Worker Perspectives on Contemporary Milieu Therapy: A Cross-Site Ethnographic Study

Yvonne Smith and Matthew C. Spitzmueller

The term "milieu therapy" (MT) is commonly used in mental health literatures. However, because MT has historically encompassed a wide range of practices, it has invited the criticism that it is simply an attractive theoretical packaging of the time clients spend between other specified interventions, such as individual and group therapies. Some have suggested that, because of its conceptual ambiguity, MT should be abandoned altogether. Despite these challenges, MT endures as a common approach to social work practice in a range of clinical settings. This article describes a study that used ethnography to investigate the perspectives of workers from two mental health organizations that claim to provide MT. By analyzing four themes common to both sites, this article brings exploratory empirical findings to bear on the question of what constitutes MT in contemporary mental health organizations. Participants reported that (a) everything in the physical and social milieu has the potential to affect therapeutic change; (b) the milieu itself functions as a therapeutic agent; (c) the milieu provides a context for modeling and practicing desired behaviors; and (d) MT is a principle-based ethos, rather than a set of specific interventions. Implications of these findings for social work research, practice, and funding are discussed.

KEY WORDS: *community mental health; ethnography; milieu therapy; residential treatment*

The term "milieu therapy" (MT) is commonly used in clinical literatures, often without a clear or operational definition (Delaney, 1997; Wilmer, 1981). Generally speaking, MT refers to the treatment of people in intentionally designed physical and interactional environments, where commonplace interactions around a range of everyday events provide opportunities to promote positive change. MT is sometimes used interchangeably with the related constructs of the "therapeutic community" (Jones, 1956; Wilmer, 1981), "optimal healing environment" (Mahoney, Palyo, Napier, & Giordano, 2009), or "therapeutic milieu" (Wolf, 1977).

Critics have cited a lack of conceptual clarity as cause for skepticism about the validity of MT as a specifiable, researchable, and reimbursable intervention for people with mental illness (Delaney, 1997; Mahoney et al., 2009). Attempts to define MT are further complicated by the fact that it is used by a wide range of helping professions and in an array of settings. These include psychiatric nursing (Mahoney et al., 2009; Thomas, Shattell, & Martin, 2002), substance abuse treatment (Tims, De Leon, & Jainchill, 1994), community mental health practice (Dincin, 1975), residential treatment for youths (Bettelheim & Sylvester, 1948; Crouch, 1998; Redl, 1959; Trieschman, Whittaker, & Brendtro, 1969), and inpatient psychiatry (Visher & O'Sullivan, 1970). Challenges to the approach have motivated scholars to define MT more precisely by focusing on particular aspects of the construct or particular historical strands of its development (Gunderson, 1978; Gutheil, 1985).

Theories of MT commonly acknowledge the role of the environment as a setting in which therapeutic change happens. According to Dincin (1975), "a great deal has been written about the importance of the milieu and the environment. . . . The creation of a therapeutic atmosphere is one of [its] hallmarks" (p. 134). Theories about the "active ingredients" or agents of change in MT vary more considerably. Some authors point to the use of activities of daily living (ADLs) as opportunities for therapeutic change (Visher & O'Sullivan, 1970). Others stress that workers can harness the agency of the total physical and social environment of the program to promote desired changes in client behavior (Mahoney et al., 2009; Thomas et al., 2002). Still others claim that when workers and clients intentionally shape the physical and interactional setting, their actions work in concert with the environment to positively change clients' behavior (Cohler & Taber, 1993). These varied

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definitions reveal a persistent slippage between "the milieu" as a context for treatment and MT as an approach to treatment in itself.

This study adopts a novel approach to the longstanding project of defining MT. Rather than develop the construct from a normative position, prescribing how the milieu ought to be conceptualized and enacted, this study aims to define MT empirically by analyzing the situated accounts and practices of contemporary mental health workers. By using ethnographic methods to examine two organizations that report using MT as a central approach to treatment, this study seeks to build a clearer understanding of what constitutes MT in mental health practice in the contemporary United States. In this sense, it does not endorse any particular definition offered by scholars of MT. This study asks, how do contemporary mental health workers understand MT and what, if anything, do they believe are active ingredients in this approach to treatment?

BACKGROUND

The origin of the term MT is often attributed to early innovators in the residential treatment of children, Fritz Redl (1959) and Bruno Bettelheim (1950). Some also credit August Aichhorn (1935), whose work on wayward children informed Redl and Bettelheim (Zimmerman, 1994). These pioneers in the field of MT worked directly with emotionally disturbed children in residential treatment settings and developed theory from clinical cases, emphasizing the importance of the physical and social environment as an agent in the treatment of children. Though aspects of Bettelheim's work and personal life are controversial (Pollak, 1998; Schreibman, 2005; Zimmerman, 1994), he wrote cogently on the ways that children's physical and interactional surroundings could be used to facilitate affective and behavioral change. He conceptualized his Orthogenic School as a therapeutic environment that could restore healthy identity and functioning to children, a model that was formulated in contradistinction to the Nazi concentration camp he himself survived (Zimmerman, 1991). By encouraging workers to view all interactions—not only psychotherapy—as sites of potential positive change, the work of early residential treatment scholars transformed the group care of children in the United States (Trieschman et al., 1969).

The historical trajectory of MT in community mental health has pursued a related, but somewhat different course. The notion, so central to MT, that everyday life in an institution can be therapeutic for people with mental illness dates to the late 18th century. Social reformers proposed that the "regimen of the house" could be a central component of "moral treatment" (Clark, 1965). In the mid-20th century, Main (1946) applied the lessons of social psychiatry, used to treat soldiers on the frontlines, to the rehabilitation of adults with serious mental illness in hospitals. He posited that a "therapeutic community" should be understood "not as an organization run by doctors in the interest of their own greater technical efficiency, but as a community with the immediate aim of full participation of all its members in its daily life" (p. 947). The concept of therapeutic community is most strongly associated with Maxwell Jones (1956), who argued that responsibility for treatment should not be confined to trained medical staff, but be a shared concern of all members who make up a community. Jones observed that the social interaction of patients has "therapeutic possibilities" even when staff are not present. In the 1960s, the therapeutic community was proposed as a means of humanizing and improving the effectiveness of psychiatric institutions, even as critics argued that "total institutions" produced the very effects of serious mental illness and chronicity that they purported to treat (Caudill, Redlich, Gilmore, & Brody, 1952; Goffman, 1961; Szasz, 1961).

Gutheil (1985) has suggested that there is a strong family resemblance between the concepts of therapeutic community and MT. In settings where treatments take place, patients and staff have a mutual impact on each other, and "the milieu process is dynamic and ongoing" (p. 1281). The early community mental health movement was also strongly influenced by models of MT. Early program initiatives included comprehensive community mental health centers, drop-in programs, and therapeutic milieus such as the clubhouse (Fountain House, 1999), lodge (Fairweather, 1969), and Soteria House (Mosher, Menn, & Matthews, 1975).

Despite the long legacy of MT in the United States, the model has come under critical scrutiny (Islam & Turner, 1982; Wilmer, 1981). Writing in the field of psychiatric nursing, Kathleen Delaney (1997) has argued strongly that MT be abandoned because the practice "lacks a sound conceptual definition" on which the "scientific community" can agree (p. 19). She charged that, without consensus on an operational definition, MT "has become a

therapeutic loophole, a catch-all term that indiscriminately serves as a rationale for the therapeutic intent of any and all inpatient nursing activities" (p. 19). Her historical review of MT highlights the slippage between MT as a unique intervention in itself and MT as a context in which interventions of any kind may be carried out indiscriminately. We agree with Delaney and others who stress the need for a clearer understanding of what researchers and practitioners mean when they use the term MT. However, this study offers a counterbalance to Delaney's charge that "outside of nursing, there is no real interest in the concept and thus no real forum for the debate" (p. 23) and that "research on milieu therapy has stopped" (p. 24).

These critiques notwithstanding, programs providing residential treatment, inpatient psychiatry, substance abuse treatment, corrections programs, and community mental health services continue to report that they provide MT. Although recent statistics are not available for all of these settings, MT may be particularly common in residential treatment programs for children. A recent study has found that 83% of such programs report providing MT (Foltz, 2004). A study by Weissman and colleagues (2006) found that more than half of MSW programs offer didactic training in MT, and almost as many offer clinical supervision in this approach. Moreover, nearly all psychiatric residencies for MDs require training and supervision in MT. PhD and PsyD programs less frequently report offering MT content, but it is covered in 17% and 16% of curricula, respectively (Weissman et al., 2006).

Given the flexibility of MT as a concept and recent criticisms of its therapeutic value, coupled with the fact that it continues to be practiced widely in mental health treatment settings and taught in social work and other professional programs, we believe that it is important to gain a better empirical understanding of what this term means to contemporary practitioners. This exploratory study investigates the perspectives of mental health workers in two mental health programs that purport to use MT. It asks: What is MT, and what, if anything, do workers believe is therapeutic about it for program participants?

METHOD

Data Collection

This article synthesizes findings from two ethnographic studies of mental health programs that report providing MT. Each study was conducted in compliance with its respective institutional review board protocol for the protection of human subjects. At each site, data were collected only from consenting adults. Participants were never observed covertly, and all people present had the right to discontinue participant observation at any time. Pseudonyms are used for both organizations, and participants' identifying information has been altered to protect their anonymity. Both programs were located in a large city in the midwestern United States. Both programs employed professional and paraprofessional mental health workers from a range of training backgrounds. We use the term "mental health worker" to denote all individuals employed by the participating organizations whose work involved the provision or management of mental health services. In both sites, an MSW degree was the most common academic preparation for direct care workers and program managers.

We use the pseudonym University Home and School (UHS) to refer to the first site analyzed in this study. UHS is a residential treatment program for children and adolescents identified as having serious emotional disturbance. Mental health workers included dormitory counselors (direct child care workers), program managers, crisis intervention specialists, psychotherapists, and executive-level management and excluded teachers and other educational staff. The first author conducted 1,500 hours of participant observation of the day-to-day clinical practice, management, and supervision activities of 78 consenting mental health workers at UHS. For example, the first author attended daily shift change meetings, weekly licensed clinical social worker (LCSW) group supervision sessions, group therapy sessions, meals, and special events, and observed workers' direct interactions with clients in residential dormitories. Fieldwork was conducted from 2010 to 2011. Concurrent with participant observation, the first author conducted 36 semistructured interviews with mental health workers and audio-recorded relevant naturally occurring conversations among workers. Clients of UHS were not interviewed during this study, though they were present during participant observation.

Community Club, the second site analyzed in this article, was founded as a stand-alone clubhouse program in the early 1960s. It now provides a range of therapeutic services, including structured group therapy, case management, supported employment, and MT. The second author conducted over 1,300

hours of direct observation of the day-to-day routines of approximately 20 mental health workers, including case managers, program directors, psychotherapists, and executive-level management. The second author attended weekly team meetings, group therapy sessions, and individual case management, and observed interactions in the common areas of the center, such as the computer resource room, the second-floor open lounge, and the dining area. Fieldwork was conducted from 2009 to 2010. The second author also conducted 73 informal interviews and 28 semistructured interviews with consenting workers, and audio-recorded naturally occurring conversations among workers.

Data Analysis

During ethnographic data collection the authors each identified emerging themes. In the iterative process of theory building typical of ethnography (Thorne, 2000), identified themes were independently checked through ongoing interviews with key informants at both sites. For example, at UHS, the first author routinely observed workers using the term "milieu" to refer to shared living areas of the program (for example, the dormitories, dining room, and recreation spaces). To refine her understanding of what workers meant by this term, she directly asked workers in different work roles to define it. She used follow-up questions to probe for examples of how workers attempted to shape the milieu and how they believed it affected particular clients.

Although data collection procedures differed between the two sites, and some data analysis was conducted independently during fieldwork, we jointly conducted data analysis for this article after the conclusion of both studies. After confirming that both studies looked at mental health organizations that claimed to offer MT, we compared relevant themes from both sites. We searched both for areas of congruence and difference in worker perspectives on MT at the two sites and found that there was a high degree of congruence. Four common themes were identified and are analyzed in the next section.

FINDINGS

"Everything Is Clinical"

Workers at both sites commonly described MT as fundamentally concerned with the creation and maintenance of a physical and social environment in which everything—from everyday, casual interactions to the physical contents of the space—had the potential to affect therapeutic change. During a mandatory orientation for new workers at UHS, Edie, the director of compliance, advised,

> Everything is clinical at [UHS]. A thing that I think of when I think of milieu therapy is this idea that our whole day is spent in the therapeutic process. It's not like this is math time. Math time is therapy time for our kids because, like, they're not gonna be able to get through a math problem and you're gonna have to help them. . . . So the therapeutic process with our kids never ends. It's not like they're getting up and getting in the shower and that's easy. For some kids getting in the shower is the most difficult part of their day. So it's important to realize that you're never off duty at [UHS]. . . . It's not [only] this therapy session. It's the whole environment. It's the teachers and the counselors. It's every interaction these kids have.

In an interview conducted months later, dormitory counselor Melanie echoed Edie's insistence that even apparently quotidian events were sites for potential therapeutic change:

> Pretty much everything is a clinical decision when it comes down to it. . . . People don't understand that something as simple as getting kids up in the morning is actually a very clinical decision at the time. . . . Everything you do can have a clinical ramification.

The ideology that "everything is clinical" in MT appeared to extend beyond human "decisions" like the ones Melanie described to include the belief that even the physical environment has clinical impacts on clients. For example, UHS workers regularly dimmed lights or quieted music to influence clients whom workers understood to be "overstimulated" by a busy dormitory environment. They frequently debated how (or whether) to redecorate a dilapidated "quiet room" that was often used by boys whose dysregulated behavior was seen as having the potential to escalate toward a "crisis." During a preshift staff meeting, workers discussed the influence of this space on clients' behavior, suggesting that the absence of valuable objects, such as a television or newer furniture, from the quiet room communicated to clients that this was a space in which they not only could but should act in physically aggressive and

destructive ways. These findings suggest that workers viewed the active ingredients of MT as encompassing more than their verbal interactions with clients in traditional therapeutic contexts such as formal group, individual, or family therapies. Routine interactions that occurred in the course of daily living within the program environment were thought to hold therapeutic potential, as was the environment itself.

Similarly, a Community Club worker named Paul observed that everyday activities there produced ongoing opportunities for therapeutic reflection and behavioral change. He described an interaction that he facilitated among members during a meal served at Community Club. Workers commonly viewed mealtime as an important resource for bringing members together as a community of peers. In this example Paul recalled that members reacted strongly to a peer who they believed was behaving rudely at the table. When members asked Paul to intervene, he redirected them to speak frankly to their peer about their reactions to him. Members told him that he seemed to put himself above them and to disregard their feelings. Paul reported that although the member initially reacted "defensively" to their feedback, he soon admitted that he did not like to think of himself as needing mental health treatment and acknowledged that he put himself above others because it was difficult for him to admit that he needed the support of peers. Paul took this exchange to be a turning point in his treatment:

> It was a real exciting experience. It was what it should be. It was probably a lot more therapeutic than most groups I do here just because it was in the environment. We were working on things as we were talking about them. So we got to work on it and talk about it at the same time.

This example mirrors Edie's assertion that everyday interactions and ADLs hold potential for therapeutic reflection and change. For Paul, the notion that everything is clinical meant that even a conversation between peers over lunch could serve as an "exciting" site of therapeutic change. In an environment in which everything has the potential to promote therapeutic change, workers value opportunities to work on behaviors and talk about them at the same time.

Milieu as Therapeutic Agent

Community Club workers often described the milieu itself as having a kind of agency, or ability to produce change, that both exceeded and supported workers' individual efforts to intervene therapeutically. In other words, workers believed that the milieu as a whole—including clients, workers, and the physical environment—produced collective effects. Community Club workers stressed their belief that membership in the social network of the program was essential to treatment. A worker named Charlie described how the milieu itself helped members to understand how their behaviors affected others. On this occasion Charlie discovered that members were using Community Club's television set to buy pay-per-view movies without permission. Charlie reported that he relied on the collective character of the milieu to educate members about how their actions affected one another:

> There were five that were watchin' the film. Four of 'em flipped over and said . . ., "We've enjoyed the movies under the radar for a while." And the one member's like, "Screw that, I do what I want." And, then the other members turn [to] him and say, "Listen, this affects everybody." When you kind of explain things to members in a way that'll affect large groups of people—you don't want to piss off the rest of the community at you—they recognize that the diversity that the program brings makes everybody stronger. And, with increased options, more people come in and there's a vibrancy to your environment. . . . You might have more opportunities for friendship with more people like you.

Charlie noted that rather than taking an authoritarian stance toward the offending members, he drew on the agency of the milieu to enlist members as collaborators in promoting their collective interest. Members joined in the conversation to remind a headstrong peer that his sneaky behavior affected everyone negatively. Charlie's statement reflected how Community Club workers invoked the milieu to talk about a collective interest that "affects everybody" and that "makes everybody stronger." Members encouraged one another to feel what Charlie described as a sense of responsibility for the milieu as a whole. In this example, when Charlie invoked the concern that "you don't want to piss off the rest of the community at you," he described the milieu as a resource for therapeutic interventions. Community Club workers interpreted the milieu as having its own kind of agency, drawing on members'

shared interests and bringing them into discussion about how best to facilitate them.

Workers at UHS also commonly reported that the therapeutic effects of MT were attributable not to discrete interventions by individual workers, but to the agency of the milieu as a whole. A staff orientation manual distributed to all new mental health workers at UHS provided a list of guidelines for working with UHS clients. It stated,

> Inherent in the concept of milieu therapy is the notion that no individual staff member provides the critical therapeutic experience. Milieu therapy is the result of a group of independent and committed individuals who combine their divergent perspectives into a cohesive program of treatment.

Here, the individual worker is conceptualized as participating in a "cohesive" collectivity through which therapeutic change may occur. Building on this sense that the milieu is a collectivity responsible for affecting change, Melissa (an associate director of residential services at UHS) reported,

> There's something about [the milieu]. It just takes it on its way. . . . Like the flow of the day just goes. It's its own character, or like entity . . . that makes decisions or has that efficacy. . . . And thankfully it tends to move for good instead of evil.

She characterized the milieu as a benevolent entity in its own right with the power to make decisions and modulate the recurring patterns of the day. Other UHS workers sometimes referred to the "magic of the milieu" as the power of the social and built environment as a whole to have therapeutic effects on clients. In one example, workers in an LCSW supervision group debated how best to treat a child diagnosed with posttraumatic stress disorder who frequently engaged in violent imaginary play, such as constructing battlefields and reenacting war scenes involving terrorists. After some discussion, workers agreed that the best way to intervene was to let what they called the magic of the milieu shape his interests in more socially and developmentally normative ways. They argued that the client's experience of being a part of the social milieu of his dormitory would shape his behavior toward more developmentally appropriate activities over time. This response stood in contrast to intervention techniques that might have, for example, limited his war playtime, removed toys from his area, or selectively reinforced alternative behaviors. By developing a plan, in a sense, not to intervene directly, workers identified the influence of the social milieu itself as the active ingredient in the intervention.

A Context for Modeling and Practicing Desired Behaviors and Affect

Community Club workers frequently reported that the milieu provided an opportunity for members to practice new behaviors that could then be transferred to so-called "natural settings." Community Club workers intentionally designed its rooms to have numerous areas in which members could gather and participate in informal social activities. The most frequently discussed element of informal social programming was the second-floor lounge, where loosely arranged chairs encircled a pool table. Members entered and left the lounge as they wished throughout the day. Around the pool table, workers led informal groups, striking up casual conversations with members about a range of topics such as substance use, employment, and housing. Myriad unwritten rules shaped program norms around the pool table, including house table rules and expectations that members would maintain respect in the face of disagreement. Katherine, a team leader, described the lounge as a setting that could "mimic real life," noting that the "stressors" that occurred around the pool table were similar to those that members might encounter "on the streets." In an interview, another worker named Josephine described how workers construed the therapeutic value of the pool table and lounge as a space for practicing appropriate social interaction.

> **Josephine:** Katherine will always say about the pool table and about the disputes, "We don't seek to create animosity." But, in part, because pool is slightly competitive, it's a great resource to get people in that space of negotiation. Where suddenly a conversation or an argument will be stirred because people enter into disputes over what can be said, over bantering going too far, etc., etc.—
> **Interviewer:** —not calling the ball.
> **Josephine:** Somebody pulling the stick back and somebody else walking into their space, and they suddenly have to negotiate their personal

space. And she'll say, "We want to be there right when that happens because that's a moment for therapeutic intervention."

Workers described the milieu as a space where the rules that governed behavior were largely (and deliberately) informal. Within the milieu, members were encouraged to broker solutions to emerging challenges and to negotiate conflicts with the help of staff. In this sense, workers believed that the milieu functioned like any other so-called "natural" setting where the terms of belonging are not formally codified and where people must work through their differences to achieve shared understandings.

> **Charlie:** It's like we're simulating what you'll probably experience in a pool hall; maybe a little worse on some days, maybe a little better on others. . . . I'd rather you learn the effect that you have on other people, and I believe there's something in people that if you come to a program like this, you're learning to try and fit into the larger society, and this is the place where you practice it.

Community Club workers viewed the milieu as a social setting in which members could practice productive coping skills without the threat of being ostracized. On occasion members disagreed with each other, felt hurt, or became upset. Workers contrasted the flexibility and responsiveness of the milieu to normative social contexts in which these sorts of challenges often led to stigma, rejection, and social isolation. Central to the idea that the milieu constituted a site of rehearsal, workers also characterized it as a place where it was "safe" for members to make mistakes and where their differences were valued rather than punished. Charlie described how he managed conflict in the milieu, especially around the pool table:

> I think conflict is great when it occurs in a group. It's such an excellent opportunity to work on shit. . . . Cuz it's something they're going to experience in the community. I don't think you should bottle it up. If you have something that you have a hard time out in a community setting and you want a little safety, protection, and support in learning how to deal with it, the best place is if it occurs naturally within a group.

A similar perspective was taken at UHS. An orientation guide described the milieu this way:

> The structure and consistency of the milieu provides students with a sense of stability, which ultimately allows and encourages them to effectively practice containing and managing overwhelming feelings and emotions.

In this example, the milieu is characterized as a consistent and structured environment in which clients can practice new ways of handling affective experiences that had been overwhelming in other contexts. This understanding of treatment as the supported rehearsal of desired coping skills was evident in UHS practices. For example, workers calibrated their physical proximity and the frequency of supportive verbal interactions to the level of clients' competence at a given activity or their apparent ability to manage their emotional state. They gradually lessened these supports as clients developed the ability to manage on their own, eventually encouraging them to engage in activities "off grounds" (such as neighborhood chess matches or trips to the comic book store) with and then without staff support. Workers understood themselves to be helping clients rehearse the social and emotional regulation skills they believed were necessary to function independently in "the real world."

MT as an Ethos

The fourth common theme is the idea that MT is best understood as an ethos, or set of principles that guide practice, rather than as a specifiable list of discrete interventions. In an interview at UHS, the first author asked co–executive director Dave to define MT. He responded that many different specific interventions might be used within MT, a statement that matched participant observation data that workers used a range of specific treatment techniques calibrated to the needs of individual clients. Dave continued,

> I think, for me, it feels more like an ethos is at the core of the milieu. And that ethos is that children are important, that their needs come first. That emotional expression is both the thing that caused the problems and that will solve the problems. And that taking time to really understand and connect with somebody so that you can have a shared, mutually agreeable, adaptive reality is what helps somebody get better.

Although Dave's definition of MT reflects the relational psychodynamic orientation of UHS—namely, that relationships and "emotional expression" are both a cause of dysfunction and a curative agent in treatment—it is notable that he framed MT as an ethos rather than as a set of specific treatment techniques. Ethos implies a culturally based way of viewing the world—a collective set of beliefs and values that guide practice. The notion that MT at UHS functioned as an ethos was reflected in the fact that workers were often surprised at the relative dearth of formal rules for clients and workers. During a staff orientation, the director of compliance, Edie, advised newcomers that "the answer to most clinical questions at [UHS] is 'it depends.'" Indeed, the idea that what to do in any particular situation fundamentally depended not on formalized rules, but on the particular needs and capabilities of individual clients, workers, or dormitory groups was so familiar that it often elicited a chuckle from workers when the first author mentioned it in interviews. Although one might argue that the idea that "it depends" functions as an ethos itself, it supports Dave's assertion that MT operates in accordance with an ethos rather than a list of prescribed and proscribed interventions.

Although Community Club workers never used the term "ethos" explicitly in explaining MT, they reported that to understand how MT works, one must observe it through a particular "mind-set" or orientation. Ethan, the program director at Community Club, explained that to understand how MT works, one first has to have a sense of what to look for.

> This place in some ways just defies peoples' experience. I mean, it so breaks down barriers and those kinds of structures that you almost have to educate people to look for it, 'cause they don't see it. They just see hanging out. It's almost like some people who walk in here and say, "OK, so when does the program start, where's the program?" And, it's just, like, are you kidding me? But, I still believe that there's a mind-set that can't see it.

According to Ethan, the everyday happenings of Community Club only became visible when viewed through the mind-set, or ethos, of MT. From this perspective, he argued, one could observe the therapeutic rationale of MT activities that might otherwise appear as "just hanging out." Community Club workers operated under organizational pressures to maximize fee-for-service billing in the agency. As a result, they often drew implicit comparisons between MT and other group therapy services offered at the center that more easily conformed to state billing standards. Workers viewed the milieu as an essential complement to structured group programing but often felt that upper-level management unfairly scrutinized it. Community Club workers reported that what critics of the milieu lacked was an ability to see that it exerted a constant effect on members. In the previous quote, Ethan explained how he believed the milieu was often misunderstood, because, unlike structured group services, it did not have a clear beginning or end. Given the apparent informality of the milieu, he argued, it could appear as if workers were not actively engaging in therapeutic skill building. But, according to Ethan, this viewpoint suggested a failure to understand the ethos of MT. This ethos made everyday social activities, like shooting pool, into ones that could be considered therapeutically meaningful.

DISCUSSION

The high degree of overlap in the accounts and practices of workers in two very different programs that reported using MT suggests that a coherent understanding of MT may be operating among contemporary mental health workers. Significantly, in neither site did workers view MT as a euphemistic catch-all term for nontherapeutic activities between discrete interventions such as case management or psychotherapy. These findings challenge Delaney's (1997) argument that MT denotes no particular set of beliefs and operates as a convenient "catch-all" for "any and all" nontherapeutic activities involving clients. Instead, the workers who participated in this study reported a consistent, shared rationale for their approach to practice, and one that resonates strongly with historical formulations of MT.

At both sites, workers emphasized that MT involved the utilization of everyday activities as opportunities for therapeutic change beyond those offered by formal, time-bounded interventions such as individual, group, or family psychotherapy. Workers' common assertion that the milieu was an environment in which "everything is clinical," along with their belief that the challenges of everyday living provided continuous opportunities for growth, echoed the influential assertion of Trieschman and colleagues (1969) that MT is concerned with making

therapeutic use of "the other 23 hours" of clients' days. These findings counter Delaney's (1997) charge that MT is little more than a euphemism for the time clients spend between formal therapeutic interventions, and suggest that her criticism may misinterpret the emphasis that MT places on the therapeutic potential of everyday activities in the milieu. Workers framed a range of quotidian activities, including dining, bathing, homework, playing pool, and waking up, as opportunities to promote positive change in the lives of clients. Workers used these everyday processes to intervene in ways that they understood to be deliberate and therapeutic.

Perhaps the most complex finding of this study is that workers at both sites viewed the milieu as a whole—including the physical environment and all of its interacting human members—as the primary agent of therapeutic change. At Community Club, this ideology was reflected in an emphasis on collective responsibility and the use of the center-based community to shape the behavior of clients. At UHS, workers similarly viewed the milieu as an "entity" or agent unto itself and relied on it as a force for changing problematic behavior. Despite its resonance with some theorizations of MT (see, for example, Mahoney et al., 2009), this finding is surprising because it is at odds with dominant Western notions of action, which implicitly privilege individual over collective modes of agency (Markus & Kitayama, 1991). It is also noteworthy given the tendency of social work research to view step-by-step, individual decision making as the primary mode of agency of practitioners (Y. Smith, 2014a, 2014b).

At both research sites, workers reported that MT assisted clients in "practicing" or rehearsing desired behaviors within an intentionally designed supportive environment. With the support of social settings that "mimic[ed] real life" while providing additional scaffolding (Vygotsky, 1978), workers sought to promote the development of skills that clients could transfer to the larger society. The belief that MT provided needed scaffolding for developing skills for successful living in "natural" communities suggests that workers saw the milieu as a temporary but necessary step toward independent living. Contrary to critics who have charged that institutional care, residential treatment, and center-based "clubhouse" programs deprive service users of opportunities to function in the wider community (Barth, 2005; Bond, Drake, Becker, & Mueser, 1999), these workers viewed MT as preparing clients for just such community integration.

A fourth finding of this study is that workers viewed MT not primarily as a particular set of discrete interventions, but as an ethos, or shared perspective and principles, that guided their practice. From this point of view, many specific interventions might reasonably be used within an MT program based on the extent to which those interventions serve the larger ethos of the program. Workers argued that without understanding the ethos of MT, observers might mistakenly view program participants as, for example, "just hanging out" rather than using an intentionally designed physical and social environment to facilitate opportunities to practice healthy social interactions. This finding suggests the potential utility of principle- or "ethos"-based models of MT, such as the children and residential experiences model of residential treatment (Holden et al., 2010).

IMPLICATIONS AND CONCLUSIONS

We conducted an exploratory ethnographic study of two mental health organizations that report using MT. We examined workers' perspectives on their approach to practice and integrated those perspectives with observations of actual practice. Some limitations of this study should be noted. First, it is important to consider that the two organizations studied, while they served different client populations and provided different modalities of treatment, were located in the same city. Therefore, it is possible that some similarities in workers' perspectives derived from similar education and training opportunities in the surrounding area. Second, this study is not designed to yield findings about the effectiveness of these MT-based programs or of MT in general. Determining the extent to which MT, as workers at these organizations practiced it, can be considered an effective intervention requires different research methods. However, the fact that workers in these two sites defined MT in similar ways does suggest that it continues to be a durable and coherent construct in contemporary mental health practice.

This study suggests that the term MT appears, despite claims to the contrary, to refer to a coherent, unitary approach to mental health practice. To the extent that MT is indeed an approach to treatment with fundamental similarities across organizations that practice it, there is a need for ongoing research on its processes and effectiveness. However, this study also reveals some potential challenges to conducting rigorous and valid research on MT. First,

because the milieu as a whole is considered an agent of change in its own right, studies of MT that attempt to isolate discrete actions of individual workers may miss important processes of client change. Second, because the milieu itself—including its inherently unique combination of workers, clients, and physical spaces—is viewed as fundamental to treatment, it may be challenging to standardize or manualize MT across program sites. And third, MT researchers should be sensitive to the fact that MT appears to be characterized by an ethos or shared perspective that guides practice rather than a particular set of discrete interventions. Without such consideration, researchers may, for example, miss opportunities to track the therapeutic impact of clients' engagement in everyday social interactions or ADLs within the supportive context of MT. To put it somewhat provocatively, viewing MT as little more than "hanging out" is akin to viewing individual psychotherapies as "just talking." Designing valid process and outcome research on MT requires a clear understanding of its rationale.

Despite these challenges, continuing research on MT is essential to understanding how it works and determining its effectiveness. Methods that incorporate ethnographic observation, narrative analysis, and grounded theory may be particularly well suited to identifying strengths, problems, or missed opportunities for maximizing the therapeutic impacts of MT programs. And despite the apparent challenges of standardizing an intervention that relies on a unique physical environment and the everyday interactions of its participants to shape the affect and behavior of clients, we support the value of studying the effectiveness of MT as it is practiced in real-world organizations. For example, it is possible to track client outcomes within a single MT program using single case designs and evaluations of individual programs (Bloom, 1993).

This study also has implications for mental health services financing. Increasingly, states are seeking to "maximize" Medicaid as a mechanism for funding mental health services (V. K. Smith, Ellis, & Hogan, 1999). Driven largely by federal financial participation incentives, this trend restructures both how mental health needs are defined and what workers must demonstrate as a condition of payment (Ganju, 2006; Spitzmueller, 2014). Medical necessity guidelines limit the scope of eligibility to activities that are reasonable and necessary based on evidence-based clinical standards of treatment, replacing social models of care with the medical model (Hoy, 2008). Fee-for-service payments generally require workers to document service delivery as a 15-minute interval of intervention carried out by an individual practitioner. Because managerial innovations privilege an individual model of agency where the worker is assumed to be the lone site of therapeutic action, they may be at odds with workers' understanding of MT as a collective form of clinical agency.

Finally, this study has implications for social work practice. Despite claims that the popularity of MT is (or should be) waning, Weissman and colleagues (2006) found that more than half of schools of social work continue to teach curriculum in this area, and social work was the most common professional training found at both sites of this study. Our findings suggest that MT enacts long-established perspectives in social work, which may partially explain its continued practice in the profession. Both the person-in-environment and ecological perspectives, considered in many schools of social work to be foundational perspectives, posit that social workers can and should address change at both the individual and social levels (Abramovitz, 1998; Germain, 1979). MT, as defined and enacted by the participants in this study, shares a strong family resemblance with these pillars of the social work profession, viewing individuals as inextricably connected with their environments. Participants in this study reported and demonstrated surprisingly nuanced understandings of people as complexly embedded in, shaped by, and shaping their social environment. Workers were not only aware of the importance of the social environment in shaping their clients' affect and behavior, but understood themselves to be helping their clients by working through the environment to maximize its therapeutic potential. Workers' concerns that MT might be mistaken for little more than "hanging out" reflected their worry that others, particularly auditors and utilization reviewers, might not share their nuanced understanding of MT as an approach based in treating a person and their environment.

To understand MT as an approach to practice that deploys a complex understanding of person-in-environment casts new light on what initially appeared to be a definitional slippage. Although workers' descriptions and enactments of MT raise critical questions about how best to study and fund it, our findings suggest that MT is indeed an approach to treatment in its own right, and one that

is characterized by a coherent and consistent set of commitments. SWR

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Yvonne Smith, PhD, *and* ***Matthew C. Spitzmueller, PhD, LCSW,*** *are assistant professors, School of Social Work, Syracuse University, Syracuse, NY. Address correspondence to Yvonne Smith, School of Social Work, Syracuse University, 244 White Hall, Syracuse, NY 13244; e-mail: ynsmith@syr.edu.* *Data collection at the pseudonymous University Home and School (UHS) was supported by the Fahs-Beck Fund for Research and Experimentation. Research for the Community Club study was supported by a grant to Evelyn Brodkin from Center for Health Administration Studies at the University of Chicago. The authors wish to thank the workers at UHS and Community Club, who participated enthusiastically in this research amid the significant challenges of their everyday work.*

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MULTICULTURAL PERSPECTIVES ON RACE, ETHNICITY, AND IDENTITY

ELIZABETH PATHY SALETT AND DIANE R. KOSLOW, EDITORS

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