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Rebecca Shulman
“Living In Front of a Mirror”: Staff
Members’ Perspectives
On Living and working in
Residential
Therapeutic Communities

ABSTRACT

This qualitative study was developed in order to gather information on residential therapeutic communities for individuals in mental health recovery. Although there is much literature on the therapeutic community modality, little is written about residential therapeutic communities (RTCs) in which staff members alongside clients in the community. The researcher was interested in gathering perspectives of current and former staff members who have worked and lived in such communities. Ten participants from two separate residential therapeutic communities in New England were interviewed. Participants must have shared a home with clients for at least 3 months. All participants were asked open-ended questions that prompted them to reflect on their experience as a staff member, to describe motivations for taking the job, to name rewards and challenges of their role, and to describe how they experienced the overlap between their home life and their professional role. Major findings of the study include: staff members were motivated to take on their job because of the unique opportunity to live in a community, and staff members often experienced challenges in navigating physical, personal, and psychic boundaries with clients and with the community as a whole. Another finding was

that participants valued the experience of living and working in residential therapeutic communities for many reasons. In particular, participants noted that the complexity of navigating therapeutic and personal boundary challenges allowed them opportunities to develop authenticity as well as deepen their own self-awareness and relational skills.

**“LIVING IN FRONT OF A MIRROR”: STAFF MEMBERS’ PERSPECTIVES ON
LIVING AND WORKING IN RESIDENTIAL THERAPEUTIC COMMUNITIES**

A project based upon an independent investigation, submitted in partial fulfillment of the requirements for the degree of Master of Social Work.

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2011

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TABLE OF CONTENTS

ACKNOWLEDGEMENTS.....	ii
TABLE OF CONTENTS.....	iii
CHAPTER	
I INTRODUCTION.....	1
II LITERATURE REVIEW.....	3
III METHODOLOGY.....	22
IV FINDINGS.....	27
V DISCUSSION.....	45
REFERENCES.....	53
APPENDICES	
Appendix A: Interview Guide.....	55
Appendix B: Recruitment Email.....	57
Appendix C: Human Subjects Review Approval Letter.....	58
Appendix D: Informed Consent Form.....	59

CHAPTER ONE

Introduction

The objective of this study was to gather the narratives of individuals who have worked as staff members in *residential therapeutic communities (RTCs)* while also living alongside their clients as full-time community members. The communities of interest in this study are treatment centers for individuals in recovery from mental illness, emotional disturbance, and co-occurring substance abuse issues. The definition of a *therapeutic community (TC)* is a “consciously designed social environment and programme within a residential or day unit in which the social and group process is harnessed with therapeutic intent. In the therapeutic community, the community is the primary therapeutic instrument” (Roberts, 1997, p. 4). The purpose of this study was to explore how staff members who have lived within such communities view their experience of blurring the boundaries between their work as staff members and their identities as full-time members within intentional community settings.

This qualitative thesis seeks to answer the question, “What are the rewards and challenges for staff members who live within residential therapeutic communities?” In particular, this thesis examined this question through the frame of psychodynamic theory. The literature on therapeutic communities (Main, 1957; Meinrath & Roberts, 2004; Reay & Revel, 1999; Whiteley, 1986 cited in Clements, Ramakrishna & Mckay, 2010) illustrates that that staff members who work in therapeutic communities face particular challenges. Often these challenges can be linked to the structure of the therapeutic community model which aims to flatten the staff hierarchy, promote open communication between all community members, and blur the roles between staff and clients (Whiteley, 2004). The working hypothesis behind the primary research question is that living within the RTC heightens both the rewards and

challenges for staff members who work within the setting. This thesis explored questions beyond the primary research question, looking at how staff members navigated the overlap between their professional and personal roles within the community. This study had a sample of ten participants. The researcher used an interview guide in order to maintain consistency throughout the interview process. However, questions were intentionally open-ended and participants were encouraged to share personal anecdotes and include any additional input relevant to the research topic.

The literature review suggested that staff members who work within therapeutic community settings for individuals with mental illness are susceptible to the same therapeutic processes and stressors as the clients within the community. Current research illustrates that staff members in therapeutic communities are encouraged to engage with the community with a high degree of authenticity and openness. Research also shows that staff members who work in therapeutic communities can be susceptible to burn-out from working with clients who are experiencing extreme emotional and psychic suffering. Participants in this study reported that there are many challenges inherent in working and living in a residential therapeutic community setting. All participants reported that they found their experiences as staff members to be rewarding because despite the challenges of job, and sometimes because of those very challenges, the experience of living and working within a residential therapeutic community led to increased personal growth and feelings of social connection.

CHAPTER TWO

Literature Review

The purpose of this thesis is to explore the unique role of staff members within the modality of *residential therapeutic community* (RTC). The study focuses on residential treatment centers that use the therapeutic community model as a modality for individuals in recovery from psychiatric and addiction issues. In particular, this study examines a very unique subset of RTCs—namely those treatment facilities that function as intentional communities and are designed such that staff members make their full-time home in the community alongside clients. The communities in this study maintain a client base with a high proportion of individuals diagnosed with personality disorders, schizophrenia, bipolar disorders, and those with co-occurring substance abuse. The research question that guided this study is: “What are the rewards and challenges for staff members who live within residential therapeutic communities?” There is extensive literature that comments on the challenges faced by staff members in residential settings and some literature that focuses on staff in therapeutic communities. However, there is virtually no empirical research that addresses the life and work experiences of staff members who make their homes in intentional community settings with individuals in recovery from addictions and mental illness.

An Alternative Approach To Treating Mental Illness

What is a therapeutic community?

For the purposes of this study, it is important to understand the treatment approach of residential therapeutic communities (RTCs). The original therapeutic community model began in Britain in the 1940s to treat veterans of World War II. Since that time, the therapeutic

community approach has become ubiquitous in the treatment of many different populations, including individuals with addictions, mental health clients, HIV patients, and incarcerated individuals. Due to the popularity and expansion of the modality within and across fields of practice, the term therapeutic community has taken on divergent meanings. It can be somewhat murky territory to discuss the therapeutic community modality without first defining the type of community in question.

The definition of a therapeutic community (TC), as established by a 1998 systematic international review is “a consciously designed social environment and programme within a residential or day unit in which the social and group process is harnessed with therapeutic intent. In the therapeutic community, the community is the primary therapeutic instrument” (Roberts, 1997, p. 4). For the purpose of this study, it is helpful to distinguish between two main types of TC. In its current manifestation, therapeutic communities can be separated into the *democratic* model and the *concept* model. The first type of TC dates back to the 1940s and concerns itself with the treatment of psychiatric patients. The second type of therapeutic community evolved in North America in the 1960s as an abstinence-based based, highly structured, disciplinary and behavioral treatment approach for the rehabilitation of individuals with addictions.

Historically, in North America and in the U.K., democratic TCs operated according to a non-hierarchical model in which authority structures are intentionally flattened. In contrast, the TCs established for the treatment of addictions operated according to a concept (hierarchical) model that specifically delineates the roles of staff members and clients (Woodward, 1999). There are many commonalities between these theoretically different models. While some TCs are very rigid in their structure and theoretical orientation, other communities blend aspects of the democratic and concept approaches.

This study focuses on the TC approach that blends psychotherapeutic and rehabilitative methods as conceptualized originally by Maxwell Jones. Jones has been considered a standard-bearer of the TC clinical modality that combines insight-oriented practices with more “practical and educational rehabilitation of persons’ work skills, social skills, socio-cultural skills, or other ‘survival skills’” (Beseda, 1979, p. 21). The approach was developed for a population of psychiatric patients in order for those patients to receive milieu treatment that incorporated the treatment of intrapersonal, interpersonal and social network problems all at once (Beseda, 1979). Jones theorized that the future of the mental hospital would include

the establishment of *open communication*, with *flattening of the staff hierarchy*, and in order to facilitate such, *role blurring*, whereby the therapeutic input would not be restricted to the professional staff, daily large group community meetings to discuss the real issues of the moment, democratic decision making and a single therapeutic goal, namely the adjustment to social and work conditions outside without any ambitious psychotherapy (Whiteley, 2004, p. 240).

It is Jones’ democratic model of therapeutic community that is of interest in this study expressly because the flattening of hierarchy between staff and clients—and among staff—aims to create a relational dynamic that is distinctive within mental health treatment. While the model has been extensively commented on, little empirical research has focused on gathering staff perspectives of their experience.

Democratic therapeutic community: early history and evolution of theory.

In describing the evolution of the therapeutic community, Stuart Whiteley (2004) commented, “perhaps the true seeds of the Therapeutic Community were already dormant in our society” (p. 236). He pointed to the “era of moral treatment” in mental hospitals in Britain and the United States during the 18th century. These hospitals were influenced by Quaker humanitarian principles and the example of The Retreat, an asylum established by Quakers that emphasized a respect for “human rights and the value of relationships” (Whiteley, 2004, p.236). Whiteley also pointed to the *living-and-learning* experiments with adolescents and young adults who were typically “offenders, homeless or otherwise socially handicapped young people” (p. 236). The young people were housed in short-term residential communities that utilized concepts of “shared responsibility, participation and democratic decision-making” (Whiteley, 2004, p 236). The living-and-learning experiments were based on Planned Environment Therapy, a theoretical and practice model put forth by child psychoanalyst Marjorie Franklin in the 1930s.

As stated previously, the therapeutic community model has its roots in the treatment of World War II veterans. Two hospitals were established in Britain—Northfield in Birmingham and Mill Hill in London—in order to find new ways to manage and treat “shell-shocked” psychiatric patients.

Northfield.

The Northfield hospital was designed to rehabilitate individuals such that they might be able to return to military service. Two psychoanalysts, Bion and Rickman, worked together to create an innovative approach to working with these individuals. The Northfield model harnessed a group approach in which the group was to “study its own internal tensions” (p. 245).

Northfield also employed military drills as a way of reacclimating soldiers to their "normal" occupational tasks. At a time when group-analytic processes were largely unknown to the psychoanalytic profession, Northfield employed many group-process principles. After Bion left Northfield, Foulkes arrived at the hospital and established sessions of group therapy in the wards of the hospital. Foulkes' approach at Northfield was influenced by the American psychoanalyst Trigant Burrow's group-analytic methods and by Kurt Lewin's social theories. Foulkes believed that Northfield hospital operated as a "social field" in which the behavior of the individuals within the field "is subject to forces inherent in that field" (Whiteley, 2004, p.238). Foulkes' approach eventually led to the establishment of the *community meeting* which brought together all members involved in the treatment project within the Northfield community. Community meetings continue as an integral part of the democratic therapeutic model today and require the participation of all members of the treatment team—staff as well as patients.

Finally, Thomas Main arrived at the Northfield community towards the end of the war. He added to the project by recognizing the concept of *interrelated systems* at work at Northfield (Whiteley, 2004).

Mill hill.

The other hospital treating military personnel that was at the inception of the TC model was Mill Hill. Located in London, the hospital was staffed by the leading psychiatric teaching hospital in the UK, which had a practice of blending social, genetically based and organic psychiatry. Maxwell Jones led the unit for military personnel. Over time, his lectures to soldiers on the etiology of their neurotic symptoms evolved into group discussions that became the community meetings of the TC model. These meetings were concerned with "here-and-now"

situations that captured the soldier-patients' attention, and utilized democratic decision-making in conflict resolution (Whiteley, 2004).

After the war, Thomas Main and Maxwell Jones both went on to establish their models of therapeutic community in alternative settings. It was Maxwell Jones' approach to using the TC model to treat personality disorders that caught the attention of American social anthropologist, Robert Rapoport.

Community as doctor.

Rapoport put forth a number of critical findings from his examination of Jones' Belmont community at Henderson hospital. In a book titled *Community as Doctor* (1960), Rapoport's team offered both criticism of unhelpful factors involved in the TC process and identified key ingredients of the true Therapeutic Community. His criticism of the model included the findings that there were a number of contradictory elements in place. These included:

- a) [The therapeutic community] could be damaging to those with poor ego-functioning;
- b) there seemed to be a conflict of aims between staff with a rehabilitative aim (assisting the damaged patient to survive life's traumas) and those with a curative aim (eradicating the psychological symptoms);
- c) despite the assertions that 'we are all equal here' there was a prominent dependency on the professional staff, who continued to see patients for individuals sessions, and Rapoport pointed out that those patients who had the better outcomes were those who had formed close relationships with the staff (Whiteley, 2004, p. 242).

The tensions within the therapeutic community model seem to be an unavoidable aspect of the design. Ideally, administrators and supervisors in therapeutic communities are aware of the naturally arising tensions and are able to moderate the negative impact.

Rapoport's observations of Belmont led him to identify ideological themes that are frequently cited in the Therapeutic Community literature today. The themes that he identified are not curative elements in and of themselves but rather conditions that promote change. Rapoport labeled these themes *permissiveness*, *communalism*, *democracy*, and *reality confrontation* (Whiteley, 2004).

Whiteley (1987) conducted an investigation of a therapeutic community at Henderson Hospital in the U.K. in which he asked patients to determine what factors were most important in moving their therapy forward. He established that patients in the early stages of treatment first sought *acceptance* and the *installation of hope*. Later on in the treatment came *learning from interpersonal actions* and *self-understanding*. An interesting finding from Whiteley's study was patients identified that important curative interactions could occur at any point during treatment. However, there were more incidents of these meaningful and constructive interactions within the bounds of the community but not during official treatment activities.

Whitely linked Rapoport's four themes to more specific curative factors. He described: *Permissiveness* allows for catharsis, self-disclosure and the assumption of self-responsibility. *Reality confrontation* can promote self-awareness and the development of identity and self-concept and learning through interpersonal actions. *Democracy* allows self-management to emerge and altruism to flourish as a patient is allowed to contribute meaningfully to the treatment of others. *Communalism* promotes interaction with others,

responsibility, sharing, the abandonment of fixed social roles and attitudes, and the development of new relationships (2004, p. 243).

In identifying the specific opportunities for group in each of Rapoport's themes, Whiteley's research allows us to better understand the nature of growth that can occur within the TC setting and links the themes in the TC model to established curative principles operating within group psychotherapy (2004).

In a recent article that provides a case illustration of one modern day Residential Therapeutic Community, Dickey and Ware (2008) referred to a fifth ideological principle of therapeutic communities identified by Rapoport—namely that of *reciprocal relationships*. They defined these relationships as “characterized by the respect and dignity accorded to each party” (p. 107). They also put forth that Rapoport's *Community as Doctor (date)* sums up “the fundamental premise of contemporary therapeutic communities: living in a community is healing” (p. 106). Authors in therapeutic community literature have frequently made the case that living *in community* is healing for those in psychiatric recovery. Since there are so few therapeutic communities in the U.S. that are structured such that both staff and clients spend equivalent amounts of time in the shared setting, there is little evidence that confirms or refutes the notion that living in therapeutic communities might be healing for staff members as well as clients.

Present day.

As stated earlier, since its inception in the 1950s, the therapeutic community has diverged and digressed from its earliest model. Clark (1965) made a distinction between the Thomas Main style of therapeutic community and the Maxwell Jones style of therapeutic community—The

Therapeutic Community *Proper*. Clark felt that the therapeutic community model had become diluted and that the term was used to refer to any “warm, personalized, individualized treatment environment” (cited in Beseda, 1979, p. 23). In a paper written in the 1970s, Clark stated that, “for many in the U.S. the therapeutic community is last generation’s fads, the fashion of the 1950s, gone like the hula-hoop, Camelot and the Apollo mission” (Clark, 1977 cited in Beseda, 1979, p. 23).

In their introduction to *Therapeutic Communities: Past, Present and Future*, Campling and Haigh (1999) described that the ethic of therapeutic communities became “deeply unfashionable” in the 1980s and 1990s (p.11). Though it seems that the democratic residential therapeutic community is out of vogue in the changing world of psychiatry, supporters of the model value the importance of “ideas such as democracy, permissiveness, communality, the inherent value in work, the importance of self-reflective open communication, mutuality, and interdependence” (p.11) and therapeutic communities live on in different iterations (Campling and Haigh, 1999). Regardless of the divergence from the original mores of early therapeutic communities, the heart of the therapeutic community model is retains some:

basic aims....They seek to enable their members to make decisions for themselves, responsibly , rather than blindly reacting to present or past authority; to this end, they flatten the internal authority structure as much as possible, reduce role differentiation and encourage an honesty in social interaction which is generally unacceptable in surrounding society (Norman,1972, p. 143).

In the U.K., therapeutic communities of all types have been incorporated into the public health system to treat psychiatric illness. The development of the Association of Therapeutic

Communities (ATC) in 1970 has expanded to include international membership, and the associated peer reviewed *Journal of Therapeutic Communities* continues to disseminate research and scholarly articles on the modality. Despite the copious amount of literature on the TC, it has been difficult to establish the exact number of residential therapeutic communities currently operating today. It has also been difficult to find specific statistics on the number of residential therapeutic communities that employ staff members who live as a part of the client's home and community full time (as opposed to employing residential staff in shifts).

The recovery movement has been spurring psychiatric providers to offer increasing opportunities for social and community integration for individuals with mental illness. Given this initiative, it has become particularly salient to study residential psychiatric settings that provide such opportunities. Dickey and Ware (2008) proposed that the therapeutic community model should be used in residential programs and evaluated as one method of providing more recovery-oriented opportunities for individuals in psychiatric recovery. They argued that the therapeutic community model is in keeping with the philosophy of the recovery movement and that the themes as identified by Rapoport in *Community as Doctor* (year) provide intensive experiences for social integration. In light of the claim that therapeutic communities provide an important opportunity for social integration, it is important to better understand the way that staff members view their experience within the community.

The Psychodynamic Theoretical Underpinnings Of Therapeutic Community

Broadly speaking, the therapeutic concepts that undergird the therapeutic community ideology are based in psychodynamic theory. Other theoretical constructs are important to the model, including social psychology and systems theory (Hinshelwood, 1999). For the scope of this study, I will limit the discussion of theory to several psychodynamic principles relating to

the therapeutic community model. These include, attachment theory, Winnicott's concept of potential space, and ego psychology.

In writing about the psychoanalytic origins of today's therapeutic communities, Hinshelwood (1999) noted that the originators of the model TCs at both Northfield and Mill Hill were heavily influenced by the psychoanalytic thinking of their era. Bion and Jones both went into analysis with Melanie Klein after the war ended. Thomas Main and Bion both stressed the importance of the idea of *the group as a whole* and understood community as the instrument of treatment, and Main contributed the idea of a *culture of enquiry* to the concept of the therapeutic community. The culture of enquiry Main described is much like the work of psychoanalysis itself; in which the analytic dyad constantly attend to the interaction between them, looking for unconscious processes, transference and counter- transference. The culture of enquiry is linked to Freud's dream analysis- the unifying principle being that enquiry into unconscious forces is therapeutic (Hinshelwood, 1999).

In writing about the psychoanalytic origins of therapeutic community, Hinshelwood (1999) also highlighted several aspects of modern day TC psychoanalytic practice that had its roots in the work at Northfield and Mill Hill. He identified the following:

- Insightful learning is itself a curative force in overcoming personal resistance and neurosis
- The state of the organization is kept under continuing examination, analysis and renewal
- Frank communications are freed up among all members, staff and patients (p. 41).

Concerning the use of these aspects of psychoanalytic TC practice, Hinshelwood (1999) noted:

None of this is easy, and as always in the past, the therapeutic community requires an openness to both staff and patients to the state of their internal worlds. In some ways, working in a therapeutic community is an intensely professional activity, and in some ways it is the most naturally human relationship with each other (p. 47).

Attachment theory and potential space.

Several writers have commented on the impact of attachment theory and object relationships on the structuring and practices of therapeutic communities (Kennard, 1994; Hinshelwood, 1999; Whiteley, 1994 & 2004;). Whitely (2004) pointed to the attachment dynamics that occur within the TC environment, stating that often the attachments that patients make within the TC will be:

The first successful attachment that a patient will have made after repeated failed attachments in his earlier personal development. He will test out, act-out, but finally take the risk of attaching to the community as a whole, to the staff and to other patients (p. 244).

Whiteley (1994) discussed the process by which these attachments occur within therapeutic communities. He stated:

What is being created in this Winnicottian potential space is a restructuring of the Foulkesian dynamic matrix which is both the facilitating medium in which development can take place, communications established connections made and relationships forged,

but also, the community as a whole (as well as key individuals within it) that can become an object of transference to which an attachment can be made in the Bowlby sense (p. 371).

Whiteley (1994) explained the challenges of a staff member who becomes an object of

“transference projections” and “countertransference demands”. He said that these demands:

have to be sensitively handled to shift the emphasis onto the community without seeming to reject the individual, because it is through working with the community that the separation-individuation process will progress. Empathy and the provision of the facilitating environment in which attachment can be attempted is the primary task for staff. The provision of the facilitating environment includes the boundary and limit-setting for borderline patients and in the therapeutic community it not only controls the antisocial personality, it also provides security for the anxious patient. The traditional blank-screen function of individual psychoanalysis is not feasible in the therapeutic community when so much of the therapist is ‘on view’. Main (1975) spoke of the need to make realistic and commonsense comments in the community meeting and not wait for the Nobel Prize-winning formulations to emanate, and Guntrip (1968) has spoken of the need for a therapist working with such clients to be a sufficiently real person to the patient to give him or her a chance of becoming a real person. Foulkes, commenting on the therapist’s function in the large group (of a therapeutic community) writes: this does not mean that... the therapist treats the group but, on the contrary that he establishes a culture, a tradition, a spirit in which the group feels free to investigate. . . [and it is] based on unfettered, frank and spontaneous communication (Foulkes, 1975b, p. 378).

David Kennard (1994) described how therapeutic communities employ concepts that are integral to attachment theory and object relations. Kennard referenced Donald Winnicott, one of the most influential thinkers in the realm of object-relations. Kennard wrote that:

The therapeutic community has something of the features of Winnicott's *Potential Space*.

The term Potential Space was used by Winnicott to describe the metaphorical space between the mother and child in which both experimented in an interactive way with closeness and distance, separation and togetherness, boundary setting and boundary keeping. Similarly, the potential space of the therapeutic community recreates a learning experience for both patients and staff (cited in Whiteley, 2004, p. 244).

It is of particular interest for the purposes of this study to note that those who write about therapeutic communities often make reference to the reality that psychodynamic principles at work impact on staff as well as on clients. Whiteley commented on the writings of Peter v. der Linden (who wrote about a therapeutic community in the Netherlands) stating that v. der Linden described a setting that is a *Potential Space* for both staff and residents. Peter v. der Linden describes the community in saying:

This setting possess its own creative value, its own educational moments that have no counterparts in ambulant therapy. The therapeutic community is both a physical space with working, eating, sleeping, leisure and creative areas such as the art room or gym, and also, through its rules, customs, and expectations, it is a psychic space (cited in Whiteley, 2008, p. 244)

The concepts of attachment, object-relations, and potential space tie into concepts of ego psychology.

Ego psychology and therapeutic communities.

According to Beseda (1979), the *living-and-learning* process that occurs for both staff and clients in the TC relies heavily on Heinz Hartman's concepts of ego psychology. According to Hartman, the ego exists within the personality of an individual. It performs certain functions that, ideally, create a functioning personality. Ego functions include reality testing, observation, mood regulation, cognition, modulation of needs and drives and autonomous ego sphere (walking, talking, etc.). Ego functions can be impeded by the ego's defensive strategies that attempt to protect the individual from painful feelings (Beseda, 1979). According to Beseda (1979), the living-and-learning experiences within the TC environment require individuals to make continual use of their stronger ego functions. The multiple and varied types of interactions and settings in the TC model provide many occasions for an individual to practice and strengthen healthy ego functioning. In the case of poor ego functioning (such as limited reality testing, defenses such as denial, projection, loss of ego boundaries, fusion and/ or loss of impulse control), the therapeutic community model provides what Rapoport referred to as *reality confrontation*, giving individuals a chance to address and change interpersonal and defensive strategies that are maladaptive. Beseda (1979) also noted that in order to overcome ego deficits, a person must have other people to imitate as positive role models and eventually must internalize those models. Living within community, naturally there are more role models available for internalizing.

Previous Relevant Literature And Studies That Address Staff Role In Therapeutic Community And Other Residential Settings

There is an existing body of work that has shown that the therapeutic community modality can be an effective treatment option (Cullen, 1994; Dolan, Warren, Menzies & Norton, 1996; Lees, Manning & Rawlings, 1999 cited in Clements, Ramakrishna & MacKay, 2010). Existing literature (Corrigan & Phelan, 2004; Dickey & Ware, 2008) documented the importance of social integration for individuals with mental illness. Dickey and Ware have provided case illustrations and qualitative data to show how social integration occurs in therapeutic communities as they provide opportunities for *connectedness* and *citizenship*.

Given the importance of staff as primary objects of attachment and key facilitators of empathy and mutual 'real' relationships in therapeutic communities, it is important to conduct studies that reveal how staff members in therapeutic communities experience their role.

In examining literature on staff members in therapeutic communities, authors have repeatedly commented on two observable outcomes: first, that staff in therapeutic communities face particular types of demands (Main, 1957; Meinrath & Roberts, 2004; Reay & Revel, 1999; Whiteley, 1986 cited in Clements, Ramakrishna & MacKay, 2010) and second, that that staff members may stand to benefit emotionally and psychologically from their work.

It has been noted that staff members are faced with particular challenges in their work. Some of these challenges stem from difficulties inherent in managing professional and organizational duties while at the same time trying to maintain a flattened-power hierarchy. As previously discussed, challenges also extend to the psychic challenges of actually living in the therapeutic community faced by staff.

In a study on staff turnover in a therapeutic community for disturbed boys, Khaleelee (1994) employed a defense mechanism test as an aid for selecting and developing staff members. In the case of the particular therapeutic community, the author noted that working in the community created “high levels of stress which threaten the staff members’ own integration—their own strength of ego functioning” (p. 4). The same study demonstrated that for staff members who stayed in their jobs for several years, they found the experience:

threatening but also therapeutic, and that may have entered into their motivation for joining: the staff member was able to rework unresolved issues and reach a new level of integration. Many valued this. The fact that both staff and children were going through parallel processes was probably beneficial for the treatment task (p. 5).

Other findings from the study included a series of hypotheses about the motivation of staff that came to the community, including that staff members came to the community because it provided an “appropriate integrating environment for working through personal childhood issues” (p. 9). Unconscious motivations included: identifying with a parental figure, trying to repair a “damaged” or “damaging” parental figure, identifying with an impoverished or damaged child and wanting to make the child “better”. A conscious motivation for these staff members was that they saw their employment in the community as part of their career path before moving on to another job or further schooling. The author suggested that working in the therapeutic community provided staff with a therapeutic opportunity for regression and growth. However, only some staff members seemed to be able to make use of the opportunity, while others left the community, feeling that the stress was too great (Khaleelee, 1994).

In another paper titled '*Being Real and Being Therapeutic*' *Revisited* (Clements, Ramakrishna, & Mackay, 2010), the authors discussed therapeutic communities' demand for staff reflexivity that is not limited to just the traditional therapeutic hour but rather continues throughout the day. The researchers coded for themes within a discussion type interview between various staff members within one therapeutic community. The findings showed that staff members feel pulled by two separate directives—the first being that they become fully immersed in the community and emotionally responsive to clients, and the second being that they stay professional and objective. The authors describe this dynamic as the *central tension* between being real and being therapeutic. In their conclusion, they cited group analytic and social constructionist paradigms which:

debunk false dichotomies of self versus environment, individual versus group, subjective versus objective and personal versus professional, and help to explain why an individual staff member's ability to experience, reflect and verbalize impacts on the whole group process. Working in a TC is less about 'doing' and more about 'being'; in other words being real *is* being therapeutic (p. 88).

Both the Kahleelee and Clement studies addressed various challenges, rewards and pitfalls of working as a staff member in a therapeutic community, including the heightened stress of being emotionally available to troubled individuals for periods of time that extend beyond the traditional therapeutic hour. They also noted that some of the same experiences that create stress also provide the very instances for therapeutic change that TCs aim to provide.

Summary

In examining the literature on therapeutic communities it is clear that while the operative principles of many therapeutic communities have become diluted in practice, certain principles are upheld. Role blurring, flattening of hierarchy, and mutuality are important curative factors that therapeutic communities employ to benefit individuals in recovery. The literature on TCs also emphasizes the challenges inherent in the position of staff member in the TC model. However, only a few studies comment on the advantages of the staff role for those who occupy those positions. The literature suggests that staff do stand to benefit from the curative properties of therapeutic communities. However, because true intentional therapeutic communities are very rare, there has been little investigation into residential staff members' experience of living, day in and day out, alongside clients in communities that flatten hierarchy and emphasize role-blurring. This study aims to add to the body of knowledge on therapeutic communities by giving voice to the individuals who have chosen to take on the role of residential staff member in a unique therapeutic setting.

CHAPTER THREE

Methodology

Using qualitative research methods, this study explored the question “What are the rewards and challenges of living as a full time staff member in a residential therapeutic house or community?” The purpose of this study was to better understand how staff members navigate the dual roles of helping professional and community member in therapeutic settings where those lines are intentionally blurred by having staff and clients live in homes or communities together. This researcher encouraged the participants to consider how the blurring of professional and personal identity has impacted their work and their personal life.

This researcher interviewed 10 participants using a semi-structured interview with an interview guide (Appendix A) that inquired about the impact of navigating a professional role that is intentionally blurred to encourage an authentic use of self. The interview had 5 closed questions. Three questions pertained to demographics including age, education and current occupation. Two additional closed questions inquired into the therapeutic setting that the participant had worked in and the dates that the individual had worked in the setting. The remaining questions were all intentionally open-ended so that participants’ narratives could be addressed while minimizing the possibility of interviewer bias. The prompts that addressed the heart of the research question were “Please describe how you dealt with the overlap between your personal life and work life” and “Please describe and give examples of the challenges/ rewards for staff members living in this type of therapeutic setting”.

While a significant body of research on the therapeutic community modality exists, very little research has focused specifically on the experience of staff members who live as full time

residents and helping professionals in such communities. This study is meant to provide a greater understanding of the unique position of live-in staff in residential therapeutic communities and to shed light on how the role impacts the individuals who take on such a position.

Sample

Non- Probability sampling techniques, specifically convenience and snowball sampling were used to obtain participants for this study. In addition, the researcher is former staff member of a therapeutic community and was able to use former work contacts for recruitment. The researcher first contacted the HR director and clinical staff of one therapeutic community and requested help in distributing recruitment material (Appendix B). Potential participants were sent a recruitment email. They then contacted the researcher through phone or email to schedule an interview. The researcher screened participants through phone or email to determine eligibility using the inclusion/exclusion criteria. Demographics of staff members in the therapeutic settings contributed to lack of diversity in the sample.

Of the final sample, eight participants contacted the researcher after being told about the research by clinical staff or the HR director of one therapeutic community. The remaining 2 participants were personal contacts that were contacted directly by email. The screening questions were conducted through phone and email to ensure that the participants met the criteria for the study before scheduling an in-person or Skype interview.

Exclusion and inclusion criteria.

The criteria for the sample specifically focused on those who have worked or are currently working in a therapeutic community while also making that community their full-time residence. The sampling criteria focused on individuals who have lived in the TC for more than 3

months, those who have lived in the community in the past 20 years, and excluded those who may have been dismissed from the community for improper conduct.

Sample description.

The final sample consisted of 10 participants. The participants ranged in age from 22-43. Four men and 6 women were interviewed. Of the participants, 3 had completed a graduate degree, 5 had completed a bachelor's degree, 1 participant had attended some college, and 1 participant had some high school education.

Data Collection

After receiving approval from the Smith College School for Social Work, Human Subjects Review Board (Appendix C), this researcher conducted 8 face-to-face interviews in Massachusetts and Vermont ranging from 20 to 60 minutes. The interviews were conducted in locations for the participants' convenience in their private homes or offices. All of the interviews began with the signing of consent forms (Appendix D). Two interviews were completed via Skype as the participants now live outside of New England. These participants were mailed consent forms. Upon the return of their signed consent forms, interviews via Skype were scheduled at the convenience of the participants. The consent form outlined the study, guaranteed confidentiality and described the potential risks and benefits of participation. Participants were able to read the consent form and ask questions about their participation. The letter also informed participants that they could choose not to answer any question, stop the interview at any time, and withdraw their data from the study any time before April 1st, 2011. Both Participant and researcher signed and dated the consent form and participants were given a copy of the form for their records.

Each interview consisted of two parts- demographic questions and open-ended questions about experiences. Questions addressed the participants' experiences with mental illness and with working within the therapeutic community setting. Questions addressed rewards and challenges, staff members' perception of their work environment, and issues of navigating personal time versus work time within the community or home where participants also had a role as a helping professional.

The interview guide helped individuals maintain consistency throughout the interview process. The researcher audio –recorded and manually transcribed the interviews and removed all identifying information. All participants' identifying information was concealed and participants would not be identified by their direct quotes. All materials were locked and secured according to federal regulations. The participants were informed that if answering any of the questions elicited uncomfortable thoughts or feelings, that they were not required to answer any questions, and the interview could be terminated at any time.

Data Analysis

The interviews were audio-recorded and then transcribed by the researcher. After the transcriptions were completed the data was analyzed using content/theme analysis techniques (Anastas, 1999, 414). The transcriptions were read through multiple times. In the first reading, major themes in each narrative and initial connections in people's stories were noted. The transcriptions were read again, seeking themes and applying codes to each narrative. The process continued of coding and re-coding in the subsequent readings. The codes were then charted making note of each time a code arose in narrative while also analyzing the themes and evidence

of theory that arose in each interview. Finally, direct quotes that illustrated each theme were chosen.

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CHAPTER FOUR

Findings

This chapter contains the findings from interviews conducted with 10 individuals who have lived in residential therapeutic communities as helping professionals. This study set out to gather data about the experience of being a staff member in a residential therapeutic community setting for the treatment of individuals with psychiatric and substance abuse issues. Specifically, the study was designed to gather stories of staff members who have lived alongside clients in a residential therapeutic home or community and to explore the rewards and challenges of a unique residential position as a helping professional. Of the 10 participants in the sample, 9 participants had staff positions in a residential therapeutic community setting located on a rural, working farm. The farming RTC operates on a multi-tasking model in which staff members serve as “house advisors”, living in homes with clients while also working with clients in various farm tasks. One participant lived as a “housemate” to one client in a therapeutic community located in a medium sized town in Western Massachusetts.

The findings are divided into 4 sections with sub-categories. Section 1 presents demographic and descriptive characteristics of the participants. Section 2 described motivations of participants for taking on a unique residential staff position. Sections 3 and 4 describe the challenges and rewards of working and living in a residential therapeutic community.

Major Findings

Many staff members came to their jobs at a treatment facility motivated by a desire to be of service to others. While discussing the rewards and challenges of such a position, participants repeatedly reported that living and working in a therapeutic community ultimately facilitated their own growth and self-awareness. A consistent theme in the narrative of participants was that living in close proximity to individuals in recovery presented many challenges and stressors. Participants expressed that it was a constant challenge to continuously define and re-define their personal boundaries in relation to clients, other staff, and to the community as a whole. However, participants' narratives reveal that, ultimately, the navigation of these interpersonal boundaries required them to develop an authenticity and a capacity for self-reflection that many participants value immensely as it led to their own personal growth.

Demographic characteristics.

The sample consisted of ten participants from two different residential therapeutic communities in New England. Participants ranged in age from 22 to 43 at the time of the interview. Six out of 10 participants are female. Eight participants were currently still working and living in a residential therapeutic home or community in some capacity. Two participants had left their positions and were working in a different field outside the helping professions. Length of employment in the RTC setting ranged from 7 months to 7 years. All participants had at one time in their RTC experience shared living accommodations with their clients. The educational background of the participants ranged from one participant who had completed some high school to 3 participants who had completed graduate degrees, but none of participants held graduate degrees in a field related to their current profession. Seven participants said that they had prior *lived* experience with psychiatric or substance abuse –either personally or in their

immediate families. Eight individuals said that they had completed coursework related to their work in the helping professions, describing relevant courses in abnormal psychology, gender studies, and drug and alcohol continuing education courses.

Motivations.

Using an interview guide I asked participants to describe their motivations for taking on a unique role in the helping professions in which part of their job description was to live alongside clients in recovery from mental health and/ or substance abuse issues.

Recovery: “I knew it would help me if I worked in the biz.”

Two participants expressed that their own recovery from mental health and substance abuse issues was a motivating factor in taking a live-in position in a residential treatment center. One participant described the appeal of living and working in a setting that promotes recovery. She described her motivations as:

Very selfish actually. I was scared of doing something other than recovery related. I knew it would help me if I worked in the biz. I knew it would be clean and sober. Room, board, not having to worry about the things I had lost. It was an easy way to start rebuilding my life.

Similarly, another participant described wanting to work as a staff member in an RTC because “I was going to more understand the nature of what I had to deal with through the experience of others. They say you learn 90% of what you teach.” The participants went on to describe the appeal of a structured work environment that they hoped would reinforce habits of recovery that they had been working on and allow them to act as role models for others. A third participant described coming to the staff position simply because he needed to find employment. However,

he described an ancillary motivation as a curiosity “about how living one-on-one with somebody going through psychiatric recovery was going to lead to my own growth in myself”.

“I was looking to live in community.”

Several participants described being drawn to the job because of the lure of living in a community. In many instances these participants had lived in some type of intentional community in the past and had identified that they preferred a communal lifestyle. Other participants had not lived in an intentional community before their RTC positions but were looking to radically change their lifestyle. One participant described how she found the position in the RTC:

I went on a really long road trip in and very intentionally decided I would look for work in a remote community that was agricultural or hands-on in some way but did something else also- like work with kids or work with adults or worked with some population or did something besides just the straight agriculture. And I sat in the library doing some research on the internet and I found this job. And I applied. . . and it ended up that this was the job that was one that I went with.

Another participant described having lived in intentional communities throughout college and seeking to continue living in an intentional community.

Taking on a Helping Role.

Several participants identified that they came to their RTC job with the intention of exploring a career in the mental health field after having tried other professions. Other individuals described wanting to work more directly with people and feeling that they had something to offer. One participant described, “I wanted to work with people and explore that to

see if I liked it as a career option”. A second participant echoed that sentiment saying that the work in the RTC combined her interest in mental illness with her interest in farming and sustainability. A third participant who worked in an administrative position prior to coming to the RTC remembered that she had the desire to help people more directly, describing, “I wanted to be actually connected and not pushing paper.” Still another participant described his motivations for taking the job as, “I was able to do for others what had been done for me”. Finally, one more participant described:

I thought I would have something to offer, understanding, empathy for um, how difficult it can be to try to function with whatever you want to call it- the struggles of life with a mainstream that doesn't understand and isn't necessarily patient. I guess I thought I might be encouraging to people who were struggling with life.

Challenges.

Several questions were aimed to illicit responses about the stresses and challenges for staff members in the RTC. These questions prompted participants to share stories of challenging aspects of their jobs or difficult moments in their work.

How to be a “Professional Friend.”

Participants mentioned the reoccurring theme of navigating an authentic relationship with clients in a shared living environment while also having authority and obligations as a staff member. Residential therapeutic communities intentionally ask staff to be themselves with clients, to share living space, eat with clients, and participate in recreational activities together. One participant said:

We encourage our staff to just get down and dirty with [clients] in a way that blurs the line, I always tell guests- you won't be able to tell who is staff and who is client and that is on purpose. That's actually a point of pride for us. We are trying to just get along here like its any other neighborhood.

For many staff in such settings it is common to spend "off-time" in the community with residents. At the same time, staff members have the responsibility to uphold certain expectations and standards of ethics and safety in the setting of a treatment center. Within the RTC modality the hierarchy of staff and client is intentionally blurred to promote more genuine interaction. Many participants describe the challenge of determining how to navigate the dilemma of authentically relating while also maintaining some degree of professional distance. One staff member described the challenge as follows:

It's really hard (particularly in the role of living with clients) to figure out the difference between being friends and being friendly. And the term I used to orient new [employees] is 'professional friend'. You have to be close enough so that [clients] trust and believe in you and believe that you are an advocate for them but not so close that you lose the therapeutic distance to tell them things they need to hear. If you won't tell him that it's time to take a shower then you are not doing your job. It's not ethical for us to just sit around and be friends with residents.

Another staff member described the difficulty he had in setting firm expectations with clients:

I think that maybe when you're living and working with people it's hard to be tough with [clients] and hold their feet to the fire. You're going to be eating meals with them. . . . seeing them all the time. In a contained setting like therapy where it's once a week,

therapists can kind of push someone and hold them to whatever task or idea that they might be avoiding. So, I noticed ...I backed off a lot because I knew that I was friends with people and that I'd be eating lunch with them. Was I really going to press them on starting to look at their sobriety? It's hard to stay tougher or set more stringent boundaries with people if you're sharing so much time and space and activity with them. I think that kind of goes with a general trajectory of when staff members first arrive here they want to connect with people and they often do that by wanting to be liked. The tendency is to connect with people and the tendency is to want to be liked. I think that kind of lends itself to people pleasing and wanting to say 'yes' ... as opposed to being able to say 'no' and then you go home and you don't see that person that you just said no to... Separation makes it a lot easier to be firm and more strict than when you live with someone.

Yet another staff member described the difficulty of the job as follows:

You're part parent, part peer, you're a staffer but you are beholden to a lot of the same rules of the community or the house. But you (as a staff member) have the freedom and flexibility of leaving. It's actually harder if you become friends with people. Not letting people get away with things- that's a struggle. You have to treat people the same but you are going take a shine to certain people. To develop a closeness but also a distance, it's a challenge.

Privacy, Personal Space, "Time off from Work."

Participants were asked to describe the impact of living in their place of employment and to describe how they dealt with the overlap between their personal life and their work life.

Nearly all participants said that the blending of their home life with their work life presented a challenge, and nearly all staff members used the word “boundaries” in describing this difficulty.

As one staff member said:

If I think in literal terms about boundaries, I also think in symbolic terms of boundaries. If you’re living in the same house as [clients]... I think that lends itself to boundary issues whether in terms of personal space or in terms of [clients] pushing to get something from you.

Another staff member described the challenge of separating work time from time off:

I work all the time. It’s really hard for me to totally disengage because I live smack in the middle of it. Something as simple as going to my car on my day off, I could run into [clients] and it could be as simple as saying hello or there could be some ensuing drama and I get dragged into it....my work day ends. But it really doesn’t.

Many staff members described that it was a challenge to learn how to be both authentic and relate in a professional manner. One staff member said, “you just can’t fake it with the people that are right next to you every waking moment and sometimes in the middle of the night.”

Impact Clients’ Psychiatric Illness on Staff: “Mental illness is the kind of thing that doesn’t just effect the individual, it effects the community.”

Several staff members expressed that living in proximity to individuals with substance abuse issues and mental health issues could be draining. Many staff members used language that indicated feeling like they were being invaded by the symptoms of clients. One staff member described what he calls “some osmosis going on...- so that I’m picking up on their anxiety and depression and tension.” Another staff member explained, “mental illness is the kind of thing

that doesn't just affect the individual [who is experiencing it], it affects the community; being in proximity to that may have a diffusive effect on the overall relationship to one's environment."

He went on to describe that it can be stressful to be constantly interacting with many individuals who have intense emotional needs or whose interpersonal abilities may be impacted by their symptoms. One staff member described trying to avoid clients on her off days after reaching a point of compassion-fatigue:

On a weekend, I spent so much energy then on not seeing those people that it was hard to feel revitalized because of these "energy-suck people". You'd try to avoid them—plot your day around not seeing them—and that is also kind of an energy suck. I remember that has being challenging.

Another staff member recalls feeling physical symptoms that she attributed to the stress of her job. She describes feeling emotionally flooded by the intensity of her clients' psychiatric difficulties and state that it was a challenge for her to establish a sense of psychic distance from clients in the community setting:

[The job] certainly had its ups and downs. The worst of times were incredibly stressful and I found myself taking what I would call, 'mental health days' myself just to be able to step outside what people [our clients] were experiencing around me. It took a great deal of effort and time to learn how to separate myself from those around me.

Participants often linked their struggle to establish internal and external boundaries to a lack of experience and training in the mental health professions.

Lack of Training.

Of the 10 participants that were interviewed, none had specific training in the mental health professions before coming to their residential staff position. RTC settings historically aim to reduce stigma by, “treating people like people and not by their diagnosis”, as one participant stated. Several staff members reported that when they first arrived in the RTC setting, they felt unprepared to work with individuals in psychiatric crisis. One participant described her insecurity about her lack of mental health training:

I know there are [staff] people who are more confident who just wing it and don't feel like they are damaging people. I always fear I'm not helping enough or giving wrong advice. So I go to other staffers- who have the experience, the expertise.

Another participant stated, “you don't have training to be working with the clients that we have here so you're kind of just thrown into the mix of things.” While the majority of participants reported that they were able to seek out supervision from trained professionals in their place of employment, they also described feelings of confusion, uncertainty or emotional overwhelm that came from working and living closely with individuals who were experiencing the effects of addiction, psychosis and personality disorder.

Rewards

Feeling useful and feeling connected: “The best sense of satisfaction is really getting outside of yourself and helping other people and simply being nice to someone who is struggling.”

All of the participants reported that they felt an immense sense of gratification from being helpful to clients and, in certain cases, being able to see clients make improvements in their lives.

They describe the intangible rewards of their jobs in terms of feelings of being useful and being genuinely connected. As one participant put it:

It's rewarding for me because I know that I'm playing a role by pointing things out or by letting things be until [the client] can kind of see it for themselves. . . or even leading by example in certain circumstances. . . . It's rewarding knowing that I am part of a team and part of a situation in which it's working to help someone to a certain degree. I think there is improvement being had and that my presence was contributing to that.

Another participant poignantly described the rewards of genuinely relating to someone struggling with mental illness:

I guess its helping me in the sense that it's the last thing that I'd naturally do. I'm an egomaniacal self-serving individual. The best sense of satisfaction is really getting outside of yourself and helping other people and simply being nice to someone who is struggling. It's a really easy thing to do but it doesn't come naturally to me or to a lot of people. The compassion and the love- its really love- that everyone feels for each other here- it's a little hokey and maybe unrealistic but the whole compassion and respect for the individual-getting to know and care for them- is the healthy relationship stuff we teach here. It really is the most rewarding thing. It takes the fear and stigma away from mental illness-to find what in each individual is valuable, even if its not easy-is very rewarding. . . Some of the illnesses that people have here are scary because they're so awkward. People are non-communicative. They are staring off into space. They seem angry or preoccupied and you wonder how are you ever going to connect and then you find that they're this musician or artist or whatever. . . discovering that is really

rewarding- a reminder to never judge a book by its cover. . . we've had some real tough cases... and inside there is just a good person. We don't always find it but there are glimpses... of something that makes someone special.”

One participant shared her feeling of satisfaction that came from a genuine use of self in helping someone in recovery:

With any kind of modality in mental health or the therapeutic arts you are not going to get huge success rates but when you see somebody really get it and really succeed that's made the more special by the fact that you didn't use 'so and so's theory of such and such' or 'this and that method' but you just used your real authentic self in dealing with their real authentic self to try to get them to that place.

“I don't know where else I could live where I would feel so loved.”

Three participants used the word “family” to describe the sense of connection that they felt with the therapeutic community. One participant explained that when the modality is working as it should, it creates:

more of the positive aspects of a functional family. In some ways I think that that is what is most helpful for people- staff and (clients). It's the time that we spend with them in a nurturing and empowering way. Which is what good families can do for each other in the best of situations.

The same participant also said that she appreciated:

the constant socialization at a level that you could choose. You could walk by someone and just say hi. Or you could seek anyone out at any time and have some company.

Whether it was resident or staff. So that was nice.

Another participant stated:

There's always fun people to hang out with. People who might not seem fun in one context, you get to find out they are a total riot in another context. That's awesome.

That's just a good life reminder- that everyone's got something.

Setting.

All of the participants stated that despite various drawbacks in terms of lack of privacy, they appreciated the benefits of living and working in the same place. Several participants mentioned the convenience of not having to commute and having their room and board tied to their job. One participant summed up this benefit of the job by saying:

an impact was being able to wake up 10 minutes before work started and then being there five minutes early. And just not having to worry about a lot of errands or grocery shopping or commuting. If you have an eight-and- half hour workday and you don't have to worry about errands, that frees you up. It frees up your life basically to kind of do what you like to do rather than doing things that you need to do or sitting in traffic. So that was a pretty big impact that I was looking for. I valued living where I work even just.. . . .
logistically.

Of the 9 participants who lived in the farming therapeutic community, all of them cited that they found the daily work tasks of running the farm to be healing in and of themselves.

Several participants also cited the healing impact of the rural setting. As one participant stated “The setting is just pretty breathtaking”. Another participant reflected “this is just a beautiful place. There’s a lot to be said for working in a place that has healing natures in itself”.

Feeling less fragmented.

A few participants articulated that living and working in the same place created a sense of unity in their personal identity that felt healing. One participant speaks to the sense of fragmentation:

I think a lot of the problems in our society are from atomizing it and from putting people in little boxes...I think the more splits and specializations we have in our society, the more we are lending ourselves to just being pretty small pretty small people relative to our potential of who we actually are as human beings.

Another participant described the feeling of continuity she achieved at the RTC with this metaphor:

I like when (my life) is all one whole cloth. And whether you're at work or at home- it's all sort of the same thing -usually in the best possible way and sometimes in the worst possible way. There's no off button. But I like the work so much it's fine with me if that's my life all the time.

Personal Growth: “It was like living in front a big mirror all the time.”

One of the rewards that all the participants most often referenced during the interviews was that they felt that the complexity of their job forced them to reflect on themselves and develop in ways that they appreciated. One staff member explained:

Living in community, whether you are a staff or client, makes you face yourself every day and the challenges that you face personally. The rewards of that are growth- learning who you are- essentially learning to love who you are.

In addition to the reward of increased self-acceptance, participants mentioned that they appreciated having to develop a more genuine way of interacting. As another participant stated:

For me it was an interesting way of learning to be around people on a daily basis; a more genuine way. I mean, when you don't have any place to run to, you can't not interact, you can't be totally fake—because that will be obvious the next day if things radically change in your presentation. So how do you have a social self that is genuine yet preserves enough boundaries? That's something you get to work on every day because you don't have a choice. But that's a good thing. It made me think differently about what I needed or wanted from other people in general in my life. To be able to appreciate smaller moments and achievements- not because they meant something in the external world, just because they were enjoyable or meaningful for themselves.

Several participants expressed that learning occurred through feedback from the community. As one participant described:

It was like, living in front a big mirror all the time. I don't know. For a while it's fun and there are moments where at first it's new and cool and then you realize that you just can't fake it with the people that are right next to you every waking moment and sometimes in the middle of the night. Just all these people that you're living in close proximity with. They reflect an image of who you are and you can see yourself ways you didn't really know. I was forced to face some unfortunate parts of me. I guess that's the biggest thing.

Of course, it's self-centered but that's the biggest thing I remember—just learning a lot about myself. I think there's a lot of mirroring that goes on here. Our own patterns that come up and why we do the things we do. You kind of have a glimpse of yourself and you start changing. And maybe when you try something and it doesn't work and then you get discouraged and it's just kind of this constant feedback loop, and analysis and awareness and doing something differently, and interpreting those results...I think to live where you work and to do this type of work -if you're looking at yourself it's easy to raise your own self-awareness and I think that there are so many opportunities to do something different here just by the nature of how social it is ...many interactions, many different types of people, many different types of things you do in a day. That probably lends itself to more opportunities to see one's own blind spots or work on things that could be going more smoothly...I think that in a lot of jobs and a lot of settings you can get into a rut and it isn't as rich socially and interactively.

Participants described that receiving feedback was not always pleasant but ultimately added to their growth, like one participant described:

There are often people in the community who will not hold back things they are thinking you are faced with insults, compliments, dreams, nightmares, your whole being is infiltrated by the whole community. That goes back to learning how to keep strong boundaries. But if you keep strong boundaries, that's how you learn who you are.

Most participants were able to link their increased self-awareness and comfort with themselves to their experience of living in a community. One participant summed it up:

Oh I don't know—I think everyone should at some point live in a community and learn how to interact as a whole. I think everyone should at some point in their life. It forces you to face who you are.... In the staff role, if you can't be true to who you are, you can't help anyone else.

Summary

This chapter revealed the findings from 10 interviews with individuals who work or had previously worked as staff members in RTCs while also living, full-time within the milieu setting. The major themes were divided into three categories labeled motivations, rewards and challenges. The themes were then further categorized by subheadings in each category. The findings highlighted motivating factors for working in an RTC including: the desire to take on a professional helping role, the desire to live in an intentional community, and in the cases of two participants, the desire to bolster their own mental health or substance abuse recovery process by living in a structured setting and serving as role models to others. The findings also revealed that staff members face challenges specific to living in the RTC setting. Themes include the challenge of being a “professional friend”, establishing a sense of privacy and psychic space, and the lack of related training that participants had prior to their job. Findings highlight that staff members in the RTC settings found many aspects of their jobs to be extremely rewarding. All participants reported that their role in the RTC was personally rewarding, beyond remunerative benefits. Themes in the reward section include: feeling personally useful and authentically connected to others, feeling a sense of integration from the overlap work, home and community identities, feeling a sense of personal growth from facing the challenges inherent in the RTC staff role. In particular, interviewees describe benefiting from developing a sense of their own

authenticity and learning to set limits for themselves and with others regarding the use of their time, their personal space, and their emotional engagement with others. The next chapter will compare the major findings of this to the literature discussed in the literature review chapter of this thesis.

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CHAPTER FIVE

Discussion

The purpose of this qualitative study was to gather the narratives of current and former staff members who have lived in therapeutic communities that serve individuals in recovery from mental illness and co-occurring substance abuse. The primary research question asked: What are the rewards and challenges for individuals who choose to make their full time homes as staff members in residential therapeutic communities? A review of the literature reveals that academic writings focus on the evolution and theory of the therapeutic community modality, the efficacy of the modality for clients, the relevance of the model to the recovery movement, and the challenges for staff members who work in the therapeutic community setting. However, there is a gap in the literature concerning staff members' perspectives of their work in therapeutic communities. In particular, the literature does not address the relatively rare and uniquely structured residential therapeutic community settings in which staff members live, full-time, in such communities. It is worth exploring this particular subtype of the therapeutic community model. As David Kennard has pointed out, in a time of limited funding resources, it is worth teasing out “ exactly which elements of the TC are essential and which may be discarded in aid of increasing cost-effectiveness (Clements, Ramakrishna & Mackay, 2010, p.87). This study has aimed to give voice to those individuals in unique staff roles and to address the gap in the literature on therapeutic communities.

In the previous chapter, I presented the findings of the study. In the discussion chapter, the major findings will be juxtaposed with research and theory from the literature review. Next, implications of the research will be discussed as they pertain to the modality of the residential

therapeutic community and the field of social work at large. Finally limitations and recommendations for future areas of study will be discussed.

Major Findings

Challenges.

This study supports prior literature that illustrates that working in a therapeutic community can be particularly difficult because the modality places unique demands on staff members. (Main, 1957; Meinrath & Roberts, 2004; Reay & Revel, 1999; Whiteley, 1986 cited in Clements, Ramakrishna & Mckay, 2010). Several participants of this study described the challenge of maintaining a role of responsibility for clients while also establishing an authentic and open relationship with clients and other staff members. The authors of a prior study labeled this challenge for TC staff members as “the tension between being real and being therapeutic” (Clements, Ramakrishna & Mckay, 2010, p. 76). They went on to say that while “openness is a feature of any psychotherapeutic relationship, the difference in a TC is that it takes place not just within the therapy hour and the consulting room but in the process of daily life” (p.76). The findings of this study reveal that for staff members who live in the TC setting, the tension between being real and being therapeutic is even more pervasive because it can extend into their off-work hours.

Rex Haigh described the degree of openness that TCs expect of staff members as “. . . the questioning of motives, the relentless challenging of defenses, and inquisitiveness about observable relationships. The defining characteristic is the expectation and demand that communication is more open, more deep, and more honest than happens in everyday situations” (1998, p. 251 cited in Clements, Ramakrishna & Mckay, 2010, p. 76). The findings from this study reflect Haigh’s observation about staff members in therapeutic

communities. Several participants in this study echoed the idea that you cannot “fake” your way through life in a therapeutic community. One participant summed up the challenge that staff members face with the question: “How do you have a social self that is genuine yet preserves enough boundaries?” All of the participants in the study supported that the idea of navigating boundaries- whether they be physical boundaries, psychic boundaries or interpersonal boundaries- was a constant challenge within the TC. The theme of boundary regulation for staff members is in keeping with the theoretical literature linking object-relations theories with the TC model. The literature draws on Winnicott’s idea of *potential space* that describes how participants in a relationship, “experiment in an interactive way with closeness and distance, separation and togetherness, boundary setting and boundary keeping” (Whiteley, 2004, p. 244).

Another challenge that participants of this study named was the difficulty of being around individuals who are suffering emotionally and who may be struggling to develop healthy interpersonal skills. This finding concurs with the literature on staff roles within the TC. Participants in a prior study described, “the personal impact of working in such a disturbed and disturbing environment, the unrelenting reflection of powerlessness in the face of human suffering” (Clements, Ramakrishna, & McKay, 2010, p. 86). Several interviewees in this study mention that the struggles of their clients could take a physical and mental toll on them as staff members. These findings concur with findings from a prior study that examined staff roles in a therapeutic community for children. The study described how the demands of the role, coupled with the behavior of the children, “created high levels of stress which threaten the staff members’ own integration-their strength of ego-functioning” (Khaleelee, 1994, p. 8). The findings of this study show that participants’ ego-functioning was often tested by the stress of the work. One participant described how, as a staff member, “your whole being is infiltrated by the whole

community” as “you are faced with insults, compliments, dreams and nightmares”. The description reflects the literature on attachment theory and therapeutic communities. The literature posits the TC model works in such a way that both staff and clients internalize the community (Whiteley, 1994).

Rewards.

All of the participants in this study reported that they greatly valued the feeling of connection that came from living as a part of a community. This finding supports the theoretical literature that states that the therapeutic community becomes an attachment object for both staff and clients (Whitley, 1994). Some participants described the rewards of always being able to find company and companionship. Other participants used the phrase “like family” to describe the sense of connection that they felt to their community. Several participants also described feeling truly cared about and even “loved”. This finding also concurs with previous literature. As described in one prior report, “the necessity of emotional availability for the work brings difficult experiences but also powerful positive ones, which can be equally difficult to make sense of” and that the rituals of the TC environment “create a powerful sense of belonging in the staff team” (Clements, Ramakrishna & Makay, p. 86).

One of the major findings of this study is that the rewards and challenges of the staff role in a TC are often the flip side of the same coin. Many participants showed an awareness that the conditions that created the biggest challenges in their work were often the conditions that yielded great benefits in terms of learning, self-awareness, and connection. As one former staff member put it:

Living in a community, whether you are a staff or client, makes you face yourself every day and the challenges that you face personally. The rewards of that are growth- learning who you are – essentially learning to love who you are.

This comment is concurrent with research on therapeutic communities that shows that patients benefit from learning from interpersonal interactions and also from greater self-understanding (Whiteley, 2004). The findings from this study demonstrate that staff members who live in therapeutic communities report experiencing some of the same benefits as clients.

Another participant, reflecting on his therapeutic community experience stated:

I was forced to face some unfortunate parts of me. . . I think there's a lot of mirroring that goes on here. Our own patterns that come up and why we do the things we do. You kind of have a glimpse of yourself and you start changing.

This participant's revelation captures the dual nature of the learning that can occur for staff members in therapeutic communities. While many staff members describe that their learning experiences may have been stressful or even painful, they also reveal that the experience of psychological growth is highly valuable. The comment also shows that staff members are benefiting from the curative impact of reality confrontation described in the literature review.

The findings of this study show that most participants were aware of the complexity of their role within the community. The findings also show that staff members were able to appreciate the complexity of constant boundary regulation and navigation of interpersonal relationships because it provided opportunities for them to grow as people. The findings show that participants were able to value the complexity and the tensions created by their role rather than become defeated by them. This finding points to the ego-strengthening capacity of

therapeutic communities. It is also supported by current post-modern, intersubjective, and psychoanalytic literature.

In modern psychodynamic literature, the Winnicottian notion of potential space, often mentioned in the therapeutic community literature, is re-imagined as *third space*. This space is understood as both a physical and a psychological space. Third Spaces are “places or states of ambiguity in-between different “realities” that exist within and between subjects” (Keenan & Miehl, 2008, p. 167). Keenan and Miehl (2008), have suggested that repeated third space experiences and re-examinations of one’s subjectivity can result in psychological development over time” (p. 167). They argue that tension, when experienced in the proper conditions of third space, allow people to grow and productively change from experiences of “ambiguity, complexity, and paradox” (Keenan & Miehl, 2008, p.167). The findings of this study show that staff members who live in therapeutic communities are repeatedly engaged in third-space activities which contribute to their ability to navigate complexity and to grow from that experience.

Implications for Social Work Practice

This study may illuminate the unique experience of individuals who live and work as helping professionals in residential therapeutic communities. Participants in the study spoke candidly about navigating physical, relational and psychic boundaries while living as members of therapeutic communities. Participants also articulated that living in the therapeutic community setting as staff members provided many different types of challenges. Reflecting on their experiences, staff members frequently valued these challenges as opportunities to deepen self-knowledge and to grow personally and professionally. These findings add depth to the

knowledge about staff roles in therapeutic communities. They also provide unique insight into the experience of helping professionals who live alongside clients in therapeutic settings.

These findings are relevant to individuals who conduct research on therapeutic communities and also those who work within therapeutic communities. The findings may be especially useful to individuals who supervise staff members within therapeutic communities because they point to the value of encouraging the ambiguity and complexity that is built into the modality. Young staff members, new staff members, and individuals without clinical training will need wise supervisors who can guide them and contain their emotions as they navigate the liminal experience of boundary regulation within the TC. This is even more important for staff members who live within therapeutic communities. These findings may also be of use to those within the social work field who broadly interested the themes of boundary navigation between helping professionals and their clients.

Limitations and Recommendations for Future Research

This study focused on the narratives of a few individuals who have lived within therapeutic communities. Due to the sample size, the study offers more depth and less breadth regarding the experiences of therapeutic community staff members who live within their community. Additionally the study is limited by the fact that only two therapeutic communities are represented within this study. Therapeutic Communities vary greatly from community to community and it would not be useful to present this study as generalizable across residential therapeutic communities. It is important to note that many of the individuals who participated in this study have lived and worked together closely. It is likely that their thoughts and feelings about their experiences did not occur within a vacuum but rather are the products of

conversations with each other and therefore influence and bias the overall narrative. Similarly, the researcher in this study was also a former staff member who lived within a residential therapeutic community and therefore brought her own biases to the research process.

Future studies on the staff role within therapeutic communities should include a larger sample size and a more diverse sample. Additionally, it may be useful to conduct studies that compare RTCs that have full-time residential staff members to RTCs that employ staff members in shifts to determine if there is a distinguishable difference between the approaches. Finally, future research should focus on clients' opinions of living alongside staff members so that their voices can offer a more complete picture of the unique intentional community model of therapeutic communities.

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APPENDIX A: INTERVIEW GUIDE

A) Demographic Information:

1. How old are you?
2. Current occupation?
3. What were the dates of your employment in the residential therapeutic setting?
4. What was the name to the residential therapeutic community that you worked in?
5. What was the last grade you completed in school?

B. Please name any courses that you have completed that are relevant to your work in a residential therapeutic setting for individuals in recovery from mental illness.

C. Do you have first hand experience with mental illness?

D. Please describe how you first came to work in the residential therapeutic home or community

1. What were your motivations for taking on this unique residential staff position?

E. Briefly describe the impact of living full-time in your place of employment.

F. Please describe one or two memorable interactions with other members of the household or community (can include staff and/or clients).

G. Please describe:

1. How you believe that your residential therapeutic community or home is unique compared to other therapeutic settings for individuals in recovery from mental illness.

2. How you believe that your residential therapeutic community or home is similar to other therapeutic settings for individuals in recovery from mental illness.

H. Please describe (and give one or two brief examples from your personal experience)

-any particular challenges for staff members living in this type of therapeutic setting?

-any particular challenges for clients living in this type of therapeutic setting?

- any particular rewards for staff members living in this type of therapeutic setting?

-any particular rewards for clients living in this type of therapeutic setting?

I. Please describe how you dealt with the overlap between your personal life and your work life.

J. Please describe :

1. Any helpful supervision or guidance you received from other staff members
2. Any advice you would give to new staff members in a residential home or therapeutic community

K. Please make any other comments you have regarding this study

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APPENDIX B: Recruitment Email

Subject: Attention: Current and Former Residential Therapeutic Community Staff Members

Hello

My name is Rebecca Shulman. I am a social work student at Smith College School for Social Work. For my master's thesis I will be researching perspectives of people who have worked and lived as staff members in a residential therapeutic home or community.

I NEED YOUR HELP!!!

I am asking for your help to find people to participate in my study. Participants must have worked at the residential therapeutic setting in the past 20 years and meet the following criteria:

- a) Worked as live-in staff member in a residential therapeutic setting for a minimum of 3 months
- b) Have left the staff position voluntarily (not been dismissed from the staff position)
- c) Have worked in the residential therapeutic home or community in the past 20 years.

I plan to interview people (either in person or via Skype) about their experience working and living in the residential therapeutic community. The interview should last anywhere from 20 to 60 minutes.

If you, or anyone you know may be interested in participating, please call me at xxxxxxxx or send an e-mail to xxxxxxxxxxxx . In your phone message or e-mail include the following information: your name, a good phone number to reach you at, and a couple of times you can be reached in the next few days. If you would like to participate, please contact me by March 1st, 2011.

If you have any questions about the study or are not sure if you qualify for participation, please call me at XXXXXXXX or e-mail me at xxxxxxxxxxxx.

If you know of anyone who may be interested in participating in this study, please forward this e-mail on to them.

Thanks in advance for helping me out with my research.

Sincerely,
Rebecca Shulman

APPENDIX C: Human Subjects Review Approval Letter



Smith College
Northampton, Massachusetts 01063
T (413) 585-7950
F (413) 585-7994

March 14, 2011

Rebecca Shulman

Dear Rebecca,

Your revised materials have been reviewed. They are fine and we are now able to give final approval to your very interesting and useful study.

Please note the following requirements:

Consent Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Good luck with your project.

Sincerely,

A handwritten signature in cursive script, appearing to read "Ann Hartman".

Ann Hartman, D.S.W.
Chair, Human Subjects Review Committee

CC: Michael Murphy, Research Advisor

APPENDIX D: INFORMED CONSENT FORM

January 14, 2011

Dear Potential Research Participant,

My name is Rebecca Shulman and I am a MSW student at Smith College School of Social Work conducting qualitative research for my master's thesis. The purpose of my research is to explore the rewards and challenges of living as a full-time staff member in a residential therapeutic home or community along with individuals in recovery from mental illness. The research may also be used for publication and presentation.

Your participation is requested because you have worked as a staff member and resided in an intentional residential therapeutic home or community for a minimum of 3 months at some time after January 1st, 1990. If you choose to participate, I will interview you about your work and living experiences, memories of your relationships with other staff members in the residential setting, and your general thoughts about working in a residential therapeutic setting. In addition, I will ask you to provide demographic information about yourself. The interview will be conducted either in person or via Skype. The interviews will be audio-recorded and will last between 20 and 60 minutes.

There are minimal risks associated with involvement in this research, the most being emotional discomfort or stress that could potentially arise from discussing work experiences during the interview. The benefits of participating in this study are that you have an opportunity to share your memories about a unique communal living experience, and contribute to an important area of research, to further understanding about how to supervise and support staff in helping professions.

Your participation in this study is confidential and every effort will be made to protect your confidentiality. I will take measures to label audiotapes and interview notes with a pseudonym instead of your real name. Additionally, I will lock consent forms, audiotapes, and interview notes in a file drawer and keep electronic files password-protected during the thesis process and for three years thereafter, in accordance with federal regulations. After such time, I will either destroy them or, if I continue to have further need for them, will maintain the material in its secure location until I no longer need them or destroy it. In the written thesis, I will not use demographic information to describe individual participants but rather combine the demographic data to represent the subject pool in the aggregate.

Participation in this study is voluntary. You may refuse to answer any interview question(s) and you may withdraw from the study at any time without penalty by indicating that

you are no longer interested in participating. You have until April 1st, 2011 to withdraw from the study; after this date I will begin writing the Findings and Discussion sections of my thesis.

If you have any additional questions or wishes to withdraw, please contact me through the contact information listed below. Should you have any concerns about your rights or about any aspect of this study, you are encouraged to call me or the Chair of the Smith College School for Social Work Human Subjects Review Committee at 413.585.7974.

YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.

Participant's Signature

Date

Researcher's Signature

Date

Please keep a copy of this form for your records.

Thank you for your time and I look forward to your participation.

Warmly,

Rebecca Shulman

XXXXXXXXXX