Social Systems and Psychiatry

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Psychiatrists, like politicians, would seem to be in danger of losing credibility. This trend is probably a healthy one if it forces us to re-examine the whole purpose of the "mental health profession." To start with, these three words are suspect.

"Mental" raises that old bogey of one part of society being O.K. while the other part is not O.K. The dichotomy changes with the course of history. The not-O.K.'s "progress" through the centuries from victims of demoniacal possession to heretics when the church was the dominant force in society. Then as the state took over we had witches and then lunatics. Now that the "sickness" concept is in vogue (for the past 200 years), we make enormous efforts to substantiate our position as that of doctors treating disease. But in many ways we seem to be losing ground.

The use of the term "health" seems to be largely a myth. All of us could probably be more healthy (whatever that means) if we placed a high priority on the optimal function (physical, mental, emotional) which any one individual is capable of achieving. But to do so would mean change from a largely conformist culture, dominated by the forces of power and money, to a more flexible and spontaneous way of life.

And, finally, the word "professional" is beginning to look a bit "tatty" in many people's eyes. Those temples of wisdom, the universities, are no longer seen as sources of a highly prized preparation for a successful career but may lead to unemployment and disillusionment, and as we shall discuss later, the nonprofessional is playing an increasingly important part in social organizations for change.

I'd like to develop these three themes further and suggest a possible solution in terms of systems theory and the adoption of open systems.

The concept of mental illness treated by doctors in mental hospitals or other psychiatric facilities is being re-examined in many ways. Many psychiatrists delight in vilifying state hospitals and have achieved what many regard as a solution by the development of community mental health centers. In fact the Kennedy administration in 1963 made this effort part of a national policy. A very fair appraisal of the whole development is offered in a recent H.E.W. publication.[1] Various authors are quoted, and their reactions range from approval to disapproval of the current trend to depopulate mental hospitals and to find alternate accomodation for the

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patients in the community. But in most writings in this field the mental hospital is treated as a "dead duck" incapable of resuscitation. To me this seems unfair and unimaginative. After all, approximately 150 years ago we reacted against the punitive, prison-like lunatic asylums of that day, and for a short time the so-called moral treatment approach was favored. Relatively small institutions were run by a staff who treated patients as people, and humane values prospered. But the tide soon turned against the so-called insane, who without any compliance on their part were labeled as "sick" and compelled to be "treated" by doctors.

The concept of madness is as old as history. Szasz has documented the history of madness and society's primitive reactions to deviancy throughout the centuries. He feels that as far as mental hospitals are concerned little has changed through the centuries.

> Institutional psychiatry is largely medical ceremony and magic. This explains why the labeling of persons – as mentally healthy or diseased – is so crucial a part of psychiatric practice. It constitutes the initial act of social validation and invalidation, pronounced by the high priest of modern scientific religion, the psychiatrist; it justifies the expulsion of the sacrificial scapegoat, the mental patient, from the community.[2]

The dissatisfaction that many psychiatrists and others in the mental health field feel with the present attitude toward deviancy, mental illness, and crime is epitomized by our concepts of "treatment." These range from the physical treatments common in mental hospitals (drugs, electric convulsion therapy, psychosurgery, etc.) to the individual psychotherapy of private practice, with community mental health centers somewhere in between. All these methods are based on the premise that there is a disease process which can be countered by physical or psychological treatments.

I would like to follow a totally different trend which is gaining momentum, and is based on the belief that environmental forces are of primary importance and that the concept of "disease" is in most instances an artifact which is perpetuated by the vested interests of psychiatry and which forms the basis of teaching in most medical centers.

If we assume that the social environment initiates the process of change, in the direction of deviancy, then we must follow this evolutionary process from childhood onwards. First let us look at the social forces that impinge on the child at school.

Even in elementary school, children have the *capacity* to understand the dynamics of behavior, but their teachers cannot impart such knowledge because in most cases they lack the necessary skill themselves. Take an eight-year-old boy who is aggressively demanding toward his peers, but who ingratiates himself with his teachers. He is given favoured status by the teachers because he knows how to please them, and can be trusted not to overlook shortcomings in his classmates; in other words he helps the teacher to keep them in line. Here we have the ingredients of a successful later entrepreneur. Does the teacher really want to reinforce these essentially success-oriented values? We hope not. But can the teacher see in this situation a possible reflection of the frightened child of an overbearing

father, whose wife's only ability to cope is by submission? Even if the parents *were* known to the teacher and the impact of their behaviour on their child was obvious, would the teacher be in any position to help his pupil? Nearer to the teacher's area of influence, would he ever learn the contradiction between the boy's helpful, ingratiating behavior towards *him,* and his overbearing attitude towards his peers?

This vignette typifies the problem in relation to education. It raises the basic question: what are the schools supposed to accomplish? Is preparation for a satisfying and fruitful life the primary responsibility of parents, or teachers, or is such preparation left to the uncertain pressures and prejudices of the child's own peer group? The social structure surrounding most elementary school children is haphazard at best. Information sharing, *i.e.* communication of facts and feelings, seldom flows with any freedom between the interfaces of home, classroom, and playground. In this context the child may identify with any one of these areas and "grow" in relation to the aims and expectations of one or more of these social organizations.

But this "growth" may be imitation of and conformity to the mores of one particular group or groups, rather than the outcome of a social learning process.* This lack of a cohesive social structure would appear to be a root cause for much of adults' intolerance of youthful "deviancy," and for the lack of trust so characteristic of the young person's perception of adult institutions.

The need for a social organization where the communication of thoughts and feelings (social interaction) between people of all ages can be a daily occurrence would seem to be self-evident. Nevertheless, this goal is seldom conceptualized, far less practiced. Indeed the opposite trend is more clearly in evidence. Part of the function of a school is to free the parents to "do their own thing" without interference from their offspring. Clearly some degree of insulation between the age groups is called for, particularly in a competitive society, but even the opportunity for shared social intercourse in the evenings is now largely taken over by the emergence of endless television programmes, usually featuring violence or other questionable social values.

All these trends are understandable and can easily be rationalized, but can we escape altogether from an uneasy feeling that modern living is cell-like and frees us to a great extent from responsible social roles? The ultimate outcome of this trend is readily seen in the plight of the deviant, the underprivileged, the mentally ill, and the aged, where in extreme cases a supportive social structure is virtually nonexistent.

My argument is that unless society assumes responsibility for the social environment in which young people grow up, and unless adults are willing to listen and learn from youth, the world will remain a jungle, where individuals feel isolated and vulnerable. Fear and anxiety propel most people to form relationships which offer some degree of understanding, and a group identity, but no opportunity for social learning.

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*By the term "social learning" I mean two-way communication in a group, motivated by some inner need or stress, leading to overt or covert expression of feeling, and involving cognitive processes and change. The term implies a change in the individual's attitude and/or beliefs as a result of the experience. These changes are incorporated, and modify his personality and self-image.

Arthur Koestler[3] sees the purpose of education as "catalyzing the mind," and goes on to say that "man cannot inherit the past; he has to recreate it." For him the essence of education is discovery *for oneself* – a process of reliving a problem and resolving it largely by one's own efforts. Starting with the basic assumption that there is nothing new under the sun, the reliving of problems which are new to the individual, but previously have been solved by others, imbues the experience with a quality of creativity, *i.e.* a positive emotional experience which has the personal stamp of a living learning situation. The opportunity for such experiences is greatly enhanced by the intervention of a catalyst (educator) who helps the student to proceed along the road to discovery, but leaves the actual process of problem-solving to the student.

In this context education becomes an evolutionary process with ever-widening parameters as new discoveries are made, and the student relives other people's earlier discoveries. For the purpose of this treatise problem-solving is limited to social interaction. This concept sounds deceptively simple, but who can reconcile differing ideologies as they relate to problem-solving? The educator, for example, may espouse the concepts of Freud or of Jung, for whom problem-solving procedures took largely different forms.

The nature or direction of the change cannot be predicted, but in the final analysis is determined by the quality of the various individual inputs and by the capacity of each group member to listen to his peers and to compare his own attitudes or beliefs with those of the other members. Such a process is largely foreign to our culture, where competitiveness, one-upsmanship, inattentiveness, selective listening, or passive memorizing are more characteristic of a classroom experience, or of education generally. Nor does the presence of a facilitator insure that the group will address itself to learning as a social process. Although his function in theory is to help the group to help itself to problem-solve, learn, and grow, his attitudes, beliefs, and values inevitably show through, no matter how "objective" he attempts to be.

In brief, social learning is a very limited concept and relies on a system of beliefs which at this time are incapable of proof. But it does afford one alternative to the current stereotype of teaching in schools where the role of the pupil tends to be that of a passive listener, and where the excitement of discovery and learning as a social process is all too rare.

When education is largely based on this stereotype of teaching, it is no wonder that social learning is relatively uncommon, and that attempts to introduce it to the school system usually encounter strong resistance. This is understandable because teachers can only teach what they themselves have been taught. In much the same way a doctor is taught his discipline at medical school, but when he starts in general practice, he has to learn from his fellow practitioners and may fail dismally at this social learning aspect of his role.

Family life may in some circumstances offset the limitations of education at school, but it is a rare parent who can use "here and now" situations involving conflict for social learning with any consistency.

If we are to learn about learning, a new philosophy of education has to

emerge. Information sharing and memorizing of facts are clearly necessary as one aspect of education. Their importance may be distorted by the present examination system, but that together with the relevance of many subjects taught is not germaine to this discussion. What does matter is the introduction of social learning into the school curriculum or whatever social system (prison, factory, church, etc.) we are involved with.

The physical structure of a lecture theatre or classroom epitomises the dilemma when we attempt to introduce social learning. The lecturer or teacher literally occupies the center of the stage, being the only person that everyone can see without craning or turning around. Clearly the expectation is for communication channels to flow to or from him rather than randomly between any two people in the room. Eye contact and other forms of nonverbal communication, even if thought to be significant, cannot occur between most people in the room, other than between teacher and pupils.

To change this physical organization, and replace it with something like a Greek theatre, or saucer-shaped auditorium, where everyone is relatively visible to everyone else, is to alter the group's awareness of its members and enormously increase the possible varieties and quality of communication.

When a teacher abandons his podium, and the pupils their desks, and everyone sits in a circle, we create a new social structure in the physical sense, and it is a relatively short step to informal interaction between any two people in the group. But established patterns die hard, and for a time the communication still tends to flow from teacher to pupil and back again, and so on, *ad nauseam.*

Here we have the basic element of free communication, at first in the sphere of information-sharing and later, if confidence grows, in the relationships of individuals to the group at a feeling level. We are introducing a comparatively new element in this interactional situation – *i.e.*, nondirectiveness. The class is no longer passively following the leader (teacher) along the formalized lines of subject matter, but is beginning to explore the world of spontaneous interaction. Anyone who has attempted this transition to social learning knows the enormous built-in resistances to such lowering of personality barriers or defenses, based on the universal need to hide much of one's identity from the world at large, or even a specific class or group.

In our culture the idea of "illness" sanctions such intimate disclosures between the medical profession and the subject and/or his family. And this intimacy requires a vow of secrecy between doctor and patient, the so-called Hippocratic oath, which if taken too seriously may be a hindrance to later social learning.

But trust based on such a flimsy pretext as the realization of a certificate to practice medicine lacks the evolution of a learning process which concerns us here.

In general it could be said that the word "treatment" is a device frequently used (or abused) to free up communication channels between the professional and the patient.

It would seem far more reasonable to widen the concept of treatment to include social learning, which if learnt at an early age in elementary school, and reinforced by parents and social institutions generally, could in the

course of generations of evolution, transform our present day culture with its negative attitude towards deviancy.

If problem-solving came to be considered as being as important a skill as, say, mathematics, or chemistry, and was an essential part of every school curriculum, the role of the student (and of the teacher) would change dramatically, and society would become more tolerant and understanding.

It may be unrealistic to think of a culture in which problem-solving and social interaction skills are firmly established; but what could do more to prevent the isolation and stereotyped values of our time? A value system based on understanding what lies behind behavior might change our preoccupation with wealth and power, and lead to a more humane society which cares for all individuals equally.

Social learning may take decades before it becomes a significant factor in school practice and in the development of children at home, but already there are hopeful trends, *e.g.*, the interest taken in the relatively few open schools in existence, and the social learning approach epitomised by the work of Glassner,[4] Silberman,[5] Rogers,[6] and many others.

In the meantime, we have a legacy of mentally handicapped people to treat, and psychiatry has not as yet evolved any clear and consistent approach to this problem.

Let us start with residential communities.

Systems Approach to Residential Treatment

I believe that the social organization in which one works, *e.g.*, a hospital or ward or hostel, is as significant a factor in change as the individual skills (psychoanalysis, etc.) which we possess as mental health workers. In other words, a patient's "recovery" may be determined as much by the social forces in his environment as by specific treatment modalities. And yet the training of most mental health workers is largely based on our ideas of psychopathology and treatment, both by psychotherapy and chemotherapy, and to a great extent ignores training in theoretical concepts associated with communication theory, learning theory and social systems theory. In my experience, departments of psychiatry in universities may have outstanding professionals in mental health practice and research, who work, however, in an environment of distrust, rumour, rivalry and miscommunication which is the antithesis of a learning environment.

The potential for growth in such a system is largely absent, and one is tempted to ask if professionals who cannot deal with their own interpersonal problems, rivalries, etc., are suitably qualified to treat patients. In this context, the training of staff and treatment of patients can be seen as overlapping areas of learning and growth.

To simplify my argument, let us imagine a psychiatric ward of say thirty patients with maybe ten to twenty staff. An analysis of the social organization will give some indication of the roles and role relationships of the staff and patients. This in turn will highlight the expectations of the social system. Perhaps the role of the patient is to be sick, and unwittingly his illness patterns are reinforced by admission to hospital. Little or nothing may be done to involve or develop a positive self-image. The psychiatrist traditionally follows his own bent as a psychotherapist, organicist, or

whatever. The functions of the other team members are largely subservient to his treatment bias, while the patients passively submit to this treatment regime. I have deliberately parodied the situation, which I hope is rare in an age when multiple leadership in a multidisciplinary setting is rapidly gaining favour.

Let us skip the process of change to a more democratic egalitarian model, which may take at least several years, and look at what I would call a favourable outcome.

This model of a therapeutic community (what the behavioral scientists call an open system) would entail frequent, preferably daily, meetings of all patients and staff, where the patients experience a supportive environment which encourages communication of both content and feeling. The role of the staff is to open the door for such information-sharing by their relationship skills, both natural and acquired through training. If these are largely absent, the patient/staff meeting (or community meeting as it is often called) will come to be dreaded by both patients and staff because "nothing happens" and no one's self-image is enhanced. In brief, no group is better than the people in it. But if the relationship skills of the staff have already been assured by appropriate selection of individuals who can stand the scrutiny of their performance in these daily community meetings, and have a basic training in group dynamics, systems theory, and psychotherapy, then something positive does begin to emerge.

The process of change in the direction of a more effective use of the social environment (the community meeting representing a microcosm of the ward life) is greatly helped by a daily staff review of the community meeting, immediately following the patient-staff meeting.

In my experience staff usually try to avoid what is potentially a painful learning situation. The doctor may be too busy, or the nurses express a concern to get back to the patients (by having coffee in the nursing station, well insulated from the patients!).

My preference for this review is to attempt to "process" the meeting. How did it start, did patients and staff arrive in time, who spoke first, etc. All staff have been exposed to the same interactional situation but will react individually according to their personalities, training, and status. In order to catch the process of change, the sequence of events, *e.g.* content at both conceptual and feeling levels, non-verbal communication, the emotional climate of the meeting, themes which "catch on" and involve everyone, non-sequiturs, avoidance mechanisms by both patients and staff, have all to be relived as far as possible.

Resistance to such a detailed scrutiny of staff performance can take subtle forms. An amusing anecdote about a patient which is not related to the "here and now" of the meeting, deferential respect for the status of staff members which inhibits the free flow of communication, the silence expected of the new staff member, especially in the lower status levels, fear of not saying the "right thing" or of ridicule, are all common. After all, who wants to have his or her performance scrutinized daily? Only people who are motivated to learn and who welcome an opportunity to see themselves through other people's eyes. We are approaching the concept of a therapeutic culture where criticism is linked with a positive function of

growth and not the negative "put-down" function commonly attributed to this term.

In brief, I have tried to touch on the dynamics of change and learning which can emerge from a daily scrutiny of staff/patient interaction in a community meeting followed by a staff review, preferably lasting as long as the community meeting. To me this represents a training opportunity *par excellence,* often avoided because learning is a painful process.

Clearly the success of such reviews is dependent on many variables which I will not elaborate here. But the quality of training of the staff, the nature of the patient population, the sanctions of the governing body, and above all the skill, enthusiasm and integrity of the leader or leaders are of paramount importance.

Given a social organization based on interaction at ward level, many other aspects of a flexible social system follow. Staff meetings to examine the attitudes, feelings and beliefs of the various staff members will usually lead to an examination of the authority structure, delegation of responsibility and authority to the system (including the patients), shared decision-making, consensus, and so on.

The model that emerges will inevitably reflect the attitudes of the staff, particularly those in authority. Such a system, if effective, will be flexible and in a constant state of flux. A new staff member should have an impact on the whole organization, which in turn has a responsibility to use the newcomer's positive attributes to enhance the treatment goals of the ward.

Let me repeat that such a process of change will take years, but a therapeutic culture, once established, can survive the changes of staff if new staff are motivated to learn and grow. We are conceptualizing a system which has its own dynamic and which promotes change in both patients and staff. Some people recognize a treatment modality loosely called social therapy, but I prefer to think of a social system for change which is complementary to other treatment methods, whether psychotherapeutic or organic. The term "social learning" seems more appropriate to me because the same concepts of systems theory apply to other social organizations such as schools, churches, factories, etc.

Research validation, as is so often the case in psychiatry, is lacking, but who can question the value of by-products such as trust, emergent leadership, social learning, and self-fulfillment, which in my experience are associated with open systems?

The systems approach to behavioral change which I have described is growing rapidly, and implies that each individual in the system becomes aware of other options to his usual behavior. The change in behavior is determined by the nature of the social network to which he now belongs, and through which he now finds a group identity. This contrasts sharply with individual psychotherapy where the change is confined to his relationship with the therapist, and the better understanding of his intrapsychic events.

The very newness of the systems approach has led to much confusion. Long papers are written about the difference between the therapeutic community approach and milieu therapy. In my last book[7] I have tried to get away from the term "therapeutic community" and use the behavior

science concepts of systems theory, organizational development, open systems, etc. The term "therapeutic community" has become largely meaningless because everyone has his own particular idea of such a social organization and this usually means a largely authoritarian model, often masquerading as a democracy, involving both patients and staff. What is so tragic, and here I think nsychiatrists themselves are to blame, is the failure to grasp the need for extensive new training, borrowing from the social sciences. To operate an open system in a residential community seems to me to go far beyond our formal skills in individual and group therapy. The National Training Lab has contributed in this field, but much more is needed and the training departments in hospitals have hardly begun to assume this aspect of their responsibility.

A Systems Approach to Treatment in the Community

Almond[8] has drawn attention to the fact that social organizations that qualify as healing communities can be found in the U.S., epitomised by Synanon. In a religious context, self-denial and commitment to group goals in isolated communities may represent a very potent support system, *e.g.* the Hutterites and the Shakers. He discusses healing communities in three other cultures: the Zar Cult of Ethiopia, the Tensho Sect of Hawaii, and the Zuni Healing Societies.

Mansell Pattison[9] traces the evolution of treatment models from the turn of the century, starting with Freud's individual psychotherapy firmly rooted in the medical doctor-patient model. Then around 1920, the child guidance movement, while focusing on the "sick" child, included the parents as part of the family system. Stemming from this child guidance movement, group psychotherapy evolved in the 1930's. This method started as the treatment of *one* person *in* a group, and it took several decades for the concept of treating *all* persons simultaneously in a group to emerge. Then, in the 1940's and 1950's, came family therapy, which broke away from the idea of an identified patient, and it was no longer clear who was sick and who was well.

Then in the 1960's came the treatment of larger groups, *e.g.* multiple families (16 to 25 people), married couples – group psychotherapy with 4 or 6 couples in one group, etc. About this time home visitation treatment programs emerged. The mental health professional visited the home of the "sick" person and might seek help not only from the family but also, on occasion, from friends, relatives, or neighbors.

Mansell Pattison notes, "The sixth and final step has been to formalize contacts and relationships between family members and non-family members to include in the psychotherapeutic situation any number of persons who are related by either kinship, friendship, or functional relationship (employer, etc.) or community residence. This social network of relationships then has been made the focus of psychotherapy. In all these instances, the focus of therapeutic work has shifted to the social system of the individual patient, and the therapy of the patient is achieved via change in the psychosocial system."[10]

Thus it would seem that in both hospital (residential) and outside community settings, a systems approach to treatment has been achieved. The two dimensions (intra and extra mural) may be combined, as in Paul Polak's

Southwest Denver Community Mental Health Center.[11] This organization has developed various forms of hospital alternatives, including four houses with 8 to 10 prison referrals in each, six homes where 2 patients live with the home owners, a day care center, an alcohol recovery center run by ex-alcoholics, and so on. But the main emphasis of this center is to involve the community as much as possible. The Center has a citizens' board which is governing, not just advisory, and also a large volunteer programme with one staff member assigned full-time to volunteers' training. Sixty-five per cent of all referrals are first contacted in their homes, and a treatment strategy is worked out with the family system. This is an example of a social systems approach ranging from crisis intervention in an urgent home conflict, to a growing use of community resources, backed up by mental health professionals who are all "generalists" serving on a 24 hour rota. This approach has almost entirely eliminated referrals to the local mental hospital.

When we are talking about a psychosocial system for treatment, our goal is to create a social field which can be of therapeutic benefit to the emotionally disturbed person. In the community we are beginning to use the kinship system to create a social system for change. If there is an extended family structure with close geographical links forming a psychosocial system, a systems approach to treatment may be relatively easy compared with that in an isolated, withdrawn nuclear family. In either case, involvement of friends or neighbors may reinforce or even replace the family kinship system.

A few attempts are being made to involve whole communities in giving supportive care, and this applies particularly to the severely disabled, often suffering the effects of institutionalization in a mental hospital. The Church seems to be becoming more active in this sphere. But as yet we know far too little about the methods needed to create neighborhood feelings of interest and responsibility in helping the needy.

One interesting model[12] focuses on the plight of markedly impaired patients in the community. The staff's goal is to teach those basic coping skills necessary to live as freely as possible in the community. They advocate that treatment is most effective if it takes place in the individual's natural environment. They argue that with this type of patient, unless treatment is taken to the patients, they will soon lose interest and drop out of sight. This would seem to apply to many such patients attending Community Mental Health Centers, outpatient facilities, etc. The staff believe that initially they must assume an extremely directive and assertive approach. Thus they help the patient to get confidence to do his own shopping or to board a bus to work, and so on.

Because the multidisciplinary staff go out to the patient, they need only a small office. This they use as a meeting place and for staff training through discussion of current problems and application of the principles of social learning.

As a kinship system is usually absent with this type of patient, they try to create one through the local YMCA, the church, or any other interested social organizations.

Summary

I have tried to show that the mental health profession, which too often

exclusively follows the orthodox psychiatric view of illness as a disease of the mind or body, can profit from seeing illness also as a disturbance of the patient's psychosocial system. Schools and education generally tend to operate as closed systems with relatively little opportunity for social interaction, information exchange, shared decision-making, social learning, and growth. All our institutions, *e.g.*, hospitals, prisons, churches, etc., tend to be closed systems, which inhibit spontaneity and social maturity.

In an open system, the social forces in the environment can be so organized that the individual becomes aware of his behavior as seen by others. Such a system can help him to modify his behavior by adopting more acceptable behavior patterns. This approach to treatment, sometimes called sociotherapy or psychosocial systems for change, is becoming more familiar and complements individual, group, and family therapy, as well as physical methods of treatment.

If children are exposed to open systems at school and in the home, they may learn the coping skills which will prevent later mental illness and which allow them to identify with a supportive peer group at times of stress.

References

1. Deinstitutionalization: An Analytical Review and Sociological Perspective. National Institute of Mental Health, Series D, No. 4 (1976)
2. Szasz TS: The Manufacture of Madness. New York, Harper and Row, 1970, p. 267
3. Koestler A: Rebellion in a vacuum, in Nobel Symposium 14, The Place of Value in a World of Facts, ed. Tiselius A, Nilsson S, Stockholm, Almqvist and Wiksell, 1968
4. Glasser W: Schools without Failure. New York, Harper and Row, 1969
5. Silberman C: Crisis in the Classroom. New York, Vintage Books, 1970
6. Rogers C. Freedom to Learn. Columbus, Ohio, Charles E. Merrill, 1969
7. Jones M: Maturation of the Therapeutic Community. New York, Behavioral Publications, 1976
8. Almond R: The Healing Community. New York, Jason Aaronson, 1974
9. Pattison EM: Psychosocial system therapy, in The Changing Mental Health Scene, ed. Hirschwitz R and Levy B. New York, Spectrum Publications, 1976, ch. 8
10. *Ibid.*
11. Polak P: Social systems intervention, Arch Gen Psychiatry, 25 (1971), 110-117
12. Test MA, Stein L: Practical guidelines for the community treatment of markedly impaired patients, Community Mental Health Journal, 12 (1976)