The Importance of Relationships in Therapeutic Communities: A Systematic Critical Case Study

Abstract

Relationships are central to therapeutic community treatments and the process of change that is facilitated. In this paper we present a systematic critical case study of a service user who undertook a course of treatment at a now closed therapeutic community day service in south London. Using the contents of electronic patient notes, outcome measures, review letters, staff reflections and a post treatment interview, we show the importance of relationships within TC care. While literature regarding the efficacy of TCs does exist, there is less research concerning in-depth case studies of treatment. The importance of relationships within the TC model has been theoretically explored but not clinically demonstrated in literature. Our case study supports findings from a recent RCT concerning TC care versus 'treatment as usual' for borderline personality disorder. Our research further supports an approach emphasising the importance of relationships to TC work with personality disorder beyond any specific therapeutic modality.

Introduction

The Therapeutic Community has a long history dating back to post World Ward 2 Britain. As a treatment modality, it gained international status and has been used in the treatment of a variety of mental health conditions. Despite this international adoption and a solid theoretical basis, empirical evidence of the TC model is lacking. Many authors have written on TC theory and empirical investigations do exist, most recently, the publication of the first randomised control trial (Pearce et al., 2017). Yet little has been written on assessing whether TC theory contributes to the experience and processes of change for patients who receive treatment. Furthermore, the relational aspect to treatment that we feel is central to TC treatment has received little attention aside from one article (Pearce & Pickard, 2012), highlighting the key aspects of belongingness (which parallels our emphasis on relationships) and responsibility in TC care. In this paper, we present a case study of a patient who attended our TC for three years. During this time, she made significant changes to her life, describing the TC intervention as lifesaving. We present a case study as it facilitates an in-depth examination of TC treatment. A case series was not practically possible due to several constraints, including the recent closure of the TC under investigation and the availability of patients who had consented to being included in the research. Patient notes and rating scales would have been more feasible data sources for a case series, but would fail to fully capture the nuances of relationships and the mobilisation of other theoretical TC concepts in the treatment.

In this paper, we will address the degree to which a process of change within a TC relies on the quality of the relationships built between staff and patients. According to the criteria for classifying types of case studies as outlined by Kaluzeviciute (2021), our case is a systematic critical case study. It is systematic as it involves a research team and multiple different data sources. We mobilise data points from several sources to triangulate, and therefore, verify,

our findings. Our case may be considered a critical one as it tests the theorising of Pearce and Pickard (2013) on the importance of relationships in TC care. In terms of change, we define this as diachronic process that is significant to patients. It facilitates shifts in behaviours and beliefs, thereby offering opportunities to create a healthier lifestyle and more meaningful relationships. We begin with a literature review of the efficacy of TCs and the use of case studies in psychotherapy research. A description of the TC in which this research was conducted is provided, as well as a summary of the patient's demographics. A narrative account of the patient's time at the TC – based on a post treatment interview, electronic notes, outcome scores and therapist accounts – is reported, followed by a critical assessment of the material. We then consider the relational dynamics at play and how these contribute to a process of change in the patient. Ultimately, our case study is a springboard to a larger consideration of the importance of relationships to contemporary TC theory and practice.

The Therapeutic Community

TC treatments are a group-based, participative approach to treating mental health problems. They promote patient empowerment and have flattened hierarchies between staff and patients. The approach of the original therapeutic community model is defined by four predominant themes: democratisation, permissiveness, reality confrontation and communalism. Contemporary theory emphasises: the role of attachment; the "culture of enquiry" within which all behaviours, thinking and emotions can be scrutinised; the network of supportive and challenging relationships between members; and the empowerment of members when they are made responsible for themselves and each other. Recent studies by Chiesa et al. (2004) found the TC model had better outcomes for those with a personality disorder (PD) diagnosis than the general psychiatric model at the end of treatment. Within the study, the best results were from a step down programme of outpatient treatment following a residential TC treatment. The study also separated medium and long term residential treatment and noted that the long term residential programme provided mixed results with high drop-out rates. Furthermore the long term programme was superior to general psychiatric management in terms of social inclusion and symptom distress but not to self-harm and rehospitalisation rates. In a further study at seventy-two months post TC treatment, the positive outcomes were maintained (Chiesa et al., 2006). Another study from the same group showed long-term community-based therapy for PD had better results compared to long-term TC residential treatment (Chiesa et al., 2017). As suggested in Chisea et al. (2006) there have been high dropout rates reported within TC care (Rutter & Tyrer, 2003). These may be linked, for example, to high expectations from staff or too strict application of sanctions to boundary violations. This in turn could activate early dysfunctional attachment patterns leading to drop out.

The first TC randomised control trial compared four TCs to 'treatment as usual' for patients with a PD diagnosis. At a two year follow-up, those in TCs showed significant improvements in satisfaction and lowered levels of aggression and self-harm compared to those who received 'treatment as usual' (Pearce et al., 2017).

In a paper investigating the efficacy of TCs, Pearce and Pickard (2013) suggest that belonginess and responsible agency combined produce TC effectiveness. Belonginess refers to the drive to foster sustained positive relationships with others. These relationships must be long- term, involve frequent contact, be positive in nature and involve mutual concern. The authors suggest that belongingness also motivates change because of the risk of suspension from the TC; a desire to belong enforces adherence to TC rules. . An increase in belongingness reduces suicidality and aggression, while increasing well-being. Responsible agency is an acknowledgement that some of the patient's problems are within their control. This is required if behavioural change – facilitated by a psychotherapeutic process – is to be achieved. Responsible agency is a core part of TC care; it is explicit in its need for members to have agency in their actions and consistent consequences if they abdicate from this.

TCs can be residential or non-residential. In the UK today there are very few residential TCs remaining although historically there were more. The residential TC can be considered more of a closed environment which enforces more group interactions thereby offering more material and opportunity for therapeutic work. Counterbalancing this, the concept of social verification which suggests behavioural change is more effective if its changes are validated by people outside the TC. This is more of a challenge in residential TCs, which, combined with an increased running cost, may have contributed to their decline (Haigh & Pearce, 2017).

The Case Study

Recent case studies of patients with PD who have completed TC treatment could not be identified. In the current climate, case studies are given little empirical weight in contemporary healthcare and do little to impact decisions about service provision and treatment. Kaluzeviciute & Willemsen (2020) critically assess the case study method by noting its history back to Freud (and with it, the already existing versatility of Freud's case-based reasoning), while addressing the main criticisms levelled against case studies, namely, that they lack empirical validity and generalisability. They suggest that the case study is a scientific thinking style, no more or less valid than others, that leads to practical (*know-how*) knowledge. The case study is a pragmatic endeavour aimed at problem solving in the real world rather than a purely theoretical exercise. Considering several case studies together creates, by analogy, a complex network of similar and dissimilar cases which may be useful for clinicians, and may support generalisability of a different kind, one that contrasts statistical generalisation.

Kaluzeviciute & Willemsen suggest two types of generalisation are possible from case studies. The first is analytic generalisation, where an inference is made from a single, representative case to a theory. The theory is then applied to other relevant and similar cases in the future. Repeated cases confirming the theory leads to robust knowledge about *a specific phenomenon* (e.g., a mental health condition). The second is empirical generalisation about *specific populations* under analysis, where multiple cases showing variation are needed to understand how certain phenomena are experience in clinical populations. Given the lack of comparative case studies in the PD population of contemporary TCs, our case study is less applicable for empirical generalisation. It will, however, be suitable for analytical generalisation.

Kaluzeviciute (2021) further suggests that case studies can complement randomised control trials, specifically by combining the macro data (observed in RCTs) and micro processes (outlined in single case studies). In this way, our case study compliments the aforementioned RCT of TC care (Pearce et al., 2017).

Kaluzeviciute (2021) notes that systematic case studies lack an evaluation method. She introduces two Case Study Evaluation-tools (CaSE): first, a CaSE Purpose-based Evaluative Framework for Systematic Case Studies; and second, a CaSE Checklist for Essential Components in Systematic Case Studies. Kaluzeviciute's CaSE tools are retrospective frameworks and as such, will be used to evaluate our case study.

The Therapeutic Community

The TC in this case study – which has now closed – was based in South London within an NHS psychiatric hospital and catered for those with a PD diagnosis. The treatment course consisted of: a weekly, pre-treatment starters group for up to six months to test the readiness of each potential community member; an eighteen-month three day per week intensive programme; and a weekly, post-treatment leavers group for one year. The theoretical outlook was largely psychoanalytic and psychodynamic interpretations of events and pathologies presented were most predominant. Thirty-six patients were treated at any one time across the starters group, intensive treatment, and leavers group, with proportionally more being in the intensive programme.

The TC week consisted of: three community meetings for all patients and most staff; small group therapy of a maximum of eight patients led by two staff members; psychodrama; art therapy; a life skills group; and one-to-one therapy sessions. Lunch and tea breaks were taken together.

Patient Background and Demographics

We will refer to our patient as 'Alma'. Alma has granted permission for the use of her case. Alma is of white British ethnicity and aged fifty. She has an ICD 10 diagnosis of F60.3, Emotionally Unstable Personality Disorder. She is married to a man and has been in this relationship for many years. Alma and her husband do not have any children.

In Alma's early life she experienced abuse, shame, and rarely felt cared for. She did not feel safe or trusting of those around her. In her late childhood and adolescence, she went into a residential children's home. She was misunderstood as disruptive, a troublemaker, and attention seeker. When Alma left care services, she found her own accommodation, a job and became self-sufficient, something she had learnt from her childhood. She met her husband who was consistent and reliable, and stuck with her through difficult times. After Alma left the social care system, her sister – with whom she had a difficult relationship – died. This was destabilising and Alma attempted many actions to end her life. She was admitted to psychiatric wards for lengthy stays and felt she had been labelled a "revolving door" patient. Responsibility and agency were often taken from Alma , including use of the mental health act to detain and treat her, as clinicians did not know what else to do to help. Alma started with the TC in July 2017 and ended the intensive part of the programme in

January 2019. She then attended a weekly Leavers Group for a further year until August 2020. Her initial assessment with the TC was in July 2015 and in total, she was known to the TC staff for just over five years. Alma was selected from a cohort of patients who had completed the whole course of treatment within the therapeutic community. Alma came forward of her own accord to talk about her experience and the research team felt her case exemplified the importance of relationships to healing within a TC context.

The interview part of the case study took place on 11/09/2020 and lasted for one hour and a half. It took place over video call as this was Alma's preference, and proceedings were recorded. Two of the authors and Alma were present for the interview. The interview was transcribed using computer software and the authors then reviewed the transcript following the interview, correcting for inaccuracies generated by the software. For the purposes of triangulation, we also used beginning, middle and ending treatment reports from the TC team, as well as outcome scores, when considering the data generated by the interview. The reports are written documents finalised and edited by the patient's individual therapist, and includes comments from all staff on patient progress. We can, therefore, reasonably conclude that they contain an adequate description of Alma's course of treatment. We used the HoNOS[1] (Health of the Nation Outcome Scales) scores, which were taken over the duration of treatment, as another marker of change. Finally, two of the authors – referred to as therapist one and two – provided their own written accounts of their time with Alma. The research team was made up of three authors (AH, MJ, CB) who all worked in the TC with varying levels of involvement in Alma's care.

Narrative of Patient's Journey

We start with a chronological account of Alma's time with the TC. Starting treatment was a prolonged process as Alma was engaging in self-harm through cutting and taking serious overdoses regularly, which required medical intervention. This was a barrier to starting with the TC as self-harm : 1) went against the community expectations of agreeing to take responsibility for one's own destructive behaviour and 2) did not evidence a wish to work with staff in achieving this. To help Alma start with the TC, meetings were arranged with therapist two. Alma also had several meetings with the consultant psychiatrist and clinical service lead (therapist one) to try and negotiate conditions in which it would be safe enough to begin treatment and to establish treatment goals.

This process took many months and at times, it felt as if Alma managed to sabotage her own treatment by her dangerous behaviour and refusal to agree to any boundaries around the therapeutic process. Her attachments, however, to her one-to-one therapist, the hospital, and the service became important aspects of her care. Her attachments to the hospital and service are reminiscent of Henri Rey's (2017) "Brick Mother", where the physical body of the hospital provides safety, containment, and stability. Alma eventually agreed not to self-harm or take overdoses of her prescribed and over-the-counter medications during treatment. She further agreed that if she did self-harm or take an overdose, she would be suspended; if this behaviour persisted, she would be discharged. She often stated, *"you've got me over barrel"*

[1] HoNOS is a measure of health and social functioning in those with serious mental illness across NHS services

in response to this agreement yet in later reflections, Alma saw this behavioural contract as central to completing the programme.

Alma joined an engagement group led by therapist one. The therapist noted: *"Alma brought her resentment and mistrust of me and my motives into the work but over time she was able to lessen the attacks."* As she approached the start of the full TC programme, attendance was set at 80%. Failure to meet this expectation would result in suspension and potential discharge. Alma was suspended several times at the outset of the treatment programme. Reflecting on these early days, she said:

> *I found it really hard […] I didn't have much belief in the programme at all and I had no belief in professionals […] It was difficult starting treatment in the sense that we didn't get started while I took overdoses and wouldn't get medical treatment.*

In retrospect, however, Alma noted that it was the boundaries and suspensions that led to her eventual engagement with the service:

> *It was boundaries for me, it's always been about boundaries. I think you have to have firm boundaries for me to respond and I don't know why this is but that's an issue for me. I mean you hate them but you sometimes need them.*

Both therapist one's and two's respective accounts also noted the importance of boundaries; they commented that applying boundaries in Alma's case was their role for some time. They noted that Alma *"rebelled, acted out and nearly left many times"* in response to boundary setting but was able to stay in the TC. Once started, it became clear that Alma was adept at recognising and navigating group dynamics; she could be extremely helpful to others as well as skilled at avoiding attention on her own issues. A stock phrase from Alma of *"it is what it is"* allowed her to deflect conversations about her own feelings and to foreclose any curiosity about her thoughts and mental processes. She could be very destructive in groups, attacking staff and leading initiatives in community groups to challenge rules and boundaries. This could be disruptive and at times, she felt very powerful – albeit in a negative manner – as a leader of rebellions, lashing out at staff and other community members to whom Alma took a dislike. Therapist one, who co-facilitated her small group, noted that:

> *This [facilitating the small group] was pivotal as the work there meant that our relationship could be allowed to develop further with more depth and nuances than my initial role of authority."*

At her first three-month review, Alma's tendency to distrust others was commented on as a barrier to engaging with the programme. Therapist two noted that, from Alma's perspective: "*The simple glancing at a watch or clock meant the therapist wasn't interested, had something else better to do or they didn't care.*" It was also noted, however, that Alma was keen to change and clearly now wanted be part of the TC. The following treatment goals were identified: upholding the agreement that was set around overdosing and self-harming; maintaining an 80% attendance rate; improving emotional recognition and management; developing an understanding of what it is that drives Alma to treat herself so brutally;

understanding what it means to reach out for help and how to do this and when; developing trust in relationships; and being able to talk more about herself rather than facilitate discussions about others.

With Alma's agreement, her treatment goals were extended to explore her relationship with her husband. Some couples sessions were planned, in the hopes that these would have a positive impact on her work in the TC. Therapist one's account noted, *"The work that [therapist one and two] did with her and her husband was very important for Alma in seeing that maybe I was not only there to thwart or annoy her but was there to help."* During the sessions, the therapists wanted to encourage Alma's husband to free himself from the policing role into which he had fallen, such as hiding medication that could be used in an overdose. Alma's husband was encouraged to hold his wife accountable for the impact of her actions on their relationship and to reach out sooner for help before she was in crisis.

As treatment progressed, Alma described a "eureka moment" which allowed her to feel she could trust professionals. It took place not in a therapy group, but over lunch. Alma's lunch had been mistakenly eaten by someone else. Alma was frustrated and disappointed with the community for making a mistake. However, therapist two offered her his lunch as a replacement. At that moment, Alma felt:

> *Wow. OK, maybe I'm in the right place…that made more sense to me and I think at that point, I thought I need to take this a little bit more seriously and trust a little bit more […]*

On reflection, she felt this was because the therapist was helping her meet a basic need, the need to eat, something she had not had in her childhood. The therapist, and the TC by proxy, were saying that it was important for Alma's needs to be met. This small act led Alma to trust more and she was, accordingly, able to engage meaningfully in the therapy. Therapist two recalled using empathetic validation, asking whether the situation that synchronistically constellated was linked to Alma's feelings around her treatment goals. Offering up his own fish chips was a smaller manifestation of the holding, containment, and consistency that the TC could provide, if only she would allow it. The act of kindness by therapist two brought about a real authentic moment of recognition (Benjamin, 2017) that facilitated trust and a sense of real, genuine care.

There were other community moments outside the daily groups that Alma noted to be important. Over the Christmas period Alma described the importance of the relationships and the community in non-therapeutic spaces:

> *Christmas, Spending it within the community, I think it really brings people together that time of the year, we did secret Santa and you know the consultant dressed up as Father Christmas and it was all terribly funny…I think Christmas was really important.*

Alma commented that the TC outings, where the community would visit a park or other outside space, were also important. In reference to a visit to a park she said:

It was a really nice day when the weather was brilliant. The park was really pretty, and we had like a big picnic after then. We had a quiz didn't we?

Considering these TC events outside in non-therapeutic spaces, Alma stated that:

They are very much part of the therapeutic community because it's a different way of being together, isn't it? […] I think it helps people learn to be more tolerant of each other. I think it helps with helping you know people, helping each other out, teamwork, that sort of thing.

Being with the staff in a different space was also important. Alma noted that:

You see them as human beings 'cause you get so caught up in your own bubble. I think sometimes you see the doctors and the therapists, you just see them as that. You forget they actually are people that laugh, joke, go out with friends and have a life outside of their job. And it just brings at home. They hurt like people do and they laugh, and they have all these other range of emotions that we have.

Having developed more trust in the motives of staff members, seen them as more human and cultivated a stronger sense of belonging in the community, Alma was more able to hear other's views. She felt staff challenged her often, but she came to a new understanding of their motivations:

I learned that you're challenging me, 'cause it was coming from the right place. That's coming from a place of caring. It comes down to trust and it took me a long time to build that trust […] It was gaining that secure attachment.

At her next review, it was commented that Alma had started to engage more in groups; the general 'slow start' and 'façade' that seemed to define her initial engagement was breaking down. This reflection supported Alma's own assessment that things had started to change, although her eureka moment and other notable, transformative experiences were not mentioned during the review. In the last six months of her treatment, Alma was able to describe building a secure attachment to the TC. Towards the end, she found the large community groups, which had been so challenging, now provided some of the most beneficial experiences. Interestingly, her small group feedback in her final review indicates that Alma was dismissive about her attachment to the programme. Given her comments in the interview, it was perhaps hard to disclose such an attachment to the group, even in the latter stages of treatment. Alma was also able to meet the attendance requirement and refrained from self-harming and overdosing s during the latter stages of the treatment. The last review noted how hard it was to say goodbye for Alma, and how staff felt it hard to engage her on the topic. She moved into the leaver's group that was facilitated by therapists one and two. Reflecting on the final stages of Alma's work, therapist one noted:

"[Therapist two] and I running the group was very powerful as we were with her throughout her journey with us, playing key roles in her treatment. By the end phase of the group Alma said she did not feel abandoned or rejected by us but more able to

contemplate a life outside of the psychiatric world […] redefining herself as someone who could do normal things in life like make friends, be sociable and hold down a job."

Considering her work with the TC overall, therapist two noted:

"Alma learnt to trust me as her individual therapist, she was less suspicious of my motives, she believed in what I said…she improved in reading mine and other's feelings more accurately. She took this experience outside of treatment[…] Alma was grateful for the commitment and reliability of the staff; she was grateful and appreciative […] overall, we laughed, we sparred, there were moving moments in treatment, there [were] several steps forward and then a few back, there was frustration and irritation, there was trust, respect and care."

Alma noted that she was more trusting of professionals in general, and this spread to other relationships with which she had previously struggled. She does not resort to aggression as much to get her point across. She also described being more able to make meaningful friendships and to get along with others, both in and out of the workplace. The couples work had further improved Alma and her husband's relationship. Alma also commented that she was more able to see how her actions affected others. She still takes overdoses and self-harms at times, but she noted that the professionals involved in her care all say that she is more open and honest with them. She noted that one professional used to say she was like a porcupine because she was so prickly, but this had now changed.

Over the course of her treatment, Alma's HoNOS score fell in a linear fashion from 29 in March 2017, 19 in February 2019, 16 in February 2020, and 13 in September 2020. The greatest decrease was over the course of the full programme, but the continued fall while Alma was in the leaver's group highlights the importance of this group and the continued changes in her symptomatic burden after treatment had ended.

Discussion

Kaluzeviciute's (2021) CaSE approach to evaluating case studies describes two methods of assessing the quality of cases. As per her definitions, we feel our case study is a purpose based systematic critical case study that tests existing theories. It could be considered a representation case study, as it likely does represent the experience of a person with personality disorder in an NHS TC. Given, however, our aim to specifically evaluate whether relationships and belongingness were key vehicles of change as per previous theory (Pearce & Pickard, 2013), we felt the critical case study to be the most appropriate description.

Kaluzevicuite (2021) provides a checklist and open-ended questions to consider when evaluating cases. We have used the checklist to support the design and write up of our study. The open-ended questions have been answered in Table 1. The CaSE approach has highlighted that there are no in-depth descriptions of transference/countertransference reactions in our case study. Despite this limitation, we feel that our study adheres to the CaSE

approach and can therefore be used to support the theory and research described involving relationships and TC effectiveness in personality disorder.

In terms of bias, it is important to note that the research team worked within the TC and advocate for its efficacy. Regarding the aims of this project, the importance of relationships in TC care was already part of the research team's thinking about TCs. The research team itself was made up of two men and one woman, all of whom are white British. Professionally, the team was comprised of a psychiatrist, group analyst, and MBT therapist. We are liable to bias towards the effectiveness of TC care and the centrality of relationships in the entire case study. Not only are the research team believers in the TC model, we were affected by the closure of our service. While we have endeavoured to consider and mitigate for this, unconscious bias will likely remain in our work. The research group is made up of multiple professional backgrounds and genders but is not ethnically diverse. With regards to ethnicity, the backgrounds of the core research team are the same as the subject of the case study. The fourth author of this paper – an academic from a BAME background highly involved in Equality, Diversity, and Inclusivity initiatives – was external to the research group and treatment within the TC. His input allowed for a degree of objectivity and criticality to the research methodology and its findings.

Alma arrived with difficulties in relationships and was provided with opportunities to rework these through experiencing similar patterns and dynamics in the TC. Her initial dislike of the community group – but simultaneous awareness that this is where change could be facilitated and experienced – further shows this relational aspect at play. The dynamic context and factors that led to Alma's engagement highlights the centrality of belonging; having an idea or notion of a community to which one belongs means patients must see themselves as being a part of something bigger than themselves. This in turn leads to an acknowledgement that what one does affects others. Indeed, the opportunity to work psychologically on oneself in groups – regardless of its size and *modus operandi* – offer the message that everything affects everything else, and all relationships are meaningful and important. In this regard, we are reminded of Indra's Net as an apt image depicting the intricate network of relationships of responsibility we are describing here. This emphasis on mutual and interconnected responsibility is clearly seen in Alma's story, even downtime and lunch together led to opportunities and challenges to repeat or change negative relational patterns. We can see in our study how the TC fosters a joining up of often fragmented aspects of a person that is crucial to facilitating change, but equally, it is a process that can initially feel threatening. We feel this sense of being known was frightening for Alma, and this was discussed with her during her time at the TC. Within our case study, we can see how the TC offered Alma an opportunity to make life-changing alterations to the way she interacted with herself and the world. These changes then allow her and, by extension, those benefitting from a TC treatment, to witness and enact their own agency; individuals are empowered to take responsibility for managing themselves in ways that enhance and build on the positive work done during treatment.

Comparing our case study themes to the TC theory presented by Haigh and Pearce (2017), we note some slight, but not insignificant, differences. Haigh and Pearce describe belongingness, social learning, promotion of responsible agency, and narrative development as specific therapeutic factors in the TC. The idea of belongingness is evident in our study,

and when Alma was finally able to make herself part of the community that included staff, she was able to make changes. Social learning and responsible agency are seen in the use of boundaries in Alma's case, which she felt were essential to her ability to engage in the programme. Narrative development, the questioning and reworking of patient histories, is less evident in our study.

Haigh and Pearce describe four principles that are essential to TC functioning: democratisation, permissiveness, reality confrontation and communalism. The concept of permissiveness, which allows behaviours to exist so that they may be explored (and so long as they do not harm others), is partly challenged by the boundaries that were put in place to help Alma. Self-harm and overdosing could still be discussed, and indeed some self-harm was allowed during her treatment. However, there were clear lines and consequences of behaviour that harmed herself, which meant permissiveness had limits. This is not to say that it could not be discussed – indeed this is crucial – but the idea that it would be permitted may not have allowed Alma to engage in the programme in the first place. Reality confrontation is intertwined with using boundaries as it compels the patient and all TC members to consider self-harming behaviours. This is a clear part of Alma's story; being in the community forced her to confront these specific issues. The concept of communalism is related to belongingness and strongly emphasises the relational aspect that we think is central to how TCs facilitate change; the knowledge that what we do impacts others and vice versa was a key factor in Alma's development.

Another theoretical concept that finds expression in our study is the *milieu* of the TC. This describes the negotiation of culture, relationships, and one's environment as key to therapeutic effectiveness. The milieu concept also highlights the importance of informal time together, such as the pivotal moment over lunch or the importance of the Christmas celebration in our case study, as opportunities for learning and personal growth. They also foster a sense of belonging. During the community outing Alma was able to see staff as human beings with their own emotions. Alma felt that these moments all contributed to her ability to trust staff and use the TC. The emphasis on relationships in the literature therefore parallels our own findings. The understanding of relationships in the milieu approach, however, is focussed on getting patients to take responsibility for their own difficulties as well as the problems of other patients in the TC. While this is clearly an important aspect, it is a different emphasis on relationships when compared to what is being demonstrated in our case study. In our research, the relationship dimension is more about a validation of care and seeing others as people with their own feelings that allowed Alma to trust others.

Haigh and Pearce also highlight the importance of a culture of enquiry and a flattened hierarchy in TC theory. These were key aspects of our TC approach but have interestingly not been directly mentioned as important in our case, except that Alma, through participation in the community groups, became curious about, and more of, the nature of first impressions, i.e., that these were not necessarily accurate representations of individual character. To remain open to change – which to us denotes a shift towards plurality, multiplicity and the flexibility and elasticity of the self – was certainly beneficial in Alma's recovery and individual development. It also points to a burgeoning sense of criticality and willingness to ask difficult questions.

A key aspect of TC care, Responsible agency, also features as central to Alma's story and resultant change by the end of therapy. The agreed contracts and boundaries put in place were described as significant for Alma. In relation to responsible agency, the TC has a no blame culture which was supported by staff during their many interactions with Alma. Our case study supports Peace and Pickard's (2012) emphasis on the importance of belongingness in TC care. We feel this is an important point for future TC projects and treatment interventions attempting to operate along TC lines. So long as responsible agency and belongingness are maintained, interventions for personality disorder could prove effective.

Our case demonstrates that relationships within TC settings are important vehicles for change in patients with personality disorder. This case is a valuable follow-up to theoretical work already highlighting the importance of relationships for enacting change, and to the one RCT evaluating TC care compared to TAU in BPD. The availability of this treatment on the NHS has been threatened over the last decades because of changes in funding systems and the growing expansion of evidence based manualised therapies with positive outcomes – cheaper, quicker, and requiring less time and intensity. Manualised therapies such as mentalization based therapy (MBT) and dialectical behaviour therapy (DBT) have something to offer to the right cohort with the requisite skill levels and training. There may, however, be a group of people who will not benefit from these approaches and will require more intensive, long-term TC-style input. The group that would most benefit from this approach, we suggest, are those usually described as having moderate to severe personality disorders and complex emotional and interpersonal problems. To deny them access to the specialised services we describe here would leave them exposed to more costly admissions which will, in turn, lead to unnecessary distress and suffering.

Our case study highlights the power of relationships and group working within a community. We suggest these cannot be replaced by standalone manualised treatments as adequate or equivalent to the higher-level needs and complexity of presentations we meet in NHS Psychiatric care**.** The TC approach in some ways transcends adherence to a specific psychotherapeutic dogma as it features a multitude of approaches to therapy, which is itself a mark of the need for a flexible approach within which complex behaviour and needs may be met. This being said, we are also aware of the iatrogenic harm that the TC model can do to is patients, for example increasing incidents of self-harm (Chiesa et al., 2011). Indeed, there is no panacea for the treatment of those with a PD diagnosis.

The evidence for TC effectiveness is seen as lacking due to the complexities of empirical research within the field, but this does not equate with assertions that it does not work. We acknowledge our emotional attachment to our TC and we mourn its loss. Regardless, this case study has satisfied criteria that allow it to be considered a systematic case according to Kaluzeviciute's framework (2021). We feel it supports the literature that describes relationships as playing a key role in TC effectiveness and treatment. A focus on relationality – and how this permeates all aspects of TC treatment and activities – is crucial to working successfully with people with personality disorder. Arguably, relationality is central to any effective therapeutic intervention, but our research has shown that an explicit mobilisation of the principles of relationality in a TC setting aligns with its existing group-oriented focus and ethos; it frames all behaviour as impacting and impactful. How we choose to express our

agency affects all those with whom we are intricately connected. Our findings will be relevant to those TCs working with patients with personality disorder, and perhaps to any professionals working with patients with personality disorder in the long term. We hope that this case study can contribute to our understanding of TC effectiveness as it illustrates the importance of relational approaches to working with personality disorder.

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Table 1 is a sperate document.

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