issues in milieu treatment

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By "milieu treatment" we refer to various aspects in the organization of a total treatment system that can facilitate improvement of patients.¹ When we practice milieu treatment, we "treat" the organization as much as the individual. An understanding of this prevents the mistaken view of milieu treatment as an alternative approach to mental illness, competitive with somatic treatments or psychotherapies. A number of serious research studies have approached milieu treatment in this simplistic way; the result has been its debunking as a treatment for schizophrenia in comparison, for example, to treatment with phenothiazine drugs alone (May 1968). The issues are far more three-dimensional in the actual treatment settings where we try to help patients with the best available resources, be they pharmacologic, psychotherapeutic, or organizational. To understand the place of milieu treatment in such comprehensive situations, we must consider a myriad of interacting factors: other therapies, including drugs; program size; makeup of the patient population and the staff; relation of the treatment setting to the wider environment; timing of a patient's admission in relation to his "career" (i.e., personal history of deviant behavior and its treatment); and his length of stay.

Instead of trying to propose one "way" to "do" milieu treatment, I shall discuss a number of salient issues like those above. In doing so I hope to convey my conviction that milieu treatment, especially for schizophrenic patients, is an extremely complex, varied endeavor that we are only beginning to understand clearly. The faddish impatience of our modern technological era may be leading to a rejection of milieu treatment before its application has been fully understood. The 19th century decline of moral treatment—apparently a highly effective technique—is a warning to us to understand and apply the milieu techniques developed in the past 25 years before we are swept off in new directions.

No one program description would be adequate to cover the variety of settings now existing. Each issue to be discussed involves one aspect of the complex interrelations that, overall, comprise milieu treatment:

- Management;
- Medication and milieu;
- Patient careers;
- The "milieu of the milieu";
- Therapeutic community—including therapeutic process, charisma and communitas, and authority and nurture;
- Specific problems in working with schizophrenics in milieu treatment;
- Specific format and activities used in milieu treatment;

"Milieu treatment" or "milieu therapy" is often used interchangeably with "therapeutic community." Although in many settings there is reason for the use of both terms, they relate to two different levels of treatment. Milieu

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¹ I have chosen to refer to persons receiving care in institutions as "patients," since the majority of inpatient care continues to be in hospital settings. In other settings, the appropriate designation might be "client," "resident," or "member." While "patient" has negative connotations to some, it remains the most generally recognized term and is probably preferable to the use of a diagnostic label.
Therapy refers to the use of the total milieu—formal treatment program, staff reactions, special activities, peer relations—in the overall treatment program of the individual patient. Therapeutic community refers to an enhancement of the treatment organization through encouraging its development as a cohesive social group. Like milieu treatment, the term therapeutic community is frequently misunderstood. It is often misinterpreted to mean a permissive, roleless, egalitarian brotherhood among sufferers and helpers. Properly conceived, therapeutic community may in fact aspire toward a communal ideal. But its therapeutic quality is crucially dependent upon its attention to detail and process, whether in the sharing of power with patients or in the day-to-day progress of any particular individual. Thus, I will be discussing therapeutic community in a later section as one important facet of milieu treatment.

Milieu techniques and treatment programs have not usually been developed for schizophrenics alone, except in chronic wards and some specialized research designs or programs. Therefore, many of the comments here about programmatic aspects of milieu treatment are not limited to this diagnostic group. Since schizophrenia may be a cluster of disorders with certain common features, this lack of specificity is not a major problem. Further, major acknowledged differences in the institutional experience of individuals have led to the designation of at least three categories of patients—acute, chronic, and recurring—with a functional significance for milieu treatment that is most likely far greater than diagnosis alone.

The single factor that influences milieu treatment most profoundly is length of stay. In the implementation of a milieu program, this consideration affects every other issue in some way. The role of the milieu in a patient's total experience, and the effect of the individual's stay on the total milieu, determine how intimately these effects can, and should, become interwoven. Specifically, any treatment technique that requires a committed involvement on the part of both patient and staff—individual psychotherapy, therapeutic community, token economy—must have time for an interaction to develop. The shorter this time, the more limited will be the involvement and, necessarily, the more one-sided the approach.

A Core Issue: Management

Once hospitalization, or placement in some kind of program beyond outpatient care has occurred, "administrative" or "management" issues become central to treatment. This is not to ignore the importance of intrapsychic, interpersonal, or biological factors, but all of these are inevitably played out around the individual's status as a patient (Goffman 1961). Admission to a treatment program implies that family, community, and outpatient resources have not been sufficient to deal with the behavior and/or subjective state of the disturbed individual. In the process of admission, the institution inevitably accepts a degree of control and authority over the patient. Likewise the patient, directly or tacitly, expects the institution to exert controls and guide aspects of his behavior. The way in which authority is handled by staff, and the way in which power and responsibility are gradually returned to the patient, are important elements in milieu treatment.

In milieu treatment, the focus on management as the core of the organization has a number of important functional implications. It means that: 1) The patient and all staff members are involved on a daily basis with the relevant issues; 2) there is no special, abstruse expertise connected with management that gives any one subgroup a special, exclusive role in treatment; 3) the important sociological concomitants of institutional treatment—labeling of the patient as a deviant, his adoption of a "sick" role—can be dealt with head-on; and 4) inappropriate controls and restrictions are less likely to occur. I shall discuss each of these aspects of management in turn.

Universal Involvement in Management Issues

A criticism of various forms of "medical model" treatment—custodial, pharmacological, or psychotherapeutic—is that decisions about a patient are made by those least directly placed to observe or experience the effects. In such settings decision-making becomes a complex, subtle business, with the less powerful groups (patients, aides, nurses) influencing decisions through deliberate, selective presentation of information to higher-ups (Braginsky, Braginsky, and Ring 1969 and Dunham and Weinberg 1960). When management issues are dealt with more openly, such deceptions become less necessary. Power distribution may not change, but it becomes difficult to ignore the fact that patients and aides have better information about patients' behavior and feelings than busy nurses, physicians, and specialized therapists. Acknowledgment of the greater information
available to aides and patients often leads to sharing power with them more explicitly. For example, in behavior modification programs (which tend to make traditionally implicit patterns explicit), aides are usually behavior observers and thus are recognized as the source of crucial information about target behaviors and reinforcements. Through having his important role in the behavior therapy system recognized, the aide becomes a legitimate member of the therapeutic team. Interestingly, many therapeutic units are then able to free aides for more long-range activities (such as planning, placement, and aftercare) because their behavior-monitoring functions have become more focused (Almond 1974a).

Similar observations can be made about patients in therapeutic communities who assume certain traditional staff roles: “specializing” other patients, leading meetings, observing and reporting behavior. Again, there is a double gain: Patients not only supplement nursing staff but demonstrate that they are not limited to the role of being “sick.” This also provides modeling for newer patients. This pattern of “role paralleling” will be discussed later in more detail.

Management-as-Therapy vs. “Therapist-Administrator Split”

The separate operation of “therapy” on one hand and “administration” on the other has tended to confuse both patients and staff, and has usually led to a conflict resulting in a loss of dignity—and efficacy—for both. This has been best documented for psychoanalytically oriented institutions, but also holds true where family therapy or group therapies are emphasized, and is certainly true in treatment units emphasizing pharmacotherapy. When one part of the staff feels excluded and disparaged by another, it is far more likely to carry this status difference into its relations with the patients. But if the philosophy of the treatment program puts first emphasis on management, such divisions are less likely. The psychotherapist takes his place as an expert on conceptualizing one aspect of the patient’s hospital experience, just as the aide is an expert on the patient’s daily behavior outside of “therapy” meetings. Within this perspective of management, each staff group has its unique and equally legitimate place in the organization, in its own eyes, and in its relation to the patients.

The value of this role-legitimizing is not its democratic, equalitarian, leveling effect. Its real value lies in making interactions of patients with staff as therapeutic as possible. Only to the degree that the lowest ranked level of staff feel like therapists (in the broad sense of having a significant part in changing the patient’s behavior) will they be able to act and influence therapeutically. Further, in therapeutic communities where patients come to take on certain responsibilities and powers usually accorded staff, this legitimatization will be critical, as I shall explain later.

Delabeling and Relabeling

One argument frequently raised against all institutional treatment is that the fact of hospital admission tends to fix the troubled person in a “sick” role, as embodied in a diagnostic label. Empirically, this criticism tends to be true, at least as we measure the effects of labeling in terms of readmissions (i.e., if admission can be aborted, further admissions are less likely). Whether avoiding admission makes for better individual functioning, or less overall societal burden is not yet known. Certainly, recent massive closings of some State hospitals have only shifted the location of these labeling processes, transferring the chronic and semichronic patients, with their marginal lifestyles, to the streets and the transient hotels of local communities.

Those working in a hospital setting should not ignore the fact that hospitalization in itself has powerful effects on self-concept, on the attitudes of family and community, and on the expectations of both sides. By giving management a major focus, it is possible to diminish the natural tendency toward labeling. Efforts can be made to encourage the patient to maximize the continuity of activities that are important to his self-esteem and place in the community, such as work and family life. Likewise, staff can work with family members and employers to minimize their anxiety about the patient and to avoid any consequent rejection. Where labeling is a concomitant of pathological family processes that require one “sick” member, it may be possible either to modify these processes, or to help the patient to separate from his prior role in the family system.

Avoiding the “Asylum” Pattern

The patterns of institutional care that have been the subject of reform ever since moral treatment developed in the late 18th century are no accidental aberrance.
They are, if anything, to be expected in a society that is both anonymous and individualistic. Bizarre, unpredictable deviants are a threat to society, not so much because they are likely to be dangerous as because they arouse inner anxieties and set a dangerous example. Such individuals are best "put away" in institutions capable of prisonlike controls. Therefore the task of staff in therapeutic settings still includes a constant resistance to the encroachment of pressures toward control rather than treatment.

Because of its attention to detail, the management approach can be a good vehicle for monitoring and limiting the drift toward control-oriented custodialism. By focusing on specific decisions and issues, the question "Are we doing this to control the patient for society, or for therapeutic benefit?" can be answered day-to-day. Broad rationalizations based on generalities will be less successful when the staff are all involved with everyday issues concerning their individual patients. Of course, it is also necessary to maintain a strong overall valuation of humane and therapeutic care to uphold a management emphasis on protecting the patient from society's fears. The surest way to do this is to include the patient as an active participant in management's decisionmaking processes (a point that will be illustrated when I discuss "Therapeutic Community").

Medication and Milieu

The availability of psychotropic drugs has had a widespread impact on all psychiatric care, especially within institutions. The major tranquilizers, the antidepressants, and drugs such as lithium offer means of altering the symptoms of the major disorders associated with admission. From the point of view of milieu treatment, drugs are enabling. A great deal more can be done with a patient who is not so withdrawn or excited as to be inaccessible to social interaction, and who can communicate meaningfully with staff.

One aspect of drug treatment can be a pitfall for milieu treatment. Drugs offer a relatively easy way for staff to achieve control of deviant behavior. But a quiet ward is not a therapeutic ward. The dosage and effects of phenothiazines must be carefully monitored so that nighttime sedation and antipsychotic effects are not gained at the cost of the patient's being sedated, semi-sedated, or parkinsonian during the day. This requires skill, attention, and experience on the part of the psychiatric staff. For the unit as a whole, it means maintaining an expectation of alert patient involvement in ward life. If patients are exposed to a hospital culture that expects drugs to make people dysfunctional, then drugs will do this. If the staff, instead, conveys an expectation that drugs are not an excuse for passivity, withdrawal, or daytime sleeping, these are unlikely to occur, except where genuine drug effects are operant. Put another way, the staff can make the placebo effect work for the patient and the milieu.

A second aspect of drug therapy that interacts with the milieu is the pattern of medical roles enacted around the giving of medications. Standard hospital practice makes the drug sequence part of the medical model of care: M.D. prescribing, nurse administering, aide checking and reporting behavioral effects, and patient passively receiving. This model and these roles are not necessary and should be modified or altered to fit the milieu program. In most cases there will be some requirement for medical or staff supervision of drug treatment. But usually it is possible to share the responsibilities revolving around drugs to a considerable extent; all staff members, and patients as well, can be educated about dosages, side effects, and target symptoms. With experience, nonmedical staff, and even the patient, can recommend the choice of drug and the dose and can monitor effects as well as, or even better than, the psychiatrist. The educational process leading to this can become part of the milieu treatment program as a patient learns to monitor his own drug reactions, or participates in doing so for other patients.

Phases of the "Patient's Career"

The critical issues in milieu treatment will be largely determined by two aspects of what has been referred to as the "patient career": the personal aspect and the institutional aspect (Goffman 1961 and Levinson and Gallagher 1964).

There is a highly individual history of problems and treatment for each person, differing with each institutional involvement the experiences. Is this an acute break in a previously well-functioning individual? A recurrence of an acute, intermittent problem? A deterioration of a marginal adaptation? Hospitalization with a diagnosis of schizophrenia can imply a great variety of life-patterns, even when the term is used conservatively. The goals of treatment—and the role of the milieu—must be adjusted accordingly.
In the case of an acute break with a previous history of good function (i.e., “reactive” schizophrenia), the goals will include attention to the developmental and environmental stresses that precipitated illness. The treatment setting may provide opportunity for corrective experiences with a surrogate milieu “family” and an intermediate-length treatment (1 to 6 months) may be valuable, avoided by offering positive reinforcements, primarily for serious therapy work, and by mildly discouraging symptomatic behavior, especially through peer norms and pressures.

Patients with recurring hospitalizations usually need encouragement to avoid deepening their institutional dependency and help in dealing with environmental stresses that may have precipitated the recurrence. Thus the focus of the milieu here would be only briefly on the patient within the milieu, and would rapidly shift to the home (family, living unit, job setting). This focus may reveal some change, usually in the person’s emotional support network, that explains the recurrence. The hospital staff’s active involvement with the outpatient therapist will be valuable. With such hospitalizations, staff may need assurance that their efforts are not Sisyphean labors but are meaningful and effective. It may be helpful for them to realize that expectations for a recurrent patient are limited and must be reevaluated from year to year or over several admissions. In cooperation with outside therapists, goals can be set that involve very gradual shifts toward long-term change, with readmission frequently serving as an opportunity to effect steps in this direction.

For the chronic patient, institutional care can be made therapeutic even when discharge is impossible. In this case staff members need to identify clearly the limited range of changes possible and to adjust their sights accordingly. Behavior modification approaches and token economy programs can bring about impressive increments of new behavior (Lindsley 1960). Discharge should be carefully evaluated to assure that it will actually be an improvement for the patient. If it is not a goal, then patient and staff should adopt an attitude of trying to maximize the opportunities for making life as rich and varied as possible within the institution.

Each institution has a place in a wider network of treatment agencies. Patients usually come to the institution from some other agency and leave for further care by another agency (residential or outpatient). We have learned that much behavior is situationally determined, i.e., it is a result of the impact of the setting on the individual, or of an interaction between the two. Thus in evaluating any individual, it is important to know his particular route to the present milieu and his behavior in prior settings. Much can be learned from this to the benefit of all who are presently concerned. The temptation in therapeutically oriented settings is to assume that treatment elsewhere has been a failure and to “start from scratch.” But interactions from previous settings are often repeated, so close examination of what went well and what did not in prior treatment will be helpful.

Similarly, outcome of a particular treatment experience is highly dependent upon the setting and the type of treatment to which a patient is discharged, and upon the effectiveness of the transition. A poor transition period can sabotage the best aftercare program. If a patient has become involved in the treatment, he will experience a natural loss at discharge and a stress with the change to a new environment. It is, therefore, especially important that the termination of involvement in itself be a phase of milieu treatment, with time and attention given to it in formal and informal aspects of therapy. “Acting-up” can be anticipated in the form of avoiding medication, premature departure, or reemergence of symptoms. The schizophrenic may find it difficult to express sadness over the loss and to handle the anxiety of change. Farewell rituals such as goodbye parties may be useful in helping him cope with grief, since these provide a ready made format for the expression of feelings and for clearly and publicly saying goodbye. In therapeutic meetings the last days or weeks can be a time of review, especially if the patient’s progress is slipping backward. Staff can also assist the transition by encouraging or even requiring the initiation of aftercare considerably before the departure itself, and by encouraging or requiring a return to the treatment setting for a few days or weeks after leaving.

The “Milieu of the Milieu”

In the design, evolution, and operation of a milieu treatment program, careful attention must be paid to the wider framework within which it is operating. This framework almost inevitably imposes constraints upon the internal program in terms of anticipated length of stay, staffing patterns, and referral procedures. Both a brief-stay, acute unit that treats first-break and recurring...
schizophrenic episodes and a State hospital unit with chronic schizophrenics can have effective milieu programs. Implementation of these programs will vary considerably. It is most important to observe the limits and strengths of a given milieu; often limits can be converted into strengths. For example, a poorly staffed ward for chronic schizophrenics can utilize the skills and experience of nursing aides and patients themselves in ways that would not be considered in well-staffed settings.

An examination of the framework of the milieu may reveal that some assumed limitations do not exist. For example, a brief treatment program may find it possible to develop its own aftercare services to avert readmissions. Liaison with other agencies may provide access to new resources and alternatives, unburdening the treatment staff. Some milieus build a wall around themselves, priding themselves on their programs. This may be a useful contribution to internal cohesion, but it does not necessitate poor relations with the larger milieu. Certain personnel may specialize in bridging the gap to other agencies.

**Therapeutic Community**

**The Therapeutic Process**

Therapeutic community is not created by group meetings, patient-staff meetings or even by patient government. These may be structural aspects of a therapeutic community program, but by themselves they do not assure that therapeutic community will function effectively. Effective functioning requires that certain processes occur that are critical to the therapeutic experience. I suggest that these processes be classified in three categories, roughly sequential (Almond 1974b). These are: attention saturation, behavior modification, and role paralleling.

**Attention Saturation**

This involves the use of one or more of a variety of powerful techniques to direct a significant proportion of the sufferer’s attention away from his inner preoccupations in order to make social influence possible. In the case of the schizophrenic individual there is usually a preoccupation with some form of autistic experience: hallucinations, paranoid ideation, delusional thoughts, diffuse anxiety, thought disorganization, empty depression. While we know that many schizophrenics are exquisitely aware of their environments, the power of their psychotic experience (along with its frequent secondary-defensive function) prevents engagement with the environment. Therapeutic communities seek to engage attention by active, often-intrusive social contact. This may take the form of one-to-one contacts between the patients or staff (including individual psychotherapy); group meetings, small or large; and charismatic contact with a leadership figure. In these various contacts, interpersonal social pressure is used to convey to the new patient the importance of involvement in the community. In non-Western healing communities and American encounter groups, the variety of techniques for attention saturation is wider, including intoxicants, emetics, and cathartics; movement, dancing, and ritualized chanting; complex religious ritual activities; and verbal attack on character patterns and symptoms (Almond 1974b). In conventional psychiatric settings, antipsychotic drug therapy is perhaps the most powerful technique for getting the schizophrenic patient's attention. In addition to drugs, therapeutic communities use certain social pressures to engage the patient and token economies use rewards. Whatever the technique, it is important to recognize that a milieu can have little influence before it has gained the patient’s attention.

**Behavior Modification**

In general terms, this is a process of engaging the patient in a give-and-take situation in which he is rewarded for behaviors desired by the milieu and is helped toward goals of value to himself. As the newcomer increasingly attends to his environment, the staff can begin to selectively reinforce desirable behaviors. These will include behaviors that make for an effective community, such as taking responsibility for other patients and community needs. Also important to reinforce are behaviors valuable to the individual, such as the achievement of changes in symptomatic behavior, in recurrent self-defeating patterns, and in relationships. As time progresses, the goals will move from diminution of symptoms to interpersonal changes and then to preparation for discharge. A sequence of behavior levels, ward
Figure 1. Movement of an acute schizophrenic patient through a therapeutic community ward—Sequence of upward progress.
responses, and reinforcing privilege statuses for one therapeutic community ward dealing with a hypothetical acute schizophrenic patient is diagrammed here (figure 1).

Role Paralleling

The third aspect of therapeutic community process revolves around the tasks of delabeling (relabeling), and the new social role and self-concept that result. From the first moment of entry (or even before, when there is a waiting list for admissions), the patient can be shown a role modeled after healthier, more effective members of the treatment community, both staff and other patients. A patient “sponsor” who shows the newcomer around is demonstrating that patients can assume functions typically carried out by staff. Patients taking blood pressures, monitoring upset patients, making decisions about each other’s privileges, or participating therapeutically (in a therapist role) in group meetings—all exemplify the role-paralleling process in action. The process is two-sided: On the one hand, the patient who plays the stafflike role is asserting his capacity to be competent, helpful, and responsible. We have learned from studies of role playing that enacting and transmitting to others a set of beliefs are the most powerful ways to incorporate them. Here, the beliefs or conclusions relate to such questions as, “Am I sick or well? Competent or incompetent? Active or passive?” Enacting a role closely paralleling staff roles leads patients to the more positive answers. On the other hand, each bit of role-paralleling behavior shows the rest of the community, both patients and staff, that patients are not limited to a sick role.

Role paralleling requires sensitivity and careful work by the staff. Staff members must be willing to relinquish some of the protections and powers of their traditional roles and to take risks by giving patients more responsibility. But at the same time, they must constantly monitor this process to be sure that these increments of responsibility and power can be handled by the patients. With schizophrenics, these cautions in relinquishing staff functions are especially important. Patterns of dependency and passivity are often so fixed that compliance can be mistaken for real cooperation. The quality of the role performances must be carefully evaluated by the staff. It is not enough to share power; once it is shared, the staff must constantly assess how it is being used. Ultimately, responsibility for treatment remains with the staff. When signs of patients’ misuse of power appear, the staff must move in and actively insist on change.

Charisma and Communitas

Any therapy requires the presence of some special conditions that facilitate the difficult process of personal change (Frank 1973). Here these are interpersonal: Either individual-individual or individual-group. I refer to the special quality of the bonds that develop in these two kinds of interaction as healing charisma and communitas; respectively (Almond 1974b).

Charisma refers to the special feelings that develop between two members of a therapeutic community, one usually being of higher rank or greater experience in the community than the other. Communitas refers to special relatedness existing within groups or within the community as a whole. The two kinds of relatedness have in common the creating of a sense of elevation, of making the participants something more than ordinary, able to transcend ordinary limits. Developing and maintaining charisma and communitas is the task of the long-term staff. Freedom must be given for staff members to develop their charismatic qualities. These qualities vary from one person to another—charisma is not a fixed set of attributes, but a capacity to evoke certain responses in others. For mental health workers interacting with schizophrenics, charismatic behavior may well lie in quiet, empathic listening. Senior staff must ensure that their own charisma is actually transmitted to subordinates, i.e., that it enhances the latter’s charisma, and that it is transmitted in turn to the patients. This means that supervisors must encourage originality, a sense of specialness, in each staff member. Charisma can be transmitted to staff and patients throughout the community by way of role expectations. These define the possibilities for taking on responsibilities, confronting difficulties, voicing problems openly, and so on—for tackling things that are challenging.

Communitas, the general atmosphere of specialness in the therapeutic community, can be facilitated by maintaining certain values within the total culture. This includes the valuation of interactions such as sharing problems, providing mutual support, and having a sense of common cause and of cohesion as a group. Any particular community may (and should) have its own, unique values
and styles. The training of incoming staff members and the reinforcement of positive patient behavior in these areas can ensure that the community’s values are norms of daily life.

The mutually supporting interplay of healing charisma and communitas, and their manifestation in the norms and roles in a therapeutic community, are indicated in figure 2. This network of interactions is crucial to maintaining effective processes for the milieu treatment of individual patients. In fact, the interplay of individual therapeutic efficacy is circular, as is shown by the diagram in figure 3.

Authority and Nurture

Traditionally, mental hospitals have emphasized authority or nurture or both as primary functions. As we evolve toward a more therapeutic attitude, these two aspects of residential care continue to be important elements. Certainly these are major themes in any treatment system dealing with schizophrenic problems. But either extreme of these two functions is incompatible with therapeutic community—whether permissiveness or authoritarian control, or indulgence or deprivation. In a study of one particularly effective therapeutic community, as measured both by immediate results and followup studies, Almond, Keniston, and Boltax (1968) found that the culture emphatically did not value either authoritarian controls or indulgence by staff. Instead, emphasis was on self-control of impulses bolstered by charismatic authority, medication, and social pressure. Similarly, on this particular unit the patients’ need for nurture was fulfilled through the general feeling of communitas, which provided social support for positive self- or community-enhancing behaviors rather than unconditional support.

While these observations on authority and nurture hold true for any therapeutic community, they are particularly important in dealing with schizophrenic individuals, whose previous experiences with authority and love have so often been aberrant, or even blatantly destructive. Too much love can be overwhelming to those with uncertain ego boundaries, paranoid ideation, and low self-esteem. Too much freedom can be frightening where there is a poor sense of self-control, a struggle with aggressive
Figure 3. Interplay of the therapeutic processes of a therapeutic community in terms of patient's progress.

Efficacy of the community is renewed; charismatic roles of staff and communitas norms are validated

Patient returns home; outpatient therapy; patient views self as able to live and work outside hospital

Patient espouses the norms of communitas, and a charismatically enhanced patient-as-therapist role

Patient learns to deal with own life and problems

Events leading to patient's admission

Patient at admission: viewed by others and/or self as "sick," i.e., disabled, dependent, irresponsible (A)

Medications

Specific individual, family therapies

Interactions with staff

Interactions with experienced patients

Dealing with privilege sequence

(B)  (C)

(A)  (D)  (E)  (G)  (H)
impulses, and a weak sense of differentiation between fantasy and reality. These reactions are corroborated not only by behavioral observations, but by schizophrenic individuals' describing their subjective experience with treatment.

**Milieu Treatment of Specific Problems in Schizophrenic Disorders**

No simple one-to-one prescription of milieu responses for particular behaviors in the schizophrenic repertoire is appropriate. In fact, with much symptomatic behavior, milieu treatment should be continued without regard to the symptoms. Here I am speaking of hallucinations, delusions, and other "bizarre" behaviors. When these are occurring, staff can clarify reality and try to avoid distortions of ordinary behavior patterns and social expectations in their own actions. In other words, I am suggesting that except where specific responses to symptomatic behavior are part of the treatment value system it is best to ignore or neutralize their impact. This will avoid needless reinforcement and secondary gain. If these symptomatic manifestations are accompanied by anxiety, this can be identified and appropriate reassurance given through such measures as specialing, extra medication, or physical contact. Specialing can be done by other patients, in fact often more effectively than by staff, since the benign meaning of the contact is more likely to be clear to the patient being treated. It is often helpful to alert the entire treatment community to one individual's crisis and to present it as a community problem. Locking doors or other forms of protective reaction may be useful in enlisting community aid, and such measures can often be taken in consultation with the patient group. I would encourage the use of additional contact with the patient first, to avoid what might become a regressive invitation to the community as a whole.

Much the same can be said about the treatment of self-destructive, suicidal, and assaultive behaviors. Here staff may have to participate more directly. For example, the black depression accompanying many acute schizophrenic episodes is often not characterized by the psychomotor retardation occurring in other depressions. Suicidal behavior in such instances may be more unpredictable, sudden, and earnest than in other kinds of depressions. Assaultive behavior requires staff assistance, because it can evoke fears of loss of control in other patients, as well as constituting a danger to staff and the patient community. Emphasis should be on reassuring the assaultive patient about his own self-control and the availability of supplemental human, chemical, or physical controls if necessary. A firm, unpanicked attitude will often obviate the need for other controls. If they are used, clear explanations should be given to the patient involved and to others as well, emphasizing the expectation that this will be a temporary situation.

Manic behavior in schizo-affective disorders (or in misdiagnosed cases of mania or hypomania) is handled as an exception to many precepts of milieu and therapeutic community treatment. Manic patients do better with less stimulation and thus should not participate in large group meetings, especially those with an unstructured format. Nevertheless, the patient community can be enlisted in helping patients through such periods, setting needed limits to their self-stimulating (and often entertaining) cycles of activity. When such behavior is under control or is waning, manic patients can be valuable community members and need to be encouraged to put their energy to appropriate use.

It is best to ignore paranoid thinking. A differentiation should be made, however, between chronic paranoid schizophrenia, a psychotic decompensation in a paranoid personality, and paranoia as a primitive organizing attempt in an acute, undifferentiated schizophrenic episode. In the last situation, some reality clarification and interpretation may be helpful; in other manifestations, the paranoid process is invariably more powerful than any rational argument that can be offered. It will be more constructive to emphasize the expectations and limits of the milieu and to disregard paranoid delusions than to argue. The patient can usually modify the paranoid delusions to comply with these limits once his anxiety and hostility begin to diminish.

Frequently, severe problems of dependency and passivity characterize schizophrenics, either acute or chronic. As I have already indicated, treatment of these problems requires careful evaluation and planning. The amount of change possible and the factors underlying the patterns (such as a person's role in his family) should be evaluated. Then graded steps toward change can be outlined, with realistic provision of positive reinforcement of progress.

Perhaps the most challenging problem in milieu treatment is that described by T.F. Main (1957) as "the ailment": the patient whose pathology seems to feed on the help he receives. Such patients, who tend more often to be borderline personalities than schizophrenics, require
a united front from the milieu to avert their magnificent capacity to recreate their inner good/bad splits in the world around them. Discharge may be necessary, and surprisingly, often short-circuits the pattern of self-destruction. It is important to recognize that for such individuals the warmth and acceptance of the milieu, with its possibilities for love and intimacy, evoke paradoxical attitudes of self-hatred. Outpatient treatment over a long period and/or intermittent, brief hospitalizations may become more effective as trust slowly emerges.

Specific Formats and Activities

I have obviously included little of the “how to” variety of prescription for milieu treatment. This has been deliberate. I am firmly convinced that the best program design evolves from the staff directly responsible for developing and maintaining the program; only in this way can the particular local factors—the variety of patients encountered, their length of stay, the staff skills and interests—be responded to most effectively. Yet it is also true that milieu programs often apply a rather routine set of activities without much consideration of their implications and interactions. The “standard” milieu program, as I have observed it, usually includes one or more community meetings weekly; two to five small group meetings weekly; one or more family group meetings; some form of patient government; and such usual activities as specialized therapies, exercise, arts and crafts, and outings. These are all too often uncoordinated, each having its own staff leadership and little continuity other than the patient himself. What does each of these therapy activities do? How can they contribute to an overall milieu program for schizophrenic patients? What other therapies and activities would be useful additions, and in what way?

Large, community group meetings (sometimes called patient-staff groups) are best understood as ritual situations. Arrivals and departures of patients and staff are announced; ward issues and crises are discussed. Where patients participate in decisionmaking the community meeting can be a time of review, with agreement or challenges by the staff reinforcing or correcting patients’ handling of responsibility. I personally do not favor an unstructured, open format for large meetings. Such situations have been shown to be ineffective as a means of increasing patient participation and sharing power with them (Rubenstein and Lasswell 1967). In fact Rice (1971) discovered that such settings frequently induced regressed behavior in normal groups. Structuring large meetings does not mean dictating to patients, but simply that the staff must create or insist on structure. Often the format can emphasize patient leadership. One individualized version of the large group meeting, held in a setting where patients and staff were divided into three semi-autonomous small groups, had patients giving weekly informational reports on the progress and problems of group members to the other two groups.

Small groups are often the heart of a milieu program. In dealing with 5 to 10 patients it is possible to attend to each member, especially if the group meets daily or at least several times weekly. The staff may prefer to have an unstructured format, or to use techniques such as role playing. It is best for some, if not all, group therapists to be part of the regular ward staff, so that active issues from patients’ daily lives can be attended to. Unlike outpatient groups, staff should bring up such issues and actively facilitate patient participation. Interpretations should be limited to the here-and-now, rather than including psycho-genetic and dynamic factors. The role of the leaders should also emphasize their function as “social engineers” monitoring the norms, cohesion, and effectiveness of the group. Leaders may prefer to work one-to-one with patients while the rest of the group listens. In this case, the leader must ensure that the impact of one patient’s experience on the others is explored. It also requires sensitive collaboration to avoid making other staff members into spectators. Regardless of therapeutic technique, the small group meeting offers the staff opportunities for developing individual leadership styles and personal charisma.

The small group can be powerful therapeutically because it evokes a “family transference” and can thus be an effective corrective experience. In some cases the small group can be the administrative unit as well, thus combining therapeutic community processes with these primary group forces. This system may work best in intermediate-stay programs, where admissions and discharges are gradual enough so that there is moderate stability of membership. When the staff team itself remains constant, opportunities for staff development, training, and leadership increase.

Patient government will depend to a large degree on average length of stay. In acute units (average stay 1 to 3 weeks), patient government may not be possible. If there
are enough responsible patients to make it work it can be useful, but it needs active collaboration and supplementation by staff, with patients' roles and responsibilities clearly defined. In intermediate-stay units, patients may be able to run at least their own part of the program, with one or more staff as advisors. In long-stay units patients may be given a flexible amount of staff help, depending on their level of competence. The value of patient government for schizophrenic patients lies in its opportunities for enacting roles of real, yet supervised, responsibility. Such experiences open up a variety of possible therapeutic events, both on the level of ego functioning and, less obviously, in the interpersonal transactions involved in the assumption of responsibility.

Specific therapeutic techniques such as psychodrama, art therapy, gestalt therapy, assertiveness training, dance and movement therapy, and other techniques can be useful within a milieu program. The choice of these should be determined by staff interests and the needs of the patient population.

Behavior modification is, in my view, not a specific technique, but a way to conceptualize and implement any therapeutic activity. The concepts may be applied to moment-to-moment interactions or to entire therapeutic programs.

Individual therapy within a milieu program can have a widely varying role. From the milieu point of view, it is important that individual therapy and milieu treatment complement and support one another. The individual therapist can use the events of the patients' daily experience in the milieu to focus more accurately on the intrapsychic issues aroused by the milieu. It is unrealistic to try to recreate the conditions of outpatient therapy by considering the milieu a separate world "outside" therapy. Thus confidentiality should generally be conditional, in recognition of the reality that both therapist and patient are members of a larger community. In fact, sharing of sensitive material in individual sessions is frequently a first step toward sharing it more widely. The therapist can often successfully encourage the patient to take up issues that are important to him with the community. If the secrets shared involve dangerous or self-destructive behaviors, the therapist, I feel, can be more constructive in pointing out why he must share this concern with others in the milieu than he can in preserving confidentiality. With regard to any one patient, these issues may require individualized, sensitive consideration. The point is that too often individual therapy is seen as separate from milieu treatment, whereas it is, in fact, merely a formalized version of the many one-to-one contacts that occur in a residential setting.

Application of Milieu Treatment

The settings in which milieu treatment is used vary greatly, and such variations are necessarily accompanied by modifications in the technique. If we consider the treatment of an acute schizophrenic episode, for example, the application of milieu techniques would be different in an acute-treatment general hospital ward, an intermediate-stay setting, and a long-term psychotherapeutic center. The goals and styles of these milieus are very distinct, and milieu techniques must be appropriately adopted in each case.

In an acute-treatment setting, the goals for treatment of a schizophrenic episode include symptom reduction, some degree of restoration of social contact, and preparation for aftercare. Staff roles will be active with the staff members coming to the patient. Antipsychotic medication will, in most cases, reduce autistic preoccupation within a few hours or days and will enable social contact. Even in a brief-stay unit some degree of support and involvement by other patients can be expected, but staff must take the lead. Evaluation, as an important part of aftercare referral decisions, is also a staff function. A major milieu issue in such a unit is the maintenance of behavior consistent with the expectations of both patients and staff that recoveries will be rapid. Senior staff thus must retain sufficient authority to support the unit culture. In terms of structure, such units function best when small, or when subdivided into small staff teams caring for 5 to 10 patients. This enables a more direct focus on the individual and provides a smaller, familylike social unit for the patient to relate to instead of an overwhelming number of new faces. Small-group therapy techniques can then be employed as a primary modality, with little or no time spent on large community meetings. Within the small group, patients may be able to go through at least a part of the role-paralleling process.

In an intermediate-stay setting (1 to 6 months' stay), important therapeutic work can be done beyond symptom control and disposition—exploration of such precipitating factors as family dynamics, social limitations, work or school problems, recent personal loss, stress, or failure. In addition to identifying such causes, and independent of
whether they may be seen as contributory or secondary to the schizophrenic process, intermediate-stay treatment makes possible some reworking in these areas. This can occur on two levels: 1) on an “as if” level, with transferencelike reenactments of, for example, family patterns within the milieu; 2) in real-world changes, such as a return to school or work, with the support and scrutiny of the milieu.

These reworking experiences require a dynamic, flexible milieu. Even when patients enter as acutely disturbed, it is vital that there be strong expectations for a quick return to active, competent behavior. Thus, therapeutic community techniques can be more fully employed. Senior staff must model the sharing of power and responsibility by doing so with line staff, and must guide the line staff in doing so with patients. Structure of the treatment setting may be more complex than is usual, with patients involved in a variety of different groups, meetings, and activities. This provides a better simulation of the challenges of life in the outside community and provides more varied situations for improving deficient ego skills. Family therapy can be particularly useful, with multifamily as well as single-family meetings offering differing opportunities and supports.

In a long-term residential treatment setting (6 months to several years) aimed at major changes in personality and the repair of early developmental deficits, the milieu plays an important collaborative role with individual psychotherapy. Unlike psychoanalytic psychotherapy with outpatients, where the patient takes responsibility for acting-out behavior, the patient, the therapist, and the therapy are all part of the milieu. While a degree of privacy may be necessary for the psychotherapy relationship, major developments should be shared with the milieu staff and vice versa. In fact, recent examples of the dyadic model do not make such a clear division between psychotherapy and milieu staffs.

In long-term milieus, it is possible and desirable to establish a full program of activity appropriate to the age and needs of the patients. Thus, school programs, jobs, recreation, and social relations—both intramural and extramural—should be provided for. Emphasis should be placed on group and community meetings that are relatively structured and that relate to the real roles and responsibilities of the patients in the setting. While latitude must be allowed for individual creativity and for periods of regression related to the psychotherapy process, this must be carefully distinguished from patients' use of the milieu for resistance. This is especially true when the pathology of several patients combines in an antitherapeutic culture. Limit setting, and guidance toward more appropriate handling of affect is as important here as it is in brief-stay settings.

Whatever the setting, clinicians can take advantage of the standardized measurement instruments now available for assessing the qualities of milieus (for example, see Moos 1974). Using such tools it is possible to monitor, compare, and develop aspects of treatment environments with greater certainty. Outcome research is now beginning to relate milieu features to posttreatment status (Robert Ellsworth, personal communication).

Summary

Milieu treatment has been discussed here as a set of considerations in the creation and operation of mental health settings that care for patients on a more-than-outpatient basis. Considerable experience has been gained in the application of milieu techniques in the past 25 years. At the same time, the variety and tasks of milieus have increased and become more complex. This is particularly true for the schizophrenic range of disorders, where the problems encountered may range from management of acute symptomatology to rehabilitation of the chronically institutionalized. The practitioner of milieu treatment must provide for both the individual and the organization. The best planned program cannot succeed with poor staff morale or a hostile patient group. Thus the leaders of such units must be sensitive to phenomena of the institution's social system as much as to individual pathology and dynamics. The resources and limitations of the program’s mandate, the strengths and weaknesses of staff, the ebb and flow of social dynamics in complex organizations, the qualities and needs of the patient population—all require careful attention for an effective milieu. I have reviewed specific aspects of milieu programs—group therapy, community meetings, patient government, team treatment—to consider their place in a wider program. The milieu management of problems frequently encountered in schizophrenia has also been considered briefly.

I have argued here that the best specific program for a given milieu is usually devised by the staff who will implement it. Attention to daily events and planning, which I have referred to generally as “management,” is
more critical than the arbitrary use of particular techniques of therapy. This emphasis corresponds with the importance of developing ego skills and enhancing adaptive qualities in schizophrenic individuals. Similarly, in implementing therapeutic community I have listed a set of general therapeutic processes that facilitate the engagement and change of the individual patient, as well as processes important in maintaining the community as a whole.

References


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