

ANALYSIS OF THE THERAPEUTIC FACTORS IN THE THERAPEUTIC COMMUNITY PODSUSED AMONG THE WAR RELATED DIAGNOSIS AND THE OTHERS

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SUMMARY

Therapeutic community/TC/ is a sociotherapeutic method that uses sociotherapeutic and psychotherapeutic techniques for various mental disorders. In Croatia, during and after the war many war veterans have been in treatment through TC and many of them still participate in it. Majority of them were diagnosed with PTSD diagnosis, but some of them also had other diagnosis, e.g. depression, paranoid delusion, etc.

In this paper we describe principles of TC that we use in Croatia and we also try to find out which curative factors of TC are the most important for this population. We applied semistructured intervju based on Yalom book of practice and theory of psychotherapy to explore what factors do war veterans find the most important and relevant for their resilience and better coping with everyday issues.

Key words: therapeutic community -war veterans - Post Traumatic Stress Disorder

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INTRODUCTION

Therapeutic community

Therapeutic community (TC) is a sociotherapeutic method that implements sociotherapy and psychotherapy in treating patients with various mental disorders. The main idea is group responsibility, cohesiveness and empowerment of self-responsibility and avoiding dependence on professionals (Štrkalj-Ivezić 2014). It can be used in different therapeutic settings such as hospital wards, daily centres and daily hospitals, or any kind of setting where patients and staff are in a formal or informal interaction (Campling 2001, Association of Therapeutic Communities 1999).

The principal characteristics of a therapeutic community is that everyone must participate and that decisions are made based on the input of every participant so that everyone can be a part of forming everyday activities (Campling 2001, Pisk 2010). Basically, participants are allowed and encouraged to ask questions, about themselves and about others, about the professional staff, psychological processes that take place in the group, group processes and relationships in the group and of course management structure.

In order to achieve the main objectives and to establish a therapeutic alliance all participants must be treated as equal. That does not mean that any kind of order should be thrown away. In modern therapeutic communities staff are well aware of the importance of structure and responsibility that is required in order to maintain therapeutic work (Campling 2001, Association of Therapeutic Communities 1999).

There are two main models of therapeutic communities: democratic and hierarchical or behavioural (Kennard

1998, Rawlings 2001). The Democratic model was developed as a method of group therapeutic work with patients that is mostly based on social learning and it is linked to Maxwell Jones (Jones 1952, Jones 1968). On the other hand the hierarchical model was developed as a self-help method for drug abusers and it mainly uses behavioural techniques (Vandeveld 2004).

Considering the constant changing and developing of therapeutic communities it is very hard to define them and categorise them. The basic principle would be that neither is the staff entirely “healthy” and neither are the patients entirely “sick” meaning that there is generally an equality between the two because they share similar experiences and psychological processes and no matter the symptoms, any problem an individual has is in his relations to other people. So therapy is very important in that it is a learning process which includes developing new skills on how to connect better with people, how to understand oneself and others so they could cope better with stress (Kennard 2004). For example, Maxwell Jones defined principles of his work through 6 axioms: 1) two-way communication takes place on all levels; 2) decision making takes place on all levels; 3) leadership is divided; 4) there is consensus in decision-making; 5) social learning is done by interaction that takes place “here and now” (Jones 1962, Jones 1982).

In line with that, Rapoport defined four principles for a therapeutic community to work (Rapoport 1960):

- Democratization: every participant, including staff, has an equal opportunity to participate in the organization of the therapeutic community.
- Permissiveness: everyone can freely express their thoughts and feelings without any kind of negative result.

- **Communion:** free interaction and direct communication is a tool to develop sense of sharing and belonging.
- **Confrontation with reality:** all participants must be confronted with his/her own image as they are perceived by other members and staff.

All of these principals are connected, but it must be noted that reality cannot be forgotten and boundaries linked to democratic decision making and responsibility of the staff must be assured in order for the community to work. Permissiveness is limited to expressing feelings but it must be taken into account that other members are not hurt or neglected (Campling 2001).

As a therapeutic method, this kind of community consists of two parallel processes – development of each member and effective functioning of the community as a whole. It is the staffs' responsibility for conducting both of these processes but if it is a good functioning community the responsibility is shared between other members (Jones 1968). Most of the processes are done in groups and in everyday life of the community, although some of them include individual psychotherapy.

There are four phases in the process of treatment in therapeutic communities (Kennard 2012):

- **Inclusion:** recommendations, preparation and selection are an integral part of a TC. It includes new and old members as active participants of the process which starts with a recommendation. New members are afraid of the upcoming therapy so they need support from current or ex members.
- **Assessment and preparation:** after the decision to be included in TC is made, there must be a formal assessment which includes acceptance of the therapeutic agreement which refers to accepting the rules of TC.
- **Treatment:** there are different kinds of TC programs. Some meet once a week, others are daily, from sociotherapeutic to psychoanalytic, cognitive-behavioural, humanistic, interpersonal or systematic groups. Some of them include individual therapy while others argue that this can disturb group dynamic. Typically it consists of 3 to 5 attendances a week, a mixture of big group meeting, small therapy groups, community meals and leisure time. Mostly they consist of 12-24 members in three small groups, duration 12 to 18 months.
- **Recovery:** until recently, being a part of a TC was terminated by releasing the patient from the hospital. While today it is recommended to enable support during release and returning to their social network. This can be done with monitoring groups that have a practical goal to help ex members become a part of their social network again.

Some of the indications for TC is that suitability of each member should be evaluated according to that TC in that period of time. Mental disorders that are indi-

cated to be treated in a TC are personality disorder, self-injury, depressive disorder, bipolar disorder, anxiety disorder, addiction (Campling 2001, Kennard 2012). Contraindications for TC are physical addiction, acute mania, depression with severe retardation, dementia, and antisocial personality disorder (Kennard 2012).

Yalom therapeutic factors

Irvin D. Yalom (1970, 1975, 1985, 1995) has developed therapeutic factors which are believed to create therapeutic change in group therapy. They have had great impact on group therapy in a way that it helps therapists to gain a better understanding of the group therapy process and the elements that help create a cohesive group. As he defined them therapeutic factors are mechanisms that effect change in the patient (Yalom 1970). These factors include altruism, cohesiveness, universality, interpersonal learning, guidance, catharsis, identification, family re-enactment, insight, instillation of hope, existential factors. These factors are very useful for the therapist in a way that can guide them towards improving their work in group therapy. Many researchers have been investigating the effectiveness of these factors for different types of patients: alcohol addiction (Lovett 1991), those struggling with learning disabilities (Brown 1995), obsessive-compulsive disorder (Kobak 1995), grief (Price 1995), incest experiences (Randall 1995), and hearing impairment (Card 1995).

Measurement of these factors has been quite difficult so Bloch and Crouch (Bloch 1985) have described two basic approaches "direct" and "indirect". The "indirect" approach is also called "critical incidents" approach which is essentially done by asking patients to describe the most important event for them that occurred during group therapy (Lese 2000:24). These descriptions are then rated qualitatively, and because it is unstructured it biases the patient less than the direct approach does. In order to measure these factors Yalom created Q-sort which is the best representative of a direct approach. It is designed as a 60 item questionnaire where each 5 questions cover all of the 12 factors. The factors in the questionnaire differ from the ones in his theory in a way that interpersonal learning is divided in two factors – interpersonal learning – Input, interpersonal learning – Output. Statements are assessed in accordance to how helpful they find them in a group therapy setting. Each item is ranked on a Likert-type scale with a range from least to most helpful (Yalom 1970).

Therapeutic community TC Podsused within Psychiatric Clinic Vrapce has been established since the 70's. The goal was to treat neurotic problems, adjustment disorders and personality disorders. From 1991 it became the main place to treat war veterans and PTSD problems, but it continued to have a mixture of patients, not solely war veterans. War veterans are still 60 to 70%

of the patients in TC. The majority of them are those with complex trauma or with comorbidity of PTSD and other psychiatric conditions, like depression, abuse, adjustment disorders and somatic disorders.

The TC is organized as a day hospital. Patients have a program from Monday to Friday from 8 o'clock a.m. till 1 o'clock p.m. It combines different groups with a "working goal", like occupational therapy, leisure activities, sport and fun, with psychotherapeutic groups.

The psychodynamic approach has been used to understand deeper levels of communication, transference and counter transference issues, defence mechanisms, as well as psychodynamic group theory. As well as this basic approach relaxation techniques, problem solving, assertive training have been added, and occasionally cognitive-behavioral treatment for certain domains (e.g. anxiety, aggression, depression etc.) has been added.

Considering the fact that the therapeutic community has been existing for a long period of time it was important to find out what are the most helpful and most important curative factors for our patients during their time spent in the therapeutic community. Restek-Petrović, Bogović, Grah and Mihanović (Restek-Petrović 2009 25) aimed in finding a difference between inpatient and day hospital group therapy patients but no significant difference was found. In this case the order of importance of each factor for these groups was not very different. For example the order that they found was: instillation of hope (M=23.48), cohesion (M=22.19), interpersonal learning-output (M=22.10), interpersonal learning-input (M=18.24), identification (M=17.05), universality (M=15.71).

The aim of this study was to examine the importance of Yalom's therapeutic factors in the therapeutic community, and to determine whether there is a difference in perceived importance of Yalom's therapeutic factors between a group of patients with war related diagnosis and a group of patients with diagnoses not related to war. We hypothesized that there will be no significant difference between the two groups in perceived importance of therapeutic factors and that the order of important factors would not differ much from the ones found in previous research, because the previous research was conducted with a similar type of TC and a similar type of group psychotherapy.

METHOD

Participants

The research was conducted on 53 patients included in a therapeutic community in Psychiatric Clinic Vrapče in Zagreb. There were 38 male and 15 female patients. They were divided into two groups, one consisting of patients with diagnoses related to war (N=37) and one consisting of patients with diagnoses not related to war (N=16). Table 1 shows a description of patients' demographic characteristics.

Table 1. Demographic characteristics of the sample

Gender	
Male	38
Female	15
Education	
Elementary school	6
High school	39
College education	5
University degree	3
Marital status	
Single	6
Married	38
Divorced	9
Working status	
Unemployed	5
Employed	15
Retired	32
Schooling	1
Taking medicine	
Yes	49
No	4

Procedure

The participants have been asked to fill up Yalom's Q-sort questionnaire. Criteria was that they spent at least 30 days in TC within the last 6 months before the filling up the questionnaire. It consists of 60 statements where each 5 statements represent one therapeutic factor. The assignment is to evaluate for each item how helpful it is for the patient and how useful did he find it to be. Evaluation is made on a Likert-type scale with 7 degrees ranging from very useless to very useful. Scores were made for each factor individually by adding up scores for each of the 5 items that describe it. For the purpose of this study we examined which of the factors were most useful for the patients and if there is a difference between the two groups of patients that were examined.

RESULTS

In order to find out which factors are most important to patients in our therapeutic community, mean scores were calculated for each of the 12 factors. As noted before, every factor is described by 5 items on a 7 degrees scale. The result for each factor was determined by calculating its mean. Figure 1 shows mean results for all factors on a whole group level. As can be seen, patients in our therapeutic community find existential factors to be most important to them (M=27.6) and identification the least important (M=21.89). Installation of hope (M=27.06) and interpersonal learning- "output" (M=24.45) were also found very important and helpful factors in members of this therapeutic community.

Next we compared two groups (patients with diagnoses related to war and not related to war) in perceived importance of factors. As shown in figure 2 group of patients with war related diagnosis find installation of hope (M=26.46) the most important factor followed by

existential factor (M=26.41) while the group of patients with diagnosis not related to war have inversely result. They find existential factor (M=30.38) the most important and installation of hope (M=28.44) the second most important.

To test if there is a significant difference between these two groups in perceived importance of each therapeutic factor a T-test comparison was used. Table 2 shows the results of t-test comparisons for all 12 factors. The only significant difference was found for existential factors ($t=2.65$, $p<0.05$) in a way that patients with diagnosis not related to war found this factor more important (M=30.38). No other significant difference was found.

Finally, we investigated whether there is a difference between the groups in overall perceived importance of the therapeutic factors. For that purpose, we computed a single factor ANOVA which is shown in table 3. As can be seen, no significant difference has been found between a group of patients with diagnoses related to war and diagnoses not related to war in perceived importance of Yalom's therapeutic factors ($F=0.19$, $p>0.05$).

Table 2. Results of a t-test comparison between patients with diagnoses related to war and not related to war in perceived importance of each Yalom's therapeutic factors.

	t-test	p (two-tail)
Altruism	-0.89	0.38
Group cohesiveness	-0.73	0.47
Universality	1.33	0.19
Interpersonal learning - "input"	0.68	0.50
Interpersonal learning - "output"	0.15	0.88
Guidance	-1.51	0.14
Catharsis	-0.69	0.50
Identification	-0.61	0.55
Family re-enactment	0.49	0.63
Insight	1.74	0.09
Installation of hope	1.32	0.20
Existential factors	2.65	0.01

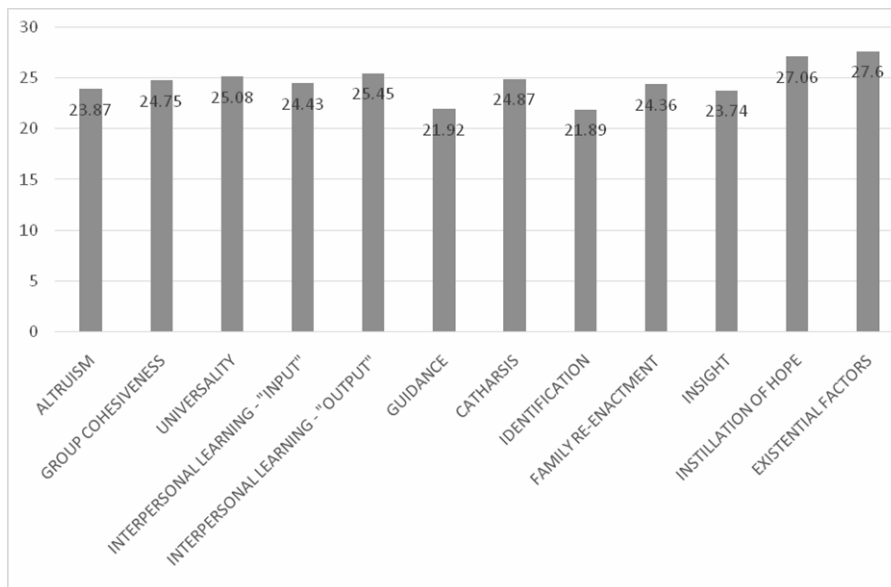


Figure 1. Mean scores for Yalom therapeutic factors in therapeutic community (N=53)

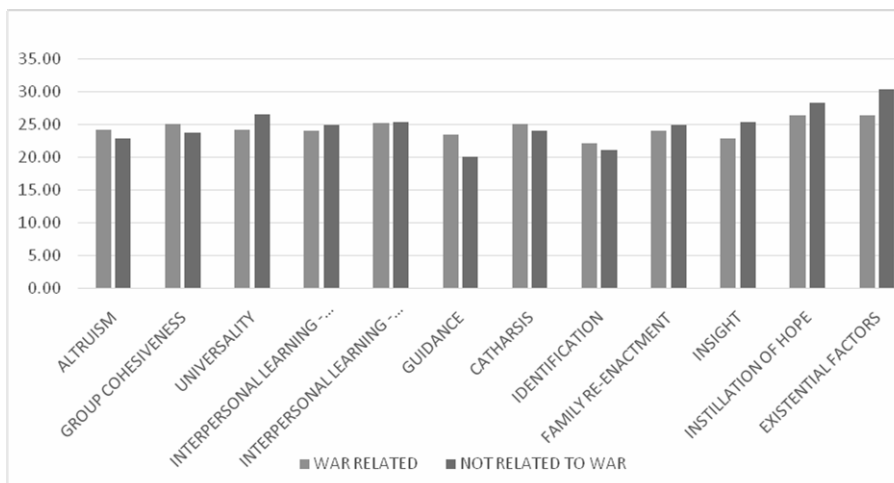


Figure 2. Mean differences between groups of patients with diagnoses related to war (N=37) and not related to war (N=16)

Table 3. Results of ANOVA between patients with diagnoses related to war and not related to war in perceived importance of Yalom therapeutic factors

Source of Variation	SS	df	MS	F	P-value	F crit
Between Groups	0.90	1.00	0.90	0.19	0.67	4.30
Within Groups	106.37	22.00	4.83			
Total	107.26	23.00				

DISCUSSION

Therapeutic community is very important for the people that are a part of it, patients and professional staff. Each member has an obligation to participate and in that way help others to learn more about themselves and about others which is an important tool that can help them return to their social network. Investigating what they find most helpful and most important in therapy is an obligation for professionals in order to find ways to improve their work and the way how the community functions.

Results obtained with this research are helpful in that they give a better understanding of our patients and the way they differ. Most important factor for them is existential factors. This has not been found in previous research (Restek-Petrović 2009) but if we take a look at the economy in Croatia and that most of these patients are retired or some even unemployed it is reasonable to expect that just surviving is essential to them. Next is installation of hope. Most of the patients are war veterans or have diagnoses related to war. That means that most of them have, not so long ago, suffered very traumatic or even near life death experiences. That has made them very vulnerable and all they have got left is hope that they can instill to each other. A similar result was obtained by Restek et al. (Restek-Petrović 2009), their participants found this factor to be the most important for them. Guidance was perceived the least important factor which can be a result of the impression that items under this factor can make. It is possible that they found these items offensive in a way that “nobody should tell me what and how I should do things”. This can be a valuable result, it can show how guidance therapeutic community is perceived, so that it can be modified or even explained to members that the role of the community is that they should guide each other to a new behavioural pattern that can help them inside their social network.

Restek et al. (Restek-Petrović 2009) have compared inpatient and day hospital group therapy patients in perceived importance of Yaloms factors. They found no significant difference between them. The same is shown in this investigation. The two groups of patients (diagnoses related to war and not related to war) show no significant difference in their perceived importance of the factors. This could be due to a small overall sample and the big difference in the number of patients in each group.

We additionally investigated whether some difference can be seen between them according to each factor individually. The only significant difference was found for existential factors. This could be a result of the fact that in the group of patients with diagnoses not related to war most of them are in debt or have money problems which then makes it very difficult for them to survive each day. This result has not been found in previous research and existential factors were generally not found very important for the members of the therapeutic community.

Results of this research can be helpful in guiding us towards improving our therapeutic community and group therapy. Knowing what our patients need most is very important so that we can find a way to help them achieve those goals and include them in their social network more easily.

CONCLUSION

Overall rating of therapeutic factors was high /even the lowest above the average/ and did not differ a lot which shows that TC helps through a variety of different therapeutic factors.

Existential factors ($M=27.6$) and instillation of hope ($M=27.06$) were perceived as the most important therapeutic factors in therapeutic community. Statistically significant difference between patients with war related diagnosis and not related to war was found only for existential factors ($t=2.65$, $p<0.05$) in a way that patients with diagnosis not related to war found this factor more important ($M=30.38$). There is no statistically significant difference in overall perceived importance of Yalom's therapeutic factors between a group of patients with diagnoses related to war and a group with diagnoses not related to war ($F=0.19$, $p>0.05$).

Acknowledgements: None.

Conflict of interest: None to declare.

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