

Madness and chaos in the culture of a therapeutic community

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Abstract

Purpose – *The purpose of this paper is to explore the perceptions of staff members working in a psychiatric therapeutic community in relation to ideas of “madness” and “chaos”.*

Design/methodology/approach – *The paper is a qualitative study based on oral history group witness seminars.*

Findings – *The findings indicate that many of the participants experienced working in a therapeutic community as both exciting and unsettling; some found themselves questioning their own mental health at the time. Despite a sense of “madness” and chaos in the life of the community, there was also a feeling that it provided a containing environment for some very disturbed patients.*

Originality/value – *This study is unusual in drawing upon staff member’s perceptions of their own relationship to “madness” in response to being involved in the life of a therapeutic community.*

Keywords *Qualitative research, Therapeutic communities, TC history, Madness, Mental health continuum, Staff perceptions*

Paper type *Research paper*

Background

The Phoenix Unit at Littlemore Hospital in Oxford was a psychiatric ward run on therapeutic community lines. It was established by Dr Bertram Mandelbrote, known by staff as “Bertie”, who was appointed Superintendent of Littlemore Hospital in 1959. Originally from South Africa, Mandelbrote had previously been Medical Superintendent at the Coney Hill and Horton Road Hospitals in Gloucester. Whilst at Gloucester he instituted some quite radical changes with most wards being organised on open-door principles. Patients’ behaviour rather than their diagnosis became the main focus of attention and regular staff meetings were held so that a whole range of hospital staff became involved in the project. Mandelbrote (1965a) described these experiences in a symposium on psychiatric hospital care. So, when taking up the post at Littlemore, he already had a track record of transforming institutional cultures. On arrival Mandelbrote soon set about reorganising the existing wards in the “A-Division” of Littlemore Hospital into three Units, each of which was run on therapeutic community lines:

The Phoenix Unit was composed largely of chronic psychotics who could not be readily discharged [...] but who showed a certain degree of social competence and were not degraded in their habits. (Mandelbrote, 1965b, page 383)

Dr Ben Pomryn became Mandelbrote’s Deputy and was influential in determining how the Unit should be organised. He had gained considerable experience by having previously worked with Maxwell Jones, a pioneer of the therapeutic community approach, at the Henderson Hospital in London (Robinson, 2012). There were no locked doors on the Unit and each day would start with a meeting of the entire community of patients and staff at which a wide range of topics were discussed, including the behaviour of the patients on the Unit.

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The community has tended to adopt the role of modifying aberrant behaviour or drawing attention to aberrant behaviour as it occurs from day to day:

[...] Aggressive expression and outbursts and sexual topics have featured from time to time and have been contained with remarkable understanding and tolerance, only rarely getting out of hand. (Mandelbrote, 1965b, p. 383)

Additional meetings of the entire community would be called if difficult or challenging behaviour was displayed by a patient. However, the approach adopted by Mandelbrote and Pomryn also allowed patients considerable freedom to behave in ways that could seem quite chaotic or “anarchic”. It is possible that permitting what could be described as the seeming “anarchy” present in such a setting is, paradoxically, also a means of facilitating growth. “I [...] began to notice in therapy groups that, far from being regressive and inhibiting when patients began to talk all at once, it could be tallied to a maturing phase in group life” (Winship, 2008, p. 391). Armstrong (2018) has described how staff members on the Phoenix unit were able to provide a permissiveness environment as they faced fewer bureaucratic constraints at that time than would be the case now. Meetings aside, for the main part of the day groups of 6–10 patients were allocated to a nurse and most of these groups engaged with various work tasks such as gardening, carpentry, car-washing and domestic work. Social events were put on in the evening and relatives groups also met in the evening (Mandelbrote, 1965b).

The early days of the Phoenix Unit can be seen in the context of a period of some fairly radical challenges to mainstream psychiatry. At the time, the Unit was being developed, R.D. Laing (1960) published *The Divided Self* which took a highly critical stance towards conventional psychiatric understandings of schizophrenia. Later, in 1965, Laing was amongst the founders of Kingsley Hall, a community which supported people to go through psychotic experiences without physical restraint or medication. In another book, *The Politics of Experience*, Laing (1967) developed his ideas of the need to allow and facilitate an inner journey of discovery for people who were viewed as psychotic. Around the same time Michel Foucault’s book *Madness and Civilization* suggested that madness could be seen as an alternative mode of human existence which is devalued by the state and other powerful institutions (Foucault, 1965).

Whilst the Phoenix Unit was not developed on Laingian principles, the works of Laing and others such as David Cooper and Aaron Esterson were familiar to many people with an interest in mental health in the 1960s and 1970s, including those who actually worked in the psychiatric system (Nolan and Hopper, 1997). The books authored by Laing *et al.* were published by Penguin as paperbacks and so were widely available at that time. The prevalence of seemingly radical ideas about allowing the expression of madness in order to treat it is likely to have influenced a number of people who worked within therapeutic communities from then onwards.

Another significant influence on thinking during the 1960s and beyond was the work of Erving Goffman. His book *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates* (Goffman, 1961) brought to a wide audience the idea that what he termed “total institutions”, such as asylums and prisons, play a key role in determining behaviour and constraining the lives of their inmates. Importantly, he showed how psychiatric patients could conform to the roles and behaviour expected of “mad people” by those in authority over them; this was the concept of “institutionalisation”. This concept was very relevant to the reorganisation of hospital facilities along less rigid and hierarchical lines as well as to a re-examination of what could be expected of psychiatric inpatients.

There are a number of ways of understanding the key elements of a therapeutic community; some were conceived around the time the Phoenix Unit started, others have been developed more recently. Rapoport (1960) set out four principles of democratisation, permissiveness, communalism and reality confrontation that were seen as underpinning the processes that occurred within therapeutic communities at that time. These clearly represented a very different approach to that described by Goffman in his description of the authoritarian practices of the asylum and are discussed in more detail towards the end of this paper. Williams and Winship (2018) have referred to the three “Hs” of homeliness, hope and humour, with particular reference to how they can inform work within prison environments. Haigh (1999, 2013) and Pearce and Haigh (2017), writing about therapeutic communities, have identified five

“quintessences” which they describe as “universal principles that apply to all human beings rather than only to particularly disturbed people in specialist psychiatric units” (Pearce and Haigh, 2017, p. 50). They comprise: attachment, containment, communication, inclusion and agency. It is beyond the scope of this paper to discuss all five quintessences, but one, containment, is very pertinent to the discussions which are covered in this paper.

By the 1960s, the concept of containment was quite well developed within the field of psychoanalytic therapy with both Wilfred Bion (1961) and Donald Winnicott (1965) describing how it could be applied within group work. Pearce and Haigh (2017), drawing upon this work, see containment as being linked very closely to the idea of boundaries within the therapeutic community. “Boundaries provide both physical and psychological security to enable therapy to take place, in a straightforward way, represented by clarity about expectations around time-keeping, attendance and behaviour. In this way they combine the functions of containment [...] and holding [...]” (Pearce and Haigh, 2017, p. 112).

In the culture of the democratic therapeutic community, where meanings of madness and individual identity are explored on a daily basis, it would not be surprising to find that the nurses and other staff working closely with service users start to question their own relationship with sanity and madness. Additionally, if there was a psychoanalytic or group therapy aspect to the therapeutic community’s approach, then staff members might be expected to have an awareness of their own mental and emotional states (Fussinger, 2011). Whilst being personally challenging, working in a therapeutic community can also provide significant learning opportunities for staff (Vyas *et al.*, 2017).

Although standard bio-medical psychiatric practice tends towards the binary categorisation of individuals into either mentally “healthy” or “unhealthy”, an alternative approach, often favoured by psychological therapists, is that of a mental health continuum, or scale of wellbeing, on which individuals move up or down depending on their circumstances (Leach, 2015). Within a continuum approach, there may be no clear distinction between mental health and mental ill-health, rather it is a matter of degree. However, when a binary model of “sanity” and “madness” predominates, staff might be disturbed by the suspicion that their own mental health might be in question and be concerned that they would be in danger of “crossing a line”.

Study design

A series of witness seminars were held across one weekend in October 2016 in which 19 former staff members at the Phoenix Unit were brought together with four other interested individuals, who acted as facilitators or observers, to contribute to an oral history of that hospital ward. Their roles included: junior doctor, consultant psychiatrist, senior registrar, mental health nurse, student nurse, nursing assistant, social worker, art therapist and clinical psychologist. Participants had largely been involved in the Unit in the decades spanning the 1960s to the 1980s, with the earliest involvement starting in 1965.

For each witness seminar a number of individuals known to members of the research steering group, whose careers had included some significant involvement with the Phoenix Unit, were invited to participate. They were provided with a brief introductory paper outlining the purpose of the project, and were asked individually to describe their own involvement with the Unit. As the meeting developed, spontaneous interaction was encouraged. Several of those present knew others well, and had shared many similar experiences, prompting memories and confirmation of events. All sessions were electronically recorded and professionally transcribed, and the transcripts were returned to participants, who were invited to edit their own contribution, but not that of any other participant.

The participants gave their permission for the event to be recorded and for the resulting material to be used for research and publication purposes. These recordings are now managed and preserved as part of the Planned Environment Therapy Archive of the Mulberry Bush Organisation’s “Third Space” resource in Toddington, Gloucestershire. In accordance with the procedures agreed with the participants the identifying initials used when quoting their words have been changed to ensure anonymity. The transcripts were examined for emerging themes

by the author, these were then shared for discussion with the research project's steering group. For the purpose of this paper, two related themes were selected:

1. staff recollections of identifying having similar experiences or feelings to those of their patients; and
2. the expression of "madness" in the everyday life of the Unit; embracing ideas of chaos and containment.

Reflections on staff members' similarities with patients

In line with the informality of the ward staff on the Phoenix Unit did not wear uniforms or badges, which was one way of decreasing the boundaries of distinction between staff and patients. Another way in which the distinction was lessened was the active involvement of patients in the therapeutic process through the daily meetings. There were also more subtle ways in which staff felt that there was less of a divide:

OA: [...] that was the part that was hard sometimes, to tell the difference between the staff and the patients, you know.

JG: [laughs] Yeah.

OA: I mean, I don't think I ever had the experience of being: "Are you a patient here?" But I remember – and, I suppose, that was part of the attraction of the Phoenix in the ways, that one felt quite like a patient, or could – you know, that part of oneself, you know, is quite close.

At a time when there was still a degree of formality in many mental health services the more liberal climate of the therapeutic community made it easier for staff members who were less conventional to fit in:

ES: I went there and it was an incredibly refreshing place to go for me, personally, because, you know, it was the – sort of the '60s hanging on, I had long hair, a big beard, I dressed how I liked, and that was completely accepted[...] And we weren't allowed to linger in the office, we would get chucked out of there if we sat around chatting, and you had to be on the floor all the time. And that was really, really, great for me – fantastic – I loved it, and so that there was an equality between everybody.

And from that[...] I learnt that we're all the same, really. You might have a mental health problem, but you're the same as me who doesn't. We're all human beings anyway.

The daily community meetings provided an opportunity for everybody, patients and staff, to explore their vulnerabilities, thoughts and feelings:

IG: You could say things in community meetings that were pretty mad [laughs][...]

OA: Yeah, and that was an attraction really.

MR: And you could also experience failings and be reasonably honest about them, with the other staff.

Although some participants described this process of self-discovery and realisation of personal vulnerabilities as being helpful, there was also realisation that it could be a destabilising experience:

MR: And that was one of the learning elements that made it[...] that you could find out things about yourself, as well as recognise that you were finding out things about the patient.

OA: But[...] I wonder[...] where was the mediating factor in that, because sometimes I think that must've been quite difficult, particularly – I mean some of us went there when we were quite young[...].

Some participants saw a danger in over-identification with the patients and one person felt the doubts about his own mental health quite intensely:

RJ: I got close to, you know – it – crossing a line[...] the thing it took me a while to discover, because I came into the student nurse life as a[...]young, impressionable 20 year-old, who was pretty screwed up, by a very difficult upbringing, and[...] there's whole issues around that. So, the idea of coming into mental health for a paid cure[...] me getting paid for my cure was[...] never more accurate than in my case. [...] the Phoenix Unit placement, particularly, was at a time when things inside me were only just being woken up.

So, for some staff at least, there was a realisation that they had more in common with the patients that might be expected, but there was also a fascination with the feeling of “madness” within the Unit.

The expression of “madness” in the everyday life of the Unit – chaos and containment

Although participants did not discuss explicitly what they meant by the terms “mad” and “madness”, there was a sense that it was to do with behaviour that would not usually be encountered in everyday life and which was often quite disturbing to witness; this was also referred to as “chaos”. The “madness” and “chaos” experienced by staff as part of the culture of the Phoenix Unit was a common theme in the group’s discussion:

JB [...] I was there in ‘65 – ‘66. I got there quite by chance. [...] So I go there and I get accepted as a nursing assistant. And it’s chaos – absolute chaos. I’d never experienced anything like it in my life. I’ve been – my life had been fairly ordered up until art school – and art school’s very chaotic. Then I was a bit of a hippy and that was chaotic, but nothing like this – I’d never experienced anything like it.

MA [...] people were allowed to rage and run amok much more than they would be in another environment. And, I suppose, I have sort of mixed feelings about whether that was necessarily – [laughs] such a good idea [laughs]. But it certainly was the way it was.

Participants described behaviour such as patients breaking windows, damaging walls, taking their clothes off, “raging and running amok”. This sense of chaos clearly made a big impact on staff:

ZS: Sometimes I’d be utterly confused [...] coming home, and feeling absolutely confused [laughs] and thinking: What the hell was going on? These are acutely ill patients, how do you contain that? [...] I was just there during the day, and wondering: How do the nurses work at night with this? How do they contain this level of chaos? And that’s still on my mind about: How did they manage it? And how difficult it must’ve been.

Although this chaos was experienced as disturbing, paradoxically it also seemed to be a part of the attraction of working on the Unit:

IG: [...] it was the maddest place I’ve ever worked in my life, you know, and that if the patients weren’t sufficiently mad, the staff would find a way of ramping it up. [laughing together] I never quite worked out how they did it, but they [laughs][...] it was never allowed to go sort of a quiet, peaceful period, [laughs] where one might reflect on it. It was always – crazy, really, in one way or another.

This account suggests that staff and patients together “co-produced” a culture of madness and seeming chaos on the Unit and that this was consistent with the therapeutic community approach adopted at that time:

OA: [...] there was something about the permissiveness of Phoenix which, of course[...] was so great for the staff. I really liked it[...] I thought it was fantastic, actually. I really was attracted to the kind of chaos, and madness[...] a bit struck dumb by it at the same time, you know. That sort of seesawing experience between the two and – my experience of the patients were that they did come to be mad [...] And it was permissible to do that.

When comparing their experience on the Phoenix Unit to that on other wards, participants felt that there was a very different culture and a model of practice linked to permitting expressions of madness:

OA: [...] because I worked on Ashurst A and also the Phoenix, I was just trying to capture like something about the way that we worked with the patient in that way, because there was something about the raw madness in Phoenix, which you kind of got close to, in a certain kind of way, and I haven’t quite[...] got the words for it[...] and in Ashurst A we were also working with very, very, seriously disturbed people, but in a very – in a much more kind of – or incisive kind of – you know, we were kind of, I don’t know, getting into it with a different kind of manner, you know.

However, amid the seeming chaos, some staff at least sensed that there was some underlying containment even if it was not clear how this was achieved:

IG: I think the bit that really stayed with me is this paradox of what a loose, chaotic environment we licensed, and yet achieved a greater and better containment than other key Unit structures. And we took – we carried enormous risk [...] and we managed to contain it, and as to – I’m not quite sure how[...]

The above participant is not alone in identifying that, although containment took place, it was difficult to pin down the mechanisms through which this took place:

IL: [...] it seemed to be chaos, but I could tell – [laughs] I could see that somewhere there was some order there, and I think that's my – was my first impression of Phoenix, that it seemed when you walked in that it was total chaos, but, actually, there was a lot of order and structure there, and there had to be to contain the level of disturbance that was being experienced by individual patients. I mean, people were floridly psychotic – we had people who were deemed dangerous, we had murderers there, we had all sorts of people there and we didn't have a single lock on the door. So, actually, underneath the seeming chaos and all these interconnecting networks, that there seemed to be a community there some – I don't know, things going [...]. There was a structure there, and there was sort of proper containment. It might not have seemed like it to the outsider, but when you were in it, it was quite clear.

Although they found it difficult to describe exactly how things worked out on the Unit, participants mentioned the importance of mutual support from staff and the value gained from the freedom provided to learn from embracing, rather than subduing, the sense of “madness” that was being expressed within the Unit.

MR: [...] you had a sense of support amongst the staff and although it was chaotic, it was a place I felt had a great interest to learn from. And it was chaotic, but I could meet people how they were in all their levels of disturbance [...].

Discussion

The nature of staff–patient relationships in the 1950s and early 1960s was quite formal and the boundaries between the two were emphasised in the uniforms worn by nursing and other staff, as well as in the exercise of staff power and authority over patients (Brimblecombe, 2005). The participants in this study clearly enjoyed the opportunity to do things differently. There was quite a lot of laughter during the seminars as participants looked back over their experiences and indeed it has been suggested that humour can play a valuable part in facilitating interactions within therapeutic communities (Williams and Winship, 2018). However, the use of therapeutic community principles within psychiatric hospitals was not universally welcomed, as evidenced by the ending of David Clark's experiment at Fulbourn when he was replaced as superintendent by the much more bio-medically inclined Martin Roth in 1976. Similarly the culture of the Phoenix unit became less experimental following the retirement of Bertie Mandelbrote in 1988.

During the life of the Phoenix Unit as a therapeutic community, the involvement of service users in the therapeutic process was relatively novel in the field of psychiatry. More recent practice, in some institutions at least, has valued peer support and the employment of “experts by experience”. This to some extent has been influenced by various approaches that embrace the concept of “recovery” (Winship, 2016). Peer-supported “open dialogue” is a technique that has some similarities with the therapeutic community approach and is being tried out in a number of NHS Trusts (Razzaque and Stockmann, 2016). Service user involvement in mental health research, training and treatment programmes has now become established whereas previously these would have been largely the domain of “professionals” (Millar *et al.*, 2016).

Another example of the challenge to the divide between service providers and service users has been the promotion of the concept of “mutual recovery”, which argues for the need for both parties to come together to work on their mental wellbeing (Crawford *et al.*, 2015). So the discomfort experienced by staff in Phoenix Unit when identifying areas of common concern with patients might be less evident now. Nevertheless, there can still be stigma attached to the declaration of mental health problems on the part of professionals working in psychiatric services (Vaughn *et al.*, 2017).

The discussions in the seminar groups concerning madness and chaos illustrate some aspects of the four principles of: democratisation, permissiveness, communalism and reality confrontation that were identified by Rapoport (1960) as underpinning the work of therapeutic communities around the time that the Phoenix Unit was becoming established.

Democratisation encourages patients to engage in shared decision making (Pearce and Haigh, 2017). Reducing the distinction between patient and staff on the Unit helped staff to see that patients were capable of contributing to the therapeutic process and, as some participants

commented, were really just other people with their own problems. However, a therapeutic community operating within a hospital setting still has to set some limits. Manning (1989) suggests that there is a negotiated order within the community, with some aspects being more open to genuine negotiation than others. The daily meeting was a significant element in the democratic therapeutic process where questions of meaning and identity were explored and where issues of challenging behaviour and difficult relationships could be addressed by staff and patients together (Greene, 1999).

Permissiveness allows boundaries to be challenged, motivations and perceptions to be explored, and the status quo to be questioned. Participants stressed the unique experience of working in the Unit. The statements that there were occasions on which staff may have ramped up the “madness” and chaos suggests that rather than trying to maintain order, staff members were excited by the drama associated with a permissive approach towards certain forms of behaviour and self-expression on the part of the patients. The toleration of difficult behaviour, as long as it is followed by opportunities for developing an understanding of its effects, is a key part of the therapeutic approach (Pearce and Haigh, 2017).

Communalism leads to staff connecting with patients more closely than in more formal settings; one participant commented on how staff members were not permitted to “linger in the office”. Time in group meetings, doing tasks or socialising within the Unit was spent together with patients. Anything that happens or is said in communal activities is subsequently open to exploration in therapeutic community meetings (Pearce and Haigh, 2017). This close connection with their patients allows staff to get know them in a way that is rarely possible in other treatment settings and may have contributed to some staff members realising that they had more in common with the patients than they first thought.

Reality confrontation is a “mechanism whereby problematic behaviour is understood and, gradually, changed” (Pearce and Haigh, 2017). Against the backdrop of Laing and other “antipsychiatrists” denouncing the constraints of mainstream society and suggesting that madness could be an appropriate response to an intolerable situation, staff might well have questioned former beliefs about what it means to be “mad”. The state of psychiatry at that time reflected significant differences in opinion between biological and social psychiatrists, between conservatives and radicals (Fussinger, 2011). In addition, as at least one participant admitted, one motivation for working in mental health could be to address one’s own issues.

That some participants questioned of their own mental state at the time, says something about the therapeutic community’s ability to bring personal issues into the open. Another influence may have been that of psychoanalytic therapy, more prevalent in the field then than now, which requires practitioners to be in therapy themselves. This recognises that everyone has issues that they will bring to the therapeutic encounter and that they will be affected by the process of engaging with other people’s distress (Kennard, 1998). David Sedgwick’s book *The Wounded Healer* made the case that the analyst should be open to the idea that they are as much in therapy a their client during the time they spend together (Sedgwick, 1994). This openness to personal vulnerability positively allows staff to be authentic in their roles and has the potential to contain patient’s distress and disturbance through the power of engaging in genuine relationships. On the other hand, this approach can be challenging to new, or vulnerable, staff and patients who might prefer the certainty of a more formal approach to treatment.

The ideas and practical experience developed in the Phoenix Unit and other therapeutic communities continues to inform practice today (Pearce and Haigh, 2017). Although therapeutic communities are not widely used in adult mental health provision, they continue to make a significant contribution in certain areas such as in the treatment of people with personality disorders, and their legacy helps to inform treatment approaches which acknowledge the importance of relationships for recovery from mental health problems.

Conclusion

The therapeutic community has been one significant component of “social psychiatry” which seeks to go beyond bio-medical and individualistic psychotherapeutic interventions for a range of mental

health problems. It has left a legacy, not only in the continuation of therapeutic communities in some areas of practice, but in a wider, more socially focussed, understanding of how people with mental health problems can be supported. If there is now a more open attitude towards involving services users in designing and delivering treatment services and towards staff being more aware and open about their own mental health issues, the personal insights gained from working in settings such as the Phoenix Unit could be helpful in developing collaborative models of practice.

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