WHERE THE CHANGE IS: EVERYDAY INTERACTION RITUALS OF THERAPEUTIC COMMUNITIES

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ABSTRACT

This thesis has been concerned with how everyday social interactions facilitate personal change in the lives of therapeutic community (TC) client members. TCs are planned social environments that aim to provide a safe setting whereby troubling relational patterns can be explored through confronting past trauma and dysfunctional interpersonal dynamics. All aspects of community life, particularly everyday social encounters, such as smoking breaks and meal times, are potentially therapeutic. Whilst there are have been numerous studies focusing on treatment effectiveness and clinical outcomes, there have been relatively few studies that explore how interactions during these potentially therapeutic informal periods facilitate personal change. Thus, everyday social encounters are not only underrepresented in the literature in terms of mechanisms of personal change, they remain poorly understood in practice.

Therefore, this research specifically investigates how everyday interactions support personal change by: examining the mechanisms of interaction rituals outside of structured therapy; questioning the function of peer-to-peer interactions; exploring how social interactions reflect TC values; studying the influence of power and social control that may exist; and looking to understand client members' definitions of change. The study used a narrative ethnographic approach within two adult-democratic TCs, one residential and one a day community, for individuals with a diagnosis of personality disorder. Specific methods of data collection included over 700-hours of participant observation, in-depth interviews with clients and staff members and document analysis.

Drawing on Interaction Ritual (IR) theory, this study explores the role of emotions, feelings of inclusion and how power is used during everyday interactions. One of the key findings is that transforming negative emotions into positive long-term feeling occurs through the process of inclusion and solidarity. Crucially, community members will tolerate high levels of negative emotions if they feel included in the TC. Both communities had an overall rhythm to community life that provided the emotional tone and pace of each day. Importantly, solidarity and emotional rhythmic entrainment, the process by which individuals become in synch with one another,

were crucial for establishing and maintaining inclusion and producing positive change outcomes. Where solidarity and entrainment are broken, communities will invoke restoration rituals to establish connection with the entire community in order continue working towards positive change. Additionally, interaction rituals highlight dynamics of power, authority, and social control within communities, particularly between client members. Several clients reported increased feelings of confidence and tolerance towards themselves and others as a result of participating in community life.

There are two main contributions of this research for IR theory and TCs. Firstly, IR theory has not been applied widely to the field of mental health. The thesis suggests clarifying the use of emotions to include an analysis of how negative emotions are sustained in successful interaction rituals. Secondly, for TCs, this research highlights the significance of times spent outside of structured therapy. Exploring personal transformations through the lens of interactions, rather than individuals, provides a multi-layered explanation of *how* change occurs.

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CHAPTER 1. WHERE THE CHANGE IS – INTRODUCTION

In August of 2005, I arrived in the UK with the sole purpose of visiting a therapeutic community (TC), Christ Church Deal (CCD) in Deal, Kent for several months. Unlike other TCs, CCD was a volunteer lay community where everyone was equally staff and clients. It was full of individuals who had struggled with negative behaviours and had difficult life experiences, such as abuse, psychosis and self-harm. Though I was interested in community approaches to mental health, especially a lay approach, in reality I had come for myself. My life had crumbled and I found myself in the midst of an emotional breakdown having ended a long-term relationship, left my well-paid job and fallen out with my family. I had no formal mental health diagnosis but I knew I needed help facing early negative experiences, and more significantly, my own patterns of self-destructive behaviour. Whilst I had been in individual counselling therapy and had been part of a peer support group in the US, I had never been part of a TC. Through living in the community, I began to understand that change happened through relationships with one another. As the motto went, 'it is people who hurt us and people who heal us'. I experienced my own changes, including reconciliation with my family.

CCD had a self-described narrative culture whereby storytelling was actively encouraged at every opportunity. Every form of change, big or small, was celebrated. We also collectively mourned failures in the community, such as one member's suicide. Over time, I noticed that people appeared to be *sustaining* changes over years without medication and, for most of them, without the involvement of mental health services. Two things happened as a result of my time in CCD: one, I became even more interested in TCs and community based approaches to mental health, and two, I appreciated the possibilities of change through relationships.

With my interest in TCs expanding, I trained as a lead reviewer for the Community of Communities, the quality assurance and accreditation programme for TCs (Royal College of Psychiatry, 2015), and visited a number of TCs in mental health, addictions and prison sectors. I was introduced to

more people in TCs through doing these reviews and, as a result, heard more stories of self-transformation and sustained change. Through taking part in the reviews, it became clear to me that the social support and interactions of both staff and client community members was just as important as the formal therapy. Indeed, clients were always swift to state that the TC was '24/7 therapy', meaning every aspect of community life appeared to be therapeutic. This approach to therapy mirrored what I had experienced in CCD.

My confidence in positive changes and TCs continued to grow. From that confidence, I wrote a PhD proposal to examine change from a narrative perspective, to understand how TCs positively changed individuals' identities. However, there were limitations to my perspective. Firstly, and most importantly, in living through my own process of change, the finer details as to just how complex that process was had faded in light of experienced change. Secondly, as I have no training or experience as a mental health professional, I had no direct understanding of mental health units. I was aware of these limitations when I started fieldwork, particularly my lack of experience within mental health, and sought to deliberately remain open to what I was going to find. Nonetheless, I still entered the field with an *individual* focused understanding of change and began to look for how *individuals* navigate their social interactions. What I found through doing fieldwork directly challenged my conceptions of change and forced a theoretical shift from looking at individuals to *interactions*.

In this chapter, I outline the personal and research process of formulating the study focus and methodology. More specifically, I explain how I moved from studying individuals and their identified areas of positive self-transformation to studying interactions during a *process* of change. Lastly, I discuss the three themes that underpin this research: social interaction rituals, TCs and personal change.

1.1 The Research Study

This doctoral research study uses narrative ethnographic methods to understand the role of interactions between therapeutic community (TC) client members during a process of personal change. As discussed, the rationale for this study originally arose from my involvement with TCs in the UK. Rather than prioritise change outcomes, the study seeks to understand the mechanisms involved in the process of change from the perspective of TC client members.

Many TCs are based within the context of a health service in flux. There is currently a significant need within the health sector to understand the role of everyday interactions and emotions. Citing emotions such as fear and apathy in the National Health Service (NHS), the Francis Report (Francis, 2013) highlighted failings in health services, especially a culture that had become too focused on outcomes, or clinical targets, at the expense of patient care. The basic importance of *how* individuals interact with one another and operate within a system was lost. Amongst other issues, the Francis Report revealed that it was in the *everyday*, the *mundane moments* of practice where the most significant failings occurred. Berwick (2013) produced a report based upon the interpretation of the Francis Report in which he advocates that the NHS should work to create a culture of 'pride' and 'joy' rather than 'blame' and 'fear'. These everyday emotions contribute towards building a safe and healthy culture of an organisation. Berwick's report echoes other research post-Mid Staffordshire that explores *compassion* in NHS care and patients' *trust* and *confidence* in NHS staff, including Newdick and Danbury (2013), Straughair (2012) and Ballatt and Campling (2011). These positive emotional experiences are central to producing safe and effective clinical practice. Contextualising this for therapeutic communities, it is not enough that a therapeutic intervention 'works' (Haigh, 2005). What matters is *how* that intervention is carried out in everyday practice, what people bring to it and how people experience it. An emphasis on what matters over what works, including the knowledge of *how* positive emotions are built up and transferred amongst members, is the backdrop of this thesis. It is concerned with how individuals interact on a daily basis, the experience of being in a TC and how

individuals change. Drawing off of Haigh's (2005) paper, *The trouble with Modernisation: we need better relationships, not policies and procedures*, this thesis prioritises the role of everyday social encounters within TCs.

Historically, TCs have been concerned with the culture and process of personal change, not just the clinical outcome (Jones, 1968; Main, 1977). Within a TC context, everyday social encounters provide the potential for realising personal change through a process that Jones's (1968:70) describes as 'social learning', that 'little understood process of change which may result from interpersonal interaction'. Thus a tea and coffee break, lunchtime or smoking break are all considered potential therapeutic moments because of the social interactions that may occur within them.

However, what actually occurs during these moments? Aside from practical skills such as time management, budgeting, cooking and cleaning, what processes are these encounters facilitating in the community? How do these interactions contribute to the process of personal change? Why do these moments matter? Building upon interaction ritual theory developed by Durkheim (1912/2001), Goffman (1967) and Collins (2004), I conceptualise everyday TC interactions as 'rituals'. This is not ritual in the rigid sense, but ritual as a fluid, reflective and continuously evolving form of interaction that is sensitive to physical and social environments, structures and individuals. Rituals of mealtimes, smoking breaks, community meetings and chores all potentially have a therapeutic role. These interactions are meant to encourage change in client members *alongside* structured therapy (Jones, 1968). Significantly, Mahony (1979:85), an ex-service user of the Henderson TC, reveals that moments outside of structured therapy is where things 'happened'. In other words, everyday interaction rituals are where the change is.

1.2 Aims and Objectives

This study is designed to address the following question: *how, and to what extent, do social interactions, or interaction rituals, facilitate individual*

transformation in the lives of therapeutic community client members? To address this question, there are four main objectives to this research:

1) To explore the social processes within TCs in order to understand the mechanisms of everyday interaction rituals.
2) To explain the function of peer-to-peer interactions during formal and informal community activities.
3) To analyse how everyday interaction rituals within TCs reflect the values of the community and question the influence of power and social control that may exist within the community.
4) To identify client members' definition of change, their understanding of the role of the community during the process of personal change. This will specifically seek to understand things that help or hinder the process of change.

Instead of change outcomes, the research prioritises the change *process*. Thus rather than assume that an individual will gain an improved sense of self and a stronger sense of belonging in the social world as a result of TC involvement, this study focuses on the social mechanisms involved with individual transformations, understanding the dynamics of this process and questioning what clients felt they gained through being in the community.

The study design uses participant observation and narrative interviews in order to explore transformative change in a TC setting. Such an approach enables an analysis of both the mechanisms of everyday interactions and the meaning of change. There are two communities in this research, both accredited through the Community of Communities (CofCs) (Royal College of Psychiatry, 2015), the quality assurance branch of the Royal College of Psychiatrists. Both were 'adult democratic' communities in England for individuals with a diagnosis of personality disorder (PD) and borderline personality disorder (BPD). To maximise participant anonymity and confidentiality, I use pseudonyms for the two sites. The first site, Powell, was an independent, charitable residential community for women. Powell received referrals and funding from National Health Service (NHS) localities throughout the UK and was one of the few remaining accredited residential communities

for adult mental health in the UK. Representing a more typical contemporary adult mental health TC, Hawthorne was a day community for men and women that was part of a Personality Disorder Service in the NHS. Therapy in both communities lasted between 8-12 months.

In keeping with the tradition of ethnography, the research questions guided my research focus but did not determine the direction of the analysis. Indeed, as has already been acknowledged, this research did not originally set out to study the role of social interactions. The focus of this thesis shifted to interaction rituals by the time I completed my work with Powell and I entered Hawthorne with a different framework than I had originally intended. Unsure whether this new lens of interactions rituals would suit Hawthorne as well as Powell, I deliberately sought to remain open to fresh perspectives. Throughout my time with Hawthorne, I found that this shift did work and confirmed the new theoretical direction.

As Larsen (2007) writes, to increase study reliability it is important to follow the findings as they emerge. Both the explanation for using rituals in this thesis and the emphasis on interactions is found in the story of how this theoretical shift occurred. In the next session, I discuss this shift in more detail.

1.3 A Theoretical Journey of Transformation

When I began this research study in the autumn of 2011, my intention was to study individual positive changes in the lives of TC client members. After clients had identified transformations, I wanted to work backwards using their narratives to understand how that change had been achieved. I expected to use narrative analysis, with its emphasis on storytelling and meaning making, as the theoretical lens to understand the data. However, during the research design, I realised that this approach was too focused on change outcomes and I instead sought to go into TCs to watch how individual change occurs in action. My research design therefore took me into two TCs for adults with a diagnosis of PD and BPD using participant observation alongside narrative

interviews. I expected that the storied interviews would form the centre of analysis with the fieldnotes in the background, contextualising the narratives.

Then, at the start of fieldwork, I found myself facing another conundrum. Though I had purposefully sought to enter the communities with a vague definition of personal change in order to let meanings of change be shaped by the communities and the participants themselves, I soon found that my definition was more fully formed than I had anticipated. In short, I expected change to occur more linearly. Moreover I was in a residential community that some weeks had daily episodes of self-harm and dissociation. Frequently the timetable was interrupted as the community stopped and drew together to help an individual client member in distress. Additionally, all of the clients simultaneously continued to choose destructive forms of relating whilst making positive changes. I watched one client make subtle but significant changes only to nearly kill herself with a ligature and leave the TC prematurely on Section 2 of the Mental Health Act. My expectations of change swiftly crumbled. By the end of the first month of fieldwork at Powell, I felt theoretically, conceptually and emotionally at a loss to understand the processes I was witnessing:

> I feel like my naïve bubble has burst, which feels a good thing. Hard but needed to happen. What did I expect? I know change is not easy. I know it's full of stops and starts and that some people choose not to change. But I guess this is the difference between knowing it on one level from my experience and seeing it on another from others' perspectives. (Powell, reflections between Days 13 and 14, 6/12/2012)

Whilst I had been part of a TC, most of the individuals in CCD did not have a mental health diagnosis. In contrast, client members in Powell all had a diagnosis of PD and many entered the TC on the acute end of psychiatric services. Additionally, I had been part of CCD for several years, watching individuals change over time. At Powell however, time was limited to 12-months. Therapeutic change did occur within Powell, it just looked very different to my conceptions of it.

My fieldwork highlighted that I was watching individuals construct their story of change on a daily basis. Forms of storytelling occurred but it took place episodically, spontaneously, sometimes in long segments and other times in short snippets. Narrative analysis for all of its flexibility in meaning making suddenly felt rigid in its adherence to stories that are coherent and chronological (Baldwin, 2005). In order to understand what I was observing and experiencing, I pushed aside my original theoretical framework and started focusing on the *interactions* that occurred within Powell. Initially I viewed interruptions of self-harm, distress or dissociation to the community timetable as just that, interruptions. However by looking at interactions rather than individuals, I came to understand that the interruptions were part of the overall rhythm of community life. Thus my data challenged me to understand change not by beginning with change, or even the individual, but with the interactions between individuals. From this perspective I began to observe how the dynamics that client members built and shared together impacted them. It was then that I could start to understand the mechanisms involved in the change process through daily social interactions.

Additionally, I was unaware of just how much storytelling occurred by living it, day in and day out. At the start of interviewing, I still thought that the interviews would illuminate the whole process of change and the observations would be the context to the interviews. In contrast, in doing the interviews, I realised that I already knew the clients and much of their stories of being in the TC because I had lived part of it with them. Their interviews provided the context to what I had observed and already been part of with them, not the other way around.

I took this approach into Hawthorne, though I was uncertain whether a focus on interactions would still be appropriate. Whilst more complete forms of storytelling occurred at Hawthorne, they still had an episodic style to them that was similar to Powell. Though there were less overt forms of distress at Hawthorne, it was clear that meaning making, like at Powell, was occurring *through* interactions. Furthermore, notions of change, identity, power and belonging only made sense when viewed first from the perspective of the

interaction and then the individual. I also realised that an examination of the mechanisms of social interactions within the communities would enable a richer understanding of personal change.

In search of a lens to understand my data, I came across interaction ritual theory as outlined by Goffman (1967). In his collection of essays, *Interaction Rituals: essays on face-to-face behavior,* Goffman (1967) applies Durkheim's (1912/2001) analysis of rituals in religious life to everyday social encounters. Goffman argues that in a study of interactions, one must begin with the interaction, not the individual. As I read his work, those loose pieces of my data that had confounded me began to shift into a much more meaningful framework, though I still felt unable to fully articulate it. Around that time, I read Collins' (2004) *Interaction Ritual Chains* that builds upon Durkheim, Goffman and Mead to develop a theoretical model of interactions. The problem, according to both Goffman and Collins, is that a focus on individuals reifies them, stripping them of their unique responses to situations. I could see this problem in my data but more significantly, individual experiences just did not make sense when viewed in isolation. However when I viewed them from the lens of interactions, I realised everyday interactions *were* the story of change, at least change in process. Clients delved into their past and painful histories whilst simultaneously planning and shaping their futures. They were unmade and remade in the smoking areas, in the lounge, at the dining table and in community meetings.

Allowing my theoretical position to be guided and changed meant traveling some distance from where I had started. However, when I started the write-up for this thesis, I faced a pressing question: is this study about TCs, rituals or personal change? In search of an answer, I went to my data. Overwhelmingly the data contained numerous accounts and reflections about social situations rather than a central focus on personal change. This research then is more about rituals, but rituals that are contextualised within TCs during a process of personal change. Therefore rituals, TCs and personal change are inseparable within this thesis and continuously

intertwine. The next section introduces these themes and their role in more detail.

1.4 Everyday Social Interactions (Rituals), TCs and Personal Change

This study is about the role of social interactions, or *interaction rituals*, within *TCs* during a process of *personal change*. These three themes serve as the pillars for this thesis. The literature and theoretical reviews (Chapters 2 and 3, respectively) each lay the foundation for these themes, and the analysis chapters (Chapters 6-9) are underpinned by their concepts.

However it must also be acknowledged that this research involves participants with a diagnosis of personality disorder (PD) and borderline personality disorder (BPD). Though this thesis is not explicitly about the nature of PD, its myths or stereotypes, it is significant that a social interaction model is applied in communities established to treat those diagnosed with a mental health disorder characterised by *interpersonal* difficulty and challenging patterns of *social interactions* (Millon, 2011). The thesis indirectly provides a challenge to health models that view mental health disorders, such as PD, as untreatable and as a condition to be managed primarily through psychopharmacological interventions (Bentall, 2009). Therefore whilst conceptions of PD are not one of the three main themes of this study, they are present in the background and provide a distinct tone to the research than had it occurred in a different context. Chapters 2 and 9 will expand more upon this.

1.4.1 Everyday Interactions Rituals

Studies on rituals are not unique to sociology. There is a rich tradition of ritual theory in anthropology, religious studies and psychology. In tracing the history of rituals and ritual theory, Bell (1992:3) writes that ‘few other single terms have been more fundamental in defining the issues basic to culture,

society, and religion'. However, there is confusion over what is meant by the study of rituals. Anthropologists and religious theorists alike have used rituals in overlapping and contradictory ways. Moreover, from a psychological perspective, rituals can be seen as repetitive or compulsive habits (Ling, 2008). Due to Goffman's influence, sociology has had a different perspective, with rituals as the 'catalyst in the construction of social cohesion' (Ling, 2008:9). The sociological allegiance to rituals is distinct, and yet not wholly separate, from religious studies and anthropology. In order to clarify how rituals are used in this study, it is necessary to briefly contextualise ritual research.

Interest in rituals began in the late 19th-century (Collins, 2004; Bell, 1992) with the study of religion. It was Durkheim (1912/2001) and his interest in religion amongst Aboriginals in Australia that provided the model for ritual studies that would influence anthropologists and sociologists. Durkheim views Aboriginals' religious actions as rituals that convey meaning. In particular, he draws upon psychology to highlight that rituals practiced collectively have the potential to emotionally energise individuals more than if they were on their own. Additionally, he notes that rituals generate symbols with sacred, reified meanings. When insiders or outsiders violate these symbols, individuals will react with moral indignation and fear of the gods' response. This in turn generates a social fear in a group that ensures all members adhere to the principles of the ritual. From Durkheim, ritual theory followed the functionalist tradition made influential in anthropology by Malinowski, Mead, Radcliffe-Brown, Homans, Turner and Douglas (Collins, 2004; Bell, 1992).

Though theorists differ in their specific emphasis of rituals, they all envisage rituals as descriptions of social order. Within this tradition, rituals reflect macro-structures in society. However in the 1930s, Mead began to write about micro-interactions. Crucially, and in direct opposition to functionalism, individuals and the social world are characterised as processes and not fixed structures (Mead, 1934). Blumer (1969) expands Mead's theories into the symbolic interactionist tradition to argue that individuals act

towards things on the basis that meanings have for them, and that meaning arises from social interactions. Goffman (1967), a contemporary of Blumer and a micro-sociologist interested in everyday interactions, took Durkheim's work on rituals and applied his principles to everyday social encounters. Rather than looking at rituals as a reflection of society, Goffman sees the *situation* as creating structure. Like Blumer and Mead before him, Goffman views the self as socially constructed through social encounters. More recently, Collins (1975, 1981,1987, 2004) provides a particular sociological view of rituals that is rooted in the microsociology of Mead and Goffman but uses some of the functionalism of Durkheim to analyse the role of rituals in shaping structures. As with Goffman, everyday social interactions can be viewed as rituals that have a particular role within micro-societies.

For Collins (1987:198), the micro shapes the macro through a repetition of social interactions, which are connected by what he calls 'chains'. As he argues, 'situations generate and regenerate the emotions and the symbolism that charge up individuals and send them from one situation to another' (Collins, 2004:44). To that end, Collins develops a model of interaction ritual chains (IRC) that serves as a mechanism for analysing social interactions. Thus ritual theory in sociology does overlap with ritual studies in religion and anthropology. However sociology's epistemological premise is very different to that of the functionalists in anthropological studies on rituals. Where the fundamentalist tradition view rituals as stale and bearing little resemblance to social life (Douglas, 1996), sociologists see rituals as fluid and very much active in shaping, not just reflecting, micro-societies such as groups and communities.

IRC theory, its mechanisms and its outcomes, will be outlined in more detail in Chapter 3. Here, it must be acknowledged that Collins (2004) has a theoretical interest in providing a link between the micro and the macro through interaction rituals. In his view, repeated rituals that are connected through chains shape macro structures. Unlike Collins, my interest in rituals in this study is not in making generalisations or predictions about social structures. Rather I am interested in using ritual analysis as a framework for

understanding the nature and role of social interactions within TCs. Like Collins, I see an interaction ritual as a 'mechanism of change' (Collins, 2004:43). It has the potential to produce changes in patterns of interactions, interpersonal relational patterns and even individual changes. Nonetheless, the theory has not been widely applied to mental health and I found in using the theory that it could not fully explain some of the interactions in the TCs. Therefore, Chapter 10 outlines a recommendation for IRC theory to expand to incorporate the diverse interactions that are present within TCs.

1.4.2 Therapeutic Communities

The context for this thesis is therapeutic communities (TCs). TCs are planned social environments that aim to provide a safe setting whereby troubling relational patterns can be explored, often through reprising interpersonal dynamics found in family relationships (Spandler, 2009; Jones, 1976). The community, comprising both staff and clients, works collectively to address issues underlying distress. TCs understand that social relationships can contribute to some forms of mental distress and as such, they value the potential for relational networks to restore individual mental health (Boyling, 2011). Additionally, TCs seek to have a democratic environment whereby all aspects of community life are open to question by both staff and clients (Spandler, 2009).

TCs seek to challenge the stigmatisation, isolation, loneliness and misunderstanding that is often associated with mental distress (Roe et al., 2010; Larsen, 2007; Jones, 1968). Moreover, as the label of a mental diagnosis, such as PD, may cause some individuals to feel excluded and marginalised by society (Stalker et al., 2005), incorporating peer support is central to helping individuals feel a sense of shared history and validation (Davidson et al., 1999). Drawing on this approach, TCs seek to create an environment of mutuality and belonging amongst client members (Haigh, 2013). Building a positive sense of self is important, along with learning healthier and empowering forms of social interactions (Jones, 1968). From

the perspective of TCs, everyday social encounters provide an opportunity for an individual to experience positive changes that may manifest in a variety of ways, including feelings of hope, increased self-understanding, enhanced interpersonal relationships, improved behavioural patterns and a sense of living a flourishing life (Jones, 1968; Dunstan and Birch, 2004).

However, it is acknowledged that TCs sit within a mental health context that continues to be dominated by a 'medical model' that seeks to understand mental distress using the same scientific, positivist techniques that underscore formulations of physical illnesses (Roe et al., 2010). In contrast, Palmer (2001) identifies that unlike physical diseases, mental disorders are initially recognised within social encounters. If meaningful symptoms are first noticed within social communications, it seems plausible that signs of personal change will also be recognisable within social encounters. Indeed, Jones (1976:22) writes that 'interaction between individuals forms the basis for the future processes of change through social learning and growth'. Therefore understanding the role everyday social interaction rituals is key to understanding personal change in those experiencing mental distress.

1.4.3 Personal Change

Arguably two key questions arise in relation to the role of interaction rituals during a process of personal change within a TC: what is change and how is it defined in this study? Theoretically, Chapter 2 will outline how conceptions of change are closely tied to the nature of the self, which is acknowledged to arise within social encounters (Blumer, 1969). Nonetheless, my intention with this research was to allow definitions of change to arise from the communities and the participants themselves. When I realised that my definitions of change were too fixed, and too linear, I worked to suspend my conceptions about change to explore how it was defined, understood and used within the communities. Unsure of how change would eventually be defined, and keen to look for mundane details, I looked for any subtle indication of change, positive or negative in the client members. Client members' changes in

clothing, appearance and behaviour captured my interest. For instance, I noticed when clients wore slippers instead of trainers, when they began to speak more in meetings or started talking more during breaks, when they self-harmed, when they struggled to eat meals, when they asked for help and when they isolated. All of this represented change and all of it was meaningful. Furthermore the topic of change in the communities was a frequent item of discussion. Clients often feared they were not changing enough or in the areas they had set out to address upon arrival. Despite their fear at their own lack of change, clients regularly highlighted to one another how they were changing and how different they were from when they first arrived. Change, and talk of change, therefore was always present in my observations.

During the client member interviews, I asked how they felt about their process of change. Some client members spoke about behaviour changes, such as reduced self-harming. However, the clients spoke more about how they *felt* different. These feelings included increased confidence, decreased anxiety, more accepting of themselves and increased feelings of hope. Therefore personal change in this thesis is subjective and closely linked to emotions. Of course not everyone identified positive changes and the tensions and complexity of change is explored in Chapter 9.

1.4.4. A Note on Terminology

As it is recognised that terminology can invoke epistemological, political and social meanings that may or may not be intended, it is necessary to clarify the use of certain words and phrases within this thesis. Firstly, the term ‘clients’ is used to indicate those participants who are in receipt of therapy within TCs. The main reason for this choice over other terms such as ‘service user’ or ‘patient’ is because this is what the TC literature and TC networks use, and what was used by both Powell and Hawthorne. Secondly, there is some overlap between sociological, social psychological and psychodynamic frameworks within the communities. Both clients and staff for instance often

used ‘belonging’ interchangeably with ‘attachment’ within the TCs. In the main, I adhere to sociological terms, as this is a sociological study grounded in sociological epistemologies. Thirdly, I also re-use terms such as ‘self-harm’, ‘dissociate’ and ‘disconnect’ that were originally used in both communities by staff and clients. Use of these words is more colloquial rather than clinically informed.

1.5 Overview of Chapters

This thesis is organised into the following nine chapters as follows:

Chapter 2, *Literature Review,* critically assesses TCs, personal change, power in TCs and social support. Firstly, the origin of TCs is outlined along with a review of relevant TC literature and criticisms. Secondly, notions of personal change are explored in relation to the nature of the self. Thirdly, the use of power within TCs is examined. Lastly, theories of social support are discussed.

Chapter 3, *Interaction Ritual (Chain) Theory*, presents the theoretical framework for this study. It critically reviews interaction ritual theory and argues for the use of ‘action’ rituals, or key rituals, that are subsequently used in data analysis. Lastly it reviews recent studies using interaction ritual chain theory and highlights the limitations of this model, especially in regards to mental health.

Chapter 4, *Reflections on Methodology*, outlines the epistemological position of critical realism that underpins this research. It secondly debates whether this research is ‘narrative ethnography’ or just ‘ethnography’. It then provides the research design and systematically presents how this research was conducted, discussing data collection, saturation, and analysis, and reflects upon the role of the researcher.

Chapter 5, *Life in Community*, introduces both Powell and Hawthorne through the data, in particular the fieldnotes. Rather than present a stilted summary of

the how the communities operated, this chapter shows what life was like through re-presented interactions.

Chapter 6, *'Where the Action is': key interaction rituals of TCs'*, is the first data analysis chapter and begins with the identification of 12 key rituals from the two communities. Secondly, it analyses how solidarity is achieved and sustained and questions the role of emotions, particularly negative emotions.

Chapter 7, *Ritual Entrainment, Symbols and Function*, builds upon Chapter 6 and assesses how each ritual was connected to other rituals within the community. It then examines the role of symbols within the communities before categorising the rituals into distinctive, but overlapping, functions.

Chapter 8, *Power and Social Hierarchy*, explores how power was used in the TCs by specifically looking at the dominant forms of power that existed in both communities. It then questions the flattened hierarchy approach of TCs and advocates for the use of fluid hierarchies.

Chapter 9, *Everyday Interaction Rituals and Personal Change*, is the final analysis chapter and shifts the analysis to examine the impact of interactions on client members and explore the relationship between rituals and change. It begins by outlining definitions of personal change by the clients, contextualising positive and negative change and presents clients' perspectives on what helped and hindered their therapy process.

Chapter 10, *Discussion*, revisits the themes from Chapters 2 and 3 and provides a summary of the research findings (Chapters 6-9), and notes significant comparisons between Powell and Hawthorne. It then identifies two main areas of implications for interaction ritual chain theory and practice within TCs.

CHAPTER 2. THERAPEUTIC COMMUNITIES, PERSONAL CHANGE AND SOCIAL SUPPORT

INTRODUCTION

In TCs, both structured therapy, including group psychotherapy and/or individual therapeutic interventions, and times spent outside of formal therapy are valuable for generating insight and personal change (Jones, 1952). Both Jones (1968) and, more recently, Haigh (2013) refer to role of informal times as 'social learning' and 'living learning', respectively. These related concepts are important as they specifically acknowledge that community chores, community meetings, meal times, cigarette breaks and numerous other social encounters between clients and staff are part of therapy. In writing about his experiences of life within the Henderson TC, Mahony (1979:85) highlights the significance of times spent outside of structured therapy:

> Anyway, the groups themselves weren't the places that things 'happened'. They gave cerebral insight and stirred feelings up, but it was during the unstructured times of the day, weekends, night-time, down the pub, etc. when the intellectual insights of the day or the week or month percolated down to the 'gut'.

Though client members take part in groups as well as individual psychotherapy (the latter only in some TCs), the place where things happen is outside of structured therapy time. More recently, Whiteley (2004:243) makes a similar claim regarding where important therapeutic events occur in a TC:

> [W]e found that although they could arise in any of the group therapy structures in the treatment day, slightly more of these important and beneficial incidents took place within the community boundaries *but outside the formal therapy groups* (emphasis added).

Both Mahony's and Whiteley's reflections raise the question: how, and to what extent, do these informal times facilitate the process of change? This is the main question that this thesis seeks to address. The purpose of this review is to contextualise a study of social situations in relation to the process of personal, therapeutic change within TCs. It will specifically address the following:

- Outlining the history of, and research in, democratic adult mental health TCs
- Defining the nature of the self and personal change

- Exploring the role of social support

Owing to the interdisciplinary nature of this topic, it has been necessary to use a broad approach to the literature review[1], selecting themes across mental health, sociology and therapeutic communities. This review is comprehensive yet is by no means exhaustive. Themes and concepts discussed here will be developed throughout the thesis.

Whilst sociology has traditionally sought to understand the social processes underlying mental health (Durkheim, 1897/2006; Parsons, 1951; Goffman, 1961; Scheff, 1967), in recent years medical and pharmaceutical sciences have dominated both explanation and treatments of psychological distress (Roe et al., 2010; Winship & Hardy, 2007; Busfield, 2001; Rose, 2001). These studies, whilst important in their own right, are not able to capture the 'intersubjective, social and cultural aspects' that are at work within the therapeutic process (Larsen, 2007:334). Moreover, they rely on a positivist approach that does not fully allow for a flexible and reflexive account of human social interactions. However, Larsen (2007) maintains that knowledge of underlying social processes is necessary for a meaningful understanding of clinical outcomes. Additionally, it will be contended in this thesis that personal change is negotiated through social interactions.

The review that follows begins with an introduction to the origins of TCs within the UK for adult mental health, specifically personality disorder and borderline personality disorder. It critically assesses literature related to change, including efficacy studies, and explores the key criticisms of TCs. Having outlined the context of the study, the review will move on to explore conceptions of the self in relation to notions of personal change and the use of peer support within TCs.

2.1 Therapeutic Communities (TCs)

Though TCs have diverse and far-reaching origins, and draw off a range of sociological and psychological theories, a full and exhaustive review of their history is

[1] Literature for this review was identified through academic databases (ASSIA, Sociological Abstracts, Web of Science, PsycINFO (Ovid)), TC journals and books, mental health related literature, relevant references from principle texts and general internet searches.

beyond the scope of this thesis. Others, particularly Perfas (2014), Haigh, (2002), Kennard (1998, 2004), Manning (1989), have written elsewhere on the history and development of TCs. It is however important to give a broad overview of how TCs in their present form evolved in order to contextualise a study of social interactions within communities. Furthermore, this review will only focus on adult democratic TCs within mental health, specifically in relation to PD and BPD.

Present day adult mental health TCs can mainly be traced to post-World War Two and two separate but related approaches. The first approach was by Thomas Main, a psychiatrist at Northfield Military Hospital, who developed a social therapeutic model of treating traumatised soldiers returning from the war (Holmes, 2005; Haigh, 2002). After concluding that one-to-one counselling interventions were ineffective, Main introduced the idea of using the whole hospital to therapeutically treat patients and in doing so, found that hospital institutions could be therapeutic (Main, 1946, 1977). Institutions as therapeutic required giving clients a voice in their treatment and supporting the staff to understand the client's 'plight', and equally, helping clients understand the perspective of the staff (Main, 1977:11). In other words, both groups had to work closely together to create a 'culture of enquiry' to resolve daily interpersonal tensions within a community context (Main, 1977:11). This was a significant shift that required staff to relinquish some power and adapt their role to respond directly to patient need (Kennard, 2004). At the Cassel Hospital, this approach became known as psychosocial nursing (Barnes, 1968). Main, alongside Bion (1961), emphasised behaviour and social relationships and was largely 'psychoanalytic in nature' with the therapist as interpreter (Clarke, 1994:279).

Taking a slightly different approach was Maxwell Jones, working at Mill Hill, then later the Belmont Hospital (renamed as the Henderson Hospital). Instead of the therapist at the centre of TCs, Jones emphasised social learning as a central feature (Jones, 1952). Clarke (1994:279) highlights that despite their differences, the two approaches prioritised a 'social construction', rather than a medical, model of mental distress. Thus Main and Jones, whilst not ignoring individual pathology, both acknowledged that social environments and interpersonal relationships contribute to mental breakdown. This idea in many ways contradicted historic notions and practices of responding to mental distress (Manning, 1989). As Manning (1989)

highlights, mental illness has historically been categorised as a moral deviance addressed by the church, a societal problem handled by the state and, more recently, a medical condition managed by the health profession. Moreover, it contradicted treatments of mental distress by 'healthy knowledgeable staff and sick obedient patients' (Main, 1980:53). By using a social approach to treatment, both staff and patients work together to achieve personal change. Staff are expected to show their vulnerability and relinquish (some) professional power whilst patients take an active role in not only their own but others' therapy.

Writing 25 years ago, Whiteley (1990) credited Jones and his concept of social learning as primarily influencing the definition and application of contemporary TCs. As TCs developed, they have become defined by the following beliefs: relationships are most effective in achieving change when they mirror the external social world, personal change is defined by the patients in line with their wider social world, regular group meetings and social interactions are therapeutically important, the community has a 'flattened' hierarchy of functioning and decision making, and the structure is fluid and adapts regardless of tradition and roles within the community (Campling, 2001; Clarke, 1994). Democracy within TCs also has a therapeutic role. As Winship (2004:286) writes: 'One of the most curative aspects of therapy may simply be the experience of voice for the disenfranchised patient who has previously felt alienated and socially dislocated'. Additionally, TCs value the process of obtaining consensus amongst members more than the actual outcome (Jones, 1976). In this way, conflicts and disagreements are actively encouraged in order to directly confront problems that arise (Winship, 2004). However, TCs have undergone several changes from the time of both Main and Jones. The antipsychiatry movement of the 1960s and 1970s saw TCs adopt a permissive culture, such as in Kingsley Hall, led by R.D. Laing and Joseph Berke. During the 1980s and 1990s, the culture within mental health changed away from the permissiveness seen at communities such as Kingsley Hall and Paddington Day Centre. As prominent criticism of TCs emerged (Kesey, 1962; Sharp, 1975; Baron, 1987), TCs had to evolve to reflect health policies and initiatives in order to secure funding. For instance, present day TCs need to produce evidence based research and compliance with audits and quality assurance standards (Kennard and Lees, 2012).

Though TCs developed mostly within hospitals, they have evolved into many different types of organisations in various sectors including: mental health, independent/voluntary communities, prisons, children's homes and day centres, addictions and learning disabilities (Royal College of Psychiatrists, 2015). In addition, since 2003, the Community of Communities (CofC), a project part of the quality assurance branch of the Royal College of Psychiatrists (2015), have accredited communities as TCs. The accrediting process is rigorous, requiring careful justification as to how a particular community meets the TC criteria; communities must also apply for accreditation every three years. In between accreditation visits are annual peer reviews that are carried out by members of other accredited TCs.

Communities in the CofC network focus on a wide range of issues including personality disorders, eating disorders, alcoholism, gambling addiction, psychosis, drug addiction and a range of other personal and mental health related issues. Despite the diversity of TCs, they all share common values. These qualities, refined by member communities at The Consortium for Therapeutic Communities (TCTC) Annual General Meeting (AGM) in October 2013, are defined as Attachment, Containment, Communication, Respect, Interdependence, Relationships, Participation, Process, Balance and Responsibility (TCTC, 2013). At the same AGM meeting, member communities discussed and approved adding 'Community' as the 11th core value.

Both communities in this research were accredited TCs. However it is worth acknowledging that the ethos of TCs, particularly the value of social relationships and peer support, does exist in other social environments that are not accredited communities. As such, this thesis aims to offer insights into social milieus within mental health regardless of whether they are officially identified as TCs. For instance, the Safewards Model, developed by Bowers (2014:503), advocates that staff on acute units take an 'inquisitive' approach with patients whereby they are attentive to patient distress, behaviours, needs and absences. Bowers's approach is reminiscent of Main's 'culture of enquiry' discussed above that also requires staff to question and respond to patient need and conflicts within the environment. Additionally, Star Wards (2006), developed by former service user Marion Janner,

emphasises patient involvement in their treatment and in the running of the ward. Patient involvement at this level shares similar principles proposed by Jones (1952, 1968), particularly the principle of flattened hierarchy. The Star Wards model also advocates twice daily community meetings and maximising the amount of quantity, and quality, of patient and staff interactions in order to foster healthy relationships. Though recognising the limitations of a TC approach on acute wards, Star Wards nonetheless calls for wards to run in a TC style (Star Wards, 2006). Social environments such as these advocate user-involvement, group approaches and negotiation as in TCs. Therefore, it is hoped that this study will be useful to both TCs and social environments within mental health that are developing recovery facing work.

Several of the adult democratic TCs within mental health specifically focus on treatments for PD and BPD. Whilst this thesis is not explicitly about PD, it is worth acknowledging some of the controversies of PD in order to contextualise this study.

2.1.1 Personality Disorder and TCs

Characterised by a cluster of symptoms including relational instability, emotional deregulation, and risky behaviour such as self-harm and suicide attempts (Stalker et al., 2005), personality disorder (PD) is among the most challenging disorders to confront modern mental health care. Perceptions regarding clinical treatment and effectiveness are mixed (Gask et al., 2013; Roth and Fonagy, 2005; Manning, 2000). Psychopharmological treatments in particular show little evidence of treatment effectiveness (Gask et al., 2013; Roth and Fonagy 2005; Roy and Tryer, 2001; Sanislow and McGlashan, 1998; Soloff, 1994). However, TCs have emerged as a 'specialised treatment regime' for those with a diagnosis of PD (Spandler, 2006:142). TCs acknowledge that social environmental factors, particularly during early childhood, play a significant role in contributing to the symptoms characteristic of PD (Johnson et al., 1999; Pilgrim, 2001; Castillo, 2003; Stalker et al., 2005). Theorists such as Trevarthen (2000) and Schore (1994) argue that emotional development begins in interactions with early, primary care givers, making emotional and cognitive development inseparable. Drawing on these theories, TCs seek to reprise troubling

dynamics in early childhood in order to enable clients to learn healthy ways of managing emotions and relationships (Jones, 1968).

Nonetheless, there are tensions with the treatment of PD within TCs. Whilst TCs have developed a more socially progressive approach to PD that views distress and symptoms as a logical response to early negative experiences, it does mean that TCs perpetuate the notion that PD is an illness that must be treated and contained by mental health professionals (Spandler, 2006). This is especially problematic as there are significant controversies surrounding the notion of PD as a diagnostic category. Even the definition of PD is contested and differs between the International Classification of Diseases (ICD) (World Health Organisation, 1992) and the Diagnostic and Statistical Manual of Mental Disorders (DSM) (American Psychiatric Association, 2013) [2] (Pilgrim, 2001; Gask et al., 2013). Symptoms of PD are identified through social interactions and interpersonal relationships, which makes diagnosing PD not only difficult but highly contentious (Manning, 2000). However more fundamentally, theorists and service users have critiqued the notion and purpose of the diagnostic category of PD (Kendall, 2002; Pilgrim, 2001; Kinderman et al., 2013; Potter, 2009). Thus Lewis and Wessely (1997:183) argue that PD encompasses 'more controversy' compared to 'almost any other area of psychiatric practice'. By implicitly accepting a medical model, it is much more difficult for TCs to critique its conception and function. Furthermore, this acceptance may align TCs as interventions that regulate societal conceptions of normality through interpretation and peer monitoring for individuals who have already been identified as difficult to treat and 'harder to manage' (Netwon-Howes et al., 2008:574; Spandler, 2006; Rose,1999).

This thesis is not intending to directly challenge conceptions of PD or even to critically assess TCs as a treatment intervention for PD. However, it must be acknowledged that TCs are not a 'gold' standard in confronting mental distress such as PD, despite their recognition that distress is rooted in earlier experiences. There are difficulties, tensions and contradictions within them that they have not adequately

[2] Debates surrounding PD were revisited with the publication of DSM-V (American Psychiatric Association, 2013) where, after much discussion about redefining and reclassifying PD, the model and classifications remained largely unchanged. Specific characterisations of PD are divided into 10 categories within three clusters.

addressed as they juxtapose their social approach with a medical model. Furthermore, like all mental health services, there are often differences between how TCs *say* things are done and how they are actually done in *practice*. These acknowledgments are important for this thesis as one of the key questions of this research is the dynamics of power and social control within communities. It will therefore be necessary to carefully interpret research findings in light of these contradictions.

2.1.2 Research within TCs

The pioneers of TC research, including Jones (1952, 1968, 1976) and Rapoport (1960), specifically utilised traditional sociological theories, such as Mead's taking the role of the other, to conceptualise social interactions between individuals and groups and directly inform TC practise (Manning, 1989). However whilst the early founders were committed to conducting ongoing research, efforts declined in the 1960s and 1970s (Morant and Manning, 2005). There has been resurgence in TC research since the 1990s in both qualitative and quantitative studies, yet under constant pressure to secure funding, these studies largely prioritise research which directly impacts clinical practice (Morant and Manning, 2005). This includes outcome based research to demonstrate effectiveness and/or research that will inform best practice, treatment efficacy and organisational structure of the TC (c.f. Dolan et al., 1996; Lees et al., 1999; Chiesa and Fonagy, 2000; Armstrong, 2005; Hesse and Pedersen, 2006; Freestone et al., 2006). Randomised controlled trials (RCTs), the positivist 'gold standard' of medical and clinical research, are favoured for their ability to produce measurable results (i.e. evidence-based practice) which can then be directly linked to funding priorities (Morant and Manning, 2005:236). However, RCTs are difficult to apply within TCs as, by its nature, TC intervention is holistic, not easily segmented into observable parts and it is hard to randomly allocate to conditions. Therefore despite existing studies demonstrating TC effectiveness (Lees et al., 1999; Lees, et al. 2004), reception of TC research, especially in the UK, has been mixed (Gask et al. (2013); Manning, 2010; Cameron, 2006).

However it is worth noting that RCTs have been criticised for their assumptions concerning representativeness, researcher impartiality and notions of what constitutes 'effectiveness' (Slade and Priebe, 2001). Barlow and Nock (2009) identify that RCTs aggregate group means on the basis of overall change for the treatment group. This masks individual-level patient data, which invariably demonstrates varied responses to treatment. It thus provides a spurious account of change, obscuring what worked, how and for whom. Such a critique of RCTs overlaps with Haigh (2005) who is also critical of research that only focuses on what works. What matters gets missed, and, I would add, for whom it matters. Furthermore, a lack of clinical outcome in the treatment group may not be due to a shortcoming with the intervention, but may be down to improvements in the control group, which again, an RCT may not necessarily explain. Additionally, Larsen (2007:334) acknowledges that in positivistic mental health research, there is a 'black box' where treatment outcomes are described without an explanation of *how* they came about. His view coincides with Lapsley et al. (2002:45) who write that those recovering from mental illness often make significant personal changes prior to experiencing a 'turning point', or positive outcomes from therapy. These changes are often 'barely discernible' yet lay 'the foundations for the turning point' (Lapsley et al., 2002:45). This suggests that the intricate dynamics of personal change may be easily missed and it is therefore important to explore this change as it occurs in order to interpret the outcomes, positive or negative, of therapeutic interventions. Morant and Manning (2005:240) further argue that TCs are especially suited to sociological research that recognises 'the inseparability of the individual and the social'. Moreover, as Larsen (2007:334) suggests, an interpretivist approach within mental health can highlight the 'interpersonal dynamics of service delivery', and can aid researchers in understanding therapeutic effectiveness and what it means. Thus, this microsociological research that utilises an interactionist approach enables an in-depth analysis of self-transformations, specifically highlighting the mechanisms of how personal change is mediated through social situations.

TCs have produced qualitative research alongside quantitative studies, including in the form of staff and client member reflections (Mahony, 1979; Castillo, 2013; Castillo et al., 2013). These studies are undoubtedly great resources for TCs, provide a needed forum for the client member voice and help us understand the 'on

the ground' experiences of TCs. However it still remains that research conducted by staff or client member participants in the community potentially have a vested interest in producing a particular kind of narrative about the community. Thus we need more theoretically robust research that is independent of any one TC to go alongside these valuable accounts. Some outside researchers have of course embedded within communities to produce research. Most relevant for this thesis are the notable ethnographic studies that have contributed to an understanding of TCs, acknowledged in Table 1 below:

Author	Title	Design	Main Findings
Rapoport (1960)	*Community as Doctor*	Ethnography informed by anthropology, descriptive and analytical study of daily life in a residential hospital TC.	Four principles of a TC were identified including democratisation, permissiveness, reality confrontation and communalism.
Baron (1987)	*Asylum to Anarchy*	Ethnography of a London based day community using Goffman's (1960) *Asylums* to critique power within a 1980's TC.	Power within the TC resembled anarchy, leading to tyranny of the TC whereby power replaced TC ideals.
Bloor et al (1988)	*One Foot in Eden*	Ethnography using 8 different types of TCs as comparative study conducted over 10 years, compiled from 6 individual studies. To date, it is only ethnographic work in TCs that captures both breadth and depth amongst the different communities.	Six principles of TC work were found amongst all communities: reflexivity, interpretation, intervention, domination, selectivity and habitation. In addition, the TC culture was found to be an agent of therapy.
Rawlings (1998)	*The Therapeutic Community in the Prison: problems in maintaining therapeutic integrity*	Ethnographic study of UK prison TC exploring the tension between TC principles and prison environments. Data collection was naturalistic, gathering information as it occurred.	Staff members' struggles to apply TC principles within a regimented prison environment were highlighted. The importance for 'managing the boundary' between prison requirements and TC philosophy was stressed (292).
Freestone (2005)	*Overview of an Ethnographic Study of the UK DSPD Pilot Units*	Institutional ethnography that focused on power, sociology of the body and risk in a UK DSPD Unit. Theory was informed in particular by Goffman, Foucault and Bourdieu.	An ethnographic approach enables researchers to understand values and norms within an institution. Mealtimes were found to take on 'ritualistic status' involving 'symbolic power' (461). Community meetings highlighted the struggles between 'bureaucratic' and 'clinical' capital' (462).

Table 1: Notable Ethnographic Studies of TCs

Rapoport's (1960) study, based upon the Henderson Hospital, was particularly influential within TCs and helped lay the foundation of TC practice. Suggesting that the community itself was the 'doctor', rather than an individual with specific

psychiatric qualifications, emphasises how the culture of a community could promote well-being. His approach therefore builds upon the work of both Main and Jones. The first principle, democratisation, suggests that both staff and clients should an equal share of power in regards to the TCs decision making. Decision making includes both therapeutic and administrative decisions. Permissiveness in a TC means tolerating behaviours and ways of interacting that may be considered 'distressing' or 'deviant' according to 'ordinary' standards (Rapoport, 1960:58). Communalism identifies that the TC functions according to close interpersonal relationships whereby staff and clients mix freely together over meals, outings, meetings, etc. Lastly, reality confrontation means that clients are given continuous feedback as to how their behaviour impacts others in order to challenge unhelpful self-beliefs. However, Rapoport's research highlights that there are inherent contradictions between TC theory and TC practice (Whiteley, 2004). For instance, despite a culture of acceptance, TCs could at times be damaging for some client members. Contradictions in the staff team as to what constitutes change could also create tension and confusion amongst the staff team and client group. Lastly, despite the declaration of equality, some clients could become overly dependent upon staff members (Whiteley, 2004).

Additionally, and importantly for this research, Rapoport was one of the first to explicitly identify times outside of therapy as having a significant role within a community. Whilst he did not go any further in analysing the specific mechanisms of these social situations, these principles have been so important within TCs that Haigh (2013:10) refers to these four principles as 'Articles of Faith'. Nonetheless, Haigh (2013:10) also argues that the principles are out-dated for contemporary TCs and has updated them to include five important 'experiences' to promote emotional health: attachment, containment, communication, inclusion and agency. Overlapping with Rapoport's original four principles, Haigh suggests that TCs promote a culture of belonging whereby troubling and distressing behaviours are contained. Communities should promote open communication between all members of the TC and everyone should feel equally included. The concept of agency extends Rapoport's democratisation to include negative forms of power and self-empowerment alongside shared decision making. Haigh's reconceptualisation of the principles of TCs not only updates them for modern practice, significantly, it also identifies belonging,

inclusion and power (positive, negative and self-power) as key components to TCs alongside democracy, tolerance and open communication.

Easily the most in-depth ethnographic account of TCs, Bloor et al.'s (1988) research incorporates eight communities across adult mental health, children and young people, learning disabilities and addictions. Though TC practice has since moved on, due to the breadth of their study, it is still an important piece of research for comparing therapeutic practice across a range of different communities. Their six key principles differ from both Rapoport and Haigh as they use an explicitly sociological approach to identify 'common properties of therapeutic work' that contain 'common dimensions of variability, universally present while differentially extensible' (Bloor et al., 1988:186). The principles that Bloor et al. (1988) highlight shows the different ways community members work to facilitate change. However whilst their fieldnotes do centre on social interactions and what could be considered rituals, such as the 'anthroposophical prayers' conducted in the Camphill community (Bloor et al., 1988:134), like Rapoport, they do not provide a mechanism for analysing these social interactions, nor do they specifically consider how these encounters facilitate change. Furthermore, much of their focus centres on staff interactions with clients, particularly in their discussion of the principles of therapeutic work, and there is limited discussion about the nature of the dynamics between clients themselves in comparison to that of staff members.

Rawlings's (1998) study explores some the tensions found in applying a TC model within a UK prison, particularly balancing democratic components of TC work with traditional prison work of order and regulation. However, once again, the dynamics often centre upon the relationships between staff and clients and do not fully explore either social situations or dynamics between client members.

Freestone's (2005) study differs from the others because he explores the values and norms within a Dangerous and Severe Personality Disorder (DSPD) unit using two social situations as analysis: meal times and community meetings. Both encounters are outside of structured therapy times, meaning they do not involve explicitly psychotherapeutic analysis like therapy groups. Mealtimes are considered 'ritualistic', though it must be noted that Freestone does not fully explain what he means by 'ritual' and seems to adopt a more psychological and ceremonial

interpretation of ritual that is highly structured and formulaic. Nevertheless, through this social situation, he does provide an account of how clients interact with one another and some of the tensions between clients and staff members. Food and food items are found to have 'symbolic power' and 'weight' that may provide some form of power to clients within an institution whereby all other aspects of their lives are curbed (Freestone, 2005:461). Community meetings provided an opportunity for client members to share their 'true feelings' about one another that provide a deep sense of reality that differed from other aspects of community life (Freestone, 2005:462). For staff, community meetings are reminiscent of Rawling's (1998) study in that there are tensions between having a therapeutic role versus maintaining peace and order. Significantly for this thesis, Freestone is the first to conceive of social situations outside of structured therapy as 'rituals'. The limitation of his study is that it was a pilot study and as such, the findings from it are limited. Moreover, he does not specify what he means by rituals, nor does he consider the community meetings as ritualised forms of interactions like the meal times. Had he connected community meetings as rituals that are ceremonial and formulaic, he may have been able to strengthen the relationship between meal times and community meetings as particular types of practice within the community.

Baron's (1987) study of Paddington Day Hospital, a London based day community, presents a particular narrative of how power is used within a TC. She argues that the TC's use of psychoanalysis imposed a negative self-view of clients that stifled any meaningful discussion and debates because clients could be 'psychologised and silenced' (Spandler, 2009:677). Moreover, under the 'guise of democracy', with no formal rules, the TC used a form of psychotherapy that was manipulative and ultimately destructive for the TC and its clients (Baron, 1987:247). Her account of Paddington was later reinterpreted by Spandler (2006:134) who argues that 'rather than being an example of 'bad' TC practice', the community highlights the tensions of using psychoanalysis within democratic communities. It is therefore questionable as to how empowering TCs are when they are closely fused with the hierarchical practices of psychoanalysis. Through providing balance to Baron's critique, Spandler identifies that the problems that Paddington faced in the 1980s continue to plague contemporary TCs. In particular, TCs, and TC research, has still not accounted for the contradictions of applying theoretical TC principles in

practice that were noted by Rapoport (1960), Whiteley (2004) and Manning (1989). Additionally, like Paddington in Baron's account, there continues to be a gender imbalance with a primarily dominant male TC lead with female nursing and support staff. This problem is also reflected in TC research whereby white male, clinicians' voices, including Main, Jones, Rapoport, Whiteley, Kennard, Haigh and Hinshlewood, dominate the history and developments of TCs. Furthermore, TCs have still not addressed the 'messianic' leader difficulty that Hobson (1979) depicts whereby TCs can rise and then swiftly decline when a charismatic TC lead either burns out or leaves.

Despite these difficulties, TC research, including the notable ethnographic studies, has done much to advance the research evidence base for TCs and mental health more widely. Such research has influenced contemporary models in mental health and wider social contexts including, the Enabling Environments initiative (Johnson and Haigh, 2011; Haigh et al., 2012), Star Wards (2006), and has links with the Soteria House concept (Soteria Network, 2011; Kennard, 2004). Whilst I have already highlighted the limitations of quantitative studies and argued for the need for more robust, independent qualitative research, there is one additional limitation to discuss in relation to this thesis.

2.1.3 Limitation of TC Research

Though there are potentially several limitations to TC research, including a perceived lack of research evidence (Gask et al., 2013), I would specifically highlight one significant limitation that directly relates to this thesis: a lack of explanation as to the role of time spent outside of structured therapy and how these social times play a role in the process of change. This is a substantial oversight as the times spent outside of formal therapy have been identified as contributing to the therapeutic process (Whiteley, 2004; Mahony, 1979). However there has been little research focusing on these encounters within communities. Knowledge about the importance of these social times therefore remains tacit. The closest TC research studies are by Rapoport (1960), Bloor and Fonkert (1982), Bloor (1986), McKeganey and Bloor (1987), Bloor et al. (1988) and Freestone (2005). However, with the exception of

Freestone (2005), non-therapy times are not the explicit focus of their research. For instance McKeganey and Bloor (1987) include an analysis of small psychotherapy groups and community group meetings, noting differences in importance, treatment and communication between the two groups. They do not include though other aspects of 'group times' such as meal breaks, informal times, community chore groups and cigarette breaks. Thus the role of 'everyday social life…as an agency of therapy', as the authors state in the beginning of their work, actually seems underdeveloped (McKeganey and Bloor, 1987:156). In order to understand how everyday social life plays a role in the therapeutic process, it is necessary to examine how these aspects of life outside of structured therapy influence personal change.

Therefore one must examine *how* individuals interact with others to understand the mechanisms of these social situations. An investigation into the interactions within a TC can potentially identify the social processes and structures at work, as well as the various influences and factors on transformative personal change. Bloor et al. (1988:60) highlight that TCs have a transient view of the self, as the self is a social process. They contend that the self can be reconstructed either via the social structure, which they term 'instrumentalism', or through repeated portrayals of unhelpful behaviour, which they describe as 'reality confrontation'. Like Rapoport's reality confrontation, this has links with Mead's (1932) 'taking the role of the other' as the TCs seek to situate a person in a context whereby the consequences of his/her actions are exposed (Outhwaite, 2005:114). Individuals not only reflect upon their own behaviour, they also imaginatively conceptualise how their behaviour impacts on other people. This awareness is akin to Jones' (1976:22) conceptualisation of 'social learning' whereby individuals learn from one another about their own unhelpful ways of relating and how to interact more healthfully. It is within these interactions that the process of personal change can occur.

Having outlined TCs and discussed relevant literature and limitations in relation to a study of social situations during a process of personal change, it must then be asked, what is change and how is it conceptualised? The next section will address personal change, including conceptions of the self and the role of social support within mental health.

2.2 Personal Change

Before addressing the question, 'what is personal change', it is first necessary to examine the nature of the self in order to ascertain on what basis personal change is defined. This thesis adopts an interpretative and interactionist framework to examine the role of social situations during a process of personal change. Such an approach has links with symbolic interactionism (SI). Though this study does not explicitly use SI the way Blumer (1969) outlines, it does have overlaps, particularly concerning the self and transformative change. Therefore it is important to clarify how this thesis uses SI in relation to personal change.

Rooted in pragmatism, SI is a theoretical approach that argues that individuals act on the basis of meaning (Blumer, 1969). Individuals ascribe meanings to every 'object', which can be 'anything indicated or referred to', including things that are physical, social and/or abstract (Blumer, 1969:11). Moreover, meanings arise through social interactions and through a '*process of interpretation*' (Blumer, 1969:5). The process of interpretation involves an individual first reflecting upon an object's meaning and then deciding whether to revise its meaning on the basis of how he/she interprets the social context. Rather than simply reacting to stimuli, individuals are continuously engaging in a process of reflection and interpretation (Roe et al., 2010). This 'pragmatic' action means that individuals are able to interpret and adjust their definitions of meaning in order to suit their social environment (Roe et al., 2010:31). In terms of the self, this process of meaning is significant because the self is also conceptualised as an object that is capable of change. Defining the nature of the self therefore from a symbolic interactionist perspective provides the basis for understanding individual self-transformations.

2.2.1 Conceptions of the 'Self': an interactionist perspective

Symbolic interactionism holds that an individual has a self, which is an object that he/she can engage with in interaction (Blumer, 1969). The self is not a fixed 'structure', but rather is a 'process' that is recognised as it is compared and contrasted in relation to others (Blumer, 1969:62; Bloor et al., 1988). Mead split the individual in two and distinguished between the individual understanding of 'I' and the

socially constructed ‘me’ (Outhwaite, 2005; Mead, 1932). Here the former is seen as personal identity separate from society and the latter represents the idea of oneself that is produced and continuously modified by the interaction and exchanges of others (Manning, 1989). Moreover Mead also noted that people take on several different roles in their relationships with others and may have several different and overlapping ‘me’s’ (Outhwaite, 2005). Though Mead has been criticised for this ‘self-society’ dualist split, it is nonetheless useful to envisage how social encounters contribute to a sense a self (Manning, 1989:77). Likewise Goffman (1959) conceptualises the self as a series of performative acts; individuals are engaged in a theatrical performance involving linguistics, emotions and perceptions of reality.

As Benton and Craib (2001:187) argue, the self is formed through interaction, ‘in doing rather than in being’. Burkitt (2008:190) further states that individuals develop a ‘core’ self rather than a self that is an ‘unchanging entity’. From this perspective the self is continuously engaged in some process of change. However this does not mean that the self is ‘unstable’ but rather that it is being reconstructed with ‘some stable elements’ in place that are self-identifiable and recognised by others (Burkitt, 2008:190-191).

Furthermore, Summers-Effler (2004b:275) highlights that self and meaning making is an interactive process that is presumably ‘purposeful’. However she identifies that SI does not provide an explanation as to what that purpose is. By arguing that the self is ‘neither fully genetically programmed, nor completely socially constructed’, she posits that the self consists of some evolutionary predispositions and the capacity for personal development and creativity (Summers-Effler, 2004b:276). As such, individuals have an ‘inborn motivation’ to seek out socialisation. Collins (2004) further argues that individuals are motivated to act in order to increase positive self emotions following interactions with others. Importantly, an individual’s view of the self will be linked to the experience of social interactions. Positive interactions contribute towards building a positive sense of self. Individuals want to be seen in a positive light in order to feel good about social encounters and themselves (Collins, 2004; Summers-Effler, 2004a, 2004b). It is this social drive that allows for the process of self-reflexivity and self-awareness that Mead (1934) identifies (Summers-Effler, 2004b; Schore, 1994). Significantly, this

means that the drive for social interaction is *emotional* as well as cognitive. Chapter 3 further explores the role of emotion within social interactions.

An individual's sense of self arises within interaction through a process of self-reflection with the aim to promote a positive emotional view of the self. This means that personal change is therefore recognised by the individual and others through social encounters.

2.2.2 Self Transformations and Personal Change

If personal change can be recognised within social interactions, the next question is what constitutes change. For those within TCs, one of the aims of therapeutic intervention is to help individuals change by learning to live interdependently within their social environment (Jones, 1968, 1976). Embedded within this aim is an understanding of change that is behavioural (e.g. reduction of self-harm) and transformative (e.g. changing relationship with self and others). However change cannot be assumed in all individuals, as there may be many factors that impede these outcomes. Therefore it is necessary to recognise transformations as they occur and remain sensitive to the various dynamics that not only enable change, but those that also prevent it. It is recognised that the process of personal change draws parallels with the recovery literature and it is therefore necessary to contextualise this study in relationship to discussions about the nature of recovery within mental health.

An attempt to define recovery within mental health has been difficult as it has different meanings to different people and varies even within professional bodies (Spandler, 2014; Jacobson and Greenley, 2001; Pilgrim, 2008). There are debates about whether recovery involves being symptom free and a return to previous modes of living (Young and Ensing, 1999) or whether it means accepting life's 'limitations' imposed by mental distress (Anthony, 1993:15). Despite a 'uniform' consensus as to what recovery means, Davidson et al. (1999:483) argue that it will broadly include 'some component of acceptance of illness, having a sense of hope about the future, and finding a renewed sense of self'. For those experiencing mental distress, recovery may also mean a 'deeply personal, unique process' (Anthony, 1993:14) whereby the goal is not to live symptom free but to live a meaningful and empowered

life (Spandler et al., 2007). Nevertheless, this may differ from the view held by mental health professionals. Pilgrim (2008) for instance notes that there is a discrepancy between professionals and service users as to the nature of and possibility for recovery. The former sees recovery as compliance with professional knowledge and treatment interventions whilst the latter views recovery as independence and autonomy from mental health professionals. Additionally, recent research (Castillo et al., 2013; Katsakou et al., 2012) into PD has advocated treatment that is tailored for the client, which involves the client as a co-collaborator in the process of change (Roberts and Wolfson, 2004). This approach is echoed by Spandler et al. (2007:792) who write:

> User-centred notions of recovery, by definition, should not seek to impose particular essentials of what 'recovery' may mean for people, preferring individually defined accounts and goals.

In keeping within this framework, this doctoral study seeks to capture personal change from participants' perspectives. Therefore what change means will reflect the definitions held by client members and may therefore differ from staff members' expected outcomes.

However change is defined, it is necessary to understand that the individual process of change is not linear and involves disruptions, successes and setbacks (Davidson et al., 1999; Lapsley et al., 2002). Lapsley et al. (2002) suggest that the most significant changes occur during a process of both forward and backward movement. Care then must be taken when interpreting an individual's change process in order to not dismiss setbacks as an indicator that change is not taking place. Moreover, Deegan (1996) identifies that change is not an arrival point but is a lifelong process. From this perspective, I am looking more for patterns of change, rather than specific 'outcome evidence' that change is occurring. In addition, the aim of this research is not make value judgements on individuals and/or their change process. Instead it is to explore how meaning about transformative change is constructed within a community context, mediated through everyday social situations, and how this is understood and reflected by community members.

Furthermore, as has been stated, change in TCs is closely linked with addressing troubling past and present events (Jones, 1968). Often there is the

recognition that these unhelpful past experiences continue to influence the present and manifest in difficulties with interpersonal relationships and managing social encounters. The link between the past and the present then is not as two separate entities, but as 'intertwined in a complex knot of temporality, experience and identity' (Treacher Kabesh, 2011:2). Whilst personal change does involve understanding these past experiences, Treacher Kabesh (2011:13) identifies that processing the past also involves a recognition that there are 'gaps, absences, silences and shards' which cannot be fully understood or worked into a coherent narrative. For this thesis, it is especially important to allow these missing pieces and inconsistencies within individuals' experiences and not be tempted to draw tidy conclusions to every dilemma. Moreover, and particularly important for this research, TCs require that clients do more than just engage with the past. Clients must also take responsibility in the present for how they are experienced by others, which is the process of social learning.

Lastly, Castillo et al. (2013) identify that change within a community occurs through certain stages. These stages are referred to as the 'hierarchy of progress' and include: feelings of safety and trust; care; belonging; knowledge of boundaries; containment and skills; hopes, dreams and goals; achievements and transitional recovery (Castillo et al., 2013:268). Some of these stages have links with Haigh's (2013, 1999) five key principles of TCs that also refer to things such as containment, belonging and empowerment. Like Haigh, they identify that joining a community can be a daunting experience for a newcomer. Building a sense of safety and belonging are key to building rapport that will enable honesty and social learning. However Castillo et al.'s (2013) pyramid expands Haigh's principles through recognising that certain social processes, especially learning the boundaries, recognising achievements and having goals and dreams for life after the community, are important components during a process of change. Moreover, they acknowledge that change takes time, years instead of months. Impediments of change include a fear of recovery as it may mean losing a 'network of support' that clients are unable to get from friends and family members. The critique, however, of this pyramid is that it does present the journey of change within a community as sequential. Though the model was developed in collaboration with service users, which is a real strength of the study, it does the raise the question as to whether this process is really so

hierarchical in practice. For instance, the process of belonging could incorporate learning community boundaries. Likewise feeling safe may include some containing experiences. By studying change in process, in real time rather than just through reflections, this doctorate will be exploring the complexity of the change process within a TC and considering whether the mechanisms of change can be mapped as sequential.

2.2.3 Limitations of Symbolic Interactionism in Relation to Personal Change

There are three main limitations of SI in relation to personal change. Firstly, SI research often focuses on those who are 'cognitively functional' in the everyday context of their lives (Tibbetts, 2004:25). Representations of those individuals 'whose cognitive and associated behavioural states exhibit a degree of disorder and chaos so severe they are unable to organise their behaviour in a meaningful or practical way' (Tibbetts, 2004:28) are notably absent from the literature. Although symbolic interactionism has a tradition of attempting to understand experiences of mental distress (Goffman, 1961; Rosenhan, 1973; Szasz, 1961; Baron, 1987), this approach has been underrepresented in recent years (Tibbetts, 2004). Moreover, Tibbetts (2004:34) argues that SI research should include studies whereby the 'self', 'agency' and 'social interactions' are impaired due to mental illness. Baldwin (2005) echoes Tibbetts in his critique of narrative practice, which theoretically draws on SI, for prioritising coherent and chronological narratives and thereby ignoring the voices of those who experience acute mental distress. To this end Larsen (2007) conducted a study that explored service provision and to what extent therapeutic interventions could be improved within a Danish early intervention psychosis unit. He found that the experience of psychosis was frightening and required 'renegotiation' of the self (Larsen, 2007:342). In this case, feelings of fear and anxiety 'destabilised their sense of self' and individuals had to engage in meaningful therapeutic social relations in order to understand their experiences and make a plan for their future (Larsen, 2007:342). Larsen's study illustrates that whilst SI research with those experiencing mental distress are few, it is possible to explore the process of meaning making when cognition is impaired due to extreme mental and emotional distress. A self in distress still engages in meaningful social interactions, and theorists such as Tibbetts

(2004) and Roe et al. (2010) therefore contend that more studies are needed to understand this process.

Secondly, SI takes a particularly individualistic perspective. The focus of much SI research, including Burkitt (2008), Jenkins (2008), Larsen (2007) and Tibbetts (2004), begins with a focus on the individual rather than the social situation. Though a primary focus on social situations is explored in the next chapter (Chapter 3), it is worth acknowledging here that Goffman (1967) and Collins (2004) are especially critical of this framework as it reifies individuals and strips them of their unique responses to social situations.

Thirdly, SI often downplays or even ignores issues of power (Burkitt, 2008). Although Goffman (1961) addresses the issue of subjectivity and power in *Asylums*, more recent studies overlook it. For example, Larsen's (2007) study in early psychosis mentions that some clients felt patronised by the staff, but does not delve further into the power issues underlying staff/client interaction. Similarly, Charon (1979:171) acknowledges the interplay between individuals and their wider society, claiming that each individual 'controls and directs' their own self-formation. However people with mental health difficulties may experience less control and direction within their own life due to socio-cultural factors, including from therapeutic approaches such as TCs that rely on staff-led interpretive techniques. The process of self-construction can potentially become a representation of social control when there are social situations with an unequal distribution of power.

Additionally, theorists such as Rose (1999) trace the origins of the self in modern society, exposing the power and meaning attached to the pursuit of a positive sense of self. For Rose, the more individuals use their subjective experiences to transform their sense of self, the more reliant they become on the process of introspection. Interpretivism, as it is used by the psychotherapeutic disciplines, can result in an intricate form of social control in collaboration with institutions that seek power and capital gain. Instead of power being aggressively and overtly exercised over individuals, individuals are willing participants in their own subjectivity. Therefore, questions of power within TCs require careful understanding.

2.3 Power within TCs

As Chapter 1 acknowledges, this thesis adopts the Foucauldian view that power is an inherent aspect of social interactions (Bloor et al., 1988). From this perspective, power can be both destructive and creative for individuals (Haigh, 2013). Moreover, as mentioned above, many contemporary TCs adopt a flattened hierarchy approach to power whereby all member voices are equally valued in therapeutic and administrative decisions. Bloom and Norton (2004:230) contend that TCs represent a 'vital attempt' to provide therapeutic spaces to address the effects of neglect and abuse. Promoting group-based approaches with the treatment of PD, Winship and Hardy (2007:153) argue that TCs seem 'best able to facilitate exploration of inherent staff tensions occurring in the division of clinical and custodial responsibilities.' Kennard (2004:306) similarly writes that TCs have a 'tolerance for the expression of conflict, a desire to enable people to take responsibility for their lives', coupled with a 'natural sense of democracy' that encourages all members to have a voice in the community.

However, TCs, like any therapeutic milieu, can also create negative social environments that stigmatises patients. An example of this is featured in the ethnographic exploration by Bloor et al. (1988) whereby a concept house TC deliberately used shame as a motivator for change and used techniques such as haircutting and social exclusion from the outside world in a way reminiscent of Goffman's (1961) *Asylums* and Kesey's (1962) *One Flew Over the Cuckoo's Nest*. Rose (1999:50) is also critical of TCs for moving away from 'direction' to 'interpretation', and implies that residents within TCs are more exposed to social control. For this thesis, it is particularly important to remain sensitive to issues of power when seeking to understand how social interactions facilitate transformative change within TCs. Questions regarding abuses of power and conformity in mental health environments are always present (Bloor, 1986).

In addition to the concerns noted by Rose (1999), Sharp's (1975) critique of TCs illustrates that the communities use their interpretive position to manipulate participants and exercise conformity and control in their lives. Sharp's (1975:81) main argument is that social control and therapeutic interpretivist approaches are 'systematically inter-related'. Through labelling and assigning blame in the service of

'interpreting' social behaviour, TCs exploit the vulnerability of those with social difficulties (Bloor, 1986). Thus interpretation in TCs is arguably akin to a dialogical method of social control. More recently, Spandler (2006) highlights that linking democracy with psychoanalysis can potentially individualise and pathologise client members' perspectives, particularly when clients' views are in opposition to staff.

There are then two opposing views of TCs: agents of social control and manipulation, and agents of social expression to promote greater wellbeing. The question then arises, how is one to make sense of these two perspectives? A potential explanation is that these two views are actually addressing two differing types of power. On the one hand, power in TCs is manipulative and controlling, which is akin to Lukes' (2005) third face of power, a type of power that changes behaviour through domination and manipulation. From this perspective, TC clients 'submit' themselves to the 'domination' of the TC in order to achieve personal change. Such a view of power sees clients in TCs as continuously manipulated to think and behave in certain ways as dictated by the TC. On the other hand, power in TCs is creative and empowering, drawing on the validation of patient perspectives and experiences of mental distress (Stickley, 2006; Barnes and Bowl, 2001; Rose, 2003; Deegan, 1996; Pembroke, 1998). Power from this view is that individuals are empowered to creatively resist domination and position themselves more freely in relation to one another. Through democratic structures, TCs seek to minimise the manipulative forms of power and maximise individuals' creative power. As Winship and Hardy (2007:152) write:

> The collective of the group can exercise its urge towards *empowerment* and *agency*; even the weakest (or more unwell) members of the group can be drawn along by this urge. These dynamics are as beneficial to staff…Oppression is superseded by a concerted sense of fair play, as the group exercises its voice and will to righteousness (emphasis added).

Therefore, one of the questions of this thesis is to explore how both forms of power are used within the communities. As Spandler (2006) highlights, it cannot be assumed that a modern democratic structure ensures that client members will be empowered to live interdependently.

Nonetheless, in response to the social control criticisms, Bloor (1986) queried whether interpretation is inter-related with social control. Whilst his investigation is in

direct response to Sharp's (1975) study, the arguments he uses could also apply to the wider criticisms of power and social control within TCs. Bloor (1986) showed that the interpretive work of staff sometimes resulted in social control but that social control was not an inherent result of interpretation. Crucial to this is the distinction between 'social control' and 'orchestration'. The former is accepted as a negative attribute that does not allow for dissent and differences of opinion where the latter can result in the 'autonomous participation of residents in their own treatment' (Bloor, 1986:308).

Additionally, social orchestration is linked with reality confrontation whereby residents actively participate in each other's therapeutic treatment in both formal and informal settings as it is felt that social learning is more effective in peer-to-peer relationships. Social orchestration, unlike social control, is about setting boundaries on the 'autonomy of the subordinate' whereas social control involves the 'manipulation' of interaction (Bloor, 1986:319). Bloor does note that whilst power is acknowledged to be an 'embedded feature of therapeutic communities, as of all social life', neither social control nor orchestration is an inherent attribute of power. Interpretive work in TCs does not therefore directly result in social control (Bloor, 1986:318).

However there are some problems with Bloor's (1986) distinction between social control and orchestration, namely that he does not seem to acknowledge that it is the staff members that decide and impose the boundaries within orchestration and decide when to reassert control. Thus it can be argued that the line between social control and social orchestration is a thin one at best, and at worst simply involves renaming the same problem. Whilst Bloor (1986) believes the difference between social control and orchestration are clearly two distinct concepts, it does not seem like he has accounted well enough for the ways in which control can be construed as orchestration and whether or not staff are even aware of the difference to be intentional in facilitating the latter in their approach. However, setting aside these points, it does seem reasonable to agree with Bloor (1986) that because the TC explicitly makes the potential for social orchestration to occur, it uses less manipulative therapeutic interventions than some of its counterparts. If manipulation

and social control do routinely exist in TCs, then the same could be said for all psychotherapeutic interventions (Bloor, 1986; Spandler, 2009; Rose, 1999).

It must also be acknowledged that, as mentioned earlier, TCs have changed since the 1970s and 1980s. Communities now function with more explicit boundaries (Haigh, 2013). Other influences, including the service user movement that validates the patient perspective and patient empowerment (Stickley, 2006; Rose, 2003), feminism that has challenged the patriarchy in therapy (Anderson, 1997) and policies to ensure the safeguarding of vulnerable people (Adlam et al., 2013), have all changed how TCs operate. Therefore, TCs now undergo more accountability and responsibility through identifiable standards and clinical constitutionalism to make the process of client member safety more transparent (Campling, 2001; Winship and Haigh, 2000). Nevertheless, the criticisms of TCs regarding the use of interpretation in therapeutic work highlight the importance of sensitivity to power and social control within the community. Some of these critiques are re-joined by Bloor (1986) in his defence of TC work. However it still remains that power in TCs is a challenging issue. Significantly, Spandler (2006) suggests that TCs have been slow to realise that other branches of psychotherapy now apply democracy in their practice. Thus TCs may no longer be able to argue that their democratic approach sets them apart from other psychotherapies. Moreover, rather than critiquing these practices as they once did with traditional psychiatry, TCs may continue to perpetuate social expectations of normality, turning deviant social behaviour into more socially acceptable functioning that Rose (1986, 1999) is critical against. As such, Spandler (2006:142) identifies that 'TCs have come up with remarkably few alternative forms of democracy'. Though this thesis is not about reforming TC practice by suggesting alternatives, it is important to acknowledge the potential for social control and social regulation within communities is very much a contemporary concern. An awareness of how relationships are formed and in what context, and a sensitivity to issues of power and social control will also be helpful in exploring what actually constitutes change and how differing definitions may be at work within the communities.

For this study, the most significant limitation related to power within TCs is that it has not been fully explored between client members. Studies by Sharp, Baron and Bloor focus on the imbalance of power between staff and clients but do not explore

the differing social hierarchies and power that exists between clients. Furthermore, Rapoport (1960) devotes a chapter on the social roles of staff but says very little in regards to the system of social roles amongst the clients. Even in relation to TC practice, Spandler (2006:130) acknowledges that 'psychoanalytic discourse' in TCs focuses 'more readily on sibling 'rivalry' rather than on solidarity'. This doctoral research explicitly sets out to acknowledge the role of social control and power within the communities. As power is negated through interactions between client members, this makes client member relations, often conceived in terms of social support, vital. Crucially then, questions of power, particularly between client members, are closely linked to the role of social support in TCs.

2.4 The Importance of Social Support

As first established by Durkheim, the association between social support and mental health has been well documented (Best et al., 2014; Holt-Lunstad et al., 2010; Pilgrim et al., 2009; Berkman et al., 2000; Hammer, 1983). Just as it is understood that those experiencing mental distress often have fewer close relationships and perceive that their social support is not adequate (Kawachi and Berkman, 2001; Pilgrim et al., 2009), it is also acknowledged that within therapeutic interventions, social support has been found to be an important factor in aiding personal change (Lapsley et al., 2002; Corrigan and Phelan, 2004; Hogan et al., 2002; Davidson et al., 1999; Haigh, 2005; Pilgrim et al., 2009). Critical components of social support include compassion (Spandler and Stickley, 2011; Gilbert, 2010) and kindness (Ballett and Campling, 2010), both of which are achieved through social relationships. Social support can take many different forms and can include family and friends (Lapsley et al., 2002), clinicians and therapists (Pilgrim et al., 2009), mental health staff teams (Middleton et al., 2011) and peer support (Davidson et al., 1999).

TCs traditionally encourage social support within community environments and particularly seek to develop peer support amongst client members (Jones, 1968; Davidson et al., 1999). Additionally, TCs share common features with the peer support movement. Whilst reality confrontation, collaborative decision making and

conflict are important aspects of a TC, so too is the development of peer roles. Those in a TC are not expected to simply receive treatment from the community as they are also expected to actively play a role in their own and others' therapeutic intervention. This coincides with Davidson et al.'s (2006:444) definition of traditional peer support as 'reciprocal in nature', even though some clients may be more skilled or further ahead in their therapeutic process than others. Hogan et al. (2002:425) argue that interventions that value 'reciprocal support...demonstrated more encouraging' outcomes in those experiencing mental distress. Davidson et al. (1999:168) advocate for the development of 'mutual support' for those experiencing mental illness and argue that:

> a structured process of social interaction may allow people to adopt socially valued roles, in which they are no longer restricted to a passive role of "patient" relying on expert advice but now also may serve as role models for newer members, provide feedback and assistance to others, and received feedback for their own efforts to address their problems.

It could be argued that this is what TCs aim to achieve as mutual support is considered more empowering than simply receiving support (Haigh, 2005). To achieve this, peer support is not only offered during structured therapy sessions, it is also valued in community situations outside of therapy, such as meal times or through completing chores, as every aspect of daily life is considered an opportunity for social learning (Jones, 1976; Mahony, 1979). These situations also present occasions for members to share their life experiences, discuss new revelations, offer assistance and feedback, plan for the future and life outside the TC, and practice new ways of relating informally with their peers (Mahony, 1979). The positive outcomes for mutual support include new self identities, a renewed sense of life's worth and new perspectives on the natural and social world (Davidson et al., 1999). Crucially however, the social environment of a TC must foster compassion in order for members to have compassionate relationships (Spandler and Stickley, 2011). Thus social support is not only an individual responsibility, but is the responsibility of all within the community to promote and sustain.

Additionally, it is noted when clients help each other they are often able to overcome isolation and despair as they find mutual understanding, support, hope, and individual autonomy (Davidson et al., 1999). Jetten et al. (2009) argue that

belonging to a group can offset any negative consequences of stigma and discrimination. For instance, Dingle et al. (2012) identify those with serious mental health problems were able to create new social identities through choir singing that increased their self-esteem and emotional regulation and strengthened their links with the local community. Furthermore, a study conducted by Best et al. (2014) highlights that clients experience their TC's social network and their identity as TC members as positive. Feelings of belonging are particularly relevant for this study as social support within TCs can challenge the stigma that is often associated with a diagnosis of PD. Individuals with this diagnosis report feeling marginalised and judged by the health professionals (Manning, 2010; Castillo, 2009; Wright et al., 2007; Horn et al., 2007; Stalker et al., 2005). Lewis and Appleby (1988) found that this client cohort was particularly disliked by psychiatrists, making PD a moral judgment rather than a diagnosis that can result in therapeutic neglect. Moreover, there are several derogatory labels given to those with a PD diagnosis: attention seeking, manipulative, not really mentally ill, bad, difficult, uncooperative, inconsistent, unreliable, liar, abusive, dramatic, and wasting time and resources (Wright et al., 2007; Chandler, 2012; Stalker et al., 2005; Lewis and Appleby, 1988). Whilst all mental distress and disorders incur stigma and stereotypical representations from the general public through media, literature, TV and film, PD is particularly polarising in the health professions (Wright et al., 2007; Newton-Howes et al., 2008). Castillo's (2003) study identifies that participants express hopelessness at having a diagnosis of PD. She further highlights that the language of the DSM-IV[3], such as 'limited capacity to express feelings', 'callous unconcern for others', 'disregard for social obligations', 'inconsiderate' and 'untrustworthy' reinforces negative views of PD (Castillo, 2003). These examples are troubling not least because the experience of living with PD is extremely difficult (Zanarini and Frankenburg, 1997; Rogers and Dunne, 2011).

However, whilst social support is generally conceived of as positive, there are some limitations to social support theories to acknowledge. Moreover, it has to be questioned whether social support can have a detrimental effect, such as in-group marginalising or bullying.

[3] The most updated version of the manual in 2003

2.4.1 Limitations of Social Support

For all of the positives of peer support, there are several limitations to social support theories. Firstly, the definition and application of peer support is varied. Davidson et al. (2006) distinguish between peer support that is one-directional (more experienced service user helping another service user) to those that are symmetrical (two service users equally helping each other). The former is considered 'intentional', similar to relationships with mental health providers, whilst the latter is 'naturally occurring' in the 'broader community' and resembles friendship roles (Davidson et al., 2006:445). However the peer support role of TC client members encompasses both. Client members intentionally choose to be part of the TC and may form naturally occurring and reciprocal relationships with other client members. Still, it should not be assumed that all relationships are reciprocal or that all relationships develop into friendships. Therefore reflecting upon support amongst client members within TCs may further expand the definition and application of peer support.

Secondly, it should be acknowledged that social support might not be appropriate or even desired by everyone experiencing mental distress (Davidson et al., 1999). Not everyone who experiences isolation as a result of mental health difficulties will feel that part of their treatment should include a network of social support. Therefore it should not be assumed that all individuals within a TC will find a support approach helpful as it may not suit certain personality types (Davidson et al., 1999), or there may be certain issues inherent within a particular support network that reinforces or adds to the distress that individuals are experiencing. Issues of power, social conformity and dominant group narratives are closely related to this point. Brown and Harris (1978) hypothesised that the "'dark side" of social capital' occurs when individuals in 'close-knit communities' do not '"conform"' to defined group norms, leaving individuals feeling depressed and anxious (Kawachi and Berkman, 2001:463). When this occurs within mental health groups, the result is that individuals may actually leave the programme feeling worse than when they started (Davidson et al., 1999). In addition, clients in TCs may present with challenging behaviours and attitudes and there may be instances where staff and other client members fail to respond with compassion. Therefore researchers should be cautious when exploring social interactions within a therapeutic community to not assume that all social support is positive.

Thirdly, whilst Davidson et al. (1999) promote role changes from 'patient' to 'helper', it is not clear how these shifting roles are negotiated and understood within TCs. More recently, Davidson et al. (2006) argue that theories of peer support are only beginning to be developed and understood. They highlight that it is unclear how individuals who are recovering will function in a peer support 'provider' role and what the nature of the relationships will be with other clients. For instance in TCs, positive risk taking is a core standard and client members are often encouraged to take various roles and responsibilities within a community (Community of Communities, 2014). However, the process by which individuals develop the ability to transition into a different role, and potentially hold multiple roles within the community, is not fully conceptualised. Perhaps more significantly, the impact of client member changing roles *on other client members* within the community is not all understood. As Goffman (1959) identifies, a central element of everyday social encounters is managing and moving between various social roles. Client TC members often have experienced a breakdown in how to manage and conduct social relationships (Haigh, 2005) and reconstructing the ability to change roles is part of the therapeutic process. Understanding how this develops through daily social engagements is therefore important to conceptualising the overall process of transformative change.

Fourthly, much of the social support research focuses on the outcomes of support and does not explore the processes at work within these interactions (Hogan et al., 2002; Davidson et al., 1999; Corrigan and Phelan, 2004). For instance Corrigan and Phelan (2004:519) in their study of individuals with a diagnosis of mental illness found that whilst social support seemed to reduce distress symptoms, it is unclear 'how social support promotes symptom remission'. Perhaps more significantly, Haigh (2005) writes that focusing on the outcomes within social support research prioritises 'what works' over 'what matters'. In other words, studies that examine whether social support works and whether it is effective ignore the meaning of support to those who receive it. Haigh (2005) argues that this omission removes personal agency and creativity as it requires that support be routinised according to a set of rational mechanisms that are universally applied. From this perspective, instead of reflecting and constructing meaning based upon unique experiences, individuals need only respond to a prescribed agenda of recovery (Rose, 1999).

Lastly, much of the peer social support within TCs occurs outside of structured therapy. Indeed, clients will spend far more time outside of therapy than in. What then is actually occurring during these moments, what kind of support are clients providing to one another and what does this support mean? It would therefore be important to understand how participants within a TC interact within one another and what their relationships with others in the community mean to them. As Haigh (2005) notes, the question should not be so much do the relationships work and is personal change achieved, but rather, what do these relationships and interactions actually mean, how are these meanings constructed and do they play a role in transformative change? Thus understanding the meaning of helping relationships and the impact of peer support upon other client members could develop the role of social support within TCs.

SUMMARY

The role of times spent outside of therapy is especially important for this thesis as these social encounters are theoretically conceptualised as part of the therapy process. *How* this actually works in practice is the core question of this study. This chapter has provided a brief outline of adult democratic TCs, defined the nature of the self and personal change, and explored the role social support during a process of therapeutic transformation. Each of these areas is significant in their own right and this thesis combines a perspective from each to explore the role of social interactions within TCs during a process of change. To that extent, there are three main points to emphasise from this discussion. Firstly, TCs openly identify and value the social components during a process of personal change. Everyday social encounters that occur outside of structured therapy are considered crucial aspects of the therapy. However, to date, there has been very little literature that focuses explicitly on these social situations. Additionally, other theorists as have previously noted the tensions of power and social control within TCs as mediated through everyday interactions. Missing from this literature, however, is a discussion about the nature of power between client members themselves.

Secondly, this thesis does not make any attempt to definitively define personal change. Instead, what change means will be directed by the client members. Despite the lack of a concrete definition of change, it is recognised that the process of change is not linear. Change is a complex social process that is full of forwards, backwards and side steps. Moreover, this thesis uses a symbolic interactionist approach in relation to the nature of the self. Identity and personal changes arises from social encounters. In other words, change is worked out in the encounters between individuals, reflected upon within the individual and then re-presented back within social encounters. However, a limitation to an individual focused approach means that the individual is reified whilst the uniqueness of individual responses to social situations is minimised. As will be argued in Chapter 3, reversing this focus, thus starting with the social situation, rectifies this difficulty.

Thirdly, social support can play a significant role during the process of therapeutic transformation. Significantly for TCs, much of the social support work occurs outside of structured therapy. This raises the question as to what sort of support client members are actually providing for one another during these moments. Furthermore, as with the issue of power and social control, there can be a dark side to peer support and it cannot be assumed that every social encounter is therapeutic.

Combining all three of these areas – TCs, personal change and social support – highlights the following gaps:

1. How everyday social interactions facilitate a process of personal change.
2. Everyday social encounters as the context for where change occurs.
3. Negotiation of power between client members, including how peer support roles develop and change.
4. The dynamics of transformative change *in process* from the participant perspective and the various oscillations that may occur.

Crucially, I contend that to address these issues, it is necessary to begin first with the social interaction. The next chapter will introduce the main theoretical framework, interaction ritual chain theory, and define how ritual theory is defined and utilised within this study.

CHAPTER 3: INTERACTION RITUAL CHAIN THEORY

INTRODUCTION

Chapter 1 identifies that this doctorate began with an emphasis on personal change. Of primary significance were individuals as they negotiated their change in the context of their therapeutic community. Thus, this focus placed the individual first within the community and their interactions as secondary and peripheral. However as I explain, this emphasis changed within the first few weeks of fieldwork and the social situations within the communities became the primary focus, not the isolated individual. Understanding the mechanisms of these situations became key to understanding change itself. This theoretical shift is underpinned by Interaction Ritual Chain (IRC) theory. IRC theory is a 'radical' micrsociological approach that draws on Durkheim, Goffman and Mead (Collins, 2004:xi). It places the situation, rather than the individual, at the centre in order to explain the dynamics that occur during social interactions. The theory is especially useful for a study within TCs as it enables a rich understanding of the processes that occur between members, including how power is negotiated and used.

Collins (2004:5), referencing Goffman (1967) argues, 'not individuals and their interactions, but interactions and their individuals'. The premise for this approach is that interactions primarily shape and influence individuals. This is not to deny that individuals bring unique dynamics to situations, but rather it recognises that these dynamics are themselves shaped by previous social interactions. Even when individuals act alone, they are continuing in a form of action that contains elements of past interactions (Collins, 2004). Moreover, from the perspective of the social situation, it is possible to explore how individuals respond to the dynamics in any given encounter. Understanding the mechanisms of interactions highlights what is actually occurring moment by moment and how people use and negotiate things such as power. Within a community context such as TCs, a study of interactions provides a way of studying distress and issues of power and control that other frameworks like symbolic interactionism is not able to fully explain.

Though the analysis chapters will engage with IRC theory and the data, it is necessary to outline the main elements of the theory and how they relate to social interactions and personal change in TCs. Additionally, as it would be impossible to study all rituals within a community within a single thesis, it is necessary to theoretically define 'key' rituals. This chapter will therefore address the following:

- Introduce and outline interaction ritual chain theory
- Define 'key' rituals
- Discuss research using interaction ritual chain theory
- Identify the limitations of IRC

Throughout the discussion, I link the theory to a study of TCs to explain why an interaction ritual focus particularly suits a study exploring personal change within the context of a community.

3.1 Interaction Ritual (Chain) Theory

Placing interactions before the individual in microsociology is linked to Goffman (1967) who highlights that it is misleading to have an individual driven focus precisely because individuals do not develop and change in isolation. A primary focus on the individual risks a reified 'cult of the individual' (Collins, 2004:4). Reifying the individual is problematic because individuals are dependent upon social interactions, even interactions with oneself, for meaning making and development (Goffman, 1967; Blumer, 1969). This position does not negate individuality or uniqueness; on the contrary, it upholds them. Collins (2004) acknowledges that individuals are unique but argues that a central focus on the individual actually denies and undermines the complex ways that an individual develops because the uniqueness is assumed and therefore unexplored. In addition, Collins (2004) points out that a focus on interactions does not deny the agency of the individual. Instead, interactions are the interplay between microstructures and individual agency. However, Collins (2004:6) further argues that the term 'agency' is convoluted and carries both the 'glorification' and 'condemnation' of the individual. Moreover, a primary focus on interactions within TCs is especially relevant because TCs openly acknowledge the

role of others, staff members and peers in the personal change process. Individuals and social identity are therefore not excluded from the process, or denied their importance in exploring change within the community. Nonetheless, they are not the foremost focus of attention. Rather, it is the everyday interactions that are the lens through which the individual, change and the TC are viewed.

However, this framework does not imply that every community social encounter is necessarily significant in the role of personal change. It is important to distinguish between those interactions contributing to change and those encounters that are routine and lack reflexivity. The use of interaction ritual theory is therefore useful in both identifying and distinguishing relevant interactions. In this doctorate, the definition and use of a ritual is the one outlined first by Durkheim on the macro level, extended Goffman on the micro level, and later expanded upon by Collins. Whilst a full scope of the definition and use of rituals is outside this thesis, it is necessary to note that this is not the only definition of ritual and theorists have used it differently across various disciplines including anthropology and religious studies. A ritual as used in this doctorate is defined as 'a mechanism of mutually focused emotion and attention producing a momentarily shared reality, which thereby generates solidarity and symbols of group membership' (Collins, 2004:7). Figure 1 illustrates the four main ingredients and outcomes of rituals:

Ritual Ingredients → *generating* →	**Ritual Outcomes**
1. Bodily co-presence	1. Solidarity
2. Barrier to outsiders	2. Emotional energy (EE)
3. Mutual focus of attention / emotion	3. Symbols of the group (sacred objects)
4. Shared Mood	4. Standards of morality

Figure 1: Interaction Rituals (Collins, 2004:48)

Key to interaction ritual theory is that rituals are not produced in isolation of one another as each ritual either builds upon a previous successful ritual or bears hallmarks of a failed ritual that has been re-created or re-produced. These are social interactions that are held together by 'chains' that connect them to past and future

rituals. Individual rituals thus have a past, a present and a future (Collins, 2004). A single ritual also operates in relation to other rituals within a group (6, 2007). Moreover, rituals are not fixed or static and their level of stability is in part dependent upon the participants engaged in the interactions. Additionally, as Cheal (1992:367) argues, rituals 'signify social structures, that is to say, patterns of relationships and the cognitive categories and emotional commitments upon which they depend'. Rituals also reveal 'individuals' unobservable, internal states of being' (Cheal, 1992:367). For this study, a focus on rituals highlights the process of individual, internal change that is externally worked out in relation to others.

From the perspective of IR theory, rituals exist on a continuum ranging from formal and ceremonial to natural and informal. Natural rituals, such as smoking breaks, are spontaneous with no formal procedures. In contrast, formal rituals, such as community endings, are ceremonial with a set structure guiding interactions. However regardless of categories, all rituals share common features. Within IR theory there are four main ingredients that generate four main outcomes in order to be a 'successful', and hence repeatable, ritual.

3.1.1. Ingredients and Outcomes of Rituals

For both Goffman and Collins, the first essential ingredient of an interaction ritual is bodily co-presence as rituals have to occur face-to-face. Goffman and Collins argue that face-to-face requirement is needed because individuals use others' reactions to decide their own responses. These responses can be either conscious or unconscious. In particular, Goffman's (1967,1959) face-to-face requirement draws on his theory of 'face work' whereby individuals act on the basis of 'saving face'. Thus, individuals need to physically see, hear and sense one another in order to make minuet adjustments to their behaviour and interaction style in order to present the best 'face' to the other. Collins, writing several decades later, mainly adheres to this bodily co-presence requirement, though he does acknowledge that the increasing advances of technology may enable the presence of non-face-to-face rituals (Collins, 2014). In TCs, most of the communication does occur face-to-face

and the limited number of interactions that occur via technology will be explored in the analysis chapters.

Secondly, rituals need to include a boundary between who is included and who is excluded. Just as formal rituals such as wedding and funerals involve some form of invitation, daily interaction rituals are not inclusive of everybody at any time. In a TC, the boundary on one level seems fairly obvious as it can simply denote who is a member of the community and who is not. However rituals are multi-layered and serve multiple purposes. As such, some community rituals may exclude certain members of the community and generate cliques and sub groups. Inclusion and exclusion are linked to power and social control as questions arise as to how individuals are deemed to be 'in' or 'out' within the group. However, Smith and Stewart (2011) acknowledge that even the desire to be included can strengthen social bonds between members. Thus, notions of inclusivity and exclusivity are not necessarily negative, and it is especially important to be cautious with any value judgements in order to remain sensitive to the complexities of the dynamics of the social processes. IRC theory therefore enables a micro-levels lens to observe power and social control within TCs.

Thirdly, Collins argues that individuals involved in a ritual need to be mutually focused on a common object or mutually engaged in a common activity. In addition, individuals communicate their focus of attention to each other, either verbally or through other bodily ques. The mechanisms of shared attention involve attention to the activity or object at hand, and also the awareness of each other engaged in the ritual. As with bodily co-presence, individuals will make adjustments in relation to one another as their attention becomes more focused. Also, like bodily co-presence, shared attention can be conscious or unconscious.

Shared attention then gives way to the fourth ingredient, a shared mood or emotional state. Collins (2004) stresses that the third and fourth ingredients are the central ingredients because the more individuals are focused together, the more the shared emotional experience will build, thus strengthening the boundaries between insider and outsider. Moreover the emotional state becomes central to members' conscious awareness. Within an adult mental health TC, emotions, including emotion management and emotional exploration, are significant components to

community life (Castillo et al., 2013; Bloor and Fonkert, 1982). Understanding how emotions work in practice, and particularly the link between inclusivity/exclusivity, is therefore crucial to exploring dynamics between community members.

Once all the ingredients are in place, successful rituals then generate four main outcomes. Firstly, rituals produce group solidarity, the feeling of belonging to the group. In TCs, joining a community does not immediately translate to feeling like or even being viewed as a 'full' community member (Haigh, 2013). Belonging has already been identified as a core process of change within communities (Campling, 2001; Castillo, 2013; Castillo et al. 2013). The process of group solidarity and belonging is therefore important to building a sense of community within the TC. Moreover the sense of belonging further reinforces the boundary between who is in and who is out. Thus IRC theory is ideal for studying these social processes.

Secondly, rituals generate emotional energy (EE) within each participating individual. Emotional energy is long-lasting emotional feelings that individuals retain after the ritual has finished. EE is different to the emotional mood of the group that consists mainly of transient emotions such as joy, anger, shame, pride and happiness, which Collins (2014:300) refers to as 'first-order emotions'. Collins (2014:300) emphasises that EE is made up of positive emotional feelings such as enthusiasm and confidence, which he calls 'higher-order social emotions'. This emotional energy feeds back into the shared emotional mood, a key ingredient in producing and sustaining the ritual. Moreover, EE is 'carried from interaction to interaction' and intensifies during successful rituals (Summers-Effler, 2006:138). Ultimately, members will be drawn to repeat those rituals that provide the highest amount of EE. In the main, positive EE is needed in order to create a sense of belonging and sustain feelings of group membership. Rituals that generate primarily negative feelings and emotions will lack a commitment to the ritual because participants will either abandon it or create a new ritual that produces more favourable emotions. Over time, individuals within groups develop an expectation for future interactions based upon EE (Summers-Effler, 2006). However this thesis will question the role of negative emotions as TCs deliberately encourage the emergence of difficult, painful and negative emotions.

Thirdly, interaction rituals create symbols that are representative of the group. A symbol can be an object, an idea, gesture, words, or visual image. Collins (2004:49) links symbols with Durkheim's 'sacred objects' and highlights that members will treat symbols with care and respect, defending them against attack (real or perceived). The manner in which symbols are treated distinguishes people from not only insiders and outsiders, but also more importantly, between compliant and devoted insiders and those insiders who are rebellious or not fully integrated. Symbols can generate both positive and negative emotional responses from members. The emotional attachment to symbols is significant as symbols are stored in an individual's memory and can invoke an emotional response even when he/she is not engaged in the ritual and is away from other members of the group (Goss, 2007). These 'emotional memories or meanings' can impact future social interactions and even personal identities (Collins, 2004:81). Any EE generated by the ritual will be stored in the symbol, which can then be incited through discourse and memory once the situation changes. As will be developed further in the analysis chapters, rituals and their symbols are closely related.

Fourthly, members experience a strong sense of morality from belonging to the group, participating in the ritual and valuing the symbols. This feeling is so strong that participants will ensure that 'transgressors' either comply or become outsiders (Collins, 2004:49). Therefore rituals generate implicit social rules that all members must comply with, the majority of the time. These rules or codes of conduct can be symbols in their own right, defining the identity of the community. Thus to break an implicit rule, or to dismiss a symbol, is to break or separate from the rest of the group. If individuals wish to belong to the community, they will not only participate in shaping the rituals, they will also conform to the emotions, symbols and morality generated by the group. From the perspective of TCs, this process is akin to 'learning the boundaries' (Castillo et al. 2013:269), which is a key component of adjusting to life in a community. Through this fourth ritual outcome, peer pressure and social control are inherently present within interaction ritual theory. Furthermore, this pressure can quickly become justifiable, charged with a sense of rightness when it is exerted over its members. The sense of morality generated by rituals is particularly pertinent for TCs and peer support. As Chapter 2 identifies, peer support can be equated with peer monitoring (Rose, 1986). However, this is not to imply that peer pressure and

social control are necessarily negative and again caution is needed before assigning value judgements in the analysis.

The definition of rituals is important because it is what separates a ritual from mere routine. Both rituals and routines involve individuals, groups and interactions, and both are repeated. What distinguishes a ritual from a routine is the shared focus of attention and emotion (Payr, 2010). In rituals, participants each focus on a common object and share a common emotional mood (Collins, 2004). Routines, in contrast, lack shared attention and emotional dynamics. Even in a group context, there will be little cohesion as participants act as *individuals* rather than a *group*. Rituals become routine 'when they lose their symbolic strength' (Payr, 2010). Crucially, successful rituals are those rituals that members seek to repeat, and also those that hold symbolic value and draw participants together through shared attention and emotional outcomes (Collins, 2004). Moreover, members will adhere to the rituals and justify their use and their symbols to both outsiders and to each other. However, even when a ritual is repeated, there is variation in each ritual occurrence as it is impossible to produce the exact same combination of shared attention, emotional energy and entrainment. Thus, whilst the structure and form of a ritual may stay more or less consistent, the emotional mood and level of entrainment will vary. In TCs, a study of rituals enables an analysis as to how interactions are carried out, why they are repeated or successful, and an exploration of the various oscillations that may occur.

Emotions and entrainment are particularly important for TCs, as emotions are such a core element of community life, and will therefore be explored in further detail.

3.1.2 Emotions, Entrainment and Emotional Energy (EE)

In IR theory, the role of emotions is central. Emotions, along with attention, attract members to participate in the ritual. They are the glue that holds together solidarity, separates members from non-members, provides the motivation for enforcing group standards and ultimately determines the success or failure of a ritual. Durkheim (1912/2001) was one of the first to note that emotions, positive and negative, are stronger when they are shared, producing collective effervescence. When collective

effervescence builds, it produces rhythmic emotional entrainment (Chapple, 1982) of all members 'into a mood that feels stronger than any of them individually, and carries them along as if under a force from outside' themselves (Collins, 2014:299). Signs of rhythmic entrainment include a synchronisation of bodily movements such as gestures, posture, eye movement, tilts of the head, and speech, including utterances, pauses, tone, pitch and volume. When rhythmically entrained, there is fluidity to speech and bodily coordination as if two or more individuals are moving together as one. There is a rhythm and a flow to the interactions, like a dance, that can either be 'caught' by other newer members, or be exclusive so that some (or all) outsiders are barred from participating. Hence, as Chapple (1982) identifies, individuals learn to *anticipate* others' responses rather than *react* to them. This is significant because it suggests that individuals become synched in their mood, bodily movements and speech during successful interactions.

Emotional and rhythmic entrainment can be thought of as what Trevarthen (2000:157) refers to as the 'musicality' that is innate in all individuals. He writes that '[t]he rhythmic impulse of living, moving and communication is musical' (Trevarthen, 2000:157). Trevarthen's research on early communication in infants illustrates how musicality operates on the neurological level and how body coordination (i.e. acting) is tied to emotions. Biologically, the 'musical impulse moves the body and also involves the excites neurochemistry of felt elation and sadness or of vitality and repose' (Trevarthen, 2000:161). Rhythm, emotions and acting are intricately linked together in the brain. Musicality is the coordinated rhythm of individual bodily acts that enable the body to function as a single system, which Trevarthen and Aitken (1994) refer to as the Intrinsic Motive Formation. Emotions then 'arise from one's anticipation in acting' (Trevarthen, 2000:161). In other words, emotions are not static; like action, they are constantly in motion and generated through interaction. Interacting and emotions are thus intrinsically tied together. Furthermore, Trevarthen (2000:161) argues that 'musicality is the coordination of this acting emotionally'. Individuals become attuned to others' 'impulses' and can respond in rhythm to one another. This coordination is something that humans learn in utero so that moments after birth, an infant and its mother are emotionally and rhythmically entrained in their actions towards one another.

For ritual theory, Trevarthen's insights also potentially provide a physiological explanation of how individuals come to coordinate their rhythmic movements and have a complex awareness of one another's emotional responses that lead to further action. Moreover, analysis by Trevarthen and Aitken (2001) on the neuropsychological strata highlights that healthy social environments and interactions are essential for social development. In contrast, research by Bick et al. (2015) and Burns (2006) identifies that a lack of healthy social engagement in early life has a negative upon the acquisition of sophisticated socio-cognitive skills necessary for healthy emotional and relational functioning. Combining neurocognitive research with IRCs suggests that individuals then develop patterns of interactions that are based upon previous interaction histories. Thus, if individuals experience negative interactions, their expectations of social encounters will also be negative (Summers-Effler, 2002). One of the aims of TCs is to challenge these expectations through healthy forms of emotional entrainment within the community to facilitate positive social learning.

Emotions therefore underlie rhythmic entrainment. As noted earlier in Figure 1, the emotional mood produces feelings of solidarity and gives the group its identity. Moreover, emotions are also important for generating symbols, or more specifically, for giving symbols meaning. Collins (2014) argues that emotion in cognition gives certain thoughts and memory meaning. When symbols of successful rituals are linked with solidarity, individuals are recalling the positive EE associated with that symbol and ritual, rather than the specific events of the past. Cognition is not *a priori* emotion. Like action and emotion, cognition and emotion are inseparable (Trevarthen, 2000). Individuals then can be emotionally motivated to act without having a conscious awareness of their actions (Turner and Stets, 2005; Hallett, 2003). This process is supported biologically. Trevarthen (2000:163) writes:

> Primitive' emotions have a force, energy or "arousal" derived from the motive image of action they regulate, and a second dimension related to the positive or negative, pleasurable or painful effects expected in the body, and hence related to the approach/avoidance motivation or "value" in the intended action. They also evaluate the efficiency, elegance and grace, or conversely the roughness and harshness, of moves of the self and of others.

In terms of ritual theory, Summers-Effler (2004b) uses two notions of the self – the sensing self and the contextualising self – to argue that the sensing self can respond to its environment in relation to emotional arousal in the body to develop habitual forms of action that are outside of conscious reflection. This is significant because, as Chapter 2 argues, it highlights that the motivation to act and repeat certain types of action is not always a process of cognition, but one of emotion. Interaction rituals that generate positive EE can potentially produce change for individuals who experienced negative interactions of abuse, trauma and neglect. This can occur in two ways. Firstly, positive social encounters can create conflict with one's negative expectations of social situations, which in turn can prompt reflexivity and a conscious decision to give expectations new definitions (Damasio, 1994). Secondly, if over time negative expectations are not reinforced, these expectations can slowly shift, becoming embedded within new (healthier) emotional meaning (Summers-Effler, 2004b).

Thus Collins (2014:300) stresses that successful rituals 'transmute any shared emotions into a new emotion: the collective effervescence of solidarity'. Not only are positive transient emotions like joy more intense when shared, but so too are negative emotions such as anger, shame and fear. In mental health communities, sharing of emotions is a core component of community life as members work to address painful experiences with one another. The analysis chapters will explore whether the experience of intense negative emotions can still lead to positive EE if they are transformed into feelings of belonging to the group. For TCs, the translation of negative emotions is significant because much of community life may involve frequent and intense negative emotions. Nonetheless, these rituals, such as mealtimes and smoking breaks, are repeated. Negative EE results when individuals leave a ritual feeling isolated or alienated (Collins, 2014). Too much negative EE will lead to the ritual's failure. In contrast, positive EE perpetuates the chain element of the ritual as members go from one encounter to the next, building a collective of emotional energy (Collins, 2004). The question to be addressed in the analysis chapters is whether these rituals are repeated because the structure requires them, or because they genuinely contain elements of solidarity.

Expanding Collins's model of EE, Summers-Effler (2004a) distinguishes between those rituals that produce solidarity and shared positive EE, and those rituals that produce power and EE inequalities. In solidarity building rituals, positive EE can be shared collectively amongst members. Conversely, in 'power' rituals, dominant members of a group maximise their EE through taking the EE of subordinate others (Summers-Effler, 2004a:310). In other words, only the dominant members gain positive EE whilst subordinate members loose EE. Emotions within power rituals are still 'built up' but they are not shared as 'the focus is on reciprocal emotions, such as anger and fear' (Summers-Effler, 2004a:310). This distinction is important because it identifies that the difference between solidarity and power rituals is not necessarily one of *status* but one of *emotion*. Solidarity rituals are possible when members have unequal positions, such as a consultant psychiatrist and a client member in a TC, but what makes the interaction problematic is when there is an emotional imbalance whereby one gains EE at the expense of the other.

From the perspective of IRC theory, TCs have the potential to generate numerous rituals. As it is not possible to adequately analyse all potential rituals, it is necessary to theoretically establish the key rituals.

3.2 Key Interaction Rituals

Though Collins (2004) admits to seeing successful rituals 'almost everywhere', Goffman (1967) was more precise about what constitutes a significant ritual. In his essay, 'Where the Action Is', Goffman (1967:185) writes that significant interactions are those that contain 'action', which are 'activities that are consequential, problematic, and undertaken for what is felt to be their own sake'. These occasions hold elements of risk, chance and fate. In addition to risk, an interaction becomes 'fateful' when it is both 'problematic *and* consequential', when it will impact upon future interactions (Goffman, 1967). To illustrate his point, Goffman uses the analogy of a coin toss between children. It is an ordinary, almost mundane activity, yet wrapped up within it is the opportunity to gain something (such as money or objects) and importantly, status. For Goffman, character and status are closely linked to action. Individuals build their reputations, and acquire status, as a result of action

rituals. Status then can translate into power and influence further action rituals. For instance, criminals may gain a reputation of being 'tough' through repeated fights or certain types of crime. As their status increases, their level of influence over weaker individuals grows so that, at a reputation's most effective, they do not need to act in order to demonstrate their power. Moreover, reputation and character are not static. Individuals are capable of building and losing their status from interaction to interaction.

Acknowledging the role emotions play in these types of interactions, Goffman (1967:185) argues that 'an individual may be more concerned with the *intensity* of the action he (sic) finds than its kind' (emphasis added). Thus these are not rituals that produce a mundane, or weak emotional feeling in ritual participants. Rather these are moments of intense feeling (positive or negative) that continuously attract individuals to participate. Individuals are attracted to the opportunity for action, not necessarily the action itself. Goffman (1967:269) explains, 'When persons go to where the action is they often go to a place where there is an increase, not in the chances taken, but in the chances that they will be obligated to take chances'. Crucially, the 'outcomes' of a ritual are not guaranteed. Like Goffman's analogy of a coin toss, the fortunes and futures of participants are determined through the ritual. Additionally, the ritual becomes consequential if the outcome impacts upon future interactions.

Nonetheless, direct individual involvement is not the only attraction of an action ritual. Goffman writes that experiencing action vicariously is also a motivator to participating in these rituals, even as an observer. Where action does occur, 'it is likely to involve someone *like* themselves but someone *else*' (Goffman, 1967:269). His assertion highlights that solidarity is necessary in action rituals as individuals find commonality with one another. During the ritual, it is enough for individuals to relate to the person directly involved in the action. Individuals then not only experience their own involvement in the ritual as indirect participants, they also identify a part of themselves in the individual who is directly involved in the action of the ritual. This is Mead's (1934) taking the role of the other so that action rituals occur on three levels – first order (self), second order (others) and third order (perceived self as viewed through imagined eyes of others). In TCs, this means that an individual can observe

the behaviour of another and then relate the consequences of that behaviour to their own actions.

Though 'Where the Action Is' centres on gambling and deviant behaviours in society, Goffman (1967:170) notes that encounters in mental health institutions can be transformed into 'fateful' activities due to the nature of clients' distress. Translating Goffman's theory to TCs, risk would refer to not only physical risk, such as bodily harm, but also emotional risk in terms of vulnerability and feeling negative emotions. Risk and opportunity are central to TCs as risk is not viewed as something to be eliminated, unlike in other mental health settings. Rather, a culture of permissiveness is encouraged to maximise 'positive risk' taking in order to promote increased freedom, responsibility, choice and empowerment (Rapoport, 1960; Haigh, 2013; Community of Communities, 2014). Opportunity refers to those situations that provide the most amount of chance for personal change, including the chance to develop insight into particular behaviours, which may be a precursor to change. As Jones (1968:70) acknowledges, social learning occurs through moments of 'conflict or crisis'. The negative potential (risk) of an action is juxtaposed with the possibility (opportunity) for positive change and growth. Thus, for example, chairing a meeting may potentially feel intimidating and exposing for a client. All eyes will be on the client chair and the client will have the responsibility to maintain order and enforce the community norms and values. If the community is working cohesively, the ritual of chairing a meeting may help empower the client to confidently lead meetings and challenge any negative self-beliefs that may arise. Even occasions when the ritual may go wrong, and the client chair loses the authority and order of the meeting, is an opportunity for discussion and feedback about what went wrong. Moreover, as action rituals also involve vicarious action, those clients who were not chairing the meeting can identify with the chair to also learn from his/her experience. Therefore risking negative emotions, such as shame, is a potential opportunity to confront those emotions with support in order to gain a sense of pride. For TCs, ritual theory is especially applicable because the environments are emotionally variable, are meant to create a sense of belonging and group membership, and produce signs and symbols.

In the next section, I explore research that has applied IRC theory into a variety of contexts.

3.3 Research on Interaction Ritual Theory

Both Turner and Stets (2005) and von Scheve et al. (2014) note that Collins's theory, though very comprehensive, is difficult to empirically test systematically due to its complexity. However several researchers have applied Collins's framework in diverse contexts including charity groups (Summers-Effler, 2010), restorative justice (RJ) groups (Rossner, 2013, 2011; Sherman et al., 2005), violence (Collins, 2008), sports (von Scheve et al., 2014; Cottingham, 2012), science and technology (Vertesi, 2012; Parker and Hackett, 2012), education (Milne & Otieno, 2007; Olitsky, 2007; Hallett, 2007), business (Goss et al., 2011) food service industry (Hallett, 2003), religion (Heider and Warner, 2010; Collins, 2010), military (King, 2006) and technology (Ling, 2008). Whilst Turner and Stets (2005) make a valid critique that most research uses Collins's framework to interpret interactions in existing communities, situations and organisations, the studies are very useful for strengthening and expanding IR theory. In particular, much of this research has explored under what conditions IRs are successful and when they fail. Summers-Effler (2010) with her research on Catholic Workers finds that whilst group members can experience burnout and separation from the group, they are able to continuously engage in group-specific rituals that emotionally bond them together, thereby sustaining the rituals. Like the Catholic Workers group, TCs can be emotionally demanding environments for all members. There may for instance be times when communities do experience fatigue and burnout.

Additionally, Summers-Effler (2010) highlights that work with different types of groups will generate different emotional responses and tones. Likewise Rossner (2013, 2011) shows that restorative justice (RJ) rituals are successful when criminal perpetrators express and feel regret whilst victims and family members/friends experience reconciliation and offer forgiveness. However RJ rituals can fail when only superficial feelings are produced. This raises the question as to whether emotional experiences are authentic or inauthentic and how members differentiate

between the two. Sherman et al. (2005) also use IR theory to explore RJ rituals and propose that they can reduce harm to victims. Collins (2008) demonstrates the importance of emotion, particularly how emotion is interpreted, during moments of violence. Contrary to common perception, he uses images from CCTV to illustrate how the emotion conveyed on the part of the perpetrator is fear, not anger.

Ritual outcomes, including emotional entrainment and solidarity, have been explored in the contexts of sports, religion, military and science and technology. In looking at sports and national identity, von Scheve et al. (2014) find that emotional entrainment during the 2010 FIFA World Cup predicted shifts in national identity and emotionally charged national symbols. Cottingham (2012) expands IR theory to demonstrate that solidarity is stronger amongst sports fans than Collins (2004) originally proposed. In their study of Scared Harp singing, Heider and Warner (2010) show that solidarity is not contingent upon whether members know each other prior to engaging in the ritual. Their findings echo research by King (2006) who explores military exercises in the US and UK. In King's study, soldiers demonstrated high emotional solidary and rhythmic entrainment, regardless of whether they were friends. Thus successful rituals are not dependent upon participants forming close personal friendship attachments. This is particularly relevant for TCs whereby individuals likely do not know each other prior to joining the TC and may or may not form friendship attachments. Moreover, it is uncertain whether any attachments that do form in the community remain once individuals leave the TC.

In her study on the NASA teams that control the Mars Rovers, Vertesi (2012) highlights that unlike other NASA teams that have clear authority hierarchies (similar to the military), the Rover teams work on a flattened hierarchy and the ritual of 'seeing like a rover' is an embodied social process that involves all of the team members. Solidarity is thus particularly strong and, because team members rotate roles and responsibilities, troubleshooting problems and blame is equally shared amongst the team (Vertesi, 2012). Vertesi's study is important for TCs because adult democratic communities also operate on a flattened hierarchy model. It will therefore be questioned how the communities actually share responsibility and problem solving in practice. Parker and Hackett (2012) also apply ritual theory to scientific collaborations. Their research shows how emotions structure a research group's

growth and development. Innovation that drives scientific movements occurs during periods they call 'hot spots and hot moments' of emotionally charged situations. They also find that the number of participants influences the strength of the emotion, so that larger numbers weaken the emotional bonds. Emotions have already been identified as a core component of life in communities but the study by Parker and Hackett further emphasises just how central the role of emotion is in relation to how a group functions as a whole. Key for TCs will be how they translate negative emotions into positive EE.

In education, researchers (Milne & Otieno, 2007; Olitsky, 2007; Hallett, 2007) explore the use of emotion and power, and how rituals contribute to creating 'communities of practice'. For instance Milne and Otieno (2007) explore the use of emotion during scientific demonstrations in classrooms. Their research illustrates how as 'sites of interactions', scientific demonstrations increase student engagement, emotional energy and willingness to learn. Both Olitsky (2007) and Hallett (2007) link interaction ritual theory with Bourdieu in education contexts. Olitsky (2007) uses ritual theory to explore communities of practice in an educational setting. Using video ethnography, she demonstrates how the social process of learning is ritualised and under what conditions certain rituals are more successful. In particular Olitsky suggests that rituals will be most successful when students have opportunities to share cultural capital with their teacher, can act as peripheral members and share knowledge through talking amongst themselves. Thus student engagement is key to the studies by Milne and Otieno (2007) and Olitsky (2007) in producing positive emotional energy, solidarity and positive learning outcomes. This has links with TCs whereby knowledge and experience are shared between staff and client members (Main, 1977; Jones, 1968). Client members' opinions, experiences and beliefs are valuable contributions to the therapeutic process of all members. Translating this research to TCs suggests that successful rituals, and potentially positive change, may depend upon client members' opportunities to engage and take ownership of therapy and community processes.

Additionally, Hallett (2007) explores power dynamics between teaching staff at a US elementary school. He extends Bourdieu's theory of social capital to interactions and uses symbolic power and deference as a 'meso-level account of the

interactional-institutional link' (Hallett, 2007:166). By placing the emphasis on interactions, Hallett argues that power can (re)define actions, meanings and the social order. His work follows on from his 2003 study that examines solidarity in food serving staff and customers through interaction rituals. One of the key findings to emerge from his research is that individuals purposefully do not always cognitively control their actions as they choose instead to respond emotionally. Hallett's research also has implications for TCs, which can be emotionally charged environments. Understanding individuals' emotional responses may be important to understanding how solidarity functions within communities.

In the field of business, Goss et al. (2011) argue that emotion is closely linked to power, agency and constraint. Contrary to much of entrepreneurial research, they advocate the 'social dynamics of situations', as opposed to the focus on isolated individuals working within the sector (Goss et al., 2011:224). They also highlight that an emphasis on 'power-as-practice' allows for it to remain a fluid outcome of rituals rather than a 'fixed property of individuals or structures' (Goss et al., 2011:225). This is directly relevant for this research as I also contend that a focus on the situation as more helpful than on isolated individuals for explaining social dynamics such as power and the role of emotions.

Lastly the question of bodily co-presence is challenged by Ling (2008:119) who studies the social patterns of mobile phone users. He contends that the use of mobile phones can produce 'mediated ritual interaction', which is a medium strength social bond. These bonds are the strongest when individuals also meet face-to-face and these mediated rituals help them sustain their bonds to one another. Collins (2014:309) acknowledges that as electronic and social media continue to enhance communication, interaction rituals may be 'incorporated into mechanical devices'.

All of the above research has implications for this thesis. Of particular relevance are inauthentic/authentic emotional experiences, potential community member burnout, the social process of change, and community members working on a flattened hierarchy as a whole to produce individual transformative change. Though IR theory has been adopted in a variety of contexts, it has not been widely applied in mental health and, to date, has not been used in TCs. Using this theory within communities for individuals who are actively experiencing varying degrees of

emotional and mental distress highlights some limitations that will need careful consideration during data analysis. In the next session I will discuss some of the key criticisms and limitations of IRC theory, particularly in relation to mental health.

3.4 Criticisms and Limitations of Interaction Ritual Theory

IR theory as developed by Durkheim, Goffman and Collins is not without its detractors. Most notably, Kemper (2011) argues that all three theorists overstate the importance of emotion in ritual theory and ignore status-power relations. He proposes that rituals should be defined as "the enactment of a type of relationship" rather than a series of mechanisms held together by emotion (Kemper, 2011:173). For Kemper, a focus on the emotions misses the key to rituals, which is the relationship between individuals as he argues that any emotional experience is secondary to the relationship. Key to this relationship is status and power as individuals relate on the basis of increasing their status-power standing in regards to their reference groups, or social networks. Kemper also advocates that a sociological notion of the self is unnecessary as individuals only act in relation to their reference groups and on the basis of status and power. Thus, one only must know the rules of the ritual in relation to their reference groups. However, whilst Kemper does make some valid critiques about the weakness of power rituals in current IR theory, there are also problems with his approach. Firstly, Kemper seems to separate emotion from cognition, which is not supported by Trevarthen's (2000) work in neuropsychology. Additionally, Kemper ignores the ways in which some actions may be an emotional response and therefore sub-conscious. As Heider and Warner (2010) illustrate, emotional entrainment is possible even when no prior relationship exists between members. Secondly, and importantly, Jean-Pierre (2012) highlights that sweeping away theories of the self in favour of reference groups denies not only individual agency, but also fails to explain the complexity of individuals' motivations and loyalties. It also does not explain acts of irrationality. Furthermore, Kemper's take on the theory does not account for how individuals may have to override expectations from some members of their reference groups (such as friends and family members) in order to break unhealthy patterns of relating. For clients in TCs,

this could include changing the way they relate to those outside of the community or even altering their relational pattern with other community members.

In addition to Kemper's critique, there are a number of limitations to IR theory as outlined both by Goffman (1967) and Collins (2004). First, there is a discrepancy with their assumption that rituals require bodily co-presence. Goffman's requirement for bodily co-presence is understandable given the time he was writing. Mass forms of communication via the internet, where multiple individuals can conduct multiple conversations over instant messaging, telephone/video calls social media, blogs and chat forums, did not exist. However, Collins is a contemporary writer and so his adherence to Goffman's bodily co-presence can be challenged. In addition to Ling's (2008) study on mobile phones, there are additional points of the bodily co-presence requirement to critique. To start, Collins uses 9/11 and the US gun culture as examples of shared rituals in America. Whilst 9/11 did generate strong emotional feelings and solidarity amongst Americans, most Americans never saw the towers directly and many of them privately read news stories, interacted with others by telephone, text and online, and watched the story unfold on television. It is unclear what impact discussing 9/11 face-to-face had for Americans and how this was different from technological interactions in establishing entrainment, solidarity and morality. What is clear is that Americans used a multitude of non-bodily present forms of communication, none of which Collins takes into real consideration. It is plausible that bodily co-presence may not have been needed in order to establish some of the rituals surrounding 9/11, or played a role in generating ritual outcomes. A similar argument can be made concerning gun culture. Again, Collins highlights that gun owners are often fervent and thus entrained in pro-gun arguments. These emotions are then charged up through gun exhibitions and interactions with other gun owners. Arguably though, there are many gun-related rituals that involve technological interactions through online chat forums, social media, news articles and television. Chat forums and social media can be particularly powerful in generating emotions and entrainment through text, functioning as 'a new third place' (Steinkeuhler, 2007:313). Whilst this research study is not concerned primarily with technological forms of interactions, the use of technology, particularly text messaging, is relevant as a community ritual and will be discussed in the analysis chapters.

Secondly, Heider and Warner (2010) criticise Collins for assuming that all participants need to experience the same emotional experience or 'mood' as a result of ritual participation. Their research on Sacred Harp singing suggests that a ritual may invoke emotional responses in participants but responses can vary widely. Drawing on Rappaport (1999), Heider and Warner highlight that whilst it is necessary that a ritual produce a reaction, it need not be an equal or identical reaction. They further call on Collins to 'abandon "shared mood" and return to Durkheim's terms, namely the concept of the "collective consciousness"' (Heider and Warner, 2010:90). For TCs, this point is especially apt as not all clients may share the exact same emotional response within a respective ritual. What may cause one client member anxiety may provoke anger in another, as I will explore in the analysis chapters. Therefore, following Heider and Warner, the requirement of 'shared mood' appears to be confusing and too simplistic for TC settings.

Thirdly, whilst Collins is clear that individual rituals are linked together by chains that connect a ritual's past, present and future, he does not fully expand upon how rituals are connected to other rituals. For instance, Hallett (2003) identifies that what occurs before and after a ritual is significant. The emotional residue from one ritual can influence another. This suggests that rituals connect across time and space with other rituals through entrained emotional energy. Thus the questions arises, when rituals occur in close knit groups, like TCs, what is the overall impact upon the emotional feeling within the community? Chapter 7 will explore how this process works in practice.

Fourthly, Collins' analysis of positive emotions is limited (Turner and Stets, 2005). He argues that people will move towards interactions with the highest EE payoff, in other words that individuals will rationally decide which rituals will give them the biggest positive emotional gain. His account therefore seems to rely on overly consistent emotional states that appear unrealistic, especially in a mental health setting where clients often experience significant, and variable, distress. As Jones (1968:69) identifies about social learning in TCs:

> Learning of this kind is complicated and painful: old learned patterns, adequate in previous situations, must be unlearned because they stand in the way of acquiring new and more adequate patterns of behaviour.

Whilst Collins (2014) does acknowledge that negative emotional experiences can generate positive emotional energy and solidarity, he does not explain *how* this is achieved. It is also unclear whether participants would necessarily feel confident and enthused following rituals of negative emotions or whether positive EE can include differing emotional experiences amongst group members. In a TC full of potentially negative emotional expressions, understanding how feelings of belonging is achieved through negative emotions will be important for distinguishing between successful and failed rituals. Additionally, Collins seems to assume that individuals are always drawn to positive emotions, that they are aware of making this choice and that this choice is available to consciousness at some rational level. However, rationality and consistency can be especially problematic when individuals are experiencing acute distress. Here, IR theory does not explain the complexity and struggle of the personal change process. If individuals were simply drawn to positive emotional interactions, and consistently and rationally sought out those encounters with the highest EE, change would appear to be rather straightforward. But as highlighted earlier, the process of change in practice is full of backward and forward steps. In contrast, Summers-Effler (2002:47) argues that the 'motivations that guide us through interactions are usually below the level of conscious awareness'. Motivations thus become apparent during conflict as the individual faces a 'tension' between what is 'expected' and what is 'felt' (Summers-Effler, 2002:47). Conflict arising from these processes may be perceived as threatening the social bond, or solidarity, experienced through interactions. Her explanation therefore suggests that the decision in terms of emotional payoff is not a rational choice but an emotional one (Summers-Effler, 2004a). This explanation also fits with the aforementioned study by Hallett (2003) regarding the emotional motivating actions of food service staff.

Furthermore, not everyone positively changes and Collins does not explain why individuals may continuously repeat negative emotional experiences that appear to provide little positive emotional pay-off. Again, Summers-Effler addresses some of this by acknowledging that individuals bring their past experiences, positive and negative, to any given interaction ritual. She expands IR theory by noting that individuals will assess EE in terms of '*perceived* potential' (Summers-Effler, 2002:43), selecting the response/behaviour that in their experience, will generate the most favourable outcome. In particular Summers-Effler explains that for individuals who

have a history of mostly negative EE, they will continue to reproduce those patterns if they believe there are no better alternatives available to them, even if it drains them of energy. In these scenarios, individuals are often seeking to minimise the loss of EE as a result of a negative interaction (Summers-Effler, 2004a). This suggests that negative patterns of relating are repeated because they are familiar, though not necessarily habitual. Some individuals may therefore be drawn to negative emotional experiences, not because they particularly enjoy them, but because these responses are familiar, and what is familiar is often deemed safe (Panelli et al., 2004; Zingmark Licentiate et al., 2002).

However whilst Summers-Effler (2004b) argues that repeated negative patterns are the result of strategies to minimise EE loss or a real threat to one's sense of solidarity with others, I would argue that the threat could occur merely if a person *believes* it is real. This distinction is vital because perceptions of interaction fundamentally shape the view of the encounter so that sometimes only negative EE is taken, even if positive EE is being offered. TCs challenge repeated behavioural patterns based on familiarity through processes such as reality confrontation, whereby individuals are presented with an alternative view of their relating (Rapoport, 1960). However, this does not mean the individual will accept the new perspective or even acknowledge an alternative view as positive or preferable. Furthermore, Trevarthen's (2000) work has illustrated how the brain will always manage bodily behaviour in a way that is perceived to be beneficial and safe for the individual, whether that is regulating systems of blood and airflow, or emotional responses. When exploring issues of change in relation to negative patterns of relating, such as self-harm, the question becomes what negative patterns actually mean to the individual and why they are perceived as positive.

Additionally, whilst Summers-Effler does allow for the role of negative emotions in some rituals, she assumes that all negative emotions will remain negative. However, in TCs, some negative emotional experiences may eventually have positive gains. Much like a physical operation can be very painful but ultimately have positive results, the process of therapeutic change may initially be emotionally difficult but over time may lead to increased feelings of wellbeing. Therefore a more balanced approach may be to recognise that positive and emotional states are not

sharply divided and that they overlap. Individuals may therefore be drawn to an emotional response of *some* sort, which can be both positive and/or negative.

SUMMARY

This chapter has outlined the mechanisms IRC theory, defined key rituals and discussed criticisms and limitations of the theory. Central to this chapter is that IRC theory is a theoretical analysis of social situations. From the perspective of the social interaction, it is possible to explore a range of social dynamics including the role of negative emotions, the transfer of power, ritual and community oscillations, community norms and values, enforcement of standards, differing and changing emotional response, and changes to social groups. As it is not possible to explore every TC ritual within this thesis, the analysis chapters will focus upon 'key' action rituals. Chapter 6 identifies these rituals. However, IRC theory has not been widely applied to mental health. As such, there are limitations to the theory, particularly surrounding the role of negative emotions and how individuals choose positive forms of interactions. The analysis chapters will explore social interactions within TC using the IRC model, including solidarity, emotional energy, entrainment, symbols and standards of morality, whilst questioning and addressing acknowledged limitations.

Prior to the presentation of the analysis, the next chapter will detail the research methodology of narrative ethnography, which builds upon an interactionist approach. Additionally, Chapter 4 describes the research design, ethical considerations and process of data collection.

CHAPTER 4. METHODOLOGY

INTRODUCTION

This doctoral study seeks to understand the process of change as it occurs through everyday encounters within a therapeutic community (TC) context from the perspective of client community members. As planned social environments, TCs acknowledge the potential therapeutic role of both structured therapy times and unstructured social encounters (Whiteley, 2004; Manning, 1989; Mahony, 1979; Jones, 1976). To date, TC and mental health research has overlooked the importance of unstructured time during therapeutic interventions. These everyday social situations are not only underrepresented in the literature, they remain poorly understood in practice (Brownlie, 2004). As Chapter 3 states, this research is positioned within an interactionist tradition (Mead, 1932, 1934; Collins, 2004) that prioritises the role of social situations during the process of therapeutic change. On that basis, this thesis adopts a qualitative methodological approach. Specifically, it uses narrative ethnography, a method that enables an exploration of social interactions through the use of participant observation within a storytelling framework (Davies, 2008; Gubrium and Holstein, 2008; Chase, 2005).

Rooted within anthropology, ethnography has a rich tradition of research and is found within a variety of fields of study including sociology (Hammersley and Atkinson, 2007). Broadly defined, ethnography is an empirical investigation of social phenomena using interpretive techniques with unstructured data to explore a small number of cases within a particular setting (Hammersley and Atkinson, 2007). As a methodology, it has been widely applied within mental health (c.f. Goffman, 1961; Rosenhan, 1973; Bloor et al., 1988; Freestone, 2005; Quirk, 2006; Larsen, 2007). In this doctoral study, it involves participant observation within TCs, in-depth narrative interviews, semi-structured interviews and text analysis.

An ethnographic approach within TCs can act as a vehicle for ‘the careful elucidation of the complex and dynamic nature of therapeutic community culture and practice’ (Manning and Morant, 2004:31). There are often variations between how TC culture is conceptualised in the literature and understood by TC members, and

how it works in practice. For instance, Whiteley (2004) writes that Rapoport's (1960) ethnography found discrepancies between TC discourse and practice. Ethnography is well positioned to question and remain sensitive to these differences.

The use of narrative within mental health research is well established (c.f. Deegan, 1996 Lapsley et al., 2002; Etherington, 2008; Hornstein, 2009). Narrative analysis has a long oral and literary tradition, yet a single definition of narrative is difficult to clearly characterise (Riessman, 1993). It is generally described as talk organised into sequential order around events that provide meaning and insights into people's experiences and constructions of the world and is structured in a storied framework with a loose beginning, middle and end (Elliot, 2005; McAdams, 1993). Additionally, embedded within narratives are values, culture, emotions and definitions of meaning. Thus Fetterman (2010:55) advocates that a narrative approach within ethnography generates 'useful insights into a participant's view of the world and relating those insights to the specific topic of study in a short period of time'.

In this chapter, I discuss the use of ethnography in TCs and critically develop my methodological approach, arguing that the classification of 'narrative' ethnography is the most suitable for this doctorate study. I then provide an account of my research design and ethical considerations, describe how I conducted the research and reflect on my role as a researcher. However, before discussing narrative ethnography in further detail, it is first necessary to clearly state the epistemological assumptions underpinning this research (Murphy et al., 1998). Interpretive research is vulnerable to the positivist critique that argues it can only describe, rather than explain social phenomena (Sayer, 2000; Davies, 2008). For this research to establish validity and to justify explanation of social interactions as well as description, this research is informed by a critical realist position concerning the nature of reality. In the next section I will briefly outline this position.

4.1 The Nature of Reality within Interpretive Research

Ontological and epistemological questions are particularly important within interpretive research that seeks to understand social reality from the participant's perspective (Gobo, 2008). There are many different ways to tell the same story and

each version may seem to give rise to multiple, and even conflicting, realities (Riessman, 1993). Thus whether to consider all interpretations of reality as equally valid, or to prioritise one version over another, becomes a complicated issue within interpretive research (Sayer, 2000). In concurrence with Hammersley (2002:73), this study uses 'subtle realism' to combine elements of social constructionism and critical realism. Of primary interest in this research is understanding the role of the community and social support networks in facilitating self transformations from the participant perspective. Following Davies (2008), I argue that the use of realist ontology is compatible with interpretive epistemology and that such an approach enables interpretive research to explain as well as describe social reality.

Traditionally, interpretive qualitative research is linked with social constructionism and *verstehen* (to understand), and experimental quantitative work is associated with positivism and *erklären* (to explain) (Middleton et al., 2011). However, sociologists have more recently challenged this sharp separation and questioned whether interpretive research can explain as well as describe social phenomena (Davies, 2008). In response, critical realism has developed as an epistemological approach that seeks to comprise both *verstehen* and *erklären* (Benton and Craib, 2001). Critical realists accept the validity of both approaches and acknowledge that epistemological assumptions underpinning research will depend upon ontological positions and research questions. In this thesis, the research questions relate primarily to questions of practice, specifically *how* community members use social interactions to facilitate therapeutic change. From a subtle realist perspective it is possible to differentiate between what individuals say (discourse) and what they do (practice) (Craib, 2009). Though practice is known and understood through the lens of discourse, which is reliant upon social constructs, it does not mean that practice is a by-product of discourse or that they are the same (Sayer, 2000; Pilgrim, 2000).

Realist ontology is particularly important for issues related to validity and reliability in interpretive research as there is the risk that the researcher's interpretation will be conflated with the informant's interpretation (Sayer, 2000). Researchers need to be sensitive to participants' own understanding of their experiences and not presume that the researcher's interpretation must also be the

one held by informants (Cottle, 2002). Differences in interpretations may be justified yet 'researchers need to ask themselves if this 'surplus' is indeed addressing unacknowledged conditions, meanings, and unintended effects actually present in a particular setting' (Sayer, 2000:46). Etherington (2004) maintains that is therefore important for researchers to take care and use reflexivity when analysing data so as not to limit the imposition of their own values on participants.

4.1.1 Reflexivity and Realism

> I arrive at Powell just before 4pm. As I walk up the entryway, I try to picture what it would be like and feel like if I were a resident coming here for admission. I feel daunted by the task in front of me but also just ready for the uncertainty to be over. Let's get on with it. (Powell, Day 1, 16/11/2012)

As the above fieldnote acutely reflects, my fieldwork, whilst situated within a community of individuals, is firstly recorded and then recounted from my own perspective. As I attempt to understand the experience of participating in a TC from client members' perspectives, I continuously question and compare my own experiences and understanding to theirs. Rather than attempting to exclude my presence as a researcher, I use reflexive ethnography that acknowledges that I co-construct the social knowledge within this study (Emerson et al., 2011; Davies, 2008; Van Maanen, 1988). I do not conduct research *on* study participants as I am very much part of the research process *with* participants.

Traditional methods of validation using experimental models strive to get as close as possible to a postulated idea of objective truth (Riessman, 1993). In interpretive research, those methods are not applicable as researchers accept that informants' stories and researchers' findings are not meant to be factual accounts (Davies, 2008; Etherington, 2008; Riessman, 1993). An interpretation should relate to the study's context and researchers should be as transparent as possible with the methods employed (Elliot, 2005). This is particularly relevant when disparities occur between discourse and practice within a single narrative or when contradictory narratives exist within one community. For example, in a TC where staff and clients are intrinsically integrated, it is expected that there will be a variety of potentially contradictory opinions regarding mental health problems, therapeutic interventions,

short and long term outlooks, and even the nature of transformative change (Jones, 1968). Determining which versions possess a greater degree of validity will depend upon several factors, including researcher presuppositions and the believability of participants (Riessman, 1993). It is the researcher's task to be transparent with one's choices in order to determine the validity of the interpretation (Elliot, 2005).

To that end, I have deliberately used my own physical and emotional responses throughout my fieldnotes as a means of understanding what I heard, saw and did (Hubbard et al., 2001). Therefore, in order to maximise the transparency of the research, my role and voice are visible throughout the text. In using reflexivity, I recognise that I enter the field with a particular theoretical framework, contextualised in my own views of social reality, and my own unique responses to what I observe. All of this combines to influence the way I record, interpret and represent the data and therefore must be reflected upon and accounted for within the research. Yet as noted by Davies (2008) and Hammersley and Atkinson (2007), the use of reflexivity within ethnography does not negate a realist position as data can still represent social reality, not just how researchers perceive reality.

Having established that this study takes the ontological position of subtle realism whilst focusing on meaning construction within social encounters, it is necessary to critically assess how this study uses both narrative and ethnography.

4.2 Narrative Ethnography

Studying change as it occurs necessitates an ethnographic approach as it enables integration through participating and observing within a community over an extensive period of time. Moreover, qualitative research within TCs requires listening to individual stories about members' experiences. Both traditional forms of ethnography and narrative analysis have been used to understand mental distress, recovery and psychiatric environments (Kaysen; 1993; Baron, 1987; Goffman, 1961). Equally, whilst narrative has enjoyed a significant contribution to some types of service user accounts of mental illness (Hornstein, 2009; Etherington, 2008; Speedy, 2008; Laplsey et al., 2002; Deegan, 1996), it has generally assumed that stories have coherency and chronological structure (Baldwin, 2005). Nonetheless, some

experiences, such as psychosis or dementia, defy these coherent structures. The process of meaning making from the perspective of the client member experiencing distress is not fully conceptualised. Thus, the combination of both ethnography and narrative analysis seems well suited to this doctoral study.

Narrative ethnography may include narrative interviews alongside observational data (Gubrium and Holstein, 2008; Miller and Holstein, 1996). However I contend there are two issues with this approach in relation to this thesis. Firstly, there is the question of whether narrative ethnography is significantly different to traditional ethnography, thereby justifying a specific label. Secondly, as the research process of this study unfolded, the emphasis and conception of narrative and storytelling changed to reflect the data. Specifically the focus shifted away from individual accounts of change to the social interactions and rituals of community life. It is therefore now necessary to carefully define what is meant by narrative ethnography, explore the limitations of this approach in mental health settings and question whether classifying this doctorate as 'narrative ethnography' is appropriate.

4.2.1 'Narrative' Ethnography or Just Ethnography?

Combining elements of 'traditional' ethnography with other forms of approaches is common practice in contemporary social research (Atkinson and Hammersley, 1994). Ethnographies may be classed into categories including, but not limited to: realist, reflexive, feminist, interpretive, institutional, narrative, critical, impressionist, performative or autobiographical (Hammersley and Atkinson, 2007; Davies, 2008; Smith, 2005; Van Maanen, 1998; Denzin, 1997). Whilst there are clear crossovers between categories, in the main the variances allow researchers to emphasise particular elements within their research design, data collection, analysis and eventual write-up.

A definition of narrative ethnography varies and can simply refer to the researcher's mode of constructing an ethnographic text (Goodall, 2000; Van Maanen, 1988). Narrative ethnography from this perspective highlights the researcher's reflexive practice in selecting analytic themes, characters, voices and structures within the text. From this view, it is very similar to reflexive ethnography as

advocated by Davies (2008), openly acknowledging the researcher's role throughout the data collection process and in selecting themes and content. Following the 'narrative turn' in the social sciences (Hyvärinen, 2006:21), Van Maanen (1988) argues that narrative theory underpins all ethnographic writing. Yet narrative ethnography can mean more than a storied approach to the written text. In particular, Gubrium and Holstein (2008) use traditional ethnographic methods of participant observation with narrative analysis in order to explore storytelling, meaning making and experience within a social environment. Their interests in storytelling look at the process of story construction as it occurs in action with other social players. They argue that one of the weaknesses of relying on first person accounts, as narrative analysis tends to, is that it ignores the social environment in which stories are told. Therefore Gubrium and Holstein (2008) suggest expanding narrative analysis to include recollected stories and the study of narratives in process in relation to their social context.

Additionally, Gubrium and Holstein (2008:11) argue that a narrative ethnography is less 'self-conscious about researchers' representational practices' and focuses instead on the 'narrative practices of those whose experiences and lives are under consideration'. From their view, narrative ethnography seeks to understand the social context of the narrator(s) and to explore the narrative construction within what they classify as the 'narrative environment' (Gubrium and Holstein, 2008:12). Of interest are the everyday social interactions, referred to as the 'interactional control', and the institutional narratives, both the dominant and counter-challenging narratives, of a community (Gubrium and Holstein, 2008:16). Thus they argue that it is the '*interplay'* between interactions and institutions that shape narrative practice (ibid:19). Moreover, Pentland (1999:715) argues that the 'evaluative context' of a story, learned through immersion in the field, reveals how 'culture guides action' and highlights what it is that drives processes and choices within an organisation.

Furthermore, Bruner (1997) makes a significant point about narratives within ethnography that links in with Gubrium and Holstein's (2008) definition. He contends that most ethnographers presume that data collected in the present is then organised into their own reconstructed narrative account with an imposed beginning, middle

and perceived future, and thereby creating the story. Instead, and perhaps more accurately, the researcher steps into an already existing narrative structure that is continuously being formed and reformed within a community, and will continue after the researcher's departure (Bruner, 1997). Indeed, Hymes (1996:13) writes that 'what we seek to find out in ethnography is knowledge that others already have'. Rather than discovering knowledge as such, narrative ethnographers acknowledge that the reality of the social world within in a community already exists independent to researchers' awareness of it (Craib, 2009; Cromby and Nightingale, 1999). Participants themselves may not be conscious of it, but at some level they know it, live it and embody it. The aim of the researcher is not to discover or create a narrative of this reality, but to learn it through interaction with participants. Through this learning process, as recorded through fieldnotes and interviews, the researcher is co-constructing the community's narrative. A narrative approach to ethnography therefore enables the co-constructed written text, or the resulting storied structure, to be treated as a 'primary narrative', rather than a secondary source of information, that will then 'establish what is to count as data' (Bruner, 1997:267). This is an important distinction of narrative ethnography and echoes Etherington (2008:29), who proposes narrative stories are 'knowledge constructions in their own right'.

Thus, there seems to be a compelling argument for the justification of 'narrative' ethnography. Of particular relevance for this doctorate are the tensions and discrepancies between stories that may reveal issues of power, marginalising, social control and social status within a TC (Brown and Harris, 1978). However, there are problems with this approach. Firstly, and paradoxically, downplaying the researcher's role within an ethnographic account as Gubrium and Holstien (2008) suggest, carries risks of misrepresenting the data (Cottle, 2002) and the conditions under which ethnography is produced (Craib, 2009; Davies, 2008). Moreover, Bruner (1997:272) explains that 'ethnographies are co-authored' because the 'ethnographer and informant come to share the same narratives'. However, sharing a narrative is the acknowledgement that through a shared interaction, shared meanings are co-constructed. These shared meanings may not be identical but they will be related to one another. Therefore, lessening this 'self-conscious' position ignores how the narrative is lived, shared and constructed between the researcher and informants, and eventually produced in a written text (Bruner, 1997). Presenting

ethnography predominantly as a reflection of the participants' experiences, whilst minimising the researcher role, is therefore misleading and weakens a study's reliability (Davies, 2008).

Secondly, narrative analysis in the social sciences largely relies upon first person recollected accounts (Etherington, 2008; Riessman, 1993) with a structure that organises an individual's experiences into a coherent storied format. Conversely, experiences in process are very different to recollected depictions. Everyday experiences are complex and often chaotic. This is particularly the case within mental health settings, such as TCs, where client member distress can interrupt the formal and informal structure of community life (Adame and Hornstein, 2006). More importantly, Baldwin (2005:1023) argues that 'narrative theory and practice deny the possibility of narrativity to people with severe mental illness' by ignoring stories that do not follow a linear and coherent trajectory. In this way, complex mental health clients pose three main challenges to narrative theory: reduction of narrative agency and the ability to author one's own story, the lack of normative narrative form and structure, and the inability of the listener to relate to the teller. In order to avoid dispossessing those experiencing severe mental distress of their own narratives, Baldwin advocates both listening to the small, episodic stories and using observational techniques to piece together narratives.

Thirdly, whilst I concur with the suggestion by Gubrium and Holstein (2008) that narrative ethnography centres on social interactions rather than the individual, they do not provide a theoretical framework for analysing interactions. Even Baldwin (2005) does not provide a means of analysing interactional data. This is problematic because much of narrative theory prioritises individual accounts, even when studied in process, and therefore cannot adequately theorise social interactions. Hence Goffman's (1967) insistence, and more recently echoed by Collins (2004), that researchers begin first with interactions and then individuals. Unlike other forms of narrative ethnography that may only follow one individual, this study explores meaning making between the TC and the individual client members. Interaction rituals provide a more holistic approach to connect interactions to wider co-constructed meanings.

In order to address these methodological critiques, I advocate that narrative ethnography, as used in this thesis, incorporates the following:

1) a storied approach to the written text with a clear acknowledgement of researcher role (Davies, 2008; Bruner, 1997);
2) ethnography is treated as a primary co-constructed text based on the recognition that researchers step into pre-existing institutional and individual narratives through the community's social interactions (Chase, 2005; Bruner, 1997);
3) an acknowledgement that the interplay between interactions and institutions determines what narratives are valued and recounted (Gubriubm and Holstein, 2008; Pentland, 1999);
4) the use of episodic rather than chronological forms of narration with an emphasis on meaning instead of coherence (Baldwin, 2005);
5) that the methodological framework takes interactions, not individual storied accounts, as the starting place to understanding individuals and their social environment (Collins, 2004).

The narrative component of ethnography acknowledges that interplay between interaction and institution shapes what types of narratives are valued, told and passed down to newer members. This in turn reveals social norms and morality, the motivation behind action and power structures within a community. Thus, narrative ethnography is not only justifiable for this thesis, it is a crucial element of analysis.

4.2.2 Multi-Sited Ethnography

As noted in Chapter 2, there is a tradition of using ethnography in TCs. However, with the exception of Bloor et al.'s (1988) work, the studies are single site. Bloor et al. (1988:2) argue 'there is no such thing as a single 'representative' TC and that a study exploring TC culture and practice requires a 'comparative framework since a central feature of therapeutic community work is its variability between different communities'. This thesis seeks to build upon their model by incorporating two TCs in the analysis. Moreover it is acknowledged that the use of two sites also draws on

the multi-sited ethnographic approach that Marcus (1995) advocates. Hannerz (2003:207) notes that multi-site studies move beyond comparisons to ascertain the 'interconnectedness' and 'relationships' that the sites may share with one another (Hannerz, 2003:207). As accredited TCs, the two communities in this doctorate shared a common ethos, as established by Haigh (2013, 1999). Both communities helped individuals with a diagnosis of Personality Disorder and most clients were funded through the NHS. Given the current pressure on public mental health funding, the two communities faced similar challenges. Differences between the communities, such as a residential TC compared to a day community, also provide meaningful contrasts. Furthermore, as the theoretical position focuses on interaction rituals, establishing the relationship of rituals between the communities expands the analysis of rituals, community dynamics and issues relating to power and social control.

Covering the breadth and depth that Bloor et al. (1988) achieved in their work spanning 10 years between three researchers is not possible within a three-year doctorate with one researcher. It is recognised that two communities in this study, whilst limited in comparative analysis, nonetheless draws on Bloor et al.'s (1988) framework and seeks to expand the current knowledge of meaning construction within a TC environment.

4.3 Research Design and Ethics

This project has been designed to explore the process of personal change within two TCs as noted in Table 2. In the interest of maximising participant anonymity and confidentiality, the names of both communities are given pseudonyms in this research and no other identifying location is provided.

Community	Service Type	Sector	Client Group	Treatment Length
Powell *(Site 1)*	Adult Democratic	Independent	range of mental health difficulties including PD and BPD	12 months
Hawthorne *(Site 2)*	Adult Democratic	NHS	range of mental health difficulties including PD and BPD	12 months

Table 2: List of TCs

4.3.1 Selection of Research Sites and Access: Powell

In February 2012, I approached the Consultant Psychiatrist and Group Analyst for Powell to discuss the possibility of conducting ethnographic research with the community. Following on from our correspondence, I conducted an initial site visit on 19 March 2012 to meet with community client and staff members and discuss the possibility of conducting the research. After ethical permission had been obtained, I conducted a second site visit 5 November 2012 and began fieldwork on 16 November 2012.

4.3.2 Selection of Research Sites and Access: Hawthorne

I initially visited Hawthorne as a lead reviewer for the Community of Communities annual review process of TCs. After the peer review, I approached the Principal Adult Psychotherapist and Team Leader about involving the community in the research. I was invited to attend a staff meeting on 10 May 2012 and received permission to consider them as potential research site, pending the approval of NHS ethics. Due to their building move in April 2013, the site visit was delayed until 29 April 2013 and fieldwork began on 20 May 2013.

4.3.3 Ethics and Study Information

In conducting this research study I adhere to all ethical guidelines as outlined by the University of Nottingham, the Economic and Social Research Council and the NHS. Moreover I comply with all ethical requirements for the two respective communities. There are three main components to this study: participant observation, narrative interviews (clients only) and semi-structured interviews (staff only). Copies of the Participant Information Sheet, Research Probes and Consent Form are available in Appendices 1-3.

Ethical permission was obtained from the following professional organisations: School of Sociology and Social Policy, NHS Research Ethics Committee, Powell Research Governance Board and NHS Research and Development. I had an

honorary research contract at both sites. In addition, the study was sponsored by the University of Nottingham and adopted by the Mental Health Research Network (MHRN) and the Comprehensive Research Network (Trent).

It is recognised however that the notion of ethics in a research study does not end with obtaining research ethical approval. Rather, ethics is a process that is continuously reflected upon and revisited throughout all stages of the research, including write-up and dissemination (Ramcharan and Cutcliffe, 2001). Abiding by the 'first do no harm' principle that underpins all ethical guidelines is not always as straightforward as it may appear, particularly in qualitative research (Orb et al., 2001). For all aspects of the study, there are several key ethical issues that required careful consideration.

Firstly, there is the issue of explaining the research. The aims and objectives of the research, including my role as a researcher, were fully transparent throughout the study. Secondly, there is the process of obtaining informed consent. For the participant observation element, all staff and client members of the TCs were asked to read the Study Information Sheet and sign the Consent Form if they agreed to participate in the study. All participants were over the age of 18 with the capacity to provide consent for participation within the research. There was 100% participation from TC members at both communities. All references to participants and identified others (parents, partners, other health staff, etc.) were anonymised through the use of pseudonyms and the exclusion of any identifying information.

For both sets of interviews (narrative and semi-structured), research participants were those that were, or had recently been, current members of the respective TCs. Informed consent was obtained from all informants. No identifying information appears in the research and all participants have a pseudonym. The process of interviewing, including the interview questions, is further explored below in Section 4.5, The Role of the Researcher.

All research participants involved in the three aspects of the study were advised that they were free to withdraw from the study at any time without any consequences. Moreover all participants were asked to participate without the fear of pressure or coercion.

Thirdly, whilst confidentiality is central to maintaining the privacy of participants, there are times when it is necessary to break confidentiality. It was stressed to all research informants that there were two exceptions to the confidentiality clause: if I became aware of any significant harm to a person under the age of 18 years old and if they expressed an active intent to commit suicide or self-harm. In both instances participants were advised that I might need to notify the relevant authorities and/or a relevant TC staff member. None of the participants however disclosed any such information and I therefore maintained confidentiality at all times.

Fourthly, there can be issues during ethnographic research whereby members of a group directly or indirectly request confidential information on other group members. In the main throughout this study, both staff and clients refrained from asking me information about others. Once, a staff member at Powell remarked that she would "love to know what goes on during the client only business meeting" that I also attended, but she did not press me for details. However managing the balance between staff and client member groups was difficult at times and I further expand upon this issue below in Section 4.5, The Role of the Researcher.

Fifthly, there can be the problem of informants sharing more than they may be comfortable revealing or taking on the researchers' interpretations of their story (Elliot, 2005). Elliot (2005) identifies that some in-depth narrative interviews with their relaxed and informal setting may end up resembling friendship conversations with the result that the narrator shares information usually reserved for close friendships. She also acknowledges that some interview sessions may feel like therapy for the informants. As interviews in this study took place within the therapeutic environment of the community, this issue is especially pertinent (Menzies and Lees, 2004). Moreover, speaking about difficult past events, such as abuse or trauma, can trigger emotional distress (Orb et al., 2001). I was able to minimise this risk by firstly ensuring that all interviews occurred within the physical premises of the communities so that clients could always speak to a member of staff following the interview if necessary.. Additionally, when participants showed hesitation or emotional distress (e.g. crying), I always reminded the participants that they did not have to tell me anything they did not wish to and that we could stop at any time. Moreover, whilst I

did engage with client members throughout all stages of the research and aimed to validate their experiences, I was careful to not overly influence participants' perspectives by making evaluative comments about the TCs, other members or any aspects of their narratives. I discuss how I managed ongoing access and writing of fieldnotes below in Section 4.4.2 Participant Observation.

Sixthly, analysing and interpreting the data can pose difficulties during write-up and dissemination. Issues such as power and re-presentation are significant, as the researcher must reflect upon whose account, the researcher or the researched, is being represented. Throughout the research process of data collection, interviewing, transcribing and selecting data for analysis, deliberate and/or unintentional decisions may challenge a participant's perspective (Riessman, 1993). Furthermore, conducting analysis may mean that the research takes on a different interpretation to the one held by participants (Sayer, 2000; Bosk, 2001; Anspach and Mizrachi, 2006). Whilst researchers ultimately have to justify their interpretive choices when the work is disseminated, this issue cannot be completely resolved within the research as the power relationship is always present in narrative ethnography and even the most stringent forms of accurate reporting cannot eliminate it (Riessman, 1993). However being mindful of the power I possess as a researcher and being transparent with choices in the research can minimise the power dynamics (Elliot, 2005; Lawler, 2002).

Additionally, it is worth acknowledging that all data is stored on the University of Nottingham secure servers in password protected files and that analysis occurred on University of Nottingham secure networked computers. Signed consent forms are stored in a locked filing cabinet at the University of Nottingham. Other ethical issues, such as writing fieldnotes, use of recording device and managing researcher role are discussed below in Sections 4.4.2 and 4.5.

Ryen (2011:432) acknowledges that 'knowledge production comes with moral responsibility towards research participants'. When specifically considering the responsibility to participants within this study, I have been mindful of the trust that interviewees bestowed and that they provided access to their memories, their identity and the ethical principles that guide their lives. In addition to adhering to ethical

guidelines and requirements, I also continue to take an ongoing reflexive and evaluative position throughout all stages of the research.

The section that follows outlines the process of conducting the research by firstly providing information about both communities and their client members, and then discussing data collection, saturation, analysis and the role of the researcher.

4.4 In the Field: Powell and Hawthorne

Both Powell and Hawthorne were accredited as adult democratic TCs and as such, went through rigorous accreditation cycles every three years and participated in annual peer reviews through the Community of Communities (CoC) (Royal College of Psychiatrists, 2015). Powell was an in-patient unit for women only and was one of several specialist units for complex needs embedded within a charitable mental health hospital. There were 25 members of staff, six of whom were male. In contrast, Hawthorne was part of a wider PD service and its origins were connected to a former mental asylum established in the mid-19th century. Hawthorne's unit treated both men and women. Originally an inpatient unit, Hawthorne became a five-day a week community in the early 2000s. Hawthorne had 10 members of staff, one of whom was male. Both communities had a male clinical lead with oversight of the TCs.

4.4.1 Participant Demographics

Participants in this study included both staff and client members with the focus of the research on the clients. Whilst not having access to the clients' medical notes, and not collecting any formal data on clients' demographics via questionnaires, the time I spent with clients enabled me to record their self-reported demographic information. At Powell, clients (12 clients at the time of data collection and three programme graduates) were aged between 20-60 years old with seven out of 15 clients in their 20s. Their ethnicity was white British. Clients had a diagnosis of PD and additional diagnoses including psychosis, post-traumatic stress disorder, eating disorders, and physical health problems. Many of the clients had experienced childhood sexual

abuse, neglect, and physical and/or sexual assault. A few of the clients had been arrested for physical assault and disorderly conduct. Several clients suffered with dissociating, which is loosely defined as being in an altered state of consciousness (Holmes et al., 2005). In this state clients may have reverted to younger forms of themselves, taken on different personalities or switched off entirely from their physical and social environment so that they were awake but non-responsive. Most often clients had no memory of disassociating. Episodes of dissociation/disconnection were frequent and could occur at any time. Additionally, all of the clients struggled with some form of self-harm, defined by staff and clients as anything involving physical self-injury, self-neglect and putting oneself in a dangerous or vulnerable situation. Forms of self-harm that occurred during my fieldwork included absconding, ligatures, cutting, eyelash pulling, punching, hair pulling, burning, fire setting, over-dosing, over/under eating or drinking, purging, intoxication, attempts at drowning, consuming chemicals, drug misuse, and attempts to jump off of buildings.

At Hawthorne, there were a total of 16 client members during data collection. Seven were male and nine were female, though at the start of the research, the men outnumbered the women by five to three. The ages of clients ranged from 20-60 with 10 of the clients in their early 30s or younger. The majority were white British whilst one member was Asian. Like Powell, clients at Hawthorne had a diagnosis of PD. Additional diagnoses included psychosis, obsessive-compulsive disorder, substance abuse and social anxiety. Eating and food was problematic in approximately half of the clients. As with Powell, Hawthorne clients had experience of childhood abuse and neglect as well as sexual and physical assault in adulthood. Some clients had also been arrested for crimes including physical assault, theft and disorderly conduct. All of the clients reported difficulties in relationships. Self-harm was defined in similar terms to Powell and the majority of clients engaged in some self-harming behaviour during my fieldwork. Unlike Powell however, all acts of self-harm occurred off-site. Only one client member reported difficulties with dissociation.

4.4.2 Participant Observation

Participant observation formed a substantial component of the data collection process. In providing an account of this stage of the research, I reflect specifically on sampling time and activities and writing fieldnotes.

Sampling Structured Time/Activities

In designing the research, it was envisioned that the amount of time and type of structured activities would be negotiated with each host community. When I first arrived at Powell, I was given a copy of the community timetable and excluding formal therapy times, community meetings, client business meetings, TC business meetings, visitor assessment groups, some occupational therapy groups, meals and activities were made available to me by both staff and client members. Likewise at Hawthorne, excluding formal therapy times, I was able to attend community meetings, lunch times, some Living Learning groups, visitor assessment groups, and all therapy break times. However, negotiating access at both sites did not just occur at the beginning of the fieldwork. Access was continuously negotiated throughout the time I was with the TCs with both staff and client members.

In structuring my time with Powell, I aimed to do 3-4 days per week, spending 10-12 hours on the unit per day. I had no set schedule of days, seeking instead to sample a mix of days, weekends and waking night shifts. This style and the amount of hours spent with the community were to help me identify informative sources of activity whilst allowing time for reflection (Hannerz, 2003). Overall, I conducted 486 hours and 30 minutes of participant observation over 51 days, or 16-weeks.

At Hawthorne, I was restricted in data collection by the days and hours that the community was open. I aimed to do 2-3 days per week, alternating my weekdays, spending 6-7 hours with the TC per day. In total, I conducted 260 hours of participant observation over 36 days, or 15-weeks. Whilst there is only the difference of one week between sites, the differences in hours and days spent at each community were primarily due to the fewer hours and days that Hawthorne was open compared to Powell. Moreover, I found that because Hawthorne was the

second community, data saturation, the point where no new data emerged, occurred more quickly than at Powell. I discuss data saturation further in Section 4.4.3 Data Saturation: saying goodbye.

Sampling Unstructured Time/Activities

Observing unstructured time was one of the most central features in the research design as it directly relates to the question of what occurs in-between structured therapy times. Sampling unstructured time appears straightforward as it simply means spending time with the clients outside of groups. However in practice it entails a complex source of time and activities.

Firstly, there was the challenge of defining and categorising unstructured time. Much of my informal time involved sitting in the lounge at Powell, one of the central locations within the unit, and in the large community room at Hawthorne. Yet it is difficult to encapsulate clearly what this usually entailed because the activities were so diverse. Spending time in Powell's lounge could involve anything from watching TV, chatting, playing an instrument (guitar, piano, flute or ukulele), singing, karaoke, colouring, reading the newspapers, playing games or jigsaw puzzles. Likewise at Hawthorne, activities included listening to music, reading newspapers and brochures, playing with a softball or Frisbee and talking. Both the activities and nature of the conversations varied. I observed, and at times participated in, everything from discussions about films/celebrities/TV shows and favourite types of music, to discussing topics such as relationship histories, past experiences of mental health wards and difficulties with food.

Secondly, I could not control for how many clients, and indeed which clients, would be available during informal times throughout the day. At Hawthorne, the clients could only be in the TC room or in the smoking area. However at Powell, clients could be in their rooms, attending various appointments, or involved in individual activities. Most frequently, the pattern comprised of clients coming in and out of the lounge and staying for varying durations. Thus the number of persons and mix of individuals in the room would fluctuate at any given point.

Thirdly, it was challenging to know how and when to seek out unstructured activities that may be occurring at both sites. Naturally joining something uninvited required skill and the awareness of when it was appropriate to participate and when to remain uninvolved. At all times I was conscious that the priority was the clients' therapy and their therapeutic needs. I therefore sought to ensure that I was not obstructive or causing the clients any discomfort.

Writing Fieldnotes: transforming everyday experiences into text

Emerson et al. (2011:xv) suggest that many ethnographers find their fieldnotes 'a little bit dirty, a little bit suspect, not something to talk about too openly and specifically'. Murphy and Dingwall (2003) note that until recently, fieldnotes were not explicitly discussed. In part, this is because fieldnotes are very personal, highly confidential and 'potentially damaging' to participants, host institutions and researchers (Murphy and Dingwall, 2003:59; Malinowski, 1967). Yet describing how fieldnotes become theorised text establishes the validity and credibility of the research (Murphy and Dingwall, 2003). As this is a reflexive ethnography study with an emphasis on researcher transparency (Davies, 2008), it is important to explain what events and descriptions were prioritised during the observations.

Keen to be transparent about my research and my role as a researcher, I originally intended to write notes in front of community members rather than retreating to a separate space (Emerson et al., 2011). However after discussion with both communities, clients requested that I confine my writing to the staff office. There were several advantages to taking notes in the office. Firstly, I was able to ask staff questions about aspects of community life, including risk management or mental health policies, and sit in on staff handovers, which enabled me to catch up on events that had happened whilst I was away. Secondly, at both sites, the staff office door was usually open. As clients frequently came in and out of the respective offices to speak with staff, I was able to observe countless interactions between clients and staff members. Thirdly, the staff offices did provide a space where I could easily record my fieldnotes 'contemporaneously', or, as events occurred (Emerson et al., 2011:17). Other fieldnotes were written, or audio recorded, after I left the

communities for the day. Fourthly, clients could clearly see me writing in the office by observing me through the door or by coming in to the room. Having the separate space meant that I could interact and engage with the clients naturally without having to pause to jot notes, thereby avoiding an artificial element to our interactions.

Throughout the data collection process, I aimed to record events, interactions and individuals with as much detail as possible. As Emerson et al. (2011) advocate, I avoided judgemental phrases such as 'she looked angry' or 'sad' and sought instead to describe the particular look of an individual's face and/or body language: 'Tessa's were arms crossed, brows raised, eyes narrowed, head to the side, lips scrunched – did she believe their explanation?' (Powell, Day 4, 19/11/12). I made detailed notes about sights and smells and noted my physical and emotional responses to situations such as the taste of the food, the temperature in the room, and my emotional exhaustion at the end of a 12-hour day.

4.4.3 Data Saturation: saying goodbye

I used two main criteria for assessing data saturation in the field: immersion in the community and the point where no new ideas emerged (Francis et al., 2010). Both are closely related. Immersion in the field included the point where I became viewed as a member of the community. At Powell, the first time I recorded this was on Day 31 (29/01/2013) when a staff member remarked that she no longer noticed when I arrived and left as I had become "part of the furniture". Additionally, at TCs I noted that my language in the fieldnotes gradually changed to 'we' rather than 'they' when describing activities.

I initially thought it would be difficult to assess the lack of new ideas emerging, as social life within the TC was so varied. However, after three months at Powell I felt I had an understanding regarding the interactions and behaviours that were initially perplexing to me. At Hawthorne, because it was the second site, familiarity with TC processes occurred more quickly and I felt familiar with the community after two months. Towards the end of fieldwork at both sites, I therefore began to question whether my familiarity with the TCs would impede data analysis.

In preparation for my departure, I had an 'ending' with both TCs. At Powell, the clients and staff members discussed my leaving with the community and my official 'ending' was held over lunch on my last day. I provided homemade brownies and presented each of the clients with a thank you card and a card for the community as a whole. Additionally, because writing pens were scarce within the TC, I gave the community a client pencil case full of pens. In return the clients gave me a thank you card signed by all of them and two clients gave me more personal thank you cards.

Likewise at Hawthorne, my leaving was discussed during a community meeting. In keeping with the TC tradition for conducting endings, I selected the menu for lunch on my last day, the TC bought a cake and I took the final few minutes of the Morning Meeting to thank the TC. I also presented the TC with a card, a mug tree, which they had repeatedly stated they wanted, and chocolates for both the clients and staff members. The clients also wrote my name on the blackboard and wrote messages of good wishes to me, and gave me a personal card that they had each signed, whilst the staff presented me with flowers.

4.4.4 Client Narrative Interviews

Though the participant/observation process concluded in early March (Powell) and at the end of August (Hawthorne), interviewing concluded in October 2013. The process of saturation for interviewing was different to the participant observation. Pre-selecting interview informants felt both contrary to the inclusive ethos of the TC and carried the risk of pre-determining the story of the thesis. I therefore invited all current client members at both sites to participate. Access to Powell Graduate Group members was negotiated via a letter written by me that was then distributed to the group.

In total I interviewed 21 client members: 12 from Powell (including 3 Graduate Members) and nine from Hawthorne. A further two Powell client members had wanted to be interviewed but left on Section 2 of the Mental Health Act before I could interview them. At Hawthorne, client members who had already left the TC were no longer in contact or participating in the equivalent of Powell's Graduate Group, and I therefore did not have the opportunity to interview any former members.

There are many modes of narrative interviewing and some researchers advocate a completely unstructured approach with minimal to no input from the researcher (Jovchelovitch and Bauer, 2000). However others, including Riessman (1993), Etherington (2008) and Speedy (2008), view the narrative interview as a co-constructed story between the interviewer and interviewee. Thus asking questions and responding to an informant's story are appropriate. I therefore constructed a set of Research Probes (Appendix 2) to serve as an interview guide. With the exception of one client who requested I take hand written notes, interviews were audio recorded. All client interviews were then transcribed verbatim.

As the process of participant observation unfolded, I was keen to conduct the narrative interviews as I hoped to gain a fuller account of clients' life stories. However, the first couple of interviews quickly highlighted to me that whilst the clients were in many cases eager to share their story of community life with me, the ease with which they voiced their experiences varied. Whilst some clients could converse effortlessly with me about their lives prior to coming to the community and their views about being a community member, others were anxious and clearly struggled, despite being keen to be interviewed.

Therefore I devised a different style of interviewing that had a loose narrative structure that took the clients through what life was like prior to coming to the community, what it was like joining and their experiences of community life to date. Questions also focused upon the clients' perceptions of change and how they understood their own change process. Ethically, I was mindful of any distress experienced by the clients (Menzies and Lees, 2004) and offered to stop the interview when needed. Whilst this revised structure did seem to help clients relax, my concern was that this structure might have overly influenced the type of story the clients told and increased the power imbalance between us (Lawler, 2002).

Clients had the option of conducting the interview all at once or over several sessions. Most clients opted to tell their story in one setting and four clients (Powell) requested multiple sessions. Additionally, Powell underwent a significant time of distress during the interviewing stage when three client members left prematurely in a week. Due to the extraordinary number of self-harm incidents and the heightened

level of distress, I re-interviewed clients to specifically learn their perspective during this time.

Upon reflection, my time participating and observing had given me more understanding of clients' individual stories than I had initially realised. Moreover, I found I had rapport with clients based upon shared experiences in the TC. Clients recounted many incidents that I had also been part of with them. This provided me with an unexpected amount of context to what they shared. However, there were still aspects about clients' lives I had not realised and I had not fully appreciated some of their beliefs about change, their perspective of life in the community and their understanding of relationships within the TC until I interviewed them.

4.4.5 Additional Sources of Data

In addition to fieldnotes and client member interviews, I interviewed a total of seven staff members. Five at Powell and three at Hawthorne were pre-selected for semi-structured interviews in order to provide specific contextual information. Selection of staff members was purposeful, as I choose those staff that would be best placed to provide contextual information alongside the fieldnotes and client member interviews (Fetterman, 2010). Additionally, community members at Powell and Hawthorne provided me with sources of personal statements and grey literature. For example, 10 clients from Powell provided me with copies of their Commitment Statement, a short piece of writing regarding their therapy outcomes and commitment to the community programme completed after their two-week assessment with the community. One Powell client also requested that I use her Assessment Letter, a letter she wrote to the community following her initial Assessment Visit. Staff members from both TCs also gave me forms including the TC boundaries, handbook, meeting agenda formats and written therapy forms (templates).

4.4.6 Data Analysis

Like much of qualitative research, the primary mode of analysis was thematic (Pope et al., 2000). The process of analysis began with fieldnotes whilst still at Powell and

prior to conducting client member interviews. Reading through notes at this early stage provided some loose themes that were beginning to emerge, particularly around the notion of 'ritual' (Goffman, 1967). Preliminary data analysis continued throughout the process of interviewing and data collection at Hawthorne. In total, there were approximately 800 pages of typed, single spaced A4 fieldnotes between the two sites. All fieldnotes were read concurrently multiple times for interaction rituals and key themes. I was conscious not to impose interaction ritual theory upon the data throughout the in-depth analysis, allowing the notes and interactions to speak for themselves. These initial readings and notes were conducted by hand. Fieldnotes were then loaded onto NVivo for further reading, coding and annotation.

The first process of data analysis for the client interviews was transcribing the data (Langellier, 2001). Like the fieldnotes, I conducted multiple readings of the transcripts, noting key themes and making annotations. However unlike the fieldnotes, I deliberately did not load the interview transcripts onto NVivo as I wanted to keep the narratives whole and analyse key quotes in relation to the rest of the story so as not to draw unintended or unfounded interpretations of the data. Relevant sections from staff member interviews were transcribed verbatim. These were all then cross-referenced with other interviews and the fieldnote data.

For both the fieldnotes and interviews, I also engaged in what Jackson et al. (2013:9) call *'emotional reflexivity'*. I read the text and transcripts paying close attention to my emotional reaction to the data. In doing so, I was able to confront my conceptions of change based upon my own experiences and consider how this impacted upon my interpretations. As a result, my interpretations shifted as I engaged with participants' voices and perspectives in the data.

Fieldnote quotations that appear in the thesis have undergone very little rewriting from the original notes. Nonetheless, with both the fieldnotes and the interviews, it has been necessary to remove non-relevant sections. This is noted in the text as follows:

[…] exclusion of non-relevant text
… at least three second pause (interviews only)

All fieldnote quotations appear in the present tense and are then referred to throughout the thesis in past tense.

4.5 The Role of the Researcher

Ethnography relies on reflexivity to understand the researcher's own position in order to ascertain 'whether the results of the research are artefacts of the researcher's presence and inevitable influence on the research process' (Davies, 2008:3). The role of the researcher in an ethnographic study is significant as 'emotional and non-conscious human processes' impact upon 'conscious experiences, activities and interactions' (McDonald, 2008). Because a non-objective researcher is the lens through which data is seen, collected, interpreted and re-presented, it is therefore necessary to reflect upon how researcher role, position and reactions shape the study (Etherington, 2004).

I carried out the research with no formal role within either community, neither as a staff nor a client member. The most frequent question I encountered from other non-TC staff members and service users from within the host organisations was, "Who are you?" However, an ethnographer has no set job description and in a setting where roles, positions and boundaries are clear and understood by all, I added a strange dynamic. I was an outsider both to the host organisations and to the communities (Bryman, 2001; Gold, 1958), yet was able to cross the traditional lines between staff and clients (Rawlings, 2004). Therefore, I found that my role and position were continuously evolving.

At both TCs I was able to move beyond just observing to actually participating in groups, meal times and clients' leaving process. During groups at Powell, *everyone* was expected to speak. I was no exception. I ate the same food as the clients during meal times at both TCs, chatted throughout the meal and helped clear up. However during other activities, such as Assessment Visits, I only observed the interactions, staying silent for the duration of the meeting. Therefore throughout the research process, my role was not rigid as I moved fluidly from observer to participant, and back again, often within the same activity (Davies, 2008; Bryman 2001).

Whilst I was allowed freedom to move between client and staff groups, managing the dynamics between the groups was difficult. Significantly, I sometimes felt isolated from both groups with my allegiances pulled in competing directions. For example, some clients at Hawthorne added copious amounts of salt to a staff member's drink. I watched them do this and then agonised over whether to intervene before the staff member sipped her drink. With only seconds to decide, I opted to let the situation unfold, as I knew the member of staff was not allergic to salt and it posed no health risk. Observing how the staff member challenged the clients that had added the salt provided me an opportunity to watch how the conflict was addressed. However, I felt guilty and questioned whether I should have intervened.

Despite my participation in the TCs, as Rawlings (2004:139) argues, I was always aware that I was 'not really a member of the group'. Morant and Warren (2004:148) describe this process as becoming an 'outsider on the inside', being neither 'in' nor 'out'. With Powell and Hawthorne, I learned what it is like to belong to the communities and I allowed myself to be viewed as a member, with both the staff and clients frequently referring to me as one of them. Nonetheless, I had to simultaneously seek to maintain a certain distance in order to continue the research process (Rawlings, 2004).

Moreover, feeling part of the TC meant that I emotionally experienced life in the community along with staff and clients. Often these emotions were difficult and I struggled to always know how to respond, especially as a non-clinical researcher. Managing my own response became an essential component of my work.

4.5.1 Managing researcher distress

> 'As I walk onto the grounds for my waking night shift, [...] I see a figure in bright pink with long blonde hair coming toward me as I approach the building. [...] I see that it is Holly, wearing her bright pink robe, pyjamas, and fluffy pink slippers. "Hi Holly", I say looking her directly in the eye, instantly concerned. [...] "I can't take it anymore, I just can't take it anymore" she tells me and begins to cry. We are alone. I tell her I am sorry and offer her a tissue, which she refuses, saying, "I'll be alright". She then starts to walk away. I call after her, asking if anyone else on the unit is aware that she has left and she nods. [...] She turns her head to me and says, "they're probably calling the police". I stand there and feel torn. I partly want to go after her, to follow her, but [...] if

> someone wants to leave they can. Plus she says that the unit is aware. I pull out my phone to call the unit whilst I watch to see where Holly goes. Yet I am literally only feet away from the office. Stay and watch or go tell the unit?' (Powell, Day 40, 15-16/02/2013)

As an ethnographic researcher working amongst clients with complex mental health difficulties in therapy, I listened to their recollected accounts of abuse, neglect and trauma. I also watched them address deep hurt, shame, anger and fear, challenging negative coping mechanisms that had become ingrained and familiar. Whilst I had concerns about upsetting the clients by my questions and even just by my presence, I soon learned that the clients were also mindful about upsetting me. Thus managing my reaction to distressing situations such as an incident of self-harm was essential so that they did not feel they had to censor themselves around me.

However, managing my own distress was very difficult at times. Though I have no clinical training, I still felt a personal sense of responsibility to Holly's absconding described above. This was compounded by the police officer chastising me for letting her walk away. As I gave my account to the police officer, I remained deeply worried that I had been the last person to see her. If she came to harm or harmed herself, I wondered how I would ever justify letting her walk away to myself as a person, not just as a researcher. Just as my physical senses were a great tool in helping me question and understand the community, so too were my emotional responses. By recording my reactions to things I found surprising, confusing and upsetting, I am able to explore my sense of normality and expectations compared with those within the community (Hubbard et al., 2001). Moreover, throughout the fieldwork, there were moments I felt out of my depth in knowing how to respond to accounts of suffering and incidents of self-harm. I was completely unable to help or to alleviate clients' pain and distress in any way and, at times, I felt disempowered. As staff came together to clinically support each other, all I could do was absorb what I was seeing, hearing and experiencing. However, through openly reflecting upon my emotional and physical responses, I noted that during the research process my definitions of personal change, hope, compassion, recovery, storytelling, friendship, agency and power were transformed.

SUMMARY

This chapter has outlined how ethnography and narrative interviews are used within two TCs to explore the process of personal change. Anchoring this study in critical realism enabled me to critically engage with the shared reality in both Powell and Hawthorne, whilst allowing me to explain and critique emerging phenomena. These phenomena included dynamics of power and social control, community inclusion, emotions, the importance of social support and personal change. In particular, I have argued that classifying this thesis as 'narrative ethnography' actively acknowledges the reality and ongoing narratives within both communities. Furthermore, this chapter has provided an account of how I conducted data collection and analysis with the communities. Through reflecting on my role as a researcher, I explained how I moved fluidly between staff and client groups and between participant and observer. The difficulties that I encountered in the field, including witnessing client member distress, required me to critically engage and change my conceptions of change. In order to present an explanation of the daily reality in the community that underpins data analysis, the following chapter re-presents everyday life in Powell and Hawthorne as told through the fieldnotes.

CHAPTER 5. LIFE IN THE COMMUNITIES

INTRODUCTION

Daily life in both communities was not easy and the choice of a TC was a difficult option for therapy. Powell Graduate member Lori remarked that it was as a "huge sacrifice" to join a 12-month programme. Client members told me that they had families, some with partners, dependent children or parents, education and jobs outside of the community. All areas of their life were impacted or interrupted during their therapy. Moreover the clients considered a TC the most intense form of therapy. This aspect specifically appealed to Hawthorne clients:

> I think I came to the TC because it was fulltime treatment and I felt like an hour or two months apart was never going to get anywhere. (Mary, Hawthorne Interview)

> I felt that was the only one that would help me. […] I knew I'd get more support from this than anything else. (Laruen, Hawthorne Interview)

Whilst clients at Powell also had to choose (and apply for funding) to come to the community, most of the clients, except one, had been in and out of long-term acute units, and all had exhausted other forms of available therapy. For Powell clients, it was often a choice between further acute unit stays and the TC. Thus coming to Powell was seen as the last chance of having a "better" life:

> And I kind of just knew I had to do something to, so I wasn't going to end up going into hospital for the rest of my life. (Erica, Powell Interview)

Clients were therefore aware that they were choosing a tough form of therapy, and once in the communities, reported that the therapy was "exhausting" and harder than having a full-time job. Heather, who I interviewed in her final week at Hawthorne, said:

> I hated every minute of every day, being here […]. I want to be here but I don't want to be here.

Powell and Hawthorne clients described life in the community filled with continuous analysis where anything could be brought to group for discussion and where they had to manage very intense and variable emotions. Furthermore any area of a

client's life was open to challenge, even those areas that clients were not interested in changing. For instance, Julie from Powell had no intention in altering her views about her body and food yet was confronted almost daily about her eating patterns. However, equally, clients also shared that they deeply valued their commitment to the TC, the TC itself and others within the community. This raises the question, what was it actually like to be in the communities? What was going on and why was it so difficult yet valuable?

The purpose of this chapter is to convey the daily narrative of life in the two communities. In doing so, the aim is to move beyond mere description of the communities in order to explain community life through interaction. This doctorate primarily questions *how* social interactions within the community actively play a role in facilitating change. Embedded within interactions are issues of power and social control, social hierarchies, understanding of individual and others' transformative change, and the overall experience of what it is like to be a member of a TC. Thus, in order to analyse the role of the community in the process of personal change it is necessary to see how the communities and its members interacted. Moreover, the interaction-based questions of this thesis require an awareness of not only how the respective communities functioned in theory, but also knowledge about what the communities were like in practice. Therefore this chapter communicates the lived experience of both TCs and represents the felt sense of being part of the communities.

Before presenting the two communities, a comment is necessary about the language and discourse used in the fieldnotes. Both communities each had their own 'lingo', words and phrases that were unique to them and had specific meanings. For instance, at Powell, 'grounding a client' would refer to the community's attempt to help a client who may be 'stuck' in a 'flashback' become aware of her present-day surroundings such as sights, sounds and scents. I deliberately use their words and phrases in order to preserve the community narratives. Certain words therefore do not encapsulate a diagnostic category, but rather reflect the ways in which the community used terms or phrases.

The account that follows is a re-presented narrative of life within both TCs through events that occurred daily or regularly throughout the day. I begin with a

brief description of the physical space of the respective communities followed by a sample of a recurring event. Fieldnote excerpts are deliberately long in order to communicate a sense of community life. In the telling I move through morning meetings, meal times, informal times, shopping trips and smoking breaks.

5.1 Powell

Situated just outside of a city centre , Powell was housed within an organisation that sat on sprawling grounds imbedded between farmers' fields and a university. The main building of the organisation was the original Georgian mansion from the 18th century and numerous other buildings, dating from various time periods, were dotted around the property. At the very back of the main building was the Powell community, which included clients member bedrooms, a lounge, kitchen/dining area, art room, two Quiet rooms and a Snoezelen room (a therapeutic sensory room). The decor of the Powell unit was similar to the rest of the organisation. There were numerous pieces of Georgian styled writing desks, chairs, tables, bookshelves, gilded and wooden mirrors, paintings and a piano. Floor-to-ceiling windows gave view to a wide expanse of manicured grass and, beyond that, farmers' fields. Both staff and clients continuously remarked on the beauty of the grounds and the building throughout my time with Powell.

Life in Powell was full, busy and ever changing. Joining the TC was like stepping into a flowing river that never stopped moving; days and events blended fluidly. From Monday to Friday there were two daily community meetings and various meetings interspersed throughout the week. In order to get a sense of Powell and how the clients interacted together, I present a morning meeting, dinnertime and an informal time.

5.1.1 Start of Day Group

Morning meetings at Powell were referred to as 'Start of Day Group'. All clients and staff on shift were required to attend. More senior staff members, including the clinical psychologist and consultant psychiatrist, as well as day staff, would attend

when available. The community sought to have approximately less than four to five members of staff in any one meeting in order to ensure that staff did not significantly outnumber the clients. Thus, those who were not on shift patterns, including me, had to negotiate access to each meeting.

Each meeting had a client 'chair' who opened the meeting with a greeting of "good morning", to which all responded. Every person present would then speak about how he/she was – emotionally, physically, or otherwise. Staff members (including students such as me) aimed to keep our contribution to a minimum so that the clients had more opportunity to speak. When the person speaking would finish, he/she would 'pass' to the next person on the right or left. These meeting were often emotionally charged. Clients would often dissociate during the meeting, resulting in the use of ice packs and scented oils, called 'ice and smells', to 'ground' them in the present. Ice packs were held against various parts of bare skin, usually the face and hands, though some clients stowed them down their tops. Scents were held directly under the nose.

The excerpt below depicts the tensions, dynamics and support from staff and clients during the turn of Kristen, a client who was often physically ill with various symptoms. Throughout Kristen's turn she argued with the clients and staff about remaining in the community. Clients in particular attempted to sympathise, challenge and support her:

> Then it is Kristen's turn. Silence at first. Kristen sits with her bare feet resting on the chair, in a foetal position and trembling a bit. Martha gets up to give her the ice but Kristen has one hand buried in her lap and the other resting against her cheek. She will not take the ice from Martha, even when Martha holds it up to her free cheek. So Martha pulls Kristen's hand away from her face and pushes the ice into her hand. Not hard but not slow and gentle either. Kristen takes the ice in her hand and then transfers the ice to her hand resting in her lap. Her now free hand goes straight back up to her face to cover her right eye whilst her hair falls forward obscuring the rest of her face. Sitting next to her I can only just make out Kristen's left eye and nose through her hair.
>
> The group tells Kristen that they need her to communicate and to talk. Kristen says, "I have nothing to say to anyone". After some prompting and coaxing from the group, Kristen then starts to talk about how "shit I feel", that she has a really bad migraine and that people expect her to be here in group, which "feels really mean". When asked if she is

angry, Kristen denies this saying that she doesn't feel anything, just unwell.

There is a lot of back and forth between Kristen, Tessa, Alison, Erica, Lindsey (support worker), Margaret (nurse), Wendy (OT). Kristen cuts across people speaking and interrupts them almost as soon as they get talking. She refuses to make eye contact because she says her head hurts too much and it is really mean of the group to make her sit there when she feels so bad. Tessa keeps repeating that no one is forcing Kristen to do anything, that it is her choice to come to group. Kristen says it is not a choice and that if she doesn't come, people will be angry with her. The argument continues and Kristen starts to cry and trembles more. Erica gets up to give her some tissues but she will not take them. Droplets of tears and snot form at the end of Kristen's nose.

Eventually Kristen begins to wipe at her nose with her sleeve. Tessa and Margaret (nurse) and Lindsey (support worker) keep trying to bring the conversation back to how Kristen will manage today. However Kristen will have none of it, often cutting across people before they can finish speaking. After more back and forth between the other clients and Kristen, she eventually says, "This place is making me worse and I want to leave here and just get better. I officially discharge myself".

Tessa and Alison are getting visibly frustrated. Their faces contort, and their eyes roll and flash whilst they shift their bodies in their chairs. As Kristen kept repeating she will leave and not commit to her safety, Tessa says, "You know it don't work like that here Kristen. Staff can't discharge you like that, and you know that".

Lindsey (support worker) agrees saying calmly, "Kristen, we have a duty of care here." Alison keeps raising her eyebrows, shaking her head, bobbing her legs up and down, and sighing loudly. Tessa is also shaking her head, rolling her eyes, narrowing her eyes and pursing her lips making an occasional snort/sighing sound. The rest of the group (the new client member Holly, Amy and Julie) stay mostly quiet with narrowed eyes and furrowed brows, their faces long while they follow the conversation.

Kristen will not commit to her safety or staying on the unit this morning. Eventually Kristen goes silent and continues to cry and tremble. The group encourages her to open her eyes and look around the room, but her eyes stay shut.

Martha asks, "Where is the ice? Does she still have hold of it?" I lean over and can see the ice has slipped down her lap and only the side of her palm is touching it. Tessa gets up to check where the ice is, then goes over to the small round table in the centre of the room where the icepack and sprays are. She sprays a bunch of smelly spray onto a tissue and walks back over to Kristen, holding it up to her nose. Nothing from Kristen.

> Tessa then leans over Kristen and begins to rub her arms, saying very gently, “Kristen, Kristen, do you know where you are?” At Tessa's touch, Kristen cries out, recoils hard from Tessa, her breathing fast and ragged. Her arms come up in front of her, her hair falls back from her face, her eyes are still closed, and I can see her face is red and tear streaked.
>
> In a pitched, panicked voice, Kristen cries out, “Don't touch me, don't touch me, get away from me!!” as she bats and waves her arms in front of Tessa. This all happens within seconds. Her legs have risen so that her feet are no longer on the chair but form a shield in front of her, and she is almost in a perfect ball position on the chair. Tessa continues to touch her arms, speaking in gentle soothing tones until Kristen begins issuing muffled screams, screams that sound chocked off because of her ragged breathing.
>
> Lindsey (support worker) then intervenes and calmly says, “Let’s end the meeting here, everyone back down to the unit and I will stay with Kristen”. She explains that it looks like Kristen is having a flashback and she will try to ground her, meaning bring her back to the present. I watch as everyone clears the room, (Alison practically bolts) and Tessa and Martha kneel down with Lindsey (support worker) next to Kristen. But Lindsey (support worker) clears them both out so that she alone is left with Kristen to help calm her down and hopefully coax her from the room back down to her bedroom. (Powell, Day 30, 23/01/12)

Following the meeting I was curious about the client members’ response to what had happened. Once outside in the smoking courtyard, Tessa explained how even though she was “upset” by Kristen she still supported her. The others then affirmed her and then proceeded to dramatically retell what happened to another member who had missed the meeting. Clients factually reported what happened but the way they told their narrative, accompanied with eye rolling and negative mutters about Kristen, made me question whether they would have described it the same way in front of a member of staff or Kristen. I also noticed that no one challenged Tessa’s use of touch with Kristen and whether that had been appropriate.

Furthermore, I was very intrigued by the question of agency, specifically Kristen’s agency, throughout this encounter, and how the community would explain this to themselves. Later that day, Kristen, when fully present and aware of her surroundings, said that she did not remember the morning meeting at all and had absolutely no desire to leave the premises. A member of staff commented later away from the clients, “how convenient”. There was no mention of Kristen’s flashback, Tessa touching Kristen or Kristen’s anger during the meeting. I then questioned

whether the community accepted Kristen's narrative and whether it would impact upon further interactions with her.

In addition, the excerpt above highlights several interaction rituals, including ice and smells that will be discussed in the analysis chapters. Meetings such as the one depicted above were common. Community meetings had challenging dynamics as members focused together to specifically reflect on how they were and provide feedback to others.

5.1.2 Meal Times

Meal times within the community revealed the implicit social rules, structures and norms at work. These included attitudes about food and eating, where to sit at the table, what was okay to talk about, and how clients' managed their difficulties with eating. During meal times I was able to observe how the clients and staff interacted with one another and how they managed any distress that might arise.

The fieldnote below is from my first day at Powell. It reflects my process of working out how to get food, where to sit and my issues with acclimating to life around the dinner table:

> We move on to the kitchen, where people are gathering for dinner. I feel nervous again. I look at the table, it's big and it's all set. There are bowls of fruit laid out and it does look inviting. I am hungry, but suddenly unsure if it's really okay to eat with them. Why this reaction to the food? People queue to dish up and I hover at the back, unsure. They know what to do. They have ordered their food already and know what to expect. Those that have dished up go sit down. But I don't have a clue how this works. I finally grab a plate and wait to dish up as the others have done. This feels so strange. I am standing there holding a plate whilst Sophie (nurse) searches for a serving spoon and I feel like an extra limb. Plus it's odd having someone else dish up my food for me. The portions are quickly explained – I have to eat a third of carbs, protein and vegetables. I get the food and head over to the table. Is it assigned seating, favourite seats, like the mugs? I choose a seat and watch people's reactions to see if they mind my choice. All seems good. I sit down and start eating. They (not sure who?) had ordered a lentil shepherd's pie. I also have steamed carrots. It is warm, hearty and very good.

> The conversation around dinner is about the food. Alison sitting next to me has to keep her food separate. Anna sitting nearby has to mix hers all together. They laugh and remark on their different eating habits. Suddenly Anna asks Martha, who is sitting at the other end of the table, if she is alright. All heads turn. No, Martha is not okay. She looks like she wants to leave the room. She is shaking her head, her eyes very wide, and she speaks in a small voice. The problem is with the food. It's tasteless and she doesn't like it. But she stays. I was struck by how Anna noticed and asked, all the way from the other end of the table. Not staff, but a client member. Conversations turns back to light chatter. I notice that Julie, Kristen and Tessa say very little. (Powell, Day 1, 16/11/12)

My reactions to dinner on my first day helped me question not only how mealtimes worked, but also raised questions about how the community functioned. For instance, were the clients okay with having their food dished up? I felt uncomfortable at times with staff members dishing up my food for me, as if this was taking away some of my agency. At times I questioned whether staff dishing up food was de-skilling for the clients.

I quickly understood that meal times were challenging occasions for many clients due to difficulties with food and eating in front of others. Therefore I began to watch how the clients managed meal times, whether they helped one another or policed each other, particularly when it came to remaining in the room and eating the full amount of food. Even though I understood that many clients had disordered eating and therefore portion sizes were important, I sometimes struggled with how much I had to eat and wondered if it was helpful having to eat set amounts. I also queried the members' insistence that seating in the dining area was unassigned when most clients had their usual seat they sat in. This was particularly highlighted when newer members joined the TC and the seating pattern shifted. In particular, I began to understand that the clients were very attuned to one another, like Anna with Martha. I noticed that conversations around the table ranged from the intense and serious to joking. Over time I realised that meal times were an opportunity to hear smaller, episodic stories from both staff and clients.

5.1.3 Informal time

During the week, the clients had small blocks of time in between groups for either social or down time. In order to stay both occupied and calm, clients would work on puzzles, crosswords, knitting, colouring books, artwork, music making, emails and social media on their phones/laptops or the TC's client computer, writing letters, etc. There was often paperwork for the clients to complete as part of their therapy and they would frequently sit in the lounge to complete their work. In general, I found that weekends were far quieter with only one evening group meeting each day, leaving most of the day available for informal time. In addition, clients would often take leave at the weekends to visit family and friends, receive visitors to the TC or visit the local area. Others would spend long hours in their rooms or in bed, emerging only for meal times and the end of day meeting. Most people would congregate in the lounge during informal times and the clients' awareness and consideration for one another continued even during unstructured times, as the excerpt below illustrates:

> Erica comes in to the lounge and she does not look okay. She barely smiles when I say hello. Her eyes are downcast, and her face is drawn. She settles down at the table next to Kristen, who is working on her art project, sets down her mug of tea and begins to work on her puzzle. I ask how she is and she says, "fine" very quietly. Hmmm, I don't believe her and wonder why she doesn't give me a real answer.
>
> Then Kristen asks how she is and Erica says, "I'm struggling".
>
> "Me too, I am struggling too", says Kristen nodding. Erica has just had skills coaching as has Kristen. They have skills coaching when they are really struggling - it's just a 15-minute slot to reinforce positive behaviours and/or to avoid negative behaviours.
>
> Erica asks Kristen, "Are you struggling with going home too?"
>
> Kristen, "no something else", but doesn't say what. However, Erica is clearly struggling with going home based on upon how she asked Kristen and the use of the word "too". Erica falls quiet and I notice that her cheeks are flushed and she looks close to tears. She tells Kristen, "I'll walk up to Drama with you if that's alright, Kristen".
>
> "Yeah, that's fine," says Kristen. Erica concentrates on the puzzle but doesn't seem to do much with it. Not long after, they both walk up to Drama. (Powell, Day 14, 11/12/2012)

This interaction highlights the support that clients asked for and received from one another throughout the day. Whilst Erica would not respond honestly to my question of how she was, she did answer Kristen, another client. Kristen then in turn shared that she also was struggling that afternoon but Erica did not press as to why. I wondered if this was because the clients rarely pressed for 'content' details of each other's distress, focusing instead on the 'feelings' of distress. Additionally I questioned whether it had helped them by sharing with one another that they were both 'struggling', as if it helped to know each was not alone with these feelings. Lastly, moments such as these sometimes felt very personal, especially with Erica close to tears, and at times I queried whether the clients ever minded experiencing a therapeutic process in front of others in a TC.

As a residential community, I knew that Powell clients had numerous opportunities to interact with one another over the course of 12-months. They lived together and in a sense, most aspects of client member lives were 'public' in that they were lived out in front of one another for 12-months. Moreover, it was the interactions within Powell that really changed my focus to community rituals rather than individual change. When the participant observation portion of my fieldwork ended with Powell, I wondered how the structure, dynamics, and rituals would be within Hawthorne, a day community. My question at the start of Hawthorne was, would there still be the same rich sense of interaction?

5.2 Hawthorne

My time with Hawthorne began after the TC had just moved buildings. Their old building had sat near the spacious property of the old asylum buildings just outside a city centre. It had been a beautiful sprawling mansion-style house with high ceilings, long and tall windows overlooking a large garden, large community spaces with a pool table, an industrial size kitchen, dining room and library. Though the TC shared the old site with other units within the PD service, the clients had had free access to large amounts of the building and grounds.

Situated on the premises of a large general hospital complex, the new building was home to a range of mental health services including the PD service (where the TC was housed). The PD service occupied one corridor on the first level of a squat two-storey building. Unlike the previous building, the TC now only had one large room. There were no gardens, libraries or any other space for the clients to go other than the TC room. In addition, the community had to dispose of much of their furnishings, games, activities and Christmas decorations during the move and the staff had also seen their own space significantly reduced. The move to the new building was met with frustration, resistance and uncertainty from most within the community. One client member had even submitted a formal complaint to the Trust and another member often remarked that his therapy had been "cut short" by three months due to the upheaval. Staff equally struggled with the new premises with one commenting to me as she pointed at the building, "look at that," and with a wave of her arm, "does that look like a TC?"

It was a time of significant change in the history and narrative of the TC and when I joined the community, I was very aware that this community was still adjusting to its new surroundings. Whilst many of the rituals were similar between Powell and Hawthorne, the feel and environment were at times very different. In addition, because clients and staff went home every day, there was a stop-start style to the structure and feel of the community. Each day felt like it began again. Like Powell, there were opening and closing community meetings with other therapy groups during the day. Lunch, the only mealtime, was eaten together as a community. Whilst the clients were less at risk of self-harm and suicide than some Powell clients, it seemed that the emotions were no less intense. To introduce Hawthorne, I present a morning meeting, smoking break, shopping trip and closing meeting.

5.2.1 Morning Meetings

Hawthorne had morning and afternoon community meetings each day that both clients and staff members attended. Access to each meeting did not have to be negotiated by either staff members or students. Similar to Powell, there was a client member 'chair' that led the meeting. However Hawthorne meetings were both more

structured and varied. Each day had a specific meeting agenda template that the chair would follow. In addition, only client members shared how they were feeling, though both staff and clients would provide client members with feedback where appropriate. Once the group had worked through the agenda, the chair would ask if any clients wanted 'two minutes'. Whilst the 'two-minute' slots were meant to be brief, these were often longer exchanges.

The following is an example of one of these two-minute spaces. Abby shared about a telephone conversation with her mother. For the first time, Abby was able to tell her mother about being sexually abused by the extended family. Her explanation for why she chose to tell her mother was that, "it's not just my dirty little secret, this isn't mine, it wasn't my fault and I shouldn't have to keep it a secret". She further shared that her mother told her that she loved her, the first time Abby has ever heard her say that to her. The group then responded:

> The atmosphere in the room feels shocked and several people raise eyebrows staring at Abby. I wonder if they see this as a positive thing or a negative thing. Someone asks if it was impulsive to tell her mother and Abby says no, that she had wanted to tell her mum for some time because she wants to build trust in her relationships and she knows she needs to start by trusting her family (or in this case her mum). She explains that eventually she wants to have the face-to-face conversations with her mum about it, that yesterday for her, was just the start. Abby says that she could have only done that yesterday, disclose so much and talk it through in Median group, due to the "community holding my hand over the past year".
>
> Stephen (Psychotherapist) says that he feels so pleased for Abby and for the community as a whole for helping Abby with this yesterday. "I feel like applauding you Abby and the community for the work you all did in helping you work through this". He states this was very important and that Abby has travelled as it were some distance in 24-hours, to getting that stuff out to being in a place of telling her mum and now sharing about it again this morning. Abby at this point plucks her glasses off and roughly wipes her eyes with the back of her hand, ducking her head. Lauren stands up to give her tissues and Abby continues to wipe her eyes with her head bowed.
>
> Abby reiterates in a quiet, unsteady voice that she has done the work bit by bit and that she could not have done it without the community and their support over the last year. "I know I get all attacking with it sometimes", she explains with a laugh, but she states that people's feedback to her both yesterday and over the last week has really enabled her to do what she did.

> Kevin then says that “everybody should do what Abby did in Median Group. We've all got stuff we need to talk about”. He states that while he could not relate to the sexual abuse, a lot of the other stuff she shared did touch on things for him that he knows he needs to explore. (Hawthorne, Day 26, 30/07/13)

Of note from the above meeting is how the community at first questioned Abby about her decision to tell her mother about her abuse. They seemed to wait for Abby’s explanation and rationale for sharing with her mother. However I was unsure whether the other clients were convinced by Abby’s explanation because Stephen stepped in to compliment her decision. I questioned whether his comments were patriarchal and perhaps telling the group how they should be feeling about Abby’s decision. Nonetheless, Abby seemed pleased by Stephen’s comments and expressed her belief in the TC.

5.2.2 Smoking Break

At Hawthorne, the smoking area was some distance from the main building. In fact, it was impossible to see the smokers from the inside the building which gave the smoking times a sense of distance and space from the TC. Whilst the staff and client smoking areas were the same, staff never smoked with the clients or came outside with them. Staff later told me this had changed following the building move as staff had previously joined the smokers outside on the old premises.

As a non-smoker, negotiating access to the smoking group required much explanation on my part as to why I wanted to join. In the main, client members seemed accepting of my presence. However they did sometimes comment on what I was observing or question whether I would tell staff what they had said or did. Smoking breaks provided an opportunity to find out what clients really thought of a particular group, event and/or community issue. Outside, clients dropped their ‘company behaviour’ (Fetterman, 2010) and spoke openly with one another. It was also a time to hear and exchange episodic and small narratives.

The following excerpt is of a smoking break that followed a particularly contentious morning meeting. In the meeting the community had discussed crisis texts, a mobile text network for clients to support one another outside of the TC. Clients were meant to send texts to all members, unless they were on leave. However, in this instance, Robert had sent a crisis text to clients the previous night about another client, Jessie, without including her as a recipient. This led to a heated discussion about the use of crisis texts and resulted in an argument between Robert and Jessie, with some members appearing to take sides. Tensions spilled over from the group into the smoking break:

> Evan has already left for a cig break. He sailed out almost immediately after the meeting. Lauren is rolling her cig. Jessie is on her phone. Daniel is making a drink. Abby, who doesn't smoke, gets up and says to Christopher who is next to her, "I'm going outside for some sunshine. Need to fucking get away from you".
>
> Christopher tells her to get out but it didn't seem mean or like a fight was going to break out. His eyes do not flash and his body remains relaxed. I think they both mean their comments though. "Thanks for all the support!" shouts Christopher sarcastically at her retreating back as we troop out.
>
> I walk out with Jessie and begin to ask her about her bus journey. We talk about how it was cool this morning and about catching buses and trains.
>
> We meet up with the others outside and all stand in a circle. There is much joking around between Daniel and Abby. She sends him a text, just him, but she shows us what she sent. She calls him "cheeky" in the text. He jokes that she hasn't included everybody. Evan says they need a crisis meeting because she didn't include everyone. I feel very uncomfortable, aware that Jessie is next to me. I glance at her and other than shifting from foot to foot, she doesn't say or do anything. This feels awfully close to the mark to me. They (Daniel, Evan, and Abby) continue to joke about sending texts, excluding each other, and feeling left out. Lauren says nothing. Neither does Jessie.
>
> We start to walk back in and Lauren and Jessie start walking fast, ahead of the rest of us, their heads together, talking. "Shit!'" says Daniel. "I hope Jessie doesn't think we were making fun of her".
>
> Evan and Abby then query this and as we continue to walk, Evan says, "Well hopefully she knows we were just blowing off steam, our way of dealing with a tense situation" (but how would she know this unless they told her?). (Hawthorne, Day 17, 11/07/2013)

Gossiping about other client and/or staff members during the smoking break was very common. Evan's explanation of the smoking breaks as "blowing off steam" made me wonder if this was part the purpose of smoking breaks for the clients. However I was surprised by jokes related to the crisis texts and wondered about the impact this may have had on Jessie. I also noticed that this exchange was not raised during a community meeting and I questioned whether what happens outside is ever discussed as a whole community. As these breaks appeared to provide a unique opportunity for interaction that was physically removed from the TC, I questioned whether by not going outside, one would miss out on an aspect of TC life. Moreover, this interaction was unique in that it involved the clients only. It was therefore a chance to see how the clients interacted with no intervention from staff members. Nonetheless, I did also query why the staff did not go outside with the clients and if the smoking breaks were somehow reserved or protected time for the clients.

5.2.3 Shopping Trip

Hawthorne had a weekly shopping trip led by the clients to get food for the community. During a community meeting, it was agreed that one member of staff would join the shopping group. In addition, Hawthorne clients were divided into work groups of 2-4 members to cover duties such as shopping, cooking and cleaning. Groups rotated each week and clients stayed in their respective groups for their duration in the TC. Therefore each week a different group of 2-4 members shopped with a member of staff at the local supermarket. As with all other aspects of community life, the shopping trips were seen by the TC as an opportunity to build life skills through daily living. The actual experience of food shopping varied and sometimes included interactions that broke down into arguments.

Below is an excerpt from a shopping trip at Hawthorne before it was agreed that a member of staff would attend these outings. Three client members, Heather, Daniel and Carl, and I attended:

> We get in to the shop, grab a shopping cart and Daniel asks Carl to keep a tally on his mobile phone of the costs. They pull out the list and all three immediately start arguing about where to begin. Whilst they had carefully planned the meals and all the ingredients they need before setting out, Heather insists that they change around the days

> they do meals and also what they need. Her voice is very high pitched, loud and breathless. Daniel suddenly stands directly in front of her and tells her to calm down, take deep breaths whilst he demonstrates by inhaling and exhaling slowly and steadily. She nods swiftly and then sails off to look at something. Daniel rolls his eyes.
>
> Then an argument starts with the vegetables and gets more pronounced in the deli-meat section. The problem is that Carl wants to buy the cheapest of everything. Daniel refuses saying that “they won't eat it!!”
>
> Section after section they argue. Everything from whether to get eggs (“We have a load of eggs” Daniel and Carl practically shout. “Yeah! But they are all getting used today, aren't they?!” retorts Heather in an equally loud voice) to what type of bread, what type of pineapple slices, whether milk is really needed, etc. The arguments continue about cheapest versus quality.
>
> The last big argument is over sausages. Heather wants to get veggie sausages to have on hand because often a non-meat option is not available for her (a vegetarian). But it's not on the list, as both Carl and Daniel tell her. Plus it would look like she got something just for her. So she suggests getting meat sausages as well. But it's not on the list. This goes on for about five minutes, all three of them speaking in raised voices.
>
> Then Carl mutters to me about how he “fuckin' ain't doing this again” meaning the shopping and that he is really irritated about getting something not on the list.
>
> When we are finished paying, we head out the doors and there is yet another argument about whether to hand carry the bags to the car or return the cart in the car park. Daniel who is pushing the cart opts for the latter. (Hawthorne, Day 2, 21/05/2013)

During fieldwork, I was particularly curious about how disagreements in the community were addressed in the moment and then interpreted by others in the community. In this case, I watched how three clients would come together, argue, break apart but come back together again. Despite the negative emotions, they did continue to work with one another. Once we returned to the community, the shopping trip was discussed during the Afternoon Meeting and members were able to express what they found stressful or difficult. Various staff and client members provided feedback as to how it could have been handled differently. This shopping trip, which was on the second day of my time with Hawthorne, illustrated that there

was an element of TC life where tensions were allowed to manifest in order to be discussed as a community. Though we were unaccompanied by a member staff on this outing, the TC later agreed to have a member of staff present on future shopping trips. This in turn made me question the times when perhaps the clients used the authority of the staff to contain difficult emotions and help them manage potentially stressful interactions.

5.2.4 Closing Group

Closing Groups, also called Afternoon Groups, had a set structure and agenda like the Morning Meetings. Generally speaking, the meetings were meant to be a recap of the day with no new issues arising for discussion so that no one would go home feeling unsettled. If a client member was struggling, this would be an opportunity for the community to talk through how that client will manage once they leave the TC for the day. As with the Morning Meeting, the Afternoon Group had a client member chair who had the responsibility of adhering to the agenda and ensuring that appropriate items were discussed.

Changes in mood, emotions and atmosphere could happen very quickly in a short space of time. The example below is from a day where the clients went to a local park for their Occupational Therapy (OT) group. Everyone had seemed excited prior to leaving with the prospect of playing football and various other games. As this was a closed group at the time, I did not attend this outing. However I was in attendance when the clients returned and noted that most people seemed upbeat, jovial and in general getting on well together. One client, Carl, felt ill and requested at lunchtime to go home. Leaving early for the day would require a 'Crisis Meeting', which he was unwilling to hold. In addition, it was also the first day of a new client member, Jessie. As the meeting was about to begin, nothing indicated that an eruption was about to happen:

> Just before group, Christopher and Abby are joking around. Both refer to each other as "cunts". The mood in the room is a bit hyper before group, as most people are joking around with each other. It would seem they had fun playing football during OT.

Brian, who is the chair, opens the meeting and immediately hands over to Carl as he is not feeling well and wants to go home. Carl is irritated that he could not leave earlier and says he will stay home tomorrow as he does not want “to get stuck here” if feeling unwell. The corners of his mouth are drawn, his face is very long, with eyes hard and slightly flashing, his jaw set, and his skin slightly pallid. However he will need to stay to the end of the group otherwise there will be a Crisis Meeting.

Then Brian asks Jessie how her first day was. She says it was fine but finds it so hard to eat in front of people she does not know very well. The group are encouraging and explain they do not expect her to be eating with them by the next meal, but as long as she is trying (i.e. try and sit at the table). She nods her head. Abby says that Jessie will not be the only one who struggles with food as others do as well. At this, Carl takes his stocking cap, which is in his hand, outstretches his arm and hits Jessie on the leg with it, saying, “Don't want you thinking you're special”.

At this, Abby immediately says in a loud voice, “No attacking!” Carl says lightly back that he was just jesting, that he was not attacking. Abby says she will come back to it tomorrow but she did have a grimace with her smile when she said that. So is she also joking?

The conversation moves on again with references to OT. There is a suggestion that next time they play rugby. Abby cracks her knuckles and everyone laughs, pointing out that she is looking menacing. But it is light. However I note at this point that the atmosphere feels charged. There is a joke between Abby and Christopher. Christopher mutters, “Save it for the pitch, bitch”.

Leanne (nurse) immediately says, “What did you say?”

“Nothing”, Christopher replies quickly.

“No, what did you say?” Leanne (nurse) insists.

At this Abby says loudly with a smile, “Own it, Christopher!” He then repeats what he actually said. Leanne (nurse) questions what he meant to Abby by this.

Then Carl jumps in with, “You should have been in here earlier! They were dropping the c-word earlier”. This seems to irk Abby as she frowns and narrows her eyes in Carl’s direction.

Abby then gets after Carl for hitting Jessie on the leg with his cap, saying something about aggressive behaviour. Carl denies this and says in a high pitched voice, “You’re just attacking me for being a snitch!” He then repeats it, over and over, shouting, “You’re just attacking me for being a snitch!” maybe 10-15 times.

> Abby then hollers out, “What are you doing? Stop repeating that”.
>
> Other clients and staff call out for him to stop but he continues and finally says, “I’m just stooping to your level. Which is five-years old”. Carl then goes on a rant about Abby and his face transforms, his eyes bulging whilst he shouts. His whole body is rigid and I halfway wonder if he will come out of his chair. He says to her various statements including: “You’ve never liked me, not from day one! You prance around here, no one likes you, you’re a bad influence on everyone!” He also reveals that during OT today, when he knocked her over on the football pitch, he did not want to help her up because he thought, “Stay down, bitch”. Various people start to challenge this, and Abby’s face has dropped, her fists are clenched.
>
> Finally Brian cuts across them all by saying this is not to be discussed in an Afternoon Meeting. Abby starts speaking and he yells, “Respect the chair!!!” I have never heard him raise his voice. Is this part of his role – to draw order, to insist that they respect him as chair? Has this happened before?
>
> Staff and clients want this discussed tomorrow morning but Carl responds to say he is not feeling well and will not coming be back tomorrow. Staff point out to him that, “You are leaving the group with these feelings”.
>
> The group is about to end as we are out of time. Abby cannot believe this is not going to be discussed and accuses Carl of the “perfect hit and run”. With that the group closes and Carl sails out the door without a word or glance to anyone. (Hawthorne, Day 8 11/06/2013)

This group meeting was one of the more argumentative afternoon groups, and it has to be said, most of them were not as explosive. However, this exchange highlights two important issues that did reoccur on a daily basis within the TC. Firstly, the issue of language and swearing was considered problematic by the staff in particular. When clients swore in front of the staff, they would most often swiftly apologise saying, “sorry for my language”. Low tolerance of swearing seemed very unusual to me as language at Powell was often colourful and never checked. The staff explained that the clients needed to learn appropriate places and times to swear. Out of earshot of the staff, the clients frequently swore at each other and the use of the word “cunt” in reference to one another was common.

Secondly and closely related to the swearing was the use of jokes and bantering between the clients. Often the jokes had depreciating connotations attached to them and could be very sexual in nature. Newer members would

sometimes comment that the jokes felt exclusive because only more senior members would banter in this way. This made me wonder if jokes reinforced an unseen social hierarchy and I questioned how newer members were meant to feel included in the TC. The exchange with Carl made me question whether he was perhaps feeling excluded and was trying to communicate his feelings. Like with Powell, I did wonder about the social hierarchies within the community and questioned the level of inclusivity of all members.

Prior to my arrival at Hawthorne, I had queried whether the interactions in the community would still be as in-depth or as rich as they had been at Powell. Despite fewer interactions as a day community compared to a residential TC, I found that the intensity and richness of the interactions were the same at both TCs. What was lacking was seeing how the clients managed during the evenings and weekends. Nonetheless, because a significant portion of the Morning Meeting was devoted to discussing the previous evening or weekend, I still felt there was a good sense of what the main struggles were for clients and how they worked to resolve them. Instead of a 3am Emergency Meetings like at Powell, there would be a Crisis Text that joined all of the clients together remotely. I also felt that whilst there were clear differences between the two TCs, such as the use of swearing, there were many similar issues such as managing negative emotions, arguments and responding to client members' distress.

SUMMARY

This chapter has built an in-depth account of what daily life was like at both Powell and Hawthorne. Both communities had to manage problematic interactions and address difficult behaviours and emotions as part of the therapy. In the main when problems arose, both the staff and the clients worked together to try to deescalate the tensions. The balance between the running of the community and the relational dynamics between members was something members managed on a daily, moment-by-moment, basis. At all times the expectation was that everyone had a responsibility to be honest and open with one another, whilst also refraining from

abusing other members. These boundaries whilst generally clear, did have some grey areas, particularly when it came to jokes and gossiping. Generally, when boundaries were broken, the community worked together to quickly re-establish them. The following four analysis chapters will unpack the specific mechanisms involved in interaction rituals, how the communities managed power and social control and how these social encounters contributed to the process of personal change.

CHAPTER 6. 'WHERE THE ACTION IS': KEY EVERYDAY INTERACTION RITUALS

INTRODUCTION

This chapter is the first of four data analysis chapters. Before embarking on the analysis, a brief overview of the previous chapters will serve to contextualise the direction of data analysis in this thesis. To summarise, Chapter 2 identifies that TCs have not fully explored the role of social interactions outside of structured therapy during a process of personal change. Chapter 3 explains that these social situations are conceptualised as interaction ritual chains. Following Goffman (1967) and Collins (2004), the study of rituals requires that analysis begin with social interactions before examining the individual. Chapter 4 then argues that whilst narrative ethnography does not provide a systematic method of analysis for observational data, the use of IRC theory with ethnographic data can address this gap. In Chapter 5, I illustrate what everyday life was like in each community through a selection of interactions. Here, each social encounter contains a multitude of complexities that require systematic analysis. Thus, in order to explain the role everyday social interactions in the TCs, the use of IRC theory provides a theoretical framework to examine the dynamics of interactions. The analysis chapters therefore explore the mechanisms involved during interaction rituals within Powell and Hawthorne, including the function of rituals (Chapter 7) and the use of power (Chapter 8). Chapter 9 then examines the impact of IRCs with client members, specifically in relation to their understanding of personal change. Overall, the analysis combines what participants said about life in TCs with how they lived it in practice. One aim of the overall analysis is to also demonstrate how 'ordinary' social encounters are anything but. Rather they are full of complex meaning and varying emotions that can contribute to the process of change.

The first analysis chapter explains the mechanisms of everyday interaction rituals (IRs) in order to understand *how*, and to what extent, everyday social interactions facilitate personal transformation. This question focuses the analysis on the social mechanisms involved in producing change, rather than on the individual or the clinical outcomes of change. Additionally, this chapter explores some of the

limitations of IR theory as identified in Chapter 3, including whether individuals have to experience the same emotional response and the role of negative emotions in generating emotional energy (EE).

The analysis begins with interactions as the foundation for exploring the role of everyday interaction rituals in generating personal change. Specifically it addresses the following:

- What are the key interaction rituals within the TCs?
- How is solidarity built and sustained?
- What is the role of negative emotions?

I begin with the classification of everyday social processes into rituals using the IR chain definition developed by Collins (2004). The criteria for establishing 'key' rituals are derived from Goffman's (1967) essay on *Where the Action Is* and Collins's (2004) definition of a successful ritual. Six key rituals are then identified and presented from each community. With the exception of Crisis Texts at Hawthorne, which lacks full physical co-presence, all of the key rituals contain the four main ingredients of IR chains of bodily co-presence, barrier to outsiders, shared attention/mood and entrainment. Chapters 6 to 8 address the four main outcomes of rituals. In this chapter, I specifically focus on solidarity and the role of emotions. Furthermore this chapter lays the foundation for exploring how everyday social interactions worked in practice in the two TCs.

6.1 Key 'Action' Interaction Rituals

Both Goffman and Collins distinguish interaction rituals, which are focused encounters, from those social interactions that are unfocused and lacking in cohesion and solidarity, such as crowds of individuals walking down a busy street. Interaction rituals, in contrast, have shared attention and emotional experience. Moreover, rituals differ from routines. As Payr (2010) clarifies, it is the shared attention and emotions that establishes an interaction as a ritual. Applying Collins's (2004) framework to the data analysis, I filtered the fieldnotes for those encounters that contained the main ingredients of a ritual: physical co-presence, shared attention and

common mood and rhythmic entrainment. Participation in the TC automatically met the fourth requirement of 'barriers to outsiders' as rituals only involved TC members and most occurred on site. I then looked at the four main outcomes of rituals (solidarity, emotional energy, symbols and group norms and values) to distinguish interactions between routine and ritual. Using this criteria, fieldnotes from both TCs generated a list of several distinct community rituals: 57 (Powell) and 45 (Hawthorne)[4]. The two communities share 22 rituals between them.

As in-depth analysis of all identified rituals is beyond the scope of this thesis, it is necessary to define those rituals that are key and significant for data analysis. The selection of key rituals is theoretically informed by both Goffman (1967) and Collins (2004). To reiterate Chapter 3, key rituals are akin to Goffman's (1967:149) definition of 'action' rituals, those rituals that carry elements of chance and risk. Action rituals are significant because they impact upon future rituals. In action rituals, individuals can gain or lose fortunes, build or destroy reputations, power or influence. Moreover, action rituals draw individuals to them for their intensity and strong emotional feelings, even if they are not directly involved in the ritual. Collins (2004) echoes Goffman by asserting that individuals will be attracted to those rituals that give them the highest emotional reward. In other words, individuals are more prone to repeat those rituals that make them feel positive emotional energy (EE).

Applying the definition of action rituals to TCs, action rituals would be those encounters that contain the most opportunities for personal change whilst generating emotional energy and group solidarity. The risk that participants take is the experience of negative EE. However this risk is justified by the possibility of increased feelings of wellbeing leading to positive transformation. Additionally, Chapter 3 identifies that TCs purposefully encourage a culture of positive risk taking in order to maximise the process of social learning (Haigh, 2013). Positive risks are necessary for clients to practice healthier ways of relating. Both Powell and Hawthorne openly embraced an ethos of supported positive risk taking, as clients were encouraged to try new things whilst challenging negative self-beliefs. New things can include cooking, shopping, sharing stories, chairing meetings and talking

[4] A full list is available in Appendix 4.

honestly about the past and suicidal ideation. Key rituals are those interactions that have the potential to generate increased EE.

6.1.1 Selection of Key Rituals

Key interaction rituals were not only theoretically significant but were also important in the life of the TC. To explore the range of rituals in each TC, I first selected those rituals that seemed 'key' to the community using the aforementioned criteria. Six key rituals from each community enabled an in-depth analysis of the TCs' dynamics. Selecting specific rituals came from analysis of all rituals identified through fieldnotes and interviews. During analysis of the fieldnotes, I looked for those rituals that most defined 'action' rituals and specifically related to the process of personal change, rather than those that occurred most often. Using client member interviews, I listened for those non-formal therapy activities that clients at both TCs talked through with me. Importantly, the rituals discussed were initiated by clients and were rarely brought up by me. Identifying key rituals began during preliminary data analysis at Powell whilst fieldwork and interviews were on-going and continued through data collection at Hawthorne during in-depth data analysis. Throughout all stages of data analysis I re-read the data as a whole and frequently changed the list of key rituals before settling on the final combined total of 12. Thus, what distinguishes these rituals as key are those that generate increased EE, produce solidarity, contain the most opportunities for chance and risk, have the potential to facilitate positive change and impact upon the community dynamics as a whole. Following analysis, I noted that the TCs share three rituals, leaving a total of nine distinct rituals for analysis. The key rituals are noted in Table 3 as follows:

Ritual	**Description**	**TC**
Emergency Meetings (EMs)	EMs were held for clients members who were struggling to commit to their safety, had done a 'behaviour' (an incident of self-harm), or needed the support of the TC. One member of staff and/or two clients could call meetings; they lasted as long as necessary and could occur at any time outside of structured groups.	Powell

Social Time	Times spent in between community and therapy groups, individual psychotherapy and Meal Times. This included time spent during the evenings and weekends.	Powell
Crisis Texts	A text network to be used during out of hours for clients. Texts were meant to go out to the entire client group, never the staff. Though texts were meant to be short, they evolved to be quite lengthy, often referred to by the clients as “essays”.	Hawthorne
Reviews	Reviews would occur when there had been a TC boundary break. There were three options to Reviews ranging from: **Two-weeks**: meeting with a mentor on Mondays, Wednesdays and Fridays. **72-hours**: meeting with a mentor for three consecutive TC days. **Three-days**: being placed on a three-day leave from the TC. Upon returning to the community, the client member would have to be voted back in the TC.	Hawthorne
Community Meetings	Meetings were held twice daily in the community: once first thing in the morning and once in the afternoon before clients went home for the day. The purpose was to provide an opportunity for clients to speak about how they were and to address any administrative issues in the community.	Hawthorne
Smoking Breaks	At both TCs, Smoking Breaks occurred in designated areas. Both smokers and non-smokers would participate in the Smoking Breaks.	Both
Meal Times	The ritual of Meal Times would usually involve lunch and dinner at Powell and just lunch at Hawthorne. Though the actual process of eating was itself a ritual, Meal Times also included sub-rituals such as queuing for food, selecting a seat, discussion during the Meal Times and what to do with unfinished food.	Both
Endings	The ritual to mark a community member's leaving. At Powell this process was spread over several weeks and involved several sub-rituals including leaving books, individual ending meetings, community outings, and gifts. For Hawthorne the preparations for Endings would take place several weeks in advance and would culminate on a member's last day. Like Powell, it involved several sub-rituals including the blackboard, leaving gifts, photographs and the horseshoe.	Both
Distress Management	*To help a client stay ‘grounded’ if she was struggling with disassociation or disconnecting to focus on physical senses found in the present moment (i.e. the sensation of cold or a distinct scent). This was a Dialectical Behavioural Therapy (DBT) tool that took the form of 'ice' and 'smells'.* ***Ice packs:*** *hand held blue packs.* ***Smells****: various scented sprays. In addition, clients used scented oils provided both by Powell and by personal clients, and on rare occasions, smelling salts.*	*Powell*

Table 3: Key TC Rituals

These nine rituals represent significant social occasions in the life of the respective communities that presented an opportunity for social change and also

strongly reflect the feel and dynamics of the community. All key rituals have the potential to generate varying and strong emotions, they highlight the insiders and the outsiders, and they produce symbols that members in the community could invoke and rally behind. Distress Management (Powell) is singled out in the table because it is a unique action ritual in relation to the others. An example of this ritual was when a client member had disconnected or disassociated. During these states, she struggled to remain focused with the group because she may have been 'frozen' and unable to move or speak, was having a 'flashback' or regressed into a younger self. As will be discussed later on, the group's focus of attention and entrainment were established during the ritual of distress management, and the aim of the ritual was to re-establish connection with the struggling client member. Unlike the other eight rituals, distress management at Powell was a ritual necessary to sustain emotional energy and solidarity of all community rituals. It is also the only explicit therapeutic tool.

Crucially, these key rituals were 'ordinary' in the sense that they occurred on a regular, if not daily, basis. What distinguishes these rituals from mundane is their fatefulness, the fact that they are both 'problematic' and 'consequential' (Goffman, 1967:164). For Goffman, fateful moments are those encounters that are charged with complex meaning and impact upon future social interactions. Far from being straightforward interactions, key rituals were ones that presented challenges for the community to manage, such as risk in terms of threats of violence, issues of power and offered opportunities for personal change. For instance, in describing what she liked about Smoking Breaks, Amy from Powell explained:

> [I]t can be a natural conversation where they say something and you think that could help you with that. And that makes a big difference. You know since I've started to go outside with the smokers, I'm smoking myself again, um, I've had some more meaningful conversations.

Moreover, TC members' actions during these everyday rituals not only impacted upon the specific participants, but upon the community dynamics as a whole.

Having identified the IRs of the community and selected the key rituals, the next step in the analysis is to examine how the rituals operate in the TCs. To address this question I explore the rituals in regards to two ritual outcomes: solidarity

and the role of emotions. Emotional entrainment and standards of morality will be explored in Chapters 7 and 8, respectively.

6.2 Solidarity

To begin the analysis of the TCs' key rituals, I start with the ritual outcome of solidarity. As Chapter 3 explains, solidarity is particularly important in TCs as it has links with belonging and a positive sense of attachment. Haigh (2013) and Castillo et al. (2013) suggest that this is the first, and significant, step of in the process of positive change. In order to analyse how this worked in the TCs, I firstly question whether solidarity is the result of TC rituals or pre-existing bonds or the TCs' structures. Secondly I explore the link between solidarity and inclusion. Lastly, I look at instances where there is a lack of solidarity.

Heider and Warner (2010) argue that in order for solidarity to be an outcome of IRs, then solidarity cannot have existed prior to the ritual; it has to be generated through the ritual as a new phenomenon. Client members at both TCs did not have solidarity prior to joining their respective communities. As noted in Chapter 2, individuals with a diagnosis of PD and BPD often experience stigma and isolation from their social networks and struggle to build healthy relational attachments, such as social solidarity, with others (Ramon et al., 2001). Clients entered the TCs with varying experiences of mental health services, differing family and social backgrounds and contrary religious, cultural, political and social values. The client groups displayed significant variations in age, educational background, marital status, sexual orientation and family situations. There were also variations in access to financial resources, although most of the clients lived well below the average UK income and were in receipt of some form of social benefit. Additionally, clients had never encountered each other prior to being in the community. The only common link between them was their diagnosis. Yet causes and experiences of PD and BPD differ significantly (Stalker et al., 2005). Moreover, many of the clients expressed confusion and uncertainty regarding their diagnosis, what the diagnosis meant and how it differed from other diagnoses such as bipolar and psychosis. Some client members were relieved to have a diagnosis whilst others stated they felt stigmatised

and judged. Their comments perhaps reflect some of the difficulties with a diagnostic approach to characteristics of mental health, especially in terms of homogeneity in clients with the same diagnosis (Kinderman et al., 2013; Pilgrim and Bentall, 1999). In short, as client groups they lacked solidarity based on their diagnosis alone. Thus, any solidarity created through rituals was the result of participation in the TCs with neither community in itself expressing pre-existing bonds (Heider and Warner, 2010).

If the clients did not have solidarity prior to joining the community, the next question is whether the community structure itself provided solidarity. For example, some rituals, such as community Endings had their own history within the respective TCs. Therefore there may be an expectation that certain community rituals will foster a sense of peer support and belonging over time because it has been successful in the past at generating community cohesion. Conversely, staff, and some client members, explained that at times Smoking Breaks were problematic for causing division such as cliques. It is tempting to take solidarity for granted in certain rituals and assume it breaks down in others. However such an assessment is too simplistic. I observed that each new person who joined the TC altered the emotional dynamic of the group. Over time, as newer members continued to join and senior members moved on, the community structure and dynamics changed. What may have joined one group together may have proven divisive in another. For instance, when Jessie, who struggled with eating, joined Hawthorne, Meal Times suddenly became much more problematic and challenging for all within the community as she refused to eat lunch from her first day. After that, eating habits were then discussed during most Meal Times and Community Meetings. Therefore the community structure in itself also did not provide pre-existing feelings of solidarity. To understand how solidarity was generated, I explore the relationship between solidarity and inclusion.

6.2.1 Solidarity and Inclusion

When analysing solidarity in the data, I looked closely at those moments when the clients either reported feeling cohesion, or it was clear that the communities seemed to function with a felt sense of emotional connectedness. I soon found that feelings of solidarity in the TCs were closely linked with a feeling of being included. At Powell

for example, two clients, Tessa and Erica, saw Emergency Meetings (EMs) as particularly inclusive for newer members:

> Talk then moves to Emergency Meetings (EMs) […]Tessa states that EM's are a really good way to feel included in the community. They explain that when you are new, being part of an EM and helping someone through a crisis can really make you feel part of the TC. I would also agree with this. My first EM felt quite significant in this sense and every EM I have observed always feels like it does go some way in strengthening my connection to the community, even though I am not directly involved in the discussions. It must feel even more so when you are the one asking the questions of the struggling client, suggesting solutions and talking about your own feelings in relation to it all. (Powell, Day 31, 29/01/13)

As noted above, EMs were ad-hoc groups for members who had self-harmed, were feeling distressed or struggling to commit to their safety. EMs would only occur between Community Meetings, Meal Times and therapy groups, and attendance was required by all. When an EM was called, everyone had to stop what they were doing and gather together to assist the client member who was struggling. Usually EMs would occur in the lounge but if the client member could not get to the lounge then the entire community would go to her. There was no time limit on an EM and it was not uncommon to have meetings that would go well beyond 1-hour. In order to help, client members would frequently describe their own struggles, explain how they were feeling and offer their own suggestions for how to help a client member feel safe. These meetings required that clients give not only their time, but also their personal experience and their own positive solutions to often intense feelings of despair, anxiety, shame and fear. Whilst staff did intervene and offered their own perspective and ideas, the clients chaired the meeting and kept records of the conversations.

During analysis, I noted that the above excerpt was juxtaposed with examples from the fieldnotes about how EMs were emotionally draining and sometimes dreaded by both staff and clients. Initially, I could not establish why EMs would be a ritual of solidarity when they appeared to tax individuals and interrupted their activities. Upon reflection, I realised that my feelings of connection to the community occurred even as an observer and that this sense of belonging overrode my physical tiredness and emotional exhaustion. Subsequent EMs only further established my sense of connection with the TC to the point where I felt I had ‘missed out’ on

something if one occurred whilst I was back in Nottingham. As Tessa and Erica explained, it seemed that EMs helped members feel a sense of belonging in the community despite the sense of dread at the start of most meetings. Summers-Effler (2010:118-120) writes that group values and the 'emotional ideology' of a community cannot be taught; rather they have to be lived as they are '*embodied'*, not 'discursive'. EMs were thus a way that new members could become part of the emotional history of the community. Despite feeling emotionally drained immediately after a meeting, EMs generated feelings of belonging that superseded negative emotions and as such, it was this feeling of connection that produced positive EE.

Of course experiencing feelings of connection were not necessarily associated with positive emotions or even a positive sense of belonging. Likewise, sometimes it was not helping someone else that produced inclusion but rather the recognition of oneself in another client. During an interview with Anna from Powell, she explained her reaction during her first EM for a client member who had poured boiling water over herself and was refusing to commit to her safety or receive help from the community:

> And then we sit in a meeting and we're asking her all these questions and like, I don't know, I kind of wanted to say just leave her the fuck alone, she can't think straight. Like what you doing? You're asking people these really important questions when they're clearly not in a place where they can answer it. And I don't know, there's something really about it, struck me as quite cruel in a way. Um, but within 10 minutes, she was sat in the bay of the window with her headphones on, still upset but contained and able to be safe. And I just thought, God, this is really weird. Because all through the meeting I was just thinking, what the hell? And then you're like oh, I don't really get it but it does seem to work somehow. Um, and that was really strange, but I think it was watching somebody struggle was the, I really connected with [her] um right from the off. And I think it was that sense of nobody can help me. I think that's what I got from her, the fact that…she couldn't imagine there would be anyway that anybody could ever help her. And it was her job to do it alone, which is kind of how I feel.

In the interview Anna described feeling almost disturbed as a newcomer by the way the community handled the EM. In the beginning of the excerpt, she was on the outside looking in as she watched the ritual unfold. The ritual seemed to feel strange, foreign and incongruent for someone who had just self-harmed and was in distress. Moreover, Anna lacked feelings of connection and solidarity with others as

she stated that she had “to do it alone”. However, despite the meeting feeling unusual and inappropriate, by the end of it, Anna connected to the client and recognised the similarities between the two of them. She moved from outsider to insider not through helping someone else, but by connecting with the client through reflecting on her own her feelings and behaviours and finding common ground. Anna went on to discuss how this moment was helpful for her in realising that she was not alone, that not only was the community available to help but so too were some of her friends. Her feelings of solidarity extended beyond the community as she felt a different connection to her social network outside of the TC.

6.2.2. Lack of Solidarity

Nonetheless, key rituals could also generate a lack of solidarity. Meal Times at both TCs could be difficult due to clients’ struggles with food, eating and body image. The following excerpt from Hawthorne shows the difficulty in achieving shared attention and emotion, solidarity and entrainment:

> At my table are Christopher, Abby, Brian and Robert. Jessie will not eat but sits at the other table looking down with her bottle of soda in front of her. The clients try to get her to eat but she says she “isn't hungry”.
>
> Robert asks where the staff are and Abby says that they only eat with the clients on a Monday and Friday. However both Christopher and Brian clarify that they often eat their lunch with them anyway, even if they don't eat the same food. Robert makes a comment about the staff both skirting away from being with the clients and being down on numbers. Evan, overhearing from the other table, calls out that only three people will be in tomorrow. Was this to reinforce Robert’s comment or somehow defend the staff not eating with the clients?
>
> Conversation is quiet. They are not even talking with each other. Why not? They are not usually so withdrawn or subdued. (Hawthorne, Day 12, 27/06/13)

At Hawthorne, when more new clients joined the TC, the lunchroom table was split into two to make more room. I often wondered whether two tables, whereby some had their backs to others, worked against generating solidarity. The lack of solidarity is seen with Jessie refusing to eat and focusing not on the clients or any

topic of conversation, but at the table and her soda. A division occurred between the absent staff and the clients with Robert highlighting their lack of presence, both at lunch and at work through holidays and sick leave. His unspoken implication was that the staff were not putting the clients or the community first. Evan reinforced this dynamic by pointing out that 'only' three staff members would be in the next day, the minimum number of staff to run the programme. Perhaps the lack of solidarity was linked to the lack of staff member presence. However, contrast the excerpt above with the one that followed a couple days later:

> The conversation and feel of the TC room feels a bit livelier today. As I head in I notice three things: one all the clients are in there (staff are still in their office); two, with the exception of Jessie, everyone is in the dining/kitchen area of the room; three, they are all talking. I plunk down at the table with Evan and Daniel. The two student nurses sit by themselves on the other table, not talking much. Abby is at the computer but she is swivelled around in her chair to chat. Christopher and Brian are cooking. Daniel is hanging out just behind them. Just after I sit down, Jessie comes over and sits in between Evan and me. She is also flipping through a catalogue and I see it is the local college course catalogue. The conversation is about what kind of courses you can take. Of particular interest seems to be the course 'intimate waxing' and this spurns on quite a few comments and jokes about men's/women's intimate areas and pubic hairs. I don't know if they would have talked this way with actual members of staff there.
>
> […] During lunch I notice that the conversation seems to flow pretty easily between and on the two tables and I don't get the sense of it feeling like two separate tables. It seems much more fluid and together. I wonder what the difference is. (Hawthorne, Day 14, 01/07/13)

Unlike Day 12, the mealtime on Day 14 seemed to generate solidarity between staff and clients despite the arrangement of two tables. Upon walking in to the TC room, I noted immediately that all of the clients were interacting with one another without the help of the staff. The focus of attention at the start of lunch was the college course catalogue, followed swiftly by jokes. Only the student nurses seemed out of synch with this interaction, which was further highlighted when one of them, a practicing Muslim, could not eat the chorizo pork sausages the clients had cooked. The clients' neglect to prepare an alternate meal perhaps reflected their unwillingness to fully include the student nurses in this ritual. Moreover, the clients did not seem to count either the student nurses or me as 'real' members of staff as

they hardly ever checked their language or topic of conversation around us as they did with other staff members. Secondly, when the staff did come down for lunch, they stepped into the pre-existing rhythm of conversation and emotions in that the topics of conversation remained light and easy. Thirdly, despite having had to split the lunchroom table into two to accommodate new client members and the students (including me), the dynamics during Day 14 superseded the physical divide as the community conversed as one.

So what were the main differences between lunch during Day 12 and Day 14? In my notes, I speculated that the example from Day 14 could be because there were more staff members present, including two who had returned from leave. It was also possible that because it was a Monday, the clients knew the staff would be joining them (unlike Day 12 which was a Thursday). However the biggest difference was most likely what occurred before lunch on both days. Day 12 saw the return of Carl following his verbal attack on Abby (depicted in Chapter 5) and it was a very difficult Morning Meeting that ended with Carl leaving the community prematurely. Moreover it was a senior member's second to last day. That, combined with fewer members of staff, a changing client member population and a general uneasiness from the morning that carried over into the day, it was perhaps no surprise that lunch was subdued. In contrast, by Day 14 it seemed that the client members were ready to move on following the events of the week prior. Whilst it was still a challenging Morning Meeting as the staff directly asked the clients to reflect upon their contribution to Carl's leaving, there had been a higher level of solidarity in that meeting that carried over into lunch. Equally, it could be that because the clients had effectively excluded another member, they were reinforcing their own security in terms of who was in and who was out. In other words, exercising their group power produced a level of solidarity. Either way, this suggests that as with Hallett's (2003) research, not only are the ritual indigents important for establishing solidarity, but so too is the residue that remains from the preceding rituals. Ritual residues will be further explored in Chapter 7 and power will be discussed in Chapter 8.

All of the key rituals had the potential to generate feelings of solidarity and belonging. However I observed through watching new members, and experienced myself, that joining a TC and participating in these rituals would not automatically

translate into a sense of belonging, or a feeling that one is a part of the group. Jessie from Hawthorne reflected this process in her interview:

> Plus everyone has had however long they've had to get to know everyone else. […] You feel like going up and saying, hi I'm Jessie, can we be friends?

Thus, upon joining the TC, it took time to feel that one belonged to the community. Rituals such as EMs at Powell were seen by the clients as a way of establishing solidarity and finding common ground. Additionally, rituals such as Meal Times highlights that it is possible to lack solidarity one day and then generate it on another. An awareness of what occurred either side of the ritual is therefore important in understanding how solidarity is achieved. Building a sense of solidarity is essential for TCs as it leads to feelings of trust and security in the community (Haigh, 2013; Castillo et al., 2013; Genders and Player, 2004; Campling, 2001).

That solidarity can produce feelings of belonging and safety in the communities means that solidarity is closely linked with the role of emotions. However, not all of the rituals generated positive emotional feeling, as seen with Anna and EMs. Many of the rituals in both Powell and Hawthorne produced strong and often negative emotions. The section that follows questions how negative emotions fostered a sense of belonging in the communities.

6.3 The Role of Emotions

During his interview, Brian from Hawthorne reflected:

> I've seen a lot of arguments (slight laugh) in my time here. A *lot* of arguments. People walking out, people almost like come to fist fights, throwing stuff, yeah, I've seen that a lot.

As his comment illustrates, social situations in the TCs could provoke strong, and often, negative emotional responses. The role of negative emotions is crucial within TCs. TCs perhaps differ from other social groups in that negative emotions have an explicit role in the community. They are the link between unhelpful experiences in the past and unhelpful patterns of relating in the present. As Matthew, clinical psychologist at Powell explained, "When you start working on the past, it starts

uncannily to play out in the present in the community". This interplay between past and present then formed part of the group therapy. As such, negative emotions were encouraged to surface and play out during interactions so that they could be explored as a community. For instance the following excerpt of a Smoking Break just before an End of Day meeting at Powell highlights how interactions in the present could trigger painful memories from the past:

> Outside, Martha has her small bag that she uses for food shopping. It is all bunched up, with a portion of it tucked into her trouser waistband and the rest of it sticking out. Amy makes a comment that it is really inappropriate. Martha positions it over her groin to make it look like an erect penis. There is much laughter and Amy tells her to "put it away". (Powell, Day 44, 26/02/13)

Back inside the unit during the End of Day meeting following this Smoking Break, Amy displayed signs of shame as she hid behind hands when it was her turn to speak. After much coaxing, she shared from behind her hands how upset she had been by the joke as Martha's movements and the bag looking like an erect penis had reminded her of the man who had sexually abused her. Martha apologised, at which point Amy said she had nothing to apologise for as she was not to know, and the community helped Amy manage the painful feelings she was experiencing.

Feelings of anger, fear or shame that arose in the TCs were linked back to patterns of negative emotions in earlier relationships in childhood and adolescence. However, as Chapter 3 discusses, successful rituals are meant to generate positive emotional feeling. How then does IRC theory work in environments such as TCs that generate negative emotions? Additionally, do all members need to feel *the same* emotional response? Lastly, if tensions, anxieties and outbursts were common in the communities, how did rituals work to produce feelings of solidarity? This section will therefore explore how IRC theory translates to TCs in relation to the role of emotions and question whether individuals need to share the same emotional response. It will additionally examine how negative emotional energy can produce positive feelings of solidarity.

6.3.1. Translating IRC theory to TCs: the role of emotions

To briefly summarise the role of emotions in IRC theory as outlined in Chapter 3, emotions play one of the most central roles within rituals (Collins, 2004). Along with shared attention, Collins (2004, 2014) hypothesis that members share a common mood (positive or negative) that in turn produces individual emotional energy (EE), which is akin to Durkheim's (1912/2001) 'collective effervescence'. For Collins (2004:9), EE is pleasurable and 'highly rewarding'. Moreover, one of the main tenants of Collins's (2004) argument is that individuals will be drawn to those rituals that produce the highest levels of EE, such as feelings of euphoria, enthusiasm, and general wellbeing. Collins (2004) does distinguish between emotions such as shame and anger that are transient, and emotions that are sustained over time as emotional energy (EE). Successful rituals will result in positive EE, such as confidence and enthusiasm, whereas failed rituals will leave individuals feeling negative, flat or depressed (Collins, 2004, 2014). Thus a failed ritual is one where individuals do not feel a sense of belonging, where they are isolated and excluded. As an example, the Start of Day meeting at Powell depicted in Chapter 5 highlights a failed ritual. The flow of the meeting produced anger and anxiety in Kristen which in turn was fed back to the collective group, raising the anxieties of others in the room and resulting in the meeting's abrupt end. However this raises the question, if most of the interactions in the TC potentially produced strong negative emotions, why did most interactions not end in failure? I therefore argue that a key oversight of IRC in a mental health setting is that it oversimplifies the role of negative emotional responses.

In order to explore the role of negative emotions in TCs, I draw on the ritual of Reviews at Hawthorne. Reviews were used whenever a client broke a community boundary, a list of community rules that included things such as refraining from self-harm, adhering to the alcohol ban (three months for all new members), abstaining from drugs, only taking prescription drugs as prescribed, phoning in absences, and treating all members with respect. Depending upon the severity of the boundary break, how many boundaries had been broken, whether this was a pattern and/or whether the client was already on Review would determine the type of Review the client received: two-weeks (to be done three times a week), 72-hours (to be done every day for three-days) or three-days (time-out from the TC). During a Morning Meeting, clients appointed a client member 'mentor' who would assist the Review

client in the process. It was the Review client's responsibility to seek out the mentor in order to "do the Review". Doing a Review involved working through a set template with the mentor jotting down the Review client's responses to questions such as what led to the behaviour and what could be put in place if feeling vulnerable in future.

Going on Review would often provoke strong emotional responses, along with how the Reviews were managed. Staff members were clear that the process of Review was not a punishment but a system of support. Clients however varied in their opinion as to whether the Reviews were supportive or punitive. Both staff and client members could recommend that a client go on Review. Whilst Powell had a similar process called a Behaviour Analysis, a one-tier exercise that required members reflect on their negative behaviour and applied to both staff and clients, at Hawthorne only clients would be put on Review.

The example below highlights the response of two clients over the issue of "backdating" a Review, or conducting a Review on an off day:

> Jessie is already on 2-week Review but missed yesterday. Apparently so did Christopher. Both want to backdate their Reviews and do it today so that their Reviews do not get extended. Courtney (nurse) says "okay" at which point Abby protests, "What?! Seriously!!" in a loud voice and her jaw drops, eyes narrow. She was not allowed to do the same thing a few weeks ago so she is angry.
>
> Then it is agreed no one can backdate their Reviews, and then Christopher is angry, shaking his head and speaking loudly about not being supported by the community. Jessie however nods and does not complain.
>
> The meeting finishes and I wait to go outside with the smokers. Christopher immediately starts to complain about the process of Reviews and Abby snaps back at him, saying, "It's your responsibility to make sure you get it done!"
>
> "'What, so I miss a few days, the community thinks I need extra support but *I* have to seek out the support?!" he replies in a raised voice. "Fuck it, I ain't doing it", he adds. Christopher is mad because he says he genuinely got his days confused, thought yesterday was Tuesday and that today he would do his Review. Abby shakes her head saying she wasn't allowed to backdate when her mentor was off and she had to leave early so why should he allowed to. Christopher replies that the Reviews are meant to be supportive but they are "punitive". […] When we return inside from the Smoking Break, Christopher is still clearly

unhappy but is chatting with the others. (Hawthorne, Day 17, 11/07/13)

Though Christopher is critical of the Review process by calling it “punitive”, it is unclear whether he is angry at having to do the Review or the confusion and inconsistency surrounding how they are administrated within the TC. However, Reviews were not always met with heated resistance and sometimes clients, such as Megan, voluntarily shared boundary breaks in order to be placed on Review. Therefore, perhaps it was not so much the Reviews that caused negative feelings, as it was how the staff and clients managed them. The emotional dynamics of the Morning Meeting and the break time that immediately followed were dominated by feelings of anger, demonstrated by the clipped responses between Abby and Christopher.

However, I would disagree with Collins (2004, 2014) that transient negative emotions, such as anger and fear, will always lead to feelings of confidence and enthusiasm, or positive EE following the interaction. The interaction above does not suggest that Abby or Christopher walked away feeling ‘positive’ following the disagreement about Reviews. How then do negative transient emotions generate positive EE? The key may lie in Collins’s (2014:300) suggestion that failed rituals leave participants feeling ‘alienated’. Certainly, feeling punished can lead to feelings of alienation and separation from the group. But Christopher did not display signs of exclusion. On the contrary, he continued to argue with Abby and let the room at large know he was unhappy. His behaviour suggests that whilst he was unhappy with the group, he still saw himself as a fully functioning group member. Disagreements between community members can still occur in successful rituals if group solidarity remains intact. Though Christopher was angry, he did make his perspective known and did not alienate himself from the group. Entrainment, the process by which members become rhythmically in-synch with one another, can occur in arguments just as it does during periods of laughter and relaxation. Here the emotional response of anger worked to remind Christopher (and the others) of community norms and value, in particular that Reviews could not be backdated. Rather than electing to separate from the community by withdrawing, Christopher shared his attention and emotional response with the group.

Moreover, I would challenge Collins (2004) that participants need to experience the same emotional response. Whilst Abby and Christopher both experience anger, Abby's anger is satisfactory whereas Christopher is left feeling unsatisfied by the interaction. Both responses, though similar, are not the same and they do not mutually share the same feeling. Additionally, there is no indication that Jessie was angry about the decision even though it also impacted her. Therefore, as noted in Chapter 1, Heider and Warner's (2010) assertion that participants need only to experience an emotional response of *some* sort seems justified.

6.3.2 Transforming Negative Emotions into Positive EE

As the example above with Christopher highlights, maintaining solidarity is important in the presence of negative emotions. It is through solidarity that negative emotions can be transformed into positive EE. To explore this further, consider the following from Powell:

> It is nearly 9pm and I join some of the clients in the lounge. Julie, who is sitting with Anna on the sofa, is sobbing. Julie is explaining that she wants to leave the unit but her mum will not come get her. Erica is colouring but clearly listening to the conversation. I feel strange just staring so I whip out a magazine, open it and alternate between looking down at it and watching Julie and Anna. Julie says that the only time her mum really seemed "bothered" about her is when she jumped off the roof. For the first time I am very concerned. Will Julie try something drastic to prove to her mother that she should be worried about her? Erica asks Julie about her urges and Julie says she does not feel safe and that is why she is in the lounge. Margaret (nurse) then comes in and joins the conversation. Talk revolves around Julie's eating disorder. Anna at times pats Julie's leg, and tells her she will get to the point where she can picture life without the disorder. She reminds Julie that the eating disorder is not her friend and does not help or protect her - it will kill her. Julie is crying and loudly sniffing. After a while the conversation moves on but every now and again someone will either gently pat Julie's shoulder or quickly check in with her. (Powell, Day 20, 04/01/2013)

Certainly Julie was upset, but what she said also provoked anxiety in both Erica and me, and Erica asked about her self-harm urges. However everyone stayed in the lounge, including Anna and Erica, who could have left Julie to talk with Margaret. Equally Julie could also have retreated to her room. That everyone remained indicates the receipt of something positive from this interaction. Crucially then, it

seems individuals will tolerate negative transient emotions if over time they receive positive 'payoffs' from the interaction (Turner and Stets, 2005:74). This is akin to Collins's (2014) assertion that negative transient emotions can still generate positive EE if members come away with feelings of belonging. Not only did Julie receive support and feelings of inclusivity from the group, but so too did those who remained in the lounge by giving their support. Moreover, the expression of negative emotions was often a motivator for community members to draw *together* rather than to isolate. The same happened with Christopher, above, as he chose to stay in the community room to voice his frustrations. Thus both conversations of support and disagreements between community members can occur in successful rituals if group solidarity remains intact.

Chapter 3 argues that Collins' analysis of emotions in ritual theory is limited, as it does not fully consider negative emotions. Data from both Powell and Hawthorne suggests that rather than positive EE generating feelings of '*enthusiasm'*, it may be more helpful to suggest that positive EE is the feeling of *belonging*. This in turn may eventually lead to feelings of confidence in both the group and one's role in the group. The distinction is important because it expands EE to include negative emotions and provides an explanation as to why rituals with negative emotions are repeated. However negative emotions, just like positive emotions, must be accompanied by feelings of inclusivity in order to generate solidarity. It is this feeling of belonging and strength, rather than the feeling of enthusiasm, that attracts participants and leads to ritual repetition. Collins is therefore correct, in that successful rituals are internalised and that individuals are motivated to repeat these rituals, but rather than enthusiasm as Collins suggests, it is the feeling of belonging that individuals are recreating. Moreover, negative emotions could generate solidarity if members continued to share their attention and emotional responses with the group. If a member withdrew, the communities would often work to restore the cohesive feeling amongst members.

Belonging and solidarity are therefore crucial for transforming negative emotions into positive EE. Matthew, clinical psychologist at Powell, explained:

> Because if we're talking about abuse memories full of shame, then part of the um treatment for shame is actually being accepted by a group and being able to appreciate and notice, and take in that that's the case.

In successful rituals, TCs absorb the negative EE and, through solidarity, translate these feelings into positive EE of belonging and inclusivity. As Matthew says, acceptance, which includes solidarity with others, forms a part of the "treatment" within TCs. That acceptance occurs *through* negative emotions suggests that negative EE plays a significant role during the process of change. Moreover, it is significant that these instances occurred in everyday moments outside of structured therapy.

SUMMARY

This first stage of data analysis defined the key rituals of both Powell and Hawthorne and examined the ritual outcomes of solidarity and emotional energy. Although the two TCs produced a combined total of 102 distinct IRs, 12 rituals were identified as 'key' for in-depth data analysis. Key rituals in this thesis are theoretically linked to Goffman's (1967) notion of action rituals, which are interactions that contain elements of risk, chance, and in this study, opportunities for change. Identification of key rituals led to an analysis of solidarity and the role of negative emotions in the TCs. Solidarity in particular is central to establishing a ritual's success and generating feelings of belonging amongst community members. In relation to negative emotions, I argue Collins's (2004) stress on 'enthusiasm' may be overstated, as some rituals do not lead to feeling strong positive emotions. However, negative emotions will be tolerated and may be transformed into more positive emotions if solidarity is maintained. Chapter 7 will now explore how rituals operate together across time and question the function of the key interaction rituals in the TCs.

CHAPTER 7. RITUAL ENTRAINMENT, SYMBOLS AND FUNCTIONS

INTRODUCTION

Chapter 3 highlights that rituals are connected via *chains* that link their past, present and future, and that these chains connect individual rituals with other rituals. Linked rituals are closely aligned with ritual entrainment, the process by which individuals become in synch with one another through interaction. Entrainment, when combined across time, sets the pattern, rhythm and emotional feeling of TC life across all rituals. Furthermore, as Chapter 3 identifies, healthy entrainment in TCs is important for generating social learning and changing negative expectations of social encounters. Solidarity, emotional energy and entrainment then combine to produce ritual symbols that are internalised by individuals to be drawn upon once the ritual finishes (Durkheim, 1912/2001; Collins, 2004). In other words, symbols continue the process of solidarity and positive emotional energy (EE) after the interactions have ceased. One question then arises, how does entrainment work in practice?

In the previous chapter, I identify the key rituals of Powell and Hawthorne and explore the mechanisms of solidarity and emotional energy, specifically negative emotions. Additionally, Chapter 6 acknowledges that the occurrences before and after any given ritual leave residues that carry over into subsequent interactions. Rituals are thus fluidly connected to one another. This second data analysis chapter builds upon Chapter 6 by addressing the following:

- To explore the process of emotional entrainment within and between rituals;
- To analyse the role of symbols;
- To examine the function of rituals and the conditions that alter a ritual's function.

To understand how interaction rituals facilitate personal change, it is necessary to understand emotional entrainment, as its rhythmic cycles influence individuals and the community. This collective emotional rhythm is embodied within community symbols that can be invoked to communicate community values. All mechanisms of rituals then combine to influence the function of a ritual. As Chapter 1 explains, the *function* of rituals refers to the role micro interactions play within groups (Collins,

2004; Goffman, 1967). Looking to see *how* social interactions facilitate the process of change within TCs requires an exploration of the actions and effects that rituals had within the two TCs. For instance, were community rituals inclusive or exclusive of client members? Rituals are organised into overlapping categories according to the role and purpose they play in the TCs. Lastly, the context of a given a ritual, particularly variances in ritual ingredients, including time, place, person and emotion, can vary a ritual's function in any given moment. I therefore propose that each of the key rituals can serve multiple purposes within the community.

7.1 Ritual Chains: Entrainment and the Rhythm of TC Life

The previous chapter explores how negative EE is transformed into positive EE through solidarity and feelings of belonging. Building from that, this section discusses how EE operates rhythmically between members within a single ritual and over time between rituals. Emotional rhythm, known as entrainment, between individuals is important for establishing the tone and pace of a ritual that in turn influences the EE that is generated within individual members.

Entrainment is the synchronisation of participants' bodily movements, thought and speech (Collins, 2004). As individuals join with one another in interaction, they become alert to others' micro-second movements, pauses in speech, tone and pitch of voice and emotional feelings. Moreover, entrainment is emotionally experienced through feeling understood and validated within social interactions. As Trevarthen's (2000) research shows, entrainment is musicality between group members in an intricate motion of rhythm, emotion and action. This motion sustains the ritual from start to finish. For example, shopping for food at Hawthorne as described in Chapter 5 illustrates how the emotional tone at the beginning of the shopping trip set the tone for the whole ritual. The rhythm of the trip was marked by squabbling and negotiating numerous disagreements. However, in this example at least, instead of dissociating, withdrawing or otherwise ending the ritual, the clients collectively worked through their emotional responses in an *agitato* style rhythm in order to complete the task.

Importantly, entrainment depends upon members being both physically and emotionally present. However when client members dissociated or disconnected

during a given ritual, they were no longer in a position to contribute to the ritual. Whilst all clients at Hawthorne reported struggles with disassociation and difficulty remaining present during community activities, most client members at Powell actively dissociated on a regular basis. During these occurrences, the community attempted to help the client re-connect through the use of Distress Management, usually 'ice and smells'. Distress Management was a Dialectical Behavioural Therapy (DBT) tool. Ice always referred to ice packs whereas smells could be scented sprays, oils, powder and at times smelling salts[5]. Throughout my fieldwork and a portion of my data analysis, I viewed these moments of 'absence' and subsequent use of ice and smells as an interruption to the rhythm and flow of daily life. However, upon closer inspection, I came to realise that these moments were not an interruption of rhythm but rather were a *change* of rhythm. The following excerpt illustrates this change during an End of Day meeting at Powell where Alison shared about her dad's pride in her:

> At some point during Alison's talking, Kristen disassociates. Kristen sits looking down, her face *white* and her hands locked together and trembling. Alison asks if she is okay. Anna stands up and gets the ice and sprays the spray into a tissue. She walks over to Kristen. She gently pushes the ice against Kristen's hands and holds the tissue up to her nose. Anna has to stand there for a minute as there is absolutely no reaction from Kristen. Eventually Kristen takes them both. She sits rigid, holding the ice and tissue to her nose with her legs tucked to one side of her body. Her hair comes down around her face. She still trembles. But eventually she relaxes, colour comes back in her face and she starts looking around, making eye contact with the others. Kristen tells the group that she is not sure what triggered it. (Powell, Day 3, 18/11/2012)

Both the ice and smells were a way to prompt clients to 'return' to the meeting. Focused eye contact was crucial for establishing whether a client was present once again. However had Kristen's disassociation and the management of her distress interrupted the ritual, it would have had no connection to what was occurring around it. Whilst Kristen was not certain what triggered it, it is possible that Alison sharing about her dad's pride in her generated the response. Kristen's relationship with her dad was very problematic: he was a primary source of her trauma and they had very little communication. Therefore, talk about fathers may have reminded Kristen of her

[5] Only scented sprays and some oils were provided by Powell. Other items, such as smelling salts, belonged to the clients and were shared with others.

own relationship with her dad. This could have triggered an emotional response that was so overwhelming she dissociated during the ritual.

Summers-Effler (2010:167) refers to 'obstacles' that a group must respond to in order to keep the rhythm flowing. However, an obstacle implies a blockage or an interruption. Rather than an interruption, I would argue that this was a change of pace, just like a sudden change in musical time or an abrupt move from *andante* to *grave*. This distinction is important because it makes the difficulties that arise during a ritual *part* of the ritual, instead of something separate. Kristen's reaction to Alison, along with Anna's giving of the ice and smells, was a rhythmic, coordinated response. Though Kristen disassociated, most importantly, the group's entrainment continued in her absence, albeit at a different pace and with a different tone. Through ice and smells, the community worked to bring Kristen back into solidarity. Thus, the ice and smells served a vital role in ensuring that entrainment, solidarity and the success of the ritual, in this case End of Day meeting, could continue despite the interruption.

Moreover it was not just individual rituals that united members in a rhythmic flow of emotion. Community life at Powell and Hawthorne consisted of several different rituals ranging from the formal and ceremonial, such as joining and leaving, to ephemeral interactions of quick conversations or a joke in the corridor. Together, these rituals worked to produce an overarching pattern of emotional entrainment. This pattern is a matrix of the overall rhythm of community life. Understanding this rhythm enables an understanding of how rituals functioned collectively within the TCs. This in turn provides an exploration as to how clients learned to manage negative emotions moment by moment thereby providing opportunities to change their expectations of social situations.

7.1.1 The Ritual Matrix of TCs

As rituals occurred in relation to one another, the emotional mood of one ritual impacted upon another. For instance, feelings of frustration or anxiety during a Morning Meeting could continue into the next TC ritual of a Smoking Break. Figure 2

below demonstrates how each ritual was intimately connected with the IRs before and after it:

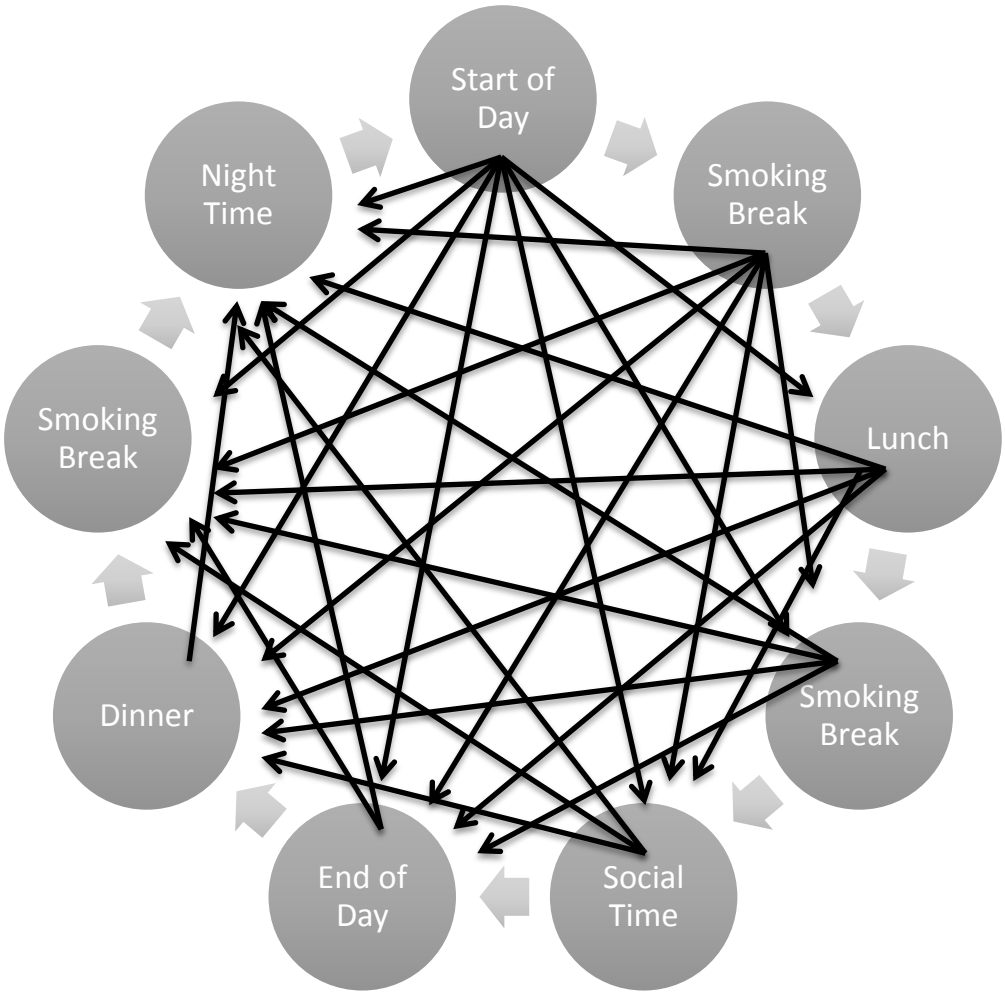

Figure 2: The Ritual Matrix

Though this figure is based on Powell, a similar matrix can be made with Hawthorne. In fact the main variances would be the removal of 'Dinner' and exchanging 'Crisis Texts' for 'Night Time'.

This figure is similar to Rapoport's (1960:80) wheel diagram, 'Daily Round of Organised Activity' of the Henderson Timetable. However whilst Rapoport's diagram reflects the breakdown of community time, Figure 2 emphasises the overall flow that occurs *between* informal rituals. The overarching movement of the ritual flows clockwise in a powerful forward push system of changing emotions. Arrows in the figure denote how, as the day goes along, each ritual bears the elements of the history, solidarity (or lack thereof) and emotional energy from the previous ritual.

Each new day contains factors of all the rituals that have gone before. Combining all the rituals together in one community matrix therefore reveals a complex system with multiple historical ritual effects feeding in to subsequent rituals. Equally, the ritual matrix does not suggest that entrainment is so powerful that once in motion the rhythm cannot be altered.

Rather, at both TCs, I frequently remark in my notes that much could change from the start of the day to the end. In the beginning stages of analysis with Powell in particular, I tried to understand these variances by attributing episodes of acute client distress and self-harm as 'breaks' in the flow of the day. An Emergency Meeting therefore initially seemed to represent an interruption to the day. I came to realise however that changes in the pattern of emotional entrainment were often linked with negative emotions, particularly feelings of shame and fear (Summers-Effler, 2010; Collins, 2004; Scheff, 1977). Nonetheless, as Chapter 6 explores, I understood how negative emotions worked in the TCs and that potentially difficult and draining encounters could produce solidarity. I thus realised that the key is how changes in rhythm were interpreted. As with Kristen's disassociation described earlier, when I looked across whole days to look for the pattern, or the rhythmic beat of the community, I identified that some alterations in rhythm were not breaks at all, any more than they were in a Community Meeting. Instead these were moments of intense emotionally charged encounters that both reflected what had occurred prior to the moment of distress and that catapulted the community into its subsequent flow. The TC could sustain cohesion during the emergence of intense negative emotions if these emotions were brought to the community to manage together. It was client members who hid their distress or negative emotions from others that threatened the cohesion of the group, as denying negative feelings severed entrainment. Therefore, Haigh's (2013) recognition that communities need to foster a sense of openness of emotional expression is particularly important in order for TCs to work cohesively moment by moment.

Additionally, because the rituals in the matrix mirror a clock of the TCs' timetable, it may seem like the actual structure of the communities provide the underlying rhythm. However, an End of Day meeting at Powell challenged this belief when the meeting dissolved into distressing chaos that lacked structure. Instead of

the chaos resulting in failed rhythm, the group maintained entrainment. During the meeting, Julie, who was already on Level Two Observation[6] following a self-harm incident using a ligature, stormed out of the meeting after arguing with Martha. The consultant psychiatrist and psychologist, along with the Observation Nurse, followed Julie after unsuccessfully using a light restraint (wrist hold):

> It is a moment where time seems to stop but everything happens at once in a blur. I glance at Martha who starts to cry. Kristen rises from her chair fluidly and begins to walk to the door, covering her ears with her hands. Alison and Carol (nurse) jump from their chairs and stand in front of Kristen. Both work to reassure Kristen, who is shaking her head and muttering about the shouting (meaning the voices she can hear in her head).
>
> Over Alison's and Carol's (nurse) talking, I hear Anna saying, "Martha, Martha, it's alright, it's not your fault". Erica is taking deep but rapid breaths in her chair. Her face is flushed. She then looks at Carolyn who sits as if in a trance. Anna and Erica begin to speak to Carolyn who will only respond by shaking her head.
>
> Amy covers her face with her hands, refusing to look at anyone. Tessa leans over and begins to speak softly to Amy until she is able to lower her hands away from her face.
>
> Then it is Alison's turn to receive support from Tessa, Amy and Carol (nurse). Alison sits with her elbows on her knees, and Amy stands up with one leg against the wall, speaking to her.
>
> Eventually everyone sits down. It has gone to 5:20pm, way past the group's end time. The room feels contained, but just. (Powell, Day 41, 21/02/13)

Though the meeting dissolved, and the timetable was suspended, entrainment continued in the absence of structure. Indeed it was the clients who were mostly aware of one another, offering support in order to remain present and focused together. Along with Carol, they maintained a mutual focus of attention with one another despite urges to flee (Kristen), hide (Amy) and non-response (Carolyn). This incident highlighted to me that even if the structure and status were removed, the interactions continued to produce solidarity and emotional entrainment.

[6] Level 2 Observation is 'Within Eyesight', meaning the client must be observed at all times by a healthcare professional.

Moreover, this is in line with Trevarthen's (2000) theory of emotions underlying rhythm and emotional response relayed through action. Here, emotions provided the musical tone and pace of the rhythm, and provided motivation for action and relational bonds. Thus it was emotion through interaction, not structures, which gave rise to entrained rhythm. When discussing this interaction later with the TC, Tessa highlighted that the structure was important for providing a framework for relationships to form based on solidarity; yet, once established, the timetable was not necessarily needed to continue the relational dynamics of the TC. Therefore, it seems the ritual matrix of entrainment is not dependent upon fixed timetabled events but rather it is the emotions that drive and sustain entrainment.

Maintaining positive EE and entrainment is challenging, however. As rituals are fluid, their level of rhythmic stability is in part dependent upon how interactions influence individuals, how individuals then influence the TC and how the emotional mood of the TC in turn feeds back to influence everyday rituals. Oscillations of entrainment are therefore conceptualised as three interrelated waves of rhythm: interaction, person and community. Unpacking this rhythmic movement enables an understanding of how Powell and Hawthorne managed negative emotional energy whilst facilitating social learning on a daily basis.

7.1.2 Waves of Rhythm

Negative EE both enabled and put pressure on the community's ability to facilitate social learning. For instance, clients reported that allowing heightened anxiety to manifest through Emergency Meetings (Powell) or Crisis Texts (Hawthorne) provided a "mirror" for them to understand the impact of their behaviour on others. Over time, these moments of learning within interactions could generate emotional and rhythmic changes within individuals. Changes in the person, such as fewer episodes of disassociation and self-harm, had an impact upon the community as a whole. If the community had more individuals who remained connected and refrained from using self-harming behaviours, the community felt stable and resilient, able to provide support to all client members and thereby increasing client members' confidence (positive EE) in the TC and in one another to manage risk. This is akin to Summers-

Effler (2010:164) who likens periods of stability to ‘stretching rubber bands’. Powell and Hawthorne could absorb tensions and negative EE through elasticity of rhythmic movement. Conversely, if members were consistently using self-harming behaviours over a period of time, the emotional tone of the community changed to match the overriding feelings of anxiety, mistrust and frustration that arose from members and their interactions. Put differently, too much negative EE strained the TC’s ability to provide support to all client members. These interrelated waves of rhythm between the interaction, individual and community are illustrated in Figures 3-6:

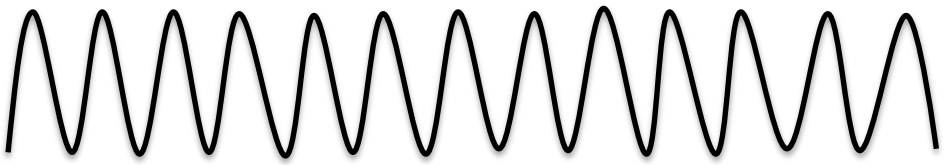

Figure 3: Interaction Wave of Rhythm

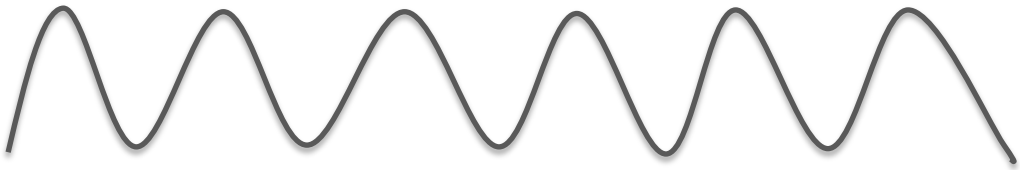

Figure 4: Individual(s) Wave of Rhythm

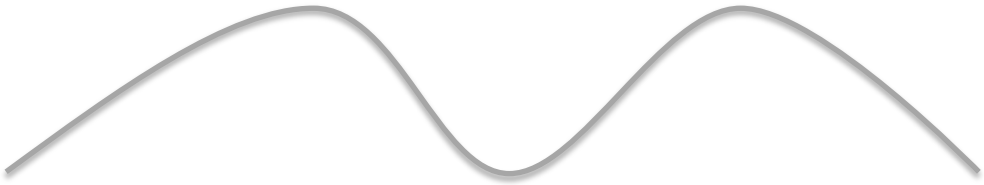

Figure 5: Community Wave of Rhythm

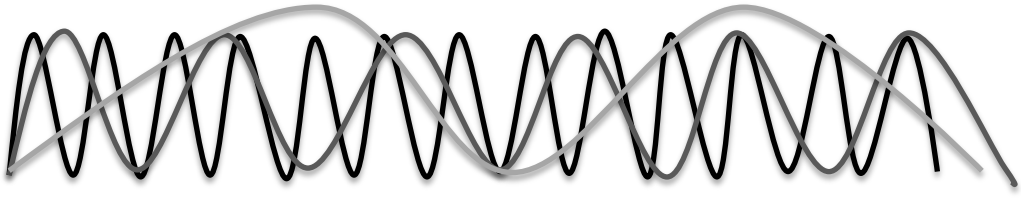

Figure 6: Combined Waves of Rhythm

These differing waves of rhythm occurred simultaneously and together produced EE (Figure 6). The quality of social interactions directly influenced the emotional mood of individuals and the dynamics within the social environment

(Hallett, 2003). Failure to absorb negative EE in an interaction (Figure 3), such as a Community Meeting, could negatively influence both individuals (Figure 4) and the overall emotional mood of the TC (Figure 5). Thus managing negative emotions within a single ritual (Figure 3) was crucial for generating a sense of positive EE in members (Figure 4). Sometimes emotional pressure would build and then dissipate. However, over time, lingering and unresolved negative EE placed too much strain on the TC that interactions within the community would collapse. This was seen in Chapter 5 whereby Carl verbally abused Abby during the Closing Meeting.

Changes in interactions and individuals could also create significant shifts within the emotional feeling of the TC. For instance, Jennifer, a Powell Graduate Group member explained that as some confrontational members left the community, the community dynamics changed:

> But then they left […] and then it went into a much more settled period where people were helpful, uh, not confrontation, they were still confrontational, but in a nice, a nice, more helpful way.

Moreover Jennifer identified that the community underwent "very distinct periods" that varied depending upon the "characters" who made it up. Other community client members echoed her reflections. Those who had been in the TCs longer often described differences between the TC as they had entered it and where it was currently. Waves of rhythmic movement are also similar to Manning's (2012) model of movement within TCs over time. Crucially, he identifies that stability within TCs is dependent upon 'internal cohesion' and 'external support'. Internal cohesion is akin to managing EE within all levels of the waves of rhythm: interaction, individual and community. All levels must function flexibly and fluidly to generate feelings of solidarity. External support refers to pressures that come from outside the TC, like an unwelcome building move (Hawthorne). Variations in internal cohesion and external support create tensions that the group must manage in order to avoid collapse, or the rubber band snapping (Summers-Effler, 2010). This then raises the question as to *how* the TCs managed rhythmic tensions.

Oscillations occurred at Hawthorne and Powell. At Hawthorne, I started shortly after the community had moved buildings, an external change that was forced upon the TC and angered the clients. Eight members then joined the community

over my 15 weeks with the TC, with three completing the programme and two leaving prematurely. I noticed that as more senior members left, newer members seemed to settle in the new environment more easily and there were far fewer conversations and frustrations about the move. It was as if the external tension was eventually absorbed by the internal cohesion of newer members. As newer members contributed to generating solidarity, the negative EE surrounding the building move dissipated. When I left, the community was facing a change in timetable alongside a reduction from five days to three days a week of therapy, driven in part by organisational changes. In leaving, I sensed another 'wave' of change forming in the community and wondered if, like the building move, newer members would offset the negative EE influenced by the changes. Therefore, organisational pressures, such as the building move and the timetable changes, could also impact upon the rhythm of the TC. Here I would agree with Summers-Effler (2010) that these organisational shifts seemed to present more as an obstacle rather than a fluid change of rhythm that forms of dissociation caused. Certainly both staff and clients at Hawthorne spoke about the building move in particular as a significant interruption in the life of the TC. Like fluid changes in rhythm, the community had to be flexible to absorb the negative feelings associated with these interruptions.

However, at Powell, the TC's ability to absorb these feelings was tested when three client members were all using serious forms of self-harm during a two-week period. Their actions invoked high anxiety in the client group and increased staff workload. Client members' tolerance wore thin after repeated self-harm incidents, the sounding of emergency alarms within the unit (indicating a request for urgent staff support and back-up) and subsequent Emergency Meetings that lasted hours, often in the middle of the night. As Carolyn said in her interview, she felt "knackered, emotionally, physically". Despite the amount of group time spent together, client members reported at the time and during interviews that they felt overwhelmed and excluded from the group because the community's energy centred on three client members. Ultimately, the community's capacity to manage these dynamics broke down and the three client members left the community on Section 2 of the Mental Health Act. Rebuilding tolerance and trust took time and was achieved through a conscious re-focus on all members, reflexivity as to how individual actions impact upon others and a return to what Erica called "normal life", defined as managing the

everyday oscillations within the TC. Transforming negative EE is therefore a delicate balance between individuals staying present in the group and the group tolerating negative feelings. As Hinshlewood (2001:90) contends, communities have to continuously work to connect all members in 'thinking' and 'communicating' or they will break apart.

Maintaining a balance of entrainment within everyday rituals outside of therapy is therefore important for TCs as it helps clients learn socio-cognitive skills necessary for healthy relationships and facilitates the management of negative emotions. Despite some difficulties, client members were usually able to sustain entrainment with one another, ensuring that solidarity was consistent. Throughout this process, EE, solidarity and entrainment were then loaded into community symbols that represented the community's values. Symbols in particular serve to maintain entrainment in between rituals.

7.2 Ritual Symbols

Following Durkheim (1912/2001) who explains the role of symbols in rituals, IRC theory holds that successful rituals will generate powerful symbols that reflect the essence of the group and can be called upon to generate an emotional response even without bodily co-presence (Collins, 2004). Collins (2004) and Ling (2008) theorise that the main purpose of a symbol is to extend entrainment in between rituals, which are internalised within individuals and treated with 'respect, as a sacred object, as a realm apart from ordinary life' (Collins, 2004:97). Symbols can be physical objects, such as the cigarette for the Smoking Break, or it can be an idea, feeling or state of being. They are significant because they embody the history of interactions in the TC and the particular meaning, values and social norms of those who invoke them. When a symbol is used, individuals draw upon the *emotional* memory that is contained within the symbol. The memory of an emotion can then influence future social interactions. Additionally, symbols are powerful rallying points for members that represent the social bonds between them. However, when symbols are violated or not shared by all, particularly newer members, group members may vehemently defend them (Collins, 2004).

Ling (2008:51) argues that the more an interaction is 'perpetual', the less need there is for a symbol. However, my data from Powell and Hawthorne suggests that there were several symbols charged with emotional meaning including food, cigarettes, self-harms scars, tattoos, the therapy circle, the building move (Hawthorne only) and ice and smells (Powell only). To analyse the mechanism and importance of a symbol, and to counter Ling's argument, I examine the ritual and symbol of Crisis Texts at Hawthorne, which in particular served to extend the TC into the evenings and weekends.

7.2.1 Crisis Texts

Crisis Texts at Hawthorne often generated strong emotional feelings. Even the name 'Crisis' Texts was debated as some clients wished to rename them 'Support' Texts to indicate that one did not need to be in a crisis in order to ask for help. Regardless of the name, the function of Crisis Texts was an informal client 'on-call' form of support. If a client was struggling in the evenings and/or weekends, he/she could send a text to the whole client community to ask for feedback and help. Often the texts had to do with urges to self-harm and/or commit a boundary break such as not turning up for the day. The whole community would discuss Crisis Texts at the next Morning Meeting, and only the Morning Meeting as the community would not discuss them anywhere outside this time. Staff neither received a copy of the text nor were texts ever read out verbatim in the Meeting. Because of the nature of the texts, the emotional mood surrounding Crisis Texts was often of anxiety, shame and frustration as the excerpt below highlights:

> Last night's Crisis Text was from Abby who is slumped very low in her chair, her head just poking up. Her fringe nearly covers her eyes and when they don't, her hand does. Abby says she was feeling very low over the weekend and is tired of her thoughts as they are "not budging". She continues to work on them but feels they are not getting better. She wanted to overdose over the weekend but only had antibiotics on her, "which would just make me throw up again" (so not worth it?). However she did not self-harm, even though she really wanted to, and she says the texts she got from the clients were very helpful - especially Brian's. Brian had told her that she would be letting not only herself down but others too if she self-harmed, meaning that he and the others would be disappointed if she did. Abby said this was a helpful reminder and she worries about

> when she goes and knows that no one will tell her that she'll be “letting' people down”. (Hawthorne, Day 22, 23/07/2013)

Abby regularly spoke about her frustrations regarding what she called her “negative thoughts”. She frequently sent Crisis Texts like this and credited the community with helping her avoid self-harm for several months. Often, Abby would say that others’ responses helped her manage negative emotions and urges to self-harm. The TC therefore seemed to become internalised symbolically within Abby through the medium of Crisis Texts. For one, she could send the text to ask others for help rather than self-harming or attempting to manage her emotions on her own. Secondly, as if she were speaking to others in the community, Abby ‘listened’ to the perspective of others and used this information to inform her actions, in this case to not self-harm. Thirdly, other client members could remind Abby about the TCs values (i.e. respect for one’s body). In addition to Abby, other client members were especially positive about the use of Crisis Texts as a way of supporting one another and managing risk, including Jessie:

> I think if, if the crisis network wasn’t there, I think I probably would have self-harmed or put myself in danger […]. Because I’ve been able to Crisis Text to say I’m really struggling, and people have been fantastic with their […] responses back um, it’s helped me and it’s saved me.

Lauren and Megan also made similar comments about Crisis Texts during their interviews, particularly in helping them not self-harm and to continue attending the TC on difficult days. This suggested to me that Crisis Texts were sacred and were given almost Messianic qualities that ‘saved’ clients.

It must be remembered though from Chapter 3 that Goffman and, in the main, Collins excludes rituals that do not involve bodily co-presence. Ling (2008:80) challenges this notion by illustrating how mobile phone use, including text messaging, fulfils the requirement of a ritual and can aid ‘development and maintenance of social cohesion’. He does acknowledge that the use of mobile phones usually works alongside face-to-face interactions. Nonetheless, Ling (2008:67) argues that text messaging ‘means we are in perpetual contact with our ‘clan’’. However, Ling theorises that this perpetual contact removes the need for symbols, as entrainment is continuous. Contrary to this view, I suggest that text messaging at Hawthorne fits both Durkheim’s and Collins’ definition of a symbol, as a

sacred object that was generated by rituals and was rigorously defended. Crisis Texts therefore were both a ritual of interaction and a symbol, extending the TC's life into the client members' unseen private lives. Additionally, through discussing Crisis Texts within the TC, texting linked members' lives outside the TC to life within the TC. Thus, Crisis Texts worked to strengthen and augment the solidarity experienced between members (Ito, 2005). By dismissing mobile communication as a symbol, Ling misses that entrainment is continuous *because* of the symbol and ignores the sacred meaning that the symbol embodies, in this case the way Crisis Texts represent the values and essence of the TC.

Crisis Texts were particularly sacred at Hawthorne. All client members had to use mobile texting. Failure to treat Crisis Texts with respect resulted in consequences. For instance, as a newcomer, Kevin did not input other client members' number in his phone within his first few weeks in the TC and was subsequently placed on Review. Additionally, clients had to adhere to the TC's values when text messaging, even though these interactions occurred outside the TC. The following excerpt highlights how the community responded when Vivienne broke community boundaries via Crisis Text:

> Vivienne explains that she got drunk when she left on Friday, texted the group to say she was drunk and Daniel responded to say something like, what's going on is this a Crisis Text, and she wrote him back saying, "fuck off". There is stunned silence in the room. Though the clients received the text about the drinking, they were previously unaware of this specific exchange. Vivienne says that she was angry on Friday at the way group had ended with only a minute left for her to speak.
>
> "I'm sorry, I'm really sorry", she says now to Daniel. Her nose turns red and she begins to cry, at times covering her face with her hands.
>
> I glance at him and see that his jaw is fixed tightly and he stares hard at her. He shares that he is still very angry about it all. There is then discussion about how this is going to be managed and how to respond. Abby suggests three days' leave because of the boundary breaks whilst Lauren feels time away from the community would be counterproductive. However the majority of the clients, including staff, seem to think it warrants three days' leave. After more discussion about how Vivienne will keep herself safe whilst away from the TC, she leaves. (Hawthorne, Day 33, 27/08/2013)

Texting whilst drunk (or under the influence of illicit drugs) constituted a boundary break within Hawthorne. Swearing at another client member, particularly over text messaging, was also treated as a boundary break. Because clients received texts away from the support of the TC, there was an expectation that texts should not offend or otherwise cause members unnecessary negative feeling. With the exception of Lauren, the client members reacted with a type of righteous anger (Collins, 2004) to Vivienne's texts and advocated for temporary exclusion from the TC. However, whilst Vivienne did clearly break the TC's boundaries, this instance highlights an inconsistency with the text system. Texts were intended to go to all members, yet often, private conversations would begin between two members, in this case, between Vivienne and Daniel. During my time in the TC, I never saw these side conversations challenged by either clients or staff. I frequently wondered why side conversations were allowed and whether all these conversations were brought back into the TC for discussion. Moreover, undue negative feeling was often subject to interpretation as clients sometimes did respond differently, and inconsistently, to individual texts.

Whilst clients were adamant that the text system was beneficial, I did wonder whether internalising the TC after hours without any staff support was helpful. My questions centred on whether it placed too much responsibility on clients and whether it could be triggering for clients. For example, further difficulties with the text networked occurred when Robert sent a text to Jessie encouraging her to take a 'bat' to the man who sexually assaulted her when she saw him at a bus stop. Though he later explained that that was how he was feeling and would want to do if someone did that to his daughter, the community explained his comments might have triggered Jessie into actually becoming physically aggressive. On the occasions I questioned the text messaging system to clients in the TC, I was met with defensiveness and felt I was questioning the community ethos by even querying the system. Combined with comments about how Crisis Texts 'saved' individual clients, it seems that as a ritual and as a symbol, Crisis Texts embodied and generated strong emotional feeling. At times, the clients did not always manage these emotions constructively via text. Nonetheless, based upon the use of Crisis Texts at Hawthorne and the clients' opinions about this system, I would argue that texting was a symbol that usually worked to sustain solidarity between individuals outside the TC. Contrary to Ling,

Crisis Texts were a symbol that enabled clients to internalise and imagine interactions with other clients outside of the TC and they continued to perform the functions of the community, including enforcing its boundaries, whilst not being physically present. Whether or not this internalisation was helpful is still a lingering question and its use may go back to the positive risk taking that TCs promote (Haigh, 2013). Furthermore, the helpfulness, or the positive EE, of any ritual or symbol depended upon the function that the ritual played moment by moment.

Thus, knowledge about emotional entrainment and the embodiment of emotions and rhythm into community symbols raises the question as to the function of rituals in the two communities, particularly whether the TC rituals were inclusive or exclusive of client members. This question is particularly important as Chapter 6 establishes that positive EE, which promotes social learning and positive change, is the feeling of inclusivity. The third section in this chapter will discuss the function of the rituals in relation to the community dynamics. Each IR is coded into categories according to function and is followed by a discussion regarding the conditions that alter a ritual's function.

7.3 Ritual Functions

Having explored the mechanisms of IRCs in Powell and Hawthorne, the question arises as to what kinds of actions and effects the rituals had within the TCs. The main aim of both communities was to help client members positively change. Thus the foundation of the community was about movement towards transformation rather than stagnation. In relation to actions, both TCs had to be strong enough to manage intense emotions, yet flexible enough to meet the needs of any given client cohort. The two overarching functions of the rituals were 1) to promote a stable environment whereby clients could 2) experience transformation. Stability and change coexisted in every interaction. To understand the effects these dynamics had within the TCs, it is necessary to identify the types of rituals that operated within the communities. Specifically, rituals are categorised according to the function they played and then examined according to their effects.

Taxonomy is a classification system for organising 'multi-faceted, complex phenomena' into a 'set of common conceptual domains and dimensions (Bradley et al., 2007:1760; Patton, 2002; Manning, 2011). Categorising rituals provides clarity in defining and comparing the complex function of rituals within the TCs. Analysing the full list of ritual in context of the fieldnotes and interviews reveals that each interaction ritual serves at least one primary function in the community. In order to decipher the roles the rituals play, the IRs were coded according to their function in the respective TCs[7]. By using pre-established categories of Collins (2004), Summers-Effler (2006), Helman (2007), Scheff (1977), Chapple (1970) and Mandelbaum (1959) five main categories are identified: Inclusion, Exclusion, Reinforcement, Anti-Group and Transitional. A new sixth category of Ownership includes those rituals that encourage both community and individual responsibility (Haigh, 2013). The category descriptions are as follows:

Inclusion

All rituals in the two TCs had the potential to be inclusive. Inclusive rituals draw individuals into the group and foster a feeling of belonging and group solidarity (Collins, 2004; Summers-Effler, 2006). Inclusivity and exclusivity simultaneously work together to distinguish between members and non-members. Yet being an official 'member' of a TC did not equate automatically with feelings of solidarity. Belonging and solidarity are not fixed entities (Collins, 2004) but work on a continuum of feeling with some members experiencing higher levels of solidarity/belonging. The process of inclusion was particularly visible when a newer member joined the TC and when a member had to work to regain the trust of the community following a boundary break.

Exclusion

Conversely, exclusive rituals are those that expel (Collins, 2004). These rituals refer to feelings of outsider status from within the community. Examples include cliques and sub-groups and when a member violates a group boundary and/or community

[7] A full list of rituals organised into categories is available in Appendix 5.

norm. Some rituals, such as Smoking Breaks, could alternate from inclusivity to exclusivity.

Reinforcement

Reinforcement rituals (re)confirm the community norms, values and expectations that members are meant to follow (Mandelbaum, 1959). These rituals draw on the sense of righteous morality that Collins (2004) outlines when group solidarity, emotional energy and symbols are in place. The primary function is to reinforce the group's values, remind members what is important and expected by all, and bring deviant members back into adherence and inclusion. In their most informal expression, these rituals also reveal the implicit social rules of the community. Both TCs had unspoken rules that could only be learned through interaction. For instance, Meal Times at Powell provided abundant opportunities to view the implicit 'rules' in place regarding where to sit, how much to eat, the topics of conversations and what to do with uneaten food.

Anti (Exclusion)

Collins (2004) describes smoking rituals as 'anti' as they contravene Western society's attitude and views regarding health. Moreover, Collins (2004) traces the history of cigarette smoking, highlighting that smoking and cigarettes is often associated with rebellion. Similarly, I identified those rituals that seemed to rebel against the group values, norms and expectations. Anti-rituals were both inclusive (of those rebelling) and exclusive (of those being rebelled against). In addition to smoking, anti-rituals include some forms of jokes and play, swearing and the process of arriving late, or leaving groups early.

Transitional

Both Chapple (1970) and Scheff (1977) refer to transitional rituals that facilitate the move from one ritual to another. In the two TCs, after a ritual had been performed

members were still entrained, sharing attention and emotional energy. Once the ritual ended, members engaged in transitional rituals to bridge the sequence of daily rituals. For example, Smoking Breaks at Powell could transition between an end of day group and dinnertime. Transitional rituals could also facilitate the bridge between exclusivity to inclusivity. For instance, when a client violated a boundary break, rituals such as Reviews and Emergency Meetings facilitated the re-establishment of solidarity. Moreover, some rituals such as Morning Meetings and Crisis Texts transitioned the community from the night/previous day/weekend. Other rituals, such as Endings, were inclusive for the community but were transitional for the client member as he/she prepared to be a non-member.

Ownership (inclusion)

One of the aims of TCs is to enable a sense of personal responsibility and ownership (Haigh, 2013). This includes responsibility for oneself and owning personal plans and future behaviours, as well as owning a sense of responsibility towards the community. Examples of ownership rituals include community chores, holding community business meetings, managing client member risk, and addressing moments of change/distress in the TC. Of all the rituals, this category contains the highest number of rituals. This suggests that one of the main mechanisms of the TCs was fostering a sense of personal and community ownership.

One key question remains after categorising the rituals: if IRs can co-exist across categories, what distinguishes the categories as unique? The primary distinguishing factor is the *function* of the category. One of the limitations of Collins is that his model of ritual effects is too linear. To overcome this critique, Summers-Effler (2006:140) argues that in reality any given interaction 'plays a role in multiple embedded emotional histories'. Furthermore, she advocates a systems approach to studying rituals that recognises interactions operate within 'interlocking levels' and that each level can have emerging characterises of its own (Summers-Effler, 2006:140). I would expand this further to say that some levels within the ritual can have overlapping and contradictory properties. This means that rituals may have

more than one function and may contain incongruent functions. Thus an informal ritual such as Crisis Texts could be inclusive, exclusive and ownership depending upon, for example, if every client had been included in the text and if the text network was being used appropriately.

Central to determining a ritual's function therefore are the conditions, or the context, in which the ritual is produced. The context of a ritual helps to determine the effect that a ritual has within the TCs. A reading of the data and the literature (c.f. Collins, 2004; Summers-Effler, 2010; Hallett, 2003, 2007; 6, 2007) indicate that there are four main variants that affect an individual ritual: time, place, person and emotion.

7.3.1 Ritual Conditions: time, place, person and emotion

Though rituals can belong to more than one category, the function distinguishes one category from another. In his work on religion for example, Collins (2010) acknowledges that variations of ritual ingredients can 'determine the specific identity and character' of particular rituals. Hallett (2003) also observed variations of emotional energy and solidarity in customer service rituals between day and night US restaurant servers. Each ritual is constrained by structures of time and place and the varying emotional and personal experiences that respective individuals bring to the interaction (Collins, 2010). The data in this study highlights that variances in these mechanisms can produce differing functions, even within the same ritual chain. To illustrate this point, I consider how Smoking Breaks can produce multiple effects of transitional, exclusion and inclusion by using a ritual formula: 'X' + 'Y' = Ritual Function.

<u>Time: 'End of group' + Smoking' = Transitional</u>

Whether a Smoking Break was inclusive, exclusive, or transitional depends firstly on when the Smoking Break occurred. In both communities, the timetable provided natural transition periods when moving from one activity to another. When a morning meeting finished, the smokers would immediately begin their ritual of moving outside to smoke. The ritual of smoking was a means of linking the morning group to the

activity that would immediately follow, usually another group. It provided an opportunity for the participants to discuss the previous meeting with one another, to raise other issues regarding the community or to discuss topics completely unrelated to the TC. As a transitional ritual, Smoking Breaks could also be simultaneously exclusive or inclusive.

Place: 'Location' + 'Smoking' = Exclusion

Place, in particular, played an important role in creating a sense of exclusivity within the smoker's group. At Powell, this meant walking from the therapy suite, located in the main hospital building, to the unit, situated at the back of the hospital. Once on the unit, a steady progression of female residents would head outside to the small smokers' courtyard. Likewise, at Hawthorne, once a meeting had finished, the smokers would begin rolling or preparing their cigarettes in the therapy room before walking to the designated smokers' area outside, either separately or in small groups. Even the act of being outside, in the courtyard for Powell and some distance from the building at Hawthorne, meant that there was a physical barrier between the smoking group and the rest of the TC.

Person: '(Non)Smokers' + 'Smoking' = Inclusion (of Smoker's Groups) / Exclusion (of the TC)

Smoking Breaks were equally both inclusive (of the smokers) and exclusive (of the rest of the TC). Once outside, the smokers would usually stand in a close-knit circle facing one another. They were a distinct group, 'the smokers', with shared needs, symbols and experiences related to smoking. Therefore, being a smoker automatically denoted membership to the smoking group on a basic level. Yet Smoking Breaks also were a barrier to parts of the TC. Boundaries to outsiders could include non-smokers and staff members. Staff who were smokers did not smoke with the clients. I queried this at both communities and the explanation was

the same: as members of staff they wanted to model healthy behaviour and they felt that smoking with the clients would condone an unhealthy habit.[8]

Participating in the smoking ritual was not open to just smokers, however. Non-smokers at both TCs frequently accompanied the smokers outside. In theory, anyone could come outside "for some air". Predicting who would come out and who would stay in was dependent upon several variables. At Powell, moments of high solidarity and high anxiety would at times result in the community operating as a close-knit unit where they seemed to move as one. During these times, everybody would head out together. For Hawthorne, the dominant factor seemed to be attendance. Remaining alone in the therapy room seemed to be the least favourable option. However, everyone coming outside together was rare in both TCs, and it was far more common for only one or two of the non-smokers to join the smoking group. Usually it was the same non-smokers who joined the smoking group and they would participate in the conversations, often with more ease than some of the smokers. Despite participation being open to all, the smoking group was often perceived as a clique or subgroup within the TCs.

The exclusivity of the smoker's group was also reflected in things such as gossip and jokes, which appeared to be shared only by those in the smoking group. In theory, clients were meant to bring everything that occurred outside in to be shared with the whole community. This did not often happen in practice however. I remarked in my notes at Powell that once we crossed the threshold onto the unit it was like entering a different world, even though the smoking courtyard was just off the unit and separated by a clear glass door. The conversations that had been flowing outside ceased once back inside; it was as if some unspoken rule meant that those conversations were saved for outside only. There were of course exceptions to this rule: Smoking Breaks could be triggering for some clients due to some of the jokes and discussions, as Chapter 6 illustrates with Amy and Martha. In these situations, clients would bring to group what they had experienced as difficult during the Smoking Break. Therefore Smoking Breaks could be both inclusive and exclusive of the community.

[8] This was the opinion of the few staff members I interviewed. It has to be acknowledged that not all staff members may have felt this way and that there may have been times in the past when staff did smoke with clients.

Emotion: ‘Smoking’ + ‘Emotional Mood’ = Inclusion or Exclusion

However there is another level of inclusive/exclusivity in the TC within the ritual itself. Closely related to the condition of ‘Person’ is ‘Emotion’. Conversations during Smoking Breaks were often cohesive, with all participating in the discussions. Sometimes though, this cohesion broke down and the social bonds of the smokers became threatened. This combination of ingredients is the most complex as there were many variables that affected whether the group was inclusive or exclusive. The clearest example of this was in Chapter 5 at Hawthorne when two members of the smoking group, one non-smoker, Abby, and one smoker, Daniel, began to joke around about an incident that had just occurred during a Morning Meeting. Earlier, Jessie had reported feeling excluded from the Crisis Text network. Abby and Daniel’s banter immediately excluded Jessie, the target of their joke, from the smoking ritual.

Likewise, at Powell contentious groups could create divisions in the smoking group leading to a loss of emotional energy and a lack of solidarity. The emotional mood following the previous group often determined whether a ritual would be inclusive or exclusive. Furthermore, the personal history that each person contributed to the interaction also impacted whether he/she responded positively or negatively within the ritual. This was not always the case, however. Even with a contentious group, negative emotional energy such as anxiety could prompt the group to draw closer together, offering mutual support. Whether these emotions were discussed or not did not matter. It was an opportunity to allow solidarity to either reform or strengthen in order to challenge the negative EE. Therefore the group could turn negative emotional energy into solidarity through working cohesively together.

Though I have used the ritual categories of transitional, exclusive and inclusive with smoking breaks, a similar formula applies to any of the key rituals. Altering the ingredients of time, place, person and emotion determines the function of the rituals. Moreover, a ritual such as Reviews could start out as reinforcement of the community values and become ownership as the community worked together to

manage risk. This variation is similar to Hallett's (2003) study whereby achieving entrainment and solidarity determines ritual success, regardless of the function or structure of the ritual. Thus the function of a ritual such as Distress Management was to assist a client member who may be struggling. However the function of the ritual went beyond this immediate goal by providing opportunities for the community to become emotionally entrained with one another and build solidarity, which in turn could generate feelings of belonging (inclusion). Of course, not all rituals generated positive EE and some interactions resulted in disunity and feelings of exclusion that the TC then had to manage. Nonetheless, as chains, rituals were connected together and what occurred in one interaction ritual could impact upon the variables of another. Therefore patterns of interactions emerged through examining the variation of ingredients that influenced the ritual and exploring what happened after the ritual had finished. Additionally IR theory provides a useful framework for explaining the mechanisms of interactions and highlighting the complexity of emotions and dynamics present in any given ritual.

Looking across the rituals during data analysis highlights that the main push and pull on rituals is inclusion and exclusion. Chapter 6 articulates that it is feelings of belonging, or solidarity that is particularly significant in establishing a ritual's success or failure. If solidarity and entrainment were maintained, or quickly re-established if lost, community members would tolerate negative transient and long-term emotions. Over time, these negative emotions could be reinterpreted as a 'rite of passage' in which participation in these activities, such as Emergency Meetings, conferred a special in-group status for members. Confronting negative emotions together generated feelings of confidence in belonging to the group and client members' roles within it. Conversely, feelings of exclusion could lead to the ritual's failure, and potential demise within the community (Hinshlewood, 2001), and also may expel client and staff members from the TC resulting in staff member resignations and clients' premature departures (Manning, 2012). Therefore, when looking at the function of IRs, the two main ones are inclusion and exclusion. Both categories also include elements of reinforcement as members emphasise the community norms and values to one another, and consequences for rebelling against the standards of morality.

As such, power and social control are intrinsic to inclusion and exclusion. Determining who is ‘in’ and who is ‘out’, and how outsiders can become insiders again, is a powerful social position to hold. To further explore the impact of inclusion and exclusion that can occur within the IRs, I examine these two functions from the perspective of power and social control in the next chapter.

SUMMARY

This chapter analyses the emotional rhythms of interaction rituals. After exploring how the rituals operated across chains and examining ritual symbols in the TC, rituals were then classified into eight categories that determined the function of the IR according to the variables of time, place, person and emotion. Like Chapter 6 that stresses the importance of solidarity, this chapter identifies that the main push and pull on rituals is inclusion and exclusion. Having analysed the function of the key rituals, questions arise concerning the role of power, the importance of peer support and relationships, along with how the interactions facilitate change. Chapter 8 will therefore address the role of power and peer support in relation to rituals and the principles of TCs, specifically examining changing roles and social hierarchies.

CHAPTER 8. POWER AND SOCIAL HIERARCHY

INTRODUCTION

In IRC theory, the fourth outcome of a ritual is moral standards, or values, that define the social rules for the group (Collins, 2004). Addressing the question of how everyday interaction rituals facilitate the process of personal change therefore requires an analysis of how power is used within interactions, particularly in regards to inclusivity and exclusivity. Through repeated interactions of solidarity, emotional energy, entrainment and use of symbols, rituals generate shared values of a group that are morally charged. These values can be explicit, such as written TC boundaries, and implicit, such as where to sit at Meal Times. Failure to conform to the values can result in exclusion from within the group, and as Chapter 6 and 7 identify, exclusion can lead to negative emotional energy (EE) (Summers-Effler, 2002). Moreover, Brown and Harris (1978) suggest that individuals who are part of close-knit groups may feel less depressed but can feel anxious about having to continuously adhere to group values. Thus, power is intrinsically linked to moral standards as abiding by community values entails a level of conformity in order to avoid potential punishment.

This thesis, like Bloor et al. (1988:190), acknowledges 'the Foucauldian view of power as a strategic relationship, a routine fact of social life in therapeutic communities as elsewhere'. Power is therefore an inherent form of social interactions. However, as ritual theory identifies, power can be inclusive or exclusive. Inclusive power is the voluntary distribution of power that is shared evenly between all participants in the group and facilitates the process of solidarity and shared ownership as highlighted by Vertesi (2012). TCs conceptualise this as a 'flattened hierarchy' where therapeutic and administrative power is distributed between staff and clients (Rapoport, 1960). As Chapter 6 argues, inclusivity is related to feelings of belonging and solidarity in positive EE. In contrast, exclusive power is centralised with one or two members, leading to decreased feelings of EE in subordinate members (Summers-Effler, 2002). Within TCs, inclusive power is encouraged and is seen as empowering (Haigh, 2013; Winship, 2004), whilst divisive forms of power and social control are considered problematic (Hinshlewood, 2001). Indeed, many of

the criticisms of a TC approach centre on the issue of power and social control (Kesey, 1962; Sharp, 1975; Hobson, 1979; Baron, 1987; Bloor, 1986; Spandler, 2006, 2009). As Chapter 2 highlights, there are two opposing view of TCs in relation to power: manipulative and empowering. I suggest that critics and proponents are referring to two different types of power including power as controlling (Lukes', 2005) and power as creative (Barnes and Bowl, 2001; Deegan, 1996). As it is possible that both forms of power may co-exist in TCs, this chapter will explore the dominant form of power and Chapter 9 will address power as creative.

Within IRC theory, Summers-Effler (2004a) distinguishes between solidarity rituals, whereby individuals maximise EE collectively through solidarity, and power rituals whereby the more dominant members maximise their EE through being in a position of authority. In power rituals, emotions build up but are not shared, with dominant members gaining EE and subordinate members losing EE. This is a form of the controlling power that critics of TCs emphasise whereby staff gain positive EE at the expense of clients. In order to counteract this form of power, TCs seek to increase solidarity rituals and creative forms of power through reducing staff hierarchal power within everyday interactions. In other words, TCs seek to minimise power as control and maximise power as empowering through shared emotional energy. For instance, Haigh (2013:13) proposes that for modern TCs, 'a major part of the non-clinical work is to specify those limits and ensure that the space within them is kept free from authoritarian or managerial contamination'. Managing power dynamics is therefore a significant component of times spent outside of structured therapy.

The principle of flattened hierarchy, a model that is intended to create equality amongst members, is largely an accepted component of TC life. Furthermore, research that explores power dynamics in TCs (c.f. Sharp, 1975; Bloor et al., 1988; Baron, 1987) has focused on power between staff and clients. There has been very little research that explores the notion of flattened hierarchy in relation to client interactions. In particular, this chapter questions the principle of flattened hierarchy and proposes that the notion of 'fluid' hierarchy may be more applicable.

The use of interaction ritual theory, with its focus on the exchange of emotional energy and inclusion and exclusion, is especially helpful in analysing

power dynamics and social hierarchies within communities. Rather than simply describing issues, tensions and problematic examples of power in both TCs, a micro-sociological analysis can explain the mechanisms involved in power dynamics within rituals. This chapter thus addresses the following:

- To analyse how power works in practice through everyday interaction rituals in the TCs.

To address this question, I first briefly discuss the standards of morality in the TCs, outline the power dynamics in relation to the clients within Powell and Hawthorne. I then challenge the concept of flattened hierarchy, arguing instead for a framework of 'fluid' hierarchy.

8.1 Standards of Morality: understanding community values

Before analysing power within the two TCs, it necessary to provide a brief definition of the community values, or standards of morality, that individuals had to follow and, at times, defend and enforce. Powell and Hawthorne had a printed list of community boundaries, given to all client members upon arrival in the TC, which outlined the expectations of behaviour for clients and staff members. These included refraining from illicit drugs and self-harm (Hawthorne), failure to attend groups without discussing absences with the TC (both), taking pictures/videos without others' consent (Powell) and completing behavioural analysis after self-harming (Powell). Powell also had two mottos: 'if you have a secret, you have a problem', coined by the consultant psychiatrist, and 'turn up, tune in and tell the truth', which was posted in every room throughout the organisation. Additionally, there were several other implicit social rules I observed throughout my fieldwork, such as no swearing at Hawthorne. Whilst swearing at Powell was usually allowed, when new client member Holly referred to a member of staff as a "bitch" during the Smoking Break to Anna and Alison, Anna immediately told a member of staff as she was concerned by the talk, calling it "bullying". Anna then challenged Holly on her behaviour during the next Community Meeting telling her that they would not "tolerate" that kind of language towards staff. Holly was then required by the clients to apologise to the staff member. Moreover, clients at both TCs expected one another to be "working hard",

defined as attending all meetings, on time, providing feedback, working to reduce self-harming behaviours, sharing openly and participating in all aspects of community life.

Violating group boundaries could be met with two equivalent review processes: a Review (Hawthorne) or a Behavioural Analysis (Powell). Discussions of Reviews and Behavioural Analyses were conducted by the whole community and once completed, read out during TC meetings. However there were variances with how boundary violations were managed by the clients. For instance, Amanda, Powell Graduate Group member, noted:

> Some people would […] cut their wrists and we could go, there, there, there. And the next day someone else would cut their wrists and we'd go, you bitch! Get the fuck out of here!

How community values were enforced was thus often dependent upon the context of the situation. This was especially the case for implicit social rules such as where to sit at group meetings and when it was fine to have extra food at Meal Times. I found identifying these implicit rules challenging at first and were often learned through either making 'mistakes', such as when I sat in unlabelled but designated client member's chair, or learned from watching other clients be challenged on certain issues, such as how much to eat at Meal Times. As Collins (2004) explains, these standards were charged with a sense of morality so that violating a standard was equivalent to violating the whole TC. Furthermore, adhering to the social rules was often rewarded with feelings of inclusion and belonging. However this is not to suggest that conformity equated with solidarity. Social standards could be challenged whilst still experiencing feelings of belonging. The remainder of this chapter therefore examines how moral standards, or power, operated in practice within Powell and Hawthorne.

8.2 Power Dynamics

In order to contextualise power dynamics within the TCs, it is important to acknowledge that all of the clients shared that during childhood and adolescence, they had been the victims of abuse from people with power over them, including

family, friends, carers and other authority figures. The clients therefore came in to the TC with a history of negative power rituals, as their expectations of social interactions were of abuse and intense negative emotions including fear, anger and shame. To combat the emotional loss of these negative rituals, client members developed what Summers-Effler (2004a:311) refers to as 'defensive strategies', which she defines as strategic attempts to 'minimize the loss of EE'. Such an approach is very different to strategies that maximise EE through solidarity. Minimising EE loss could lead to defensive strategies such as self-harming behaviours, including many of the destructive behaviours that the client participants used (cutting, burning, disordered eating). Instead of trying to maintain the *status quo* of the interaction pattern, client members in TCs were striving to change their history of relating through solidarity building interactions within the TC. Often this process involved disagreements and power struggles between staff and clients, and between the clients themselves. Thus the TCs usually had a charged emotional environment as clients began to have an awareness of the strategies they, and others, used to maximise or minimise EE. Clients were continuously engaged in a two-way process: awareness of their unhelpful strategies and learning new healthier strategies for responding to others and their social environment. As such, power struggles were often encouraged in TCs in order to facilitate this learning process.

As there may have been differences between TC theory and TC practice, I wanted to understand the challenges and tensions of these power dynamics in everyday encounters. Because I did not sit in on psychoanalytic or formal therapy groups, my concern was not with interpretations in formal therapy groups or one-to-one interventions, but with how power was negotiated in the day-to-day living. When I first began my fieldwork, I was conscious of the criticisms of TCs and paid particular attention to any signs of 'staff control' over patients and client member conformity to norms idealised by staff. However, the view of the vulnerable client exploited, or weakened, by the professional and emotionally healthy staff member (Cooper, 1967) did not seem to fit either community. Clients in both communities exercised a great deal of agency. For instance, clients chaired all Community Meetings, agreed incoming new client members, challenged each other and staff members, determined what to cook during Meal Times and decided upon aspects of their respective TCs' timetables. Thus, a one directional view of power with the staff over the clients was

far too simplistic. Issues of power in relation to client members seemed to exist on three main levels as outlined in Table 4: staff-to-clients, clients-to-staff and clients-to-clients[9].

Staff-to-clients	Negotiating or reinforcing the 'staff' / 'client' divide
Clients-to-staff	Asserting equality with the staff
Clients-to-clients	Establishing mutuality or dominance and negotiating internal hierarchies

Table 4: Power Relations

With staff-to-clients relations, the main function was to negotiate power between staff and clients, or to reinforce staff's professional roles over clients so that the division between staff and clients was pronounced. Negotiating power with the clients involved some amount of *dis*empowerment for staff as they shared their power with client members (Winship, 1995). In this way staff encouraged the clients to take shared responsibility for life within the TC and the process of living life in the TC was by way of consensus. This was seen repeatedly in the way both clients and staff used the word "we" to describe actions within the community. From this perspective, every contribution was valued and every person's perspective could be challenged. Reinforcing the divisions between clients and staff members in contrast involved power being consolidated with the staff. This division could have been invoked legally, as in statutory duty of care, or it could have involved other forms of control such as therapeutic interpretations or manipulation. When this occurred, the language would often switch to "us" and "them".

Conversely, with clients-to-staff, client members sometimes sought equality with staff or challenged staff members' positions through disagreements, clients marginalising staff members and playing practical jokes on the staff. Like power consolidation with staff, clients' would more frequently use terms such as "they" to describe the staff team rather than a collective "we". In client-to-client relationships, client members sought mutuality, through processes of solidarity explained in Chapter 6, or dominance, such as openly marginalising a client or subtly excluding others through their internal hierarchies. Power in the TCs was continuously

[9] This study focused on interactions between client members, and staff and client members. As such, any interactions between staff members, including issues of power and hierarchies amongst the staff team, were not addressed.

building, consolidating, transferring and flowing in multiple directions. Moreover, these power flows were not inherently negative. For example, if some staff members began to use their professional authority unhelpfully, a client challenge against this approach readdressed the balance. Equally, staff exercising their authority over the clients often contained intense negative emotions and challenging situations, such as Lindsay (support worker) ending the Morning Meeting at Powell when Kristen began screaming, as depicted in Chapter 5. The staff and clients therefore sometimes functioned as checks and balances to one another's power. I consider each power relationship in relation to the clients.

8.2.1 Power: staff-to-clients

Chapter 3 identifies that differences in status do not result in power imbalances if EE is shared collectively between members. Nonetheless, due to differences between professionalised staff members and vulnerable client members, and because aforementioned TC research in Chapter 2 stresses issues of control within these dynamics, the issue of staff and client member power within daily interactions felt especially important during my fieldwork. I also realised the differences between 'authority' and 'control' when looking at staff-to-client power relationships. For instance Jessie noted during her interview:

> Because in my eyes staff are staff and we're members, so I don't kind of see it as inequality thing, it's still kind of, because they are, they've got authority over us, even though we're still a community.

Jessie's comment illustrates that staff at Powell and Hawthorne always retained 'authority' in that ultimate clinical responsibility, legally and professionally, rested with them. Whilst clients and staff members may not have had equal roles, everyone's contribution and perspective was meant to be equally valued. As Erica at Powell remarked, "They [the staff] don't say, this is what I believe so you should believe that too or you know that's wrong". She went on to explain that staff members welcomed clients' perspectives. Moreover, Alison from Powell described some staff members as "friends", suggesting she felt a level mutuality in her relationships with some staff members. For some clients, EE seemed to be shared amongst staff and clients.

However at both sites, I noticed that staff and clients sometimes struggled to maintain a mutually clear line between authority and control, with the staff often claiming authority and the clients sometimes accusing them of control. Brian at Hawthorne spoke at various times about staff members overriding their (the clients') wishes. Each of the key rituals at any one point produced disagreements between staff and client members. To illustrate this, the excerpt below is from a Morning Meeting at Powell whereby, Alice, a staff nurse, was trying to get Samantha, a client member, to hold individual 'Endings' with community members. This had been the subject of debate for some weeks as Samantha was not keen on Endings and repeatedly maintained that she did not have the finances to be able to do the traditional Endings with client and staff members, namely lunches and coffee dates in the city centre:

> Alice (nurse) asks about Samantha's Endings.
>
> "I ain't doing it," replies Samantha.
>
> "Samantha!" exclaims Alice (nurse) very loud. '*I* will be so sad. *I* want an Ending with you".
>
> Samantha gets defensive, her eyes flashing, her jaw fixed, arms folded across her chest and she responds, "I ain't doing it. The more you go on about it, the more I ain't doing it". (Powell, Day 12, 04/12/12)

Individual community Endings, where a client member met up one-to-one with all staff and clients in the TC, had become an implicit social rule at Powell. Staff members confirmed to me that this was not a 'requirement' of leaving but had become the expectation. Most clients participated in this ritual without question and clients explained this ritual to me as, "that's how it's done". Samantha however openly challenged this group norm. In response to this challenge, Alice (nurse) arguably used some emotional manipulation to personalise her disappointment and her request to Samantha that she reconsider holding Endings. Here, she seemed to invoke the dominating form of power that Lukes (2005) describes as Alice sought to change Samantha's decision by implicitly invoking Alice's relationship with her and the cultural expectations of the TC. Furthermore, by personalising her request, Alice also closed down the discussion as to why it was Samantha did not want to do Endings, and Alice did not explore the leaving process with her. Rather than the

social orchestration that Bloor (1986) describes, this interaction appears to resemble social control (Sharp, 1975).

Despite Alice's appeal that she do an Ending, Samantha held firm. In a later meeting, Samantha was supported by the clinical psychologist and consultant psychiatrist who affirmed that Endings, and who she did or did not do them with, were Samantha's choice. The psychologist and psychiatrist both contended that the community as a whole was prone to focusing so much on Endings that they missed the impact of the client's actual leaving. Samantha then set the tone for future Endings whereby another client Anna, who also claimed she was "skint", refused to hold individual Endings with staff or clients. By the time Anna's leaving was approaching, the community seemed far more willing to accept Anna's choice than they had initially with Samantha. This issue of Endings highlighted to me that staff did not always side with one another during disagreements and were willing to risk divisions amongst themselves when needed. Importantly, by openly discussing Endings as a community, Samantha remained fully inclusive with TC members. Thus, whilst Alice initially attempted to influence Samantha, the whole group was willing to adjust their expectations about what happens when a client member leaves. Power dynamics in this case enabled an implicit social rule to be confronted and rewritten.

Just as Alice attempted to use her personal relationship with Samantha, so too at Hawthorne, staff members sometimes used their relationships with client members to get them think or behave in different ways. Below is an example of the lead psychotherapist using his relationship with client member Abby to get her to say goodbye to a member of staff who was leaving the organisation after lunch:

> There is some discussion between Abby and Stephen (psychotherapist) about Abby saying goodbye to a member of staff. She is being very jokey with him and at one point, Stephen (psychotherapist) says that he is offended. Abby asks if he will forgive her and he says no.
>
> "What?!!!" she calls out loudly. She then chews her lip, eyes wide. However Stephen (psychotherapist) tells her that he will forgive her if she says goodbye nicely. This works, Abby leaves to say goodbye and Stephen (psychotherapist) beams at her. (Hawthorne, Day 29, 06/08/13)

Abby often worried about her relationship with Stephen, concerned that he was angry with her, and she discussed her relationship with him frequently with other clients and staff members. Client members teased that she had a "crush" on him. Though she often joked around with Stephen, she would constantly apologise if she felt she had gone too far. Thus Stephen saying he would not forgive Abby unless she said goodbye and beaming at her once she had done it suggested to me that affirmation was being withheld and would be reinstated following compliance. However, given the power imbalance between them and Abby's fear of upsetting Stephen, to me Stephen's approach was not only manipulative, but also arguably patronising and patriarchal. I also struggled to see how this interchange was empowering Abby. Rather, it seemed to make her dependent upon Stephen for feeling positive EE, such as confidence and inclusion, as he was not sharing EE in this exchange, he was bestowing it. This appeared particularly problematic, as it was reminiscent of the negative power dynamics that Summers-Effler (2006) describes between dominant and subordinate individuals. Had Abby not complied with Stephen's request, she may have felt excluded from relationship with him, shamed or depressed. This again seems an example of the social control that critics of TCs have noted.

I then compared the above interchanges with an exchange between Paul, consultant psychiatrist, and Anna, a client member, during a morning meeting disagreement about whether she would commit suicide upon leaving the TC. In this scenario, Anna accused Paul of emotional manipulation:

> Anna states that she does not feel like she can talk about her suicidal urges because it upsets others. Erica responds that she feels it is more upsetting for Anna not to talk about them. Kristen also agrees, saying, "All of us have suicidal urges".
>
> But Anna insisted that her rational control was stronger than others and that where she can stop herself from committing suicide, she knows others could not. Also, because she is not going to do it whilst she was here, she sees no point in discussing it. Paul (consultant psychiatrist) then steps in and says that just because clients leave that he does not forget them, that he remembers clients after "they walk out that door". He says he would be very upset if Anna committed suicide.
>
> Anna replies very matter of fact, and without missing a beat, "That's emotional blackmail".

> "Yes it is", responds Paul (consultant psychiatrist) in a firm voice. He goes on to explain that he does not make any apology for that and that he does genuinely care about what happens to clients when they leave, that it has an impact on him. Anna furrows her brows into a bit of a glare and her face is tight and set, her body language rigid. (Powell, Day 26, 14/01/13)

In this instance, Paul agreed he was using emotional manipulation with Anna. Certainly one interpretation is that as a psychiatrist, Paul was anxious about a client under his professional care committing suicide. Attempting to assuage his anxiety, he used a form of control in a sentimental guise. However, staff members had feelings as well and it could also be argued that stating them was not always manipulative. Indeed, one of the other interpretations from this interchange is that Paul had compassion for Anna and her situation and expressed his concern, though Anna did not see it that way. Whilst there may have been elements of both interpretations in this scenario, the overall key to distinguishing between this exchange and the one with Stephen and Abby, and Alice and Samantha, is that Paul did not make Anna dependent upon him for receiving positive EE. Instead, Anna's refusal to acquiesce to Paul's perspective seemed to indicate that Paul could still be challenged, despite the powerful position he occupied in the TC. There is no indication that Anna worried about whether Paul would still accept her if she challenged him. Moreover, by communicating the effect that Anna's death would have on him, Paul expressed his personal feelings in an attempt to open the discussion further with Anna, crucially drawing her into relationship and sharing EE with her, rather than withholding it from her. This suggests there is a difference between manipulation and therapeutic honesty.

Additionally, as noted above, sharing power with the clients involved a level of voluntary disempowerment for the staff (Winship, 1995). For instance, at Powell client members voted to make evening 'Check-Ins', a 15-minute group whereby everyone in the room briefly stated how they were doing, voluntary. Staff wanted to keep Check-Ins mandatory for all clients. However, the clients overruled them and the staff went with the clients' decisions. Clients would also overrule staff members when it came to enforcing group values either by insisting on Reviews/Behavioural Analysis, or by insisting that certain behaviours did not warrant consequences. Furthermore, I noticed that staff members usually sought to remain approachable to

clients. At both TCs, staff would often leave their office door open for clients to come in to ask a question, share a joke or just chat. They allowed themselves to be the brunt of client members' jokes, including how they dressed and how they spent their days off, they engaged in Social Times including playing games, and at Powell, watching TV, singing and playing musical instruments. When they made a mistake, staff members apologised to clients, often in meetings or in front of other client members.

Lastly, in terms of staff-to-client power dynamics, I would concur with research by Bloor (1986) and Bloor et al. (1988) that there were occasions when therapeutic work in the TCs was used for social control, such as the interactions between Alice/Samantha and Stephen/Abby, but this did not mean that all interactions in the communities were controlling.

8.2.2 Power: Clients-to-staff

I found as my time with Powell progressed, and throughout my time with Hawthorne, that client members would challenge staff members, sometimes directly during meetings, or more passively through practical jokes. For instance, at Hawthorne, client members expressed their fury at the TC for having to close for one day due to staff shortages and demanded in a group meeting that the support worker cancel her annual leave in order to keep the TC open. Staff members resisted and the TC closed for the day, prompting weeks of complaints from clients. At Powell, client members often teased the clinical psychologist for being late to Community Meetings and individual appointments. It could be that their teasing of him was an indirect way of expressing their anger at his consistent tardiness.

Additionally, at Powell, there was a newly qualified nurse that, over time, many clients took an overt dislike to. As the weeks progressed, the clients felt that this nurse was offering unhelpful and hurtful feedback. This reached a climax during a Morning Meeting then the clients tried to force the staff team to formally review her conduct and openly suggested to staff that the community was not the right place for her. Whilst the TC may not have been a good fit for the nurse, the nursing manager and the consultant psychiatrist were quick to remind clients of the organisation's

human resources' policies and UK employment laws and that clients could not dictate performance reviews of staff members. Following this, clients refused to listen to her feedback and continuously picked up on all aspects of her relational style, complaining that she was too loud, too insensitive and not competent. Frequently the clients complained that they did not feel "safe" with her on shift. Just as I was completing data collection, I learned that the nurse was leaving the community.

It is worth noting then that client members sometimes formed an alliance to create greater solidarity amongst themselves by excluding staff members. As Heather from Hawthorne explains:

> I know when I first joined the community um there was an *air* of old community that was sort of leaving, that was very much, us and them with staff. […] And I think it's a cycle that you tend to see in communities where the staff almost become the enemy.

The 'us/them' mentality that Heather describes at times existed in Hawthorne. Though clients did not admit this happened at Powell, I certainly observed it on occasions, such as with the marginalised nurse. Thus power was not simply a matter of the staff in positions of control over clients and monitoring when rituals became driven by power rather than solidarity. Client members could also seek to maximise their EE by excluding some or all of the staff members.

8.2.3 Power: client-to-client members

Haigh (2013:34) writes that modern TCs acknowledge that each person in the community has their own agency, and that this personal power can at times be 'destructive, envious and hateful'. However, whilst TC research has looked at staff and client power dynamics, as Chapter 2 highlights, an exploration of power between client members in TCs is not often addressed. I therefore looked closely at client member interactions during the fieldwork and data analysis. Jennifer, a Graduate member of Powell recalled, "Um people could be quite cruel I think. You know, it wasn't all support, support, support, support you know". Her comments echoed what I observed and heard from some clients during the interviews. That these dynamics were sometimes present in both TCs amongst the client group is hardly

surprising, as they exist in other mental health environments (Davidson et al., 1999; Bloor, 1986). The question then is how the community responded to these dynamics, in what ways the client members engaged in power conflicts with one another and for what purpose.

Additionally, Summers-Effler (2006) argues that for those who have a negative history of power interactions, such as the TC clients, power becomes less about consolidating EE than it is about minimising EE loss. From this perspective, marginalising or excluding other members is not necessarily to create a power base, but to prevent potential increases in negative EE that may result from other clients' destructive behaviours. Moreover, not every client was consistently an 'insider'. Some clients moved frequently from insider to outsider status, sometimes by their own isolation and at other times because they were excluded from the group. To examine how this functioned in practice, I draw on two examples from Powell and Hawthorne.

The first excerpt from Powell depicts how during a Community Meeting the clients take issue with Julie's perceived lack of engagement with client members:

> Then the conversation goes on to talk about how Julie does not engage in conversation, in the group, at Meal Times, in the lounge, etc. Tessa, states in a soft, reassuring voice, "I would love more chances to talk with you". Then she goes on to say about how Julie "just sits in the lounge doing nothing. I really don't feel that is helpful".
>
> Then there's discussion about how Julie doesn't make eye contact during meetings. Julie says, "I am trying to not disconnect, so I look down so I can concentrate on what they are saying".
>
> Alison responds, "I feel like you are disinterested when you don't look at me".
>
> Martha adds, "There's normal behaviour and then-"
>
> Julie interrupts, "I'm trying!" She looks up with very wide eyes, and continues, "I do feel I am genuinely trying".
>
> Speaking more gently, Erica replies, "We don't expect it to change overnight, it takes time, it's a process".
>
> Tessa says, "As long as you are trying" in a bit of a rougher, insistent voice with her legs crossed and arms folded across chest.

> "I am", Julie responds. Staff say nothing during this exchange. (Powell, Day 45, 27/02/2013)

Unlike Tessa, who was consistently an insider, Julie was someone who moved more frequently between insider to outsider within the group. Julie did sometimes isolate from the others but, equally, some of the clients were very openly insistent that Julie adhere to the meal plan and not engage in disordered eating behaviours such as over exercising. Thus there was often tension between Julie and the other client members. In this excerpt, Tessa started out gently, appearing to try to include Julie. However this quickly turned into a point about Julie isolating herself from the rest of the TC. Though Alison's comment may have been honest feedback to how she experiences Julie's lack of eye contact, Martha all but calls Julie's behaviour abnormal, implying she is different from the rest of the group. Julie protests, is supported by Erica, and, perhaps eventually, by Tessa. Rather than the clients showing understanding of Julie's difficulty to make eye contact and engage more with the community, it seemed that Julie was left having to 'prove' that she was making an effort, and thus adhering to the morally charged community values to work hard.

Often staff allowed these dynamics to surface and play out with little intervention. Margaret (nurse), in her interview with me, explained that it was difficult for staff to intervene when a client was being marginalised as it could actually make the situation worse. For example, it may seem that staff favour the excluded client member, thus prompting further exclusion. However they did intervene following a more troubling exchange between Martha and Julie one dinnertime. Julie had thrown out her half-eaten yoghurt pot in the bin only to have Martha demand that she retrieve it and finish it. Though I did not witness this incident, staff told me it was especially concerning that Julie was forced to eat contaminated food and that they were addressing the dynamics between Martha and Julie. They particularly wanted to help Martha realise that despite the ways in which she was abused, at times she could be a perpetrator of forceful behaviour.

Differences of power between staff and clients, because of the staff members' professional expertise, are understandable. Staff members have a professional role, authority over clients and a higher standing in society in comparison to clients.

Despite these differences, the key to maintaining solidarity in interaction rituals is that positive EE is *shared*. My data highlights that at times, staff did use their power to manipulate and withhold EE from client members, creating power rituals with the clients either dependent upon the staff for EE or actively losing it. However, at times the clients could also seek to marginalise members of staff. This suggests that power dynamics flowed in multiple directions within the communities and was not unilateral. Importantly, examining the way that power is used between client members reveals that whilst in theory all client members may be equal, at times they are not. Inequality between client members directly challenges the concept of flattened hierarchy within TCs.

8.3 The Mythical Notion of 'Flattened Hierarchy': the case for 'Fluid Hierarchy'

During an interview with Tessa from Powell about the power dynamics in the TC, she remarked:

> When I first came for my first assessment, I didn't know who was staff and who was client.

Her comment illustrates one of the long-valued principles of a democratic TC: a flattened hierarchy that reduces the divide between staff and clients. In such a community, all staff and clients share responsibility for the community and their contribution within it. Staff do not wear uniforms but blend with client members. Rather than consolidating power within the staff team, it is meant to be shared amongst all. I had the same reaction as Tessa during my first encounter with Powell. A woman I took for a staff member ended up being a client. Initially, I saw this as preliminary confirmation that power in the community was indeed flattened with minimal divide between staff and clients. Moreover, I assumed that most of the power dynamics and tensions would occur during structured therapy. However, during fieldwork I realised that power dynamics in TCs were highly complex during times outside of formal therapy. I began to question what a flattened hierarchy meant and whether all clients were really equal to one another.

In order to understand about power and social control in TCs, it is necessary to recall the spirit in which they were formed. As Chapter 2 acknowledges, TCs were

established in part as a move away from traditional psychiatric approaches that denied clients power and agency in their treatment. In contrast, TCs attempted to empower and enable the client to take a much greater role in his/her therapy. Instead of the traditional hierarchal line of power that privileged the role of the doctor/psychiatrist, TCs sought a flattened hierarchy that places the client perspective on par with that of staff members. Moreover, a flattened hierarchy model recognises that everyone in the community, staff and clients alike, have individual power and agency and that all members have a responsibility for their behaviours and actions within the community (Winship, 2004; Haigh, 2013). However, the concept of flattened hierarchy does carry two problems: one, it can underestimate or ignore the role that power actually plays in interactions, as outlined above, and two, it emphasises the direction of power between staff-to-clients and assumes that client members themselves are equal. Additionally, Spandler (2006) identifies that the contradictions between TC models and TC practices are rarely addressed. I therefore question the notion of flattened hierarchy and argue that a framework of fluid hierarchy more accurately reflects the social reality of life within TCs, particularly in relation to client members.

8.3.1 All Client Members Are Equal?

The notion of client member equality in TCs, whereby all clients are equal to one another, is often assumed, especially as theorists tend to focus on staff-to-client dynamics. On the clinical level, staff and clients at Hawthorne told me that all clients were equal and had an equal responsibility for themselves and the community. In practice, as the earlier comment from Jennifer illustrates, it was sometimes a different story. I soon found at both communities that the notion of client member equality was complex and inconsistent. Moreover, the two communities varied in their approach to questions of power between the client members. For instance, Powell client members repeatedly told me they operated on a flattened hierarchy approach and that there were no cliques or sub-groups within the client membership, which was reiterated during their Annual Peer Review and Accreditation Visit from the CofC. Throughout my observations as an outside researcher, I found that this denial of cliques closed down any discussion about power imbalances between client members. However it is important to remember that the TCs underwent periodic

changes as the client cohort shifted. Staff members told me that this particular client group was more equal than client groups in the past. Therefore, staff and clients may have assumed a certain level of equality amongst this client group, particularly in comparison to other groups. Regardless of the reason, the community rarely discussed power issues between client members during everyday rituals. In contrast, Hawthorne client members were more vocal in Community Meetings and Social Times about the client member hierarchies. Whilst this in turn led to discussions about power, there still seemed at times a reluctance to openly acknowledge any current inequalities, cliques or subgroups within the community as the majority of clients stated during meetings that they felt everyone was fairly equal and that no one was excluded.

At both communities, subgroups would be pairings or small clusters of clients that became friendlier with one another than with others. This in itself did not necessarily appear to be problematic or indicative of a hierarchy, especially as clients moved between groups. Moreover, in ritual theory, there can still be solidarity if emotion is *shared*. The problem occurs when power builds with a particular group or some members feel excluded. Despite fluid groupings, I found that patterns of power inequalities emerged and positive EE did not always appear to be shared amongst all members. During the interviews, these inequalities became more evident:

> It's quite often the strong members who, not bully, but coerce or, or they just set a, a means of behaving and rather than endure a conflict, or rather than go on a limb, the weaker members will follow those stronger members. (Martha, Powell Interview)

> And I felt like certain members were more important than others. Because you've got like the whole senior member hierarchy. (Jessie, Hawthorne Interview)

> So, it's hard getting to know the group and, kind of thing is you have a pecking order in the group as well. And I'm at the bottom of it I feel. […] So it's tough, on one hand you do want to be part of a group and you want to be accepted, even just accepted, even if you're the bottom of the group, but you still want to be accepted. (Robert, Hawthorne Interview)

As the excerpts above illustrate, clients refer to an invisible social hierarchy that appeared to leave some clients with less EE than others. I observed that these

inequalities were not based solely upon like or dislike, as even those that someone disliked could still be given deference (Summers-Effler, 2004a). For instance, Tessa at Powell was close to very few people but clients often sided with her in discussions, particularly disagreements with staff members. Therefore, I observed that not everyone was equal in practice. The question then is what these hierarchies were based upon and what they mean for the TCs. From my fieldnotes and in analysing the interviews, I suggest there were three main types of hierarchies that formed within the two communities amongst the clients: senior/newer members, men/women (Hawthorne only) and older/younger aged members. I consider each of these in turn.

A difference between senior and newer members is perhaps the most natural of hierarchies within the communities. In general, senior members at the TC were the three or four clients that had been there the longest. Senior members had more knowledge about how the community worked, including the explicit and implicit social rules, and had the most social and relational history with staff and other client members. Because they had been there longer, they had more positive EE associated with feelings of inclusion and belonging compared to a newer member who had to build solidarity with the TC. As a newcomer, Jessie was aware of this dynamic and found it "intimidating", as she states: "Plus everyone has had however long they've had to get to know everyone else. […] So, it's intimidating and scary". Both communities expected different, and higher, standards of their senior members than their newer members. Not only were senior members expected to know how the community operated, they had to give more feedback, help newer members acclimate to life in the TC and demonstrate that they were 'changing'. At Powell, demonstrating change usually related to reducing self-harm behaviours and dissociating, needing fewer, if any Emergency Meetings, and speaking positively about life after the community. For Hawthorne, change was more varied and could include reduction of self-harm, improved relationships with friends and family and, especially, tangible life/career options when leaving the TC.

Senior members responded differently to these challenges. Members at Powell appeared more likely to accept this role and made a consorted effort to "step up", though Alison did describe in her interview the "pressure" she felt in this role: "Because it feels like I have to be the shiny example and I don't feel like much of a

shiny example". In contrast, whilst most newer members at Hawthorne reported looking up to senior members, senior members such as Abby, were often quick to remind the others that each person's therapy was his/her own responsibility and looking up to others merely shifted personal responsibility onto someone else. This reaction could have been an attempt to re-flatten the hierarchy amongst the client group or may have been a defence against the expectations from the TC. Either way, rather than use their senior status to manipulate other client members or consolidate positive EE, senior members appeared reluctant to take on their role and remained conscientious of others' expectations of them. Additionally, during everyday rituals, senior members sought to help newer members build solidarity with the TC. Thus despite the difference in status between senior and newer members, community rituals were usually based upon building solidarity.

Secondly, there was a gender split between male and female clients at Hawthorne. When I started with Hawthorne, there were more males than females, with two female members and five males. This did change as my time went on so that by the end there were six females and four males. The women did not refer to this split, either from what I observed in the communities, or in the interviews. Men however, were far clearer about this division. Carl in a Morning Meeting reported feeling "emasculated" and like a "predator" of women as a result of being in the TC. Donna, one of the nurses, confirmed that men often reported feeling emasculated and explained that staff were also aware of the gender imbalance within the staff team as only Stephen, the psychotherapist, was male. Additionally, Christopher highlighted during a Morning Meeting that there were no masculine type magazines available during art therapy for collages. Evan, Brian and Robert, the only male interviewees, all stated that they felt apprehensive about making any kind of comment to women as men, especially women who had been sexually abused, for fear of reminding them of their abusers or getting it wrong. Robert, in particular, noted that Jessie, a small, young female client was "allowed" to make a loud and aggressive, if not verbally abusive, comment to him of "I'll fucking kick your head in". He argued that had he, an older, muscular male said the same comment to her, he would have been automatically discharged. Mary frequently commented on Robert's marital infidelities, once labelling him, without jest, a "bastard" in front of all the clients. No one challenged her and it was not brought into group. This was unusual

because swearing at Hawthorne, even in jest, was often brought into groups for discussion. Combined, all this suggested that there were subtle but very real differences in that the males felt more conscientious to not upset the women when interacting with them whilst none of the women reported feeling conscientious in their interactions with the men. It must be remembered however that gender was not the focus of the data. As such, whilst there appears to be a gender split that at times resulted in the loss of EE, particularly for Carl and Robert, it is not fully known whether this resulted in a consistent EE loss for the men or in what ways women may have lost EE. Moreover, it is not known how both men and women may have benefited from one another in their gender differences.

Thirdly, there was a hierarchy between older and younger-aged client members. At Powell, clients frequently commented on how 'younger' clients may have been too young for the programme. The definition of 'young' however was never clearly stated. Nonetheless, Jennifer articulates this position by explaining that some people were marginalised because of their age: "Uh they often were younger. Because women discussing, you needed a certain amount of emotional intelligence before you actually come to a place like this". This view was frequently repeated amongst the Powell clients. It was almost as if older clients felt they had reached a level of either maturity or desperation through years of acute wards and self-harming behaviours that they were willing to reflect on their behaviours and change. Additionally, there was a feeling that younger clients were far more likely to exit the programme prematurely than an older member. Clients such as Julie, Kristen, Holly and Andrea, who most frequently occupied 'outsider' status in the community were all younger than 27; three of those, Julie, Holly and Andrea left the community prematurely. In contrast, the older clients were consistently insiders and at times excluded the younger members.

At Hawthorne, differences between age groups appeared subtler and it was only through an analysis of the interviews that these differences came to light. Like Powell, the definition 'younger' was never clearly stated. However unlike at Powell, younger members occupied a higher level of status than did older members. Younger members such as Jessie, Megan, Abby, Brian, Daniel, Lauren and Christopher (all under aged 35) were most consistently insiders, and were rarely

excluded. Moreover, the younger members seemed to form friendship-type relationships with one another as they had more things in common such as interests in music, films and dress. As Megan explains:

> Two or three people are sort of like acquaintances because I'm finding it more difficult to get on with them. Because I think maybe because they're older than me[…] Um, the something like the younger members, […] like I feel more like a friendship sort of thing. (Megan, Hawthorne Interview)

I observed that younger members bantered easily with one another, often through swearing and jokes, and discussed their future career and relational plans. In contrast, older members of the community struggled to integrate fully, as the excerpt from Mary below highlights in relation to the Smoking Breaks:

> Um, Stephen (psychotherapist) had also flagged up, because like I had been out to the smoker's corner and […] I bought some to have a few, and he said, well Mary didn't fit in […] He said she can't fit in with the girls because all the girls are younger and all the girls lost their father at a young age, all three of them, and I didn't lose my father at a young age and I'm not young, and I don't know and there was something and I thought (*voice changes to high pitched*), oh God, oh no I can't fit in… (*voice returns to normal*) […] I thought, mmmmm, do you need to fit into the clique or can you just be same as everybody? Don't know.

Robert and Carl both attempted to joke with the community but rather than be included, they consistently seemed to cause offense. Whilst younger members looked over college and university brochures, the older members rarely discussed future aspirations upon leaving the TC. Often it was the younger members most frequently in a position of excluding others. Thus at both communities, there were times when positive EE was consolidated within particular subgroups, including those based upon age.

However, not all of the power differences could be explained by senior/newer status, gender or age. As I looked across the various hierarchical structures, I noticed that there were always exceptions. A further analysis indicated that the TC value of "working hard" mattered when it came to insider status of both TCs. If a client was engaging with others, sharing openly about their struggles both inside and outside of the TC, bringing things into group, attending all the meetings, accepting and giving feedback, reflecting on their behaviour and working to change their relational styles, then clients were far more likely to tolerate negative behaviours and

were also more likely to show deference. Gaining solidarity and positive EE in the TCs seemed to be based more upon engagement with the therapeutic programme than on social status.

8.3.2 A Fluid Hierarchy Model

Rather than a flattened hierarchy model advocated by many TC writers, I would propose a model of fluid hierarchy that acknowledges clients at any one point might hold differing levels of power and social status. Whilst Haigh (2013:13) does recognise that the recognition of personal agency in modern TCs 'goes much further than the original "flattened hierarchy"', he stops just short of departing from it. I propose that a fluid hierarchy model is more applicable to TCs and still allows for deliberate efforts to minimise the power imbalances between staff and clients through shared responsibility and changing roles, whilst realistically acknowledging that at times, the staff do exercise more authority over the clients. Significantly, a fluid hierarchy model acknowledges that hierarchal components and power imbalances exist within the client cohort. This in itself is not problematic as long as positive EE remains *shared*. However what is crucial is whether these power roles become flexible or rigid resulting in positive EE imbalances. Moreover this follows Haigh (2013:13) who argues, '[a]uthority is fluid and questionable – not fixed but negotiated'. Flexible social roles suggest that there is room for client members to change their social position and that the community allows for shifts in its hierarchy without power being consolidated in any one individual(s), staff or client. It allows for the implicit social values and norms of community living to be negotiated, such as the example at Powell with Samantha's Ending.

In the main, most of the clients at Powell and Hawthorne were able to challenge one another and shift between power roles whilst maintaining positive EE. At times of course, this did not always happen and rituals become power based (Summers-Effler, 2004a). The main factor for exclusion from the TCs was anyone who, over time, did not "work hard" on the programme and repeatedly violated community boundaries. Thus client members could continuously shift between

insider and outsider status. Whilst some occupied insider status more frequently than others, there was at least some movement.

SUMMARY

This third data analysis chapter has explored how TC members negotiated and enforced the moral standards of the community through an analysis of power within interaction rituals. Crucially, explorations of power in TCs have not specifically focused on power dynamics between client members. Data from Powell and Hawthorne highlights that power within everyday interactions was a complex social process. Power dynamics could be helpful, as in empowering patients by recognising their personal agency, yet these dynamics could also be destructive when members were excluded. Moreover, I argue that the radical flattened hierarchy approach that theoretically guides TC principles does not actually function as a flattened model in practice. Rather, a fluid hierarchy, whereby clients shift and change social positions, seems a more accurate explanation as to how the power structure operated within the communities, particularly amongst the client group. Lastly, clients at both communities at times marginalised or excluded staff or client members. This suggests that some social interactions did not establish shared solidarity with all community members. Instead, some clients at times used interaction rituals to consolidate power amongst dominant members.

Chapters 6-8 have thus far explored the mechanisms of IRCs within Powell and Hawthorne. As Chapter 6 highlights, negative EE could be transformed into positive EE if members felt a sense of solidarity and belonging. Building upon this, Chapter 7 identifies that emotional entrainment rhythmically pulled members together and could sustain solidarity if the TC could absorb any negative EE. Moreover, Chapter 7 explains that the main influence on a ritual's function was the role of inclusivity and exclusivity. In Chapter 8, power and social control are intrinsically linked to inclusion and exclusion as members used their influence to determine who is in and who is out. All of this then brings us to the final question: what is the impact of all of these ritual dynamics on personal change? The final data analysis chapter,

Chapter 9, will address how clients defined change and examine the personal change outcomes as a result of IRCs in the two communities.

CHAPTER 9. EVERYDAY INTERACTION RITUALS AND PERSONAL CHANGE

INTRODUCTION

This research originally intended to study individuals within TCs in order to understand how, and to what extent, social interactions facilitate personal change. Such an approach placed both *individuals* and *change* at the centre of the research. As a result of fieldwork, the emphasis shifted and *interactions* became the centre of analysis with the *process* of change being viewed through the lens of everyday rituals. TCs strive for social interactions that confront, challenge and support client members during a process of change (Jones, 1976). The previous data analysis chapters have been concerned with *how* social encounters within TCs can contain very negative emotions such as anger, fear, shame and frustration and yet remain supportive and inclusive of client members. In particular, Chapters 6 and 7 argue that solidarity and inclusion are vital to generating successful rituals, feelings of belonging and personal agency in TCs. Additionally, Chapter 8 highlights that interactions within TCs can at times display power dynamics of both agency and domination, and that power struggles exist between client members.

Despite the shift in focus from individuals to interactions, I have remained interested in the question of personal change throughout this study. Thus whilst the previous analysis chapters have analysed the mechanisms of interactions, the question then is what these interactions have to do with individual transformation. In other words, how did the clients feel they were changing and what mechanisms did they feel brought about this change? Moreover, having explored dominant forms of power in Chapter 8, did the clients feel that they were gaining creative forms of power? To that extent, this chapter addresses to the question of personal change with the aim of exploring the relationship between interaction rituals and personal transformation. The chapter seeks to cross reference the analysis of interactions rituals with the clients' perspectives. Specifically, this final analysis chapter examines the following:

- How the client members defined and understood personal change;

- What the client members found to be helpful or unhelpful as part of their change process.

I begin by defining personal change from the perspective of the client members. It is important to acknowledge that the notion of personal change implies a view of the self that is flexible and able to make shifts according to social stimuli. Chapter 2 identifies that this thesis overlaps with symbolic interactionism whereby individuals through social interactions continuously engage in a 'process of interpretation' about the nature of the self (Blumer 1969:5). Thus definitions of the self, others and the social world are derived from social encounters (Burkitt, 2008). Moreover, individuals are motivated to have a positive sense of self (Collins, 2004). However, this motivation becomes problematic for those with a history of violence, neglect and trauma. Summers-Effler (2004a, 2004b) suggests that for those who have unhelpful experiences of interactions, their expectations of social encounters are often also negative, which results in a negative view of the self and can produce feelings of anxiety and depression. She contends that individuals then attempt to minimise these emotions through things such as avoidance of others, submission to unhelpful power dynamics or using self-harming behaviours. In these scenarios, individuals' motivation for interaction then is not to seek out positive emotional energy (EE), it is to reduce EE loss. To break this cycle, TCs aim to provide clients with alternative definitions for social relationships and personal identity (Stevens, 2012; Bloor et al., 1988; Jones, 1968). This is important because positive social interactions can challenge negative expectations of social situations and can prompt individuals to consider changing their expectations of interactions based upon new meanings (Summers-Effler, 2004b). Additionally, if one's social expectations are not reinforced over time, these expectations can shift to produce new emotional definitions of social encounters. Change from this perspective is fluid and linked to how clients define their expectations of interactions, their view of the self and their place within the social world. Individuals, such as TC clients, can therefore change their view of themselves, others and their social environment through social interactions.

9.1 Defining Personal Change

In order to understand what change in the TCs meant to the clients, it is important to contextualise what their lives were like before they came into the communities. All of the clients in the TCs reported experiences of unhelpful social interactions. Many clients spoke of personal histories of self-harm, abuse, violence, disassociation and psychosis, prison, broken relationships, repeated suicide attempts, disordered eating, inconsistent or non-existent employment, and for some, multiple experiences with mental health services including involuntary detention in acute and secure units. These experiences left many clients dependent upon mental health services, family and friends. As the previous chapters have explored, life in both TCs was structured to challenge negative relational patterns and provide clients with alternatives for managing distress and their social relationships. Additionally, through shared decision making during Community Meetings, Stevens (2012) suggests that clients are encouraged to use their own power and voice to contribute to the running of the TC. The question then arises: how did the clients feel they were changing as a result of being in the TC? Did they feel positive EE as a result of being in the TC? Did they feel empowered and a more autonomous sense of self? Or were there clients that were left feeling worse or negative EE?

Preliminary analysis of the 21 client interviews[10] highlighted that clients at both communities spoke about change in emotional terms, rather than behavioural. For instance, rather than talk about reduced self-harm, six clients kept using the word 'confidence' to describe how they felt they had changed. I had not asked anyone specifically about 'confidence' and therefore began to look across the interviews for patterns in relation to participant reports of increased feelings of confidence. Given that positive emotional energy, such as confidence, is also one of the theorised key outcomes of interaction rituals (Collins, 2004), I was particularly interested that clients described feeling 'confident' as a result of being in the TC. These comments included:

> []hey helped with my confidence, they helped me deal with facing things. […] I have this sense of feeling in myself that I know I'm going to be okay. (Heather, Hawthorne Interview).

[10] Out of 33 client participants in total between the two sites.

> Um but I feel like I've, I have become more confident in myself um, than I was when I came in. […] Um, yeah, I do feel I am more confident when I speak to people. (Alison, Powell Interview)

> I feel a lot more confident in that I don't have to act on urges. I don't have to have my packets [of pills] beside my bed. I don't have to go and count them when I'm feeling stress or worried. (Erica, Powell Interview)

I then noticed that a further 10 client members also spoke about how they felt able to do new things, had a greater sense of self, were able to validate themselves and felt more in control in their daily lives. This seemed closely linked to confidence and included comments about feeling empowered and more autonomous in their lives:

> I'm starting to like myself bit more than I did. […] Even if it's the smallest bit, I think liking myself is a big achievement. (Jessie, Hawthorne Interview)

> Before I felt the anxiety was ruling me. It was almost like being possessed by anxiety. […] Where now…I feel in control. I'm not saying all the time, but I am doing 80% better… (Amy, Powell Interview)

> Am I living a better life than I had before here? Damn right I am! I was on a deprivation of liberty, I couldn't go for a pee without somebody being stood outside of the door, and now I'm living in a [independent] flat, I have four hours of support a day but that's worked around where *I* believe it works, um and I've got my freedom. (Amanda, Powell Graduate Member Interview)

Crucially for Amanda in particular, this sense of autonomy did not mean complete independence from others. Rather, "freedom" meant living with others, including social services, in such a way that was not dependent upon them but was *inter*dependent whereby she could use her voice to negotiate what worked best for her.

The majority of clients during the interviews (16 of 21) directly or indirectly discussed confidence as a form of personal change that resulted from being in the TC. This suggests a subjective definition of change that was emotional rather than behavioural, as in they said they *felt* different. Some clients of course did also refer to behavioural changes, such as Erica who reported she no longer stocked pills. Nonetheless, clients primarily spoke about change in emotional terms. A definition of change as emotional is in line with Haigh (2013:14) who lists 'emotional development' as an essential aspect of TC work. Fitzpatrick and Stalikas (2008:146)

also argue that positive emotions, such as confidence, can be 'indicators' and 'generators' of therapeutic change.

Linking emotional change back to ritual theory, one of the outcomes of a successful ritual is the personal feeling of 'confidence' (Collis, 2004, 2014). As Chapter 6 identifies, confidence is an indicator of positive EE that is generated from feelings of solidarity and inclusion. Increased positive EE coupled with changed expectations of social situations can result in positive changes in identity (Summers-Effler, 2004a). It is therefore noteworthy that the majority of clients interviewed reported positive emotional feelings about themselves or their capacity to manage negative feelings as a result of being in the community. This suggests that clients were redefining their definitions of social expectations and their sense of identity based upon new (positive) emotional meanings. In other words, the clients moved from understanding the self based upon old definitions and expectations of social interactions, to a view of the self that arose in the TCs, based upon new collective meanings and expectations of social encounters. Summers-Effler (2002:50) contends that for marginalised groups, such as those with a diagnosis of PD, a 'collective identity provides a meta perspective on one's self'. When identity is shifted away from the individual, and his/her negative history of interactions, to that of the group, then the individual is able to see him/herself from the perspective of the collective. Identity comes not from the isolated individual but from the collective formation of like-minded others, which is similar to Mead's (1934) 'taking the role of the other' but on a group level. The impact this shift has on negative personal emotions can be significant. As Summers-Effler (2002:50) explains:

> When one can see one's self from a meta perspective, one can come to see one's own experience as part of a larger pattern rather than an individual experience of fear, inadequacy, lack of fulfilment, depression, or unhappiness. In solidarity, deviant emotions come to represent less of a threat to one's social bonds *because the deviant emotions themselves have come to be associated with new sources for solidarity and emotional energy formed in collective identity* (emphasis added).

Individuals use their negative emotional feelings about past encounters to find a sense of belonging and solidarity with others who have similar experiences. Thus, as proponents of TCs suggest (Stevens, 2012; Haigh, 2005, 2013; Jones, 1968, 1976), it would seem that TCs can generate creative forms of power as seen through

increased feelings of confidence and sense of autonomy that promotes interdependency with others.

However, the relationship between interaction rituals and change is a very complex process and this initial analysis is far from straightforward. Firstly, a TC approach did not work for everybody and not everyone felt they had changed positively. Of the five clients who did not describe feelings of confidence, two clients had only very recently joined the TC at the time of interview; one reported feeling very cautious about any changes experienced in the TC; one did not identify any change; and one identified negative changes. Secondly, of the clients that did identify feelings of confidence as change, many spoke of their anxiety about leaving the community, such as Tessa who referred to the TC as a "bubble" that was "not real". For these clients, they were concerned about whether they could sustain the changes they were experiencing once they left the community. Thus change, and definitions of change, has to be contextualised in order to understand the depth of client members' experiences and meanings.

9.1.1 Contextualising Negative and Positive Change

Change in the TCs was far more complex than mere reports of negative or positive emotional feeling. For instance, Jessie at Hawthorne described her personal life as "lonelier" as a result of being in the TC, a negative change, though she still felt the community was helping her. What is more, some clients who reported positive change, such as Kristen at Powell, experienced multiple relapses of self-harm and dissociation prior to successful completion of the programme. How then is change to be understood? To interpret changes, both negative and positive change must therefore be contextualised. In particular, I focus on two clients, Anna and Tessa, to explore the complexity of negative and positive change. These clients were selected because their narratives highlighted particular inconsistencies and complexities that were not found in other interviews.

Firstly, negative, or the absence of change, has to be understood in relation to individuals' stories. Anna at Powell directly stated that her time in the TC had changed her in a "negative" way:

> Um, I'm more aware of my problems. I'm more connected with…being afraid of things…feeling vulnerable…possibly acknowledging that I am vulnerable. Um…but it's taken this long to get to that point. And that was always my worry when I came in here. That I would be worse when I'm leaving. That I would be in a worse position leaving then I was coming in. But I don't, I don't see how it could be any different either (slight laugh).

Anna's negative change was sharply contrasted with how she presented herself in the community. When I first started with Powell, I initially mistook her for a staff member and spent the first several weeks trying to identify why Anna was in the TC as she did not self-harm, always provided in-depth feedback to other clients and had no difficulty speaking in groups, Meal Times or Smoking Breaks. It was only in looking past the obvious behaviours that I realised Anna had difficulties with living interdependently with others. Decisions, even small decisions about cooking a meal, could paralyse her. Despite this, it was not until I transcribed and analysed her interview that I began to understand how much Anna struggled.

During her interview, Anna revealed that most people, including mental health services, underestimated to the extent to which she needed help, as her "defences" were so strong. She had attempted suicide over 150 times, beginning in her early teens. When asked what she wanted to be different as a result of being in the TC, she responded by saying "nothing specific" as she had "no sense of who I am at all", no sense of self and no sense of a life story, just "press cuttings" that did not fit together. She went on to say, "I guess I wanted to get to a point where I could contemplate having a life" but did not ever define what she meant by having a life. Anna stated that she never felt "positive emotion" and struggled to recognise when she was feeling negative emotions such as fear. For her, life was about "just existing". Whilst other clients said that increased understanding about their problems provided them with a sense of confidence and hope, Anna explained that it made her feel "vulnerable". In the final few months of her therapy, she began to dissociate after weeks of appearing to manage her emotions. I began to realise that what I had initially interpreted as her managing emotions was perhaps an absence of emotion as she struggled to stay engaged with any emotional feeling. In groups, Anna explained repeatedly that life after the community did not fill her with hope. By the time she was nearing the end of her stay with Powell, she was insistent that she would commit suicide upon leaving the TC as she dreaded living in a council flat.

However during data analysis of Anna's story as seen through the fieldnotes and her interview, I began to question whether Anna's negative change was really 'negative'. For instance, when I asked her if she had hope for the future, Anna replied "no", but went on to reveal a small change in her outlook:

> Paul (Consultant Psychiatrist) once said, it feels very much like for me, that I'm somebody who's standing in a cave, a cave really dark, but still staring at the back wall. And never ever turning round. Um, I think sometimes I manage to turn around but I turn back very quickly. Um, but I think if anything…there's the possibility of the idea that maybe if I, there might be something there if I did turn round, I haven't managed to do it yet (laughs). Yeah.

Though Anna did not state any positive change, she did seem to be entertaining the idea of changing her perspective. In her story there thus seemed to be two processes occurring: 1) she was connecting more to her emotions, learning to validate them and recognising that she had needs, and 2) she was beginning to shift her perspective in that there may be something behind her in the cave that would be worth turning around for. Both of these things were significant changes. Anna had earlier stated that the main aim of her therapy had been to dismantle her defences and help her connect with her emotions. Clearly Powell had helped her to do this. That the result of that connection did not feel positive is not surprising as she was connecting with negative feelings from the past. The question was whether Anna would be able to continue changing and shifting her perspective once she left the community. In other words, would her negative change eventually feel positive or would she continue to get worse? If she continued to get worse, then there is potentially an argument to be made that the community dismantled her but did not empower her.

Secondly, reports of positive change were not always simple or straightforward. Some clients were concerned about what would happen after they left the TC. Speaking specifically about both the longevity and the authenticity of confidence, Tessa from Powell stated in her interview:

> I still have really low self-esteem. It's false thinking that you become more confident. It's a false situation. It's not the real world here. Here you spend 12-months getting to know people, 24 hours a day. Yeah, it's not real life here. I won't be able to carry confidence out into the world. How I feel before I came in will be the same as when I go.

Though Tessa later seemed to contradict this statement when describing how she felt able to communicate with her father more clearly, she clearly had doubts about whether her changes were real. For her, there was the sense that confidence she felt was only linked to familiarity and that once the feeling of belonging was removed by leaving the TC, negative self-feelings would return. She therefore restricted her changes to the community and felt that the advances she made during therapy will not transfer to other life contexts. Again this was contradicted during her third interview when she described having "hope" that things will be different once she left the TC and that she would be "active" in arranging things to help her continue to change. From my fieldnotes, Tessa stood out as a client who was very proactive in knowing her needs, stating those needs and then actively taking steps to live her daily life differently. As an example, she found mealtimes stressful and made worse by the noise and activity levels that came from having more than two to three members of staff present. She was one of the most vocal client members during TC meetings to reduce the number of staff present at lunch and dinner so that she could finish her food without feeling the need to purge afterward. Additionally, she took positive risks with her family members and managed to significantly alter how she related to her brother and his family, and described feeling far more accepting of the relationship with her mother.

Nonetheless, perhaps the "false situation" that Tessa described was a form of self-deception that she had changed, or that the creative forms of power the community offered were an illusion. Her statements about what life will be like once she left the community highlights that though clients reported positive changes, whether these changes were sustainable is another question entirely. It is worth acknowledging that the three Graduate Group members I interviewed all reported that they had changed and had continued to sustain their changes after leaving the TC. Lori for instance explained:

> I just want to say that you know, a year on, um, I'm, I am a different, mentally, I am a different person. Really, really am.

Like Lori, Jennifer also said explained that she no longer stays in bed like she did before she came to Powell, is proactive with her friends and continues to have an improved relationship with her husband and son. Life after the TC was not without

difficulty and all three women said that they had areas they wanted to continue to change. Amanda particularly articulated this:

> So it kind of makes you leave thinking I want I want to make the most of this and I'm getting there, definitely. And in another year's time I'll be even more so. But compared to where I was, before I came to Powell, then I've definitely got the life worth living but compared to where I want to be, I don't feel I've got it full yet.

Whilst the Graduate Group members stories are an example that life continued to be positively different after the community, three stories is not enough is fully explore the question of sustainable change.

Moreover, Tessa's story is not intended to undermine the case for positive change, or to minimise the real changes she made during her time in the TC. Rather, her narrative, along with Anna's self-report about negative change, stresses the necessity of understanding client change in context. Whilst everyday interactions may have provided an opportunity for clients to build solidarity and transform negative emotions into positive emotions, the reality is that this process was complex and not as simple as 'positive' or 'negative' change. That which seemed positive was at times accompanied by other negative emotional energy such as anxiety about life after the community and sustainability of personal transformation. Conversely, that which was negative may not be solely negative as with Anna. The line between positive and negative is blurred and thus contextualising change is necessary to understanding the individual change that arose from social interactions within the TCs.

In terms of how change was achieved, I contend in the previous analysis chapters that inclusion and exclusion are particularly important mechanisms for generating successful rituals that may lead towards some form of positive emotional energy and change. The importance of inclusion and exclusion was derived mainly from the fieldnote data. This next section will contextualise that argument with what the clients said was most helpful in their process of change.

9.2 Change: what helps

During the client interviews, I asked each participant what it was about the TC that was helpful during the process of change. Clients from both Powell and Hawthorne often commented for instance that the TC acted as a "mirror" for them as seeing other client members engage in similar unhelpful patterns of relationships and behaviours provided a key insight on how they also related and behaved. The three most dominant themes were mirroring, staff support/persistence/consistence and skills/tools.

9.2.1 Mirroring and Reality Confrontation

Clients used the concept of mirroring to mean not just imitation (Chartrand and Bargh, 1999) but also a reflection of how they themselves behaved:

> But at the same time seeing that angry person push everybody away and stomp around, […] it made me realise that when I'm angry, it makes you very hard to approach. (Mary, Hawthorne Interview)

In this way, mirroring is similar to reality confrontation, which Rapoport (1960:63) defines as clients receiving 'interpretations of their behaviour as it is seen by most others'. One of the main facets of this concept is that the community itself is meant to resemble ''real-like-life'' as closely as possible (Rapoport, 1960: 63). Interpretations came from staff and other client members and could include feedback or self-realisations as Mary described above. Thus connections were continuously made to the "outside" world in relation to interactions with family members and friends, and engagement with education, health services and work. Both Hawthorne and Powell had numerous opportunities for clients to receive feedback on how their behaviour was experienced by others. These opportunities included Community Meetings, Emergency Meetings, Smoking Breaks, Meal Times, and Social Times.

Nine out of 21 clients felt mirroring was helpful in understanding the impact of their negative behaviour on others. Alison from Powell describes it as follows:

> Yeah, it's, I think overall it's really beneficial, because it holds the mirror up to you, it does make you, it has made me see the impact of my behaviour on other people. Um and become horrified actually at the, at what I've

> done to my family, to other, to nurses looking out for me, to my partner, um and that's obviously going to um help me, prevent me from doing anything again. You know?

Reality confrontation is closely aligned with Mead's (1934) 'taking the role of the other'. Through directly experiencing the consequences of others' negative behaviour, clients were able to connect how their behaviour must impact those in their lives. Some clients, including Alison, Tessa and Amy (all from Powell), reported that this realisation was strong enough to stop them from using self-harming behaviours. Moreover, reality confrontation was not always about clients accepting the negative consequences of their behaviour. Several clients including Christopher (Hawthorne), Kristen (Powell), Abby (Hawthorne), Alison (Powell) and Heather (Hawthorne) all explained that others had challenged them with positive feedback about themselves. They reported that the realisation that not everyone judged them the way they judged themselves meant that they could begin to challenge, and in some cases change, their view of themselves. For instance Kirsten from Powell stated she experienced a significant turning point in the TC with a former member of staff: "I was able to look at her and I realised that she didn't have the same judgements of me that I, didn't have the same judgements that I did of myself".

To be successful, it would seem that the concept of reality confrontation relied upon solidarity as clients had to recognise themselves in one another in order to reinterpret their behaviour and relationship patterns. However, solidarity alone does not produce reality confrontation. Without reality confrontation, solidarity in the TC may just be about finding commonality in negative experiences. Whilst such solidarity can dispel isolation (Summers-Effler, 2002), which can in turn produce positive feelings that may lead to positive change, reality confrontation goes further. Reality confrontation requires a radical shift in perspective, stepping outside oneself to consider others (Rapoport, 1960). Solidarity does not necessarily require this. In fact, solidarity looks inward to find mutual connection whereas reality confrontation looks outward. As Alison highlights in her interview above, such a realisation can feel horrifying. Tolerance and hope, through mutual solidarity, are needed to counteract this emotional response in order to help a client member work through this feeling and their behaviours. Thus reality confrontation is linked with solidarity but in

terms of change, it actually encompasses more than just finding common ground with one another.

Lest this suggest that reality confrontation always helped clients make positive changes, it is important to identify those moments where reality confrontation isolated some clients and resulted in judgement rather than supportive feedback. Furthermore, it must be remembered that the emotional dynamics of reality confrontation were influenced by the emotions and sense of morality generated by interaction rituals. What happened when the emotional energy of the ritual was negative? How does reality confrontation work when dynamics between members soured? More directly, did reality confrontation ever go wrong? In the next section, I highlight the limits of reality confrontation in producing solidarity, inclusivity and positive change.

When Reality Confrontation Is Not Enough

The limits of reality confrontation were exposed during a Morning Meeting at Hawthorne following Carl's three-day leave for verbally attacking client member Abby during the Afternoon Meeting that was depicted in Chapter 5. Prior to being sent on leave, the community had openly expressed their views on how they experienced his behaviour. Whilst on leave, Carl had to reflect on their perspectives and relate this back to the community during the Morning Meeting:

> Carl begins speaking. He sits up in his chair, not relaxing, his back tense, and his voice is loud and a bit high pitched. He clenches a hoodie in his hands and his legs twitch. Carl says he had been thinking about things and knows it was unacceptable the way he reacted to Abby. Heather asks how he felt after Monday. He replies that he felt "all this anger directed at me" and that he felt "emasculated". Heather immediately starts asking him questions about why he responds that way, to which he answers he doesn't know. He explains he just gets wound up and says, "I take it out on the first person to annoy or upset me. In this case it was Abby".
>
> He also agrees when questioned by Brian that he might have been taking things out on the group that was part of his frustration with his girlfriend. Lauren pushes Carl and asks if he would lash out like that again. "Like I said on Monday", answers Carl in a tight voice, "I'd like to say it would never happen again but I just don't know. I hope not".

> Daniel notes that Carl had used the word “predator” in relation to himself on Monday. Carl responds to say yes, he had used that word and he does feel like a “predator”. He is trying to reflect on that issue but as he had not seen himself like this before, he struggles to believe he does have an issue with women. (Hawthorne, Day 12, 27/06/13)

As Chapter 6 explains, every interaction ritual carries the energy and emotions from not only its own well of ritual history, but also from the history of surrounding rituals (Hallett, 2003). The Morning Meeting above carried the unresolved emotional residue from the Afternoon Meeting whereby Carl had shouted at Abby. Furthermore, Carl had violated a community boundary and the client members felt a sense of indignation that was directed at him. Their response to him is in line with Collins’s (2004:49) assertion that ‘renegade insiders’ are treated more harshly than outsiders when ritual symbols, and implicit social rules, are violated. Coupled with the emotional history of the previous encounter, this moral indignation created an ‘us/them’ environment whereby the clients were entrained with one other, united in solidarity, but Carl was on the outside. During this meeting, Carl was attempting to realign himself with the TC. However, this particular meeting soon collapsed after the community voted in the affirmative to allow Carl to re-join the TC. Carl began to physically relax, the twitching stopped, his voice lowered and his breathing became less rapid. However, Jessie then questioned what the consequences would be if Carl became verbally abusive again. At this, Carl became visibly tense again, his breathing quickened, his voice became high pitched and he walked out of the TC saying he just could not do it.

In my fieldnotes, I recorded that though several of the clients had also been sent on three-days’ leave in the past, there was no mutual sharing of experiences with Carl as to how stressful and difficult this ritual could be. The clients also did not offer him their personal experiences of managing anger and anxiety as they had done in the past with others. In short, there was no mutuality, or solidarity, between the client members and Carl. Furthermore, the clients’ use of reality confrontation in this instance created a divide between Carl and the TC. Client members were very honest in how they had experienced his attack on Abby. They painted a picture of him that was different to Carl’s own view of himself. Carl said that their view made him feel like a “predator” of women and “emasculated”. It is perhaps unsurprising that this view was difficult to accept, particularly without any kind of mutuality. I

reflect in my fieldnotes that what seemed to be missing was the help from client members to work through this view of himself. Staff members tried repeatedly to assist during the meeting to mediate between Carl and the other clients. However the clients ultimately resisted. One member of staff later commented to me that the clients had acted with "mob mentality". In the days that followed, the clients were not able, or were unwilling, to reflect on their part of the interactions, insisting repeatedly to staff that it was Carl who had been in the wrong.

This example illustrates that reality confrontation alone is sometimes not enough to help a client member change. On its own, reality confrontation can be used to judge and exclude, especially if other community members reinforce a negative self-view. What appears to be missing in this process is the resistance to therapeutic nihilism (Mamede and Schmidt, 2014), offering or doing nothing to help others change, alongside the honesty about the impact of traumatic life experiences. As Chapter 2 identifies, client members helping other client members can result in mutual understanding, support and hope for one another that who they are can change for the positive (Davidson et al., 1999; Jetten et al., 2009). Whilst reality confrontation is difficult, uncomfortable and may be painful to accept, it needs to involve an element of solidarity in order to instil therapeutic hope and motivation to positively change. Successful reality confrontation is difficult to achieve without mutuality. The usefulness of reality confrontation is limited without this solidarity. When a break exists between individual members and the group, both sides have to work re-establish solidarity in order to allow for change. The danger is that a lack of mutuality will lead only to peer pressure, compliance and conformity to group behavioural norms (Lukes, 2005).

9.2.2 Staff Support and Consistency

That clients listed staff support and consistency as an important feature in their therapy was in many ways expected. Indeed, several theorists, including Middleton et al. (2011) and Pilgrim et al. (2009), speak to the importance of high quality interactions between staff and service users in producing positive changes. Specifically, they argue that therapeutic gains are made when service users feel

understood, safe and that they can trust staff members. Chapter 8 identifies the relationship between staff and clients was complex. As staff maintained clinical authority over the clients, TC power dynamics were therefore unequal. Furthermore, most of the clients reported negative experiences with mental health professionals. Nonetheless nine of the clients interviewed identified the support and consistency of the staff at both Powell and Hawthorne as a positive mechanism of change. Both sets of clients favourably compared TC staff to mental health staff in other services. Lori (Powell Graduate member) specifically remarked on their "compassion", "tolerance" and the way in which information was shared consistently and swiftly amongst the staff team. For her, staff were the most helpful aspect of the TC. Similarly, Jessie (Hawthorne) described feeling like the staff care:

> Whereas here it seems like they are doing it because they care. […] Rather than just going in, how's your week been? Crap. Well here's some more pills, see you next week. Because that's what it's been like. I don't know it's just nice that someone actually bothers with us. With us, with people with personality disorders.

Trusting the care of the staff was a process however. Abby shared that initially, she accused the staff of only providing feedback because they had to as part of their jobs and felt this was "only lip service". In time, she recognised that the staff role in the TC was "difficult" and that the staff could have chosen other careers or places to work that "would have been a lot less detrimental". The fact that the staff chose to be there in this difficult and demanding role enabled her to trust their feedback.

Additional comments of the staff included their consistency and persistence. Jennifer (Powell Graduate member) noted that she was "impressed by the staff all singing from the same hymn sheet". Amanda (Powell Graduate member) also discussed staff persistence in making a relational connection:

> They try their, they'll try the left, the right, the back, the front, the side and then they'll go back again. They just keep coming back, how can I get in, how can I make a connection and I'd never experienced that before.

These examples of staff support and consistency highlight additional processes at work within ritual theory in relation to personal change. Building solidarity with client members arguably involved some level of trust. Kohn (2008:9) defines trust as 'an expectation, or a disposition to expect, that another party will act in one's interests'.

Client members came to trust the staff to help them pursue positive changes. In successful rituals, positive EE ensued as clients learned they could trust those within the community, particularly as more successful rituals followed. Identifying support, consistency and persistence is important, not just to the clients, but also because it highlights how significant these elements were in successful TC rituals. Without these factors, solidarity may have stalled at the level shared negative experiences and clients may have lacked the motivation to pursue positive change.

What is more, Summers-Effler (2004b) writes that consistency in interactions is necessary for individuals to predict their social environment and future interactions. She contends: 'Through our need to anticipate, relationships become routinized and form what feels like a firm structure' (Summers-Effler, 2004b:301). Nonetheless, she highlights that this need for consistency is at odds with the motivation to pursue increases to positive EE. As the potential for greater forms of EE may lie outside stable social networks, individuals may be willing to risk a certain level of instability for greater EE gains. In a TC, life is all about change and finding new sources of EE through changed behaviours and relational patterns. As Hinshlewood (1999:43) writes, community life is a 'process of constant regeneration and renewal'. This is akin to the 'creative chaos', balanced by the stability that community processes and staff members provide, that Holmes and Williams (2012) argue promotes positive change in TC client members. Thus in the midst of such a changeable environment, from the clients' perspectives, the staff provided a level of stability that enabled clients to take positive risks and tolerate continual change.

What ritual theory does not fully conceptualise though is how consistency and solidarity work concurrently to produce an environment whereby individuals will risk the 'unknown for a better social position' (Summers-Effler, 2004b:301). In other words, IRC theory stops with identifying the tension between stability and change but does not ask how groups can promote both. To produce change through positive EE, individuals need more than just solidarity with others and a tolerance for instability; they also need some measure of stability in order to take chances.

Of course not every member felt staff were consistent and supportive, or were supportive at all times, as Chapter 8 identifies. Martha, for example, commented often throughout my time with Powell that there were "Chinese whispers" amongst

the staff team concerning her. She felt these rumours led to inconsistencies in her care. At Hawthorne, Robert reported that he felt the staff should intervene to stop unhelpful power dynamics more than they did. Nonetheless, negative examples or reports of staff members were a minority view.

9.2.3 Skills

Lastly, client members identified therapy skills as a helpful component to positive change. Like staff support, it is unsurprising that skills were listed as helpful during the process of change. Skills in both communities were used explicitly as a mechanism of change according to their programme information. However there was a difference in definition of skills between the two communities. Powell clients specifically referred to skills in relation to Dialectical Behavioural Therapy (DBT) skills, of which there are four main skills: mindfulness, distress tolerance, emotional regulation and interpersonal effectiveness (Linehan, 2015). Each skill had several set sub-skills to help clients stay connected, accept reality, improve communication with others and manage their emotions. Because DBT groups were considered structured or formal therapy, I did not observe these groups. However, I did observe numerous occasions where clients were continuously encouraged by staff and other clients to use their skills during difficult or stressful interactions. For instance during Emergency Meetings, clients would be required to name what skills they could use to keep themselves safe until the next group. Moreover, Distress Tolerance, one of the key rituals discussed in Chapter 7, was also a specific DBT tool. Skills were a vital part of community life at Powell and one that some clients found particularly helpful:

> I'm a lot healthier than I was previously to coming in here. And I use the programme so much, the mindfulness, the distraction techniques, um there's so much that I've taken with me. (Lori, Powell Graduate)

> But then since I've been here I've realised there are a lot of issues in my relationship and my relationships with other people in that I just, especially my family, I just do whatever they want, no matter what I want, I just do whatever they want. And um the DBT, the interpersonal effectiveness module has really helped me to see that. (Alison, Powell)

As Hawthorne did not use DBT, clients did not define skills exactly in this way. Instead, Hawthorne used a psychoanalytically informed style of group psychotherapy

and drew on concepts of transference, counter-transference and splitting to help clients understand their own and others behaviours and reactions. In addition, both Hawthorne and Powell also incorporated Living Learning skills into the therapy programme (Campling, 2001). These skills included budgeting, running meetings, cooking, cleaning and shopping. It also included interpersonal skills such as how to manage emotions, finding healthier coping mechanisms, how to communicate with others and how to look after oneself. Thus whilst Hawthorne's definition of skills was more broad, it was nonetheless similar to Powell as it focused on empowering the clients to live interdependently in their social environments. However, rather than the word 'skills', Hawthorne clients referred to 'tools':

> I mean a few people have used the analogy that this place is supposed to give you the tools that enable you to move forward. You know this place isn't a cure. […] So it's more about giving you ways to manage and cope and get on with your life. (Evan, Hawthorne)

> And you know I'm here now hoping that by the time I leave, you've got all the tools in your tool kit […] No I don't think I do have an idea what the tools are but things like managing to stay calm, don't feel panicky, be able to rationalise a disagreement, not get too emotional and fly off the handle, which I've been known to do. (Mary, Hawthorne)

Nine clients in total between the two sites felt that the skills they learned in the TC were beneficial in helping them change. In relationship to IRC theory, skills were a tangible way in which overwhelming and intense negative emotions could be tolerated and potentially transformed into positive feeling such as confidence. As such, skills were a vital part of the process of personal change in the TCs. Chapter 5 identifies that the choice to enter a TC was an emotional risk and an initial energy loss for client members as they were separated from their limited and familiar coping strategies. Summers-Effler (2004a) argues that in order to update defensive "as if" loops so that the new environment becomes preferable to the old, there must be tangible opportunities to expand one's emotional energy. She writes that 'it would have to be more than a promise or a taste; it would have to offer an immediate and continuing positive EE alternative that suggests potential success in rebellion' (Summers-Effler, 2004a:321). The application of new skills is one such 'immediate' alternative. Not only could clients learn this alternative for themselves, but they could also watch it happen with other people from the moment they entered the TC. Jennifer, a Powell Graduate member, explained:

> It was good to see other people change as well, or whatever, someone that's self-harming left, right and centre when they came in to even once a month is an achievement.

Seeing others manage their distress differently not only gave others hope that things could be different, it also taught them how to apply those skills themselves. For instance, Abby (Hawthorne) noted that her wearing short sleeves in public that exposed her self-harm scars had helped Lauren, who also had self-harm scars, wear short sleeves. Abby recounted, "And I really took on that feedback, for me to be able to wear t-shirts in public, so I think we've both helped each other subconsciously." However the responsibility for using skills still rested solely with clients, as Amy from Powell reflected, "The community can give you the skills but at the end of the day you've got to use them".

Learning and applying skills as a community did require a shared focus of attention, emotional entrainment, solidarity and moral expectations that the skills were superior to old coping strategies. However, with the exception of Distress Tolerance (ice/smells) at Powell, they were not explicitly a ritual in themselves; rather the learning and practicing of skills occurred within everyday social encounters. The clearest example of this was Emergency Meetings at Powell when a client struggled with familiar but negative coping strategies and the community pulled together to help the client put in place new skills to help them manage the situation. In order to learn these skills, or tools, clients had to trust not only staff members, but also one another. Tools required that clients' solidarity rested not with themselves and their defences, but with the community. They required a break with clients' familiar patterns of relating to themselves, others and their social environment. Clients were changing the history, or the chain, of their previous interactions and replacing them with the interactions of the TC. Moreover, as Lori highlighted above, skills became symbols of the community and of distress tolerance, and were something to draw upon once leaving the community.

At Powell, the theory of these skills was learned during formal therapy, in DBT groups, but their application occurred during everyday encounters. With Hawthorne, the learning seemed more fluid between structured therapy groups and informal interactions. Thus, whilst skills were not a component or mechanism of ritual theory, they were embedded within everyday rituals and the rituals helped enhance the

meaning of the skills. The opportunity to practice skills in real life situations, during at times potentially high-risk moments, afforded the clients a level of learning that could not have been gained through formal therapy alone. Additionally, skills highlight the importance of everyday rituals in TCs because rituals are the context where skills are solidified and where the exchange of negative EE for positive EE occurs. As a cyclical process, each positive EE gain opened clients up to more opportunities to build on their EE.

Despite the overall helpfulness of skills, a few clients were concerned whether the communities had the potential to generate an overdependence on staff and other client members. Jennifer (Powell Graduate member) specifically stated that Powell was "deskilling" and took away too much autonomy in self-care. Amanda (Powell Graduate member) echoed these comments by explaining she felt that near the end of therapy completion, clients should have been encouraged to self-manage and not allowed to request skills-coaching (one-to-one 15-minute interventions with a staff member) or hand items in that they felt unsafe with. At Hawthorne, Abby and Lauren would at times comment during Community Meetings that they relied too much on TC members, particularly the Crisis Text network. This concern led Abby to delete all of the clients' contact information from her phone, resulting in a boundary break and a Review by the community to explore her concerns. However these four were the only ones to reflect upon the dependency aspect of the TC. I did wonder if perhaps others felt this way, particularly upon nearing the end of therapy or upon leaving.

In addition to reality confrontation, staff and skills, other helpful aspects of the TC included Crisis Texts (Hawthorne only), groups (non-specific), support from clients and relationships with others.

9.3 Change: what hinders

When I asked the clients what they found unhelpful in the process of change, many of them challenged me on a division between 'helpful' and 'unhelpful' by noting that what was hard, or labelled 'unhelpful', was still helpful. Nonetheless, even if something was eventually helpful, nearly all of the clients were able to list factors that had made their time in the TCs difficult. During data analysis I sought to separate

what was considered difficult but helpful from difficult and a hindrance. Issues that were considered a hindrance were food, power imbalances and the move at Hawthorne.

Firstly, the most frequent complaint about the TCs was the issue of food. Clients at both communities referred to the food and Meal Times as especially difficult and at times unhelpful. As Powell clients had to eat everything dished out for them, those who did not have an eating disorder particularly disliked the TC's policy on food, which required clients to eat according to a meal plan and finish all of their designated food. Martha reflected:

> But it felt very much that I was losing something when I came in here […]. It never really occurred to me that someone would stand over me like a child and say, you have to clear your plate. That felt really awful you know. (Martha, Powell Interview)

On all occasions if a client member could not finish her food, she had to eat it before the end of the day or face having a Behavioural Analysis. The only exception to this was illness verified by staff members. Nearly all of the more senior members at Powell made similar comments as Martha about the punitive mentality regarding the food, with Lori (Powell Graduate Members) referring to other clients as a "pack of wolves" when it came to uneaten food. Their mentality towards one another with food seemed to sharply contrast their approach to other areas of difficulty, such as managing emotions, self-harm or disassociating. Before I started, the clients' policy towards one another had been to require all clients to eat their food by the end of mealtime. However client members explained that the community had become more caring towards one another by the time I started my fieldwork and that this policy had relaxed. Despite this seemingly relaxed policy, as previously mentioned, I did hear of, but not did witness, a client who had forced another client to eat her yoghurt after she had thrown it away in the bin.

Mealtimes as a significant aspect of life in TCs echoes research by Freestone et al. (2005) about meals and food in a DSPD unit. However, whilst meals in his research represented choice, Powell clients lamented their lack of choice in what they had to eat and how much they had to eat. Nevertheless, when I interviewed the last Powell client member, Amanda, in August 2013, some four months after

completing the participant observation portion with Powell, I learned that the unit was reconsidering the food policy. Amanda explained that they were holding a meeting with former and current members of Powell to ascertain whether those without a diagnosed eating disorder should be held to the same policies as those with an eating disorder.

At Hawthorne, the more common complaint seemed to be the inconsistency, or perceived inconsistency, from the community as to what constituted healthy eating. For instance Jessie, Abby, Lauren and Daniel were adamant that comfort eating was as problematic as eating disordered behaviours such as restricting or purging. Conversely, Mary and Robert felt that because they did not have disordered eating, they were being 'picked on' for eating items such as biscuits and chocolate. Mary commented to me during of the Smoking Breaks that she would leave the community with an eating disorder (Hawthorne Fieldnotes, Day 23, 24/07/2013). For several weeks, clients holding these two opposing views would argue with one another during both the Morning and Afternoon Meetings. Though clients at both TCs would disagree on other issues and still find common ground, on the issue of food, the client group repeatedly failed to find solidarity with one another. Contrasting the inconsistency with food with the reported helpful consistency of staff members, this seems to suggest that consistency (and lack thereof) plays a significant role in building positive EE. A lack of consistency could lead to feelings of frustration, anxiety and shame.

Secondly, and specifically related to Hawthorne, senior members during both interviews and informal conversations named the move as particularly unhelpful. Christopher, Carl, Heather and Brian felt that their therapy had been interrupted and as a result of the disruption, they received less than 12-months of therapy. Abby and Evan also named the move as unhelpful, but not because of any personal impact but due to the amount of time members spent discussing it in groups. For them, they felt that the move had been a distraction from discussing more personal issues related to their therapy.

Thirdly, several of the clients at both Powell and Hawthorne commented on the difficulties with power in the community, and in particular the peer pressure and bullying that sometimes occurred amongst the client group. Not only did this occur at

mealtimes, but inconsistencies could be seen with how the community enforced their boundaries and values. As Chapter 8 identifies, clients at both sites remarked that there were power hierarchies and, at times, some individuals were marginalised. At its worst, this marginalisation led to client members feeling excluded, isolated and more distressed. For instance, Robert at Hawthorne, an older male member, was consistently excluded, despite the fact that he was quick to volunteer for community chores, including the undesirable jobs, offered feedback and usually adhered to community boundaries. He said:

> I've tried to join in more, I've tried to make more uh, give more feedback if you like. But…I still don't feel a part of the group. I feel like there's everybody else and me. So…that gets me down, that I'm not a part of it.

Robert speculated during his interview that he was excluded because he was a male with a history of serial adultery: "They just see me as the bad guy and there's no answer for that". Whilst almost of the clients had in some way had histories of drug and alcohol abuse, criminal offences of fraud and assault (including Grievous Bodily Harm), Robert was the only one to have committed (or admitted to committing) adultery. It may have been difficult therefore for clients to find mutuality with him. However, even without a shared history of adultery, most of the clients had experienced social stigma and isolation because of their past experiences, ethnic backgrounds, sexual orientation and lifestyle choices. Targeting Robert for his adultery did not seem to fully explain his social exclusion. Rather than finding solidarity with him, the clients repeatedly resisted his attempts to integrate with the group. Clients such as Abby and Jessie frequently made pointed comments to him in Community Meetings and informal times, clearly expressing their dislike. Most telling in those instances was that no one challenged this behaviour or sought to defend Robert.

At the same time, Robert seemed struggle to understand and embody the community's values and expectations. More than anyone, he used the Crisis Text network inappropriately, discussed difficulties with other clients outside of meetings and struggled consistently with chairing meetings, often looking to other members for assistance or forgetting to allow some clients to speak. Clients implied that he was not taking enough personal responsibility for this role within the community. Thus, in addition to the lack of shared past experiences, it appeared as time went on that

there was a lack of commonality between Robert and the other clients that could not be bridged. It is possible that a certain amount of commonality is therefore needed in order to establish solidarity and mutuality. Moreover, as Robert reported that he was at the bottom of the "pecking order", this also raises the question as to what extent commonality and solidarity is needed in order to achieve a fluid hierarchy.

In the main, clients reported far more instances of things that were helpful than things that were a hindrance. This could mean that overall the TCs were generally helpful despite some instances of difficult power dynamics, inconsistencies and external pressures. However, it could also be that the clients were keen to promote a 'positive' view of the TC to me. Though I attempted to integrate in both communities, I still always remained an outsider and this barrier may have prevented further openness. Additionally, the majority of the clients I interviewed were still active members of the community and they may have had a personal vested interested in believing that their TC was helping them; otherwise, why continue attending?

SUMMARY

Having analysed the mechanism of TC interactions, this final data analysis chapter has focused on client members' perspectives of change in order to understand how everyday social encounters facilitated personal transformation. Whilst the majority of clients reported feeling some form of positive change and autonomy, it is not fully known as to whether these changes were sustainable upon leaving the TC. Clients distinguished mechanisms such as mirroring as particularly helpful in their therapeutic process, yet solidarity and mutuality were needed in order to move beyond judging. Furthermore, I identified that IRC theory does not consider mechanisms such as reality confrontation or how consistency coexists with instability. The importance that client members placed on these suggests IRC theory could be expanded. Though most of the clients were positive about their experience of life in their respective TCs, unequal dynamics between client members highlighted that client members were not always supportive of one another and at times, could exclude others. It can be questioned then to what extent some commonality is needed in order to establish solidarity. Despite the questions of sustainability of

change and the difficulties of power that at times existed between the clients, the clients' perspectives suggest that everyday social encounters did work to produce some form of positive change.

CHAPTER 10. CONCLUSION

INTRODUCTION

This thesis has been primarily concerned with the role of social interactions in facilitating personal change within therapeutic communities (TCs). Everyday encounters, such as Meal Times and Smoking Breaks, are ordinary events that may seem mundane. However, the experience of what it was like to be in a TC, to live amongst other clients and to be vulnerable with others was to be found in these ordinary moments. These interactions are not only moments that tell a story, but they are moments where the story happened, where changed was occurring and lived out. In short, these moments played an active and pivotal role in producing therapeutic change.

Nonetheless, it must be recognised that prioritising everyday and ordinary moments was not the original intention of thesis. As Chapter 1 explains, I entered the field with an *individual* focus. When I started at Powell, I had no pre-conception that rituals would feature so strongly in this doctorate. I knew everyday social interactions were important, as TCs prioritise informal times and social learning (Jones, 1968), however my intention was to follow individual client members as they negotiated their social interactions and engaged with the process of therapeutic change. Instead, the communities and participants in this doctorate directly challenged my focus. Interactions outside of structured therapy were at times chaotic and unpredictable; one moment consisting of laughter and storytelling around the dining room table and the next helping a client member who had disassociated. After I pushed aside my perspective and notions of change, I came to understand that I was viewing individuals through the lens of *interactions*. Moreover, I learned from experiencing life in TCs with the clients that change occurred by moving forwards and backwards simultaneously. Even conceptions of what change means was formed and reformed over time. Through conceptualising social interactions as 'rituals' and analysing their mechanisms, I understood that it was during these everyday moments of change where clients were living, writing and telling their story of change.

A focus on the social mechanisms of the change process is not typically prioritised within mental health research. Research in understanding *how* outcomes are achieved has been minimised (Larsen, 2007; Tibbetts, 2004). This is problematic because as Haigh (2005) highlights, what works in therapy, especially in relation to clinical evidence, cannot be conflated with what matters in therapy, particularly to client members. Moreover, recent failures in healthcare delivery reveal that emotions such as *compassion, trust* and *confidence* are vital components to everyday practices (Berwick, 2013; Newdick and Danbury, 2013; Straughair, 2012; Ballatt and Campling, 2011). What matters is *how* therapeutic interventions are carried out in the everyday, what people bring to it, how people experience it and how they feel about it. As TCs value all aspects of life within communities, it is therefore impetrative to understand the mechanisms of everyday social interactions outside of therapy, the dynamics within the TC and how emotions are built and transferred between members, particularly amongst the client group. However there remain relatively few analytic studies that specifically examine how these everyday interactions actually facilitate change.

This discussion chapter will revisit the research questions and key themes from the literature; summarise the study's findings; draw comparative relationships between the two communities; discuss implications for interaction ritual chain theory and therapeutic communities; highlight the limitations of the study; and suggest directions for further research.

10.1 Research Questions and Literature Themes Revisited

This thesis addresses the following question: *how, and to what extent, do social interactions facilitate individual transformation in the lives of therapeutic community client members?* I had four objectives related to this overarching question that included exploring the mechanisms of everyday interactions in TCs, explaining the function of peer-to-peer interactions, analysing the TCs' values and the role of power and social control, and identifying client members' definitions of personal change. These objectives guided my review of the literature on personality disorder, TCs, personal change and social support.

An emphasis on interactions is well suited to TCs as they value all aspects of community life as potentially therapeutic (Jones, 1968). Additionally, TCs hold that the culture of a community can produce change by mirroring to clients relationship difficulties and solutions (Rapoport, 1960). Democratic TCs use a flattened hierarchy approach in order to share power between staff and clients. Whilst this structure aims to minimise power inequalities and abuses between staff and clients, critics of TCs argue that it legitimises emotional manipulation (Kesey, 1962; Sharp, 1975; Baron, 1987; Rose, 1999). In contrast, proponents of TCs contend that communities are social environments that promote creativity and empowerment (Haigh, 2005, 2013; Winship, 2004). I suggested that both critics and proponents of TCs refer to two different types of power, both of which may co-exist within communities, and requires careful analysis in order to understand the power dynamics.

As a microsociological study, this research has an allegiance to a sociological tradition shaped by interpretivism, symbolic interactionism and interaction ritual theory. Following Goffman (1967) and Collins (2004), I argue that it is necessary to start with the interactions in order to understand individual change to avoid reifying the individual. This approach enables a much richer understanding of individuals and their unique responses to social encounters. By prioritising interactions in TCs, community meanings, the rhythm of community life, values, power and personal change all fit together. Collins (2004) has synthesised interaction ritual theory into a model of social interaction that explains the mechanisms of successful, and repeated, rituals. Interaction rituals are characterised by bodily co-presence and shared attention and emotion that generate solidarity, emotional energy, symbols of group membership and moral values (Collins, 2004). Central to rituals is the sharing of emotions, a sense of being in synch with one another and feelings of inclusion. These rituals produce symbols of membership and standards of morality. One of the crucial components to this theory is that rituals do not occur in isolation but are rather connected in a series of ‘chains’. Thus any given ritual can be influenced by what occurs before and after the ritual (Hallett, 2003). However, to the best of my knowledge, IRC theory has not been applied to mental health research. It was therefore unknown how interactions in TCs could transform negative emotions into positive change.

10.2 Summary of Findings

When I finished my last interview at Hawthorne, I left the field full of stories and shared experiences with those in TCs. Moreover, I was acutely aware that I had shifted my theoretical focus away from individuals to interactions during fieldwork. Due to the sheer volume of data, there were multiple themes that immediately surfaced during preliminary analysis and I was faced with the question of how to select the themes for the thesis. In order to make sense of the data, I began conducting line-by-line analysis of the fieldnotes and interviews. At the same time, I returned to my original research questions and reflected upon where I was at the end of fieldwork compared to when I started in order to balance the multiple directions the analysis could take. I was keen to not force themes on the data, but equally I wanted the themes to bear some relationship to one another and to address the question of how everyday encounters contribute to the process of change. Each point in the analysis represented multiple decisions about what to bring forward and what to leave lingering in the background. Additionally, at the start of thesis write-up, I was unsure whether the thesis was about personal change, rituals or TCs. Through returning to the data and my analysis, I came to understand that the thesis was about rituals that occur within a TC as clients undergo a process of personal change. Ultimately, I thus decided to structure the thesis around four main themes: identification of the 'key' rituals in both TCs and the role of negative emotions, the function of rituals, the role of power and social control, and the clients' conceptions of personal change.

My selection of these themes was theoretically informed by interaction ritual theory, the perceived importance of social interactions in TCs, and by a specific focus during data collection on the interactions between participants, particularly from the client members' perspectives. My intention with these themes is to explain a specific gap in the research literature and explain the significance of everyday encounters. However it must be acknowledged that another researcher may have had different areas of interests during data collection and prioritised different themes in the data. A summary of each of the selected themes is presented below.

10.2.1 Key Rituals of TCs, Solidarity and Emotions

The notion of 'key' rituals was linked to Goffman's concept of 'action' rituals, those interaction rituals that hold opportunities for risk, loss and gain. Within TCs, the idea of 'action' rituals includes those social encounters whereby clients risk potential negative feelings in order to gain a shared understanding, sense of belonging, acquisition of new skills and positive emotions. I explained that an analysis of all the rituals in Powell and Hawthorne yielded 57 and 45 distinct rituals, respectively. From the list of rituals, I identified six rituals per community that were 'key' rituals: Emergency Meetings (Powell), Social Times (Powell), Distress Management (Powell), Crisis Texts (Hawthorne), Reviews (Hawthorne), Community Meetings (Hawthorne), Meal Times (both), Smoking Breaks (both) and Endings (both).

Having identified the key rituals, I explored the mechanisms of interaction rituals, particularly solidarity and negative emotions. Key rituals had the potential to generate solidarity, which was often synonymous with feelings of belonging. None of the clients had experienced solidarity with one another prior to coming to the TC. Moreover many of the clients reported feelings of isolation and loneliness before they came to the communities. Often this was due to difficulties in their personal relationships and lack of social interactions in their day-to-day living. Client members found solidarity and mutuality through sharing their experiences with one another.

One of the limitations of IR theory highlighted in Chapter 3 is that it has not been widely applied to mental health. As such, there is a simplistic divide between 'positive' and 'negative' emotional energy (Turner and Stets, 2005). IR theory posits that successful rituals leave individuals with positive feelings of confidence and enthusiasm' (Collins, 2004). However in a TC, negative emotions abound. I therefore specifically questioned the role of negative emotions, such as anger, fear, anxiety and shame, in the communities. As Turner and Stets (2005:74) suggest, individuals will tolerate negative emotions if over time they experience positive 'payoffs'. Rather than feelings of enthusiasm, I argue that the positive 'payoff' is the feeling of solidarity and belonging that occurs within the communities. Thus client members tolerated the frequent high levels of negative emotions that were present in

key interaction rituals because they experienced mutuality and belonging with one another. This distinction is important because it explains why rituals with a high degree of negative emotions are repeated, how negative emotions are transformed into positive feelings and highlights the link between solidarity and emotions in ritual theory.

10.2.2 Ritual Entrainment, Symbols and Functions

Chapter 7 deepens the analysis of ritual mechanisms through exploring entrainment, symbols and questioning the function of rituals. Entrainment in ritual theory is the process by which members become in synch with their bodily movements, thoughts and speech (Collins, 2004). The rhythm of life within the communities was often altered due to episodes of client member distress. Rather than these episodes consisting of interruptions, they were part of the overall rhythm. Importantly, Intense negative emotions were not enough to cause breaks in the rhythmic flow of TC life. Indeed, solidarity could be maintained even when the structural components of community life dissolved, as was seen during an End of Day group at Powell depicted in Chapter 5. In these instances, the community would work to restore solidarity and the emotional rhythm of the TC that promotes inclusion. However, the TCs did not have an infinite capacity to absorb negative emotions as too much emotional strain combined with attention focused solely on one or two individuals, rather than all members within the community, could stretch the TC to near capacity.

This chapter also explored the symbols generated from interaction rituals by particularly focusing on Crisis Texts at Hawthorne. Following Ling (2008), I argued that whilst text messaging lacks bodily co-presence, one of the requirements for interaction ritual theory, interactions between client members via Crisis Texts did generate strong entrained, emotional responses that could generate feelings of both solidarity and standards of morality. However, I disagreed with Ling that the use of text messaging negates symbols. Clients internalised and imagined interactions with one another as if they were in the TC.

Lastly, the chapter concluded by analysing the function of the key rituals by categorising the rituals into six categories: Inclusion, Exclusion, Reinforcement, Anti-

Group, Transitional and Ownership. Whilst the first five categories were identified from ritual theorists including Collins (2004), Summers-Effler (2006), Helman (2007), Scheff (1977), Chapple (1970) and Mandelbaum (1959), Ownership was a distinct category that has links with TC principles (Haigh, 2013) whereby clients were continuously encouraged to take responsibility for themselves and build a sense of responsibility in relation to being an active TC member. I then examined the conditions that change a ritual's function including time, place, person and emotion. Overall, the main influence on a ritual's success was whether or not they were inclusive of all client members.

10.2.3 Power and Social Hierarchy

Ritual theory posits that the fourth outcome of a successful ritual is moral standards that are defended by group members. As feelings of inclusivity are central to producing successful rituals, notions of power are intrinsically linked to how rituals are carried out and how values are enforced. I explored the use of power within TCs, particularly how power was used between client members.

I suggested that there were three forms of power relationships within the TCs: staff-to-clients, clients-to-staff and clients-to-clients. Though a flattened hierarchy structure did require staff to relinquish some power, there were occasions where they used their power over clients to manipulate or control clients' behaviour. Whilst staff retained more power over the clients by nature of their roles and professions, clients did at times express and discuss their frustration and anger at staff. At times, clients could also overrule staff member decisions. Significantly, in relation to power between client members, I identified that client members were not always consistent with one another with how they enforced community standards. I found that both TCs' adherence to a flattened hierarchy model sometimes closed down conversations about power imbalances between the client cohort. Instead of a TC flattened hierarchy model, I advocated a fluid hierarchy approach that recognises power imbalances and hierarchies do exist within TCs.

10.2.4 Everyday Interaction Rituals and Personal Change

The final data analysis chapter shifted the analysis to questioning how the client members felt they were changing and whether they felt empowered as a result of being in the TCs. Definitions of the meaning of change came directly from client members. The majority of clients described change as emotional rather than simply behavioural. In particular, clients discussed feeling more confident, feeling more in control, and having a more positive view of themselves. Nonetheless, I argued that notions of 'positive' and 'negative' were not straightforward as some forms of 'negative' transformations may also have some 'positive' elements. Additionally, some client members questioned whether their positive changes would be independent of the TC and sustainable after they left. Thus notions of change were complex and it was important to carefully analyse and contextualise a participant's narrative.

In order to understand the mechanisms of the change process, I also explored what client members said helped or hindered the therapeutic process. Clients reported that mirroring (reality confrontation), staff support and consistency and skills were particularly helpful. Reality confrontation and consistency were linked back to rituals to highlight that these mechanisms are absent from the theory. Things that hindered change included food and Meal Times, particularly the inconsistency and lack of power about what was eaten, the building move (Hawthorne only) and the marginalising that would occur between client members.

10.3 Comparisons and Relationships between Powell and Hawthorne

I deliberately selected two communities for this doctorate in order to strengthen my understanding of how social interactions facilitate personal change. Bloor et al. (1988) argue that each TC is unique and it is difficult to compare communities to get an overall sense of a typical TC. Nonetheless, it is possible to identify the *relationships* between Powell and Hawthorne (Hannerez, 2003), particularly in regards to social interactions. Of the 57 (Powell) and 45 (Hawthorne) rituals, the communities have 22 in common. What then are the significant differences and

similarities between the two communities and how do these relate to social interactions and change?

Perhaps the most obvious difference between the two sites is that Powell was residential and Hawthorne a day community. Not only were Powell's clients participating in more structured therapy groups (art therapy, drama therapy, OT, DBT groups and small group psychodynamic psychotherapy, alongside individual sessions and skills-based interventions), there was also more *time* for informal interactions. These occurred between groups, sometimes up to 2-hour blocks of time, and during evenings and weekends. Powell clients also ate far more meals together in comparison to Hawthorne.

Powell was also situated within an institution over 200-years old. Though funding was tight, they were not under threat of survival. If there were staff shortages, these would be filled. In contrast, Hawthorne was part of an NHS Personality Disorder Service, a unit that has been significantly cut over the past five years, culminating in the building move that occurred prior to my arrival. Funding was limited and staff shortages due to absences or vacancies were not filled. This impacted the amount of time that Hawthorne staff could physically spend with client members during breaks and Meal Times. Powell staff members had far more time to develop what appeared to be deeper relationships with the client members. Additionally, staff and clients frequently commented on whether the TC would exist from one year to the next. The funding uncertainty at Hawthorne seemed to lower morale amongst the staff team and negatively impact upon the confidence that client members had in the Service. Several staff and clients expressed frustration with the funding cuts and changes to the TC.

Lastly, there were differences in the severity of distress that client members experienced. Whilst both cohorts of clients had a diagnosis of PD/BPD, Powell clients entered the TC using riskier and more frequent self-harming behaviours. Clients within both communities reported experiencing positive change, yet Powell clients reported change than Hawthorne members. The retention rate at Powell during the research was also slightly higher in comparison to Hawthorne, with three clients leaving prematurely at Powell compared to four members at Hawthorne.

Despite these differences and the different types of rituals, there are relational links between the communities that highlight how TCs used everyday social interactions as a therapeutic intervention to promote positive change. Both sites had a number of key interaction rituals, three of them shared, within their respective communities that resulted in solidarity, entrainment, symbols and standards of morality. The same social processes of inclusion and reality confrontation were at work within both TCs and the ways in which the rituals were used in the communities were similar. For instance, the function of inclusion was significant for building a shared sense of solidarity, maintaining entrainment and tolerating negative emotions. Power was also used similarly between the communities for empowering the client members and encouraging a sense of ownership and responsibility. The darker side of power, such as manipulation, bullying and marginalising, also occurred at both Hawthorne and Powell. Moreover, despite more physical time at Hawthorne, time moved fluidly between past, present and future at both communities during social encounters. Clients continuously moved between discussing their painful histories to planning for life after the community. Thus interactions at both TCs contained a fluid sense of time.

The relationship between the two sites is also pronounced when the key rituals are mapped to Haigh's (2013:6) 'quintessential' TC experiences in Table 5. Haigh describes these experiences as necessary stages to promote healthy therapeutic processes within TCs that will result in positive personal changes. In the Table below, P refers to 'Powell', 'H' to Hawthorne and 'B' indicates that the rituals were shared:

TC 'Quintessential' Experiences

Key Ritual	Attachment	Containment	Communication	Inclusion	Agency
Emergency Meetings (P)	x	x	x	x	x
Social Time (P)	x	x	x	x	x
Crisis Texts (H)	x	x	x	x	x
Reviews (H)	x	x	x	x	x
Morning Meetings (H)	x	x	x	x	x
Smoking Breaks (B)	x	x	x	x	

Meal Times (B)	x		x	x	x
Endings (B)	x				x
Distress Management (P)	*x*	*x*	*x*	*x*	*x*

Table 5: TC 'Quintessential' Experiences in Key Rituals

All nine key rituals can all be seen to contribute to part of these quintessential TC experiences. Smoking breaks at both TCs seemed to be less about empowerment or agency and more of an opportunity for clients to get to know one another and release any tensions from previous meetings through talking, complaining and joking. Endings were perhaps the most uncertain time in a community as that was when the membership shifted, a client member became an outsider and all remaining clients were reminded that they too would eventually be leaving the TC. Importantly, these experiences were shared across a day and residential TC. Even though Powell had more time in the day than Hawthorne, it did not diminish Hawthorne's capacity to generate rituals that facilitated personal change. Likewise, though Powell was residential it did not lessen the opportunities for clients to exercise agency and learn to live more interdependently with one another.

Furthermore, the clients from both communities described personal change in similar ways. Change was more *emotional* rather than behavioural, and clients from both TCs described feeling 'confident' as a result of being in their respective communities. Thus the relationship between Powell and Hawthorne centred on their joint use of times outside of therapy and the clients' definition and understanding of personal change.

10.4 Implications: Interaction Ritual Chain Theory and Therapeutic Communities

This thesis has a number of implications for both IRC theory and TCs. In reflecting upon social theorists, Davis (1971) proposes that the truth of a theory has little to do with its impact and more to do with its interest. To hold others' attention, an interesting theory must say something unexpected and even contrary to accepted

theoretical expectations. My aim in drawing implications from this study then is to find the unexpected elements between the data and the theory, as this is where any theoretical advances, and by implication, any advances in TC or mental health policy, are to be found. In relation to both theory and practice, I therefore discuss the current assumptions of both IRC theory and TCs, and offer a challenge.

10.4.1 Interaction Ritual Chain Theory

Chapter 3 discusses a number of limitations of IRC theory, especially in its application to mental health contexts. The findings chapters have further highlighted these limitations and suggested points at which IRC theory could be expanded. I will specifically discuss six theoretical implications: the role of negative emotion, motivation for action, connections between solidarity and commonality, the interplay between the individual and community in fluid networks, bodily co-presence and the role of consistency and reality confrontation.

Firstly, Collins (2004, 2014) stresses that long-lasting positive emotions, such as confidence and enthusiasm, are the result of successful rituals. Positive emotions are seen as necessary for sustaining solidarity of the ritual whilst negative emotions are viewed as working against successful interaction rituals. However, this research suggests clarifying the use of emotions in IRC theory to include how negative emotions are sustained in successful interaction rituals. For example, in TCs many of the interactions contained a high number of intense negative transient emotional feelings, including anger and fear. Emergency Meetings at Powell, for instance left everyone, including me, feeling physically and emotionally drained. Nonetheless, these interactions contained a strong sense of solidarity and an opportunity for newcomers to begin to embody the community's emotional ideology and history (Summers-Effler, 2010). They also afforded client members opportunities to be actively involved in one another's care, to challenge and support each other and to recognise the effects of their own behaviours on others. Thus whilst interactions in the TCs contained multiple and complex transient and long term negative emotional responses, these everyday rituals had high solidarity, entrainment, strong community symbols and values. Moreover, many clients during their interviews reported feeling

more confident, a positive long-lasting emotion. How then do negative transient emotions generate positive EE?

The explanation to that question is to be found in the rituals. Every key ritual contained the potential for negative emotions to be transformed into positive EE through the feeling of belonging. When all members in the TC participated in everyday interactions, they had the opportunity to gain solidarity with one another as they worked towards an explicit goal of personal change. However, interactions could also break down, resulting in a ritual's failure and members' exclusion from the TC. When this occurred, the key was re-establishing entrainment and solidarity with the whole group by allowing all members to openly discuss their feelings in order to re-establish inclusivity. If solidarity and entrainment were consistently maintained, and quickly restored when broken, then members would tolerate the presence of highly negative emotions. Furthermore, re-establishing solidarity generated feelings of security and trust (Helman, 2007), resulting in increased confidence both in the group as a whole, and in each person's role within it. However, I would disagree that successful rituals lead to feelings of enthusiasm, as I did not observe feelings of enthusiasm throughout my time with either community. Rather, feelings of confidence from solidarity enabled the clients to withstand the prevalence of highly negative emotions, both in themselves and in others. Client members' experiences of their time in the TC further suggest that it was the feeling of *confidence* that they particularly gained from being in their respective communities. Not one client discussed feeling enthusiastic. Therefore clarifying the role of negative emotions to explain *how* negative emotional energy can be transferred into positive EE of confidence would strengthen IRC theory by allowing difficult and intensely negative emotions to exist within rituals and be transformed into positive feelings through inclusivity and solidarity. Put differently, positive EE is not only a surge of energy, it can also be a steady source of energy consisting of trust and belonging that enables individuals to continuously to engage in very difficult interactions over a long period of time.

Secondly, and closely related to the role of emotions, IRC theory assumes that individuals will interact in a way that provides the highest emotional payoff. Summers-Effler (2002, 2004a) explains that when individuals have a history of

negative social interactions, they develop defensive strategies to minimise EE loss, rather than seeking to maximise EE. Minimising strategies can include staying within unhelpful relationships, avoiding others and engaging in self-harm behaviours. Whilst this explains why individuals continue to perpetuate negative relational patterns and behaviours, IRC theory does not fully seem to account for the process of self re-construction. In particular, there is no mechanism of the TC process of reality confrontation that Rapoport (1960) and Bloor et al. (1988) describe. This research challenges and expands IRC theory in that TC client members often had to accept and embrace a negative view of the self, through reality confrontation, in order to begin the process of personal transformation. Julie at Powell illustrated this during an End of Group meeting:

> She starts by saying that she found meal support difficult today, especially what Andrea had shared because, "I felt like I was listening to myself". She recognises herself very clearly in the way Andrea struggles with food. […] Anna asks how this feels. Julie gives a soft snort and replies, "Not good". (Powell, Day 35, 06/02/13)

As Chapter 9 identifies, what is missing from TCs' conceptions of reality confrontation is a third definition of the self that is different from both the client member's view and the community's experience of that client. A third view of the self is the 'could-be' version, if the person was able to change and transform. In its most helpful, this would be a positive but not unrealistic view of self. Such a view would include hope, encouragement and support along with the need to trust both in the individual and the group. Ultimately then, a third view of the self from reality confrontation would ideally provide clients with emotional rewards of confidence. However, IRC theory does not fully recognise that this process must first involve accepting negative emotions through acknowledging their reality and influence.

Thirdly, IRC theory does not entirely account for why some individuals do not change. Again, Summers-Effler (2002, 2004a) suggests that negative relational patterns, including defensive strategies to minimise EE loss, are repeated when there are no other alternatives available. Turner and Stets (2005:93) build upon this idea by explaining that long-term defensive strategies create a sense of 'hyperreflexivity' in individuals whereby their focus becomes so inward looking that they are unable to notice their surrounding environment and see others who may be able to offer

support. Thus, as I suggested in Chapter 2, if individuals *believe* there are no other alternatives available, they will continue their defensive strategies, even if others offer positive EE. However, data from both Powell and Hawthorne suggest that an individual's options are not straightforward like this. A TC may offer positive EE in the form of solidarity, entrainment and feelings of inclusion. However, unhelpful dynamics such as social control, judging, marginalising and bullying also coexist in the TCs alongside positive EE. To a certain extent, engaging with TC processes means having to engage with these unhelpful forms of interaction in order to change positively. Importantly though, these unhelpful dynamics may make it difficult to see any positive gains. This could potentially explain, at least in part, why some client members did not positively change and in some cases, left the TC worse than when they entered. For ritual theory, the significance of this is that motivations for action, including seeking and accepting positive, alternative forms of EE, are complex and need to include the ways in which positive alternatives are sometimes accompanied by negative EE. In other words, some interactions will contain both positive and negative EE and by creating sharp divides between negative and positive options for gaining EE, IRC theory overestimates individuals' willingness, and perhaps capacity, to move towards positive interactions.

Fourthly, whilst solidarity is a key component of rituals, IRC theory does not consider the limits of solidarity and how much commonality members must find together in order to continuously produce group unity and feelings of inclusivity. Heider and Warner (2010) establish that in order for solidarity to be an outcome of rituals, it cannot have pre-existed prior to the ritual. Chapter 6 explained how clients in both TCs would not have known each other prior to joining their communities and found solidarity through their shared experiences of past traumas and abuse, and, in many cases, of mental health services. Moreover, each of the clients was drawn together through a mutual goal of transformative change. However, Chapter 9 identifies that there were limits to solidarity as seen with Robert from Hawthorne. Despite his repeated attempts to integrate into community life, Robert was consistently marginalised.

Rather than the other clients, particularly the women, simply alienating him, I suggested that there were two processes at work, including a lack of shared

experience and a difficulty to adjust to the community's expectations of members. Whilst other clients had shared experiences of abuse, drug use, theft and in some cases grievous bodily harm, Robert was the only client known to have a history of adultery. No one else in the community shared that particular past experience. It could be that his mistreatment of women was too much for the female clients to accept and find mutuality with him, as they had been misused and abused by men. Additionally, the TC expected that all client members would take an active role in their own and others' feedback. Other clients consistently complained in Community Meetings that Robert did not speak enough and did not offer enough feedback to others. They also seemed to imply that Robert was relying too much on the other client members rather than taking responsibility for his own therapy. In short, there seemed to be a mismatch between Robert and the rest of the community as he articulately described in his interview with the "us and them" mentality. Perhaps in another TC, Robert's experience may have been different. However, there is an assumption with IRC theory, and potentially TC practice as well, that if one works hard enough, anybody can integrate and find solidarity with others. Thus the implication, and challenge to both IRC theory and TCs, is that a group's capacity for solidarity with all members is not infinite and, as with Hawthorne, there may be some experiences or expectations that the group as a whole simply cannot overcome.

Fifthly, Summers-Effler (2004b) contends that in societies where networks and social structures are 'stable and dense', then the focus for maximising EE through rituals comes from the group. Rather, when these networks and structures are in a constant state of change, the possibilities for EE focus more on the individual rather than the group. In this latter situation, the individual then becomes a sacred object. Translating this for TCs, it could be argued that due to the continual fluctuating membership, and aim to promote change within individuals, this 'continual change state' means that the self is treated as a sacred object. A conception of the self, particularly a self that is changing, then becomes reified above other social processes. I would agree that at Powell and Hawthorne, the self could at times become a sacred object, both in terms of who the clients were and who they wanted to be. Additionally, one of the aims of the TCs was to help empower individuals to have a stronger sense of self. However, I would challenge this sharp divide that Summers-Effler creates in relation to stable and unstable networks. Whilst both TCs

were in a state of continuous changing networks, clients also had a strong commitment to the TC as a whole. The individual was not the *only* sacred object and clients did not necessarily reify themselves over the community. Indeed, 10 out of 21 clients interviewed valorised the community itself, saying that the community had 'saved' them:

> I don't think I'd be here, honestly, if I didn't come here. So yeah, it's a cliché, you know, changed my life, but it did, it did. Saved my life. (Lori, Powell Graduate Group Member Interview)

> If I didn't get referred here I could've ended up killing myself and it not working. So literally this place kind of saved my life. (Brain, Hawthorne Interview)

Crucially, positive EE is attributed not to the individual, but to the community. Though I recognise the argument that Summers-Effler makes in relation to the importance of the self, especially in post-modern society whereby structures and relationships are more fluid (Bauman, 2003), she does seem to miss the deep commitment that members can have for their groups even when networks are in a state of flux. This highlights the original problem posed by Goffman that when the focus is centred on the individual, social processes, including the dynamics and bonds that individuals have to one another, can be ignored or minimised. My theoretical challenge therefore would be that within flexible and fluid social networks of a TC, it is often the community that becomes reified over the individual. Client members' focus was not always on themselves and the majority of clients remained intensely connected to one another. However, as I only interviewed three Graduate members, I would acknowledge that a client's commitment to others in the TC may minimise, or cease, upon leaving the community.

Additionally, it is worth identifying the implications that this thesis presents in relation to bodily co-presence and consistency in IRC theory. As Chapters 3 and 8 explained, IRC theory posits that interactions must occur face-to-face in order to be considered 'rituals' (Goffman, 1967; Collins, 2004). Collins (2014) has more recently acknowledged that interactions mediated through technology may open new possibilities for micro-sociological ritual research. Ling (2008:119) in particular argues that communication via text messaging is a form of 'mediated ritual interaction'. For this thesis, Crisis Texts at Hawthorne were an example of a

‘mediated ritual’ that provided the clients with the means to stay entrained with one another outside of the TC. However, as I argue in Chapter 8, I disagree with Ling that text messaging does not represent a symbol as the Crisis Text network at Hawthorne was afforded messianic qualities that ‘saved’ clients.

Lastly, in relation to consistency, Summers-Effler (2004b:301) argues that individuals need a particular level of consistency in order to ‘accurately predict’ their environment. This resonated with clients from both communities whereby they valued the consistency displayed in staff members. However, as Chapter 9 identified, I would expand Summers-Effler’s explanation to include how this consistency was not just important for predictability, but actively enabled clients to trust staff members and each other in order to be vulnerable in the TC and work towards change. Here, consistency was especially important in the staff / client relationship because staff retained more power and authority over clients and many of clients had experienced unhelpful interactions in the past from other mental health professionals. Thus staff member consistency helped to generate solidarity amongst staff and clients, and created a dynamic of safety and trust that would in turn facilitate the process of transformation.

Overall, this research proposes a number of implications for studying rituals within TCs and mental health contexts. Current IRC theory does not contain the elements necessary for understanding how everyday interactions can produce positive change. Negative emotions can be transformed into positive EE if solidarity and entrainment are maintained. Solidarity alone will not produce change but needs components such as reality confrontation and consistency. Thus IRC theory needs to expand in order to make it applicable for mental health settings. I will next consider the implications that this research has for therapeutic communities.

10.4.2 Therapeutic Communities

As with IRC theory, this thesis offers a number of challenges to TCs including the value of everyday social interactions, flattened hierarchy and the use of power, and the process of personal change. Firstly, TCs are a distinctive form of therapy in that they value all forms of social encounters in communities as potentially therapeutic.

However, at both TCs, I noticed that staff and clients struggled to articulate how times outside of structured therapy contributed to the process of change. Given the current, and understandable, emphasis on outcomes and clinical effectiveness, it appears that everyday encounters are not fully acknowledged, reflected upon and conceptualised as a component of therapy. I would argue that the time spent outside of the structured therapy groups was clearly important for building trust, working through misunderstandings and disagreements, and getting to know others. In both communities, clients would receive feedback, compliments, would push each other and be pushed back through daily conversations with one another and staff members. It must be acknowledged however that TCs are not alone in this tendency. For example, Berwick (2013) argues that healthcare in general has become too outcome focused at the expense of everyday processes. I would add minimising the role of times outside of structured therapy risks undervaluing smaller but significant changes.

Moreover, a focus on the big outcomes, such as significant reduction in self-harm or disassociation, may lead to some clients feeling that they are not changing according to others' expectations. This occurred at Powell whereby staff felt that one client in particular was not changing. The client herself re-asserted their statement but went on to identify areas of change in her interview with me. Understanding the specific role that everyday social interactions play in facilitating change may enable clients and staff to value the emotional changes that clients make such as increased feelings of confidence and self-acceptance.

Secondly, as I mention above in Summary of Findings, Chapter 8 challenges the notion of flattened hierarchies within TCs. Data from both Powell and Hawthorne suggest that the communities did have power hierarchies in place, including within the client member cohort. Usually these hierarchies were fluid as client members could shift between roles fairly easily as they transitioned from newcomer to more experienced member or moved continuously between helper and helped. Client members would often notice when another client took on a more substantial role in the TC, such as providing feedback in meetings or volunteering for a new job, and would remark on these changes during Community Meetings as a way of offering positive feedback or encouragement. In these types of interactions, power was

shared between members and rituals generated feelings of solidarity and confidence. However, there were also times when the clients were not so accommodating, when hierarchies were rigid and exclusive cliques formed. When this occurred, power was consolidated within a dominant group of individuals. Instead of positive EE shared in solidarity, only those in the dominant group gained EE. Thus a fluid hierarchy model seems to more closely represent TC practice. Moreover, a fluid hierarchy approach recognises that both dominant and creative forms of power co-existed in the communities. In other words, both solidarity and power rituals were present in both TCS. Returning to Bloor (1986) and the notion of social orchestration, it seems the main difference between social control and social orchestration is whether positive EE is consolidated in a power ritual or shared in a solidarity ritual. Determining the difference between the two is a question of interpretation, and I therefore remain sceptical as to the extent that social orchestration differs from social control in practice. For that reason, I contend that greater attention to the inequalities and hierarchies that do at times exist in communities, especially between client members, would provide a more useful approach than the problematic belief that power is a flattened hierarchy.

Thirdly, as expected, the process of change was complex, full of gains and relapses, and does not fit into trajectories of linear movement. Despite this complexity, at both communities I watched clients make small, subtle changes day by day. For instance Erica, a non-smoker, often remained fairly quiet during Smoking Breaks at Powell but began to assert her opinion and perspectives more over time in the smoking courtyard, particularly to more dominant client members such as Anna and Martha. Jessie at Hawthorne would not eat lunch when she first arrived in the community but slowly began to sit at the table drinking her soda and then progressed to eating food with the others. These changes did not work in a linear trajectory. Instead, positive changes were often accompanied by a backwards step, or relapse of negative behaviour and self-beliefs. A non-linear process of change confirms previous mental health research, including Lapsley et al. (2002), Davidson et al. (1999), and Deegan (1996). Additionally, I would concur with Castillo et al. (2013) that safety, trust, care, belonging, skills, goals and transitional recovery are central components to the therapeutic change process in TCs. Certainly this seems to echo much of what has been discussed in this thesis including solidarity, inclusion, skills

and consistency. Everyday rituals such as Community Meetings, Smoking Breaks and Meal Times were key interactions in establishing and sustaining these components within a community. However, I would challenge Castillo et al. (2013:5) as to whether these components represent a 'hierarchy of progress' in practice. Sequential aspects of change suggest that a client moves step-by-step through therapy. In contrast, the therapy process seemed more fluid for clients in Powell and Hawthorne. For example, Emergency Meetings at Powell offered new clients an opportunity to begin building a sense of belonging to the TC by emotionally embodying the community's values. At the same time, new clients were also learning community boundaries in terms of what behaviours were acceptable and how boundary breaks were managed. Instead of sequential steps, I would expand Castillo et al.'s model to argue that these stages do occur at *various* points of a client's process rather than at *set* points. Whilst this distinction is subtle, I contend that it strengthens the assertion that change is non-linear and that some stages of change can unfold simultaneously as a client ultimately works towards transitional recovery.

TCs have long acknowledged that times outside of structured therapy are important for facilitating personal change (Jones, 1968; Main, 1977; Haigh, 2013). However, this 'little understood process' of social learning (Jones, 1968:70) has remained underdeveloped in terms of its importance in facilitating personal change. I argue in this thesis that what occurs outside of therapy can be explained through an analysis of their social mechanisms. Everyday social encounters are vital opportunities for client members to deconstruct and reconstruct their sense of self, to learn to belong to one another and the TC, to change their expectations of social situations and experience transformative change. Equally, an understanding of times outside of therapy provide a potential opportunity for those within TCs to reflect upon some of the more problematic, inconsistent and contradictory aspects of live in community, especially in relation to power dynamics.

10.4.3 Additional Reflections

In addition to the implications of this thesis for IRC theory and TCs, there are two other reflections to be made in relation to client members' relationships with one another and narrative practice. These points do not challenge theory or methodology but rather offer some reflective comments upon the literature.

Firstly, as Chapter 2 identifies, Davidson et al. (2006) contends that peer support relationships can either be 'intentional', whereby relationships are similar to mental health professionals and clients, or 'naturally occurring', where clients form friendship roles. I highlighted that client member relationships in TCs may encompass both types of relationships and that a further reflection of client members' support of one another would expand the definition and application of peer support. As expected, clients in both TCs did have intentional and natural occurring relationships with one another. Chapter 8 has already explored the social hierarchies that existed within the client cohort in relation to power. That clients were also closer to some over others is not itself surprising. Most of the clients explained that they would not have chosen to be in a TC with specific individuals but that they were committed to supporting everyone. Jessie from Hawthorne, for instance, referred to those in the TC as "therapy friends" and "confidantes" rather than "good friends". She described how she could share very personal information with everyone in the TC but would not necessarily be friends on the "outside". Clients from Powell suggested that they would likely remain in contact with at least some client members after leaving the TC and indeed the three Graduate Group members I interviewed were all still closely connected to one another, even though they lived in different areas. However, Hawthorne clients were more reticent about whether they would stay in contact with anyone after they left the TC. Many felt like those relationships would be restricted to the TC and there was a sense that they would want to move on with their life after leaving the community. Of the client members who had already left the community before I arrived, only one person stayed in contact with one client member, and that ceased after a few weeks. Thus, in relation to peer support within TCs, this research suggests that even when relationships resembled friendships there were limits as to whether these relationships would be sustained upon leaving the community.

Secondly, in relation to methodology, following Baldwin (2005), this study highlighted in Chapter 4 that narrative research with those who are unable to provide a coherent or chronological story is underrepresented. Much of the narrative work with those who have mental health difficulties relies upon recollected accounts and there are fewer studies that incorporate distress as it occurs. This thesis builds upon the work of Baldwin (2005), Bruner (1997) and Gubrium and Holstein (2008) by drawing on a narrative approach through client member stories and the recognition that as the researcher, I stepped into continuously flowing narratives in the TCs. As such, this research represents several stories of those who struggled to tell their story in a 'coherent' form, either because of large gaps missing in their stories or because they had to give their narrative in small segments over several weeks which led to different sections of their narrative being told. Therefore the approach advocated by Baldwin (2005) and Gubrium and Holstein (2008) is helpful in prioritising smaller, episodic stories alongside interactive observations. Further research could be conducted with those experiencing acute mental health difficulties, including those diagnosed with dementia, to expand narrative practice.

10.5 Study Limitations and Future Research Directions

Looking at social interactions outside of structured therapy provides an explanation as to how these interactions facilitate personal change in TCs. However, there are a number of things that this study does not look at and cannot explain. To start, this research only explores the role of social interactions within adult democratic communities. Though everyday rituals, including Meal Times and Community Meetings, likely occur in other TCs, it is possible that they vary across different categories of communities. One possible direction for future research would be to include other types of communities such as forensic, children and young people and learning disabilities.

Secondly, the study did specifically look at interactions that occur *outside* of structured therapy. Creating a distinction between structured and unstructured therapy arguably generates a divide that is not recognised by the communities themselves, as they see all aspects of community life as 'therapy'. Though I was

conscious of this division, my aim was to understand how ordinary, mundane interactions contribute to therapy, and to identify their theoretical mechanisms and functions. This is similar to understanding the holistic experience of healthcare that a cardiac patient experiences when undergoing treatment for heart disease. Every interaction, from the nurses to the healthcare assistants to other patients on the ward, can potentially impact upon that patient's care (Berwick, 2013). It was the dynamics of these in between moments that I sought to explore. However, there are undoubtedly interaction rituals that occur within structured therapy times that also contribute to the process of personal change. Indeed, this thesis does *not* suggest that informal times could, or should, replace structured therapy or professional practice. It is unknown to what extent everyday social encounters facilitate personal change *because of* structured therapy and the expertise of staff members. Studying encounters within structured, in comparison to those that occur during unstructured times, may therefore provide a deeper and more holistic analysis as to the role of all interaction rituals within TCs.

Thirdly, this research looked at change in process during a particular time during the life of two communities. The progress of participants in this study is in a sense frozen because, in the main, I only looked at how they were changing whilst in community. I did not have an opportunity to follow-up with any of the clients once they left the TC. It is possible that those who self-reported the significant change during interviews were unable to sustain these changes once they left the community. Equally, those that reported little to no change may have found they were able to change significantly upon leaving the TC. Moreover, it is no coincidence that the three Graduate Group members I interviewed at Powell all reported sustained and continuing changes after one year in the community. These clients were committed to attending the Graduate Group, staying in contact with the TC and with one another. Indeed, these three women all phoned each other regularly to offer mutual and informal support. Their continued positive changes after leaving Powell may have had made them more willing to give an interview to me. It is worth noting that I did not receive any response from those that did not attend the Graduate Group regularly or that felt they were worse as a result of being in the TC. Additionally, I was unable to interview any client members from Hawthorne's equivalent of Powell's Graduate Group because it was not well attended by those who had left the

community. Therefore I could not make any comparisons or links amongst clients who had left the two TCs. A future research study could look more specifically at what happens to client members once they leave the community in order to understand how the process of change continues, or not, after leaving the TC.

Fourthly, in order to prioritise the client member perspective, I deliberately did not focus on staff dynamics. Nonetheless, the ways in which the staff teams operated was certainly a theme that lingered in the background of this study. Just like the clients had their own interaction rituals, such as Smoking Breaks, that were distinct from the staff, staff members had their respective rituals that were separate from the clients. Incorporating staff dynamics, including elements of power and hierarchies amongst the staff team, in conjunction with client dynamics may again yield a much fuller understanding of interaction rituals within TCs.

In addition to the research directions already proposed, there are several other directions to pursue following this research. Firstly, research that incorporates both staff rituals and structured therapy rituals would give a holistic account of all interaction rituals that co-exist within communities. Secondly, as acknowledged in Chapter 2, Spandler (2006) identifies TCs have not yet developed alternative models of power structures other than democracy. More research into alternative power structures may provide different organisational options for TCs. Lastly, expanding the research from TCs, IRC theory could be strengthened by exploring the rituals within other mental health contexts, such as acute units, and wider community organisations, such as charitable groups that seek to address social and mental health conditions. Particular questions could include, what types of interactions exist within these contexts, how individuals find a sense of solidarity with one another, particularly when membership fluctuates, and what necessary mechanisms are needed in order to sustain positive emotional energy and inclusion within these contexts. These findings could then be cross-referenced with the data in this thesis to contextualise and expand how interaction rituals operate within differing types of community groups.

10.6 Final Conclusions: going forward in mental health practice

This thesis has travelled some distance from where it first started. My data challenged me to prioritise social interactions in explaining the social process of personal change. Once I had understood the social mechanisms of interactions outside of structured therapy, I could then explore the complexities of individual accounts of life in TCs.

I have argued in this thesis that there are two main contributions of this research for IR theory and TCs. Firstly, as IR theory has not been applied to mental health, this research suggests clarifying the use of emotions to include how negative emotions are sustained in successful interaction rituals that generate solidarity and feelings of belonging. Through linking in with other theorists and writers from Durkheim to Mead, Goffman, Collins, Summers-Effler, Hallett and Ling, I extend IR theory to incorporate the complex social interactions that exists within TCs. Secondly, advocates of TCs have long contended that learning through social interactions can be therapeutic and transformative. This thesis has examined the social processes that were at work during these informal times and how these interactions contributed to the process of personal change.

Returning to Haigh (2005) and the question of 'what matters' in mental health practice, it is reasonable to question why mundane social interactions within a mental health setting are so important for personal change. Why do communities need smoking breaks, meal times and community meetings? I have argued that these are the moments where clients are unmade and remade, where they find belonging, and opportunities to transform their expectations and experiences of social encounters.

Though TCs were once a dominant voice in advocating for social learning models of therapy, they do not have the popularity or influence that they once did. At a symposium in 2011, I explained to a leading mental health academic about my research in TCs and the response was surprise that TCs were still in existence. Current austerity measures introduced by the Coalition Government, and expected to continue under the Tories, has proven difficult for mental health services, including TCs. Treatment offered by TCs is expensive and time consuming in an era that is driven by budgets cuts and the promise of more for less with quicker results.

However, it must be acknowledged that in terms of research, TCs have also not always engaged with the wider world (Morant and Manning, 2005), creating a culture of isolation from those in mental health that are proponents of social learning approaches. As TCs are re-entering these conversations in more recent years, this research aims to add to the dialogue as to why holistic forms of therapy that prioritise everyday social interactions, though expensive, are crucial. Equally, through highlighting the inconsistency between TC theory and practice and widening the focus on power dynamics to include power flows between client members, the thesis seeks to expand the conversation regarding the limitations of the TC approach (Star Wards, 2006; Spandler, 2006) in order to reflect upon how to improve TC practice. These reflections in turn have the potential to contribute to improving practice in mental health care more widely.

The significance of everyday social interactions as discussed in this thesis cannot be overstated. As Mahony (1979:85) reflects, it is in these everyday moments where transformations 'happened', where the 'action' was (Goffman, 1967:149), and where change was lived out.

REFERENCES

6, P. (2007) Rituals Elicit Emotions to Define and Shape Public Life: a neo-Durkheimian theory. in 6, P., Radstone, S., Squire, C. and Treacher, A. eds. *Public Emotions*. Basingstoke: Palgrave Macmillan.

Adame, A.L. and Hornstein, G.A. (2006) Representing Madness: how are subjective experiences of emotional distress presented in first-person accounts? *The Humanistic Psychologist* 34(2): pp.135-158.

Adlam, J., Gill, I., Glackin, S.N., Kelly, B.D., Scanlon, C. and Suibhne, S.M. (2013) Perspectives on Erving Goffman's 'Asylums' Fifty Years On. *Medicine, Health Care and Philosophy* 16(3): pp.605-613.

American Psychiatric Association. (2013) *Diagnostic and statistical manual of mental disorders*. 5th ed. Washington, D.C.: American Psychiatric Publishing.

Anderson, H. (1997) *Conversation, Language, and Possibilities: a postmodern approach to therapy*. New York: BasicBooks.

Anspach, R.R. and Mizrachi, N. (2006) The Field Worker's Fields: ethics, ethnography and medical Sociology. *Sociology of Health & Illness* 28(6): pp.713-731.

Anthony, W.A. (1993) Recovery from Mental illness: the guiding vision of the mental health service system in the 1990's. *Psychosocial Rehabilitation Journal* 16(4): pp.11-23.

Armstrong, L. (2005) Promoting Insight Through Group Feedback: the use of psychological assessment in a therapeutic community. *Therapeutic Communities* 26(3): pp.285-293.

Atkinson, P. and Hammersley, M. (1994) Ethnography and Participant Observation. in Denzin, N.K. and Lincoln, Y.S. eds. *Handbook of Qualitative Research*. Thousand Oaks: Sage Publications, Inc.

Baldwin, C. (2005) Narrative, Ethics and People with Severe Mental Illness. *Australian and New Zealand Journal of Psychiatry* 39(11-12): pp.1022-1029.

Ballatt, J. and Campling, P. (2011) *Intelligent Kindness: reforming the culture of healthcare*. London: The Royal College of Psychiatrists.

Barlow, D.H. and Nock, M.K. (2009) Why Can't We Be More Idiographic in Our Research? *Perspectives on Psychological Science* 4(1): pp.19-21.

Barnes E. (1968) *Psychosocial Nursing: Studies from the Cassell Hospital*. London: Tavistock Publications Limited.

Barnes, M. and Bowl, R. (2001) *Taking Over The Asylum: empowerment and mental health*. Basingstoke: Palgrave.

Baron, C. (1987) *Asylum to Anarchy*. London: Free Association Books.

Bauman, Z. (2003) *Liquid Love*. Cambridge: Polity Press.

Bell, C. (1992) *Ritual Theory, Ritual Practice*. Oxford: Oxford University Press.

Bentall, R.P. (2009) *Doctoring the Mind: why psychiatric treatments fail*. London: Penguin Books.

Benton, T. and Craib, I. (2001) *Philosophy of Social Science: the philosophical foundations of social thought*. Basingstoke: Palgrave Macmillan.

Berkman, L.F., Glass, T., Brissette, I. and Seeman, T.E. (2000) From Social Integration to Health: Durkheim in the new Millennium. *Social Science & Medicine* 51(6): pp.843-857.

Berwick, D. (2013) A Promise to Learn – a commitment to act. Improving the Safety of Patients in England. *National Advisory Group on the Safety of Patients in England*. [Online]. Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/226703/Berwick_Report.pdf. [Accessed 19 December 2014].

Best, D., Lubman, D.I., Savic, M., Wilson, A., Dingle, G., Haslam, S.A., Haslam, C. and Jetten, J. (2014) Social and Transitional Identity: exploring social networks and their significance in a therapeutic community setting. *The International Journal of Therapeutic Communities* 35(1): pp.10-20.

Bick, J., Zhu, T., Stamoulis, C., Fox, N.A., Zeanach, C. and Nelson, C.A. (2015) Effect of Early Institutionalization and Foster Care on Long-term White Matter Development. *JAMA Pediatrics* 169(3): pp.211-219.

Bion W.R. (1961) *Experiences in Groups*. London: Tavistock Publications Limited.

Bloom, S.L. and Norton, K. (2004) Introduction to the Special Section: The Therapeutic Community in the 21st Century. *Psychiatric Quarterly* 75(3): pp.229-231.

Bloor, M., McKeganey, N. and Fonkert, D. (1988) *One Foot in Eden: a sociological study of the range of therapeutic community practice*. London: Routledge.

Bloor, M. (1986) Social Control in the Therapeutic Community: re-examination of a critical case. *Sociology of Health & Illness* 8(4): pp.305-324.

Bloor, M.J. and Fonkert, J.D. (1982) Reality Construction, Reality Exploration and Treatment in Two Therapeutic Communities. *Sociology of Health & Illness* 4(2): pp.125-140.

Blumer, H. (1969) *Symbolic Interactionism: perspective and method*. Englewood Cliffs: Prentice-Hall, Inc.

Bosk, C.L. (2001) Irony, Ethnography, and Informed Consent. in Hoffmaster, B. ed. *Bioethics and Social Context*. Philadelphia: Temple University Press.

Bowers, L. (2014). Safewards: a new model of conflict and containment on psychiatric wards. *Journal of Psychiatric and Mental Health Nursing* 21(6): pp.499-508.

Boyling, E. (2011) Being Able to Learn: researching the history of a therapeutic community. *Social History of Medicine* 24(1): pp.151-158.

Bradley, E.H., Curry, L.A. and Devers, K.J. (2007) Qualitative Data Analysis for Health Services Research: developing taxonomy, themes, and theory. *Health Services Research* 42(4): pp.1758-1772.

Brown, G.W. and Harris, T. (1978) Social Origins of Depression: a reply. *Psychological Medicine* 8(4): pp.577-588.

Brownlie, J. (2004) Tasting the Witches' Brew: Foucault and Therapeutic Practices. *Sociology* 38(3): pp.515-532.

Bruner, E.M. (1997) Ethnography as Narrative. in Hinchman, L.P. and Hinchman, S.K. eds. *Memory, Identity, Community: the idea of narrative in the human sciences*. Albany: State University of New York Press.

Bryman, A. (2001) *Social Research Methods*. Oxford: Oxford University Press.

Burkitt, I. (2008) *Social Selves: theories of self and society*. 2nd ed. London: Sage Publications.

Burns, J. (2006) The Social Brian Hypothesis of Schizophrenia. *World Psychiatry* 5(2): pp.77-81.

Busfield, J. (2001) Introduction: rethinking the sociology of mental health. in Busfield, J. ed. *Rethinking the Sociology of Mental Health*. Oxford: Blackwell Publishers.

Cameron, D. (2006) I am Arresting You, Therapeutic Community, on Suspicion of Ineffectiveness: you are not obliged to say anything, but anything you do say may be used as evidence against you. *Therapeutic Communities* 27(4): pp.453-475.

Campling, P. (2001) Therapeutic Communities. *Advances in Psychiatric Treatment* 7(5): pp.365-372.

Castillo, H., Ramon, S. and Morant, N. (2013) A Recovery Journey for People with Personality Disorder. *International Journal of Social Psychiatry* 59(3): pp.264-273.

Castillo, H. (2013) Service User Insights into Recovery in Personality Disorder. in Walker, S. ed. *Modern Mental Health: critical perspectives on psychiatric practice*. St. Albans: Critical Publishing, Ltd.

Castillo, H. (2009) The Person with a Personality Disorder. in Norman, I. and Ryrie, I. eds. *The Art and Science of Mental Health Nursing: a textbook of principles and practice*. 2nd ed. Maidenhead: Open University Press.

Castillo, H. (2003) *Personality Disorder: temperament or trauma?* London: Jessica Kingsley Publishers.

Chandler, A. (2012) Self-Injury as Embodied Emotion Work: managing rationality, emotions and bodies. *Sociology* 46(3): pp.442-457.

Chapple, E.D. (1982) Movement and sound: The musical language of body rhythms in interaction. in Davis, M. ed. *Interaction rhythms: Periodicity in communicative behaviour*. New York: Human Sciences Press.

Chapple, E.D. (1970) *Culture and Biological Man: explorations in behavioural anthropology* New York: Holt, Rinehart and Winston.

Charon, J.M. (1979) *Symbolic Interactionism: an introduction, an interpretation, an integration.* Englewood Cliffs: Prentice-Hall.

Chartrand, T.L. and Bargh, J.A. (1999) The Chameleon Effect: the perception-behavior link and social interaction. *Journal of Personality and Social Psychology* 76(6): pp.893-910.

Chase, S. E. (2005) Narrative Inquiry: multiple lenses, approaches, voices. in Denzin, N.K. and Lincoln, Y.S. eds. *The SAGE Handbook of Qualitative Research*. London: Sage Publications Ltd.

Cheal, D. (1992) Ritual: communication in action. *Sociological Analysis* 53(4): pp.363-374.

Chiesa, M. and Fonagy, P. (2000) Cassel Personality Disorder Study: methodology and treatment effects. *British Journal of Psychiatry* 176(5): pp.485-491.

Clarke, L. (1994) A Further Critical Description of the Therapeutic Community. *Journal of Clinical Nursing* 3(5): pp.279-288.

Collins, R. (2014) Interaction Ritual Chains and Collective Effervescence. in von Scheve, C. and Salmela, M. eds. *Collective Emotions*. Oxford: Oxford University Press.

Collins, R. (2010) The Micro-Sociology of Religion: religious practices, collective and individual. *Association of Religion Data Archives Guiding Papers Series*. [Online]. Available from: www.thearda.com/rrh/papers/guidingpapers/Collins.asp. [Accessed 6 May 2014].

Collins, R. (2008) The Micro-Sociology of Violence. *The British Journal of Sociology* 60(3): pp.566-576.

Collins, R. (2004) *Interaction Ritual Chains*. Princeton: Princeton University Press.

Collins, R. (1987) Interaction Ritual Chains, Power and Property: the micro-macro connection as an empirically based theoretical problem. in Alexander, J.C., Giesen, B., Münch, R. and Smelser, N.J. eds. *The Micro-Macro Link*. Berkley: University of California Press.

Collins, R. (1981) On the Microfoundations of Macrosociology. *American Journal of Sociology* 86(5): pp.984-1014.

Collins, R. (1975) *Conflict Sociology: toward an explanatory science*. New York: Academic Press.

Community of Communities: a quality network of therapeutic communities. (2014) *Service standards for therapeutic communities*. 8th ed. Paget, S., Thorne, J. Fildes, N. and Rashid, S. eds. [Online]. Available from: http://www.rcpsych.ac.uk/pdf/Service%20Standards%20for%20Therapeutic%20Communities%208th%20Ed.pdf [Accessed 1 October 2014].

Cooper, D. (1967) *Psychiatry and Anti-Psychiatry*. London: Tavistock Publications Ltd.

Corrigan, P.W. and Phelan, S.M. (2004) Social Support and Recovery in People with Serious Mental Illnesses. *Community Mental Health Journal* 40(6): pp.513-523.

Cottingham, M.D. (2012) Interaction Ritual Theory and Sports Fans: emotion, symbols, and solidarity. *Sociology of Sport Journal* 29(2): pp.168-185.

Cottle, T.J. (2002) On Narratives and the Sense of Self. *Qualitative Inquiry* 8(5): pp.535-549.

Craib, I. (2009) Narratives as Bad Faith. in Andrews, M., Day Sclater, S., Squire, C. and Treacher, A. eds. *The Uses of Narrative: explorations in sociology, psychology and cultural studies*. New Brunswick: Transaction Publishers.

Cromby, J. and Nightingale, D. (1999) What's Wrong with Social Constructionism? in Cromby, J. and Nightingale D. eds. *Social Constructionist Psychology: a critical analysis of theory and practice*. Buckingham: Open University Press.

Damasio, A.R. (1994) *Descartes' Error*. New York: Harper Collins.

Davidson, L. Chinman, M., Sells, D. and Rowe, M. (2006) Peer Support Among Adults with Serious Mental Illness: a report from the field. *Schizophrenia Bulletin* 32(3): pp.443-450.

Davidson, L., Chinman, M., Kloos, B., Weingarten, R., Stayner, D. and Kraemer Tebes, J. (1999) Peer Support Among Individuals With Severe Mental Illness: a review of the evidence. *Clinical Psychology: Science and Practice* 6(2): pp.165-187.

Davies, C.A. (2008) *Reflexivity and Ethnographic Research: a guide to researching selves and others*. 2nd ed. Abingdon: Routledge.

Davis, M.S. (1971) That's Interesting: towards a phenomenology of sociology and a sociology of phenomenology. *Philosophy of Social Science* 1(4): pp.309-344.

Deegan, P.E. (1996) Recovery and the Conspiracy of Hope. Paper presented at the Sixth Annual Mental Health Services Conference of Australia and New Zealand, Brisbane, Australia. [Online]. Available from:

http://www.uaa.alaska.edu/centerforhumandevelopment/fulllives/pastconferences/upload/Recovery-and-the-Conspiracy-of-Hope.pdf [Accessed 27 May 2014].

Denzin, N.K. (1997) *Interpretive Ethnography: ethnographic practices for the 21st Century*. Thousand Oaks: Sage Publications, Ltd.

Dingle, G.A., Brander, C., Ballantyne, C. and Baker, F.A. (2012) 'To be Heard': the social and mental health benefits of choir singing for disadvantaged adults. *Psychology of Music* 14(4): pp.405-421.

Dolan, B., Warren, F., Menzies, D., and Norton, K. (1996) Cost Off-Set Following Specialist Treatment of Severe Personality Disorder. *Psychiatric Bulletin* 20(7): pp.413-17.

Douglas, M. (1996) *Natural Symbols: explorations in cosmology*. Abingdon: Routledge.

Dunstan, F. and Birch, S. (2004) What Makes a Therapeutic Community? A Comparative Study of Ideal Values. in Lees, J., Manning, N., Menzies, D., and Morant, N. eds. *A Culture of Enquiry: research evidence and the therapeutic community*. Therapeutic Communities 6. London: Jessica Kingsley Publishers.

Durkheim, E. (1912/2001) *The Elementary Forms of Religious Life*. Oxford: Oxford University Press.

Durkheim, E. (1897/2006) *Suicide: a study in sociology*. Translated by Buss, R. (2006) London: Penguin Books, Ltd.

Elliot, J. (2005) *Using Narrative in Social Research: qualitative and quantitative approaches.* London: Sage Publications Ltd.

Emerson, R.M., Fretz, R.I. and Shaw, L.L. (2011) *Writing Ethnographic Fieldnotes*. 2nd ed. Chicago: The University of Chicago Press.

Etherington, K. (2008) *Trauma, Drug Misuse and Transforming Identities: a life story approach*. London: Jessica Kingsley Publishers.

Etherington, K. (2004) *Becoming a Reflexive Researcher: using ourselves within research.* London: Jessica Kingsley Publishers.

Fetterman, D.M. (2010) *Ethnography: step-by-step*. 3rd ed. Applied Social Research Methods Volume 17. London: Sage Publications Ltd.

Fitzpatrick, M.R. and Stalikas, A. (2008) Positive Emotions as Generators of Therapeutic Change. *Journal of Psychotherapy Integration* 18(2): pp.137-154.

Francis, J.J., Johnston, M., Robertson, C., Glidewell, L., Entwistle, V., Eccles, M.P., Grimshaw, J.M. (2010) What is An Adequate Sample Size? Operationalising data saturation for theory based interview studies. *Psychology & Health* 25(10): pp.1229-1245.

Francis, R. (2013) *The Mid Staffordshire NHS Foundation Trust Public Inquiry, Chaired by Robert Francis QC*. [Online]. Available from: http://www.midstaffspublicinquiry.com/report [Accessed 08 August 2014].

Freestone, M., Lees, J., Evans, C., and Manning, N. (2006) Histories of Trauma in Client Members of Therapeutic Communities. *Therapeutic Communities* 27(3): pp.387-409.

Freestone, M. (2005) Overview of an Ethnographic Study of the UK DSPD Pilot Units. *Therapeutic Communities* 26(4):pp. 449-464.

Gask, L., Evans, M. and Kessler, D. (2013) Personality Disorder. *British Medical Journal: Clinical Review* 347: pp.28-34.

Genders, E. and Player, E. (2004) Grendon: a therapeutic community in prison. in Lees, J., Manning, N., Menzies, D. and Morant, N. eds. *A culture of Enquiry: research evidence and the therapeutic community. London: Jessica Kingsley Publishers.*

Gilbert, P. (2010) *Compassion focused therapy: Distinctive features*. London: Routledge.

Gobo, G. (2008) *Doing Ethnography*. London: Sage Publications Ltd.

Goffman, E. (1967) *Interaction Ritual: essays on face-to-face behaviour*. New York: Anchor Books.

Goffman, E. (1961) *Asylums: essays on the social situation of mental health patients and other inmates*. New York: Anchor Books.

Goffman, E. (1959) *The Presentation of Self in Everyday Life.* London: Penguin Group.

Gold, R.L. (1958) Roles in Sociological Fieldwork. *Social Forces* 36(3): pp. 217-223.

Goodall, H.L. (2000) *Writing the New Ethnography*. Lanham: AltaMira Press.

Goss, D. (2007) Reconsidering Schumpeterian Opportunities: the contribution of interaction ritual chain theory. *International Journal of Entrepreneurial Behaviour & Research* 13(1): pp.3-18.

Goss, D., Jones, R., Betta, M. and Latham, J. (2011) Power as Practice: a micro-sociological analysis of the dynamics of emancipatory entrepreneurship. *Organization Studies* 32(2): pp.211-229.

Gubrium, J.F. and Holstein, J.A. (2008) Narrative Ethnography. in Hesse-Biber, S.N. and Leavy, P. eds. *Handbook of Emergent Methods*. New York: The Guilford Press.

Haigh, R. (2013) The quintessence of a therapeutic environment. *The International Journal of Therapeutic Communities* 34(1): pp.6-15.

Haigh, R., Harrison, T., Johnson, R., Paget, S. and Williams, S. (2012) Psychologically Informed Environments and the 'Enabling Environments' Initiative. *Housing, Care and Support* 15(1): pp.34-42.

Haigh, R. (2005) The Trouble with Modernisation: we need better relationships, not policies and procedures. *Mental Health Review Journal* 10(3): pp.3-7.

Haigh, R. (2002) Therapeutic Community Research: past, present and future. *Psychiatric Bulletin* 26(2): pp.65-68.

Haigh, R. (1999) The Quintessence of a Therapeutic Environment: five universal qualities. in Campling, P. and Haigh, R. eds. *Therapeutic Communities: past, present and future*. London: Jessica Kingsley Publishers.

Hallett, T. (2007) Between Deference and Distinction: interaction ritual through symbolic power in an educational institution. *Social Psychology Quarterly* 70(2): pp.148-171.

Hallett, T. (2003) Emotional Feedback and Amplification in Social Interaction. *The Sociological Quarterly* 44(4): pp.705-726.

Hammer, M. (1983) 'Core' and 'Extended' Social Networks in Relation to Health and Illness. *Social Science & Medicine* 17(7): pp.405-411.

Hammersley, M and Atkinson, P. (2007) *Ethnography: principles in practice*. 3rd ed. New York: Routledge.

Hammersley, M. (2002) Ethnography and Realism. in Huberman, A.M. and Miles, M.B. eds. *The Qualitative Researcher's Companion*. Thousand Oaks: Sage Publications, Inc.

Hannerz, U. (2003) Being There...and There...and There! : Reflections on multi-site ethnography. *Ethnography* 4(2): pp.201-216.

Heider, A. and Warner, R.S. (2010) Bodies in Synch: interaction ritual theory applied to sacred harp singing. *Sociology of Religion* 71(1): pp.76-97.

Helman, C.G. (2007) *Culture, Health and Illness*. 5th ed. London: Hodder Arnold.

Hesse, M. and Pedersen, M. U. (2006) Antisocial Personality Disorder and Retention: a systematic review. *Therapeutic Communities* 27(4): pp.495-504.

Hinshlewood, R.D. (2001) *Thinking About Institutions: milieu and madness*. London: Jessica Kingsley Publishers Ltd.

Hinshlewood, R.D. (1999) Psychoanalytic Origins and Today's Work: the Cassel heritage. in Campling, P. and Haigh, R. eds. *Therapeutic Communities: past, present and future*. London: Jessica Kingsley Publishers Ltd.

Hobson, R.F. (1979) The Messianic Community. in Hinshelwood, R.D. and Manning, N. eds. *Therapeutic Communities: reflections and progress*. London: Routledge & Kegan Paul Ltd.

Holmes, E.A., Brown, R.J., Mansell, W., Fearon, R.P., Hunter, E.C.M, Frasquilho, F., Oakley, D.A. (2005) Are There Two Qualitatively Distinct Forms of Dissociation? A review of some clinical implications. *Clinical Psychology Review* 25(1): pp.1-23.

Holmes, P.R. and Williams, S. (2012) Consistency, Continuity and Stability – organizational virtues or not? *The International Journal of Therapeutic Communities* 33(4): pp.166-174.

Holmes, P. R. (2005) *Becoming More Human: exploring the interface of spirituality, discipleship and therapeutic faith community.* Milton Keynes: Paternoster Press.

Hogan, B.E., Linden, W. and Najarian, B. (2002) Social Support Interventions: do they work? *Clinical Psychology Review* 22(3): pp.381-440.

Holt-Lunstad, J., Smith, T.B. and Layton, J.B. (2010) Social Relationships and Mortality Risk: a meta-analytic review. *PLoS Medicine* 7 e1000316. doi:10.1371/journal.pmed.1000316 [Online]. Available from: http://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1000316#pmed-1000316-g006 [Accessed 1 February 2015].

Horn, N., Johnstone, L. and Brooke, S. (2007) Some Service User Perspectives on the Diagnosis of Borderline Personality Disorder. *Journal of Mental Health* 16(2): pp.255-269.

Hornstein, G. (2009) Who Owns the Mind? *Openmind* 157 (May/June): pp.6-8. [Online]. Available from: http://www.gailhornstein.com/files/Hornstein_openm.pdf [Accessed 27 June 2014].

Hubbard, G., Backett-Milburn, K. and Kemmer, D. (2001) Working with Emotion: issues for the researcher in fieldwork and teamwork. *Social Research Methodology* 4(2): pp.119-137.

Hymes, D. (1996) *Ethnography, Linguistics, Narrative Inequality: toward an understanding of voice*. London: Taylor and Francis Ltd.

Hyvärinen, M. (2006). Towards a Conceptual History of Narrative. *Studies across Disciplines in the Humanities and Social Sciences 1*. Helsinki: Helsinki Collegium for Advanced Studies, 20–41. [Online]. Available from: https://helda.helsinki.fi/bitstream/handle/10138/25742/001_04_hyvarinen.pdf?sequence=1 [Accessed 29 September 2014].

Ito, M. (2005) Mobile Phones, Japanese Youth, and the Re-placement of Social Contact. in Ling, R. and Pedersen, P. eds. *Mobile Communications: re-negotiation of the social sphere*. London: Springer.

Jackson, S., Backett-Milburn. K, and Newall, E. (2013) Researching Distressing Topics: emotional reflexivity and emotional labor in the secondary analysis of children and young people's narratives of abuse. *SAGE Open* 3(2): pp.1-12. [Online]. Available from: http://classic.sgo.sagepub.com/content/3/2/2158244013490705.full.pdf+html [Accessed 10 March 2014]

Jacobson, N. and Greenley, D. (2001) What Is Recovery? A Conceptual Model and Explication. *Psychiatric Services* 52(4): pp.482-485.

Jean-Pierre, J. (2012) Book Review: Kemper, T.D., Status, Power and Interaction Ritual: a relational reading of Durkheim, Goffman and Collins. *Canadian Journal of Sociology* 37(3): pp.346-348.

Jenkins, R. (2008) *Social Identity*. 3rd ed. Abingdon: Routledge.

Jetten, J., Haslam, A., Iyer, A. and Haslam, C. (2009) Turning to Others in Times of Change: social identity and coping with stress. in Sturmer, S. and Snyder, M. eds.

The Psychology of Prosocial Behaviour: group processes, intergroup relations, and helping. Oxford: Blackwell Publishing.

Johnson, J.G., Cohen, P., Brown, J., Smailes, E.M. and Bernstein, D.P. (1999) Childhood Maltreatment Increases Risk for Personality Disorders During Early Adulthood. *Archives of General Psychiatry* 56(7): pp.600-606.

Johnson, R. and Haigh, R. (2011) Social Psychiatry and Social Policy for the 21st Century: new concepts for new needs – the 'Enabling Environments' Initiative. *Mental Health and Social Inclusion* 15(1): pp.17-23.

Jones, M. (1976) *Maturation of the Therapeutic Community: an organic approach to health and mental health.* New York: Human Sciences Press.

Jones, M. (1968) *Beyond the Therapeutic Community: social learning and social psychiatry*. New Haven: Yale University Press.

Jones, M. (1952) *Social Psychiatry*. London: Tavistock Publications.

Jovchelovitch, S. and Bauer, M.W. (2000) Narrative Interviewing. in Bauer, M.W. and Gaskell, G. eds. *Qualitative Researching With Text, Image and Sound: a practical handbook*. London: SAGE Publications Ltd.

Katsakou, C., Marougka, S., Barnicot, K., Savill, M., White, H., Lockwood, K. and Priebe, S. (2012) Recovery in Borderline Personality Disorder (BPD): a qualitative study of service users' perspectives. *PLoS One* 7(5). [Online]. Available from: http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0036517#pone-0036517-t002 [Accessed 15 December 2014].

Kawachi, I. and Berkman, L.F. (2001) Social Ties and Mental Health. *Journal of Urban Health: Bulletin of the New York Academy of Medicine* 78(3): pp.458-467.

Kayson, S. (1993) *Girl, Interrupted*. London: Virago Press.

Kemper, T.D. (2011) *Status, Power and Interaction Ritual: a relational reading of Durkheim, Goffman and Collins.* Farnham: Ashgate Publishing Limited.

Kendall, R.E. (2002) The Distinction Between Personality Disorder and Mental Illness. *British Journal of Psychiatry* 180(2):110-115.

Kennard, D. and Lees, J. (2012) A Checklist of Standards for Democratic Therapeutic Communities. *The International Journal of Therapeutic Communities* 33(2/3): pp.117-123.

Kennard, D. (2004) The Therapeutic Community as an Adaptable Treatment Modality Across Different Settings. *Psychiatric Quarterly* 75(3): pp.295-307.

Kennard, D. (1998) *An Introduction to Therapeutic Communities*. 2nd ed. London: Jessica Kingsley Publishers.

Kesey, K. (1962) *One Flew Over the Cuckoo's Nest*. London: Penguin Books, Ltd.

Kinderman, P., Read, J., Moncrieff, J. and Bentall, R.P. (2013) Drop the Language of Disorder. *Evidence-Based Mental Health* 16(1): pp.2-3. [Online]. Available from: http://ebmh.bmj.com/content/16/1/2.short [Accessed 12 December 2014].

King, A. (2006) The Word of Command: communication and cohesion in the military. *Armed Forces and Society* 32(4): pp.493-512.

Kohn, M. (2008) *Trust: self-interest and the common good*. Oxford: Oxford University Press.

Langellier, K.M. (2001) "You're Marked": breast cancer, tattoo, and the narrative of performance identify. in Brockmeier, J. and Carbaugh, D. eds. *Narrative and Identity: studies in autobiography, self and culture*. Amsterdam: John Benjamins Publishing Company.

Lapsley, H., Nikora, L.W. and Black, R. (2002) *"Kia Mauri Tau!" Narratives of Recovery from Disabling Mental Health Problems*. Report of the University of Waikato Mental Health Narratives Project. Wellington: Mental Health Commission.

Larsen, J.A. (2007) Understanding a Complex Intervention: Person-centred ethnography in early psychosis. *Journal of Mental Health* 16(3): pp.333-345.

Lawler, S. (2002) Narrative in Social Research. in May, T. ed. *Qualitative Research in Action*. London: Sage Publications Ltd.

Lees, J., Manning, N. and Rawlings, B. (2004) A Culture of Enquiry: research evidence and the therapeutic community. *Psychiatric Quarterly* 75(3): pp.279-294.

Lees, J., Manning, N., and Rawlings, B. (1999) *Therapeutic Community Effectiveness: a systematic international review of therapeutic community treatment for people with personality disorder and mentally disordered offenders*. CRD Report 17, York: NHS Centre for Review and Dissemination, University of York.

Lewis, G. and Wessley, S. (1997) Personality Disorder. In Murray, R., Hill, P. and McGuffin, P. (eds) *The Essentials of Postgraduate Psychiatry*. Cambridge: Cambridge University Press.

Lewis, G. and Appleby, L. (1988) Personality Disorder: the patients psychiatrists dislike. *The British Journal of Psychiatry* 153: pp.44-49.

Linehan, M.M. (2015) *DBT Skills Training Manual*. 2nd ed. New York: Guildford Press.

Ling, R. (2008) *New Tech, New Ties. How Mobile Communication is Reshaping Social Cohesion*. Cambridge: MIT Press.

Lukes, S. (2005) *Power: a radical view – the original text with two major new chapters*. 2nd ed. New York: Palgrave Macmillan.

Main, T. (1980) Some Basic Concepts In Therapeutic Community Work. In Main, T. ed. *The Therapeutic Community*. London: Croom Helm.

Main, T. (1977) The Concept of the Therapeutic Community: variations and vicissitudes. *Group Analysis* 10(2): pp.S2-S16.

Main, T. F. (1946) The Hospital as a Therapeutic Institution. *The Bulletin of the Menninger Clinic* 10(3): pp.66-70.

Mahony, N. (1979) My Stay and Change at the Henderson Therapeutic Community. in Hinshelwood, R.D. and Manning, N. eds. *Therapeutic Communities: reflections and progress*. London: Routledge & Kegan Paul Ltd.

Malinowski, B. (1967) *A Diary in the Strict Sense of the Word*. New York: Harcourt, Brace & World.

Mamede, S. and Schmidt, H.G. (2013) The Twin Traps of Overtreatment and Therapeutic Nihilism in Clinical Practice. *Medical Education* 48(1): pp.34-43.

Mandelbaum, D.G. (1959) Social Uses of Funeral Rites. in Feifel, H. ed. *The Meaning of Death*. pp.189-219. New York: McGraw-Hill.

Manning, N. (2012) Collective Disturbance in Institutions: a sociological view of crisis and collapse. *The International Journal of Therapeutic Communities* 33(2/3): pp.92-99.

Manning, N. (2011) DSM – A View From Sociology. *Personality and Mental Health* 5(2): pp.112-121.

Manning, N. (2010) Therapeutic Communities: a problem or a solution for psychiatry? A sociological view. *British Journal of Psychotherapy* 26(4): pp.434-443.

Manning, N. and Morant, N. (2004) Principles and Practices in Therapeutic Community Research. in Lees, J., Manning, N., Menzies, D., and Morant, N. eds. *A Culture of Enquiry: research evidence and the therapeutic community*. Therapeutic Communities 6. London: Jessica Kingsley Publishers.

Manning, N. (2000) Psychiatric Diagnosis Under Conditions of Uncertainty: personality disorder, science and professional legitimacy. *Sociology of Health & Illness* 22(5): pp.621-639.

Manning, N. (1989) *The Therapeutic Community Movement: charisma and routinization*. London: Routledge.

Marcus, G.E. (1995) Ethnography In/Of the World System: the emergence of multi-sited ethnography. *Annual Review of Anthropology* 24: pp.95-117.

McAdams, D. P. (1993) *The Stories We Live By.* New York: The Guildford Press.

McDonald, R. (2008) Everything You Wanted to Know About Anxiety But Were Afraid to Ask. *Journal of Health Services Research & Policy* 13(4): pp.249-250.

McKeganey, N.P. and Bloor, M.J. (1987) Teamwork, Information Control and Therapeutic Effectiveness: a tale of two therapeutic communities. *Sociology of Health & Illness* 9(2): pp.154-178.

Mead, G.H. (1934) *Mind, Self, and Society: from the standpoint of a social behaviorist*. Chicago: University of Chicago Press.

Mead, G. H (1932) *The Philosophy of the Present*. La Salle, Illinois: Open Court Publishing Company.

Menzies, D. and Lees, J. (2004) The Psychodynamics of Being a Researcher in a Therapeutic Community: living the borderline experience. in Lees, J., Manning, N., Menzies, D., and Morant, N. eds. *A Culture of Enquiry: research evidence and the therapeutic community*. Therapeutic Communities 6. London: Jessica Kingsley Publishers.

Middleton, H., Shaw, R., Collier, R., Purser, A. and Ferguson, B. (2011) The Dodo Bird Verdict and the Elephant in the Room: a service-user led investigation of crisis resolution and home treatment. *Health Sociology Review* 20(2): pp.147-156.

Miller, G. and Holstein, J.A. (1996) *Dispute Domanis and Welfare Claims: conflict and law in public bureaucracies*. Greenwich: JAI Press.

Millon, T. (2011) *Introducing a DSM/ICD Spectrum from Normal to Abnormal*. 3rd ed. Hoboken: John Wiley & Sons, Inc.

Milne, C. and Otieno, T. (2007) Understanding engagement: science demonstrations and emotional energy. *Science Education* 91(4): pp.523-553.

Morant, N. and Manning, N. (2005) Principles and Practices in Therapeutic Community Research. *Therapeutic Communities* 26(3): pp.227-243.

Morant, N. and Warren, F. (2004) Outsiders on the Inside: researchers in therapeutic communities. in Lees, J., Manning, N., Menzies, D., and Morant, N. eds. *A Culture of Enquiry: research evidence and the therapeutic community*. Therapeutic Communities 6. London: Jessica Kingsley Publishers.

Murphy, E., Dingwall, R., Greatbatch, D., Parker, S. and Watson, P. (1998) Qualitative Research Methods in Health Technology Assessment: a review of the literature. *Health Technology Assessment* 2(16): pp.1-294.

Newdick, C. and Danbury, C. (2013) Culture, Compassion and Clinical Neglect: probity in the NHS after Mid Staffordshire. *Journal of Medical Ethics.* ISSN 1473-4257 doi: 10.1136/medethics-2012-101048.

Newton-Howes, G., Weaver, T. and Tyrer, P. (2008) Attitudes of Staff Towards Patients with Personality Disorder in Community Mental Health Teams. *Australian and New Zealand Journal of Psychiatry* 42(7): 572-577.

Olitsky, S. (2007) Promoting Student Engagement in Science: interaction rituals and the pursuit of a community of practice. *Journal of Research in Science Teaching* 44(1): pp.33-56.

Orb, A., Eisenhauer, L. and Wynaden, D. (2001) Ethics in Qualitative Research. *Journal of Nursing Scholarship* 33(1): pp.93-96.

Outhwaite, W. (2005) Interpretivism and Interactionism. in Harrington, A. ed. *Modern Social Theory: an introduction.* Oxford: Oxford University Press.

Palmer, D. (2001) Identifying Delusional Discourse: issues of rationality, reality and power. in Busfield, J. ed. *Rethinking the Sociology of Mental Health*. Oxford: Blackwell Publishers.

Panellli, R., Little, J. and Kraack, A. (2004) A Community Issue? Rural women's feelings of safety and fear in New Zealand. *Gender, Place and Culture* 11(3): pp.445-467.

Parker, J.N. and Hackett, E.J. (2012) Hot Spots and Hot Moments in Scientific Collaborations and Social Movements. *American Sociological Review* 77(1): pp.21-44.

Parsons, T. (1951) Illness and the Role of the Physician: a sociological perspective. *American Journal of Orthopsychiatry* 21(3): 452-460.

Patton, M.Q. (2002) *Qualitative Research and Evaluation Methods*. 3rd ed. Thousand Oaks: Sage Publications.

Payr, S. (2010) Ritual or Routine: communication in long-term relationships with companions. in Trapple, R. ed. *European Meetings on Cybernetics and Systems Research EMCSR 2010*. Vienna, Austria, pp.559-564. [Online]. Available from: http://project-sera.eu/publications/papers/EM10_L_payr2.pdf [Accessed 22 May 2014].

Pembroke, L. (1998) Self-Harm: a personal story. *Mental Health Practice* 2(2): pp.20-24.

Pentland, B.T. (1999) Building Process Theory with Narrative: from description to explanation. *Academy of Management Review* 24(4): pp.711-724.

Perfas, F.B. (2014) *Therapeutic Community: Past. Present. And moving forward to get over addiction to drugs*. Red Hook: Hexagram Publishing.

Pilgrim, D., Rogers, A. and Bentall, R. (2009) The Centrality of Personal Relationships in the Creation and Amelioration Mental Health Problems: the current interdisciplinary case. *Health: an interdisciplinary journal for the social study of health, illness and medicine* 13(2): pp.235-254.

Pilgrim, D. (2008) 'Recovery' and Currently Mental Health Policy. *Chronic Illness* 4(4): pp.295-304.

Pilgrim, D. (2001) Disordered Personalities and Disordered Concepts. *Journal of Mental Health* 10(3): pp.253-265.

Pilgrim, D. (2000) The Real Problem for Postmodernism. *The Association for Family Therapy* 22(1): pp.6-23.

Pilgrim, D. and Bentall, R. (1999) The Medicalisation of Misery: a critical reality analysis of the concept of depression. *Journal of Mental Health* 8(3): pp.261-274.

Pope, C., Ziebland, S. and Mays, N. (2000) Analysing Qualitative Data. *The British Medical Journal* 320(7227): pp.114-116.

Potter, N.N. (2009) *Mapping the Edges and the In-Between: a critical analysis of borderline personality disorder.* Oxford: Oxford University Press.

Quirk, A. (2006) The Permeable Institution: an ethnographic study of three acute psychiatric wards in London. *Social Science & Medicine* 63(8): pp.2105-2117.

Ramcharan, P. and Cutcliffe, J.R. (2001) Judging the Ethics of Qualitative Research: considering the 'ethics as process' model. *Health & Social Care in the Community* 9(6): pp.358-366.

Ramon, S., Castillo, H. and Morant, N. (2001) Experiencing Personality Disorder: a participative research. *International Journal of Social Psychiatry* 47(4): pp.1-15.

Rapoport, R.N. (1960) *Community as Doctor: new perspectives on a therapeutic community.* London: Tavistock Publications.

Rappaport, R.A. (1999) *Ritual and Religion in the Making of Humanity.* Cambridge: Cambridge University Press.

Rawlings, B. (2004) Using Qualitative Research Methods in Therapeutic Communities. in Lees, J., Manning, N., Menzies, D., and Morant, N. eds. *A Culture of Enquiry: research evidence and the therapeutic community*. Therapeutic Communities 6. London: Jessica Kingsley Publishers.

Rawlings, B. (1998) The Therapeutic Community in the Prison: problems in maintaining therapeutic integrity. *Therapeutic Communities* 19(4): pp.281-294.

Riessman, C. K. (1993) *Narrative Analysis*. London: Sage Publications Inc.

Roberts, G. and Wolfson, P. (2004) The Rediscovery of Recovery: open to all. *Advances in Psychiatric Treatment* 10(1): pp.37-49.

Roe, J., Joseph, S. and Middleton, H. (2010) Symbolic Interaction: a theoretical approach to understanding stigma and recovery. *Mental Health Review Journal* (15)1: pp.29-36.

Rogers, B. and Dunne, E. (2011) 'They Told Me I Had This Personality Disorder…All Of A Sudden I Was Wasting Their Time': personality disorder and the inpatient experience. *Journal of Mental Health* 20(3): pp.226-233.

Rose, D. (2003) Partnership, co-ordination of care and the place of user involvement. *Journal of Mental Health* 12(1): pp.59–70

Rose, N. (2001) The Politics of Life Itself. *Theory, Culture & Society* 18(6): pp.1-30.

Rose, N. (1999) *Governing the Soul: the shaping of the private self*. London: Free Association Books.

Rose, N. (1986) Psychiatry: the discipline of mental health. in Miller, P. and Rose, N. eds. *The Power of Psychiatry*. Cambridge: Polity Press.

Rosenhan, D.L. (1973) On Being Sane in Insane Places. *Science* 179(4470): pp.250-258.

Rossner, M. (2013) *Just Emotions: rituals of restorative justice*. Oxford: Oxford University Press.

Rossner, M. (2011) Emotions and Interaction Ritual: a micro-analysis of restorative justice. *British Journal of Criminology* 51(1): pp.95-119.

Roth, A. and Fongay, P. (2005) *What Works for Whom? A Critical Review of Psychotherapy Research*. New York: The Guilford Press.

Roy, S. and Tryer, P. (2001) Treatment of Personality Disorders. *Current Opinion in Psychiatry* 14(6): pp.555-558.

Royal College of Psychiatrists. (2015) *Community of Communities: a quality network of therapeutic communities.* [Online]. Available from: http://www.rcpsych.ac.uk/quality/qualityandaccreditation/therapeuticcommunities/communityofcommunities1.aspx [Accessed 02 March 2015].

Ryen, A. (2011) Ethics and Qualitative Research. in *Qualitative Research: issues of theory, method and practice*. Silverman, D. ed. London: Sage Publications Ltd.

Sanislow, C.A. and McGlashan, T.H. (1998) Treatment Outcome of Personality Disorders. *Canadian Journal of Psychiatry* 43: pp.237-250.

Sayer, A. (2000) Realism for Sceptics. in Sayer, A. *Realism and Social Science*. London: Sage Publications.

Scheff, T.J. (1977) The Distancing of Emotion in Ritual. *Current Anthropology* 18(3): pp. 483-505.

Scheff, T.J. (1967) *Being Mentally Ill: a sociological theory*. Chicago: Aldine.

Schore, A.N. (1994) *Affect Regulation and the Origins of the Self: the neurobiology of emotional development*. Hillsdale: Lawrence Erlbaum.

Sharp, V. (1975) *Social Control in the Therapeutic Community.* Farnborough: Saxon House.

Sherman, L.W., Strang, H., Angel, C., Woods, D., Barnes, G.C., Bennett, S. and Inkpen, N. (2005) Effects of Face-to-Face Restorative Justice on Victims of Crime in Four Randomized, Controlled Trials. *Journal of Experimental Criminology* 1(3): pp.367-395.

Slade, M. and Priebe, S. (2001) Are randomised controlled trials the only gold that glitters? *The British Journal of Psychiatry* 179(4): pp.286-287.

Smith, A.C.T., and Stewart, B. (2011) Organizational Rituals: features, functions and mechanisms. *International Journal of Management Reviews* 13(2): pp.113-133.

Smith, D.E. (2005) *Institutional Ethnography: a sociology for people*. Lanham: AltaMira Press.

Soloff, P.H. (1994) Is There Any Drug Treatment of Choice for the Borderline Patient? *Acta Psychiatrica Scandinavia* 89(379): pp.50-55.

Soteria Network (2011) *Soteria Network: an international movement of service users, survivors, activists, carers and professionals fighting for more humane, non-coercive mental health services*. [Online]. Available from: http://www.soterianetwork.org.uk/resources/files/Soteria-Network-Booklet.pdf [Accessed 12 November 2014].

Spandler, H. (2014) Letting Madness Breathe? Critical challenges facing mental health social work today. in Weinstein, J. ed. *Mental Health (Critical Debates in Contemporary Social Work)*. Basingstoke: Palgrave Macmillan.

Spandler, H. and Stickley, T. (2011) No Hope Without Compassion: the importance of compassion in recovery-focused mental health services. *Journal of Mental Health* 20(6): pp.555-566.

Spandler, H. (2009) Spaces of Psychiatric Contention: a cast study of a therapeutic community. *Health & Place* 15(3): pp.672-678.

Spandler, H., Secker, J., Kent, L., Hacking, S., Shenton, J. (2007) Catching Life: the contribution of arts initiatives to 'recovery' approaches in mental health. *Journal of Psychiatric and Mental Health Nursing* 14(8): pp.791-799.

Spandler, H. (2006) *Asylum to Action: Paddington Day Hospital, therapeutic communities and beyond*. London: Jessica Kingsley Publishers.

Speedy, J. (2008) *Narrative Inquiry & Psychotherapy*. London: Palgrave Macmillan.

Stalker, K., Ferguson, I. and Barclay, A. (2005) 'It Is a Horrible Term for Someone': service user and provider perspectives on 'personality disorder'. *Disability & Society* 20(4): pp.359-373.

Star Wards (2006) Practical Ideas for Improving the Daily Experiences and Treatment Outcomes of Acute Mental Health In-Patients. London: Bright. [Online]. Available from: http://www.horticulturaltherapy.info/documents/starwardsprogranandcsourbyquotepage28.pdf. [Accessed 2 February 2015].

Steinkuehler, C. (2007) Massively Multiplayer Online Gaming as a Constellation of Literary Practices. *E-Learning* 4(3): pp.297-318.

Stevens, A. (2012) I Am The Person Now I Was Always Meant To Be: identity reconstruction and narrative reframing in therapeutic community prisons. *Criminology & Criminal Justice* 12(5): pp.527-547.

Stickley, T. (2006) Should Service User Involvement Be Consigned to History? A critical realist perspective. *Journal of Psychiatric and Mental Health Nursing* 13(5): pp.570-577.

Straughair, C. (2012) Exploring Compassion: implications in contemporary nursing. Part 1. *British Journal of Nursing* 21(3): pp.160-164.

Summers-Effler, E. (2010) *Laughing Saints and Righteous Heroes: emotional rhythms in social movement groups*. Chicago: The University of Chicago Press.

Summers-Effler, E. (2006) Ritual Theory. in Stets, J.E. and Turner, J.H. eds. *Handbook of the Sociology of Emotions*. New York: Springer.

Summers-Effler, E. (2004a) Defensive Strategies: the formation and social implications of patterned self-destructive behaviour. *Advances in Group Processes* 21: pp.309-325.

Summers-Effler, E. (2004b) A theory of the self, emotion, and culture. *Advances in Group Processes* 21: pp.273-308.

Summers-Effler, E. (2002) The Micro Potential for Social change: emotion, consciousness, and social movement formation. *Sociological Theory* 20(1): pp.41-60.

Szasz, T.S. (1961) *The Myth of Mental Illness: foundations of a theory of personal conduct.* New York: Hoeber-Harper.

The Consortium for Therapeutic Communities. (2013) *TC Core Values*. [Online]. Available from: http://www.therapeuticcommunities.org/what-is-a-tc/tc-core-values/ [Accessed 01 February 2015]

Tibbetts, P. (2004) Symbolic Interaction Theory and the Cognitively Disabled: a neglected dimension. *The American Sociologist* 35(4): pp.35-36.

Treacher Kabesh, A. (2011) On Being Haunted By the Present. *Borderlands* 10(2): pp.1-21. [Online]. Available from: http://www.borderlands.net.au/vol10no2_2011/kabesh_present.pdf [Accessed 11 November 2014].

Trevarthen, C. and Aitken, K.J. (2001) Infant Intersubjectivity: research, theory and clinical applications. *Journal of Child Psychology and Psychiatry* 42(1): pp.3-48

Trevarthen, C. (2000) Musicality and the Intrinsic Motive Pulse: evidence from human psychobiology and infant communication. *Musicae Scientiae* 3(1): pp.155-215.

Trevarthen, C. and Aitken, K.J. (1994) Brain Development, Infant Communication, and Empathy Disorders: intrinsic factors in child mental health. *Development and Psychopathology* 6(4): pp.597-633.

Turner, J.H. and Stets, J.E. (2005) *The Sociology of Emotions.* New York: Cambridge University Press.

Van Maanen, J. (1988) *Tales of the Field: on writing ethnography*. Chicago: The University of Chicago Press.

Vertesi, J. (2012) Seeing Like a Rover: visualization, embodiment, and interaction on the Mars exploration Rover mission. *Social Studies of Science* 42(3): pp.393-414.

von Scheve, C., Beyer, M., Ismer, S., Koztowska, M. and Morawetz, C. (2014) Emotional Entrainment, National Symbols, and Identification: a naturalistic study around the men's football World Cup. *Current Sociology* 62(1): pp.3-23.

Whiteley, S. (2004) The Evolution of the Therapeutic Community. *Psychiatric Quarterly* 75(3): pp.233-248.

Whiteley, S. (1990) Obituary. Professor Maxwell Jones: the psychiatrist as social ecologist. *The Guardian* 20 August.

Winship, G. and Hardy, S. (2007) Perspectives on the prevalence and treatment of personality disorder. *Journal of Psychiatric & Mental Health Nursing* 14(2): pp.148–154

Winship, G. (2004) Democracy in Practice in 14 UK Psychotherapeutic Communities. *Therapeutic Communities* 25(4): pp.275-290.

Winship, G. and Haigh, R. (2000) Public Mental Health and the New Therapeutic Community. *Therapeutic Communities* 21(1): pp.47-53.

Winship, G. (1995) Patient Empowerment: individualism v collectivism. *Therapeutic Communities* 16(2): pp.113-116.

World Health Organisation. (1992) *The ICD-10 classification of mental and behavioural disorders: clinical descriptions and diagnostic guidelines*. Geneva: World Health Organization.

Wright, K., Haigh, K. and McKewon, M. (2007) Reclaiming the Humanity in Personality Disorder. *International Journal of Mental Health Nursing* 16(4): pp.236-246.

Young, S.L and Ensing, D.S. (1999) Exploring Recovery from the Perspective of People with Psychiatric Disabilities. *Psychiatric Rehabilitation Journal* 22(3): pp. 219-231.

Zanarini, M.C. and Frankenburg, F.R. (1997) Pathways to the Development of Borderline Personality Disorder. *Journal of Personality Disorders* 11(1): pp.93-104.

Zingmark Licentiate, K., Sandman, P.O. and Norberg, A. (2002) Promoting a Good Life Among People with Alzheimer's Disease. *Journal of Advanced Nursing* 38(1): pp.50-58.

APPENDIX 1

Participant Information Sheet (Participant Observation)
(Version 2.0: 24/09/2012)

Study Title: **Undergoing Personal Change in a Community Context**
Research Team: **Mrs Jenelle Clarke (PhD Student, School of Sociology and Social Policy)**
Professor Ruth McDonald (Business School)
Professor Nick Manning (School of Sociology and Social Policy)

We would like to invite you to take part in a study being conducted as part of a PhD at the University of Nottingham. Before you decide, it is important you understand why the research is being done and what participating would involve for you. Please do talk to others about the study if you wish to before deciding whether or not to participate, and ask the research team any questions you may have.

Purpose of the study

This study is about understanding what it is like to participate in therapeutic communities (TCs) from members' perspectives. Specifically this study will look at what it is like to go through a process of personal change in a community setting by observing how people interact socially. Particular attention will be given to everyday social interactions between individuals in the community and how individuals change in relationship with others.

The researcher aims to observe the social processes that naturally occur daily in a community such as structured/unstructured activities, meal times and community chore duties. It is these activities, conversations and interactions that occur between structured therapy sessions that is the focus of the study.

This study will seek to explore how individuals interact with others and behave by being a member of the community and participating in everyday community activities. Ultimately, the study will look at what it is like to participate in a therapeutic community and how being part of a TC impacts on areas such as members' sense of identity, belonging and the nature of their relationships.

This research will take place during late 2012 and will last until September 2014.

Very few studies within TCs have explored what happens in between structured therapy sessions. This study will help to highlight the value of TCs and justify continued funding on therapeutic approaches that emphasise social relationships.

Results from this study will be published in academic journals and presented within academic and therapeutic community conferences.

Why have I been invited?
You have been invited to participate in this study because of involvement with _____ therapeutic community.

Do I have to take part?
It is up to you to decide whether or not to take part. If you would prefer not to take part you do not have to give a reason. In addition, no information gathered during the observation will make any reference to you.

If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. This would not affect your legal rights.

What will happen to me if I take part?
For this study, the researcher will be observing the informal activities of the community such as meal times, chores and other unstructured activities. She will not be observing individual or group therapy sessions. The aim is to capture the naturally occurring interactions and conversations that TC members have with each other outside of structured therapy sessions.

You will not be asked to do anything that you would not already be doing as part of your involvement within the community. The researcher may occasionally ask you questions about community life. You may also see her taking handwritten field notes throughout the observation process but such observations will not be tape or video recorded. All comments and quotations will be anonymised and no personal information about you will appear in the research.

Where other individuals in the community specifically do not wish to be referenced in any way within the research, no reference to them will be made. Any references to others who are willing to participate in the research will be through the use of pseudonyms and will exclude any personal information.

It is expected that observation will last for a period of up to four months.

Expenses and payments
There are no costs to participate in this study. There is no payment offered for participation in the research.

Withdrawal
Your participation is voluntary and you are free to withdraw at any time, without giving any reason, and without your legal rights being affected. If you withdraw then the

information collected so far cannot be erased and this information may still be used in the project analysis.

Confidentiality
We will follow ethical and legal practice and all information about you will be handled in confidence.

If you join the study, some parts of your data collected for the study will be looked at by authorised persons from the University of Nottingham who are organising the research. They may also be looked at by authorised people to check that the study is being carried out correctly. All will have a duty of confidentiality to you as a research participant and we will do our best to meet this duty.

All information which is collected about you during the course of the research will be kept strictly confidential, stored in a secure and locked office, and on a password protected database. Any information about you will have your name and address removed (anonymised) and a unique code will be used so that you cannot be recognised from it.

Your personal data (address, telephone number) will be kept for up to 12 months after the end of the study so that we are able to contact you about the findings of the study *and possible follow-up studies* (unless you advise us that you do not wish to be contacted). All other data (research data) will be kept securely for 7 years. After this time your data will be disposed of securely. During this time all precautions will be taken by all those involved to maintain your confidentiality, only members of the research team will have access to your personal data.

Although what you say during the research is confidential, should you disclose anything to us which we feel puts you or anyone else at risk, we may feel it necessary to report this to the appropriate persons. In particular, if the researcher becomes aware of any information about any significant harm to a child/young person (up to the age of 18 years) and/or if you express an active intent to commit suicide, the researcher is required to report this information to a relevant staff member of your TC and/or relevant authorities.

What will happen to the results of the research study?
The information you give us may form part of the final study report. You will **not** be identified by name in the report. We may use extracts taken from the participant observation in our report on the study, but these will **not** be attributed directly to you. In addition, the results of this study will make up the thesis for the researcher's PhD in Sociology. It is hoped that this study will eventually be published in social sciences journal. All data will be anonymised i.e. no personal details of any kind will be made public.

Benefits
Whilst there are no direct personal benefits to participating in this study, the findings from this research will help those interested in therapeutic communities and in mental health research understand the interaction between the individual and the community during a process of personal change and how this impacts upon an individual's sense of self and belonging.

Risks and complaints
There are rarely any risks to taking part in participant observation studies. However, some people do experience some anxiety when they are aware they are being observed and may feel that their progress and/or their TC are being evaluated.

This research is not seeking to make any evaluative comments about your therapeutic progress or about the TC in general. Any individual comments about community life will be anonymised.

If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions. The researchers' contact details are given at the end of this information sheet. If you remain unhappy and wish to complain formally, or should want to request additional information about the study, you can do this by contacting the Chief Investigator for the study, Professor Ruth McDonald (email and phone number omitted in thesis).

Funding, sponsorship and research governance
This research is funded by a studentship from the Economic and Social Research Council, and is organised and sponsored by the University of Nottingham. The study has been reviewed by and received ethical approval from Nottingham 1 Research Ethics Committee. It has received ethical approval by the University of Nottingham School of Sociology and Social Policy. In addition, your host organisation has reviewed the study and approved the research taking place.

Thank you
Thank you for taking time to read the information sheet and for your consideration of participating in this research.

Please do turn over and have a look at the consent form. If you have any further questions, please do contact the researcher, Jenelle Clarke (email and phone number omitted in thesis).

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Professor Ruth McDonald
(Chief Investigator)

Professor Nick Manning
(Co-investigator)

APPENDIX 2

Research Probes for Client Narrative Interviews and Staff Semi-Structured Interviews

All components of the research (participant observation, client interviews and staff interviews) had three separate Participant Information Sheets (PIS). PIS for client and staff member interviews were identical to the information for the participant observation component of the research noted in Appendix 1 and included the following research probes.

Client Narrative Interviews:
If you decide to participate in this study, you will be asked to share your story about your experiences of undergoing personal change within the community and/or about your experiences with therapeutic communities.

Some interviews may last for 10-20 minutes over a period of 6-10 sessions. Other interviews may occur at once and may last between 1-2 hours (with breaks). It may also be necessary to do follow-up interviews. All interviews will be digitally recorded and transcribed.

Topics that are likely to be covered during the interview include:
- how you came to be part of the TC
- feelings upon arrival
- things that are helpful or unhelpful during a process of change within the community
- expected outcomes from being part of the community
- experience of day-to-day community participation
- how others within the community play a role in facilitating change (i.e. affirmation, confrontation, support)
- how the community responds to any changes you may be making

Semi-Structured Staff Interviews:
It is expected interviews will last between 30 minutes to 1 hour (with breaks). It may also be necessary to do follow-up interviews. All interviews will be digitally recorded and transcribed.

Staff participants will be asked their perspective regarding the therapeutic change process and the programme and structure of the community. Potential interview topics may include:
- How would you define therapeutic change?
- How do you identify that change is occurring?
- What do you see as the key mechanism of therapeutic change?
- In your view, how does the time outside of therapy play a role in the change process?
- How do you prevent group processes from becoming counter-therapeutic?
- What factors contribute to a client successfully completing the programme?

APPENDIX 3

The University of Nottingham

CONSENT FORM
(Version 2.0: 24/09/12)

Title of Study: Undergoing Personal Change in a Community Context

REC ref: 12/EM/0311

Name of Researcher: Jenelle Clarke, PhD Student

Name of Participant: **Please initial box**

1. I confirm that I have read and understand the information sheet version number ……dated..... for the above study and have had the opportunity to ask questions. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, and without my medical care or legal rights being affected. I understand that should I withdraw then the information collected so far cannot be erased and that this information may still be used in the project analysis. ☐

3. I understand that relevant sections of my data collected in the study may be looked at by authorised individuals from the University of Nottingham, the research group and regulatory authorities where it is relevant to my taking part in this study. I give permission for these individuals to have access to these records and to collect, store, analyse and publish information obtained from my participation in this study. I understand that my personal details will be kept confidential. ☐

4. I understand that while information gained during the study may be published, any information I provide is confidential (with two exceptions – see information sheet), and that no information that could lead to the identification of any individual will be disclosed in any reports on the project, or to any other party. No identifiable personal data will be published. ☐

5. I understand that the information provided can be used in other research projects which have ethics approval, but that my name and contact information will be removed before it is made available to other researchers. ☐

6. I understand that the interview will be audio-recorded and that extracts from the interview may be anonymously quoted in any report or publication arising from the research ☐

7. I agree to take part in the above study. ☐

_____	_____	_____
Name of Participant	Date	Signature
_____	_____	_____
Name of Person taking consent	Date	Signature

3 copies: 1 for participant, 1 for the project notes and 1 for the medical notes

APPENDIX 4

List of Interaction Rituals

Interaction Rituals from Powell and Hawthorne that meet the definition of 'ritual' (Collins, 2004)

	Powell: 57	Hawthorne: 45	Shared: 23	Total Rituals (P+H): 102		
	Powell Rituals	**Hawthorne Rituals**	**Shared Rituals**	**Powell Key Rituals**	**Hawthorne Key Rituals**	**Shared Key Rituals**
1	Meal Times	Swearing	Meal Times	Distress Management	Smoking Breaks	Smoking Breaks
2	Admission	Feedback	Smoking Breaks	Smoking Breaks	Endings	Endings
3	Distress Management	Chairing	Morning Group (community meeting)	Meal Times / Food	Crisis Texts	Meal Times / Food
4	Interventions	Greetings	Afternoon Group (community meeting)	Endings	Reviews	
5	Smoking Breaks	Introductions	Tissues	Emergency Meetings	Meal Times / Food	
6	Emergency Meetings	Cooking	Greetings	Social Time	Community Meetings	
7	Handing In	Menu Planning	Assessment Visitor			
8	Trips to town	Meal Times	BA / Review			
9	Check In	Assessment Visitor	Regular Review			
10	Behavioural Analysis	Morning Group (community meeting)	Texting			
11	End of Day (community meeting)	Afternoon Group (community meeting)	Shopping			

12	Start of Day (community meeting)	OT Group	Menu Planning			
13	Making a Plan	Crisis Texts	Music Playing			
14	End of Week Reviews	Regular Reviews	Playing			
15	Weigh In	Shopping	Time out / 3 Days Leave			
16	Endings	Pre-TC Group	Complaints			
17	Business Meetings	Post-TC Group	Client handover			
18	Client Business Meetings	Phoning In	Work Group			
19	Outings	Leaving Early	Cooking			
20	Queuing up for meds	Arriving Late	Leaving / Endings			
21	Assessment visits	Workgroup	Chairing Meetings			
22	Tissues	Reviews	Menu Planning			
23	Positive Statements	Birthdays	Talk of Futures			
24	Signing Out	Sign-In				
25	Leaving Books	Writing Feedback				
26	Positive Books	Cleaning				
27	Leaving / Endings	Smoking Break				
28	Menu Planning	5 Minutes				
29	Meal Support	Voting				
30	Ordering Food	Tissues				
31	Chairing Meetings	Jokes/bantering				
32	Texting	Mentoring				
33	Ringing In	Tea / coffee making				
34	Solutions	Playing Music				
35	Door Signs	Playing				
36	Two-week Assessment	Outings				

37	Time In	Medication Discussion				
38	Commitment Statements	Updating the diary				
39	Night Round	Engagement Group				
40	Time Out	Leaving - end of day				
41	Greetings	Arriving - start of day				
42	Shopping	Complaints				
43	Review	Client Handover				
44	Music Making / Playing Music	Talk of Futures				
45	Tea Making	Admission				
46	Social Time					
47	Animal Visits					
48	Baking					
49	Talk of Futures					
50	Facebook					
51	Washing Dishes					
52	Mornings					
53	Complaints					
54	Client Handover					
55	Jokes / bantering					
56	Playing					
57	Weekend Cooking					

APPENDIX 5

Ritual Categories

Powell = P **Hawthorne = H** Rituals in **bold** are key rituals

Inclusion	Exclusion	Reinforcement	Anti	Transitional	Ownership
Meal Times (P)	**Meal Times (P)**	**Meal Times (P)**	**Smoking Breaks (P)**	**Smoking Breaks (P)**	**Emergency Meetings (P)**
Smoking Breaks (P)	**Smoking Breaks (P)**	**Distress Management (P)**	Jokes (P)	Check In (P)	Handing In (P)
Trips to Town (P)	**Emergency Meetings (P)**	**Emergency Meetings (P)**	Arriving Late (H)	Queuing up for meds (P)	Check In (P)
Start of Day (P)	Trips to Town (P)	Handing In (P)	Leaving Early (H)	Start of Day (P)	Making a Plan (P)
End of Day (P)	Behavioural Analysis (P)	Check In (P)	**Smoking Breaks (H)**	End of Day (P)	End of Week Reviews (P)
End of Week Reviews (P)	Weigh In (P)	Behavioural Analysis (P)	Jokes (H)	Making a Plan (P)	Weigh In (P)
Endings (P)	**Endings (P)**	Making a Plan (P)	Swearing (H)	**Endings (P)**	Business Meetings (P)
Assessment Visits (P)	Solutions (P)	Weigh In (P)		Meal Support (P)	Client Business Meetings (P)
Phoning In (P)	Door Signs (P)	Client Handover (P)		Behavioural Analysis (P)	Client Handover (P)
Behavioural Analysis (P)	Time in (P)	Client Business Meetings (P)		Solutions (P)	Assessment Visitor (P)
Emergency Meetings (P)	Time Out (P)	Positive Statements (P)		Time in (P)	Positive Statements (P)
Tea / Coffee (P)	Jokes (P)	Texting (P)		Night Round (P)	Positive Books (P)
Music Making (P)	Swearing (H)	Phoning In (P)		**Community Meetings (H)**	Menu Planning (P)

Jokes (P)	Cooking (H)	Solutions (P)		**Crisis Texts (H)**	Chairing meetings (P)
Cooking (H)	**Crisis Texts (H)**	Time in (P)		Post-TC Group (H)	Texting (P)
Assessment Visitor (H)	Regular Reviews (H)	Night Round (P)		Social Time (H)	Phoning In (P)
Community Meetings (H)	Pre-TC Group (H)	Feedback (H)		Writing Feedback (H)	Solutions (P)
OT Group (H)	Post TC Group (H)	**Meal Times (H)**		**Smoking Breaks (H)**	Shopping (P)
Crisis Texts (H)	Leaving early (H)	**Crisis Texts (H)**			Weekend cooking (P)
Regular Reviews (H)	Arriving Late (H)	Regular Reviews (H)			Feedback (H)
Pre-TC Group (H)	**Reviews (H)**	Pre-TC Group (H)			Chairing (H)
Post-TC Group (H)	5 minutes (H)	Arriving late (H)			Cooking (H)
Birthdays (H)	Outings (H)	Leaving Early (H)			Menu Planning (H)
Writing Feedback (H)	**Endings (H)**	Workgroup (H)			Meal Times (H)
Voting (H)	**Smoking Breaks (H)**	**Reviews (H)**			Assessment Visitor (H)
Mentoring (H)	Leaving - end of day (H)	Client Handover (H)			Regular Reviews (H)
Outings (H)					Shopping (H)
Meal Times (H)					Pre-TC Group (H)
Endings (H)					Post-TC Group (H)
Smoking Breaks (H)					Phoning In (H)
Arriving - end of day (H)					Workgroup (H)

Leaving - end of day (H)					Sign in (H)
					Writing Feedback (H)
					Cleaning (H)
					Crisis Texts (H)