Empowerment in Action: Exploring Self-Agency in Therapeutic Communities and other Psychological Modalities for people with Complex Emotional Needs

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Declaration
The applicants confirm this work is original and has not been published elsewhere in any form.

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Purpose

We are a group of people with professional and lived experience of Complex Emotional Needs interested to explore the concept of self-agency. Within the Therapeutic Community (TC) we have found that group members with Complex Emotional Needs often join the group with low self agency due to early adversity and often as a consequence of being in mental health services. The development of self agency within the TC then becomes a crucial aspect of recovery, and in our view perhaps the most important factor in making behavioural change. In our contemporaneous entry to the Elly Jansen writing competition we describe how self agency can be defined as the ability to internally generate new options for action then manifest these into the real world, probably with the pre-requisite of a safe connection with others or belongingness. Rex Haigh described 'agency' as one of the fivefold quintessence of the Therapeutic Community (TC), important experiences in the development of emotional and psychosocial development.[1]

TCs promote and optimise self agency in several ways, such as the overall concept of expecting change, rejecting authority and the expert stance, and using therapeutic challenge, as well as individual aspects of taking on formal roles in the group, making contracts to change behaviour, and the process of voting in new members.[1,2] However, there has been little empirical investigation into the realities of how self agency develops, measurement, optimisation, and the consequences for TC members.

We aim here to investigate the concept of self-agency further in two ways; by exploring the experiences TC group members and surveying staff views. Specifically we are interested to discover more about how self-agency develops or changes in the course of the TC or other psychological modality, and how this can be further optimised in clinical settings.

Design

The study will consist of two parts both using a qualitative design and analysis. Part 1 will involve semi-structured interviews with people who have completed a TC. Part 2 will comprise a staff survey of psychological therapy practitioners who have worked in a TC or been trained in another psychological therapy aimed at the treatment of people with Complex Emotional Needs. This design will allow for richness in descriptions of experience and explanations for mechanisms within the topic.

Coproduction

The group combines expertise from those with professional and lived experience. This project has been codesigned and will be coproduced throughout. We have planned for regular discussion about language choices for advertising material and explanatory notes, accessibility for participants to take part in the study, and we will collaborate with Rethink Somerset to optimise diversity of responses and safety of participants as recounting experiences of mental health services can be retraumatising.

The study will require NHS Ethical Approval alongside HRA and service governance approval from the six participating organisations. The team has experience of this process.

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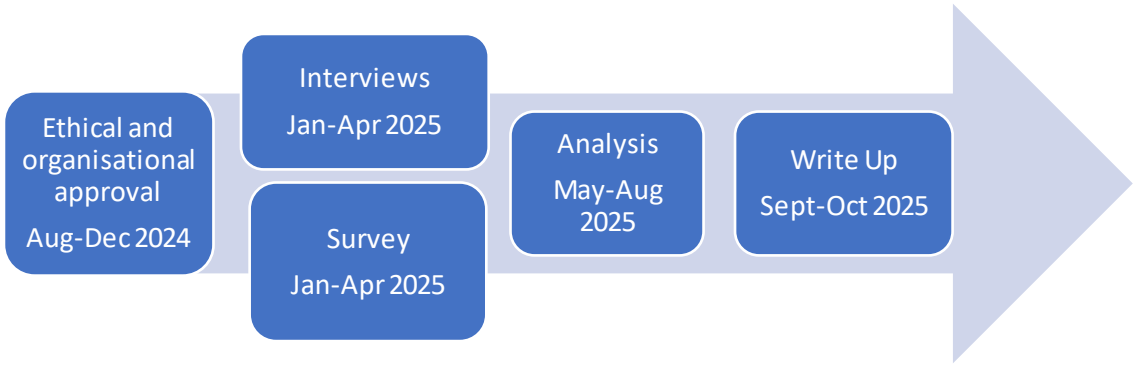
[1] Haigh R (2013) The Quintessence of a Therapeutic Environment. *Therapeutic Communities: The International Journal of Therapeutic Communities 34(1)*, 6-15

[2] Pearce, S. and Pickard, H., 2013. How therapeutic communities work: Specific factors related to positive outcome. International Journal of Social Psychiatry, 59(7), pp.636-645.

Timeline



Recruitment

In Part 1, participants for interviews will be identified using local Expert by Experience organisations and from participating services. We will also advertise via relevant organisations including TCTC, BIGSPD, Mental Elf, and Relational Practice Movement. Participants will be offered £20 for taking part. In all cases, participants will be screened by the research team to ensure a range of experiences and demographics. In Part 2, practitioners will be identified using direct mail-out in each of the six participating organisations. We aim for a minimum of 50 responses from practitioners trained in a variety of therapeutic modalities.

Eligibility Criteria:

Part 1 Interviews	Part 2 Practitioner Survey
- Aged 18 or above people who relate to Complex Emotional Needs (including what has previously been diagnosed as Personality Disorder) - Previously completed a Therapeutic Community - Level of English sufficient to take part in the interview process - May be currently engaged with or discharged from mental health services or therapy	- Clinician with professional registration or specific practitioner qualification in a TC or psychological therapy targeted at Complex Emotional Needs - Clinical experience of the above - May be currently working as a practitioner or otherwise

Procedures

In Part 1 we will conduct semi-structured interviews with people who have completed a TC. The content of the interviews will include prompt questions to ensure broad topics are covered, but participants will be encouraged to talk about their own experiences and what is important to them, and not be limited by the research team's expectations. Prompts will include asking about; perceived levels of self agency when coming into the TC and causes of low initial self agency, changes in self agency during treatment, aspects of the TC which affected self agency, and consequences of self agency change for the person's life outside the TC.

For each participant who wishes to participate and is eligible, a member of the research team will explain the study, give a copy of the Participant Information Sheet and complete the informed consent procedure with the participant. The participant will be allowed as much time as they wish to consider the information and the opportunity to question the researcher, their mental health team, or other independent parties to decide whether they will participate in the study. It will be clearly stated that the participant is free to withdraw from the study at any time, for any reason, without prejudice to future care or affecting their legal rights and with no obligation to give a reason for the withdrawal.

Following consent into the study, a member of the research team will complete the interview with the participant. The interviews will be conducted by the research team, and a group decision taken whether these should involve interviewers with professional or lived experience taking into account participant preference.

Participants complete the interview either face to face in site locations or remotely via telephone/video call based on organisational policy and participant preference. The interviews are expected to take 1 hour per participant, and it is anticipated that the interview will be completed in one sitting. Interviews will be recorded with an encrypted Dictaphone and all voice files will be uploaded and stored on an encrypted computer drive. Interview transcripts will be pseudonymised so that no personally identifiable data will be stored or accessible to the researchers analysing the transcripts. Participants will be identified using a unique participant ID. The transcripts and recordings will be stored safely in confidential conditions at the organisation which recruited the participant in a locked cabinet in a locked office these sources will be stored as per the local policies of the organisation after which they will be destroyed. Interviews will continue until data saturation has been achieved, estimated at around 20-30 participants.

In Part 2 we will survey psychological therapy practitioners from six organisations including both statutory NHS services and private organisations offering psychotherapy training and practice. Practitioners who have worked in a TC or been trained in another psychological therapy aimed at the treatment of people with Complex Emotional Needs will be invited to complete an online questionnaire. Questions will establish modalities where practitioners have training and experience, then ask about their experiences of working with self agency in these modalities. This will enable us to gain further information in how self agency is seen and managed in the TC, as well as to compare and contrast with different modalities.

Participants will be able to complete the survey in their own time although we envisage that it will take no more than 30 minutes to complete. Contact details will be given for the research team if participants have any questions about the study or individual questions. The online version of this questionnaire will be delivered using Qualtrics, a survey software used by the NHS owing to its data security credentials. Data entered into the survey will not include any personally identifiable data. Personal identifiable data will be held directly by the host NHS service on an encrypted database and the participant will be given a unique study code for completing the online survey to ensure anonymity. The research team will download the online survey data from Qualtrics at the end of the study and store it on a secure server at the at the host NHS Trust. Data will be erased from the Qualtrics platform as soon as the analysis is complete (and at most one year after the end of the study).

Analysis

Interviews will be recorded and transcribed verbatim, then both the transcripts and practitioner surveys will be subject to Interpretative Phenomenological Analysis (IPA) to determine the themes of the interviews, and contrasting experiences of the therapies. All transcripts and survey responses will be coded by at least two members of the research team individually then as a large group to audit codes and generate themes before collaborating on the report. IPA follows the six phases for Thematic Analysis outlined in Clarke and Braun.[3] This is: i) becoming familiar with the data; ii) generating initial codes; iii) searching for themes; iv) reviewing themes; v) defining and naming themes; vi) producing a report. This analysis method is considered the best fit for this project as the rich and detailed reflections we expect the interviews and surveys to yield will be used to identify patterns of meaning and generate themes for future avenues of research without the need for an initial hypothesis.[3]

[3] Braun, V. and Clarke, V., 2006. Using thematic analysis in psychology. *Qualitative research in psychology*, *3*(2), pp.77-101.

Anticipated Risks

We do not anticipate that there will be any significant risks involved in participation however we have identified a small number of risks to consider. NHS Ethics approval will be required before beginning. Disclosure of risk related information and participant distress is a potential risk. Researchers will be experienced working with distressed individuals and have been trained to manage risk. Steps will be taken to mitigate and respond each these risks following the service procedures are working closely with clinical teams where applicable. Participant wellbeing is a priority and if participants should become upset whilst speaking of their experience (either because of the questions themselves, or other reasons), the interviewer will pause or stop the interview. Some participants may find completing the 1-hour semi-structured interview tiring. If this is the case, we recommend taking regular breaks.

The main methodological risk is inability to recruit sufficient participants for each part of the study. We are confident, however, that between us we have a robust professional and lived experience networks who would be willing to participate. We will be happy to take advice on further places to advertise.

Outline Costs

Verbatim transcription for 30 hours of interviews (rate £1.40/audio min)	= £2520
Encrypted digital recorder	= £449
Expert by Experience involvement cost	= £1000
2x training in data analysis using IPA (£175 each)	= £350
Research poster printing (A0 plus carry tube)	= £50.40
£20 voucher for participation x 30	= £600
TOTAL = £4969.40	

Limitations

We are likely to hear mostly from people who are interested in talking about their experience of self-agency changing during therapy rather than those who did not find any change. This is not a major concern as the study is not designed to be representative of all experiences or be hypothesis testing. Whilst our team have a diverse range of lived experience and a range of age and gender, we recognise a lack of diversity in ethnicity. We are aware that lived and professional experiences, identities and biases could influence how the data is interpreted and have planned to mitigate this by having regular reflective practice meetings in order to explore where positionality and biases might be impacting data analysis.

Implications

We aim to use the study to further understand the part played by self-agency in recovery and progress within Complex Emotional Needs. We expect the findings to allow hypothesis generation for further quantitative study, including work towards development of a self agency measurement tool and recommendations for adaptations to therapy practice. If self agency can be optimised in therapeutic work, we believe there is potential for boosting the effects of intervention.