Understanding Change in a Therapeutic Community for People with Severe Mental Illness: An Interpretive Phenomenological Study

Julie Caroline Keys

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IN PARTIAL FULFILLMENT
OF THE REQUIREMENTS FOR THE DEGREE
DOCTOR OF PSYCHOLOGY

BY
JULIE CAROLINE KEYS, M.A.
MAY 13, 2015

APPROVED:  
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William Staudenmaier, Ph.D.
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Finally, I would like to thank the staff and community members whom I worked alongside during my time at this therapeutic community. To Sarah, E.J., Drew, and Jason, I have immense gratitude for your support, humor, and grace. To the community members with whom I lived and worked, thank you for sharing your lives with me. My life has been irrevocably changed because of you.
Abstract

In order to gain better understanding of how therapeutic communities instigate change, this interpretative phenomenological study explores the recognized agents of change as reported by current and recent community members of a particular therapeutic community. Four superordinate themes were discovered: the structure of the program, engagement in the community, intentionality/mindfulness, and applied knowledge. While the results from this study are similar in several ways to the current literature, they also expand the literature about therapeutic communities in one important way. The change agents reported as leading to healing strongly resemble current best practice for the treatment of trauma. Limitations and suggestions for further research are discussed.

Keywords: therapeutic community, severe and persistent mental illness, change, trauma
Introduction

A therapeutic community is a long-term residential living experience for severe clinical populations that is based on the idea that the social environment can be an agent for change. The therapeutic community (TC) first came into existence after World War I. After TC's began in Great Britain, they spread throughout Europe and the United states over the next 75 years. TC's serve several populations, including prisoners, people addicted to substances, dually diagnosed people, and people with severe and persistent mental illness (SPMI). Despite a great deal of antidotal evidence, relatively little research has been done on the effectiveness of therapeutic communities.

This study seeks to better understand the process of change in a particular therapeutic community, Zoe Community¹, through the lens of the current and recent community members. An interpretative phenomenological study revealed several important agents of change.

Background for the Study

I chose this research because I had the pleasure of working and living at Zoe Community, a therapeutic community for people with SPMI in Colorado, for three years during my graduate training. Zoe Community is a residential facility that houses approximately twenty adults (ages 21 and older). Community members have all been diagnosed with a severe and persistent mental illness, and they live at the community for six months to two years.

Zoe seeks to empower community members through an array of carefully chosen requirements. Zoe provides weekly process group therapy and weekly or bi-weekly “check-ins” with individual therapists. Check-ins usually focus on a particular problem the community member is facing or an aspect of her or his life that she or he would like to explore.

¹ The name of the TC has been changed.
In addition to these more traditional therapeutic treatments, Zoe requires less traditional activities. Community members must attend three meals per week, cook once or twice per month, and shop for groceries. They must also volunteer, work, or go to school twenty hours per week. For community members who are not meeting this requirement when they enter the community, a jobs group is provided at the beginning of the week to aid in finding employment or volunteer work.

Community members must also attend a variety of other meetings that pertain to their involvement with the community. Goal setting groups help to clarify and enact goals. Accountability groups facilitate the discussion and implementation of personal responsibility in community life. Finally, all community and staff members meet together once a week for a community meeting in which business is discussed, changes proposed, and victories discussed and celebrated.

Assumptions

In the time I worked for Zoe Community, I saw more changes made in people with serious and persistent mental illnesses, including personality disorders, than through any other mode of treatment. I talked with other staff members at Zoe, and they agreed that living in a therapeutic community was an especially beneficial modality. We could make some educated guesses as to why it seemed so effective, but we did not have a conclusive answer.

Among our assumptions, we believed that physical proximity of community members made a big difference in the changes they made. Most people were used to seeing mental health professionals for one or two hours a week, and some participated in a group with other patients for another hour or two per week. At Zoe Community, they were around other community members almost every hour of every day.
We conjectured that because of this closeness, they were unable to be their best selves all of the time. Eventually, people saw them for all that they were, both good and bad. It seemed to be a turning point when community members realized that they had been vulnerable, people had seen the very worst they had to offer, and they were still loved.

In addition to the added vulnerability, we guessed that the community aspect also forced people who were used to running away when things got difficult to stay and face the consequences. For example, many community members at Zoe had histories of cutting off friendships quickly and frequently, so their interpersonal lives were quite chaotic. At Zoe, it was impossible to simply cut someone off because that person lived with you, ate dinner with you, went to groups with you, and was a part of many other daily activities. Because of this, community members went through the difficult process of learning relational skills that they had fled from in the past.

We also believed that the holistic approach to treatment led to bigger changes than regular psychotherapy. We believed that community members not only gained independence by managing all of the requirements at Zoe, but they also dealt with many aspects of their life at once, not just their “mental health issues.”

In fact, many of these assumptions were backed by research into therapeutic communities. The importance of still being loved and cared for despite exhibiting one’s worst behavior is alternatively described as a sense of belongingness provided by TC’s (Peare & Pickard, 2013). The importance of learning relational skills in an environment in which it is difficult or impossible to rely on avoidance is categorized by Rappaport (1960) as communalism and reality confrontation. The holistic approach of Zoe is also indicative of Rappaport’s (1960)
principle of capacity for responsible agency, in that the more a person does for him/herself, the greater his/her sense of empowerment and accomplishment.

While we had our suspicions, and some of these had empirical validation, I decided the best way to understand how this particular therapeutic community evokes change was to ask those members who had been through that change about their experience.

**Review of Relevant Literature**

**Treatment of Serious and Persistent Mental Illnesses**

Treatment of people with serious and persistent mental illness has changed drastically in the United States in the last century. The asylums and institutions of the late-19th and early-20th centuries went through significant reforms beginning in the 1940’s. People with severe psychopathology began to be treated as members of society rather than being locked away from the “normal” population. However, it was widely believed that such persons could not actually recover or get better until the 1980’s and 1990’s (Gerhart, 2012).

In the 1990’s, the World Health Organization conducted cross-national studies that showed 28% recovery in persons diagnosed with SPMI, meaning that they reported a complete lack of symptoms. It also found a 52% social recovery rate, which was defined as being able to work, have relationships, and lead a meaningful life while taking psychotropic medications. (Gerhart, 2012, p. 430). Many clinicians were surprised by these findings, and they ushered in a new approach to treatment of persons with SPMI.

Based on this and later research, the U.S. Department of Health and Human Services issued a statement on mental health recovery in 2004 urging public mental health organizations to adopt a “recovery” approach in treating persons with SPMI (Gerhart, 2012). They went on to define mental health recovery as “a journey of healing and transformation enabling a person
with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential’ (U.S. Department of Health and Human Services, 2004, p. 1). In this statement by the U.S. Department of Health and Human Services (2004), they go on to list ten fundamental components of recovery: self-direction, individualized and person-centered, empowerment, holistic, non-linear, strengths-based, peer support, respect, responsibility, and hope.

Much research has been done about recovery models in the last decade. Deegan (2003), who is both a psychologist and a person living with SPMI, describes a strengths model used to help people with more severe psychopathology to achieve recovery. He recognizes six recurring themes in successful treatment for this population. First, reclaiming hope, something that is important in positive psychology, is seen as an essential part of recovery. Without this, a person lacks the motivation to change. The next theme is building a sense of positive identity. As a person defines his or her strengths and passions, he or she regains a positive sense of personal agency. Third, the strengths model encourages people with severe psychiatric symptoms to distance themselves from psychiatric labels, along with the stigma and misunderstanding that comes with them (Deegan, 2003).

The next step toward recovery in the strengths model is managing symptoms. This is where individual therapy, medication, etc. enter the picture. The fourth step involves building a stronger support system, which involves a person’s community. This step includes friends and family, peer organizations, and other resources in the community. Finally, recovery involves finding a sense of meaning and purpose in life. This is an existential concept that seeks to bring hope and passion to a person’s life (Deegan, 2003).
In the strengths model, Deegan (2003) encourages persons with severe psychiatric symptoms to use their own strengths to reach their goals. Goals are meant to be manageable, time-limited, and broken down into achievable parts. Through this model, he asserts that people with SPMI can move toward recovery (Deegan, 2003).

A more recent study (Tew et al., 2012) engaged in a conceptual review of international literature about recovery in people with SPMI and drew similar conclusions. It named three chief areas essential for recovery for individuals with SPMI: empowerment and control over one's life, connectedness, and rebuilding positive identities.

History of Therapeutic Communities

It is widely agreed upon that the first version of the therapeutic community appeared in Northfield Hospital in Birmingham, England during World War II. At the behest of the British government at that time, Wilfred Bion and John Rickman set up a unit within the psychiatric hospital for the rehabilitation of traumatized soldiers. The unit utilized group discussions about the communal living situation, behavioral feedback, and accountability (Dickey & Ware, 2008).

Therapeutic communities became popular in Great Britain, and then spread throughout Europe and the United States. There are two types of therapeutic communities that are generally recognized in TC literature: the democratic TC and the concept-based TC. Concept communities are hierarchical in nature, often with staff and senior clients near the top (Frye, 2004). Discipline is administered by senior residents if new members break rules. Central to this style is formal group communication, which is sometimes called "the game" or "confrontation sensitivity group" (Frye, Hammer & Burke, 1981). During these groups, residents are encouraged to vent and air grievances (Frye, 2004).
In contrast, democratic TC’s, such as the one in this study, are more egalitarian in nature (Frye, 2004). Democratic TC’s are defined as “psychodynamically informed planned social environments, which are based on the notion that types of psychological distress or destructive behavior are caused by the social network in which an individual is embedded and can be treated by a more healthy and constructive social network” (Boyling, 2010, p. 152). Democratic communities require learning through a social process (Frye, 2004). Individual and group therapy is often provided, and residents are encouraged to be themselves and learn from each other. In describing the way in which TC’s work, Mills and Harris (2007, p. 24) state:

...the therapeutic community provides a wide range of life-like situations in which the difficulties a member has experienced in their relations with others outside are re-experienced and reenacted, with regular opportunities—in groups, community relationships, everyday meetings and, in some communities, individual psychotherapy—to examine and learn from these difficulties. The daily life of the therapeutic community provides opportunities to try out new learning about ways of dealing with difficulties.

In a seminal work on therapeutic communities, Rappaport (1960) suggests five themes present in therapeutic communities. The first theme is democratization, or the sharing of power. Everyone in the community, from the director to the newest community member, has decision-making power. Second, the theme of permissiveness refers to the fact that TC’s tolerate behavior that would not be normally tolerated in society. Although the community sets limits and rules, it accepts behaviors unique to personality disordered and severely mentally ill people (Rappaport, 1960).

The third theme set forth by Rappaport (1960) is communalism. All community members are expected to work together for the good of the community. Communalism often leads to accountability as an agent of change within the community. Next, the theme of reality confrontation ensures that members learn through experience as they work together, receive
constructive criticism, and are held accountable for their actions. Finally, community members form reciprocal relationships, which perpetuate social learning in that they ensure that the members must resolve their difficulties and learn to treat each other with dignity and respect (Rappaport, 1960).

**Efficacy of Therapeutic Communities**

Over the past 75 years, therapeutic communities have been used to treat people with addictions, prisoners, and those with SPMI. While research on their effectiveness is still emerging, it is a growing field of study. In their focus group study of a therapeutic community in Belgium, Debaere et al. (2014, p.11) conclude “a TC can make a process of change possible for persons with deeply ingrained dysfunctional behavior patterns.” Likewise, a 1999 meta-analysis of TC outcome studies found strong evidence that TC’s were effective for people with personality disorders as well as offenders with mental illnesses (Lees, Manning, & Rawlings, 1999).

Studies have focused on comparing therapeutic communities to more traditional forms of psychiatric treatment for persons with SPMI. Mosher, Menn, and Matthews (1975) conducted a study comparing traditional treatment of young, first admission schizophrenics with a treatment-as-usual group being treated with medication and services at a community mental health center versus treatment at Soteria House, a “small home-like community” in San Francisco. Participants were assessed at different intervals by psychiatric professionals, family members, and themselves over a two-year period. Results showed that while there were few differences between the two types of treatment in the area of symptom reduction, the residents of Soteria House showed significantly higher psychological functioning (Mosher et al., 1975).
Research has also examined the efficacy of TC's for personality disorders. In a 2012 naturalistic study of a Swedish therapeutic community, Werbart, Forsstr, and Jeanneau followed young-adult clients (age 18 to 30) with long-term psychosis and/or Borderline Personality Disorders. The study found that most clients showed substantial improvement from the time of intake, through discharge, to a two-year follow-up.

Not only does research show that therapeutic communities for serious and persistent mental illness do indeed work, but it also suggests that TC's decrease the cost of mental health care. (e.g. Warren & Dolan, 1996; Dolan, Warren, Menzies, & Norton, 1996; Chiesa, Iacoponi, & Morris, 1996; and Haigh, 2002). In fact, Haigh (2002) showed that the cost of treatment for persons with SPMI prior to and after treatment in TC’s in Great Britian reduced by £8,571 to £12,668 ($19,066 to $12,900 with the 1996 conversion rate).

**Mechanisms of Change in the Therapeutic Community**

Just as Rappaport suggests important themes in the culture of therapeutic communities, several others have studied and suggested mechanisms of change that make therapeutic communities work. Several of those ideas will be explored below, and a summary table is provided.

Pearce and Pickard (2013) suggest that the essential factors of a therapeutic community are a sense of belongingness and the capacity for responsible agency. They argue that these two factors are emphasized to such a significant degree in therapeutic communities, that they are set apart from other therapeutic approaches. Furthermore, they suggest that belongingness makes it safe enough to take the risks of responsible agency.

The theory of belongingness postulates that human beings require frequent, positive social contact that is stable over time and includes mutual concern for each other’s welfare.
(Baumeister & Leary, 1995). TC’s uniquely foster belongingness because they focus on
challenge, support, and shared responsibility (Pearce & Pickard, 2013). Most treatment for
individuals with SPMI is individual, short-term, hierarchical, or a combination of these, so they
are unable to provide the social stability necessary to foster belongingness.

In addition to belongingness, Pearce and Pickard (2013) argue that responsible agency is
present to a greater extent in TC’s than in other treatments, such as motivational interviewing or
Cognitive Behavioral Therapy (CBT). They state that while other therapies assume clients’
agency, treatment communities overtly encourage it through measures such as voluntary
contracts, voting in of new members, providing and receiving feedback, and collective decisions
about rules. They also require members to take responsible roles in which they do chores, cook,
and host others (Pearce & Pickard, 2013).

In a 2014 focus group study on the process of change in a TC in Belgium, Debaere, et al.
name three main changes that residents in that community endorsed: more resilience and ability
to cope with their problems, more involvement in pleasant social relations, and the capacity to
make their own life choices. They go on to present four steps that they say help explain how
therapeutic communities work.

The first step toward change is defined as the encounter with a safe, caring and
challenging other (Debaere, et al., 2014). A safe environment provides continuous availability of
caring people (both staff and other residents), as well as the expectation of responsible agency
for residents. Second, the community provides the chance to recognize the way in which one
interacts with others (Debaere, et al., 2014). In the study, several residents noticed that their
dysfunctional way of interacting with others allowed them to defend against negative feelings
and thoughts.
The next step toward change is defined as the confrontation with one’s ‘otherness’ (Debaere, et al., 2014). In this step, people not only recognize their interpersonal style as dysfunctional, but they come to understand from what their particular style helps them to escape. Finally, the last step involves the realization that one lives an ‘other’ life through her or his participation in the community (Debaere, et al., 2014). This other life involves improvements in the ways in which one copes, more pleasant relationships, and more agency.

Another theory purports that TC’s address the importance of social context, which cannot be as thoroughly addressed through psychotherapy (Parish, 2012). The social context is sometimes described as “a culture of enquiry” (Main, 1989). Parish (2012, p. 331) describes the culture of enquiry in this way:

... everything that happens in the milieu is regarded as an opportunity for reflection and learning. Members of the community are encouraged to engage in continual reflection on their feelings and actions and reactions, and to offer observations of one another and of the system, recognizing that at any given time, any or all of these are likely to be obscure. The stated aim of the culture, in other words, is to promote the self-awareness of its members, individually and collectively.

Table 1

Mechanisms of Change in Current Literature

<table>
<thead>
<tr>
<th>Scholar</th>
<th>Proposed Mechanisms of Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rappaport, 1960</td>
<td>• Democratization</td>
</tr>
<tr>
<td></td>
<td>• Permissiveness</td>
</tr>
<tr>
<td></td>
<td>• Communalism</td>
</tr>
<tr>
<td></td>
<td>• Reality confrontation</td>
</tr>
<tr>
<td></td>
<td>• Reciprocal relationships</td>
</tr>
<tr>
<td>Pearce &amp; Pickard, 2013</td>
<td>• Sense of belongingness</td>
</tr>
<tr>
<td></td>
<td>• Capacity for responsible agency</td>
</tr>
<tr>
<td>Debaere, et. al, 2014</td>
<td>• I encounter a safe, caring, and challenging Other.</td>
</tr>
<tr>
<td></td>
<td>• I unfold my particular way of interacting with the Other.</td>
</tr>
<tr>
<td></td>
<td>• I am confronted with the Otherness in me.</td>
</tr>
<tr>
<td></td>
<td>• I live an Other life.</td>
</tr>
<tr>
<td>Parish, 2012</td>
<td>• Social context</td>
</tr>
</tbody>
</table>
This study phenomenological study aims to understand the mechanism of change in a particular therapeutic community through the perspectives of several community members.

**Method**

This study was approached through the format of an Interpretive Phenomenological Analysis (IPA) as set forth by Smith (2008). In a phenomenological study, a researcher is concerned with understanding an individual’s perception or a group’s perception of an event, rather than an objective, quantifiable, generalizable answer to the research question. Researchers attempt to enter the field of perception of individuals in order to see and understand life as those individuals see it.

**Research Question**

The aim of this research is to describe the mechanisms of change within a particular therapeutic community for people with severe and persistent mental illnesses. While the participants all spoke of what changes they experienced, this research aims to pinpoint the causal mechanism of the change. In other words, what about the community led to the change?

**Research Design**

The research was conducted via semi-structured interviews in which participants were given questions designed to prompt them to consider and recount not only the changes they had made, but more importantly, the agents of that change (see Appendix for complete interview protocol). These interviews were open-ended and lasted approximately 30-60 minutes. They were recorded, transcribed, and then analyzed for themes.

**Participants**

Community members and alumni of Zoe Community were given the option of participating in the study during regularly scheduled community and alumni meetings. They
were given a $10 gift card to a nearby business in appreciation for volunteering. Each community member had been at the community for at least six months, and of those who had completed the program, none had left more than a year prior to the interviews.

Seven community members volunteered and were interviewed, but only five of them were included in this study. One of participants was in the midst of a manic episode, which made it difficult to obtain cogent, reliable information. Another suffered from a specific delusion that made it too difficult to understand the questions and give answers apart from that delusion. Because of the nature of the severe mental illnesses treated at the therapeutic community, it is not always possible to get helpful information from each person at all times.

Of the five participants whose results are included in the study, all of them were female, European American, and heterosexual. They ranged in age from 32 to 42. Their diagnoses, as provided by each participant, included: Bipolar I Disorder, Bipolar II Disorder, Mood Disorder, NOS, Major Depressive Disorder, Social Anxiety, Schizoaffective Disorder, Bulimia Nervosa, PTSD, ADHD, Borderline Personality Disorder, and Personality Disorder, NOS.

Analysis of Data

Interpretive phenomenological analysis involves a step-by-step approach through which the researcher tries to understand the complexities of the meaning of a particular phenomenon as expressed by the participants in that phenomenon (Smith, 2008). In this case, the phenomenon is the experience of change in a particular therapeutic community.

The analysis is done in a series of steps that involves multiple readings of the transcripts. First, the initial notes about anything that appears significant or interesting are made in the left-hand margin. In subsequent readings, the right-hand margin is used to draw from the initial notes in order to name emerging themes or ideas. Throughout multiple readings of each transcript,
themes are adjusted to involve more psychological terminology and a slightly higher level of abstraction. The themes are then clustered into superordinate themes. The table below (Table 2) lists the superordinate themes extracted from the data, as well as the subordinate themes that make up the clusters. Table 3 reveals which themes each participant endorsed.

Table 2

Table of Themes

<table>
<thead>
<tr>
<th>Superordinate Theme</th>
<th>Subordinate Theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Structure of the Program</td>
<td>Safe/Stable Space</td>
</tr>
<tr>
<td></td>
<td>Structure</td>
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<tr>
<td>Engagement in the Community</td>
<td>Shared Experiences</td>
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<td>Intimacy with Others</td>
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<td>Received Encouragement/Appreciation</td>
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<td></td>
<td>Care of Others</td>
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<td></td>
<td>Recognition that One’s Behavior Affects Others</td>
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<tr>
<td></td>
<td>Telling Own Story and Hearing Others’ Stories</td>
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<tr>
<td></td>
<td>Accountability</td>
</tr>
<tr>
<td>Intentionality/Mindfulness</td>
<td>Paying Attention to Physical Reactions</td>
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<td></td>
<td>Focus Outside of One’s Self</td>
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<tr>
<td></td>
<td>Practicing Intentional Interactions</td>
</tr>
<tr>
<td>Applied Knowledge</td>
<td>Developing a More Thorough Understanding of Mental Illness</td>
</tr>
<tr>
<td></td>
<td>Learning from Watching Others</td>
</tr>
<tr>
<td></td>
<td>Therapeutic Practice</td>
</tr>
</tbody>
</table>
Table 3

Table of Responses

<table>
<thead>
<tr>
<th>Theme</th>
<th>Lauren</th>
<th>Kaitlin</th>
<th>Rebecca</th>
<th>Emily</th>
<th>Carolyn</th>
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<td></td>
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<td>Safe/Stable Space</td>
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<td>x</td>
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<tr>
<td>Structure</td>
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<td><strong>Engagement in the Community</strong></td>
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<tr>
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<td>x</td>
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<td>x</td>
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<tr>
<td>Care of Others</td>
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<td>Recognition that One’s Behavior Affects</td>
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<td>Others</td>
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<td>Telling Own Story and Hearing Others’</td>
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<td>Stories</td>
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*Note.* Names of participants have been changed to protect confidentiality.

**Results**

The participants’ accounts clustered around four superordinate themes: the structure of the program, engagement in the community, intentionality/mindfulness, and applied knowledge.

**Superordinate Theme One: The Structure of the Program**

**Safe/Stable Space.** Most of the participants highlighted the importance of the community as a safe and stable place to live. Some had been homeless prior to entering Zoe. Others had been living in difficult, dangerous, and even abusive environments. One participant, Kaitlin, shared, “I was just in such a wounded stated; I wanted to get somewhere safe.” Lauren described the
community as a much needed and stable “roof over my head,” something that some of them had never had. Rebecca stated: “I was really always impressed by how nice [Zoe] is; and that was like a really big deal because the hospitals that I had been in were always really cruddy and gross. I guess I felt like that’s all I deserved.”

Participants also discussed the safety of the community as a prerequisite to engaging in the process of healing and getting better. Lauren said, “I think the first stage is people come in, and it’s sort like, ‘take a breath…it’s a safe space.’” The safety of the community also allowed community members to go out and try difficult interactions, such as working, volunteering, or interacting with family members, because they knew they could come back to their safe base. In addition to the actual physical safety Zoe provided, participants also highlighted the emotional safety provided by a community of caring people who understood mental illness and were less likely to judge, and more likely to forgive. Kaitlin described this as being able to take the risk of “screwing up royally,” knowing that she would be welcomed back.

**Structure.** In addition to safety, participants cited the structure that Zoe Community requires as a necessary component of change. The organization requires that participants work, volunteer, or go to school twenty hours per week, and it offers assistance to reach this requirement. It also requires them to complete chores, attend groups, dinners, and community meetings, and cook dinner for the community. For some, their days had previously been spent doing very little, and/or being taken care of by family members, so developing this structure was a new and difficult change.

Rebecca indicated her self-worth increased because of the structure: “I guess I think I feel a little bit more proud of myself and my choices. …I’m just happy with myself and my choices… for the areas when I am responsible, or the fact that I keep my room clean.” Emily
added, “Even the dinners we have, and eating with a group of people versus eating alone. The dinners are very important...they help me sort of take the fear out of...the fear that I felt of being alone.”

Even though they described the structure as integral to change, most community members indicated getting used to the structure of Zoe was a long process, especially the requirements of working or volunteering, cooking, and doing chores. Carolyn stated that she still gets anxious when cooking, but she notices feeling a bit better over time: “If I have a new meal plan, it’s like the very first time cooking. So the more I do the meal plan, the less the anxiety is.” When discussing her process of getting used to doing chores, Emily shared, “I started hanging out with [a staff person] a lot and just helping him with whatever he needed help with. I think [Zoe] can just meet you where you’re at and start there. Instead of saying you need to be at ‘Point A’ right away, or whatever, you can just start where you are.”

**Superordinate Theme Two: Engagement in the Community**

Above all else, the participants spent the most time talking about the importance of the community for their healing. All of them described their engagement with the community as necessary for change. Carolyn shared, “Change comes about from outside of me by interacting with the community, interacting with staff, interacting with my family, and therapist, and psychiatrist. Change happens within me through those interactions. Those interactions help motivate me and give me the tools to be able to make changes.”

The participants repeatedly mentioned several components of engagement with the community: shared experiences, intimacy with others, received encouragement/appreciation, care of others, recognition that one’s behavior affects others, telling one’s story and hearing others’ stories, and accountability.
Shared Experiences. Rebecca described the importance of feeling she was not the only person experiencing difficulties: “I guess I don’t feel as completely alone...I guess it’s easier to know that other people have these thoughts too.” Lauren told about a time in which shared experiences were helpful in a group: “I think my therapist introduced the concept of flooding, and then I brought it to check-ins. I brought it to groups, and we starting talking about it. People were like, ‘Oh, I get that too.’...So there was a lot of commiseration on that.”

Kaitlin described a simple, humorous situation in which the community members bonded over experiencing the same type of psychiatric symptoms: “I remember it last Halloween at the carving pumpkins thing...the radio was on, and somebody said, ‘oh the radio talks to you too?’...and you know we all starting laughing about it.” Kaitlin and the other participants talked about shared experiences as a kind of prerequisite to engaging in many things at Zoe. It allowed them to let their guard down, trust people more, and be more open.

Intimacy with Others. All of the participants shared that the physically intimate environment in which they lived with 17 other people in one house was both difficult and instrumental in their change. Kaitlin shared that it was difficult to hide things from other people: “Cause when you’re here living, you really do get to see people...you can’t fake it 24/7, so you really do get a glimpse of people, of who they really are.”

The intimacy of Zoe was particularly important to Rebecca, who described it as quite different from what she experienced in other mental health treatment. At one point, she talked about the intimacy of community dinners: “It’s plenty of people sharing human moments, or sharing a joke, or whatever it was. There was a lot of opportunity to just be human with each other. So that was really nice. And it was nice to build trust too, that I could be seen as just human by therapists and stuff...”
Received Encouragement/Appreciation. All of the participants mentioned that their motivation to change was increased due to encouragement from others in the community, as well as appreciation when they accomplished something. Carolyn, who reported experiencing low self-esteem prior to coming to Zoe, shared, "[community members] have helped me realize that I do deserve to have friends, and that I do deserve to not be alone." Lauren also cited the encouragement of the community as important, especially about small things. When talking about beginning an exercise routine, she said, "And then having people being excited about... 'yay for walking!' You know what I meant? ...There's a lot of encouragement, I think, of the small wins, the little wins. I think that's really helpful because the big projects are so overwhelming."

Care of Others. In addition to receiving encouragement, the participants all mentioned giving encouragement and care to others as an important mechanism of the changes they made. Kaitlin described it as a process of receiving care and encouragement, starting to feel better, and then turning around and offering that care to new community members:

We've all sort of been on the fringes, and not accepted. So then when you're living in a house...to me it becomes...like a family. But knowing how raw and vulnerable I felt, it makes me want to take care of someone who has gone through...not the same thing...their own junk. To see people doing that, it makes me want to take care of them, and build them up, and make them feel like I am feeling: more competent and capable.

Recognition that One's Behavior Affects Others. Four out of the five participants stressed the importance of their realization that what they do affects other people, as well as the power of this realization to lead to change. Lauren remembered the night she was "called out" in a community meeting in which she was focusing on herself: "And so I think the beginning of that process [of change] was being told, 'your behavior does affect other people. When you don't
show up, it matters.’” Other participants recognized that something as simple as doing chores could have a significant impact on others. Carolyn shared, “I actually do chores, which I never did when I lived by myself. And now I take that on as a big responsibility... If everybody doesn’t do the chores, this place is gonna be a mess. And I don’t want to be one of the one [who] falls short. I want to be...dependable.”

Rebecca also reflected on her realization that her behavior had an effect on other people. She began to understand that while watching others and noticing the effects of their behavior on her:

When I saw other people...it’s kind of hard to be around them ‘cause you never know if you can talk to them about their day, or if they’re gonna be up or down, or how to connect. I saw the difficulty in it...I saw what a gift it was to be able to be steady, whereas I think in the past I thought it was really cool to be Bipolar; I didn’t think it affected people. And I saw I wanted to offer more to people than I had. And I hadn’t ever had that sense of belonging or knew what goes into it.

**Tell One’s Story and Hear Others’.** Throughout all of the interviews, participants kept referring to “my story,” or “her story.” When first asked about how changes were made, Kaitlin replied, “Well, initially, I think just listening to people’s stories.” They described their stories as not only their history with mental illness, but also their family and friends, activities they enjoy and excel at, and their ways of interacting with others. Having had difficulty forming relationships in the past, Lauren reported an important realization about telling stories:

And so I think I was doing this attempt to connect by doing me, me, me, me because it was the only thing I could think of...and you know, this realization that the way you make connections is by asking how they are. And that’s...always one of the first surprises to people, is that somebody’s asking...how your day was and people actually want to know...new people are always surprised by that. And I think that’s the beginning of it...The connection has to come from both people sharing information...both people telling their story. Both people giving and both people receiving, and nobody overwhelming the other in either direction.
Accountability. Finally, all of the participants emphasized the importance of accountability at Zoe. Emily asserted that accountability is “just as effective as encouragement.” She reported a history of difficulty finding a job, partly because she would not follow through with applications or interviews. The accountability at Zoe helped with this: “...and just people giving you feedback, saying you are a hard worker, and...following up on why you didn’t go.” She shared that an accountability group that community members formed helped her to meet community requirements and make changes.

Accountability in the community also helped a group of members quit smoking. Kaitlin explained, “Actually a bunch of us decided to quit smoking at the beginning of the year, and that was helpful for me personally because I like tips. I’m all about tips.” She went on to describe tips she received from others who were quitting smoking, and the tips that eventually worked for her.

Superordinate Theme Three: Intentionality/Mindfulness

In addition to the structure of the program and engagement in the community, participants identified another theme in the process of change: intentionality and mindfulness. Throughout the interviews, three sub-themes arose: paying attention to physical reactions, focus outside of one’s self, and practicing intentional interactions.

Paying Attention to Physical Reactions. Several of the participants talked about recognizing reactions in their body (i.e. faster breathing, increased heart rate, feeling of weight on chest, etc.) as important indicators of how they were doing and feeling. Lauren described her process of paying attention to her physical reactions: “Noticing the physical reactions as indicators to me of what’s going on...I think I’m more aware of [those signals]. That pit in the stomach means something. It means, ‘Stop. Don’t act out of fear,’...or like the sweaty palms...I’ve started to be more aware of what those signs are.”
Rebecca reported making the recognition that the amount of sleep she gets each night affects both her and others: “I do really make sure about my sleep routine...yeah, I really have to make sure I get enough sleep...like seeing, ‘wow,’ it really affects everyone else.”

**Focus Outside of One’s Self.** Several participants shared that mental illness sometimes leads to a kind of self-absorption. A person is so focused on getting out of bed despite the depression, surviving the party through the social anxiety, or even combatting suicidal feelings, that she has little awareness of what is going on around her. They indicated Zoe forced them to notice what was going on outside of them because they interacted with so many other people all day, every day.

Carolyn shared she isolated in her apartment before coming to Zoe Community. She stated she went for several years seeing almost no one but her mother. She did not feel lonely during that time, but she described what happened when she left her apartment and moved to Zoe:

> But when I moved here and saw everyone interacting with each other, it was the first time I felt lonely. The feeling lonely made me realize I shouldn’t isolate in my room, even though that’s what my instincts 100% told me to do...Feeling lonely helped me by motivating me to change and seek out...ways to learn how to become better connected and interact with other human beings...The loneliness made me realize it. So I still see the loneliness as a good thing.

Carolyn had to focus outside of herself to recognize that others had something she was missing, namely companionship.

Lauren also described the importance of learning to shift her focus outside of herself on a regular basis:

> There are set times to ruminate...not just ruminate...but talk about and process stuff. And then there are set times where you tell yourself you’re not gonna...I’m gonna go do this other thing for twenty hours a week and not be in my head. I’m gonna do my chore and be thoughtful about getting all of the food off of the island
or getting...making sure I’ve mowed all the grass, whatever it is. It’s not just about...yes, it’s part of being a participant in the house and taking care of our home, but it’s also get up and go do something instead of sitting in your room.

**Practicing Intentional Interactions.** Community members described their lives prior to entering Zoe as rife with difficult and destructive interpersonal interactions. They all mentioned a shift to acting with more intentionality as a mechanism of change.

Kaitlin discussed an activity she planned for the community in which it was important for her planning to be intentional: “Like when I arranged the scavenger hunt...’cause I feel like people get to know each other in low pressure situations with sort of a construct...but fun. I like to have fun. But it’s always with intentionality though.” Kaitlin described tailoring the scavenger hunt in a way that it appealed to the diverse community and allowed anyone who wanted to participate. She added that she practices intentionality in the community, and also tries to take that intentionality into her life outside of Zoe.

Lauren also discussed practicing intentionality in the community, and she went on to describe a situation in which she began to practice it in her life outside:

And I think, for me, I’ve always been the one...I explode; I’m hysterical; I’m in the corner crying for a week. That’s not productive for me anymore...it throws me...totally derails me from my life. And I think about how many times my brother has left me hysterical in a restaurant, or hysterical in public somewhere with no way to get home and no way...he’s exploded and I’ve exploded. And I’m in a corner crying hysterically in some public place, and he’s gone. So for me to kind of have this realization that I cannot engage while I’m in a flooded state, and I can prepare ahead of time and have my own car...I feel like that’s a change in action, that sort of proactive decision making as opposed to reactive coping.

**Superordinate Theme Four: Applied Knowledge**

Finally, the participants from Zoe reported learning a great deal of information that led to changes in their lives. Although some of this came through factual information conveyed through the staff at Zoe, most of it was learned in other ways. Three themes were recognized in the area
of applied knowledge: developing a more thorough understanding of mental illness, learning from watching others, and therapeutic practice.

**Developing a More Thorough Understanding of Mental Illness.** First, participants discussed their new and more thorough understanding of their mental illnesses. For most of them, this did not involve learning new facts about mental illness, but coming to a new or slightly different viewpoint. For example, Rebecca reported recognizing that she was not the only person who did, thought, or felt particular things: “And now not only do I know that other people with a mental illness can feel this way, but I also have a lot more confidence talking about my thoughts with people, and finding out that a lot of people without mental illness think similar things.”

Kaitlin described a history of mental health care in which she felt stigmatized. She reported experiencing more of an acceptance of her mental illness, both acceptance by others and by herself, at Zoe:

Well, I think probably the deepest part [of changes in my thoughts] for me was sort of accepting the mental illness aspect of it and not beating myself up. Like, ‘you did all this stuff cause you’re a bad person...you’re crazy...you gotta get help...you’re sick in the head.’ ...Being around people...that was like, ‘okay, this is a symptom clearly’...that has always been comforting if you know...maybe you’re manic, or a symptom, ‘cause I don’t personalize it so much...Having a mental illness [isn’t] a punitive thing.

**Learning from Watching Others.** As mentioned earlier, the importance of interaction with other people in the community was universally held to be important amongst the participants. Along those lines, all of the community members interviewed reported learning through watching others at Zoe, both staff and other community members. They recognized this as central to their processes of change.
According to Emily, “There’s something that you see about [Zoe] that makes you want to change or want to be a part of the community. And then you see other people changing and you can kind of internalize [it].” She added that she did not think she would ever have a job again. Then, “Seeing other people getting jobs and stuff, and seeing it’s possible to get a job even though you have a bad…not a good work history.” At the time of the interview, Emily had a steady job.

Kaitlin indicated that watching people change for the better gave her the motivation to do the same: “I think the most powerful thing is watching people be just totally vulnerable and going for it. It takes a while…but to watch people do that and see them get better…it made me change my mind about the possibility of getting well too.” She went on to say that she sometimes watched people do things she did, but in a different way, “Whoa, this is a very different approach than I’ve had, and they seem to be doing a lot better than I have.” As a result of this, she felt like she had more options to choose from in the way she acted.

In contrast, Rebecca shared that she watched other people do things the same as she did, and she realized she did not like the results. She stated, “When I saw other people not trusting, or not being open, or not disclosing, and it started to just be really apparent that it was really counterproductive.” Given the safety she felt at Zoe, and the importance of being open and trusting that she learned through watching others, Rebecca started to do things differently: “I was just more open to being wrong, I guess, because I saw people I cared about who were really cool, and were sometimes wrong.”

Rebecca also learned by watching staff in the community. She stated that before coming to Zoe, she believed that most people were sometimes emotionally volatile like her family. She was surprised to see something different in the therapists at Zoe:
Like when I would see the therapists and stuff, and they would be able to sit in a room and just be nice to people all day, and be present...just to sort of see normal behavior like that. I just thought that they must just be like my family was when they were at home. And I still don’t know how therapists were when they were at home, but I could see them over a number of hours without...none of them had any kind of hugely emotional thing happen...I realized that I want that. I'm still aspiring toward that.

**Therapeutic Practice.** Zoe Community provided a unique opportunity to practice new skills, whether they were mindfulness skills, suggestions received in therapy, things learned by watching others, or new interpersonal skills.

Carolyn indicated she learned the mindfulness skills of self-talk and deep breathing through groups, and then she put them into practice when she did an activity that cause her significant anxiety: cooking for the community. She stated, “Like when I have to cook a meal, that’s a huge anxiety-provoking experience...that can trigger panic attacks. And I’ve learned to ride the waves of it. And through self-talk and affirmations and breathing, I’ve learned that I can be successful.”

Lauren described Zoe as a place in which one could practice what is learned in ways that are not available in other mental health settings. She posed a question about what she learned, “This question of, ‘how do you apply it?’ How do you practice applying it?” She subsequently answered her question:

I think having those kinds of discussions in which...how do you navigate a fight in a community meeting? How do you navigate a bad vibe in an applicant dinner? How do you navigate a disagreement with someone else? And getting that...having those real world applications to the stuff you’re talking about in groups, to the stuff you’re getting in check ins, and then having other people and staff members to run that by, and get it reality checked all in the same space and time. So it’s not having to go to your therapist and talk about it a week later, right? Right now, we’re having the discussion. I’m having these feelings. How do I work it through right now in this moment? Tell me how to deal with it.
In summary, participants from Zoe Community identified four superordinate themes during their interviews. First, they discussed the importance of the structure of the program and the safety it provided. Next, they talked about the value of engaging in the community in various ways, including frequent interactions with other community members and staff. They also reported the use of mindfulness and intentionality during their healing process. Finally, participants highlighted the importance of being able to apply what they learned with help from the community.

Discussion

In general, these results complement and expand upon both the assumptions of myself and my colleagues, and prior research examining the efficacy of therapeutic communities. Notably, all of Rappaport's (1960) five themes that characterize therapeutic communities were mentioned by the participants. The community members acknowledged the democratization of the community in the value they placed on their observations of community and staff members in real life situations (dinners, in the milieu, etc...). Regarding permissiveness, community members discussed the importance of acceptance of who they are, including their flaws. This acceptance was also assumed to be integral to the change process by the staff at Zoe.

Participants also described the theme of communalism in their descriptions of the intimacy of the community and the ways in which they learned from each other. Next, Rappaport's (1960) concept of reality conformation is very similar to the experiential learning participants described in the themes of Learning from Others and Therapeutic Practice. Last, community members all discussed the social learning contained in Rappaport's theme of reciprocal relationships. This is also reminiscent of the assumption of Zoe staff that learning relational skills were an important part of the change process.
In addition to acknowledging Rappaport’s themes, the TC members’ themes in this study correspond with Pearce and Packard’s (2013) themes of belongingness and capacity for responsible agency. Their discussions of the safety of the community, the importance of shared experiences, and the care, encouragement, and appreciation shared in the TC all speak to a sense of belongingness. Zoe staff experienced and predicted this theme in their assumption that feeling loved, despite their flaws, was key to change at Zoe.

Likewise, participants reported recognizing their capacity for responsible agency through practicing intentional interactions, recognition that their behavior affects others, accountability, and the structure of the program.

Furthermore, the superordinate theme of Engagement in the Community mirrors Debaere, et. al.’s (2014) relational themes of providing a safe caring other and recognizing ways in which one interacts with others. Community members acknowledged the safety of the community as well as the care of others as agents of change. They also recognized that their behavior affects others and learned by watching others.

Expansion of Prior Research: Recovery from Trauma

While the results from this study are similar in several ways to the current literature, they also expand the literature about therapeutic communities in one important way. The change agents reported as leading to healing strongly resemble current best practice for the treatment of trauma.

Therapeutic communities first began as places to treat the trauma of war. In his existential phenomenological paper, Kemp (2010) postulates that therapeutic communities came about after the devastation of World War I, and after so many people lost family members and loved ones because human beings’ “communal nature as being-in-the world was at stake.” He
further states that the world, because of the state it was in, “called [therapeutic communities] into being” (Kemp, 2010, p. 291).

There is a strong correlation between SPMI and trauma. According to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, people with a diagnosis of Posttraumatic Stress Disorder (PTSD) are 80% more likely to meet diagnostic criteria for at least one other mental disorder than people without a PTSD diagnosis (American Psychiatric Association, 2013, p. 280). In addition, a 2013 study examining the prevalence of trauma in people with SPMI found that 47% of people with severe mental illness had experienced physical abuse, 37% had experienced sexual abuse, and 30% had been diagnosed with PTSD (Mauritz, Goossens, Draijer, & van Achterberg).

In her theory of Trauma and Recovery, Herman (1997) asserts that recovery from trauma requires the creation of new connections with others. She states, “Recovery can take place only within the context of relationships; it cannot occur in isolate” (Herman, 1997, p. 133). Because of this, a therapeutic community is uniquely positioned to treat trauma survivors. Herman (1997) postulates three stages of recovery: the establishment of safety, remembrance and mourning, and reconnection with ordinary life. These three stages can be observed in the community members’ accounts of their time at Zoe Community.

First, all of the participants endorsed the importance of having a safe space. They discussed this in terms of physical safety, as having a roof over their head. They also acknowledged the TC’s emotional safety in that they received care, encouragement, and appreciation from others. Furthermore, they identified the safety to try new things without worrying that they would be ostracized.
Regarding the second stage of remembrance and mourning, community members spoke of intimacy and the importance of telling their stories and listening to the stories of others in the TC. They did this in groups, in their individual therapy sessions, and in the milieu of the community.

Finally, much of the work done in the TC led to Herman’s (1997) third stage of recovery: reconnection with ordinary life. Participants acknowledged the structure of the program as an important component of change, from doing chores and grocery shopping to focusing outside of themselves and practicing intentional interactions with others.

Limitations, Implications for Further Study, and Conclusions

Limitations of Study

There were several limitations in this study. First, not all of the participant interviews could be used due to the psychological state of two of the participants. As a result, all of the interviews in this study were from only female participants. Next, the study did not make use of data from staff members in the TC or standardized instruments that assess the process of change during therapy. Additionally, due to the inherent nature of Interpretative Phenomenological Analysis, this study utilized a small sample size of five participants, but a future qualitative study could include more participants from more diverse cultures.

Implications for Further Study

While most of the participants in this study mentioned traumatic events in their lives, they were not formally assessed for past traumatic experiences or trauma-related disorders. Future studies may further explore the ability and efficacy of TC’s to treat trauma-related disorders. Likewise, research into trauma work as part of other treatments for people with SPMI might allow the integration of trauma work into other forms of treatment.
In addition, a follow-up to this study to see how participants are doing several years later would provide valuable information about the long-term effects of being treated in a therapeutic community. It would also allow them to consider the agents of change in the community after they have had more time to process the change and integrate it into their lives.

Conclusion

Residents in a therapeutic community were asked not only what changes they have made, but how they were made through the course of treatment in the TC. They identified several themes: the structure of the program, engagement in the community, intentionality/mindfulness, and applied knowledge.

Participants acknowledged the importance of having a physically and emotionally safe space to live. They also remarked on the stability of the community, providing a safe and reliable base from which to live their lives and try new things. They also reported the importance of mindfulness and intentionality in their change. They learned to pay attention to themselves as well as things and others’ outside of themselves. They also learned to practice intentional interactions.

Additionally, community members discussed the necessity of engaging in a community. Through this, they cared and were cared for, shared stories, were held accountable, and recognized that their behaviors affected other people. Finally, they learned important ways of interacting by watching others, understanding their own mental illnesses more thoroughly, and by having a place to practice what they were learning.

To conclude, results from this study suggest we rethink the way we treat people with SPMI. The results argue in favor of long-term social and communal treatment rather than the mostly individualized short-term treatment that is widely-used at this time. In addition, this study
highlights the link between trauma and SPMI, and it suggests the role of trauma treatment as instrumental for change. Therapeutic communities are uniquely able to provide long-term, social, trauma-informed care for people with serious and persistent mental illnesses.
References


Appendix: Interview Protocol

1. When you came to the treatment program, what was your understanding of the process of change?
2. How have you experienced change in the way you think?
3. How have you experienced change in the way you feel?
4. How have you experienced change in the way you act?
5. How have you experienced change in your physical body?
6. Does change come about through something inside or outside of you?
   (Other questions will be asked by the researcher only when it is necessary to clarify what the participant is describing.)