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Collection of thesis for the Ph.D. dissertation of

Zsolt István Zalka M.D.

The therapeutic community as collective agent

The establishment and analysis of the therapeutic community in the Budapest „Thalassa Ház" psychotherapeutic institution

Consultant:

Özséb Horányi, Ph.D.

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Institute of behavioral Studies and Communication

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1. The purpose of research and its antecedents

The Budapest 'Thalassa Ház' Psychotherapeutic and Psychiatric Rehabilitation Institute has been in operation since 2003 under my lead as a foundation hospital. At its start – according to the basis of its parent institution – it was the external rehabilitation ward of a big, city hospital with a social psychiatric approach, bound to be closed. As a result of our intention and efforts, since then it has been able to continue as an independent institute. As of today, it has become one of the leading workshops of institutions providing community based psychotherapy, and a teaching institute with extended connections to the international scene.

This dissertation describes and analyzes the professional and communal leitmotifs in the creation and establishment of the therapeutic community, their formation, and the evolution of the culture of the community. The systemic components of the healing efficiency of the therapeutic community are also part of the analysis. The psychologically designed environment of the therapeutic community – conceptualized as a corrective micro culture – offers the opportunity of relational healing based on social interaction for those patients who have been seriously traumatized in their childhood. The social relations of the anomic micro communities living in our culture – families – bestow inadequate coping and problem solving strategies to the younger generation. The inadequate control of the external and internal environment often manifest itself in various psychotic symptoms, social misconduct, and destructive interpersonal strategies. The paradigm of psychoterapic approach also draws the disputableness of our social relations into focus.

1.1 Antecedents – the meaning of psychotherapy

The emergence of the paradigm of psychotherapy (basically, the psychodynamic approach) radically challenged the validity of the classic, medicinal model. With its emergence, it was revealed that the true nature of somatic and mental disorders are bound to the original, caregiver relationship/environment, and it became clear that the causality of an 'illness' can not be revealed with the standard methods of natural sciences, rather lies in the fate and the choices and decisions of the individual, and the interpersonal situations in which the individual has suffered. It also became abundantly clear that social realities and the internal environment of a person are such complexities that in their mutual establishment communication via language is crucial. So, all this can be reconstructed with language: in essence, this is the practice of psychotherapy. The disturbance becomes – so to speak – part of our identity, so we need to take our fair share in coping with it. The patient has to be an active and major actor in the psychotherapic relationship.

The role assigned by classical medicine, where the patient surrenders himself as a helpless victim to the doctor's expertise, is not viable here. [Foulkes 1969, Habermas 2005] Psychotherapy has become a standard part of health services, although its availability is severely limited. Beyond the spaces of individual and group psychotherapy (in their limited sense), it is present in its systemic form in certain places of service. These are the psychotherapeutic wards. Here, a multidisciplinary team does integrating work. The team deciphers the patients' various – mostly verbal – inputs relating to their relational activities at the psychotherapeutic scene, conceptualizing them into a coherent narrative, and by giving feedback, the team realizes the strategy of the therapeutic process. This model is most prevalent in Germany, and in German-speaking countries. Typically,

these ’psychotherapic regimes’ were used for patients with psychosomatic problems and anxiety.

1.2 Antecedents – the meaning of the therapeutic community

The idea of the therapeutic community has two roots. Healing communities came into being, on the one hand, by democratizing classic psychiatric wards, primarily in the U.S.A. Here, the basis of the creation of a community was the recognition that the practice that is based on the principles of transparent decision making and hierarchic settings, and the responsibility of taking part, a practice that considers ’solidarity and communality’ its founding principle supports greatly the patient’s ability to develop their own agency so that they can master their own conditions and lives. Naturally, in these communities, patients shoulder many responsibilities that help and enrich their daily lives. On the other hand, the socially much more sensitive British group analytic scene, unfolding after the Great War, created such small communities in England where they attempted to capture both communal life and the manifestations of the psychoanalytic groups in a unified framework. With this approach, valuable experience about the dynamics of interpersonal processes in institutions and in larger groups was amassed [Pines 1999]. We can see now, that the idea of the therapeutic community is rooted in the Anglo-Saxon world. Modern therapeutic communities also conceptualize the question of repressiveness stemming from social conditions, which can also be the reason for the failures of a person to cope [Winship 2013]. In Hungary, in a fairly typical manner, this model was introduced, from the early seventies, sporadically, in only one or two psychiatric wards. These wards realized ’micro counter-cultures’, in terms of social context.

The therapeutic community of Thalassa Ház is built upon the above foundations, and amalgamating the elements of the two systems, represents a certain third quality, considering its successful clinical output. On the other hand, a basic goal of representatives of the community is to see the social basis of the institution grow, and its professional embeddedness increase. The process may strengthen those communal interactions that reflect a deeper understanding of our social relations, humanizing our mutual interactions. (Holding open days, professional and communal alike, organizing professional and policy related conferences, maintaining a presence in educational and health systems and subsystems.)

The analysis of the therapeutic community in this dissertation, the aim of the research disclosed in this paper is to present a social entity that reaches its definitive, sufficiently effective clinical achievements with the access to the various skill sets of a stable and sturdy community integrated into mutual knowledge [Hamp 2006].

2. Methods

In the examination of the *creation* of the therapeutic community, the dissertation describes the evolution of the community from the perspective of **partaking observation**. Building up the basic modus operandi of the community started with asserting its definite principles. From time to time, by analyzing clinical efficiency and the working processes of the community, the contradictions hindering further progress of the community, the problems resulting from the change in external and internal conditions became identifiable. Their feedback, and the interventions to solve these problems created further stages of evolution. In fact, the community evolved through identifying and solving problems.

Chapter one describes the intensive phase of this process, while chapter two gives a description of the elements of the resulting stable system and how it works, along with the elements of the psychotherapeutic system. Chapter three scrutinizes the system's value, norm, and rule-system. During the **conceptualization** of this normative system, I consider the ethical dimension that regulates social relations of the community *a specific factor*. The same chapter details the 'performative' dimension essential in the operation of the community, the evolutive – reflexive establishment of the scenes of reflective communal action, their significance and their distinguishable factors. (These are the motives that have always been part and parcel of the operation of psychotherapeutic communities, but in order to reveal their psychologically meaningful social relevance – and later to use them conceptually – a different path had to be taken.)

In chapter two, I present the **action research** conducted in the community. In the therapeutic community – in a complex system

– where patients take part in various activities, cooperate with a wide array of actors, it is an immense challenge to identify the concrete mechanisms of the agency of the community. A question emerged: How could I capture those elements of the therapeutic process that can be pinpointed as necessary conditions, *even if they are not conscious*? The change – like the problem itself – is seldom reflected in its complete, multi-dimension reality. Oftentimes we hear how our patients report that their interpersonal perception and activities have *somehow* changed; they are better able to balance their physical and mental wellbeing, they are more present and independent in their lives, with a more marked agency. (The improvement in their clinical profiles is *almost like a natural byproduct* of this change.) The goal of action research was to capture the elements of this communal efficiency, together with its psychic dimensions. My action research are based on a **qualitative – semi quantitative methodology**. **After conducting half structured interviews and detailed biographic anamneses**, I analyzed **the complete transcriptions** of the interviews along a predefined set of perspectives.

The dissertation reports about two similar surveys (Part II, Chapter 1. and Part II, Chapter 2.) the detailed descriptions of the interviews can be found at the corresponding surveys. I used **the identification and analysis of (conceptual) metaphors** as a partly mutual perspective and methodology.

Chapter three presents the clinical efficiency analysis of the therapeutic community as a goal-oriented system. I measured the change of life quality with **a retrospective survey**. It is a semi-structured, self-fill interview, the result of original and independent research. It measures clinical symptoms, complains, participation in further treatment, and various aspects of social functions with nominal and multi-value, ordinal variables. The survey also included an open question. The answers to it was analyzed with **content analysis**.

In the final chapter, I conceptualize summarily the therapeutic community of Thalassa Ház as a collective agent, and its path and progress on the way of transformation of therapeutic communities, along with the presentation of current international trends.

3. Results

a.

In the writings describing the thinking and experiences of the early years – as a backdrop to image what we came to have today – it is easy to capture those ambiguous moments that helped the life of the community in the beginning, but in later years, rather became hindrances, and made life progress difficult for the community.

One of these dualities causing dynamic conflicts was **the reconciliation of the psychoterapic paradigm and the therapeutic community as a method**. The other was the 'hows and whys' of the management of the cooperative situations that define the organizational reality of the institution, the recognition and management of difference between the organizational culture and the „therapeutic" culture of the therapeutic community.

At the founding of the institution, laying down the essence of the psychotherapeutic community as a defined system of method-specific psychotherapeutic activities gave us a strong basis of legitimacy. The community was everything *that remained between the activities, a matrix*; even if we took the meaning of the activities in this context as a basis when building up the system.

Then, our psychotherapic approach stood closer to the classic 'psychotherapic regime' approach. According to this, patients are surrounded by a communal therapeutic space, which is both integrative and reflexive, but where the community, as an

independent, corrective agent does not materialize in the minds of the patients. Here, the difference of mental preparedness between the staff and the patients is more marked.

In time, it became more and more perceptible and obvious for us that communal (co) operation, as an independent entity would entail a resource of a different quality that could significantly improve our efficiency.

The independent 'method' of 'the therapeutic community' has become a mental framework that the team represented with increasing consciousness. With communal activities becoming increasingly differentiated, it was becoming all the more difficult to reconcile the synergic and successive universe of roles and responsibilities, tasks, and reflective scenes with the corresponding elements of the therapeutic theatres.

It became a marked conceptual barrier: to understand the intertwining but then still separate paradigms at the same time. Later on, we managed to negotiate this duality, as the therapeutic community, as an independent, communal psychotherapeutic 'method' working within a dynamic paradigm, became interpretable as I describe it below in the analysis of the community as a special factor: an independent agent.

The idea that set our praxis into an interpretable conceptual frame was the understanding of the community as a collective (psychotherapeutic) agent. As an institution that had just become independent, we found ourselves in a situation when, beyond establishing the organizational culture of the institution, it became the professional team's responsibility to ensure the infrastructure of the institute, and compliance with the financial and administrative regulations. The idealistic norm and rule system of the therapeutic community, which aims to change individuals, is not suitable for the management of the external and internal interests of an existing

institution. In other words, a different set of norms has to apply to the life of the organization. The therapeutic community is one of the functions of the organization. Its reflecting experience 'humanize' the organization; the reworking of the organization's inevitably repressive internal (and external) contradictions further legitimizes the therapeutic community. Today, in the structure of the community, the system of various method-specific verbal and non-verbal psychotherapeutic activities constitute one of the most important sub-system. This gets embedded into a rather articulated matrix of community life. This matrix is a system of various (sub and whole) communal activities, roles, and responsibilities. Here, roles are stemming primarily from functions. Very often patients and staff cooperate with the same level of competence and preparedness. Our schedule sets the temporal and spatial boundaries of this conceptually built structure. Task and responsibilities are related to everyday life. We are the ones responsible for keeping the building clean and its surroundings (a large garden), and the community does other operative tasks as well. This articulation delineates those scenes where a certain problem, a social or spiritual phenomenon or reflection can be identified and managed, according to the 'hows and whys' of the discourse. It is the communal members' (staff and patients alike) *joint* responsibility to adequately maintain the communicational spaces set by the frames and boundaries of the constitutive principles. It is the communal knowledge of the community members crystallized into mutual knowledge [Hamp 2006] what gives the synergic preparedness of the community. The communicative state achieved by taking part in this is relevant for the patient's problematization, and in the solving of the problem. In fact it is its actual prerequisite, while, at the same time, it further improves communal integrity.

b.

The founding principles of therapeutic communities serve as a starting point for our community too. These are

- nondirectivity (democratic operation)
- tolerance
- communalism
- reality - confrontation

The constitutive principles that emphasize the communicative side of enforcing the rules and norms are also given for community members. These metanorms were originally set down by the staff, as prerequisites of cooperation, but by now – with a varying level of enforcement – they are part of the mutual preparedness, as mutual knowledge.

- clear and firm structure, at the same time, flexibility;
- clear rules of cooperation that apply to all;
- clear, open communication;
- mutuality, responsibility, and respect;
- the primary purpose of communication is understanding (this is its intention, in the sense of communicative acts)
- being conscious about the ethical dimensions of communication (ethical reflections)

It is representing rules and norms in the above mentioned fashion that interlinks the communal reality of the therapeutic community and the reality of the individual's psychotherapeutic process.

Main closely interlinked positions:

- activity orientation (conflicts – confrontation) *and* meaningfulness (it is crucial to actively or even destructively render states of the self, but the communal meaning of it must be left unrecognized);
- order is no question, *but* there are no 'self-evident' things;
- acceptance and support *and* a clear representation of the framework, confrontation;
- feedback here and now, there is no 'it did not happen';
- acting out is not a private affair: (the induced emotions and impulses materialize in the community)

From my perspective, in the communal treatment of more severe self-pathologies the matrix of the consciously built and managed norm and rule system is the preeminent constitutive basis. This knowledge comes into play during interactions in the form of personal preparedness and integral preparedness. The emerging *collective agent* has a specific effect in the healing process of self-pathologies.

It is an integral part of the culture of Thalassa Ház to co-act with patients. This is a crucial field of establishing contact with

patients who have severe personal pathologies or are psychotic. In the world of the therapeutic community, the space where the seemingly everyday situations that emerge during communal activities are followed by a number of intense interpersonal experiences. These scenes create a rich environment with multiple layers of meaning for relational work. The patterns of interactions in the interstices and the performative communal activities often serve as starting points for therapeutic work and understanding; many times providing an opportunity for corrective re-experiencing at the same time. By the tenth year of operation we managed to elaborate the scenes of reflected action, and transform their significance into communal knowledge. This dimension offers the royal way of understanding cooperation and solidarity, autonomy and conflict management. As our patients can only express their relational patterns, feelings, and inner realities in action, so unfolds the theater like, 'meaningful' world of the therapeutic community beyond the raw outcomes of communal efforts. This is the dimension of "learning from action" in the community.

c.

The goal of my first action research was to get a clear picture about the personal modalities through our patients experience the world of the various therapeutic spaces and the whole therapeutic community. I used a semi-structured interview with patients who were in the last third of their programs. The interviews consisted of three parts. It includes:

- a detailed biography (1.),

- the patient's answer (in his own words) to the questions: „*How did he experience that world of therapeutic activity in which he has taken part, and the therapeutic community? Where could he connect to his own problems?"* (2.).

- The final instruction of the interview was a request: *„Try to visualize the world of the therapeutic community in a drawing, in a way that he can see it, and describe the drawing with a few words."* (3.)

The interviews were recorded and processed with the help of volunteers, then having transcribed them word-by-word, we identified the modalities of experience in (1.) and (2.), and classified them according to their frequency. These experience modalities included picture-like expressions, and – if present – metaphors.

We identified – and analyzed, if it was possible – the 'things' aforementioned in part 3. This means the metaphors used to describe the world of the therapeutic community in its entirety („great chain metaphor" [Kövecses 2005]). One of the relevant fields of interpretation of this analysis was how patients bring into play the metaphoric structures in which they organized their therapeutic experiences. How they – literally – picture their own therapeutic process, its place and mode in their lives. Having assessed the impressive results, a hypotheses emerged: the cognitive structure that describes/organizes the capturable experience-world of traumatization, with its conceptual metaphorics, is isomorphic to the metaphorics of the cognitive structure unconsciously created about the world of reparation. Experiencing the therapeutic community in its entirety may be interpreted as a reparative, unconscious repetition of trauma. The research is to be continued.

d.

In my second action research I turned towards the relationship of the most important scene of the therapeutic community, the large group, and the whole community. Indirectly, I was making observations about the relationship between the large group and the whole institution. The „large group", the main scene of communal discourse, is a free-interaction group with three sessions a week, and the participation of the whole community. The complexity of the understanding of the large group and how it works is an excellent indicator of the prevailing (unreflected) discursive strategies in the institution. With my current research what I tried to uncover was what kind of mutual, unreflected expectations (fears, desires), beliefs, and personal cognitive constructions were synthesizing the 'rational' interpretation processes of both the patients' and the staff's in the relation of the 'large group'. What kind of summary of everyday attitudes gives the professional background of psychotherapeutic work? What is the all-communal 'scene-pattern' that serves as a backdrop for the drama of the large group?

What is being mirrored in the emergence of personal relationships towards the large group? This was my fundamental question. To map this, I used a simple, four question, semi-structured verbal interview. The questions referred to positions of theory of mind, both self and other-attributed. Questions put to the patients were the following:

1. *Why do you think there is a large group in the institute?*
2. *Why do you think having a large group is important for the staff?*

3. *Do you think the house effective?*

4. *On what grounds did you decide about efficiency?*

Questions to the staff:

1. *Why do you think there is a large group in the institute?*

2. *Why do patients think the house has a large group?*

3. *Do you think the house effective?*

4. *On what grounds did you decide about efficiency?*

Answers were recorded with Dictaphones, transcribed in their entirety with cooperation from volunteers. Altogether 12 patient and 30 staff interviews have been processed. During the semi quantitative processing of the texts, I worked with the following three marked focus:

1. frequency analysis of words and phrases in the topics (content focus)

2. Identifying emotion-related vocabulary, frequency analysis (emotional focus)

3. Identifying and classifying conceptual metaphors (conceptual focus)

My hypothesis was that there will appear a definite similarity between the patients' and the staff's metaphorics of 'private images' in the answers and the hidden cognitive patterns reflected in these. It was based on the steady operation of the 'learning system' established about ten years ago, the measurable, 'good enough' clinical output, [Nagy, Szabolcs, Valkó, Tarján,

Simon, Zalka 2011], and the therapeutic culture that has developed since then. One might say that we can cooperate well, because we are 'thinking' in similar images.

The first unexpected result was the confinable difference appearing in the answers of older and new patients. An unambiguous trend emerged in the images that depict the change in the therapeutic process. The process of change appeared in the dimensions of trust and community-mindedness. In the very first moment of assessing the answers it became glaringly obvious that the metaphorics of the patients and the staff do not display similarity, but a typical relational *complementarity*. In the patients' answers about their own large group representation, the *visual* modalities of 'importing' difficult personal things and the relational experience appeared definitively. On the other hand, in the expectations (attributed patterns) about the staff – almost exclusively – the modalities of *visuality* did.

At the same time, the metaphorics of the staff in its own representation of the large group, is predominantly based on the world of concrete physical (proprioceptors and haptic sensations) metaphorics: experiencing the world of inside/outside boundaries, and seeing. In the field of qualities attributed to patients ('experiences'), it is the world of visuality, and the past referring and relation quality metaphorics that are predominant. In summary, the process of becoming an 'old' patient from a 'new' one mirrors the transformation of the image that the patient desires to show to the real image of self and its acceptability. By the same token, this is the emergence and history of the patient – staff relationship.

This work of reflection on the large group is also the *inheriting of trust*. In the life of the person and the community, it is *the emergence of historical significance*, the enrichment of the life-world of the community.

e.

It is extremely difficult to measure the efficiency of psychotherapies and complex therapeutic systems. Beyond the challenges of applied methodology, the dimensions that can relevantly indicate the change in a patient's psychosocial functionalities are subject to question, beyond evident clinical symptomatology.

In the fifth year of the institute's operation, we decided to initiate a follow-up research. Its purpose was to monitor the relevant changes of the lives of our patients who have finished their therapies in our community to assess the efficiency of the therapeutic community.

We used quality of life as a starting point, as it is an important output variable of current research and discourse. In accordance with the approach and practice of the therapeutic community of Thalassa Ház we decided to interpret the result of our survey. To give an everyday definition to it: psychosocial functionality; activities in social roles and the satisfaction from them; the sum of self-reliance and extracurricular and recreational activities. We used a custom made, semi-structured, self-filling survey containing multiple-choice questions, and one open-ended question. Beyond the usual sociodemographic data (name, date of birth, sex), questions dealt with

- time spent in the therapeutic community
- the date of finishing the therapy
- further existence/return of the issue that was treated

- time of further inpatient treatments / rehospitalization

We also analyzed the fields of social functionality, such as:

- work
- quality of social relations judged by the patient
- quality of social relations judged by the environment
- independent conduct

The open-ended question of the survey requested further personal feedback about the time spent in the institution. During 2009 we contacted those patients whom we emitted in the period between 2008. 01. 01. and 2008 12. 31., and at least three months had passed after their release. For statistical analysis we used SPSS ver. 15.0. The answers to the open-ended question have been processed with manual content analysis.

According to our research the patients' psychosocial functionability show definite improvement after then have been treated in Thalassa Ház. Three thirds of patients do not – or only to a much lesser extent – suffers from the problem that they were treated with in Thalassa Ház. The time spent in the therapeutic community shows a significant correlation with the satisfaction with the therapy, while satisfaction with the therapy significantly correlates with the improvement in quality of life. The patients more satisfied with their therapy were more satisfied with their lives. This may be interpreted in the manner that everybody relates to its own therapy as he does to its life and vice-versa.

4. Summary

In the world of therapeutical communities, the structure of Thalassa Ház represents a more radical step forward in the following moments:

- *A complete nonverbal, performative and verbal psychotherapeutic system that is strongly conceptualized in its structure is embedded into the world of a therapeutic community that is also built with strong conceptualization*. Put it more simply, it is the amalgamation of a psychotherapeutic system and a therapeutic community, and by the reason of complexity and integration we may also talk about a third quality.

- *The value, norm, and rule system of the community set in the founding principles, its calculated and reflective realization (the 'metanorms'), is a corrective 'method' in itself.*

  The community can best display its integrated preparedness in this dimension; this is where the working of the collective agent shows itself in its entirety.

- *The complete staff of the therapeutic community takes part in the psychotherapeutic and the communal activities alike.*

  Although the interpreting and 'reflectively experiencing' positions and scenes are delineated clearly, the people are

the same. The various interstices, and the whole of the community mean the various scenes of the solving, describing and problematizing of issues, they presuppose different preparedness. The structural features of the scenes, the various instances of participation and knowledge therein and their *cross-reference* are the essential moments of the *collective agency* of the therapeutic community.

- *The world of the therapeutic community is strongly 'marked', 'reflected', and "theater-like".* (The expression of markedness is being used here in the sense of the Gergely – Watson parental mirroring theory, with a similar semiotic value.)

  In the world of the community, everything has its own reality (scenes and spaces, tools, the staff, plants, gestures, etc.) and, at the same time, everything carries an extra spiritual and social *meaning*, shaped by the traditions (culture) of the community, which is constantly available for communication. All this – in the given case – may be used dramatically to render emotions, thought, and relations. In the parental mirroring model, just like in the world of theater-likeness this is the 'markedness' or 'active culture' that Grotowski referred to [Adorján 2015]. It plays an important role in the awakening, or the self-learning process of the individual.

The community of Thalassa Ház represents a new quality through amalgamating the elements of psychotherapeutic systems and therapeutic communities.

4.1 About the collective agent

In our thesis we consider the therapeutic community, from the perspective of communication, in the sense of the participation model, a collective agent [Horányi 2007].

The clinical and at the same time communal aim is to reach that communicative state where that extra-preparedness becomes available through which relevant understanding of a problem and its adequate solution becomes realizable for the individual ('the patient') and the community. This process leads through achieving communicative states. The community integrates the preparedness of the members and groups of the community providing extra-preparedness. This integrating knowledge is one of the key moments of the community; the key moment of efficiency. Individual agents and smaller functional groups mutually reflect to their own and the other's knowledges. The set of mutual knowledges [Hamp 2006] that provides the symbolic body of the community is realized during the intentional cross reference of the knowledges. (e.g. A boundary transgression emerging in the situation of a communal "opening up" brings into play a number of preparednesses: the relevant scenes of personal understanding of the momentum may be the verbal small-group, the psychodrama, but it must be dealt with on the communal level, this is the level of the large group, at the same time, this may entail the changing of the cooperative boundaries, and this latter belongs to the contract of the patient and his therapist.) These preparednesses are present for each other there and then, they are being interpreted in each other, and thus enable the emergence of basic dilemmas and consensuses that may promote understanding of the community. (E.g. the consequences of the revealing of a transgression of boundaries: the retribution of sincerity. Where do the boundaries of permissiveness lie? Mutual knowledges require

extra preparedness to become mutual knowledges, the extra being the provision of the scenes of mutual reflectivity. (The mutual relational 'validation' of knowledges.) The more integrated the collective agent (the more mutual knowledge is present) the higher are the chances of reaching the communicative stage for the individual. (More entry points, e.g. the significance of actionableness.) All this enables a more integrated and more differentiated transformation of personality. The unfolding of the constitutive base enriches the cases of mutual knowledge towards the community. The communicative state (the acquisition of extra-preparednesses) can be achieved through communication-acts, and extra-preparedness is the prerequisite of the communicative-acts. The individual agent severely limited in its extra-preparednesses can start from the inherent, preparedness-near communicative. That is why it is fundamental to build up the initial communicative state in the realm of physical states and performativity, where the problem lies in the available acquisition of symbolic means.

And from here stems the structure of the psychotherapeutic system too: a nonverbal, performative group on the beginning of the week – and the rehabilitation program; then verbal small-groups. Likewise, the purpose of our 'accepting' groups, working with sociotherapeutic tools, is to socialize for relational work. In the focus of these groups stands the fact that throughout the psychotherapic process we are going to work with those emotions, physical states, and thoughts that appear important for us in a social situation. To be able to do this, we must be able to identify and verbally share these moments.

4.2 The international scene

Considering the international scene, a rather peculiar undulation can be observed in the judging of the importance of therapeutic communities. The inflation of the role of these

communities follow a cycle of 10-15 years, according to how hard the times that may be coming [Nicholson 2014, Yates 2017]. Their numbers rise and fall according to economic and profession-political trends. This may be related to the cyclic change in social processes and changes. Typically, in the European scene, British and Italian therapeutic communities are predominant. Thalassa Ház has been present on the international scene since the fourth year of its operation. As a first step, we joined the Alliance of Therapeutic Communities, then the developing and auditing network called Community of Communities, operating under the supervision of the Royal College of Psychiatrists. Our embeddedness deepened further when the institution was invited to join the London-based International Network of Democratic Therapeutic Communities established in 2010. Our cooperation is most significant in the field of professional workshops and training workshops. In parallel with this, we are partners/organizers of the Italian Learning from Action training group that – based on experience of the therapeutic mode of operation and Group Relation – is developing the cooperation and leadership of the teams working in various healthcare and social scenes. The opinions about the (cost) efficiency of therapeutic communities had taken a definitive turn in the spring of the year when the results of randomized, controlled follow-up research conducted by an oxford team were published [Pearce et al. 2017, Maughan et al. 2016].

Based on the results of this survey, the method of the therapeutic community has been included in the 'evidence based' methods of medicine. On the one hand, the way of progress is being indicated by exciting experiments, for example creating small living communities in the Italian scene [Bruschetta, Barone 2016]. On the other hand, the handing over of the 'knowledge' of the therapeutic communities to the more traditional institutions of the healthcare and social service systems has emerged as a definite trend [Lombardo 2014]. The implementations of the therapeutic community as an

‘adaptable treatment modality’ [Kennard 2004] into the operation of an institution results in the institutional processes becoming more organized and conscious. This adaptation may lead to the understanding of the institution’s interpersonal and cooperative culture as a factor of healing [Pearce, Haigh 2017a].

Eventually, this process means the approach-forming and humanizing effect of the therapeutic communities in the various social institutions.

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