological systems for the underpinnings of safeness. Safeness can focus on the activation of compassionate motives and affiliative emotions; on helping participants think of their role in helping others, and thus shift attention out of self-absorption and threat preoccupation; on providing opportunities for valuing and reinforcing interactions, and on trying to give experiences of parasympathetic soothing (Gilbert & Choden, 2013). There is increasing evidence that therapies which specifically focus on the development of compassion in participants produced important psychological change (Bates, 2005); several case series and single case studies have demonstrated the efficacy of developing compassion for oneself and others in a variety of clinical populations (Ashworth & Clarke, 2012; Ashworth, Gracey, & Gilbert, 2011; Mayhew & Gilbert, 2008). A number of uncontrolled pilot trials of group CFT have also been carried out (Gilbert & Procter, 2006; Laithwaite et al., 2009). A recent controlled trial in recovery from psychosis showed that group-provided Compassion Focussed Therapy was significantly more helpful than treatment as usual on a range of measures (Braehler et al., 2012). Central to this was the observation that efforts to understand and help each other contributed to participant improvement. There is also increasing evidence that compassion focused and affiliative practices impact on a range of neurophysiological processes, including producing change in the frontal cortex and other affect regulation systems (e.g. Leiber, Klimecki, & Singer, 2011; Weng, Fox, Shackman et al., 2013).



These motives for affiliative relating can be further advanced with clarification of the compassionate model. This highlights the evolved difficulties we have in the regulation of emotion, the way the mind easily creates loops between thinking and feeling which can be difficult to break out of, the fact that our social values are created in specific historical and social contexts and that we are all interdependent. This builds to an insight that much of what goes on in our minds, and certainly our mental health difficulties, is not our fault and that non-blaming insight provides a platform for the mutual taking of responsibility to help both self and others. Shaming and blaming on the other hand create defensive manoeuvres. However developing compassionate approaches in a TC is not about anger or conflict avoidance. Indeed, compassion often builds strength for honest communication and engagement with painful issues.

There are two further theoretical models that we believe are of relevance in a new generation of TCs. The first of these is Social Learning Theory and its application in Functional Analytical Psychotherapy. The second is behavioural activation and the role of the drive system in a community.

#### **(6) The contribution of Social Learning Theory and Functional Analytic Psychotherapy**

Social learning theory was developed by Bandura (1977). He suggested that human behaviour might be learned observationally through modeling: that is, from observing others which later serves as a guide for action. Thus members who have been in the community longest may model behavior to newer members. Bandura also described “reciprocal determinism”, that is, behaviour influences environment and vice versa. For example, if members in a community avoid another member, it may confirm the beliefs of this member that others do not listen or care about them. It may persuade this member to spend time more alone and increase their expression of distress and challenging behaviour. This in turn confirms the group member’s expectations that this

member is not safe or that their behavior is willful, and a vicious circle develops whereby the desire to avoid the member is further reinforced (Taylor & Sambrook, 2012).

A related approach to social learning is Functional Analytical Psychotherapy (FAP) (Tsai et al, 2008). It is grounded in learning theory and is a functional analytic view of the therapeutic relationship and behaviour between a client and therapist. There is much evidence from learning theory for shaping behaviour in context and some evidence on how FAP can enhance outcomes when it is integrated in Cognitive Behaviour therapy for depression or other disorders (Kohlenberg, Kanter, Bolling, & Parker, 2002). The first principle of FAP is that a therapist has to be aware of interpersonal behaviours, assess their function, and shape more effective interpersonal behaviours through reinforcement. Reinforcement is “natural” rather than contrived: instead of using insincere praise or tokens, FAP asks therapists to share their emotional and cognitive responses to client behaviour, promoting closeness and engagement. In a TC, this translates into reinforcing acts of courage of one member by compassion from other members (Kanter, J, personal communication). Members need to be adequately prepared for such an environment as they will be asked to speak the truth compassionately in the moment and tell others what they think, what they feel, what they need, and to try to make a deep sense of connection with others even it feels scary or risky. This can be emotionally quite intense. The rationale is practising such behaviours in the moment enables a person to transfer these skills in the broader community and other people in their life. Unhelpful behaviours (e.g. self-harming, being withdrawn, seeking excessive reassurance) are *if possible* ignored leading to extinction (unless the behaviour puts either him or herself or other members at serious risk of harm when the aim must be to ensure psychological and physical safety). The behaviour may *later* be reflected on and understood in its evolutionary context with

compassion. There is no punishment by shame even for unacceptable behaviours like bullying. Behaviours that involve courage and promote affiliation are naturally reinforced by compassion. Members would try to avoid positive reinforcement of behaviours that are unhelpful (for example “accommodating” behaviour, such as helping someone to avoid a fear by doing a task for them or being over-protective). The principles of awareness, courage and compassion complement and enhance Compassion Focussed Therapy as a core component of an effective therapeutic community. Moreover, it creates the environmental contexts that enable people to feel safe, understood, and orientated to developing compassionate interactions, and compassionate ways of dealing with their own and other’s suffering.

An important component of reinforcement is that the closer in time and place behaviour is to its consequences, the greater the effect of those consequences. Thus it is important to be aware and attentive and to respond at the time that a movement towards an act of courage occurs. Because members of a TC are living together, the principles of FAP can be extended to the relationships between members and staff. It means that reinforcement does not have to happen only in individual or group therapy time but more importantly in the times between therapy sessions and in everyday interactions between clients, between clients and staff and between staff. Thus it is important for members to be aware of what would be each other’s acts of courage and have the skills to understand the motivation of unhelpful behaviours. They may then respond compassionately and look out for any effort towards change in the moment. Whilst skilled therapists may be trained to deliver FAP, what is not known is the effectiveness of training members of TC in an adapted or “light” version of FAP. This needs to be tested empirically. The theory is that a TC requires a culture of positive reinforcement for acts of courage especially in helping others to engage with things they are fearful of and to face their own feared or avoided areas. These arise and are delivered with an

understanding of the components of compassion such as distress tolerance and empathy. There may be a formal FAP group or an emphasis on awareness to look out for in other members. Again, it is crucial for members to have in mind each client's formulation specifying unhelpful behaviours that may show up in the community and acts of courage that need to be positively reinforced to assist change. In Compassion Focussed approaches, acts of courage are learning the affiliative support of others, being open with oneself and learning to treat oneself more kindly, dropping shaming and blaming of self or others whilst taking responsibility for change. Any movement towards taking responsibility for trying to help oneself for others should therefore be positively reinforced in the moment with compassion and appropriate affiliative (especially non-verbal) behaviour and engagement.

An important feature of a social learning environment is a focus on goals as means towards acting on one's values. The goals may relate to the presenting problems or to interpersonal behaviour and relating to others. Progress towards goals needs to be monitored regularly on appropriate rating scales with feedback provided. Current TCs believe that it is important for members to be involved in a structured activity of social behaviours, which is in keeping with the principle of enablement and rehabilitation to society. A good therapeutic environment will have a range of opportunities in the form of occupational therapy, social events and everyday activities such as cooking, cleaning, gardening and volunteering in the wider community. It could also include aspects of a retreat with mindfulness meditation and compassionate imagery exercises. Activity can also assist in building capacity for mentalizing – the capacity to empathise with and understand the perspectives of other members by the process of socialising and working with others (another component of Compassion focused approaches). However, some members may benefit from a more systematic assessment and skills-based teaching of behavioural activation (Dimidjian et al., 2006; Martell, Dimidjian, & Herman-Dunn,

2010). For example, a functional assessment of activity will allow a member to have a good understanding of the contingencies (antecedents and consequences) of the behaviour that is maintaining their mood, and to then plan to act against the way they feel and in keeping with their values. However, a successful environment will provide a diverse and stable range of reinforcers of members who respond “in the moment” when an individual moves towards their goal.

### **(7) A third generation Therapeutic Community in practice**

We started with the premise that living in a community *may* confer therapeutic advantages over individual outpatient therapy and should be investigated further. Currently however we suggest that some of the processes in psychodynamically informed communities lack an evidence base. In so far as some communities encourage the expression of high emotion, they may be counter-productive. In contrast recent research has shown that the development of affiliative relations are central to the ability to engage with feared and avoided emotions and difficulties. These therefore should be the priority, focusing on the processes that will mediate these factors. In practice this will include:

- (1) Using an evolutionary model to inform members of how tricky the human brain is which provides a basis for de-shaming and blaming, and a sense of common humanity in that we are all on the same life's journey.
- (2) To provide insight into the nature of human emotion regulation and in particular the importance of affiliative emotion systems as a threat regulators, and sources of positive emotion well-being and meaning, and therefore the value of gaining access and stimulating that system.
- (3) clarifying the nature of compassion and dispelling myths about compassion such as its related to weakness or something one doesn't deserve.

- (4) Provide the interpersonal basis for secure base and safe haven, which facilitates ability to tolerate distress, empathise and understand distress.
- (5) From this affiliative context to stimulate the motivation to engage with painful and difficult things and promote the courage to act in ways that are consistent with the member's therapeutic goals and personal values.
- (6) Opening up to being able to be sensitive and attentive to the distress and therapeutic goals of others with an interest in helping people to achieve their goals - hence enable the community to operate by supporting each other's therapeutic journey and building the sense of community from that process.
- (7) Respond to acts of courage in others and provide compassionate ways of understanding the source, nature and ways of resolving and being honest about conflicts.

Our hypothesis is that when compassionate values and goals are carefully explained and placed at the heart of a community, and how and why they are rooted in the evolutionary understanding that the human brain is very tricky and easily thrown into threat processing, this provides a context of change that is different from the current TC approaches.

We now summarise the principles of a third generation TC in action. The emphasis is on inter-personal behaviour and mediating processes rather than particular structures or groups. The principles build on second generation TCs and can also be applied to psychologically informed environments and in-patient settings (especially in long-term rehabilitation units).

- 1) Members of a community would have a good psychological understanding (with a compassion focussed and contextual behavioural formulation) of their own difficulties. The emphasis would be on the context of their inter-personal

behaviour and relating to others and the development of their problems. Members would share this formulation so that other members would be aware of how their problem will “show up” in the community and what behaviours they need to look out for and how these relate to their goals.

- 2) Members would learn and practise compassion focussed approaches to their self and others so that the culture supports being motivated and attentive to each other’s needs, being empathic, respectful, sympathetic, kind, accepting, non-judgemental and tolerant of each other’s distress. Part of this will involve the use of mindfulness and compassionate imagery practices. This is an environment of *relatively* low expressed emotion and trying to prevent unnecessary activation of the threat system. This involves increasing awareness of the impact of one’s behaviour on others in a non-shaming way. (For example “Today I’d like to take more of an interest in ‘Sally’ and spend a little time really finding out a bit more about her and how I can be helpful to her while she would like me to be helpful to her”).
- 3) Members would be taught to increase awareness by focussing their attention not only on their own thoughts, feelings and memories, values and bodily sensations, but also how other contingencies affect them; how their own behaviour affects others and understand the context with the goals of other members. Awareness is therefore paying attention in the moment without judgement and being aware of one’s goals and values and acts of courage in others. Such exercises include eyes closed meditation, eyes on and inter-personal meditations, listening and walking meditations.
- 4) Members would positively reinforce acts of courage in one another. Such acts include being honest; vulnerable disclosures; being authentic; discussing losses; discussing values and what the person stands for; taking risks; confronting

difficult situations; or doing exposure and behavioural experiments to test out one's fears and expectations depending on the presenting problem. When members are aware of such acts, they can try to respond "naturally" and compassionately in the moment when another member makes an effort to change. Opening up to others also means taking joy in their successes. Helping people pay attention to these issues will over time help them begin to feel pleasure in the successes of others rather than being envious or totally closed in and only interested in themselves. We acknowledge that efforts to change in others can be difficult to be aware of in a community and remembering different preconditions in other members. This is why it is so important to increase such awareness by telling others what to look out for. Awareness of planned acts of courage for the day can be put up as reminders for others on a physical or digital notice board and discussed at a daily planning meeting. ("Today I will test out my fears of being criticised by generating a kind of voice in my mind when I start to get the anxious about speaking up in a community meeting. I'm going to try to focus my attention externally and notice and look for facial expressions of support and others".) Acts of courage would also be reflected on in community meetings and reinforced by others and to keep a log of the courageous acts that have been taken.

- 5) Members would use the principles of "extinction" by generally ignoring or walking away from the unhelpful behaviours of others unless it puts a member at physical risk. They would refrain from using "punishment" by shaming or by accommodating one another's unhelpful behaviours. Unhelpful behaviours would be reflected on and understood in a compassion focussed model. Unhelpful behaviours may be shared in a small group or as a written formulation between all members so they are aware of how they show up in the community.



- 6) Staff need to feel supported and safe with themselves and preferably are affiliative with each other. Staff who have not resolved conflicts amongst themselves are not in a position to provide safe and affiliative environments. Furthermore staff need to model being authentic, fully present, compassionate, caring with colleagues and members. Staff will need an external supervisor who can use a compassion focus and functional analytical models. One of the most important processes for staff to understand the model themselves and not engage in splitting; that is when members act to try to keep themselves safe by focussing on one member to suggest that “they shouldn’t be here”.
- 7) Members could support one another to reflect, to devise behavioural experiments to test out their beliefs, to consider an alternative understanding of their problem, or develop a more functional way of responding. Members are expected to care for and emotionally support one another and to be “held” in mind by other members as part of a compassionate approach. Members can be encouraged to enquire about and support one another’s acts of courage and kindness to others. A culture of connectedness with others will therefore evolve naturally and can be facilitated by formal structures for joining and leaving and regular meetings. There would be an option for calling “crisis meetings” when a member can obtain support from others. Members of non-residential TCs can phone or visit another member of the community so long as this can be done safely and with mutual benefit and awareness by the staff.
- 8) Members would be learning to communicate openly, honestly and naturally with one another and to validate each other when they are distressed. For some, this requires a skills-based approach that helps to recognize different emotions and to respond in less harmful ways.

- 9) Members would have a programme of structured activity and timetable for achieving their goals that is facilitated by a diverse and stable range of positive reinforcers in the environment. They would have the option of skills-based learning for rehabilitation so that the community would facilitate individuals to reach their potential and return to employment.
- 10) There would be a culture of clearly defined goals in term of acts of courage for individual members and the community, relating to inter-personal behaviour as well as presenting problems. The goals should be regularly monitored and feedback on progress provided to the member.
- 11) There could be a culture of as much democracy and informality as possible within the community depending on the context. However, democracy and influence should support one or more of the factors above and be incorporated as a strategy in individual formulations.
- 12) Boundaries or rules are developed by members and motivated by the need to feel safe and connected with one another. The function behind boundary setting needs to be part of the process of the community. However the setting of boundaries and rules are limited by their context (e.g. in forensic or hospital settings where institutions and the staff have certain boundaries in place).
- 13) There would a culture of empiricism so that members are encouraged to participate in process and outcome research to determine which factors in the environment promote and mediate therapeutic change.

### **Future research**

The research question is whether our proposed therapeutic environment can either enhance the delivery of evidence-based therapies delivered in these contexts or be powerful enough without any additional therapies. First the research will need to be on

the feasibility, acceptability and process of change. If this is positive then for cost-effective reasons, entry to a TC will probably be in the context of stepped care and designed for those with the highest need or severity or whose treatment at an earlier step has failed. We suggest that what is needed is a randomised controlled trial (RCT) of clinical and cost-effectiveness that compares our third generation TC (i) against one based on group psychodynamic therapy, (ii) against treatment as usual which be an evidence-based therapy delivered on an continuing out-patient basis; for example in borderline personality disorder who have failed Dialectical Behaviour Therapy (Linehan et al., 2006), or mentalization therapy (Bateman & Fonagy, 2009) or a schema focussed therapy (Giesen-Bloo et al., 2006). Lastly, there is need for more process research to influence the delivery of a TC. We need to understand more about the mediating factors (e.g. how best to enhance feeling safe or connected to others) that might facilitate change in a community. This would then be translated into monitoring the processes within a community to determine if the community is adhering to its model and the mediating factors in change.

### **Conclusions**

Humans evolved in close-knit communities and therefore our brains are highly focused on and influenced by the quality of our personal relationships. This makes them ideal as therapeutic levers. To date however the use of the community as a therapeutic agent is primarily orientated by psychodynamic theory of uncertain evidence. In this paper we have suggested to start again by looking at the evidence of how relationships work and in particular how they operate in various emotional and neurophysiological systems. There is increasing evidence that both compassion focused and social learning approaches hold significant promise as therapeutic agents (Hoffman et al., 2011). To date however this has not been extended into TC and to us this opens up an important

avenue for research. An environment built on affiliative relationships and compassion in response to acts of courage rather than “reality confrontation” or catharsis. This may more readily foster change, because members are more open to feedback from others, feel safe to try out new behaviours, are mutually encouraging to do so, come to recognise they can play an active part in somebody’s recovery journey all of which increases a sense of belonging. The model places at its core the positive reinforcement of acts of courage, the experiencing of being valued and supported but also the experience of joy from recognising oneself as helpful and supportive of others. While it is true that we need to be able to tolerate and work appropriately with our threat-based emotions of anger and anxiety, what actually creates meaning and value in life is a sense of being valued and valuing; that is a sense of connectedness with and to others.

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Figure 1: Process for systematic review of therapeutic communities

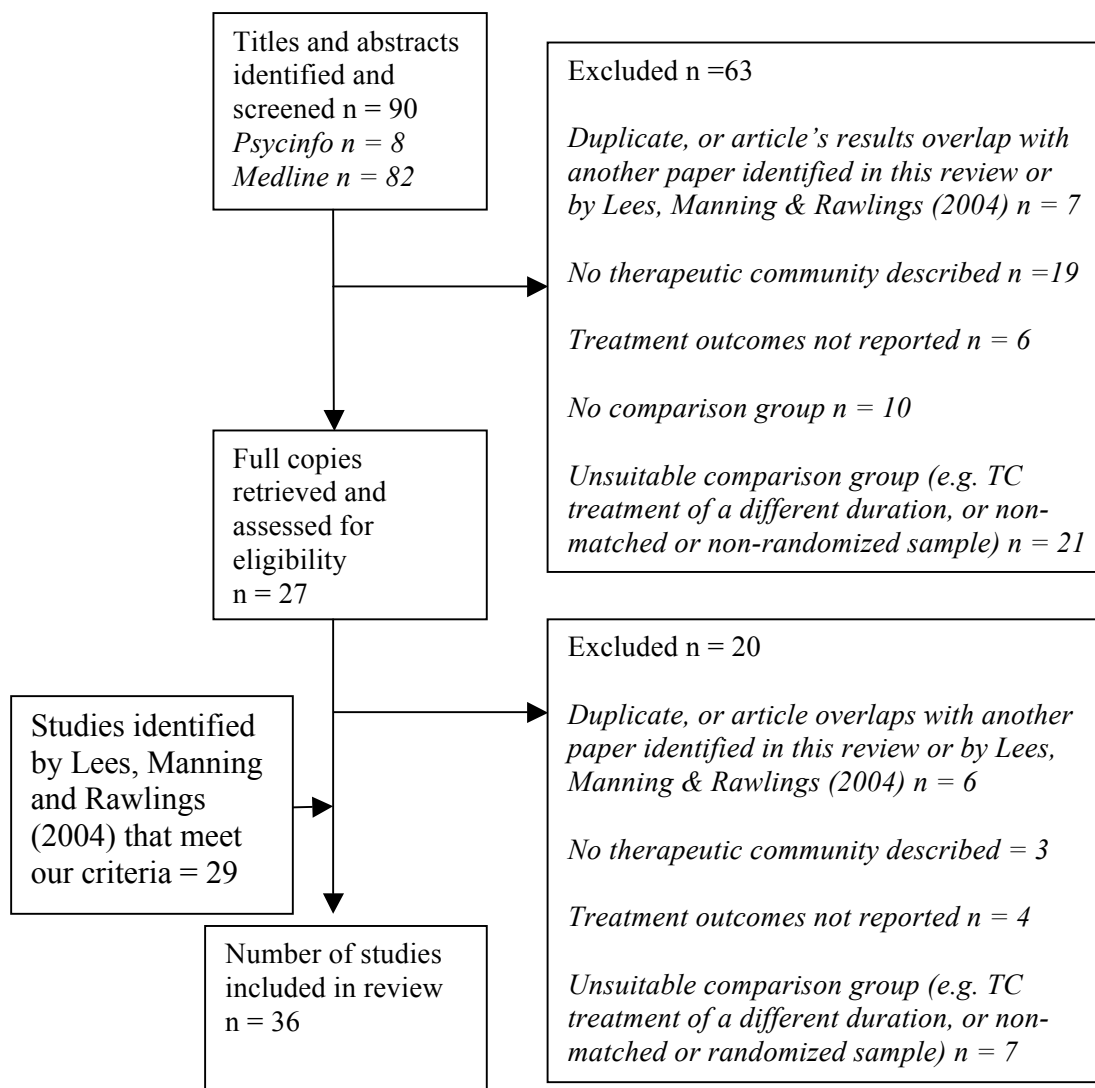
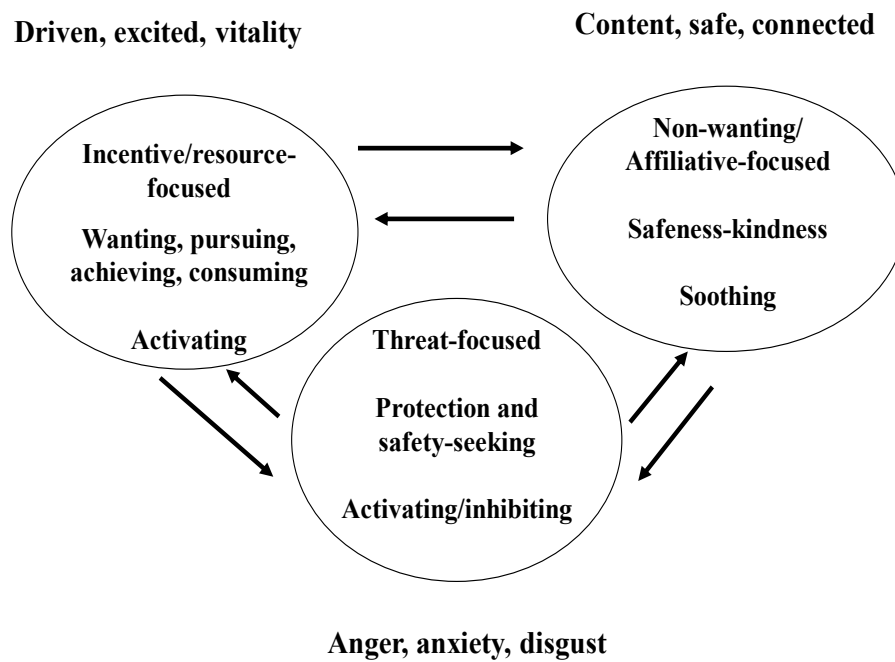




Figure 2 *Three types of affect regulation system*



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