

Volume 1

**Mutual Support Processes
in a Therapeutic Community**

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ABSTRACT

This descriptive, qualitative study explored individuals' experiences of mutual support whilst being resident in a therapeutic community for people experiencing severe emotional and social difficulties. Mutual support – the joining together of similar individuals to assist one another emotionally, socially or materially – plays a major role within therapeutic communities, where individuals are given the opportunity to share responsibility for understanding the situation they are in and to engage with peers in processing and working through difficulties. Twelve therapeutic community members were interviewed about their experiences of giving and receiving support.

The interview data were analysed qualitatively, using interpretative phenomenological analysis. Eight themes were identified which were organised into three higher-order domains relating to participants' experiences of being in the therapeutic community, the process of giving and receiving mutual support, and the impact of mutual support on participants' sense of self and perception of their difficulties. Overall, participants' experiences of mutual support were positive and the findings are discussed in relation to general psychological frameworks. The research has theoretical and clinical implications with regard to informing an understanding of how mutual support processes operate within therapeutic communities and the potential therapeutic impact of mutual support in mental health settings.

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For my mother, Thelma.

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CHAPTER ONE

INTRODUCTION

OVERVIEW

Why study mutual support processes in a therapeutic community?

This study aimed to investigate mutual support processes as experienced by members of a residential therapeutic community (TC) for people with long-standing mental health difficulties. Mutual support - that is, support provided by people in a similar situation - plays a major role within TCs, where individuals who are experiencing mental health difficulties have the opportunity to share responsibility for understanding the situation they are in and to engage with their peers in processing and working through these difficulties. It is hoped that the study will provide an understanding of how mutual support processes operate within a TC and how these processes may affect TC members. This has clinical relevance with regard to furthering understanding of how mutual support may impact on the way individuals experiencing mental health difficulties view themselves and their difficulties.

Outline of chapter one

This chapter has four main sections. The first section reviews the literature on therapeutic communities, starting with an historical context and overview of the concept of the TC. The aims of TCs within the NHS for people with mental health difficulties will then be outlined, followed by a literature review of TC effectiveness. The second section focuses on the processes and functions of

mutual support. It begins by giving a brief overview of the literature on help-seeking behaviour and social support before proceeding to outline the principles of mutual support and the application of these principles in the form of mutual support groups. The third section explores the interface between mutual support and TCs; it begins by discussing the curative factors in psychotherapy groups and TCs and then proceeds to review references to mutual support within the TC literature. The final section of the chapter summarises the implications of the literature for the present study, provides the rationale for the study's methodological approach and sets out the research questions.

THERAPEUTIC COMMUNITIES

Since its invention in 1946, the term 'therapeutic community' has been used to describe a variety of different organizations. The broad use of the term can often result in confusion about what TCs actually are. However, organizations known as TCs do have a number of significant features in common. Before proceeding to describe these, the origins of TCs will first be traced in order to provide a contextual understanding of this type of approach.

The origins of therapeutic communities

Historical overview

Although the concept of the therapeutic community was not formally recognised until the middle of the last century, the ideas underlying the concept can be traced much further back, to moral treatment at the turn of the eighteenth and

nineteenth centuries and to planned environment therapy around the beginning of the twentieth century.

Moral treatment

Moral treatment was developed in the late eighteenth century in response to the often barbaric treatment of the mentally ill at that time. The York Retreat, which opened in 1796, aimed to recognise and nurture the intact part of the patient's personality through the use of social expectation, kind and humane relationships, and social reward. This stood in sharp contrast to the common practice of physical restraints and enforced idleness in eighteenth century madhouses. The success of The Retreat received wide publicity and led to debates about institutions for the mentally ill. By 1845 a series of laws were passed by parliament which required every county in England to provide for these individuals a purpose-built asylum (Kennard, 2000).

However, somewhat ironically, by the time the last county asylums were being built in the 1890s, moral treatment had largely disappeared. Kennard (2000) proposes a number of different reasons for this. First, there is a sense it was killed by its own success as a reform movement, as social reformers, pointing to the success of The Retreat, persuaded the English Parliament and the American States to provide similar institutions on an increasingly large scale. In ignoring the size of the asylum the aim of establishing a community atmosphere was no longer adhered to. Secondly, the type of patient also began to change: in England a law was passed in 1890 requiring that only the most incurable should

be admitted to hospital which tended to push asylums towards a more custodial role. Thirdly, the individuals behind The Retreat were against establishing a new profession of experts in moral treatment. It followed that the medical profession's claims to be the natural authority responsible towards the mentally ill remained unchallenged.

Although The Retreat continued, and remains a TC to this day, it was not until the early twentieth century that TC ideology surfaced again in the form of planned environment therapy.

Planned Environment Therapy (PET)

In the 1920s and 1930s a number of pioneer educationalists began to create liberal therapeutic regimes for delinquent or difficult children. These ventures, along with many of their successors, are now described under the broad heading of Planned Environment Therapy (Kennard, 2000).

The term PET was first used before the Second World War to describe an approach to living and working with unhappy, deprived, traumatised or delinquent children, young people and adults:

...in which all the resources of a thoughtfully created environment,
the shared living experience, and above all the enormous healing
potential of relationships, are brought together for therapeutic ends

(Planned Environment Therapy Trust, n. d.)

PET, although not synonymous with the adult democratic therapeutic community, has many factors in common with it. Both hold a belief in the therapeutic benefits of delegating to the members of the community many of the responsibilities usually taken by professionals/staff, in an atmosphere which encourages open expression of feelings and exploration of relationships. In addition, both recognise the emotional benefits and opportunity for social maturation which can occur when individuals have jointly to take responsibility for the community they live in (Kennard, 2000).

The development of therapeutic communities

It was not until the time of the Second World War that the term therapeutic community was first used and the ideology of this approach developed and applied to psychiatric populations on a large scale. The term 'therapeutic community' was first introduced by Main (1946) when describing developments at Northfield Hospital in Birmingham, a military hospital during the Second World War. Whilst Main was working there, he, along with a small group of fellow psychoanalysts, had been struck by problems of low morale, conflict and disorganisation in the psychiatric wing of the hospital, and had worked hard to find a way to overcome this. Main described their approach as:

An attempt to use a hospital not as an organisation run by doctors in the interests 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 and the eventual aim of resocialization of the neurotic individual for life in ordinary society.

(Main, 1946, p.67)

Main and his colleagues were interested to promote a collaborative rather than an authoritarian style of staff behaviour and they consequently moved away from institutionalising and repressive regimes towards a more liberal, humane and participative type of culture. Alongside this they were interested in the idea of the community as a system needing 'treatment', in contrast to the generally accepted notion that all difficulties are held within the individual (Main, 1946).

During the time of the 'Northfield experiment' another similar development was being pioneered by Maxwell Jones, a psychiatrist at Mill Hill in London (Jones, 1968, 1979). Part of London's Maudsley Hospital had been evacuated to Mill Hill at the outbreak of the war and Jones arrived there in 1940 to head up a unit in which to study 'effort syndrome'. This was a prevalent condition during wartime in which physical exercise caused people to become breathless and giddy, and to suffer from palpitations and chest pains. These patients often convinced themselves that they had a serious heart condition. Jones, a research physiologist by training, set to work to determine the physiological mechanisms underlying the syndrome, and when he had done so, decided to introduce a series of lectures to educate the patients about their condition. He reasoned that if they could understand how their symptoms were caused, they might stop worrying that there was something wrong with their hearts. Then something

happened which Jones took very seriously; he noticed that the men who had already completed the course of lectures started to explain what they had learnt to the newly admitted patients, becoming enthusiastic and articulate during this process. He recognised that these patients were best helped by helping one another and that this had the effect of increasing their morale and self-esteem. As a consequence of these findings he worked to ensure that there was an atmosphere of open communication, reduced hierarchy and daily structured discussions by the whole unit.

The developments at Northfield and Mill Hill suggested that patients experiencing mental health difficulties could be helped more effectively when professionals were willing to be less hierarchical and patients were allowed to become involved in helping one another. Essentially, these ideas are to do with the importance of 'patient involvement' and the hospital as 'community'. These remain essential factors underlying the TC approach.

What is a therapeutic community?

Different uses of the term

The term therapeutic community is used to describe a number of different organisations and approaches. There are four broad yet distinct ways that the term therapeutic community is employed. These are outlined below.

Therapeutic Community Approach

Clark (1965) made the distinction between 'therapeutic community approach' and 'therapeutic community proper'. The 'therapeutic community approach' alluded to the introduction of TC ideas into large, asylum type institutions in the years during and following the Second World War with the aim of restoring to patients a more usual pattern of daily living and helping them learn how to communicate and get on with the people they lived with. Some of the common features of these hospitals would be group meetings, patient responsibilities and the belief in purposeful activity. The use of this term is now mostly confined to the past but may still be relevant today where mental health provisions are at an early stage of development.

Therapeutic Community Proper

The term 'therapeutic community proper' was originally used by Clark (1965) to describe the distinctive TC method associated with Maxwell Jones at the Henderson Hospital, known as the 'democratic type'. This method was defined by the democratic sharing of power by all members of the community (staff and patients) in all decisions that affected the running of the community and the treatment of the patients. The term is now also used to describe small, cohesive communities where therapeutic decisions and functions are shared by the whole community, and where the status differences between staff and patient are greatly reduced though not abandoned.

Alternative Asylum and the Anti-Psychiatry Communities

These can be traced back to the anti-psychiatry movement which grew up around the work of R. D. Laing and David Cooper in the late 1960s and early 1970s (Kennard, 2000). Although the anti-psychiatry movement was largely concerned with ideas and beliefs about the nature of mental illness and about the role of psychiatry in this, it also gave rise to a number of practical projects. These stood in stark contrast to the standard psychiatric approach where people suffering emotional distress were seen as 'ill patients' whose symptoms were socially unacceptable and in need of treatment. In contrast, alternative asylum was offered in the form of small communities; these offered people who were experiencing emotional distress a place of refuge in which they were given space and time to explore their difficulties and make sense of them. Inherent in this approach is the idea that psychological distress is a social problem, rooted in society rather than in the individual, in the relationships people have with their families and peers and with wider society. If we take this view it follows that a person's relationships with others are constitutive of them. Laing proposed "The ground of being of all beings is the relation between them. The relationship is the 'is', the being of all things" (Laing, 1967, p. 36).

Concept-Based Therapeutic Communities

Communities of this type are largely concerned with the rehabilitation of alcohol and drug addicts. Also known as Concept Houses, staff and residents form a continuous hierarchy in these small, cohesive communities (Kennard, 2000).

Common attributes of therapeutic communities

Despite the different origins and ways of working, organisations known as TCs do have a significant number of features in common. Kennard has listed the characteristics of the TC as:

1. A group of people who live together or meet together regularly and participate together in a range of purposeful tasks – therapeutic, domestic, organisational, educational.

May have:

2. Intimate, informal, non-hierarchical relationships.

And:

3. Regular and frequent sharing of information between all members of the group.

It is not yet a TC, but will begin to be so if there is:

4. A shared commitment to open examination and resolution of problems, tensions and conflicts within the group (a culture of enquiry).

And theoretically informed by:

5. Bringing together a psychodynamic awareness of individual and group process to bear on this examination.

All of which requires:

6. A clear set of boundaries concerning time, place and roles within which the above can take place.

(Kennard, 2000, p. 114).

More recently the TC has been succinctly defined by Haigh, Kennard, Lees and Morris:

A therapeutic community is a planned environment which exploits the therapeutic value of social and group processes. It promotes equitable and democratic group-living in a varied, permissive but safe environment. Interpersonal and emotional issues are openly discussed and members can form intimate relationships. Mutual feedback helps members confront their problems and develop an awareness of interpersonal actions.

(Haigh et al., 2002, p. 13)

Aims of therapeutic communities within the NHS

Hospital TCs within the NHS can be traced back to Main (1946) and Jones (1968; 1979) and their setting up of the Cassel Hospital and the Henderson Hospital respectively; both have become well known for treating individuals whose problems are primarily social and interpersonal. Tucker outlined their commitments as follows:

...that the treatment of patients in hospitals focus on relationships of responsibility between people; an attempt to understand the individual in the context of the underlying psychodynamics of the group; non-hierarchical relationships between staff and patients; staff and patients being open to learning from the experience of living and working together in work and therapy groups and in

boundaried informal situations; an open culture of debate and inquiry.

(Tucker 2000, p.12).

The above quote illustrates the socio-political approach inherent within the TC. For example, the staff and client group are seen as a central tool in the therapy and the treatment is seen to be within the context of doing things together. Also, patients are seen as responsive and responsible people equal in personal status to staff. Within this approach there is an emphasis on the social context of mental health difficulties, as opposed to seeing these difficulties as residing solely within the individual. Essentially then, the TC approach is a socio-political one in that it takes the view that personal identity is both dependent upon and in some way constituted by relationships with others. This contrasts with an individual approach which views the person as existing quite separately of other people (Tucker, 2000).

In the context of mental health difficulties, the TC approach takes a systems theory stance. Implicit within the TC is the idea that individual members of the community can be regarded as connected parts of a system. From this theory follows the concept that mental health difficulties are located, not primarily within the individual, but in the network of relationships of which the person is part.

Effectiveness of therapeutic communities

Research and outcome studies

The early research on TCs was descriptive, mostly comprising single case studies, and conducted by TC practitioners (Bion, 1960; Foulkes, 1948; Harrison, 2000; Jones, 1968; Main, 1946). Gradually, more sociological, anthropological studies were carried out, usually by people outside of the TC field (Rapoport, 1960).

As funding for services has become increasingly linked to outcomes, the attempt to explore the effectiveness of TCs has become an urgent issue. In 1997, the English Department of Health commissioned a systematic, international review of TC effectiveness. This focused primarily on in-treatment and post-treatment outcome for people with personality disorders in democratic TCs but also included the relevant in-treatment and post-treatment outcome studies of the effectiveness of concept-based TCs, usually for substance abusers and particularly those in secure settings (Lees, Manning & Rawlings, 1999). This review furnished a substantial number of studies of sufficient quality to undertake a meta-analysis (Lees et al., 2004). This analysis, taking careful account of sources of heterogeneity and possible publication bias, showed a clear and positive treatment effect for TCs with summary log odds ratios for the 29 studies of -0.512 (95% ci -0.598 to -0.426). In addition, according to the UK National Service Framework for Mental Health, this study fits the criteria for Type I evidence (i.e. at least one good systematic review, including at least one randomised controlled trial).

Although there is a growing body of research exploring the effectiveness of TCs, the question of *how* TCs work is still largely unanswered. Lees, Manning and Rawlings (2004) see this as being due to the difficulties in teasing out the different mechanisms at work inside such a complex and multi-faceted treatment. There is, however, a current study underway that is exploring this question, as well as effectiveness. This study is being conducted in England and Scotland and involves comparing the effectiveness of nineteen democratic and two concept-based TCs in treating people with personality disorders (Lees, 2004).

PROCESSES AND FUNCTIONS OF MUTUAL SUPPORT

As outlined above, the TC approach operates within an interpersonal framework and involves supporting people to share responsibility for understanding the situation they find themselves in, and to engage with others in processing and working through their difficulties. Fundamental to the TC approach is the process of mutual support.

This section focuses on the processes and functions of mutual support. In order to set this in context, a brief overview of the literature on help-seeking behaviour and social support will first be presented. The principles of mutual support, and their application to mutual support groups, will then be discussed.

Informal helping and help-seeking behaviour

Therapeutic communities can be distinguished from the majority of treatments in the field of mental health in that they rely on a combination of both formal and informal helping. Formal helping refers to any of the various types of help provided by a trained, professional helper (e.g. a mental health professional such as a psychologist, psychotherapist or counsellor). In contrast, informal helping can be described as “helping between ordinary people in everyday settings” (Barker & Pistrang, 2002, p. 362).

Overall, studies exploring help-seeking behaviour indicate a general preference of informal over formal help for people facing psychological difficulties (Barker, Pistrang, Shapiro, & Shaw, 1990; Brown, 1978; Gourash, 1978; Gurin, Veroff & Feld, 1960; Veroff, Kulka & Douvan, 1981; Wills, 1992). It has been proposed that people's help-seeking behaviour may be conceptualised as a pathway where minor problems are taken to informal helpers, more persistent problems are handled by non-specialist helpers such as general practitioners or priests, and severe difficulties are dealt with by mental health specialists (Barker & Pistrang, 2002; Rogler & Cortes, 1993; Wade, Howell, & Wells, 1994; Wills & DePaulo, 1991). This has been likened to people managing their own form of ‘stepped care’ (Barker & Pistrang, 2002; Haaga, 2000), beginning with the most accessible, community based forms of support and only progressing to professional help if their difficulties are not resolved satisfactorily.

A number of possible reasons as to why people generally prefer to seek out informal help over formal help have been proposed by Cowen (1982): services may be located too far away or may be too expensive and people's attitudes may not easily fit with that of services on offer. However, Cowen suggests that even if these obstacles are absent, people still prefer to talk with trusted individuals from their social networks – “people who are willing to listen when they are ready to talk” (Cowen, 1982, p. 385). This naturally preferred pattern of help-seeking behaviour suggests that mental health providers should consider people's natural bias towards informal help when designing interventions and services (Barker & Pistrang, 2002).

In addition, it has been found that even when people are receiving support from formal sources, this does not necessarily rule out the additional seeking out of informal support. For example, Cross, Sheehan and Kahn (1980) found that participants in both treatment and control groups in a comparative therapy outcome study sought out informal helping. In fact, the rate of informal help-seeking was greater in the two treatment groups than in the control group and may provide an alternative explanation for some of the gains experienced by the therapy groups compared to the control group. This finding makes sense in that we would not expect a client attending once a week therapy to stop discussing their difficulties within their informal social networks. Indeed, the work of therapy would be expected to facilitate an opening of the client's inner world and therefore help them to access and discuss their thoughts and feelings more easily (Barker & Pistrang, 2002).

The opportunity to access both formal and informal types of help is one of the distinctive features of the TC. This may account for the success of this type of approach in helping people who have not benefited from standard mental health services, where the emphasis is frequently geared towards formal professional support with little thought given to providing opportunities for informal helping to occur.

Social support and well being

The social support literature has grown exponentially since the publication of two highly influential reviews in the late 1970s by Cassel (1976) and Cobb (1976). These were concerned with the impact of social relationships on physical and psychological well-being. Since then, through the subsequent research that flourished, it has been established that social support results in benefits to both physical and psychological well-being (Helgeson & Cohen, 1996; Sarason, Sarason & Pierce, 1990). In general, studies show that poor social support is associated with poor mental and physical health outcomes (Bloom, 1990; Hogan, Linden & Najarian, 2002).

Three main types of supportive interactions have been described: informational, emotional and instrumental (Hogan et al., 2002). Informational support includes the sharing of experiential knowledge (i.e. knowledge gained from personal experience) in order to provide advice and/or guidance. This is hypothesised to increase the recipient's coping skills and sense of mastery and control. Emotional support includes the expression of caring and concern and the

communication of empathy. This is thought to reduce distress by enhancing self-esteem, decreasing feelings of isolation and stigma, and encouraging the expression of feelings. Lastly, instrumental support includes the provision of material goods which is hypothesised to increase the recipient's sense of control by enabling them to do more.

The individual's needs and context determine which type of support will be most beneficial and there is evidence to suggest that support that does not match the individual's needs may even be harmful (Cutrona, 1990). It is thought that individuals may benefit more from informational support when the stressor is relatively controllable, and more from emotional support when the stressor is relatively uncontrollable (Helgeson & Gottlieb, 2000). Informational support is recognised as being more valuable if the provider is perceived as having experiential knowledge.

Most of the social support literature has focused on support within individuals' social networks, but one interesting source of support, particularly relevant to therapeutic communities, is that provided by people facing similar difficulties. Research exploring mutual support processes has grown out of the bedrock of the social support literature. Mutual support is a specific form of social support that has been defined as "...people sharing a common problem, who meet regularly to exchange information and to give and receive psychological support" (Pistrang & Barker, 2004, p 1). This definition highlights how mutual support is distinguished from the more general concept of social support; the former being

a process involving 'similar others' joining together to help and support one another. Processes and functions specific to mutual support include shared experience and understanding (Lieberman, 1993); the helper-therapy principle (Riessman, 1965); and opportunities for social comparison (Festinger, 1954). These are outlined below.

Shared experience and understanding

Sharing experiences with other people facing a similar stressor is expected to lead to validation, normalisation of the experience, a reduction in social and emotional isolation and a sense of belonging (Lieberman, 1993). People facing a similar stressor are able to understand one another's situation in a way that naturally occurring social network members may not. There is evidence that in times of stress, natural social networks do not always behave in a supportive manner, partly from a lack of understanding and partly from feelings of threat. For example, family members and friends of people who faced cancer, or people who had been victimised by a traumatic event such as rape, were found to discourage expression of feelings and try to distract the person from their problems as they believed that it could be harmful for the person to talk about the experience (Coates & Winston, 1983; Dunkel-Schetter, 1984; Peters-Golden, 1982).

The helper-therapy principle

Riessman (1965) argued that having the opportunity to help others instils a feeling of self-efficacy and competence. In addition, the expectation is that peers

will be able to provide sound advice and useful ideas about ways of coping because they have firsthand experience with the stressor. Empirical support for this principle has been provided by an observational behavioural measurement of the helping transactions that occur in self-help groups for people with serious mental health problems, where giving help to others predicted psychosocial adjustment (Roberts et al., 1999).

The helper-therapy principle was extended by Maton (1988) in his bi-directional support hypothesis. This states that people who both provide and receive support will experience greater well-being than those involved in only one of these two processes. Evidence for this was provided by Maton's finding that members of a support group who both gave and received support had lower levels of depression, higher self-esteem and reported higher levels of satisfaction than those who either predominantly gave or predominantly received support.

Social comparison theory

In times of uncertainty and/or stress, people compare themselves with others to evaluate their feelings and abilities (Festinger, 1954). These 'lateral' comparisons may normalise experiences as the individual learns that others suffer the same problems and share the same hopes, fears and concerns. There are also 'upward comparisons' and 'downward comparisons'. The former relates to comparing oneself to a better-off other (i.e. role model) which can act as a source of inspiration to move forward. In contrast, the latter refers to comparing

oneself with someone who is worse-off in order to feel better about one's own circumstances which can enhance self-esteem.

Mutual support groups

Over the last 20 years there has been a steady increase in the number of people who turn to mutual support groups and organisations in order to help them cope during times of need (Jacobs & Goodman, 1989; Kessler, Mickelson & Zhao, 1997).

Such groups are generally based on the valuing of members 'experiential knowledge' (Borkman, 1990). For example, members have often gained valuable knowledge from their experience of suffering from and receiving support for their difficulties, and this knowledge can be communicated to other members. An important characteristic of these groups is that they are run by the members themselves; professional involvement is usually limited. Within the literature various terms have been used to describe such groups, including 'self-help groups', 'support groups', 'mutual help' and mutual aid' groups, which can cause confusion. The term 'mutual support group' will be used throughout this study.

Mutual support groups capitalise on the similarity among group members' difficult or stressful experiences to foster the process of mutual support. The support group serves as a temporary, personal community that supplements or compensates for deficiencies in the participants' natural social networks. A

support group is differentiated from a single source of support in that it exposes individual group members to varied ways of reacting to and coping with stressful events/demands. In addition it is much more difficult to discount or dismiss collective opinion than the views/experiences of an individual.

There are a number of surveys showing that members value and benefit from mutual support groups. The literature suggests that members view mutual support as one of the most helpful features of such groups. In one particular study, when asked why their group was effective, 83% of members mentioned the supportive and accepting environment it provided (Knight et al., 1980). Similar findings were reported by Maton (1988) who found that activities relating to mutual support such as sharing personal experiences, receiving empathy and problem solving were related to reported satisfaction and benefits experienced by group members.

With regard to empirical evaluations of mutual support groups, there are a number of methodological difficulties that these studies face which limits the conclusions that can be drawn (Helgeson & Gottlieb, 2000). Pistrang and Barker (2004) note that a defining feature of mutual support groups is that members choose to participate, which makes it difficult for researchers to implement traditional randomised designs; thus quasi-experimental designs are more common. However, Kyrouz and Humphreys (2003) suggest that studies should compare the outcome of the mutual support group either with a comparison group of non-participants or with a pre-measure on the same participants. Using

this criterion, Pistrang and Barker (2004) undertook a review of mutual support groups for psychological problems and concluded that overall there is mixed but largely positive evidence that such groups are beneficial, although the evidence base is small. In addition, Hogan et al. (2002) provide some evidence that support groups enhance the individual's level of psychological functioning as well as that of positive health outcomes.

There is also a small body of research which has begun to address the perception by Roberts et al. (1991, p. 716) that "...although establishing the effectiveness of mutual help is important, researchers cannot ignore the task of adequately describing the activities, helping behaviours and interaction processes that characterize the groups." Roberts et al. (1991) devised a 'behavioural observational system' to systematically describe and document the activities and interactions that occur in mutual support group meetings. Studies using this and other similar coding systems to observe these processes have documented a range of helping behaviours such as offering emotional support and information, and sharing of similar experiences (Paine et al., 1992; Roberts et al., 1991; Toro et al., 1988).

Finally, qualitative studies have shed some light on what members of mutual support groups find beneficial. For example, Solomon, Pistrang and Barker (2001) examined what parents of children with disabilities and special needs found helpful about belonging to mutual support groups. Group members indicated that such support was helpful in three broad domains: the socio-

political, which involved developing a sense of control and agency in the outside world; the interpersonal, which involved a sense of belonging to a community; and the intraindividual, which involved self change. A central theme of identity change emerged as superordinate to these three categories. Another qualitative study conducted by Mason, Clare and Pistrang (in press) explored experiences of mutual support in professionally-led support groups for people with early stage dementia. Group members reported benefits such as meeting people in a similar situation, increasing social contact and being helped to communicate in an environment where difficulties with memory and speech are accepted.

THE INTERFACE BETWEEN MUTUAL SUPPORT AND TCs

To date, there have been no studies directly examining mutual support processes in TCs. However, many of the principles and processes in the mutual support literature are similar to those described in the group psychotherapy literature and in the TC literature.

Curative factors in psychotherapy groups and TCs

Exploration into curative factors in group psychotherapy has been ongoing for nearly sixty years (Bloch et al., 1979; Bloch & Crouch, 1985; Bloch & Reibstein, 1980; Corsini & Rosenberg, 1955; Yalom, 1975). Yalom (1995) lists eleven primary therapeutic factors in groups including instillation of hope, universality; imparting information; altruism; and interpersonal learning.

Whiteley and Collis (1987) report that, compared with the curative factors in group psychotherapy, the curative factors in the TC have received less attention. In order to begin to address this they conducted a study with patients at the Henderson Hospital to explore the feasibility of extending the study of therapeutic factors in group psychotherapy to the TC (Whiteley & Collis, 1987). They found that learning from interpersonal actions, acceptance (especially in the early stages of treatment) and self-understanding were the most prominent therapeutic factors as categorised from patients' accounts of the 'most important event' in the previous week. This method of enquiry was similar to that used by Bloch and Reibstein's (1980) investigation into the curative factors in group psychotherapy.

It is important to note that in Whiteley and Collis's (1987) study, half of the 'most important events' reported by patients took place outside the setting of formal therapy groups but largely within the boundaries and life of the community, again illustrating the importance of informal helping. Whiteley and Collis (1987) note that in some ways the TC has similarities with certain methods of family therapy in which group meetings at spaced intervals allow the participants to work on the problem outside of the formal group, within the system of the family. In contrast, these sorts of interactions outside of the formal group set-up would be ruled against and regarded as destructive processes in orthodox group psychotherapy. They conclude:

What the therapeutic community has to offer, which circumscribed group therapy does not, is the opportunity to put into practice the insights or realisations gained in therapy and to experiment with new roles and modes of coping in an accepting and understanding social system. It is an ongoing, corrective, emotional experience which, because of its concern with the reality of living together and dealing with real situations as they arise, facilitates a carry-over of personal change from the treatment situation to outside life.

(Whiteley & Collis, 1987, p. 29)

Chazan (2001) described the TC as having an added dimension to the therapeutic group: whereas the dyad of individual therapy has a single, linear dimension, and the group is two-dimensional, the TC is actually three-dimensional (i.e. despite the fact that the whole community is not present at any point in time, it is constantly present in the therapeutic space). Whiteley (1999) refers to the TC as a continuous large group.

Mutual support in the therapeutic community

As stated above, there are no studies that have systematically examined mutual support processes in TCs. However, within the TC literature there are many references to mutual support, which is not surprising considering the central position that this type of support holds within the TC approach. Indeed, one of the main aims of the TC is to help people to relate to others in more satisfactory

ways. This section will focus on some of the findings that have emerged from the TC literature with regard to the concept and process of mutual support.

Lyons et al. (1988) recognised that social support networks are very often restricted in severe pathologies. This can lead to feelings of isolation and stigmatisation which can often be compounded by standard mental healthcare treatment where there is often little thought given to the need for informal support networks. This stands in sharp contrast to the TC approach, with its emphasis on the impact of social systems and social interaction on mental health difficulties. As one of the founders of the TC movement wrote, "...the most important lesson that therapeutic communities have shown [is] the importance of the 'patient's' own peer group" (Jones, 1979, p. 6). Indeed, this is such a central tenet of the TC approach that it may account for why there has been no systematic research exploring these processes. Instead it is mentioned rather than investigated within the literature; perhaps as any other essential, yet 'innate' phenomenon, would be.

There have been a number of anecdotal accounts, both from people who have been resident in TCs and those who have worked as staff within these organisations. Many of these accounts allude to the importance of mutual support. For example, Drahorad (1999) reports on the experiences of two ex-patients of the Cassel Hospital, one of whom says:

...what was most significant to me was that whatever I was beginning to feel, the routines, the structures but most importantly the people, patients and staff alike, were still around me. However awful and pathetic I felt within myself I still had a place which I belonged to and where I felt recognised and accepted. This realisation came to me as a huge relief.

(‘Sue’, quoted in Drahorad, 1999, p. 203)

Similarly, an ex-resident of the Arbours, a TC founded in 1970, reflected on her experience:

What has worked for me in Arbours is living with other people and struggling with the difficulties I’ve had with them, and them with me.

(‘Matilda’, quoted in Berke et al., 1995, p. 21)

There have also been case studies such as that conducted by Biggs (1987), which explored patients’ perceived experience of life in the Family Unit at the Cassel Hospital. She interviewed thirteen inpatients and seventeen ex-patients from a total of twenty five families. Her findings highlighted the fundamental importance of mutual support to these patients. For example, patients reported feeling a sense of relief and safety in being welcomed by other patients who were expected to care for them. In addition, for many patients it was a significant discovery to find that they could help and support others. Interestingly, current

inpatients were very concerned about their relationship with staff, but ex-patients spoke more of their interaction with other patients. The longer they had been away, the more they spoke of the mutual support they experienced. Finally, patients' confidence was more often increased by contact with other patients than with staff.

Finally, a handful of studies have explored the impact of TC treatments on substance abusers' social support networks. De Leon (2000) proposed that, according to the TC treatment approach, social affiliation with the drug-free peer community is the basis for patients initiating therapeutic change. The findings of two studies lend support to this idea. Dermatis et al. (2001) conducted a study with 322 residents in TCs for substance abusers. After controlling for socio-demographic characteristics, perceived benefit for recovery of TC treatment was associated with greater TC member affiliation, whereas level of depression was inversely correlated with member affiliation. More recently, Richardson (2002) found that individuals who completed therapeutic community treatment had larger social support networks and more close friends, reported greater satisfaction with the support they received, and were more willing to utilise support resources.

These findings have important implications for mental health service development and delivery with regard to providing a service which is successful in addressing the presenting problems of the people it is there to support. The literature discussed above illustrates the importance of providing opportunities

for mutual support to occur for people experiencing mental health difficulties. Indeed, from an evolutionary perspective, human beings are social in nature and require social relationships in order to survive and successfully reproduce; we have an innate need to seek out and positively respond to close social ties (Barrett, Dunbar & Lycett, 2001). When individuals are experiencing mental health difficulties, their capacity for seeking out and maintaining relationships is often severely affected. Yet, it would appear that, in standard mental healthcare services, these difficulties are frequently overlooked. Subsequently there is often little attention paid to encouraging social interaction amongst people suffering from these difficulties; instead the focus is usually primarily on formal help, i.e. that provided by professionals. The studies above highlight the importance of considering the broader social context.

THE CURRENT STUDY

Chapter summary and rationale for the current study

The TC can be defined as a group of people who live or meet together and participate in a range of purposeful tasks (i.e. therapeutic, domestic, organisational, educational) (Kennard, 2000). One of the distinctive features of the TC is in the way it harnesses the therapeutic value of social and group processes to create opportunities for members to confront their problems and develop an awareness of interpersonal actions (Haigh et al., 2002).

The TC aims to support members to explore and gain an understanding of their difficulties within the context of the underlying psychodynamics of the group; this

is achieved through the experience of living and working together in work and therapy groups and in boundaried informal situations. The approach taken by the TC is essentially socio-political in that it takes the view that personal identity is both dependent upon and in some way constituted by relationships with others (Tucker, 2000). With regard to mental health difficulties, the TC views these as being located, not primarily within the individual, but in the network of relationships of which the person is part; the community is therefore seen as an essential therapeutic tool in addressing these difficulties.

Fundamental to the TC approach is the process of mutual support, a specific form of social support that involves 'similar others' joining together to help and support one another. Over the last 20 years there has been a steady increase in the number of people who turn to mutual support groups and organisations in order to help them cope during times of need (Jacobs & Goodman, 1989; Kessler, Mickelson & Zhao, 1997). These groups, like TCs, capitalise on the similarity among members' difficult or stressful experiences to foster the process of mutual support. An important characteristic of mutual support groups is that they are run by members themselves; professional involvement is usually limited. TCs are different to mutual support groups in this respect as there is always staff involvement; however, there is a similarity in that the TC promotes the idea that members can often be best helped by helping each other (Jones, 1968, 1979). In addition, in many TCs (especially those of the democratic type) there is a flattened hierarchy between staff and patients.

Interestingly, studies exploring help-seeking behaviour indicate a general preference for informal help (i.e. help provided by ordinary people in everyday settings) over formal help (i.e. help provided by a trained, professional helper) (Barker & Pistrang, 2002). The opportunity to access both formal and informal types of help is one of the distinctive features of the TC. This may account for the success of this type of approach in helping people who have not benefited from standard mental health services, where the emphasis is frequently geared towards formal professional support with little thought given to providing opportunities for informal helping to occur. Despite the fundamental role mutual support plays in TCs, there has been no systematic research conducted in this area.

Aims

This study aimed to investigate mutual support processes as experienced by members of a residential TC for people with long-standing mental health difficulties. Mutual support - that is, support provided by people in a similar situation - plays a major role within TCs, where individuals who are experiencing mental health difficulties are given the opportunity to share responsibility for understanding the situation they are in and to engage with their peers in processing and working through these difficulties. It is hoped that the study will provide an understanding of how mutual support processes operate within a TC and how these processes may affect TC members. This has clinical relevance with regard to furthering understanding of how mutual support may impact on

the way individuals experiencing mental health difficulties view themselves and their difficulties.

Methodological approach

Given the paucity of research in this area, the study took an exploratory, discovery-oriented approach (Barker, Pistrang, & Elliot, 2002). Qualitative methods have been recommended for exploratory research, particularly where "...knowledge is sought concerning complex, little-understood personal, interpersonal and social processes" (Ridgeway, 2001, p. 226). In addition, a qualitative approach allows participants greater freedom to express the issues as they see them (Barker et al., 2002). This may help to counteract feelings of disempowerment so often experienced by people who have severe and long-term mental health difficulties.

The study took a phenomenological approach to the study of participants' experiences and views and endeavoured to elicit, engage with and represent their accounts of their experiences using semi-structured interviews and interpretative phenomenological analysis (IPA; Smith & Osborn, 2003). IPA, informed by the philosophical framework of phenomenology, is a qualitative method of analysis that aims to capture the quality of individual experience, particularly how individuals themselves make sense of their experience, beliefs and attitudes (Smith, 1996).

Research questions

This qualitative study explores how mutual support processes operate within a residential TC and the possible effects on individual TC members. The study aimed to address the following questions:

1. What types of help and support do individuals in a TC receive from their peers?
2. What types of help and support do individuals in a TC offer their peers?
3. How do individuals in a TC experience the process of receiving and offering help and support?
4. What is the impact of mutual support on individuals' sense of self and their perception of their difficulties?

CHAPTER TWO

METHOD

OVERVIEW

In this descriptive, qualitative study, twelve people were interviewed about their experiences of giving and receiving support whilst being resident in a therapeutic community (TC) for people experiencing severe emotional and social difficulties. This chapter begins by outlining ethical considerations. It then proceeds to describe the setting for the study, the recruitment of participants and participant characteristics. The data collection procedures and the methods of data analysis are then described. The chapter ends with a statement of the researcher's perspective.

ETHICAL CONSIDERATIONS

Ethical approval was sought and received from West London Mental Health Local Research Ethics Committee. The letter of approval can be found in Appendix 1.

All participants were provided with information sheets (see Appendix 2) and gave written consent to participate in the study (see Appendix 3). They also gave consent to have tape recordings of their interviews stored at the Planned Environmental Therapy Trust Archive which holds archives for the Cassel Hospital and for TCs nationally and internationally. In addition, participants gave consent for their interview recordings and transcripts to be used for future

educational use or research (see Appendix 4). The consent forms, which contained participants' names, were kept separate from the interview data and were stored securely. Audiotapes and transcripts were identified by code number only and stored in a locked filing cabinet.

The interviews were considered unlikely to cause discomfort or distress but participants were made aware that they could stop at any point during the interview and withdraw their consent if they wished to. In the event no participant did this or became distressed when discussing their experiences. A debriefing session at the end of each interview gave participants the opportunity to ask any questions and to discuss their feelings further; again, in the event no information with regard to additional sources of support needed to be given.

SETTING

The study was based at the Cassel Hospital in Richmond, a residential psychoanalytically oriented TC which treats adults, adolescents and families with severe emotional and social difficulties often resulting from traumatic family backgrounds. The Cassel was founded in 1919 and is one of the oldest TCs in the UK.

Referrals to the Cassel come from a wide variety of sources: locally, in the Greater London area, and nationally, from psychiatrists, general practitioners, social workers, child guidance clinics, health visitors and physicians. Patients referred are usually in a severe state of psychological distress, often having had

a wide variety of treatment; what distinguishes patients admitted to the Cassel is the extreme nature of their pathology and the ineffectiveness of previous treatments they have had. Patients usually present with a polymorphous picture of symptoms including depression, self-harm, suicide attempts, eating disorders, and often have a diagnosis of different forms of personality disorder. As a result of these difficulties there may often be a breakdown in their personal and professional relationships which may have led to serious difficulties in ongoing treatment; and a breakdown in their social situation and in their capacity to manage everyday life. The Cassel does not treat people suffering from acute psychosis; nor do they accept drug addicts, severe alcoholics or major criminal offenders: Those suffering from these difficulties have been found to be unable to utilise the Cassel's resources, or have a very destructive effect on the patient group.

A characteristic of the Cassel that distinguishes it from the majority of TCs is in its combination of individual psychoanalytic psychotherapy and group structures/community living (i.e. most TCs focus on the latter). In the model used by the Cassel there is a deliberate separation between the 'inner' world of private fantasy and feelings, and the 'outer' world of social roles, work tasks and current relationships. The external structure aims to provide a sense of order which the patient is gradually able to internalise (Kennard, 2000).

The community consists of three separate units: the adult unit, the young persons unit and the family unit. These operate independently as separate units

and jointly as one community. While in treatment patients are normally resident at the Cassel during the week but spend weekends at home. A typical week consists of twice-weekly individual psychotherapy, unit meetings, and community meetings. Patients also take responsibility for aspects of everyday life such as tasks relating to the running and upkeep of the hospital and organising leisure time. By working alongside other patients and with the support of the staff, patients are given the opportunity to learn to trust their abilities and to cope with distressing emotions in a more positive way (Grittiths and Pringle, 1997).

PARTICIPANTS

Inclusion criteria

The inclusion criteria for participants were that they needed to be: (1) aged eighteen years or over; and (2) a resident of the Cassel for a minimum of one month: very new patients were excluded due to issues of settling in and getting used to being in the TC. Recruitment was from all three units and participation in the study was open to all Cassel patients providing they fitted the inclusion criteria. There were no exclusion criteria as the study aimed to reflect the experiences of a heterogeneous group of Cassel patients rather than a homogeneous one.

Recruitment procedures

Having first spoken to the clinical director of the Cassel, the researcher then introduced the study at a community meeting (all Cassel patients are required to

attend this meeting, along with Cassel staff). There were approximately 32 adult patients at the meeting out of a total of 40. Aims and procedures of the study were explained and everybody was given an information sheet, people were then given the opportunity to ask any questions. Patients were informed that, as compensation for the commitment involved in taking part in the study (two interviews over 4 months time) they would receive £10, as well as a summary of the main themes in their interviews. They were also told that they could have copies of their interview transcript if they thought this would be useful.

Staff agreed to hold information sheets and give them to anyone who was not at the meeting. Patients were informed that the researcher would be visiting again in approximately one month's time so that those interested in participating could have the opportunity to ask any further questions before deciding whether they wished to take part in the study. Approximately 20 potential participants attended this second meeting; the study was explained again and copies of the information sheet distributed. A total of twelve people who were still interested made an appointment time with the researcher for the first interview. All of these people participated in the study.

Characteristics of the sample

Nine women and three men participated in the study. The age range of the sample was 21 to 46 years, with a mean of 33 years. Eleven participants were white British and one participant was white African. The time that participants had been resident in the Cassel at the time of the first interview ranged from one

month to twelve months with a mean of six months. At the time of the first interview, ten of the participants were resident in the Cassel and two participants had recently left (3 weeks and 3 months respectively). All participants apart from one had received previous psychiatric treatment prior to coming into the Cassel and types of problems tended to be similar; i.e. severe emotional and social difficulties, with histories of abuse and trauma. With regard to other socio-demographic information, half of the participants had proceeded to higher education and had achieved further qualifications following school; none of the participants were working at the time of the study. Seven participants were single, four were cohabiting and one was divorced. Due to issues of confidentiality, a table has not been presented with characteristics of individual participants.

PROCEDURE

At the time of the first interview, ten participants were resident in the Cassel; these people were interviewed in a room in the hospital. The two participants who had recently come to the end of their treatment and had returned home were contacted via the Cassel and asked if they still wished to participate. Both of them did and they were given a choice of either being interviewed at the Cassel or in their own home; both chose their own home. All participants were interviewed individually as it was felt that this would give them more freedom to discuss their experiences of support within the TC.

The first interview

At the start of the interview, the main aims of the study were reiterated and participants were given the opportunity to ask any questions. It was emphasised that there were no wrong or right answers and that the researcher was hoping to understand the participant's personal experiences. Participants were reassured of the confidentiality of the interviews and of their anonymity, it was explained that all interviews and questionnaires were given a patient code and all names would be removed from the interview transcript. Participants were reassured that they could stop or have a break at any time, they were also reminded that, even when they had given consent, they were free to withdraw from the study at any point. The researcher encouraged participants to let her know if she was asking them to discuss an area which felt too difficult or personal. Consent forms were then given to participants, along with a copy of the information sheet. Interviews were audio-taped and lasted between 45 and 90 minutes.

At the end of the first interview, participants were asked to fill in a brief socio-demographic questionnaire (described below) which took approximately 5 minutes to complete. Participants were then thanked for taking part in the study and were asked if they had any questions. Finally, they were told that they would receive a written summary of their interview. They were invited to meet the researcher a second time in order to give their views on the researcher's summary and to raise any relevant issues; all participants agreed to this. As some participants were due to leave the Cassel before the follow-up interview

they were given the option of leaving contact details or of being contacted via the Cassel.

The follow-up interview

The follow-up interview took place within four months of the first interview. The aim of the follow-up interview was for participants to have the opportunity to give their feedback on the researcher's summary of the first interview. Participants were also encouraged to raise any other relevant issues and were given the opportunity to ask the researcher any questions. These interviews were of shorter duration than the first interviews, averaging 30 minutes. Due to the brief duration they were not audio-taped and notes were taken instead.

At the time of the follow-up interview, three more participants had finished their treatment and one participant had left unexpectedly. Eleven follow-up interviews were conducted: eight face-to-face, two by telephone and one by post; unfortunately the participant who had left the Cassel unexpected could not be contacted. After the follow-up interview participants were given £10 as compensation for their time.

Interview schedules

The interviews were semi-structured and were guided by an interview schedule. The interview schedule was designed specifically for the study, drawing upon guidelines suggested by qualitative researchers (Willig, 2001; Smith, 1995). In addition, through the Association of Therapeutic Communities, the researcher

met two people who had been members of TCs in the past. They expressed interest in the study and agreed to comment on the first draft of the interview schedule. Having had first-hand experience of being members of TCs, they provided valuable input which was incorporated into the interview schedule.

The schedule was used flexibly, the aim being to follow what participants brought to the interview. Therefore, not all questions or prompts were asked of each participant; instead these were used to guide participants back to the focus of the study should this be necessary. Interviews were conducted in an empathic and non-judgmental manner with an attitude of curiosity (Barker et al., 2002; Burman, 1994).

The first interview (see Appendix 5)

The interview schedule contained six sections which were covered in a flexible order. These were as follows:

(1) *Context: Entering the TC/first impressions:* This section explored how participants described their journey to the Cassel, their thoughts about entering it/what they were looking for, and their first impressions of the community.

(2) *Broad experience of TC:* The aim of this section was to get an idea of how participants found the experience of being a resident in the TC.

(3) *Experiences of receiving support from peers:* This section considered participants' experiences of receiving support from peers in the TC, as well as

whether these experiences made a difference to the way they felt (i.e. whether it made a difference to how they felt about their difficulties/sense of self)

(4) Experiences of offering support to peers: In this section, participants were asked about their experiences of offering support to their peers in the TC. They were also asked about the personal meaning of these experiences (i.e. in relation to sense of difficulties/sense of self).

(5) Comparison of TC to previous treatments: This section considered participants' previous experiences of treatment prior to the Cassel and how they might compare these. In this section participants were also asked about their thoughts with regard to their experiences of peer support and professional support.

(6) Closing the interview: At the end of the interview, participants were invited to share any relevant experiences that had not already been discussed and were also given the opportunity to ask any questions.

The follow-up interview (see Appendix 6)

The follow-up interview gave participants the opportunity to give their views on the researcher's summary and to raise any relevant issues from the first interview. The content and focus of the second interviews therefore varied slightly for each participant. The following areas were covered:

(1) Was the summary consistent with the participant's impression of the first interview?

(2) Was it accurate in its presentation of detail?

- (3) Were any important details or issues omitted?
- (4) How did it strike the participant emotionally?
- (5) Was there anything in the summary that the participant wanted to discuss?
- (6) Were there any other relevant issues that the participant wanted to raise?
- (7) Did the participant have any questions they wanted to ask the researcher?

Socio-demographic questionnaire

A self-report questionnaire of socio-demographic information was administered and used for the purpose of describing the sample. This was designed for the study and asked about age, ethnicity, length of time in TC, history and nature of difficulties, educational background and living situation (see Appendix 7).

ANALYSIS

The audio-taped recordings of participants' interviews were transcribed verbatim. Any details that might identify the participant or staff were excluded to ensure confidentiality. Transcripts were then analysed using Interpretative Phenomenological Analysis (IPA; Smith & Osborn, 2003).

Interpretative Phenomenological Analysis (IPA)

The goal of the analysis was to identify themes that were common across individuals. IPA attempts to explore "...how particular individuals attempt to make sense of, or find meaning in, their [experiences]" (Smith, 1996a, p. 266). It is therefore particularly appropriate to get the 'insider's perspective' of a particular area (Conrad, 1987). This contrasts to traditional approaches to

scientific research where the aim is to produce an objective account of the object or event (Smith, Jarman, & Osborn, 1999).

The term 'interpretative phenomenological analysis' captures the duality inherent in this approach. It is phenomenological in that it is concerned with the individual's personal perception of a phenomenon, such as an event or experience. However, it also recognises the influence of the researcher's own conceptions in making sense of the other's personal world. As Smith (1996a) states, "Access [to the participant's world] is both dependent on, and complicated by, the researcher's own conceptions which are required in order to make sense of that other personal world through a process of interpretative activity" (p. 264). The outcome of IPA is therefore recognised as "...a co-construction between participant and analyst in that it emerges from the analyst's engagement with the...participant's account" (Osborn & Smith, 1998, p. 67).

Rationale for using IPA

IPA provides a structured method for systematic and detailed analysis of qualitative data. It was specifically designed to enable insight into people's psychological worlds, aiming to explore participants' experiences from their own perspective and produce rich descriptions of how participants experience situations and events (Willig, 2001). It was therefore chosen as the method of analysis as it was felt that the aim of the study was aligned with IPA, in that it was concerned with exploring how individuals endeavoured to make sense of

and think about their experiences of help and support whilst being resident in a TC.

Process of analysis

There are a number of clear and systematic guidelines on how to analyse interview transcripts using IPA (Smith, 1996a; Smith, Jarman & Osborn, 1999; Smith & Osborn, 2003). The analysis conducted in this study was guided by the outline described by Smith and Osborn (2003). However, Smith, Jarman and Osborn (1999) emphasise "...that there is no single definitive way to do qualitative analysis" (p. 220) and that the researcher should make whatever adaptations seem appropriate to the study.

Both the first and follow-up interviews were analysed together. The first stage of the analysis began by selecting one participant's interview and reading it several times until the researcher was familiar with it. During this process anything of interest or significance was underlined and noted in the left hand margin. An example of this first stage of the analysis is shown in Appendix 8. The second step of the analysis involved identifying tentative themes which aimed to capture the essence of what the participant was expressing. These were noted in the right hand margin (see Appendix 9). Once all the themes had been noted from this transcript, the third stage was to tentatively group these into a framework of themes and subordinate themes (see Appendix 10). Whilst involved in this process, the researcher continually checked back to the original transcript to

ensure that the emergent framework was an accurate reflection of the participant's account in the interview.

This list of master themes and subordinate themes for the first transcript was then used as a tentative framework for coding subsequent interviews. Care was taken to discern repeating patterns and also to acknowledge new issues emerging. In this way, definitions of themes were broadened, connections between themes were clarified and new themes were produced. Again, all new and modified themes were checked against earlier transcripts.

Once a tentative structure had been produced for each transcript, a master list of themes from all participants was constructed (see Appendix 11). At this stage, a small number of themes which occurred in only a few transcripts and which did not appear to be central to the participants' accounts were dropped from the analysis. The remaining list of themes constituted a 'master list' that reflected the experience of the majority of participants. The master themes were then grouped, for organisational purposes, into broad domains, and a master table was constructed which included the complete list of domains, themes and sub-themes (see Appendix 12).

Credibility checks

Because IPA recognises that an individual's experience cannot be directly accessed but instead can only be mediated through the researcher's own interpretation of the data, the engagement of more than one researcher with the

text can enhance the credibility of the analysis (Elliott, Fischer, & Rennie, 1999). A credibility check on the emerging themes and framework was provided by two other researchers (one female researcher with extensive experience of research exploring mutual support processes and IPA and one male researcher with experience of IPA). This consisted of both researchers independently reading several of the transcripts and then discussing respective themes and frameworks before arriving at a tentative consensus. After analysing all twelve transcripts, the main researcher then presented her preliminary master framework to the first researcher detailed above. This was discussed within the context of the original material and a final master framework was then jointly constructed.

In addition, the follow-up interviews provided another type of credibility check. Before the follow-up interview, participants were given a written summary of their first interview; at the follow-up interview they were then given the opportunity to express their views as to whether they felt the summary was consistent and accurate with their memory of the first interview. This process therefore provided what is usually referred to as 'member validation' (Smith, 1996).

RESEARCHER'S PERSPECTIVE

Integral to the qualitative approach is the view that the researcher's role "...is not a hidden passive or impersonal one in the process of the enquiry" (Pidgeon, Turner & Blockey, 1991). Thus, guidelines to good practice in qualitative

research recommend “owning one’s perspective” (Elliott et al., 1999) or reflexivity (Henwood & Pidgeon, 1992; Willig, 2001). This involves implicit consideration of the researcher’s own values, assumptions and framework of understanding in order to make apparent how these may have influenced the direction of the study and its findings.

My interest in this area of study began several years ago. Before embarking on my clinical psychology training I worked in a TC for people with severe and enduring mental health problems. When I first began this work I was unfamiliar with the concept of the TC and had not come across these organisations before. I quickly came to value such an approach as I began to understand how the community could provide a safe space in which members could begin to explore and understand their experiences. At the time I remember being struck by the contrast between the TC approach and that of the standard mental healthcare system. From my experience of working in the latter I felt that it could sometimes compound feelings of social isolation and stigmatisation as it has a tendency to view mental health difficulties as pathological and residing within the individual, as well as often not taking into account the importance of social support networks. In contrast, the TC approach, grounded in systems theory and locating mental health difficulties, not primarily in the individual, but in the network of relationships of which the individual is part, appealed to my search for a more humane and sensitive approach to dealing with people’s experiences of psychological distress.

I also began to realise how demanding and difficult being in the TC could be; for residents and for staff. The experience often left me feeling confused and unsure but I felt encouraged and inspired by the hard work and effort of individual residents and staff in their attempts to try and understand each other and the situations they found themselves in. This living-learning experience was taxing, but it was also incredibly rewarding as I saw residents gaining confidence and enthusiasm in their interactions with others. I also saw the effect of giving individuals the opportunity to take responsibility and to give to others; this was often a new experience for many of the residents who had become used to being labelled as 'ill' or 'useless'. I remained in this work for a couple of years, finally leaving to pursue a career in clinical psychology.

In my work as a trainee clinical psychologist, I have usually found myself working in services where the focus is very much on the help provided by professionals (i.e. therapy). Although services vary, I have noticed that there is often very little thought given to issues around informal support when working with people who are experiencing mental health problems. I find this approach frustrating, especially when I see the isolation and stigmatisation that many people experiencing mental health problems face, not just in the wider community but also in the mental health system that is meant to be supporting these individuals.

These experiences and interests led me to hold certain expectations and views whilst I was developing the ideas and protocol for this study. I was very aware of

how TCs can be quite wary of 'outsiders', especially those who have no links to the world of TCs, which was where I was located when I began the study. I anticipated that it might be quite difficult to gain trust and confidence from both patients and staff and wondered whether the study would be possible at all. I also wondered how I would feel returning to the TC, as I would be approaching it from the position of an investigator located outside the community rather than as an 'insider'. I also held expectations about what I thought TC members would or would not tell me; I wondered whether they might be wary of whom I was and perhaps not want to talk to me about their experiences. I also wondered about how I might be viewed; perhaps as being in a similar role to a member of staff and how this may impact on participants' accounts. For example, I anticipated that there could be a tendency for people to tell me what they thought I wanted to hear and only tell me about positive experiences of mutual support.

Further reflections on how my personal experiences, interests and expectations may have influenced the course of the research are presented in Chapter Four.

CHAPTER THREE

RESULTS

Eight themes, each comprising a number of sub-themes, were identified from the qualitative analysis. These were organised into three broad, higher order domains: 'context'; 'processes of support'; and 'impact of support' (see Table 1). The first domain, 'context', encompasses participants' experiences of entering the therapeutic community (TC), as well as their views about how it contrasted with previous treatment approaches. It thus provides a backdrop from which the other two domains can be hung. The second domain represents issues relating to the processes of receiving and offering mutual support. Finally, the third domain relates to the impact of mutual support on participants' sense of self and perception of their difficulties.

This chapter presents each of the themes and sub-themes, with illustrative quotations from participants. Extracts from transcripts have been edited for brevity and readability. An edited omission in the text is indicated by three dots (...). When there have been intervening comments by the interviewer, these are indicated by '...//...'. The source of each quotation is indicated by the participant's research identification number.

The term 'patient' has been employed throughout the text as this is the language used within the Cassel Hospital.

Table 1: Domains, themes and sub-themes

DOMAINS	THEMES	SUB-THEMES
Context	1. Journey into the unknown	Shock and surprise Feelings of uncertainty
	2. A different approach	How will it work? Usefulness of TC approach
Processes of support	3. Struggling together	"Nice to know you're not the only one" "It makes you listen" Feeling understood Reciprocity
	4. What I do affects others	Others are suffering too Looking in a mirror
	5. Others care about me	"Not being alone" "Patients care because they want to"
	6. Being accepted	"You're not judged" "People like me for who I am"
Impact of support	7. "Making me feel human again"	"I am worth something" Helping others helps me
	8. There is hope	"If they can do it...I can do it too"

DOMAIN ONE: CONTEXT

The first domain comprised participants' experiences of entering the TC and their views about how it contrasted to previous treatment approaches. Participants described their shock and surprise at entering the TC as it was unlike anything they had experienced before which led to feelings of uncertainty about how it would work. However, as time in the TC progressed, participants commented on how they came to value its approach.

Theme 1: Journey into the unknown

...I had no real idea what it was going to be like. (P5)

I didn't expect it to be anything like this. I didn't have any information really (P6)

A central theme uniting participants' accounts was that of the TC being a new experience. The majority of participants had been in standard psychiatric settings such as acute wards, but had not been in or heard of TCs before, making the entry into the TC akin to a journey into the unknown. This tended to elicit two main emotional reactions: shock and surprise; and feelings of uncertainty.

Shock and surprise

It's very difficult to imagine what it's like until you come here...one thing I was really shocked by, which I couldn't figure out at first,

was...that the patients were taking on this responsibility of chairing a group. And I thought that they must be staff. And it's only like halfway through the meeting I realised that they weren't. (P9)

I was pretty amazed, because it wasn't like anything I'd ever experienced before...everyone was really sort of working well together...there was a real feel of everyone kind of coming together and, even as a visitor, I was expected to chip in...it was very different. (P11)

The above quotations illustrate something of the initial shock and surprise at finding something so different from other mental health settings and the ensuing confusion in trying to work out what was happening.

Feelings of uncertainty

A pervasive theme running through participants' accounts was the feeling of uncertainty on arrival at the TC. *"...it wasn't explained at all. I didn't have a clue what a therapeutic community was about" (P7)*. These feelings of not knowing what to expect also generated a certain amount of worry:

I've...never had to deal with people with problems, mentally, physically, whatever. So I did find it a bit daunting coming in here and having to experience and share and see other people's problems... (P10)

In addition, participants experienced difficulties in understanding what was happening, often resulting in feelings of being separate from the community:

...I had no idea what the...community was. They were talking in another language, and I thought, "Oh dear, you know, this is really a bit grim. (P3)

Theme 2: A different approach

One of the aspects of being in the TC which was repeatedly alluded to by participants was the contrast between this approach and previous treatment approaches. The majority had been in acute wards prior to their stay at the Cassel; the latter was experienced as being very different in approach:

It is so much different to an acute unit...[there] I find they just pump you full of drugs, because...they get a quiet life then...they don't try to find out the root of what is causing your depression, why you're feeling suicidal...you don't get very much support from other patients on the acute. It is mainly staff orientated. If you've got a problem you go to the staff. (P7)

How will it work?

When participants first entered the TC, the difference in approach made many of them wonder how it was going to work:

I couldn't see how it would work, because I was in an acute unit...prior to coming here. I was very used to having a huge amount of staff input, and you basically didn't talk to one another as patients, it was actively discouraged. (P1)

The idea of talking to other patients appeared to be one which was not encouraged, indeed sometimes even actively discouraged, in acute settings. Understandably, the prospect of peers being the main source of support within the TC aroused a mixture of confusion and scepticism in many of the participants as they had never had this experience before. Several patients also remembered their initial worry at the prospect of depending on other patients for support:

At first I was quite worried, because [my psychiatrist] was saying to me that it is very much that the patients support each other, and that's something that I've never experienced before. I've always turned to staff. And I was quite concerned as to how patients would react to me with the different problems I faced...I was also worried about sharing those problems with people I don't really know, and that aren't, if you like, medical experts in one way or another. (P2)

Usefulness of TC approach

Despite initial concerns, as time proceeded and the TC became more familiar, the majority of participants commented on how they valued this approach over other treatments experienced in the past:

I would say that this, the therapeutic community [has been more useful than previous treatments]...because...it's not just focusing on yourself all the time. You know, you have to take into consideration the feelings,...how you're hurting other people, and how what you do affects other people in some way, be it good or bad, and you always have to take that into consideration. (P4)

This focus on the self in relation to others, rather than seeing the self in isolation, appeared to be an important factor in participants' appreciation for the TC approach. In addition, there was a pervasive theme in participants' accounts relating to the importance of being given the opportunity to explore their difficulties:

I was in an acute ward...it's so different. Here things are really looked at and...attempts are made to really understand, you know, what's underlying something. Whereas on an acute ward it's just like...a holding place where you're kind of held and nothing's looked at...(P9)

Several participants also mentioned the usefulness of having opportunities for both formal and informal help to occur; specifically with regard to having individual therapy alongside living in the TC:

...it's definitely the two things in combination. The individual [therapy] really only works when you're in the community...It's very private, you can talk about problems you have with people that you're around...in a community...you can see the way people respond to how you act. (P11)

The dual aspect of individual therapy and community living was also mentioned as useful with regard to gaining more self acceptance:

...I think...maybe I've got a little bit more self-acceptance and kind of idea of who I am...//...maybe as a result of therapy I was able to explore myself a bit more, and then sort of try it out in the [therapeutic] community a bit. (P12)

DOMAIN TWO: PROCESSES OF SUPPORT

In discussing the processes of help and support experienced within the TC, participants described the importance of struggling together with others who were also going through similar experiences; and the mutual understanding that ensued. Participants also spoke about how living in a community with people having similar experiences enabled them to see the impact that their behaviour

had on other people and the resulting shock at this realisation. Feeling genuinely cared for and accepted by others were also major themes; participants described a reduction in feelings of being alone and relief in not being judged.

Theme 3: Struggling together

When you see other people struggling, and the people that had the bad reviews and stuff, it gives you a kick to...get on with your own stuff, and work harder. I mean sometimes at the same time it can knock you back a bit, but...well, I tend to move on. (P6)

An aspect of TC life that was repeatedly alluded to was the experience of struggling together with the same kinds of problems. Patients described this phenomenon mainly in positive terms; for example, the importance of sharing similar experiences with others and the gains provided through other patients' knowledge. Benefits of shared experience leading to shared understanding ran through participants' accounts, along with the importance of reciprocity. However, participants also mentioned some of the difficulties that resulted from being with other people who were struggling with similar problems.

"Nice to know you're not the only one"

For the majority of participants it was the first time they had come across other people who had similar experiences and difficulties to themselves. This realisation was described by a number of participants as being a positive thing in

that it had the effect of validating and normalising their experiences, and making them aware that they were not 'abnormal':

...it's nice to know you're not the only one. The feelings you have, some feelings are the same as somebody else's feelings, which makes you think that you're not completely abnormal. (P5)

...Maybe you just sort of feel a little bit more normal being around people who are similar to you...//...self-harm scars can become a really, really big thing, and people [outside] get frightened...When I've hung out with friends at the Cassel... it's not an issue...So it makes life a lot easier, a lot more liveable and enjoyable. (P11)

Alongside these feelings, some participants described their difficulties in seeing other people suffering in similar ways to themselves:

...Part of me [feels] relieved that I wasn't the only one...but I also found it a bit sad. (P8)

It's very difficult when people start talking about things that are very similar to things that have gone on for yourself...And here I find that really difficult sometimes when someone's talking about something that's so close, or if I feel that I'm supporting somebody who's so distressed that it actually is really upsetting for me (P9)

For another participant, seeing others with similar problems made her think about what she was doing and acted as a catalyst to change:

...they've got the same problems as you have, and that can be quite comforting actually...//...Because we're all in the same boat really...//...here has been... the first place where I think...people are like me. But then I look at them and I think, "I don't want to be like them any more"...which I couldn't do before, and I won't do what I've done anymore...I think it's also helped me not to self-harm being in here...//...I mean I didn't realise there were people out there the same as me. (P3)

Participants spoke about how they had felt unable to talk about their past experiences prior to coming into the TC. Talking with others in the TC resulted in the realisation that they were not alone in the ways they had tried to cope in the past:

I think things are hidden for such a long time, and you haven't spoken about them, and then you end up doing things which are really destructive, and you realise that...other people have coped the same way. (P9)

“It makes you listen”

In addition to the relief gained from knowing that others shared their experiences, participants also talked about being able to listen to advice and consider other ways of coping:

...what I find very useful is a lot of people here have had similar circumstances, similar situations, and they're able to tell me how they've handled [that]...And a lot of it is valuable advice. I tend to listen more to people that have actually gone through the same experiences, because they've been there, they've done it. It makes a lot more sense to me. (P2)

...it makes you listen. You really prick your ears up, and you start believing , and it sinks in. If you're listening to people giving advice who you know have never been through it, you tend to switch off. (P11)

Feeling understood

Finding that others shared similar experiences often resulted in a sense of relief at being understood and in being able to voice their feelings with people who could understand:

...it's a great relief to know that others...really do understand what you're talking about when you talk about the things that have

happened in your life that have brought you here...//...It just made me feel more understood...//...Able to share more. Able to talk about things and not hide things, not to be secretive...And not to be frightened to say what was going on, not to be scared. (P4)

...I got quite a big chunk of...support...from another patient...who was in the same sort of situation...to hear that somebody else was feeling what I was, or had felt what I was feeling...//...Well basically it made me feel understood...//...it made the pressure release a bit. (P10)

This understanding allowed participants to feel they and their experiences could be talked about and become 'known':

...whatever's happened to me, or whatever I've done, it does seem to be in the realms of their comprehension. It's not something completely untalkable...unheard of, impossible to...decipher...in my head it's just a mess...Nobody could possibly understand, so just somebody understanding, or getting near to understanding something, does have a tremendous difference...//...it's a relief...going from somebody that's completely unknowable, whose experiences are completely unknowable, indescribable, to you actually managing to describe something and they know it...they understand it... (P5)

Differences between talking to staff and patients were also mentioned; several participants commented on how they felt that other patients, unlike staff, could understand their experiences, as they too had been through something similar and therefore possessed knowledge which staff did not:

...the majority of the staff probably haven't been through what we've been through, so other patients can relate to it and help you more...as I've come through the months of being here, I prefer talking to a patient than a member of staff because they understand you more. (P8)

Reciprocity

Overall, participants commented positively on the experience of reciprocity: they not only received support but gave support to other patients. Experiencing being with others who not only took support but also gave support back often led to the feeling that others could be trusted:

...in here people do stuff for others...//...It's about being there for each other... //...feeling like you can trust them. (P8)

...next time I'm not feeling particularly good they'll be able to lift me out of it, as I lifted them out of theirs. (P12)

One participant described how they found it easier to give others support after experiencing receiving support from them:

...when people started giving support...//...it made me feel easier to talk to people about their problems. Being able to come to them when they were struggling. (P10)

Another participant reflected on how they found it easier to take support from others with the knowledge that they would be able to reciprocate at some point in the future:

...I know that at some point I'll be able to help them as well. So it's not a one-way thing. And that is much easier...//...I suppose it makes it worthwhile, the fact that I have something to offer. It's not just somebody's helping me...you feel better about yourself if you can help somebody. (P1)

Several participants described how their experiences of being given opportunities to give support contrasted to previous treatments where the emphasis was on receiving support:

...I kind of built this brick wall around myself and that's been knocked down by these people, by my supporting them and by them supporting me...//...Other types of help I've experienced...it's

all about me. It's never about helping other people. Whereas...the two things here are quite combined...You get help for yourself, but you're also here to support and to help others. (P4)

A couple of participants mentioned their difficulties in sharing their difficulties with other patients due to worries about overloading them:

I think that I personally find it difficult to speak to the other patients about my problems, because I know they've got their own problems. So I feel as though...I shouldn't. (P3)

...everybody's got their own shit. And they don't need mine on top. Because if they're struggling with their own stuff, how are they supposed to help me sort the stuff going on in my head?...If I can't cope with it, how are they going to cope with it? (P7)

Another participant talked about how they found it difficult to take support from other patients as they were not used to this experience and worried they did not deserve it:

It's great to have the support, in the respect that I don't feel alone, don't feel judged. But on the other hand, I'm not used to it, and to a certain extent it makes me feel uncomfortable. Because I've never...experienced so much support in any one place...And I'm

finding that hard to cope with in the fact that why me, why do I deserve this support. But like I say, at the same time I am glad of it. I do appreciate it, because I couldn't go alone with these problems. But it does make me feel kind of awkward. (P2)

One participant described how they felt that the idea of reciprocity helped in this respect:

At first I felt guilty about having conversations with patients about my problems...A lot of people have problems feeling that they're...loading people with their problems. But yes, you...get used to it...it's the give and take, because you can talk to someone and you know that they can also talk to you if they have a problem. And you realise that it works...it something that you realise more and more as you get through treatment. (P11)

Theme 4: What I do affects others

A pervasive theme in participants' accounts was the realisation that their behaviour affected other people within the community. Many of the participants had been fairly isolated prior to coming to the TC due to their difficulties in forming and maintaining relationships, leading to reduced opportunities for social interactions and for seeing the impact of their behaviour on others. A number of reasons may account for this: several participants had histories of abuse and so experienced difficulties trusting others; in addition the majority of participants

had long-standing mental health problems which had necessitated hospital treatment, often interfering with naturally occurring social networks.

Living in a TC gives people the opportunity to live in close proximity to others and to gain more understanding about how their behaviour impacts on others; exploration of the way people interact and the way their behaviour impacts on others is actively encouraged.

I...saw...how I can be with people, and how people can react to that. And sometimes...I can do or say something which I think is insignificant, but there I find out that it can be taken to be highly significant. (P12)

Others are suffering too

The realisation that other patients were suffering too was highlighted in many participants' accounts; this appeared to make participants more considerate with regard to the way they behaved:

...If you're cutting or self-harming, or...overdosing...the rest of my family...and my friends haven't had the experiences that I've had. So...you think, "Well, blow it...they don't know what I'm thinking or what I'm feeling, so I can do this to myself." It's almost like you can justify it to yourself out there, but you can't justify it in here, because other people are suffering in exactly the same way. And

other people want to do to themselves maybe what you have done to yourself. And so you think twice about that all the time. I think part of it does come from not wanting to do it to yourself, but the other part comes from...considering other people. (P4)

In addition, the TC ethos of taking responsibility for oneself and being prepared to justify one's behaviour to others was referred to; this contrasted to participants' prior experiences:

...whereas [before] I would cut and say it wasn't my fault, here if I cut it is my fault, and I have to explain and justify and talk to other people about it...//...It's not just staff that say "Why did you do that?", it's other patients. And you can have a respect for that, because you know they're struggling with the same sort of things. (P1)

Being around others struggling with similar issues to oneself could also lead to difficulties:

...you can spark each other up; you can sort of exacerbate your own problems. Maybe someone who's depressed, and you're a bit depressed and you get more depressed, and sometimes people almost want to make you feel worse...I mean sometimes

when you're around people who have mental health issues it can be very upsetting to see other people suffering (P11)

Looking in a mirror

Being in an environment with other people who were experiencing similar difficulties also allowed participants to see other people behaving how they behaved. Participants talked about how this opened their eyes with regard to the way their behaviour affected others:

...one...thing that really struck me was when one of the patients was really really unwell, and was really suicidal, and the effect that it had on the community...And it really sort of struck something in me and made me realise how difficult it had been for my friends, and the difficulties that I'd placed them in. And how my actions affect other people. (P9)

Participants also expressed shock at seeing other patients behaving in a similar way to themselves:

...I had issues with cutting and stuff, and...my first week of being here I walked in and she'd [room mate] cut her arms quite badly...I'd never seen someone else do it...//...I was a bit shocked really. (P8)

Theme 5: Others care about me

People...might help you get to a group, get to a structure if you feel you can't manage it...And they give you support, and they have faith in you, and they tell you why you need to be there...It makes me feel appreciated and cared for. (P11)

The feeling of being cared for by other patients was contrasted to experiences of life outside the TC. There was a sense of patients not giving up on each other:

Outside in the wider community you screw up once and that's it...Here you can screw up, as long as you take the consequences, and try not to let it happen again, people are willing to work with you...Here, they'll get angry with you, they'll get annoyed with you, but tomorrow they'll be there to help you again. (P1)

There were also feelings of trepidation with regard to returning to life outside where people often do not show compassion or sensitivity to people who are experiencing difficulties:

...it's scary, because you think it's not like that outside...that level of support doesn't happen in the real world...a lot of things can be misunderstood...particularly problems that people have to face here. (P9)

“Not being alone”

One of the aspects of being cared for which was repeatedly referred to by participants was the feeling of not being alone; of feeling that others were interested in them:

...One of the benefits is...having the feeling of being supported and...not being alone...having...somebody who is interested in my welfare. (P12)

It can be really helpful...//...Knowing that other people care. That you're not alone with your problems, the feelings that you've got. (P7)

This made participants feel that they were able to rely on others rather than having to depend entirely on themselves, again reducing feelings of isolation and loneliness:

...It's knowing that someone does care enough...//...it makes me know that I'm not the only person around, that I don't have to do everything myself. (P6)

For the majority of participants, these feelings of not being alone were very different to how they had felt prior to coming into the TC:

...nobody's had the time to talk to me before, or aren't particularly interested in what I've got to say. But here it's totally different. (P2)

However, being with others in the TC also brought difficulties for some participants with regard to feelings of losing their privacy:

...it's obvious now...whatever you say to somebody, it gets round. It doesn't matter if you say it in confidence, or whatever, the whole place will know, and it will get back to staff. That's what I don't like about this place...that you can't say anything without it getting back. (P3)

...here you can't say anything without someone else wanting to know about it...I don't like it at all. It really, really annoys me. (P8)

"Patients care because they want to"

A central theme uniting the participants' accounts was that of feeling that the care they were offered by other patients was genuine. Unlike staff, patients are not paid to offer support and have a choice as to whether they offer support or not; this made many participants feel that patients offered support because they genuinely wanted to:

...The patients care because they want to. The staff care because they want to, but it's also their job. And I think you always have to remember that. (P1)

Well, I keep being told that if the patients didn't want me here I wouldn't be here now...I've struggled a lot, and there were many times I could have been discharged, and I wasn't...So...that support has been really important to me. (P3)

Again, for the majority of participants, the experience of other patients having genuine concern for them was new and somewhat strange:

...it wasn't just the staff that would come and check if I was OK. The patients actually did as well, which was very strange for me. And they actually showed concern...//...I realised that people did care, and I was thought about. (P2)

However, the issue of forming close attachments to patients and then having to deal with those people leaving the TC was one which several participants discussed as being painful and difficult, as well as bringing up issues of whether others can be relied upon and trusted:

...people leave...that's very difficult because the people you've been relying on, people who you've built a connection with...suddenly they're not there. (P1)

Two participants also expressed worry about whether other patients would forget them when they returned to the outside world:

...that person's not there for you anymore, and you're not there for them...you've built a bond with them, and it's like that bond's been broken. And it is difficult...//...I feel like they're walking out on me, and I'm not going to see them again. (P8)

...you get close to people, and then they leave...in a way you feel like they're abandoning you...And there is always the fear of... [wondering] if they still want my friendship. (P7)

Theme 6: Being accepted

...people make extra, extra, extra effort to...welcome you in, because they know what it's like to be on the outside. So many of us have felt on the outside. If you've got a bunch of people together who have felt on the outside, you know, you club together. (P11)

Due to histories of abuse and/or many years of suffering from mental health problems, several participants had issues with feeling they were somehow 'on the outside', partly due to the stigma that society still places on these experiences. A pervasive theme in participants' accounts was the notion of feeling accepted by others within the TC and the experience of not being judged.

"You're not judged"

For most participants, the feeling of not being judged meant that they could start to talk to others about their experiences without the worry of what people might think of them or how they might react:

...you're not judged in here...//...It means a lot. Instead of worrying about what other people are thinking, what other people would feel about what's happened in my past, I can say about it and people give me feedback...//...I feel like I don't have to lead a double life. I can be me. (P6)

Participants described the importance of not being judged with regard to how this allowed them to start to deal with their difficulties and to begin the journey of self-acceptance; one that is made all the more difficult if one is surrounded by people who are not prepared to accept what has happened in the past:

There's a huge stigma attached to mental health. Here I can look about and see somebody else with scars on their arms, and know

that at some point they have felt the same way I have. I can be at home and [my family] want me to cover up my arms in case any of their friends see...And that's a huge contrast [to here where people say] "It's OK, that happened in the past. Wear a t-shirt if you want."...//... It's much easier to deal with, because you don't have to keep hiding things...And it also helps me come to terms with the fact that I am very scarred...No matter what I do it's not going to go away, so I have to learn to deal with that...//...I can accept who I am better. (P1)

"People like me for who I am"

Experiences of not being judged by others gave the majority of participants a sense of validity and the freedom to be themselves, rather than trying to fit with other people's needs: *"...you don't have to put this big front on all the time"* (P10). There was also a sense of the whole self being accepted within the TC, again, making participants feel they did not have to hide aspects of themselves:

...here you feel that...the good bits and the bad bits about yourself are accepted...//...Whereas...out in the community it's like we only want to see the good bits. You know, the bad bits are unacceptable. (P4)

Participants talked about new experiences of feeling others liked them for who they were, which often resulted in feeling less alone. Again, the notion of feeling

other patients were being genuine and could therefore be trusted, pervaded these accounts:

...I don't feel so alone...I actually feel people like me for who I am. Because here people don't put on false pretences or airs and graces. You are what you are...And people are actually liking me for who I am. I've never had that before...And that means so much to me. (P2)

Frightening experiences were also normalised: others who had been through similar experiences could understand and accept why someone else might be feeling or behaving in a particular way:

...they really understood where I was coming from, and they'd experienced something very similar and very frightening...//...I felt like...it was OK to be how I was, it wasn't that I was going crazy or anything. (P9)

DOMAIN THREE: IMPACT OF SUPPORT

The third and final domain relates to the impact of mutual support on participants' sense of self and their perception of their difficulties. Participants described how the process of being in the TC had changed their perceptions of themselves; several described how they felt a greater sense of self-acceptance and self-liking. The opportunity to offer support to others was repeatedly referred

to by participants. Being able to give, rather than always receiving support, was something which participants found beneficial in that it made them aware that they were still needed and able to do things for others, leading to feelings of competence and self-efficacy. Finally, a pervasive theme running through participants' accounts was that of hope for the future.

Theme 7: "Making me feel human again"

A central theme uniting the participant's accounts was that of feeling they had something to offer. For the majority of participants this stood in stark contrast to how they felt prior to being in the TC:

...It's...making me feel human again...I don't feel I'm just existing so much. I've actually got something to offer...//...And I've never experienced that in acute before. I was just a hospital number, and...if you had a problem there, the answer was more medication
(P2)

"I am worth something"

Participants described how the process of living with other patients in the therapeutic community had the effect of making them feel they were "worth something". Again, this contrasted to how they felt prior to being in the TC:

...I didn't like myself very much. And I think they helped me to begin to start liking myself again, and realising that I am worth

something...I hadn't really been cared for like that I don't think, for a long time. And...it really sort of opens your eyes, that other people care for you. You feel, "Well, maybe I should start caring for myself". (P11)

...since I got ill...I haven't really felt significant. But here I'm beginning to. And I feel they're not just using me for someone to talk to, they actually want my advice...//...and that's given me my self-esteem back again. It's made a big difference to how I feel about myself. (P2)

Another participant described how the community had helped them to start to see that they were not responsible for past situations, subsequently assuaging feelings of guilt:

...you do change how you look at yourself. You sort of realise that perhaps it wasn't your fault...Because I suppose you're hearing it over and over again that it's not your fault. (P5)

However, the struggle to accept others' positive perceptions of oneself, especially when these conflicted with previous experiences, was highlighted by one participant:

...I really do find that difficult to accept that people do see me in a different light to how I see myself, and that I'm not always this mean, nasty person that I've grown up being told that I am. (P7)

Helping others helps me

The majority of participants described how they felt that helping others had helped them in a number of different ways. These include the idea of listening to the advice one is giving to other patients who are experiencing similar difficulties:

...it makes you understand your own problems a bit more as well...//...Because you're saying the things to them that you really should be taking on board yourself. (P4)

In addition, most participants described experiencing increased self-efficacy from the knowledge that others had taken up their offers of support:

[Helping others]...helps me deal with my own stuff as well...//...people take my opinion on...And it is nice to think that...one of my opinions has come good for someone else...//...I know I've got an opinion. I never had that before...//...It makes me feel a lot stronger in myself. (P6)

[helping others]...just makes you feel needed really...and that you are wanted. And that...you do make a difference to people...//...It's important to be able to continue living. To keep yourself alive really. (P4)

...if it was help that I was able to give...then it made me feel useful, and that made me feel good. (P12)

This contrasted to the majority of participants' experiences prior to coming into the TC:

...in the acute [ward], suddenly nobody needed me...So...probably here is the first time, apart from [with my family] that I felt needed in an emotional sort of way...//...self esteem goes up if you feel needed. You feel better about yourself. (P5)

[helping others]...makes me feel good, because I feel like I'm of use...to somebody. Somebody actually makes me feel that they want me. So I then feel wanted...needed, which makes me feel a lot better about myself...//...when I was a child I never, ever felt wanted. I never felt needed, and I sure as hell didn't feel loved. By helping other people I do get that. (P7)

Some participants spoke about how they felt that there was sometimes a danger that all their time was spent helping others and how this could be used to avoid dealing with their own problems:

...I've got some huge problems at the moment, and I'm really putting them to the back of my mind, and just concentrating on other people's problems...//...I'm just taking on too much so I can blot my problems out. (P2)

Several participants also described feelings of failure if they experienced not being able to help a fellow patient:

...you can't always help people...//...you just feel like you're letting them down...It makes you feel quite depressed. Very negative about yourself. (P4)

...if...I'm trying to support someone, and it's rejected, that can be quite difficult...//...I feel worse about myself. (P1)

Theme 8: There is hope

There's a little glimmer at the end. Before I couldn't see that. It's not a blazing light that's going to come running towards me, but sometimes I think, yes, I will be able to stop cutting, I will be able to

get back to normal life, whatever normal is. But I think the realisation is I can't do it by myself. (P1)

One of the themes pervading participants' accounts was that of hope; this was a new feeling for the majority of participants due to the longevity and severe nature of their difficulties. Several participants commented on feeling more able and confident in their abilities; the non-judgemental attitude of the TC and the opportunities to gain insight from others about one's behaviour, were mentioned in this regard:

I feel I'm more able to cope with things. When I came here I couldn't cope with anything. (P3)

I just feel less isolated [here]...[outside you're] not always sure...that your company is wanted, whereas here, most of the time it's accepted, good or bad really...//...It's made me more sociable than I used to be...my social skills are becoming stronger, I'm getting them back again. (P4)

I think the community has changed me...//...I think it's...because everyone's so open. Everyone tells you what you're doing wrong and what you're doing right. And helps you...rather than just going along being wrong and not knowing how to change it. (P6)

“If they can do it...I can do it too”

The majority of participants commented on the usefulness of being in an environment where it was possible to see how other people experiencing similar problems to themselves changed during their time in the TC. This involved the employment of upward social comparisons; in other words, there was a tendency for participants to look to other patients who were doing well and overcoming their problems in order to feel hopeful about their own situation:

I don't find them [my problems] so frightening...//...Well, other people...have got through very similar problems to mine...they have overcome it. So if they can do it, there's a chance I can do it too...//...I don't remember having hope before. But I do feel kind of inspired. (P2)

...Some of them [other patients] have come a long way...So it does give you some strength, when you know [they] can do it. It's almost like,...”I'm sure I can do it as well” sort of thing. (P5)

...it makes you feel better, because they'll [other patients] talk about how they were when they came in...and then you look at how they are now and you do believe there is some hope. Because...a lot of people have come a hell of a long way since being here...looking at them I'm...feeling a tiny bit

positive...because they have been in the same situation, and they have come through it. (P8)

...I was thinking..."I want to hear a success story,"...that somebody is leaving and is moving on. And...I did hear that kind of story...It upset me in a sort of moving way, because it's like...tiny steps just seemed quite amazing. (P9)

One participant commented on how the experience of seeing other patients changing and making progress was a new one; in previous treatments she had only seen patients either staying the same or deteriorating:

I guess it's that knowledge that things can get better, which is something that dies in a lot of people when they're very ill. You just never think anything's going to change. But when you see someone pull away from the brink...then there's hope there, that it can change. And that's what I saw a lot at the Cassel. I saw people changing all the time...//...it was the first time I noticed people with mental health issues getting better, because in acute units all I've seen is... people deteriorating or staying the same. (P11)

CHAPTER FOUR

DISCUSSION

OVERVIEW

This qualitative study explored how mutual support processes operate within a residential therapeutic community (TC) and the effects that these have on individual TC members. Twelve people in a TC for people with severe emotional and social difficulties were interviewed. The interview enquired about the types of support participants received from their peers; the types of support participants offered to their peers; and the impact of mutual support on participants' sense of self and on their perception of their difficulties. The interview transcripts were analysed using interpretative phenomenological analysis. As there is a paucity of previous research in this area, the study adopted an exploratory, discovery-oriented approach.

The analysis yielded eight major themes, organised into three domains. The first domain, 'Context', encompassed participants' experiences of entering the TC and consisted of two main themes: 'Journey into the unknown' and 'A different approach'. The second domain, 'Processes of support' represented issues relating to the processes of receiving and offering mutual support and incorporated four main themes: 'Struggling together', 'What I do affects others', 'Others care about me', and 'Being accepted'. The third domain, 'Impact of support' related to the impact of mutual support on participants' sense of self and their perception of their difficulties. It consisted of two main themes: 'Making

me feel human again' and 'There is hope'. Participants' accounts were largely positive.

This chapter will discuss the findings of the study in relation to the wider context of the existing literature. Methodological issues raised by the study will then be addressed and suggestions made for future research in this area. The chapter will conclude with an exploration of the potential implications of the study for clinical practice.

FINDINGS AND LITERATURE

The findings are discussed in relation to four broad areas. First, the difference between the TC approach and previous treatment approaches will be considered, especially with regard to the opportunities there are for mutual support processes to occur. Second, the interface between informal and formal helping within the TC will be explored. Thirdly, interpersonal aspects of the findings will be discussed, focusing on the types of social interactions and support processes that occur within the TC. Finally, intrapersonal aspects will be highlighted with regard to how the experience of mutual support within the TC can lead to changes in self identity.

Difference between TC and previous treatment approaches

None of the participants had ever been in a TC before, and the majority did not know what it entailed before their arrival. Participants described their subsequent feelings of uncertainty in entering the community, as well as shock

and surprise at how different it was compared to previous treatment approaches. This led to most participants harbouring initial doubts as to how it was going to work. However, as length of stay increased, participants described how they began to value this type of approach for a number of reasons.

The majority of participants had severe and long-standing mental health problems and many had experienced repeated hospital admissions. Descriptions of previous treatment approaches contrasted vividly with experiences of being in the TC. Participants spoke of how, during previous hospital admissions, they had often been given a lot of medication and how they felt there had been little or no attempt to try to understand their problems. There is very little in the literature on patients' own views about psychiatric care. However, the few studies that have been conducted highlight the degradation and disempowerment experienced by psychiatric inpatients (Goffman, 1959; May, 2000; Newnes, Holmes, & Dunn, 2001).

Wood and Pistrang (2004) conducted a qualitative study exploring service users experiences of an acute mental health ward and found that both patients' and staffs' accounts were characterised by an overwhelming sense of vulnerability and helplessness. Worryingly, patients' accounts suggested that assault, physical and verbal intimidation, and sexual harassment by other patients occurred regularly on the ward. These findings are consistent with previous studies (Kumar et al., 2001; Williams et al., 2003). However, despite fellow patients' behaviour being frightening at times, they were also described as a

valued source of support; patients recounted feeling understood by others who had similar experiences and how this reduced their anxiety (Wood & Pistrang, 2004). This is consistent with the mutual support research and first-person accounts testifying to the benefits of support from 'similar others' (Borkman, 1999; Faulkner & Layzell, 2002). It is also in concordance with the findings of the current study.

Despite the literature suggesting that patients find other patients to be a valued support, it would appear that there is little or no thought given to this in the majority of psychiatric services. In the current study, one of the issues which several participants mentioned was that when they had been in psychiatric wards and units they had felt they could only take their problems to staff rather than to other patients. Indeed, one participant described how staff in one particular hospital had actively discouraged patients from speaking to each other. Participants' accounts refer to the benefits of talking with other patients who have been through similar experiences to themselves; this supports the findings reported within the mutual support literature detailing the benefits of support from similar others (Knight et al., 1980; Maton, 1988). It follows that standard psychiatric services could be much improved by consideration of mutual support processes and in developing provisions for these interactions to occur.

In the current study, although participants initially felt worried about the TC ethos of patients supporting each other, they described how these initial worries began

to dissipate as they began to experience some of the benefits of this type of support. Many participants spoke about their relief in talking to others who had been through similar experiences and valued the opportunity to explore their difficulties in an environment where openness and honesty with fellow patients was encouraged. In addition, the focus on seeing the self in relation to others appeared to be another important factor in participants' appreciation of the TC approach. These accounts are highly consistent with the theoretical aims of TCs which promote "equitable and democratic group-living...[where]...interpersonal and emotional issues are openly discussed...[and] ...mutual feedback helps members confront their problems and develop an awareness of interpersonal actions" (Haigh et al., 2002, p.13).

Participants' accounts were consistent with the idea that sharing experiences with other people facing a similar stressor is expected to lead to validation, normalisation of the experience, a reduction in social and emotional isolation and a sense of belonging (Lieberman, 1993). By sharing experiences with similar others, group members learn that their reactions are normal and appropriate (Coates & Winston, 1983), even though they may have heard otherwise from people in their naturally occurring social networks. Validation is especially important for people who have often been marginalised and stigmatised and who are frequently already feeling disempowered due to difficulties in integrating into a society that commonly considers mental health difficulties to be abnormal or shameful. If people suffering mental health difficulties then experience being in services which do little to encourage the

forming of relationships with fellow human beings, it is likely to compound existing feelings of isolation and stigmatisation. In contrast, the TC attempts to address some of these issues by the very nature of the approach it takes. In light of the findings described above, it would appear that psychiatric services could learn a great deal from the way that TCs operate.

The interface between informal and formal help in TCs

In exploring mutual support processes within the TC it is important to consider the unique structures in place within TCs that facilitate the process of mutual support. TCs can be distinguished from most other treatment approaches in that they rely on a combination of both formal and informal help. This is important when considering that the literature on help-seeking behaviour indicates a general preference for informal over formal help from people facing psychological difficulties (Barker et al., 1990; Brown, 1978; Gourash, 1978; Gurin et al., 1960; Veroff et al., 1981; Wills, 1992). Barker and Pistrang (2002) propose that this naturally preferred pattern of help-seeking behaviour suggests that mental health providers should consider people's natural bias towards informal help when designing interventions and services.

The TC, in providing both formal and informal help, can provide a means of studying how people use these two types of support, as well as how they work in combination. As described in Chapter Two, a distinctive feature of the Cassel Hospital is its combination of individual psychoanalytic psychotherapy and group structures/community living (i.e. most TCs focus on the latter). The model used

at the Cassel aims to create a deliberate separation between the 'inner' world of private fantasy and feelings, and the 'outer' world of social roles, work tasks and current relationships; the external structure provides a sense of order which the patient is gradually able to internalise (Kennard, 2000). Several participants discussed the usefulness of having individual psychotherapy alongside the group structures and community living. One of the reasons for this appeared to be that the individual psychotherapy created an opportunity to explore the internal world of thoughts and feelings in a dyadic therapeutic relationship rather than in a more public forum which provokes its own set of inhibitions and self-censoring. It would appear that participants valued the more private space they were given during their individual psychotherapy sessions in that this created opportunities to think through what they were experiencing in their social interactions with others in the community.

As mentioned previously, most of the participants had long-standing and severe mental health difficulties, and frequently had histories of abuse and trauma. As a result, there were often difficulties in interpersonal and social relationships: participants described finding it extremely difficult to trust others in light of their past experiences and spoke about feeling isolated and alone before coming to the Cassel. It follows that the experience of living in close proximity with many other people in an environment that promotes the giving and receiving of support may be quite threatening for people with these histories. The particular structures set up within the TC, such as individual psychotherapy, group therapy, community activities and meetings, and the deliberate separation

between the inner and outer world, create a particular type of containment which enables naturally occurring social interactions, of which mutual support is part, to occur. Individual psychotherapy, in giving patients their own private space in which to reflect on their feelings and experiences, may help to create a safe space from which it is possible to venture into this more potentially threatening social territory and to gradually begin to feel able to participate in mutually supportive relationships.

Interpersonal aspects: Opportunities for social interaction within the TC

Key features of TCs are the opportunity they provide for people with similar difficulties to live and participate together in a range of purposeful tasks (i.e. therapeutic, domestic, organisational and educational) (Kennard, 2000). These opportunities were valued by participants for a number of different reasons that are outlined below.

The experience of 'struggling together' with others who were going through similar difficulties was reported by participants as being important in validating and normalising experiences. For the majority of participants, being in the TC was the first time they had come across others with similar difficulties and experiences to themselves. Several participants described how they no longer felt that they were 'abnormal', leading to a reduced feelings of isolation and stigmatisation. This supports the idea that sharing difficult experiences with similar others is expected to lead to validation, normalisation of the experience, a reduction in social and emotional isolation and a sense of belonging

(Lieberman, 1993). Being with similar others evoked mixed emotions in some participants; although they felt relieved to meet other people going through similar experiences to their own, they also felt sad that others were suffering in this way. For one participant, being with others who were behaving in a similar way to her made her aware of the impact of her own behaviour and acted as a catalyst to change.

Participants also described the importance of sharing experiential knowledge (i.e. knowledge gained from personal experience). Participants reported that they felt better understood by fellow patients than by staff (i.e. reasoning that patients had been through similar experiences and could therefore understand how they felt whereas most staff could only imagine what these experiences were like). This feeling of being understood resulted in feelings of relief and in a new found confidence in being able to share experiences with others; one participant described the relief he felt in progressing from a feeling of being 'unknowable' to 'being known'. Thus, the process of being with similar others who had experiential knowledge appeared to provide informational and emotional support (Hogan et al., 2002). For example, participants described how it assisted the sharing of coping strategies and advice, as well as promoting feelings of being understood through empathic communication leading to decreased feelings of isolation and stigma, and encouraging the expression of feelings.

In TCs, people not only receive help but also have the opportunity to help one another. This is something that the majority of participants mentioned as being important: it also contrasted to previous treatment approaches where support processes were described as being one way (i.e. received). Participants reported that being given opportunities to support others led to increased self-esteem and confidence as they discovered that they were able to do something that made a difference to others. This finding supports Riessman's (1965) 'helper-therapy principle' which proposes that having the opportunity to help others instils a feeling of self-efficacy and competence. Being given opportunities to help others is especially important for people such as those in the current study, who have long histories of being 'treated' and 'helped' by others. Sadly it is often the case that individuals in these situations can often end up believing that they have nothing to offer others and subsequently their self-esteem may plummet. Offering opportunities to help others can increase self-esteem by making people aware that they do indeed have something worthwhile to offer.

In addition, several participants described how the principle of reciprocity made it easier to give and take support from fellow patients. They reported that it was easier to give support to others after experiencing receiving support from them, and easier to take support from others with the knowledge that they would be able to offer support to them at some point in the future. Taking support from other patients was not always experienced as easy. For example, some participants worried about 'overloading' others who were already struggling with

their own difficulties; one participant described how the idea of reciprocity helped in this respect.

Another distinctive feature of the TC is in its capacity to provide opportunities for patients to explore the way they interact with others and how their behaviour impacts on the people around them (Kennard, 2000). Several participants described how being with others who were experiencing similar difficulties increased their consideration and respect for others and made them think about how their behaviour might impact on these people. One participant reported that, since being in the TC, she was no longer able to 'justify' her self-harming behaviour because she knew that others were suffering in the same way as she was, and that many of these patients also wanted to self-harm. In addition, several participants mentioned how being in the TC had given them opportunities to experience being with other people who were behaving in similar ways to them, and the subsequent effect that this had in making them think about the impact of their own behaviour on others.

The TC aims to create a safe environment where "Interpersonal and emotional issues are openly discussed and members can form intimate relationships" (Haigh et al., 2002, p.13). With regard to the types of problems that most of the participants experienced (i.e. long-term severe emotional and social difficulties with histories of abuse and trauma) it is not surprising that the majority of these people had issues relating to difficulties trusting others; hence openly discussing interpersonal and emotional issues and forming intimate relationships would

seem somewhat challenging to such a client group. However, a number of factors appeared to moderate this; participants reported feeling genuinely cared for by other patients as they reasoned that patients freely chose to give their support, in contrast to staff who offered support as part of their job. In addition, participants reported feeling they were accepted by other patients and not judged by them; this led to feelings of validity and freedom to be oneself. Several participants described how this contrasted to the outside world where they felt that only the 'good' parts of people are accepted and the other parts have to be hidden, leading to feelings of shame and isolation. The importance of people who share a common illness or stressor coming together, not just for emotional support and to share ways of coping, but to seek friendship and social exchange, is also documented in other contexts (Maton, 1988).

Finally, although participants' accounts were largely positive, several participants described their difficulties in forming close attachments and then having to deal with patients leaving the TC; this brought up worries of whether others would forget them when they returned to the outside world and issues of whether others could really be trusted and relied upon. In addition, a few participants mentioned how they found the TC difficult at times as they felt that they had no privacy. These issues (i.e. difficulties forming attachments due to lack of trust in others, and feelings of being intruded upon) are especially germane to individuals who have histories of abuse and trauma and subsequent long-term severe emotional and social difficulties, as the majority of the participants in the current study had.

Intra-individual aspects: The TC and the construction of self-identity

Throughout all of the interviews, participants described how they had experienced themselves change personally through their time in the TC. For example, participants spoke about feeling human again, feeling that they were worth something and had something to offer; this stood in contrast to previous feelings of worthlessness and hopelessness.

Participants described how experiencing others caring for them and needing them made them start to believe that they could be worth something, as well as helping them to start to care for and like themselves. Several participants reported how they felt significant for the first time since they had become ill; this related to their perception of being needed by other patients in the TC which resulted in an increase in self-esteem. However, a few participants spoke about the danger of forgetting or avoiding one's own problems through becoming over-involved in helping others. It is important to remember that although helping a group member may boost self-esteem it may also sometimes be at the expense of other personal resources as helping others is not without its costs (Helgeson & Gottlieb, 2000). Several participants described the sense of failure they felt if they were unable to support fellow patients and how this left them feeling depressed and worse about themselves as they felt they had let the other person down. In addition, several participants described how being with others who gave them positive feedback had changed their view of themselves; however, this was countered by others who reported the struggle in accepting

this positive feedback, especially when it conflicted with their own view of themselves.

Finally, TCs provide opportunities for social comparisons. Festinger (1954) proposed that in times of uncertainty or in times of stress, people compare themselves with others to evaluate their feelings and abilities. Participants in the current study described how their experiences of being in the TC had led to feelings that there was hope for the future. A large chunk of this hope came from seeing others in similar circumstances to themselves improving and making positive changes in their lives; leading to the belief that if others were able to do this, then so could they. Due to the severe and long-standing nature of their difficulties, participants described that they had not experienced this feeling of hope before. In addition they described how being treated in previous services where they saw other patients either staying the same or getting worse had exacerbated their previous feelings of hopelessness.

Helgeson & Mickelson (1995) observed that people engage in social comparison for reasons other than self evaluation; self-improvement is typically accomplished by comparing oneself to a better-off other. Upward social comparisons relate to comparing oneself to a better-off other (i.e. role model) which can act as a source of inspiration to move forward. Opportunities to make upward social comparisons in the TC played a major role in changing participant's views about what they were able to achieve.

METHODOLOGICAL ISSUES

Several methodological issues need to be considered in evaluating this study and reflecting on its implications. These include characteristics of the sample (e.g. how representative it is of the wider TC population), as well as issues relating to validity and reflexivity.

The sample

This section first considers the extent to which participants in the study may differ from, or have commonalities with, the full spectrum of people at the Cassel Hospital. Issues of heterogeneity and homogeneity are then addressed, and the broader issue of the generalisability of the findings is discussed.

Self selection

Participants were recruited through a community meeting at the Cassel Hospital; anyone interested was invited to another meeting to discuss the study and what it involved in more depth. Participants were thus self-selected and may have been atypical or unusual in certain respects. Those people who chose to take part may have been more interested in reflecting on their experiences – which in turn may mean that they were more mentally stable or experiencing less distressing symptoms. In addition, they may have felt more able to articulate their feelings and experiences, either because they were naturally more articulate or because they were experiencing fewer difficulties. It is also possible that those individuals who chose to participate were having a better or more

positive experience of being in the Cassel than those people who chose not to participate.

Heterogeneity and homogeneity of the sample

With regard to socio-demographic factors, participants represented a relatively homogeneous group. All described themselves as white British, with the exception of one who described herself as white African. In terms of gender, three-quarters of the sample were women, whilst the age range of the sample was 21 to 46 years old, with a mean of 33 years. Participants varied with regard to length of time in treatment at the Cassel; this ranged from one to twelve months, with a mean of six months. Types of problems tended to be similar; i.e. severe emotional and social difficulties, with histories of abuse and trauma. With regard to educational background half of the sample had proceeded to higher education and achieved further qualifications. Lastly, participants varied in their living arrangements; seven participants were single, four were co-habiting and one was divorced.

All studies involve a trade-off between heterogeneity and homogeneity (Barker et al., 2002). A homogeneous sample is advantageous in that there is less extraneous variability; in qualitative studies this means that it is easier to identify common themes across people. However, the findings are less likely to be generalisable to the target population. In contrast, the advantage of a heterogeneous sample is that there is greater generalisability as the sample is more representative of the target population.

The participants in the present study were a relatively homogeneous group in terms of ethnicity, gender, age and types of problems, but heterogeneous in terms of length of time in treatment in the Cassel, educational background, and living situation. However, it is difficult to know how representative they are of Cassel patients generally.

Generalisability to the wider population

Caution should be exercised in using the findings of the present study to draw conclusions about the wider TC population. The small sample size, self-selected nature, and socio-demographic homogeneity are likely to limit the applicability of these findings to other TC populations. In addition, the broader TC population includes people who are experiencing different types of difficulties to those which the Cassel treats. For example, some TCs deal specifically with psychotic experiences or substance abuse. Further research drawing on a greater number of TCs could begin to illuminate the limits of the generalisability of the findings of this study.

Validity

Validity in qualitative research has been defined as “whether an interpretation is internally consistent, useful, robust, generalisable, or fruitful” (Stiles, 1993, p. 607). Guidelines on validity in qualitative research (Elliot et al., 1999; Stiles, 1993) shall be referred to in addressing the validity of the current study.

Adherence to the fundamentals of good qualitative research practice can minimise the possibility of validity being compromised by researcher bias (Stiles, 1993). With regard to the current study, care was taken to situate the sample (Elliott et al., 1999) by describing the context of the setting, the recruitment process and participant characteristics. In addition, the process of analysis has been detailed in Chapter Two and the interpretation and understanding derived from the analysis have been “grounded in examples” (Elliott et al., 1999). The reader is therefore able to participate in interpreting the presented data, as recommended by Smith (1995). Credibility checks (Elliot et al., 1999) on the preliminary codings and final framework were conducted by a second and third researcher, as described in Chapter Two. In addition, participants were provided with summaries of the themes identified in the interview and were asked whether the themes adequately reflected their experience; this provided a form of ‘member validation’ (Smith, 1996; Willig, 2001).

Reflexivity

The process and interpretation of qualitative research and data is inevitably influenced by the researcher’s own experiences, preconceptions, beliefs, values and theoretical perspective and it is not possible to completely set these aside. For this reason, an important part of the analytic process is reflecting on how one’s own assumptions and beliefs may influence the research process. These issues of reflexivity have been emphasised within guidelines for qualitative research (Elliott et al., 1999; Stiles, 1993; Willig, 2001).

The beliefs, assumptions and framework that I brought to the study (see Chapter Two) may have influenced the course and outcome of the research in a number of different ways. During the interviews I tried to be mindful of my own beliefs and expectations as I was aware of the possibility of interview bias. To minimise this, I attempted to allow participants to 'tell their story' with as little intervention from me as possible; I also strove to conduct the interviews in a respectful, non-judgemental manner. In addition, I asked participants about negative experiences of offering and receiving support as I was not just looking for positive experiences. However, it is likely that at some level my interest, beliefs and presentation did influence the direction and content of the interviews; for example, my responses to participants – when I empathised, reflected back and in what I chose to follow up, - may have shaped the stories they told. In addition, my identity as a trainee clinical psychologist may have influenced participants' perception of me; as a 'professional' I may have been perceived as allied to staff, which in turn may have influenced their accounts. For example, social desirability factors may have been present and participants may have presented their accounts in more positive terms.

It is difficult to ascertain to what extent the above factors affected the direction of the interviews and the subsequent analysis and findings of the study. However, their impact is likely to have been limited to some extent by the credibility checks provided by the second and third researchers, as well as the member validation provided by the participants when they gave their feedback on the accuracy of their interview summaries.

FURTHER RESEARCH

Suggestions for possible improvements to the study have already been highlighted at various points above; this section draws these together, along with other possible avenues that would be useful for future research.

Some of the methodological considerations described above could be overcome by specific research into these areas. For example, a replication of the study across other TCs would be informative with regard to tackling issues of heterogeneity; TCs are heterogeneous in terms of their approach, structure, and types of difficulties treated. Replication of the current study across a range of other TCs would help to discover the extent to which the findings can be generalised to the wider TC population.

In addition, a longitudinal study over multiple time points would be useful to gain an idea of whether participants' experiences of mutual support may change over time, especially in light of Biggs (1987) study which found that TC inpatients were very concerned with their relationship with staff, whereas ex-patients spoke more of their interaction with other patients; the longer the time the individual had been away from the TC the more they spoke about mutual support. Such a study could also shed light on whether the impact of mutual support processes are sustained over time. This could be conducted using a combination of qualitative and quantitative approaches to further our understanding of individual experiences within a context of statistical information on existing mental health difficulties and change over time.

CLINICAL IMPLICATIONS

The findings of the study have a number of implications for the provision and delivery of services for people experiencing mental health difficulties. These clinical implications are twofold: They can inform our knowledge about how mutual support processes operate in the TC and impact on individuals living there which can further inform good practice and service delivery within TCs. In addition they can be used to think about and explore the possible implications for standard psychiatric services.

This research indicates that what appears to be helpful to people who are experiencing mental health problems is not just being given formal support, but in being given opportunities to access informal support also. TCs are distinctive in their capacity to offer both types of support and the study was therefore able to tentatively explore how participants utilised these. Participants reported finding it useful to be able to access both types of support; whilst informal support provided opportunities for social interaction and the sharing of experiences with similar others, formal support offered a more private forum where these interactions could be reflected upon. These two types of support were thus reported to be complementary with formal support helping to create a safe contained space which enabled participants to venture into the more potentially threatening world of mutually supportive relationships with other patients in the TC.

The experience of being in the TC environment appeared to foster processes of mutual support and provide individuals with a different way of thinking about themselves. The TC, with its emphasis on the "...attempt to understand the individual in the context of the underlying context of the group" (Tucker, 2000, p. 12) offers an alternative view, ideology, and way of thinking about what it means to experience mental health difficulties. Participants accounts illustrated how having opportunities for social interaction, and feeling they made a difference to others, gave them empowerment, agency and control. This contrasted to their experiences of previous treatment approaches in which they described suffering passively and in isolation.

This study highlights the value of the TC in providing a communal ideology for people who would otherwise be individual recipients of services. Dalley proposes that collective mutualism "should be based on the principles of group concern, shared care and mutual support" (Dalley, 1992, p. 108). The findings of the current study illustrate the importance of mutual support for people who have previously felt isolated and stigmatised due to their experiences of severe and long-term mental health problems.

In contrast, standard psychiatric services often do little to encourage informal help and mutual support, subsequently failing to address the social and interpersonal needs of the people they treat. People experiencing mental health difficulties often feel disempowered, isolated and stigmatised in a society that frequently treats these difficulties as something to be 'got rid of' rather than

'understood'. There is also a tendency to see mental health difficulties as being 'in' the individual and in isolation from the social system of which the individual is part. This view, along with the failure to provide opportunities for social interaction and mutual support to occur, can leave individuals who access these services feeling isolated, ashamed and abnormal, as indicated by participants' accounts in the current study. It would appear that standard psychiatric services could be much improved by consideration of the implementation and provision of opportunities for informal help and mutual support processes to occur, alongside the more usual structures of formal support.

CONCLUSION

This study set out to explore individuals' experiences of mutual support whilst being resident in a TC for people experiencing severe emotional and social difficulties. The overall experience of the participants was positive, and the study identified a number of ways in which mutual support processes were beneficial; these were highly consistent with the findings from the mutual support literature. The study also provides a preliminary insight into the ways in which mutual support processes operate within the TC and the impact that these have on individual members. The findings provide further evidence for the benefits of mutual support; thereby underlining the importance of providing people experiencing mental health difficulties with opportunities to support one another, alongside the usual provision of professional support.

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APPENDIX 1

Letter confirming ethical approval

Ealing Hospital



NHS Trust

LOCAL RESEARCH ETHICS COMMITTEE

Ealing Hospital NHS Trust

Level ten, Uxbridge Road, Southall, Middlesex, UB1 3HW

Tel: 020 8967 5652 Fax: 020 8967 5652

23rd September 2003

Miss Maddy Loat
Clinical Health Psychology
University College London
Gower Street
London
WC1E 6BT

Re: LREC 03/25

Dear Miss Loat,

Many thanks indeed for submitting this project to our Ethics Committee. It was considered by the Committee on the 2nd September, and has been ratified. My thanks for attending the meeting, this certainly makes enquiries and questions much more straightforward! Please let us know how your project progresses. With best wishes.

Yours sincerely,

Dr Colin Michie MA.FRCPCH.FLS
Consultant Senior Lecturer in Paediatrics
Chairman LREC

APPENDIX 2

Information sheet for participants



Sub-Department of Clinical Health Psychology
UNIVERSITY COLLEGE LONDON
GOWER STREET LONDON WC1E 6BT

Maddy Loat, Trainee Clinical Psychologist (Researcher)
Dr. Nancy Pistrang, Senior Lecturer in Clinical Psychology (Supervisor)
Phone: 07905 943 654

Mutual Support Processes in a Therapeutic Community
- Information about the Study -

We are inviting you to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish.

What is the purpose of this study?

This study is interested in exploring experiences of mutual support in the therapeutic community (TC). Mutual support is a process in which people with common concerns attempt to give and get help from each other. We are interested in hearing about your experiences of mutual support whilst living within the Cassel Hospital. To date, there has been no research conducted in this area and we hope that this study will help us to begin to understand more about how these processes operate within the TC and how they impact on individuals living there. The study gives participants the opportunity to reflect on their experiences of living with others in the TC and to think about how these experiences affect the way they view themselves and their difficulties. This information will be useful with regard to informing services and good practice within TCs.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given further information and will be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time without giving a reason. If you do not decide to take part this will not affect your treatment at the Cassel in any way.

What does taking part involve?

Should you decide to take part, you will be interviewed on two occasions, with the second interview happening approximately 4 months after the first. In addition you will be asked to complete a brief questionnaire that involves answering general questions about yourself. With your permission, we would tape record the interviews, so as to have a complete record of what was said. Each session would last about 60 to 90 minutes. At the end of the second interview, all participants will be given £10 for their time. In addition, if you would like a copy of the transcript of your interview this can be arranged.

Confidentiality

At all stages of the study we will take care to respect the privacy and right to confidentiality of participants. All information which is collected from you during the course of the research will be kept confidential. Any information about you will have your name stored separately so that you cannot be recognised from it. In writing articles for publication based on this research, we will not reveal the identity of anyone who took part.

Ethical approval

All proposals for research using human subjects are reviewed by an ethics committee before they can proceed. This study was reviewed by West London Mental Health NHS Trust Ethics Committee.

Further information

If you are interested to take part, or would like to know more, please contact Maddy Loat (details above).

APPENDIX 3

Study consent form (participation)



Sub-Department of Clinical Health Psychology

UNIVERSITY COLLEGE LONDON

GOWER STREET LONDON WC1E 6BT

Maddy Loat, Trainee Clinical Psychologist (Researcher)

Dr. Nancy Pistrang, Senior Lecturer in Clinical Psychology (Supervisor)

Phone: 07905 943 654

CONFIDENTIAL

Mutual Support Processes in a Therapeutic Community

CONSENT FORM FOR PARTICIPANTS

(note: one copy for participant, one copy for researcher)

Please read the following questions carefully and circle either 'yes' or 'no' as appropriate in each case:

- | | |
|---|----------|
| 1. Have you read the information sheet about this study? | Yes / No |
| 2. Have you had an opportunity to ask questions and discuss this study? | Yes / No |
| 3. Have you received satisfactory answers to all your questions? | Yes / No |
| 4. Have you received enough information about this study? | Yes / No |
| 5. Do you understand that you are free to withdraw from this study at any time without giving a reason for withdrawing? | Yes / No |
| 6. Do you agree to take part in this study? | Yes / No |

Participant's full name: _____

In signing below, I fully and freely consent to participate in the study entitled 'Mutual support processes in a therapeutic community'

Signed (participant): _____ Date: _____

I hereby confirm that I have provided an information sheet and have discussed the implications of participating in this research with the above:

Signed (researcher): _____ Date: _____

APPENDIX 4

Study consent form (audio-recording)



Sub-Department of Clinical Health Psychology
UNIVERSITY COLLEGE LONDON
GOWER STREET LONDON WC1E 6BT

Maddy Loat, Trainee Clinical Psychologist (Researcher)
Dr. Nancy Pistrang, Senior Lecturer in Clinical Psychology (Supervisor)
Phone: 07905 943 654

CONFIDENTIAL

Mutual Support Processes in a Therapeutic Community

CONSENT TO RELEASE RECORDINGS

(note: one copy for participant, one copy for researcher)

The reason we are recording is to better our understanding of what you have said; we use the tapes to listen carefully and repeatedly to each interview. When we publish our findings, it is often useful if we can include verbatim extracts from the interviews (with names and other identifying information removed). We may also use the tapes to inform other professionals with regard to aiding their understanding of the experience of being a member of a residential therapeutic community (with names and other identifying information removed). We will not do these things without your consent, which you may withdraw at any time in the future.

Please circle 'Yes' or 'No' for each statement below:

1. I give consent for all or part of the transcript of my interview to be published in scientific journals or books.

Yes / No

2. I give consent for the recording of my interview to be used for educational purposes.

Yes / No

3. I give consent for the recording and transcript of my interview to be placed in the Planned Environment Therapy Trust archives.

Yes / No

If you have any questions about anything on this form please ask Maddy Loat (contact details above).

Name (please print)

Signature

Researcher's name (please print)

Signature

(Date)

APPENDIX 5

Interview schedule (first interview)

Mutual Support Processes in a Therapeutic Community

Interview Schedule, First Interview

This is an interview guide – not all questions will be asked the same way of each individual.

Accessing the TC and first impressions

I'm interested in finding out how you came to the TC and your experience of joining it....

Sample questions: Where did you hear about the TC?
What did you imagine it would be like?
What interested you about it?
How did you first contact the TC?
What were your first impressions?
How long have you been a member of the TC?

Experience of the TC

Can you tell me about how you have found the TC so far, the experiences you have had and what changes if any it has made to you... ..

Sample questions: What do you find helpful about the TC?
What do you find unhelpful about the TC?
In what way, if any, have you felt supported by the TC?
In what way, if any, have you felt unsupported by the TC?
How have things changed for you since joining the TC?

Views of mutual support processes within the TC

I'm interested to find out more about your experiences of mutual support within the TC and how these experiences may have affected your views....

Sample questions: What kind of help/support, if any, do you receive from your peers?
What kind of help/support, if any, do you offer your peers?
How do you experience the process of receiving help/support from your peers?
How do you experience the process of providing help/support to your peers?

Mutual Support Processes in a Therapeutic Community

Interview Schedule, First Interview (continued...)

How, if at all, has the process of receiving peer support impacted on your view of yourself?

How, if at all, has the process of providing peer support impacted on your view of yourself?

How, if at all, has the process of receiving peer support impacted on your views of your difficulties?

How, if at all, has the process of providing peer support impacted on your views of your difficulties?

Has the process of receiving support from your peers resulted in any negative experiences?

Has the process of providing support to your peers resulted in any negative experiences?

Has the process of receiving support from your peers resulted in any positive experiences?

Has the process of providing support to your peers resulted in any positive experiences?

Comparison of TC experience to previous treatment experiences

I'm interested in how your experience of being in the TC compares to other types of help you may have received in the past....

Sample questions: How does the TC experience compare to other types of help you may have experienced in the past?

Which approach have you found most useful/helpful and why?

Other Q's How do you feel support from peers compares to professional support in terms of specific advantages and disadvantages?

Is there anything we haven't talked about that you think is important for understanding your experience of being a member of the TC?

Anything you would like to ask me?

Thank you

APPENDIX 6

Interview schedule (follow-up interview)

Mutual Support Processes in a Therapeutic Community

Follow-Up Interview

Is the summary consistent with your impression of the discussion?

If no, in what way do you feel it is inconsistent... ..

Is the summary accurate in its presentation of detail?

If no, in what way do you think it is inaccurate... ..

Were any important details or issues omitted?

If yes, which details/issues do you think were omitted... ..

How did it strike you emotionally?

Is there anything in the summary that you would like to discuss?

Are there any other relevant issues that you wish to raise?

Is there anything you would like to ask me?

APPENDIX 7

Socio-demographic questionnaire

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Mutual Support Processes in a Therapeutic Community

SOCIO-DEMOGRAPHIC QUESTIONNAIRE

We are interested in the range of people participating in the study. It would help us if you could fill in these details about yourself. This questionnaire is anonymous.

What age are you? _____

How would you describe your ethnic background? (e.g. Asian, Irish.....)

How long have you been a member of this therapeutic community? _____

Have you ever been a resident in a therapeutic community before? Yes/No

If yes, when and for how long?

What would you identify as your main problem? _____

At what age did you first experience (mental health) difficulties? _____

Age of first contact with psychiatric services? _____

What age did you leave school? _____

Highest Qualification Achieved? _____

Living Situation/Marital Status? Single/Cohabiting/Divorced (please circle which applies)

Are you currently employed? Yes/No (please circle which applies)

If no, if you have been employed in the past, when was approximate year you last worked? _____

Thank you

APPENDIX 8

IPA Stage 1: Initial notes in margin

IPA Stage 1: Initial notes in margin (P11)

<p><i>Support from other patient</i></p> <p><i>- Wanting to help as she could see benefits</i></p> <p><i>Feeling understood</i></p> <p><i>They've felt like I have and got through-turned it around for me</i></p> <p><i>- Made me believe things can get better</i></p> <p><i>Forming relationships - makes hard work easier</i></p> <p><i>Always people to talk to</i></p>	<p>...When I came into the hospital I slept a lot, I didn't have much motivation. This particular girl that I shared a room with that <u>would help me get up in the morning.</u> She just, you know</p> <p>- that I turn up to structures, that I do things because <u>she could see the benefits, having been there longer.</u> There were times at the beginning when I was incredibly pessimistic and quite despairing about life, and <u>people who'd been through that and knew that feeling in a way that only, you know, people with those problems can do, they helped me just see it in a different way,</u> they'd just turned it round. And they're my age, and <u>I know that they've felt like I have, and that's made me believe, you know, that there is perhaps a positive – and really those – you know, the people that became my friends – you know, while you're there you're talking about things that are very deep, so someone gets to know you very quickly. They get to know your past, and they get to know what makes you tick. So you form incredibly close bonds, and again, that kind of balances out the hard work,</u> because you have these very, very strong relationships and it makes the whole process possible. <u>You've always got someone to talk to,</u> you have</p> <p>As well just having a laugh and giggle, and we can do that, and we understand that that's important.</p>
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APPENDIX 9

IPA Stage 2: Emerging themes

IPA Stage 2: Emerging themes (P11)

<p>...When I came into the hospital I slept a lot, I didn't have much motivation. This particular girl that I shared a room with that would help me get up in the morning. She just, you know - that I turn up to structures, that I do things because she could see the benefits, having been there longer. There were times at the beginning when I was incredibly pessimistic and quite despairing about life, and people who'd been through that and knew that feeling in a way that only, you know, people with those problems can do, they helped me just see it in a different way, they'd just turned it round. And they're my age, and I know that they've felt like I have, and that's made me believe, you know, that there is perhaps a positive – and really those – you know, the people that became my friends – you know, while you're there you're talking about things that are very deep, so someone gets to know you very quickly. They get to know your past, and they get to know what makes you tick. So you form incredibly close bonds, and again, that kind of balances out the hard work, because you have these very, very strong relationships and it makes the whole process possible. You've always got someone to talk to, you have As well just having a laugh and giggle, and we can do that, and we understand that that's important.</p>	<p><i>-Being with similar others</i></p> <p><i>-Feeling understood</i></p> <p><i>-Listen to others (they've been there too)</i></p> <p><i>-There is hope</i></p> <p><i>-Acceptance (forming relationships)</i></p> <p><i>-Struggling together</i></p> <p><i>Not alone</i></p>
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APPENDIX 10

IPA Stage 3: Themes and sub-ordinate themes

IPA Stage 3: Themes and sub-ordinate themes (P11)

1. New experience

Amazed

2.5 'didn't really understand'

1.26 'it was very different'

2. Contrast to previous treatments

No comparison

18.39 'two things in combination'

15.10 'in a league of its own'

3. Struggling together

Being with similar others

Feeling understood

Reciprocity

Listen to others - they've been there too

16.43 'feel a little bit more normal'

2.20 'they know why things are difficult'

8.31 'it's the give and take'

6.21 'it sinks in'

4. What I do affects others

Others suffering too

11.6 'owe it to that person...to treat them really well'

5. Feeling appreciated/cared for

Not alone

3.14 'they have faith in you'

3.21 'you're a team'

6. Acceptance from others

Not judged

Not bad person

18.4 'welcome you in'

7. Learning to like & respect myself

I am worth something

Helping others helps me

10.37 'start liking myself again'

9.10 'giving helped me understand self'

8. There is hope

Others have overcome difficulties

7.12 'first time I noticed people with mental health issues getting better'

5.11 'like getting this magic key'

(2.5 = page 2, line 5)

APPENDIX 11

IPA Stage 4: Master list of themes

IPA Stage 4: Master list of themes

1. Journey into the unknown

Shock and surprise

Feelings of uncertainty

2. A different approach

How will it work?

Usefulness of TC approach

3. Struggling together

"Nice to know you're not the only one"

"It makes you listen"

Feeling understood

Reciprocity

4. What I do affects others

Others are suffering too

Looking in a mirror

5. Others care about me

"Not being alone"

"Patients care because they want to"

6. Being accepted

"You're not judged"

"People like me for who I am"

7. "Making me feel human again"

"I am worth something"

Helping others helps me

8. There is hope

"If they can do it...I can do it too"

APPENDIX 12

IPA Stage 5: Master table

IPA Stage 5: Master table

DOMAINS	THEMES	SUB-THEMES
Context	1. Journey into the unknown	Shock and surprise Feelings of uncertainty
	2. A different approach	How will it work? Usefulness of TC approach
Processes of support	3. Struggling together	"Nice to know you're not the only one" "It makes you listen" Feeling understood Reciprocity
	4. What I do affects others	Others are suffering too Looking in a mirror
	5. Others care about me	"Not being alone" "Patients care because they want to"
	6. Being accepted	"You're not judged" "People like me for who I am"
Impact of support	7. "Making me feel human again"	"I am worth something" Helping others helps me
	8. There is hope	"If they can do it...I can do it too"