

# From Outsider to Insider: The Residents' Experiences of Joining the Acorn Programme Therapeutic Community

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*"... you've got to go through it ...  
it's hard but it's a necessity of the joining process ..."*  
[A resident's comment on entering the Acorn Programme]  
(Roo, July 2006)

*ABSTRACT: This paper explores clients' experiences of joining a therapeutic community. Six current residents in the Acorn Programme were interviewed using a semi-structured format, and the data were then analysed using Interpretative Phenomenological Analysis (IPA). The main themes were divided into two categories: those referring to the assessment process itself and those referring to the start of being a member of the community. The main themes in the assessment period were: fear and anxiety about being judged; things being different; challenges; and making a positive choice. The initial period after joining the community elicited experiences of: choosing to stay and wanting to leave; being alone in a group; hope, and learning new skills; the experience being worth the distress; and then being hit by reality and feeling left. These themes were supported in the literature, which describes joining as a time of crisis and return to old coping styles and attachment behaviours. This study was limited by the unique setting in which it was conducted; however, as a therapeutic community, further research in other similar communities may support the current findings.*

## Introduction

The above comment from an Acorn resident describes a common element of the process of becoming an insider in a therapeutic community (TC); she reflects that it was difficult and painful, but necessary. The residents, the

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community, staff team and the environment can either make this transition successful or overwhelmingly negative. Therefore, exploration of residents' experiences can be an essential resource in ascertaining a balanced response from the TC in facilitating a successful joining process. This article seeks to explore residents' experiences from their perspective and add to the limited knowledge and research in this area.

Qualitative research into the therapeutic community residents' experience of the assessment and joining process is limited; the most relevant found, by Blount, King and Menzies, (2002), discusses the importance of preparation in reducing dropout. Findings included the overall perception of the assessment process as negative due to not being prepared enough to find themselves in a room of up to ten people ready to interview them. They also discuss the use of preparation for admission, including face-to-face contact to answer questions, and to ensure the information sent prior to attending assessment is sufficient.

Rutter and Tyrer (2003) conducted a study on the value of TCs as a treatment for personality disorder; they subsequently found the experience of the resident interview panel had not prepared them for the reality of life in the community, some describing it as intolerable. It should be considered that the overall anxiety of attending for assessment may hinder an accurate recollection of the whole assessment experience.

Foster (1979) describes the admission and discharge from the therapeutic community as the most significant transition periods, and describes this sociologically as boundary crossing from one social system to another. The process places the individual in a crisis situation in attempting to learn new sets within the therapeutic community.

If we understand the joining process as a 'crisis', this would influence the community's response as within any other crisis situation in the community. However, it cannot be associated with only the new community member but with the whole community. We could understand the 'crisis' of joining in the theory of attachment: as Humphreys and Bree (2004) write, joining could tap into fears based on early experiences of attachment. Many residents enter the Programme self-harm-free; therefore, the crisis of working on stopping behaviours is substituted with the crisis of joining and gaining a place in the community. Energy is placed in forming or avoiding forming therapeutic alliances and attachments; once this crisis is over, the re-emergence of previous crisis situations re-emerge and so the containment of living within a TC takes over.

The response to this experience can often lead residents to terminate therapy early. Chiesa, Drahorad and Longo (2000) stated that, between 44% and 66% of residents leave therapy early within hospital-based treatments for personality disorder, and highlighted the need for better understanding of early dropout. Blount et al. (2002) go further, with a wider spectrum of between 30% and 75% of patients likely to terminate treatment early, giving rise to a universal problem in retaining residents in psychotherapy services.

Linehan (1993) suggests inadequate commitment to therapy is the chief reason for early termination either by the therapist or resident. Therefore,

commitment within the early stages is vital in predicting resident retention. Strategies are used to gain and regain commitment; examples of dialectical strategies include the importance in allowing the residents to choose. To choose to enter a TC is a fundamental component, and this mirrors the DBT (Dialectical Behaviour Therapy) approach of highlighting the 'freedom to choose', not just therapy but the choice to learn to live without self-defeating behaviours, and thus offering the TC as a safe place to explore this.

Routine data that is collected from the Acorn Programme showed 10% of residents who accepted a place left within two weeks, 21% left within 12 weeks or under and 69% either completed the programme or stayed in excess of 12 weeks, which is the minimum recommended stay. Reasons for premature discharge range from: residents' unwillingness to commit to change; inability to give up self-defeating behaviours; high-risk behaviour during the assessment period; the resident deciding that the treatment is not appropriate for them; or that it is not the right time for them to participate in treatment. Whilst our data shows fewer than average premature terminations in therapy, it is still an area which we feel could be improved.

## **Method**

### *Context*

This research took place within the Acorn Programme at The Retreat, York. The Acorn Programme is an 8-12 month inpatient and day patient treatment programme for women with self-defeating behaviour. The ages of residents range from 18 years upwards, and up to 16 residents undertake it at any time. It is a group programme with an integrative model of treatment using a combination of group and individual work, including DBT and psychoanalytic therapies. Most residents have been diagnosed with Borderline Personality Disorder or Complex PTSD, but this is not a requirement for admission to the programme. The main admission criteria are: existence of self-defeating behaviour, and a commitment to changing this. The exclusion criterion for the programme would be an unwillingness to give up self-defeating behaviour.

All residents are assessed individually, and within a community group, for their suitability to join the programme. The individual assessments are carried out by the Consultant Clinical Psychologist or Consultant Psychiatrist. The resident being assessed then joins the community for lunch, and attends a structured, DBT-informed community assessment group. Decisions about acceptance are made by the community as a whole, and all views are considered. When a resident joins the programme there is a two-week assessment period, during which both the resident and community are asked to think about whether this programme is suitable treatment for the individual. The community then makes a decision at the end of two weeks as to whether this programme is likely to be helpful for the individual. If commitment to the programme is questioned, the resident may be asked to complete a third assessment week. The individual is also asked for their decision about whether or not they want to stay. If they

decide to commit to the programme, the entire group then signs their handbook.

Within this process telephone support is given by nursing staff two weeks prior to admission to help the prospective client to remain self-harm-free, and then on admission two client buddies are allocated, usually senior residents, for the two-week assessment to help with orientation to community rules, procedures and expectations.

### *Participants*

Six participants were selected from current residents on The Acorn Programme at The Retreat, York. One resident dropped out during the interview process. The residents had been on the programme between three and eight months. They were aged between 20 and 55. Residents were chosen by the researchers to provide a breadth of positive and negative experiences and a variety of different lengths of time in treatment. Residents were excluded from this sample if they were currently in crisis or had only recently joined the programme.

### *Materials*

A semi-structured interview technique was chosen for this project as there is a good fit between the data this generates and qualitative analysis (Smith, 1995). A semi-structured interview schedule was designed specifically for this project. The schedule of open questions was used to allow the researchers to guide the discourse rather than dictate exactly which issues were addressed (Smith, 1995). The main areas covered were: experience of the assessment process; experience of joining the community; emotions surrounding joining and thoughts about leaving. Prompts were included in the schedule to help elicit cognition and beliefs that residents may have formed about these experiences.

**Comment [U1]:** There isn't an appendix to this paper.

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### *Ethical issues*

Ethical approval for this study was sought by the researchers. A COREC form was submitted to the local ethics committee and the hospital research and audit committee reviewed the research application before the research began. Approval was given with minor amendments by the research and audit committee. On attendance at the meeting for the COREC approval the researchers were informed that this was not necessary as the research was evaluating current clinical practice and could be viewed as a service review.

Other ethical issues this research faced were dealing with power imbalances between the researchers (senior team members) and the participants (clients) where informed consent is concerned. There may have been issues of clients feeling pressured to take part in the research as senior members of the community are carrying it out, who may also be their individual therapist and

involved in their clinical care. To limit the impact of this, they were given information about the project and consented by the Assistant Psychologist who is a more junior member of the community and not their individual therapist.

To help the participants' data remain anonymous, the participants were asked to choose a name under which their data could be presented to the team, and the wider community. They were informed that these data were likely to be published in a wider forum when the interviews took place, and specifically agreed to this occurring. Data which could identify the residents to outsiders were also removed after transcription.

### *Method of analysis*

Interpretative Phenomenological Analysis (IPA) was used to analyse the data collected for this project. IPA is a psychological form of analysis concerned with trying to understand the lived experience and how people make sense of their experiences (Smith & Osborn, 2003). IPA is a phenomenological method in that it attempts to explore an individual's personal perception or account of an event or state as opposed to attempting to produce an objective record of the event or state itself. IPA also acknowledges that, whilst trying to get the insider's perspective on their world, it cannot do this either directly or fully. This access is dependent on the researcher's own frame of beliefs and cognitions, which are necessary to help them make sense of other individuals' worlds through interpretation.

### *IPA procedure*

IPA was applied to the five complete transcripts. The analysis was conducted by first reading and re-reading the transcripts (Smith & Osborn, 2003). After several readings, the researcher made notes on the left-hand side of the transcript, detailing a description of the content of that section. In the next stage the researchers re-read the transcripts and created right-hand themes. These represent interpretations of the data. Typically these were psychological processes and cognitions that it was believed the data represented. The two main researchers (J.C. & M.M.) then met together to discuss the main themes. Each researcher then analysed a section of the other's transcripts to increase the validity of interpretations. Differences in themes were discussed until agreement on their representation linguistically was found, or evidence for their existence was proven to the other researcher's satisfaction.

### *Procedure*

Potential participants were identified by the clinical team, excluding residents currently in crisis. They were then approached by the Assistant Psychologist and given a copy of the information sheet. They were then told the Assistant Psychologist (AP) would approach them again after 24 hours, at which time they could

either decide not to take part or fill in a consent form witnessed by the AP. A suitable time to do the interview was then decided between the AP and the resident. The interview took place in an office off the unit to facilitate the residents' talking about both the positive and negative parts of the process of joining the community. All interviews were done by the AP and recorded on an audio-tape and transcribed. The interviews took between 20 minutes and one hour.

## Results

The main themes discovered in the analysis were divided into two groups: those referring to the assessment itself and the following two-week assessment period; and those referring to the beginning of being a member of the community. Table 1 shows which participants expressed which main themes.

**Table 1**

<b>Assessment themes</b>	<b>Charlie B</b>	<b>Roo</b>	<b>Molly</b>	<b>Pippa</b>	<b>Whisky</b>
Anxiety and fear	*	*	*	*	*
Fear of judgement	*	*	*	*	*
Different from the usual	*	*	*		*
Demanding - overwhelming & a challenge	*		*	*	
Making a positive choice		*	*	*	*
<b>The beginning of being a member</b>					
Choices - desire to leave & determined to stay	*	*	*	*	*
Being alone in a group	*		*	*	*
Hope		*	*	*	*
Learning new skills	*	*	*	*	*
Worth the distress	*	*	*		*
Reality hits			*	*	*
Being left	*	*			

### *The assessment process: themes*

The themes relating to the assessment itself are considered in this section. They include: fear and anxiety; fear of judgement; different from the usual; being demanding; and, finally, making a positive choice. This period appeared to be one of intense emotions and had many links to the participants' past experiences of treatment and care.

This initial phase appeared to be the most anxiety-provoking part of the experience for the participants. They expressed fear, anxiety and were frequently worried about being judged. As residents who have often been rejected in their lives, it appears this very first part of joining a community taps into their most basic fears and beliefs about themselves, as described below.

### **Fear and anxiety**

Terrified of (the) meeting ... because of past experiences ... (Roo)

Terror, absolute terror. (Charlie B)

### **Fear of judgement**

I was totally convinced I would be turned down by the group in the first fortnight.  
(Charlie B)

I felt as though I'd said too much ... so I was kind of judging myself. (Pippa)

I think I expected people to be negative towards me. (Whisky)

I can see how new residents coming on the programme are scared of it because it's like a huge decision: 'are we staying here; are we going to be rejected?'.  
(Molly)

The fear of rejection and self-judgement as not good enough is a common theme among the participants. Given the women on the programme have often had traumatic abusive experiences, sometimes by a family member, it is unsurprising they fear being rejected by a place offering help. Many of these residents have confused boundaries between care and abuse, and being given power and offered a choice could be misperceived as a chance to reject them. It is also a real possibility that the community could reject them. However, it feels that the participants' catastrophised and over-extended this possibility to become a certainty.

Once the residents' emotions start to reduce, it then appears that the differences in the Acorn Programme start to become evident. One of the main differences perceived was a sense of acceptance and working together as a community, in contrast to the earlier fears of rejection. This is both difficult and positive at the same time, and led some participants to perceive overwhelming challenges and demands. This shows some ambivalence in the participants which is further expressed when they talk about wanting to leave. They notice a difference but this appears to frighten them and they are not sure if they can manage this new experience, as quoted below.

### **Different from the usual**

[What is different?] Well, almost everything and you get to know people. (Whisky)

Staff are so approachable; it is different to acute units. (Roo)

The group thing was so different to anything else. (Charlie B)

People accepting you for who you are with all your behaviours and willing to work with you; that's not something you find in a lot of different hospitals; a lot of hospitals shy away from you or lock you up. (Molly)

**Demanding**

It was like a challenge to actually be able to come into a group. (Pippa)

It was just too much. I couldn't cope with all the emotions: just seemed to come in constant waves that overwhelmed me. (Charlie B)

I found that really difficult while trying to get to know people ... trying to eat your meals, get a good sleep pattern, [and] trying to fit into groups ... I found that really difficult. (Molly)

It seems that the final part of the initial assessment process is the participants having the space and support to make a positive choice. For some of the participants it seemed to be particularly important as they had lacked the opportunity to make these choices before. This choice appears to be based on their optimism and hope about the possibility of this community helping them. The optimism after the initial assessment period waxes and wanes over time, especially after the decision to stay is made. This appears to evidence more ambivalence perhaps because they begin to fear change:

Came out on quite a high, thinking, yeah, this is where I want to be. (Pippa)

You've got choices here which you don't have at home. (Roo)

It's really hard; it's a huge decision to make, but one of the best decisions I've made so far. (Molly)

**Comment [U2]:** Should be either: 'to be evidence of more' or 'to evidence more'  
**Deleted:** of

*The beginning of being a member of the community*

This section explores the themes relating to the participants' experiences after the initial assessment period. The themes explored here are: choices - desire to leave & determined to stay; being alone in a group; hope; changing; worth the distress; and, finally, being left.

This seems to reflect the process of therapy itself, where first a choice is made whether to begin and start trusting and building relationships, which is at times retracted; and then hope is instilled about change, which allows change to happen. Then the participants notice that change is not without a price and become more realistic about their goals and the work itself, and finally they realise they are alone again.

Firstly, choices and isolation are considered. Once the decision to stay has been made, the residents often seem to retract this, perhaps as a defence against hope that things could change, and to protect them from further

rejection and pain. In this initial period of joining the community there is a mixture of hope and fear. It seems that the fear of change leaves the participants isolated in groups and wanting to leave, to return to the safety of what they know. The tendency to isolate instead of seeking help may also reflect their self-defeating coping strategies, which these residents have used for many years, and is one of the reasons they are referred to the Acorn Programme: see the quotes detailed below.

### Choices – desire to leave & determined to stay

Horrendous, I wanted to pack my bags and go so many times it's unbelievable.  
(Charlie B)

You want to leave, get to that stage where you're about to leave and the change is you don't leave.  
(Whisky)

I reached crisis point and I just wanted to go.  
(Roo)

... Didn't want to be here, I was one of those people who were like 'I'm going!' 'OK Molly are you?' 'Yep!' 'So there's the door.' I think it was more of a case I felt I couldn't do it, I didn't deserve to be here.  
(Molly)

### Being alone in a group

I kind of sit in a corner somewhere, isolate myself not saying anything.  
(Pippa)

I felt alone, didn't feel part of the community.  
(Whisky)

I did isolate a lot of the time.  
(Charlie B)

The next important theme is the optimism the start of therapy seemed to instil in the residents and how this may relate to the participants' initial referring problems. Hope was a common theme amongst the participants, though at times it seemed slightly unrealistic. This could reflect 'black and white' thinking found in this resident group. It also possibly reflects their inability to hold an object in their consciousness which is both good and bad simultaneously. Examples of this are shown next.

### Hope

Like you're going somewhere, everything is going to be sorted out.  
(Pippa)

I was also quite excited about coming ... I remember I packed my bags two weeks before my date ... it was hard explaining to my family.  
(Whisky)

I was looking forward to coming ... [This] was my last chance.  
(Roo)

I knew I had to be here, I wanted to be, well not wanted, I want to get better. I want that better life.  
(Whisky)

I think I was looking forward to coming, to get my life back on track. (Roo)

There must be something different, you know there's people leaving and they seem to be OK; maybe there's a chance I could be like that. (Molly)

After the participants allowed themselves to become part of the community, this seemed to facilitate change. Participants reflected that, during the initial time on the programme, they felt they had learnt new ways of coping, but this was not as simple as being taught new skills. This seems to be a more naturalistic ecological process in which new skills are assimilated through the environment and being with others. As can be seen in the quotes shown below relating to the next theme, worth the distress, change was not an easy or painless process for the participants.

### Changing

They must have toughened me because I'm still here nearly six months down the line. (Charlie B)

It's really, really hard but if there weren't groups I wouldn't have moved on. (Charlie B)

I think it's made me become a lot more helpful, a lot more empathic to other people. (Pippa)

I think it's made me a stronger person. (Molly)

Whilst the participants were mostly positive about making choices, being hopeful, and making changes, the participants were clear that the initial period in therapy and the assessment process brought up many distressing issues for them. However, most reflected that these experiences were a necessary part of treatment. These are residents who for many years have used behaviours to avoid emotions and this may be the first time they have been guided and strongly encouraged to feel emotions and not act. This seems to result in a flooding of emotions in the initial period, and an accelerated learning curve which enabled them to cope differently, as can be seen by the quotes below.

### Worth the distress

And I can look back and say yes that was a good learning curve; at the time you don't see it but when you look back afterwards you see it. (Charlie B)

But in the end it is useful when you get out of it. (Whisky)

Well I can't exactly say evil, but it is a necessity ... so you need to go through all, everything. (Roo)

Yeah it was hell, and hard work but it was just real honesty. (Molly)

The final part of the process for some participants appeared to be a feeling of being abandoned, usually by their buddy in the community. This appears to be an area which needs improvement in the programme: whilst reaching a depressive position at the end of therapy would be acceptable, it seems for some people this happens earlier than they are able to cope with. Idealisation in therapy is necessary for change and progress and this feels a very early point at which to be disillusioned, though noticeably they are disillusioned and feel abandoned by the community members, not staff.

### Being left

Whereas after the first week my buddy seemed to disappear ... (Charlie B)

Probably expecting more than actually happened ... I felt let down. (Charlie B)

My buddy seemed to disappear ... I didn't feel I could ask for help. (Roo)

## Discussion

This research showed that residents joining a TC experience a wide range of intense and sometimes painful emotions. The main themes found during the initial assessment phase were: anxiety and fear; fear of judgement; demanding and sometimes overwhelming challenges; and making a positive choice. The next phase in which the client slowly became a member of the community elicited the following themes: a desire to leave; determination to stay; being alone; hope; learning new skills; and the process being worth the distress. This was followed by reality hitting hard and sometimes the experience of being left.

The limited literature in this area supports the themes found in this study. Humphreys and Bree (2004) suggest the 'crisis' of joining would tap into early attachment experiences and this was commonly found in our study. Attachment experiences in the residents often included rejection, judgement and abuse. This may relate to their intense fears and perception of threat to their self and fear of being overwhelmed, as seen in this quote:

Terror, absolute terror. (Roo)

This link to attachment experiences, as suggested by Humphreys and Bree, can also be seen in the residents' reactions to the experience. It appears that the client acted out early attachment patterns during the initial period in the community. This was seen in both ambivalent and anxious/avoidant attachment reactions, as shown below:

... Didn't want to be here, I was one of those people who were like 'I'm going!' 'OK Molly are you?' 'Yep!' 'So there's the door.' I think it was more of a case I felt I couldn't do it; I didn't deserve to be here. (Molly)

I kind of sit in a corner somewhere, isolate myself not saying anything. (Pippa)

The themes found in this study also reflected the research by Foster (1979), which described admission to a TC as a crisis, and sociological boundary crossing. The residents themselves described the experience as different from anything else they had experienced and a crisis, as seen below:

The group thing was so different to anything else. (Charlie B)

I reached crisis point and I just wanted to go. (Roo)

Due to the limited literature in this area, further links could not be explored in this article. Hopefully, this research will add to this neglected area of study.

The limitations of this study are chiefly in its generalisability. The Acorn Programme is the only one of its kind and unusually mixes DBT-informed therapy, psychotherapy, creative therapies, individual therapy and a group-based TC programme. However, there are other TCs throughout the UK who work with similar client groups.

A further limitation on generalisability is the extreme nature of the residents' problems when they are referred to the Acorn Programme. Being outside the NHS, residents need to obtain out of area funding to attend and, as the therapy is inpatient for up to one year, this can be an expensive treatment option and only the most severe cases are likely to receive this funding.

A criticism of many qualitative studies is their objectivity and consequent validity of findings. As members of the Acorn team we have never pretended to be totally objective, and the use of IPA allows our subjectivity to be accepted. Reflecting on the process has highlighted possible issues and conflicts raised by doing this research; this is explored further below. In future research, the validity of the analysis produced could be enhanced by participants reading and commenting on our interpretations.

Some of the limitations could be overcome through further research in this area. It would be informative and interesting to use the same interview and analysis techniques in other therapeutic communities. To further develop our understanding of clients' experiences, it would be helpful to explore the other key transitions, such as leaving and becoming a day patient. It may also be useful to explore the clients' experiences after the initial 'crisis' of joining and fear of rejection has passed. Clinically we have noticed that self-harm tends to return in this period; therefore, it may be important to aid our clinical effectiveness to understand this process. Finally, myself and the other researcher have reflected on how this process has changed us and our views as participant researchers and clinicians.

## Reflexivity

*J.C.*

Conducting this research project was very enlightening for me. Even though I am a clinician with the team and personal therapist to a number of the resi-

dents I found out surprising new things during this process. Firstly, I learnt that, no matter what people tell you, if you are doing a service evaluation it doesn't need ethical approval. I feel I wasted many hours filling out a COREC form and attending a meeting where I was very nicely told to go home as I didn't need ethical approval!

Secondly, I thought being a therapist to a number of the residents could hinder my objectivity but I found it helpful in the end. I found it conflicted with my clinical work more than it affected the research. Although the residents used false names, they picked names that, as their personal therapist, I could identify so it was hard to not know who said what. I feel I learnt a great deal about their attachment patterns through the research, mainly in their feelings around leaving and what happened when we disappointed them. It was frustrating not to be able to use the knowledge clinically as I often felt this was linked to their behaviour on their programme and sometimes the research meant I was able to predict early departure, which otherwise I wouldn't have been aware of in the same way. I found this conflict between being a researcher and clinician in the team difficult at times but also enjoyed being able to help the team understand the difficulties residents experience when they join in a more evidence-based way.

### *M.M.*

The experience of switching roles for the first time from being a nurse to that of a researcher was challenging: not truly understanding at first the process, and then the anxieties of implementing IPA for the first time alongside a colleague who is experienced in this method was high, but also very rewarding and enlightening along the way.

Working closely with the clients on a daily basis and having knowledge of them, I too was able to identify individuals, thus making it a challenge not to transfer the knowledge gained to either reflect back in the community meetings or within individual DBT sessions. However, having an advanced insight into the clients' experience enabled higher levels of acknowledgment within my own reflections and processing.

The research as it is intended has motivated and enabled me to make the process of joining a more empathic process. It has also highlighted to me that, from all we hear about the clients' lives in the community, there are always areas which we subsequently miss or do not ask about. Now we have the opportunity to refine the joining process but maintain the dialectic stance and not go too far towards comfort and make it uneventful.

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