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Learning from the therapeutic community experience in the UK and Japan: Group Culture and Japanese mentality

Aprender de la experiencia de la comunidad terapéutica en el Reino Unido y Japón: Cultura de grupo y mentalidad japonesa

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I am very honored and pleased to be asked as one of a keynote speaker in the 21st IAGP International Congress, titled Groups for the World, Strength, Inspiration, and Transformation

What I would like to talk about today is (1) personal experiences working into therapeutic communities in the U.K. (2) Trying to establish therapeutic communities in two Japanese mental hospitals, problems and difficulties encountered in practicing therapeutic communities' concept, (3) How it relates to Japanese group culture and mentality, and I'd like to add (4) Influence of the Covid-19 experience, and online group.

OPENING REMARKS, THE BEGINNING: A VERY STIMULATING, EYE-OPENING LECTURE BY DR. D.H. CLARK.

The Beginning: In 1967, I was a second-year trainee at the Psychiatric Department in Tokyo University. During my training, I had visited large national and municipal mental hospitals in Tokyo and started to work as a part-time psychiatrist at a small private mental hospital on the outskirts of the city. I could not pinpoint why, but it felt dreadful to see patients waiting to be told what to do, or what not to do, by nursing and medical staff.

That year, I attended a very stimulating and eye-opening lecture by Dr. D. H. Clark, then a WHO consultant to the Japanese Ministry of Health and Welfare. He had visited mental hospitals and mental health organizations throughout Japan and produced a report, known as the Clark Report.

He showed a slide of a ward group in Fulbourn Hospital, an English mental hospital. The slide showed a group of approximately 20 patients and staff members, and a mongrel dog in the middle. I instinctively felt the difference in the way the patients were treated at that hospital. Patients and staff and dog seemed to be talking to each other freely.

This was my first exposure to therapeutic community and group therapy.

Dr. Clark argued that mental illness should not be treated in the same way as physical illness. Physical illness is diagnosed by a doctor and, with the assistance of nurses, patients are treated accordingly. However, mental patients should be treated differently. Patients should be helped to understand how and why they suffer and they should have a say in their treatment.

From what I had seen in my training, there seemed to be two groups of patients: 'good' obedient ones and 'bad' aggressive, trouble-making ones. The good ones were treated kindly, and the bad ones strictly and restrictively. Dr. Clark's ideas challenged this and came as a revelation to me.

I then happened to come across a paper by Maxwell Jones in a professional journal, in which he discussed the importance of the nursing staff's role in treating long-term hospital patients. The paper seemed to chime directly with my experiences in the university hospital ward, so I wrote to Dr. Jones directly to ask his opinion on my interpretation of the situation. He kindly wrote back to me, expressing a deep and sympathetic understanding.

We corresponded a few more times until he suggested that I come and work with him in Scotland.

1. Dingleton Hospital (1968-1971)

In 1968, I took the opportunity to go to the UK to experience psychiatric practices there; first in Dingleton, Scotland, and then in Fulbourn, England. I learned a great many things. Firstly, the importance of being aware of your own and others' feelings, and how this requires training. Secondly, how establishing a culture of free talking (allowing patients to have a say in changes to the hospital, for example) was effective. I also observed how reality confrontation, which at first sounded aggressive to me, is necessary for growth. Dr. Maxwell Jones, the superintendent at Dingleton, used the terms 'social learning' or 'painful communication' to explain that we need to confront reality, no matter how painful it might be. My experience in the UK also made me realize the important role that leadership and the organizational structure of hospitals plays in establishing such a culture.

After a grueling ten-day trip from Yokohama harbor, via Moscow, Vienna, Paris and London, I took a train to Edinburgh, and from there to Melrose. I was met by Dr. Maxwell Jones himself at the platform. A tall bespectacled man, he carried my two huge suitcases (no little wheels in those days) to his car without any difficulties. He must have been over 60 years-old then. I must confess I could not offer to carry even one of them, now). He then showed me around various interesting spots, including a village antique shop, a delicatessen, a hotel supposed to provide good wine and food and, at the end, Scott's view, where the Ivanhoe author used to stop his carriage on his way back from London. I was completely charmed by his warmth, kindness and humility.

The next afternoon, I was introduced to a hospital group meeting of maybe around a hundred people sitting in concentric circles. You could not tell who were staff or patients. There were some old ladies at the front, knitting or doing some mending. They made me, the foreign newcomer, feel welcome. As we chatted, despite language difficulties, I felt amazingly relaxed and accepted. I felt the power of the group, not pressure, for the first time.

GENERAL STRUCTURE OF THE HOSPITAL

The day in Dingleton began with a meeting and ended with a meeting. All staff, from kitchen, engineering and cleaning staff to the Superintendent, spent most of the time in groups discussing their work and examining the feelings which arose while working together. The first meeting started at 8.30am followed by the community council (C.C).

The 8.30am meeting happened every weekday with executives, namely the superintendent, the hospital secretary, the chief nursing officer, and the head of the social work department. Even though I was a junior doctor, I was fortunate to be invited to join these meetings which were set up to discuss and deal with requests from the government and other executive issues. What was discussed there was relayed to the hospital meeting (C.C.). The C.C. was attended by representatives of every part of the hospital, including nursing staff, PSWs, team secretaries and patients who had topics to bring up. Every single thing was discussed in the C.C.

Now, this is Maxwell Jones in his mid-70s (Figure 1) This is Dingleton hills from above. And this is the front of the hospital. I used to live the top of the entrance called matron's quarter.

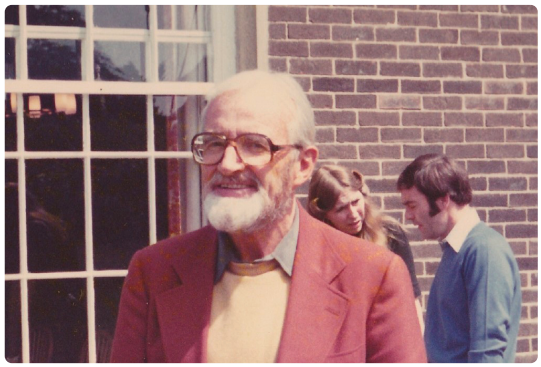

Figure 1. Maxwell Jones, at IGAP Congress in Copenhagen

LANGUAGE PROBLEMS. SCOTTISH BORDER DIALECT

Let me talk about languages as disturbance next. Dingleton hospital was situated near the top of a hill in Melrose, Scotland, in what is known as the Scottish Borders.

The Scottish language itself is quite different from the English we were taught. Border dialect is different again. The language people used there was utterly

incomprehensible for me in the beginning. For example, a nurse said 'A dinnae ken' with upward intonation. I did not have a clue what she was saying. It later turned out to mean 'I don't know'. Of course, this language was used in any group situation, including business meetings and therapy groups.

Trying to overcome these difficulties, I concentrated on using all the senses I have: listening (not only to the meaning but intonation, accent and phrasing) watching and even smelling. By utilizing all the senses, I became able to see what was going on in the group better, while not fully understanding the meaning of the language itself.

A colleague of mine from the Dingleton period pointed out in his recent letter:
"*What I remember from that period is your sitting in groups, not understanding all that was being said, but noticing the non-verbal interactions, and raising questions in the reviews about those. It showed me more clearly how important it was to notice the hidden agenda."*

SCHIZOPHRENIC LANGUAGE

The next thing is 'Huntlyburn Project'. I was one of the initiators of the 'Huntlyburn Project'. Huntlyburn was a big house owned by a gentleman who had made it available to Dingleton hospital to use. We decided to use it for the chronically very disturbed schizophrenic patients to live together with nurses and myself as a doctor.

We worked together, painting the walls, doing repairs, cooking meals, making the beds, and having group meetings every evening. The project itself was a wonderful experience for me and I learned a great deal. However, it is 'language' that I would like to mention here.

After some weeks at Huntlyburn, staff at the main hospital pointed out that my use of language was becoming strange. I had developed the patterns of schizophrenic language, as though my thought processes were disturbed. I had no idea what was happening with my language, but I realized that I might have taken on features of Schizophrenic thought and language patterns.

CONFRONTATION WITH NURSING STAFF

After being assigned the role of an admission ward doctor, I spent almost all my free time studying case files of the patients on the ward and talking to them. I thought it was quite a natural thing to spend long hours on the ward as a young registrar and felt that running the ward was my sole responsibility. One morning, I was told that there would be a crisis meeting and I should be there. Initially, I was excited to attend such a meeting not knowing it was in fact a confrontation meeting about my own conduct. The nurses claimed that I spent too much time on the ward even late in the evening and accused me of not trusting them.

I was baffled by their aggressive attitude. As far as I was concerned, I was fulfilling my basic duties and had not paid much attention to what the nurses were doing. In my arrogance, I told the nurses what I felt about their work, not understanding much about the meaning of their work.
It was painful to be a target of what I saw as unreasonable aggression. However, it dawned on me that I was not conscious of how the other staff were relating to the patients. This experience made me realize the meaning of teamwork.
Maxwell Jones' objectives:

- Use the total resources in the hospital.
- Emphasis on the free communication.
- Daily community meeting.
- Active involvement. He always said to me to get involved.
- Understanding the hidden agenda through social analysis, aiming at changes and personal growth. Changes and personal growth are another slogan. Maxwell always spoke about.

2. Fulbourn Hospital (1971-1974)

Now, after two years of experience in Maxwell Jones and Dingleton Hospital, I went to Cambridge, England to Fulbourn Hospital.
As I said in the beginning, Dr. David Clark was the superintendent of Fulbourn Hospital. He assumed his superintendent position in his early thirties and was a very strong leader of the whole hospital.

Figure 2. David Clark, at Kegonnotaki, Nikko, Japan

He was a very strong leader but a democratic one. David was usually ebullient and could be overbearing, but he knew he had a tendency to 'steamroll' people and was happy to be told to 'shut up'. I was quite good at stopping him.

Fulbourn was run basically on therapeutic community lines. The basic atmosphere of the hospital was free and egalitarian. It had a so-called 'Industry' for work activities, an occupational department for artistic and manual work, and hostels for patients to live in after being discharged from the hospital.
David was also a practical person who had found that administering a huge hospital needed a different approach than a smaller institution such as Henderson or Dingleton.

He had great insight into human nature and was a skilled administrator. He was neither particular about details nor keeping up appearances, but rather he was excellent at weighing up situations and making spur-of-the-moment decisions.
Therapeutic Community, as you know, are divided into two types. One is Dingleton type, and one is Therapeutic Community Proper, like Fulbourn.

Now, after 3, 4 years of Fulbourn experience, I came back to Japan.

3. Coming back to Japan

I initially tried to introduce the Therapeutic Community concept focusing on R. N. Rapaport's observations, because I thought that slogans like Democracy, Egalitarianism, Permissiveness might be more easily understood and accepted.

I wrote several papers introducing the concept and theory, with practical suggestions on its implementation. I also translated Max's recent publication, 'Beyond the Therapeutic Community', for Japanese practitioners. Both publications received a quiet reception.

Just over 2 years after returning to Japan with eager ambition, I was offered the directorship of a 250-bed private mental hospital in a rural area of Chiba prefecture. By then, I was more aware of the state of the mental health scene, as I had been working as a researcher in the Tokyo Research Institute of Psychiatry. I had made extensive trips to research public and private mental hospitals and Japanese mental health in general.

With my experience of therapeutic community in the UK, and my research findings and thoughts that had developed in the intervening two years, I started my directorship with some clear objectives:

- Establish a culture of free talking.
- I thought 'Freedom' was essential for the patients and staff.
- Create a system in which decisions were made through open and free discussion.
- Set up group situations as an essential part of hospital activities. i.e. set up regular ward meetings.
- Try to respect any comments from any person, staff or patients.
- Try not to show my expertise in psychiatry, therapeutic community, or group therapy, but rather be one of the team members. Be careful not to be put on a pedestal.
- Use group analysis and group dynamic understanding to clarify problematic issues arising in daily hospital practice.

Additionally, I was keen not to talk about 'The Therapeutic Community' too loudly. I had seen new concepts and theories changed in Japanese culture while keeping the same imported labels. For that reason, I put the practice first and the name last.

I was aware that the introduction of a new method or practice to a mental hospital was an almost impossible task, so I sneaked in by the back door, so to speak. Thinking back on that time, I now see that I was brave but naive. There were many difficult issues to overcome, such as how to prevent the 'sloganization' of the concepts of democracy, freedom, responsibility, and permissiveness. I also knew I would need to have comrades working with me. The first thing I did was to convene informal study-discussion evenings with the two senior nurses and a pharmacist. They talked about the difficulties of daily clinical work and I listened. This was a good introduction to the hospital for me.

Away from the hospital, I started to form training group psychotherapy groups for psychologists, PSWs, nurses and psychiatrists for group experience and group supervision, which were organized on the therapeutic community principal. These groups joined with other groups, which would later become the Japanese Association of Group Psychotherapy.

From the beginning, I stressed the importance of creating theories by ourselves from observation and experience of groups, instead of copying quasi established theories.

Through my work, I began to realize there were differences between Japanese and British group mentality - Japanese group dynamics seemed to require a different kind of formulation. Thoughts and experiences of 'the group' and

the influence that it exerts on people have been a major part of my professional life over the last fifty-five years.

4. The problems I encountered practicing therapeutic community Principles.

Of course, developing a new system in ordinary Japanese hospitals was met with various levels of opposition and resistance, both conscious and unconscious. Adding to this, Japanese behavior in a group seemed different from British behavior.

FORMING GROUPS

I noticed that the Japanese liked to form groups quickly and did not want to examine their feelings. Any negative feelings tended to be smoothed out by a quasi warm and kind attitude. Group members wanted to believe this atmosphere as the real one, but it often had the effect of sabotaging the formation of real group bonds and the ability to look at the inner feelings they had been experiencing. This can happen in any culture, but is made more likely when groups form too quickly in this way.

DEMOCRACY AS A STUMBLING BLOCK

In a letter before he died in 1990, Maxwell Jones remarked that therapeutic community principles would be very difficult for me to introduce to Japanese mental hospitals because there was no democracy in Japan. I thought at that time that democracy did exist and was practiced in Japan, but I did not fully understand his comment. However, I have been thinking about what he meant by democracy since then.

Democracy has to be practiced rather than sloganized.
In a hospital, practicing democracy means to listen to what patients really feel. To make this possible, as I stated earlier, establishing a talking culture is essential. We need structure such as group meetings and activities in order to enable this.

ACTIVITIES AND WORK PROGRAMS

Most of the ordinary 'good mental hospitals' in Japan have in their work programs, activities including annual festivities (bon-odori and others) sports days, bazaars, and garden parties. Patients take part in the organization of these activities and enjoy them.

A problem is that, although hospital staff try to stimulate their patients' initiatives, they may be too directive and not allow patients to work in their own way. Activities and programs tend to be viewed as good entertainment for patients to enjoy, rather than integral parts of treatment. Activities are often prepared for the patients and organized at the convenience of the staff.

It is curious to mention here that activities and programs should be organized by staff and patients *in cooperation* and, above all, patients' initiatives and creativity should be encouraged. Maxwell Jones, when visiting the OT department in Matsuzawa Hospital some 70 years ago, commented that very few of the patients would wish to be discharged from the hospital because of the way the nurses were coddling them. Making patients dependent on staff makes the staff depend on this kind of relationship, and vice versa.

COMING IN TO A GROUP

It is no exaggeration to say that my initial experience of the large groups in Dingleton determined the way of my professional and personal life. When you participate for the first time in a group, you immediately sense the special group atmosphere, especially acceptance (or not). This experience influences the relationship between newcomers and the group.

Earlier I talked about how Japanese groups can form very quickly. Such groups do not necessarily accept a person whole-heartedly, rather they do so only on a superficial level. Only groups which are ready to engage in a real interaction create the special atmosphere which allows newcomers to feel part of the group. When this happens, it influences the group and its members deeply.

5. Covid 19 experience and closing remarks

Now I'd like to touch on a little bit on COVID-19 influence on the group and my experience from being online. We cannot feel good when you get into the online group. You saw this on the wall of people's faces, but we cannot feel the group atmosphere. Our abilities to sense nonverbal aspects of the communication become limited. As a result, we have to heavily rely on the verbal contents of the communication. This is the difficulty I had to face. And now I am sorry I was somehow coughing a lot. My talking is a bit unclear. I hope that you can understand some of them. Thank you very much for listening. Thank you.