Doctorate in Clinical Psychology | Lancaster University

Thesis

How do democratic therapeutic communities work? Exploring the experience of democratic therapeutic community membership

Lancaster University

Doctorate in Clinical Psychology

Trainee Number: 17/27

2017 Intake

How do democratic therapeutic communities work? Exploring the experience of democratic therapeutic community membership

Abstract

The thesis is comprised of three sections, each with their own aims. The thematic synthesis aimed to explore how the therapeutic environment of a democratic therapeutic community (DTC) is experienced, depending on whether the member/former member had attended a DTC in the community, or a DTC in a prison. The research paper aimed to explore how belongingness is experienced at the time of DTC membership; and, what happens to one's sense of belongingness following discharge. The critical appraisal aimed to reflect on the thesis and, where possible, to synthesise the findings from the two papers. The thematic synthesis involved a total of 10 articles: five concerning DTCs in the community, and five concerning DTCs in prisons. The research paper involved semi-structured interviews with seven former DTC members – interview transcripts were analysed using thematic analysis. Three analytic themes were developed from the thematic synthesis: (i) operational elements of a DTC; (ii), connecting with the group; and (iii) facilitating therapeutic engagement. Findings from the thematic synthesis indicated that the experience of the DTC environment was broadly similar for both settings. Four analytic themes were developed from the research paper: (i) belonging and trust; (ii) spectrum of connection; (iii) being yourself; and (iv) ensuring belonging after membership. Findings from the research paper indicated that belongingness is a persistent feature of the DTC journey, beginning with an initial stage based on recognition of shared suffering, before progressing to a second stage predicated on joint participation in the therapeutic process. From the thesis, two complementary models have been proposed: (i) a model depicting the course of DTC-related belongingness; and (ii)

an integrative model combining the findings from the two papers. The consistency of the findings across the thesis, as a whole, offers a degree of common understanding to the diverse DTC landscape.

Declaration:

I declare that the research reported within this thesis is my own and has not been submitted for any other academic award.

Acknowledgements:

I would like to offer my sincere thanks for the academic (and, at times, emotional) support of my research supervisors, Dr Suzanne Hodge, and Dr James Kelly. Their comments and insights were truly invaluable, whilst their manner will have a lasting impact on the professional that I would like to be – inquisitive, respectful and collaborative. I would like to extend my sincere thanks to the "DTC Umbrella Group", who helped to shape the project in its infancy and, prior to the COVID-19 pandemic, were keen to support recruitment for the project. I would like to express my earnest gratitude to the individuals that participated in the research, each of whom welcomed me in to jointly explore what was often a difficult, but rewarding, period of their lives. I would also like to thank Dr Gill Aspin, for her offer of clinical support with the project, and my fellow trainees, for their ad hoc advice and wisdom. I would like to thank my mother, and my late father, for providing stability and encouragement, for as long as I can remember. Finally, I would like to express my deepest thanks to my wife, Karen, who emitted strength, warmth and calm at those times that I felt lost and overwhelmed.

Contents

Chapter 1 Therapeutic environment and the experience of democratic therapeutic community membership: a thematic synthesis 1-1

Introduction 1-1

Materials and methods 1-5

Identifying relevant literature 1-5

Quality appraisal 1-9

Thematic synthesis 1-10

Characteristics of selected studies 1-11

Results 1-11

Operational elements of a DTC 1-12

Connecting with the group 1-15

Facilitating therapeutic engagement 1-18

Discussion 1-19

Clinical implications 1-24

Strengths, limitations and future research 1-26

Conclusion 1-27

References 1-29

Table 1 1-37

Table 2 1-38

Table 3 1-39

Figure 1 1-43

Figure 2 1-44

Figure 3 1-45

Appendix A 1-46

Appendix B 1-47

Appendix C 1-49

Appendix D 1-51

Chapter 2 Democratic therapeutic communities and the experience of belongingness: a qualitative exploration 2-1

Method 2-5

Design 2-5

Participants 2-5

Participant characteristics 2-6

Procedure 2-7

Analysis 2-8

About the researcher 2-9

Ethics 2-10

Results 2-10

Belonging and trust 2-11

A spectrum of connection 2-14

Being yourself 2-15

Ensuring belonging after membership 2-17

Discussion 2-20

Clinical implications 2-24

Strengths, limitations and future research 2-26

Conclusion 2-28

References 2-29

Table 1 2-35

Table 2 2-36

Table 3 2-38

Table 4 2-41

Figure 1 2-43

Figure 2 2-44

Appendix 2-45

Appendix A 2-45

Appendix B 2-47

Chapter 3 Critical Appraisal 3-1

The search for a DTC 'recipe' 3-2

Existential bracketing 3-5

Relationship between the proposed models 3-6

A recipe for everyone? ..... **Error! Bookmark not defined.**

The three phases of DTCs 3-8

The spectre of COVID-19 3-11

Conclusion 3-13

References 3-15

Figure 1 3-1

Figure 2 3-1

Figure 3 3-2

Figure 4 3-3

Chapter 4 Ethics Proposal 4-1

Appendix A 4-15

Appendix B 4-34

Appendix C 4-35

Appendix D 4-40

Appendix E 4-41

Appendix F 4-43

Chapter 5 Appendices not covered elsewhere 5-1

Appendix A 5-1

Appendix B 5-3

Chapter 1 Therapeutic environment and the experience of democratic therapeutic community membership: a thematic synthesis

Background: democratic therapeutic communities (DTCs) are a group intervention, primarily offered to persons in receipt of a personality disorder diagnosis. DTCs have been applied in both community and prison settings; however, the physical properties of the two settings differ considerably, particularly, with respect to security concerns. Aims: to explore how the therapeutic environment of a DTC is experienced, depending on the setting within which the model has been applied (i.e. community or prison). Methods: a total of 10 articles (five concerning DTCs in the community and five concerning DTCs in prisons) were analysed via thematic synthesis. Results: three analytic themes were developed: (i) operational elements of a DTC; (ii), connecting with the group; and (iii) facilitating therapeutic engagement. Conclusions: findings indicated that the experience of the DTC environment was broadly similar for both settings: the operational elements of a DTC, coupled with a sense of connection within the group, appeared to contribute to a DTC environment that facilitated therapeutic engagement by promoting responsibility, engendering trust, and supporting members to feel safe enough to be vulnerable.

Key words: therapeutic communities; personality disorder; belongingness; responsible agency.

Introduction

Therapeutic communities (TCs) are a group intervention, defined as 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" (Roberts, 1997, p. 4). Democratic therapeutic communities (DTCs) have their roots in the UK and are primarily used to treat relational difficulties, emphasising democratic decision-making and a flattened hierarchy

between DTC members and facilitators (Akerman, 2019). DTCs are most commonly associated with treatment for those in receipt of a personality disorder diagnosis. For a brief commentary on how DTCs are thought to work, please refer to the research paper.

The diagnosis of personality disorder is not without controversy. Broadly speaking, personality disorders are characterized by longstanding (two years or more) intrapersonal and interpersonal difficulties (World Health Organisation, 2019). Traditionally, personality disorders have been categorized along three clusters: (cluster A) odd, eccentric; (cluster B) dramatic, emotional, erratic; and (cluster C) anxious, fearful (American Psychiatric Association, 2013). However, the categorical approach has been described as conceptually and empirically problematic (Pocnet, Antonietti, Handschin, Massoudi, & Rossier, 2018). More recently, the International Statistical Classification of Diseases and Related Health Problems (ICD-11) has adopted a dimensional approach, where the severity of personality dysfunction is considered alongside five possible trait domain qualifiers: (1) negative affectivity; (2) detachment; (3) disinhibition; (4) dissociality; and (5) anankastia (Bach & First, 2018). Challenges associated with diagnoses of personality disorder vary from person-to-person, but might include: an incoherent sense of self, difficulties with regulating self-esteem, difficulties with perspective taking, relationships that are marked by volatility, occupational instability, dissociation and psychotic-like beliefs (Bach & First, 2018).

Diagnoses of personality disorder are relatively common within the UK, with a prevalence of 4.4% within the community (Coid, Yang, Tyrer, Roberts, & Ullrich, 2006). Nonetheless, at the start of the 21st century the provision of personality disorder services in the UK was found to be lacking. A report by the National Institute for Mental Health in England ([NIMHE], 2003), detailed that just 17% of NHS Trusts (in England) provided a dedicated personality disorder service for adults, whilst only 40% of Trusts reported to offer *some* level of service for adults with a diagnosis of personality disorder (NIMHE, 2003). The

report called on all Trusts to consider how to meet the needs of adults with a diagnosis of personality disorder, along with a list of recommended interventions, of which DTCs were one. In the years since the NIHME report, DTCs appear to have established a foothold in the treatment landscape for adults with a diagnosis of personality disorder. A recent survey of 56 of the 57 mental health trusts in England revealed that 83% of Trusts had at least one dedicated personality disorder service and, of those Trusts, 23% provided DTCs (Dale et al., 2017).

The literature indicates positive-to-mixed findings with regards to the efficacy of DTCs for the treatment of personality disorders. DTCs have been reported to offer a clinically effective means of intervention for adults with a diagnosis of personality disorder, demonstrated in both community (Chiesa, Fonagy, Holmes, & Drahorad, 2004; Barr et al., 2010; Pearce et al., 2017), and prison settings (Lees, et al., 1999). However, a recent review reported improved interpersonal outcomes following either forensic or residential DTC treatment, only; concluding that evidence for the efficacy of both day DTCs, and mini DTCs, was mixed (Capone, Schroder, Clarke, & Braham, 2016). In light of their inconclusive findings, Capone and colleagues determined that DTCs may not be conducive to positivist approaches of investigation, owing to the complexity of the intervention and the heterogeneity of the population.

Whilst DTCs have shown promise as an intervention for adults with a diagnosis of personality disorder, no formal DTC treatment manual exists (Pearce & Haigh, 2017). With respect to all forms of TC, some have argued that attempts to manualize treatment would detract from the relational focus of the general TC approach (Pearce & Haigh, 2017). Reflecting on the TC landscape as a whole, the absence of a treatment manual has likely contributed to substantial heterogeneity (Vanderplasschen, Vandevelde, & Broekaert, 2014). Recognising the need to establish both a means of replicability across that diverse TC

landscape, and a means of measuring adherence to the TC method (Pearce & Haigh, 2017), the Community of Communities (CofC) was founded in 2001. The aim of the CofC is to act as a quality improvement and accreditation network for all forms of TC. Since the inception of the CofC, 10 core standards (Royal College of Psychiatrists, n.d.-b) have been established which apply to all TCs, representing the minimum basis for CofC accreditation (see Appendix A for a list of core standards). It has been argued that CofC accreditation might evidence an understanding of, and an adherence to, the TC approach (Pearce & Autrique, 2010), suggesting a minimum standard of delivery across all accredited TCs. Nevertheless, CofC accreditation is voluntary; thus, the member directory may not represent all TC provision in the UK.

The 2019-2020 CofC member directory is predominantly comprised of DTCs, though there are a small number of TCs that specialise in treatment for addictions. DTCs in the CofC member director span a variety of settings, including: Her Majesty's Prison (HMP) services; NHS services, independent / voluntary services; and children and young people's services (Royal College of Psychiatrists, n.d.-a). To become a member, a service must have undergone a review against the CofC core standards, suggesting that approved members of the CofC would share some similar characteristics. Yet, the environmental setting of the DTC might influence how those standards are applied, undermining the proposed consistency that CofC accreditation might suggest. A review of prison DTCs reported on the presence of a conflict between the inherent need for security regulations within prisons, and the democratic decision-making processes that are a key component of DTCs (Lees et al., 1999). Security restraints can significantly reduce the extent to which DTC members within a prison can take ownership of their community and exert influence over its functioning (Leggett & Hirons, 2007). For example, a study of perceptions of the institutional environment reported that ratings of staff control (i.e. the extent to which staff control inmates via rules, schedules and

their interpersonal nature) did not differ between participants from the general prison population, and participants from a prison DTC (Dietz, O'Connell, & Scarpitti, 2003). These findings imply that decisions in the prison DTC were no more democratic, and the hierarchy between members and staff no more flattened, than for the general prison population. Thus, it would appear that the inherent requirement for security that exists within prison DTCs represents a fundamental and unique challenge to the democratic nature of DTCs, when compared to their community counterparts.

Given the fundamental differences between community and prison settings, the aim of this qualitative synthesis is to explore how the therapeutic environment of a DTC is experienced, depending on the setting within which the model has been applied. Comparisons, and contrasts, will be drawn between how the therapeutic environment of community DTCs, and prison DTCs, respectively, are experienced by their members. Findings from this qualitative synthesis will provide crucial insights into the consistencies, and inconsistencies, which exist between the experiences of persons who attended a community DTC, and those who attended a prison DTC.

Materials and methods

Identifying relevant literature

The design and reporting of this synthesis were informed by the Enhancing Transparency in Reporting the Synthesis of Qualitative Research (ENTREQ) reporting guidelines (Tong, Flemming, McInnes, Oliver, & Craig, 2012) (see Appendix B for complete ENTREQ guidelines).

A pre-planned search strategy was implemented using the SPIDER tool (Cooke, Smith, & Booth, 2012), with the aim of capturing all relevant papers within the literature (see table one for completed SPIDER tool).

[Table one near here]

To begin, the systematic search was limited to peer-reviewed journals with a focus on physical and/or mental health. A systematic search of AMED, CINAHL, MEDLINE Complete, PsycArticles, PsycINFO, SocINDEX and Web of Science databases was conducted in May 2020. Free text search terms were identified through a combination of common thesaurus/subject terms and terms used in previous quantitative reviews within the TC literature (e.g. Vanderplasschen, et al., 2013; Malivert, Fatséas, Denis, Langlois, & Auriacombe., 2011; Magor-Blatch, Bhullar, Thomson, & Thorsteinsson., 2014). Despite the difficulties associated with the diagnostic label of personality disorder (as detailed in the introduction), adults with a diagnosis of personality disorder were chosen as the target sample. The reasons for selecting this target sample were threefold: (1) personality disorder is a term that is widely used within the DTC literature; (2) many DTCs specialise in offering treatment for persons in receipt of a diagnosis of personality disorder (Pearce & Haigh, 2017); and (3) as a search term, “personality disorder” provided a degree of specificity that helped to restrict the parameters of the review. Using participant sample search terms to return more specific papers was particularly important as it was not possible to do so via intervention-specific search terms – within the TC literature it is not uncommon to find that the type/model of TC under investigation has not been specified in the article title or abstract. It is possible that restricting the target sample in this way may have inadvertently meant that some eligible DTC research was not returned within the described search strategy. To reduce the risk of excluding relevant articles, reviews within the TC literature tend to utilize a broad TC search term, such as "therapeutic communit*" (e.g. Vanderplasschen, et al., 2013), or “therapeutic community” (e.g. Malivert, et al., 2011; Magor-Blatch, et al., 2014), rather than

specifying a particular model of TC. The database search returned an initial set of 217 articles, of which 27 were duplicates and a further two did not contain an abstract, nor could the paper itself be sourced, resulting in a total of 188 unique articles. Vanderplasschen and colleagues (2013) conducted a search of the International Journal of Therapeutic Communities (IJoTC) in their quantitative review of the effectiveness of TCs for addictions. A manual search of the IJoTC was conducted on their website, returning 83 articles. Combining the articles retrieved from the database search and the screening of the IJoTC resulted in a total of 271 unique articles.

I screened the titles and abstracts of the unique articles independently, against the following inclusion criteria: (i) published in the English language (due to no translation facility) (one paper not included); (ii) published in a peer-reviewed journal; (iii) qualitative data collection/analysis was specified (however, variation among specific qualitative approaches was permitted, including the use of mixed methods approaches, so long as the qualitative findings were distinguishable from quantitative) (70 papers not included); and (iv) participants included persons who were/had been members of a TC (no limitations were imposed on length of TC membership as this might result in a truncated set of experiences) (37 papers not included). The following exclusion criteria were then used to screen the remaining 163 papers: (i) the paper was a review or commentary article (79 papers excluded); (ii) qualitative findings were not supported by quotations from members/former members of a TC (as such quotations would help to ground the synthesis in the words of those members) (six papers excluded); (iii) where multiple stakeholders were represented, it was impossible to distinguish between stakeholder groups (e.g. DTC members/former members, from facilitators) (three papers excluded); (iv) the TC was primarily concerned with the treatment of substance misuse (rather than issues relating to personality disorder) (25 papers excluded); (v) the majority of members/former members of the TC under investigation had not received

a diagnosis of, or had not presented with difficulties consistent with, personality disorder (i.e. long-standing intrapersonal and/or interpersonal difficulties) (one paper excluded); (vi) TC membership was primarily comprised of children/young adults and/or persons with a diagnosis of learning disability (as DTCs for these two populations follow a model which is different to those for adults) (40 papers excluded); and (vii) if TC member/former member characteristics had not been presented, as the absence of this information would preclude definitive answers to previous exclusion criteria (specifically, criteria iv, v, and vi) (one paper excluded). However, exclusion criterion seven came with one caveat. If an article named the specific TC(s) that were involved in the research, and if member characteristics were not present in that article, I referred to the CofC member directory (Royal College of Psychiatrists, n.d.-a) which contains a description of each CofC registered TC within the UK. Articles that did not include member characteristics, and were not identifiable in the CofC member directory, were excluded.

Following implementation of the exclusion criteria, eight articles remained. Consistent with similar reviews within the TC literature, the reference lists of the final eight articles were screened for articles that would meet the criteria for this review. Two articles were retrieved from the screening of reference lists, resulting in a final total of 10 articles to be included in the review: five papers concerning DTCs in the community, and five concerning DTCs in prisons (see Figure one for a flow chart depicting the systematic search process).

[Figure one near here]

Quality appraisal

It has been said that validity in qualitative research is a matter of judgement, whilst rigid checklists increase the risk of becoming "an end in themselves rather than enhancing validity" (Murphy, Dingwall, Greatbatch, Parker, & Watson, 1998, p. 11). Nevertheless, as a means of making my personal judgements of methodological quality transparent to the reader, I applied an adapted version (Lord, Field, & Smith, 2017) of the 10-point Critical Appraisal Skills Programme [CASP] checklist for qualitative research (CASP, 2018). The adapted version allows researchers to assign a grade of weak, moderate, or strong in relation to the questions posed by the CASP tool, resulting in a final quality score ranging from 8 (indicating poor quality) to 24 (indicating high quality) (see table two for completed CASP scores). The mean CASP score across all 10 papers was 16.6 (range = 12-20), indicating that the systematic search identified papers of average quality. The mean CASP score for the five papers concerning community DTCs was 16 (12-19); whilst the mean for the five papers concerning prison DTCs was marginally higher at 17.2 (range = 13-20), suggesting comparable quality between the two subsets of papers. The question with the lowest scores pertained to consideration of the relationship between the authors and the participants (CASP question six). CASP questions seven (consideration of ethics) and eight (strength of data analysis) were also characterized by weak-to-moderate appraisals. Specifically, articles may not have detailed how the research was introduced and explained to participants, or whether independent ethical approval had been sought, and provided by, an appropriate body or organisation. With regards to data analysis, authors might have named the analytical method used, but neglected to provide an in-depth description of the analysis process. It was common for authors to neglect the inclusion of contradictory data within their qualitative analyses.

[Table two near here]

Thematic synthesis

I conducted the qualitative synthesis, independently, using the thematic synthesis approach of Thomas and Harden (2008). In accordance with their method, "data" was taken to mean all text within the "results" and/or "findings" sections of the identified papers, capturing both participant quotations *and* the interpretations offered by authors. This approach is in contrast to meta-ethnography, where a distinction is drawn between participant (first-order) interpretations and the authors' (second-order) interpretations of participant data (Britten et al., 2002). In meta-ethnography, only second order interpretations would be included as data as the available first order interpretations can only ever represent a fraction of a participant's interview (Atkins et al., 2008). However, Atkins et al (2008) argue it can be difficult to distinguish first- from second-order interpretations and question the value in prioritising second-order interpretations in instances where issues of reflexivity have not been addressed. Atkins et al conclude that, ultimately, all data presented in an article can be considered second-order interpretations as participant quotations have been selected, and presented, by the authors. It is this latter point which perhaps best represents Thomas and Harden's rationale to what constitutes data. The data was coded (inductively) line-by-line, paper-by-paper, to search for concepts relevant to the research question. Codes from each paper were then entered into individual spreadsheets and analysed separately to arrive at a catalogue of paper-specific concepts (Walsh & Downe, 2005). Paper-specific concepts were grouped together in a single spreadsheet and analysed for similarities and differences, developing a set of "descriptive themes" which captured the whole data set. Descriptive themes were then analysed and interpreted in the context of the review questions, resulting in new meanings and the emergence of more abstract "analytic themes".

Characteristics of selected studies

Table three displays the key characteristics for each of the papers included in the thematic synthesis. The 10 papers were published between 1987-2018; nine of which were conducted in the UK, and one in Canada. The extent to which demographic information was reported for the various participant groups varied across the included papers. There were 206 participants in total across the 10 papers. Two papers utilized the same dataset to answer distinct research questions; thus, these participants were only included once when calculating the total participants involved. These two papers also reported 746 hours of participant observation but, they did not specify the number of members registered to each of the two DTCs that were under observation.

The papers reported here employed a variety of qualitative methods, including interviews (eight papers), observational techniques (four papers), and focus groups (three papers). All 10 papers utilized quotations to support their analyses, which commonly described important themes across their data. Specific analytic techniques included variations on the thematic analysis approach, framework analysis, and interpretative phenomenological analysis. The two oldest papers provided no description of their approach to analysis.

[Table three near here]

Results

Three analytic themes were developed from the reviewed papers: (i) operational elements of a DTC; (ii), connecting with the group; and (iii) facilitating therapeutic engagement. Papers from both community and prison settings contributed to each of the analytic themes (see Appendix C for a thematic grid charting the progression from paper-specific concepts, to

analytic themes). All three analytic themes will be presented, in turn, with supporting quotes from the 10 reviewed papers.

Operational elements of a DTC

Nine papers directly commented on the operational elements of a DTC. These structural elements can be broken into three subthemes: safety through boundaries; distribution of power; and everything-is-therapy.

Safety through boundaries

Of the nine papers that discussed the operational elements of a DTC, all directly commented that the DTC environment was one that encouraged structure through adherence to a known set of parameters, referred to as "boundaries" (P8, M; C9, A[1]), "ground rules" (C5, A) or "community values" (C7, A). One author commented that "rules and boundaries held by the community helped people to feel safe" (P8, A). Though the physical safety of members was a recurring theme across both settings, there was a difference in terms of where the perceived risk to safety lay. For community DTCs, the primary risk to physical safety was perceived to be risk-to-self, with the topic of "self-harm" (C5, C6, C7, C9, C10) arising in all five papers. Self-harm posed obvious physical risks to the individual, and had the potential to heighten anxiety for (and between) others, too, "There was often tension between Julie and the other

[1] The letter "C" indicates that the paper investigated a community DTC, whereas the letter "P" indicates a prison DTC. The letters "C" and "P" are followed by a number to convey the paper from which the quote was taken, e.g. "P8" represents paper 8, and "C9" represents paper 9. These identifiers are followed by either the letter "A", to indicate that the quote is taken from the author of that paper, or the letter "M", to indicate that the quote is from a participant (i.e. a DTC member).

clients over her struggles adhering to the meal plan, her self-harming behaviours and engaging in groups, all of which increased others' anxieties" (C7, A). For prison DTCs, the primary risk to physical safety was perceived to be risk-from-others (P1, P3, P4, P8). For example, an author commented that where a member perceives themselves to be judged, "Often they will want to resort to aggression as a way of dealing with this, a strategy they have used many times in the past…this can expose the group to risky situations" (P1, A). Where persons presented as unsafe, a thorough review would follow, not only to provide support to the individual concerned, but to contain the distress of other members, too, "These ad hoc meetings were convened for clients who self-harmed, were feeling distressed, or struggling to commit to their safety. The meetings provided an opportunity to share feelings and seek support." (C10, A).

Distribution of power

Of the nine papers that discussed the operational elements of a DTC, eight (four community, and four prison-based) directly commented on efforts to distribute power among the DTC members. Power was primarily distributed via two processes: democratic decision-making, and a flattening of the hierarchy between DTC members, and staff. Democratic decisions might take the form of a formal vote, "Rebecca - a recently admitted alcoholic - requested weekend leave to return home. The matter was briefly discussed by the members and agreed by a show of hands vote." (C6, A). Alternatively, democratic decisions might result from a more general sense of participation and inclusion, "Having a voice in meetings and participating in running the community allowed residents to feel responsible not just for themselves but for the wider community." (P3, A).

A member of a community DTC illustrated the impact of a flattened hierarchy by commenting that, at first, they could not differentiate between DTC members, and staff,

"When I first came for my first assessment, I didn't know who was staff and who was client" (C7, M). Flattened hierarchies were discussed in greater detail by members of prison DTCs, "…many commented on the marked difference in terms of the lack of, or a reduced 'them and us' dynamic, compared to other prisons." (P3, A). Here, the experience of power inequalities in mainstream prisons appears to draw the flattened hierarchy of prison DTCs into greater contrast. Similarly, when recounting approaches to managing self-harm, a member of a community DTC contrasted the authoritarian approach of other community services they had received, with the more democratic approach of the DTC, "…one day centre would automatically ask me to leave...tablets won't be allowed in, the other day centre just takes them off me and that's it, but here I have to think about it, I'm responsible…" (C5, M). For members of community DTCs, the ability to draw contrasts between approaches to power depends on an individual's history with services (or, lack thereof). By contrast, members of a prison DTC must first apply for membership following initial placement in a mainstream prison, meaning every member of a prison DTC is able to draw comparisons back to the mainstream prison from which they came.

Everything-is-therapy

The DTCs operated within an overarching framework where everything that occurred within the DTC could be viewed as therapeutic, imbuing the therapeutic environment with a fluid quality. Four of the five community-based papers alluded to the "everything-is-therapy" nature of DTC work. For example, the process of completing everyday activities/chores (which may well take members beyond the physical premises of the DTC) were treated as events ripe for therapeutic review:

> We get into the shop. […] They pull out the list and all three immediately start arguing about where to begin…Despite the arguing, the clients did continue to

> work together. Once we returned to the TC, the shopping trip was discussed during the afternoon meeting and members were able to express what they found stressful or difficult. (C7, A)

The fluid nature of DTCs was also reflected in the importance of informal space, which provided an opportunity for members to reconcile challenging events from the day, "As interactions like crisis texts and community meetings were often emotive, smoking breaks were important for 'blowing off steam', as described by Evan…" (C10, A).

By contrast, the papers concerning prison DTCs made no reference to the fluid qualities described by the community DTC papers. However, when compared to their community counterparts, a prison-based DTC includes procedural security features that would impose strict control on individuals' movements (Leggett & Hirons, 2007), which may account for the absence of this specific feature in the narratives of prison-based DTC members.

Connecting with the group

Across all 10 papers, DTCs were positioned as an environment where members (and staff) felt "connected" (C10, M), or encouraged to "connect" (P1, A), with one another. A number of words/phrases were used to signal the existence of a connection between two (or more) people, including "strong community bonds" (P4, A), "friendship" (P3, M), "attachment" (C5, A; C9, A), "close relationships" (P4, A; P8, M), "supportive ties" (C6, A) and "belonging" (C5, A; C10 A).

Connecting with the group meant holding overt concern for the welfare of one's peers, and a motivation to help alleviate their suffering. Papers concerned with community DTCs commented on the "collective concern" between members (C5, M), "the attentiveness

of residents to each other" (C6, A), and of members being motivated to offer support "because they care" (C7, A). Similarly, papers concerning prison DTCs noted the importance of "caring for others" (P8, A), of having "empathy for others" (P3, A), and how DTCs are "about benefit to yourself and benefit to others" (P4, M). Collective concern was positioned as a persistent feature of the DTC experience that required long-term commitment, as illustrated by the following extracts, taken from a community DTC paper, and prison DTC paper, respectively, "Abby says that she could have only done that yesterday, disclose so much and talk it through in group, due to the 'community holding my hand over the past year'." (C10, A&M); "It took me quite a while I don't know how long it was in the end, over a year of twenty-one people telling me 'what!?!' 'that's not ok'." (P8, M). The latter quote illustrates the sometimes-challenging nature of collective concern, with the speaker indicating that feedback was not readily accepted to begin with. For both community and prison settings, collective concern frequently occurred in response to displays of distress and/or challenge, "Despite negative emotions, these interactions could facilitate opportunities for support and feelings of belonging." (C10, A). Thus, though an interaction itself may be unpleasant, collective concern and support can lead to a pleasant outcome.

Mutual negative experiences were frequently cited as being vital to establishing understanding between others. Connection through mutual negative experience was present in four of the community papers (C5; C6; C7 & C10), and five of the prison papers (P1; P2; P3, P4 & P8). For both community and prison settings, respectively, mutual negative experiences frequently related to similarities between members' trauma and/or mental health histories:

> I realized there were other men in there who had the same type of problem what I've had. I'm not unique in that way because Fred or John is telling me

> something "that happened to me that", the way he felt about that – I used to get that. (P8, M)

Connection could also be established through the shared experience of engaging in the challenging nature of DTC work, irrespective of what setting the DTC was in. For example, members might connect over their dislike for a particular therapeutic activity:

> …several clients at Powell did not like art therapy, which occurred once a week, and would frequently complain about it during break time rituals. The opportunity to openly complain was itself premised on a shared (negative) emotion, and further reinforced a sense of solidarity. (C10, A)

Prison DTCs had the added complexity of members relating to one another's offences. Connection through offence-related phenomena could be particularly challenging as it might prompt reflection on one's own offence history, "[I] struggle with hearing others I can link in [with]. Feel like they're talking about my past, my history, my offending. Constantly reminded of what I've done by listening to others. [It's] never easy." (P1, M). Another challenging aspect concerns when an individual would relate to the offence history of a fellow member, not as perpetrator, but as victim, "He explained that he had been sexually abused as a child and found it difficult to be in therapy with sex offenders." (P4, A). Despite the added complexity of relating to members' offence histories, it was felt that such a process could still result in beneficial outcomes, "The man came to agree that if he chose to do so, he would have the opportunity to communicate the ways in which victims can suffer and potentially gain an understanding of the reasons behind some sex offending." (P4, A).

Facilitating therapeutic engagement

This theme was present across three of the community papers (C5; C6 & C10), and five of the prison papers (P1; P2; P3, P4 & P8). The operational elements of a DTC, coupled with a sense of connection among the group, formed an environment that facilitated therapeutic engagement by allowing DTC members to take responsibility for their own well-being, and that of their fellow group members. For example, structure might encourage individual responsibility, "[…] it's giving me structure […] and instead of just being laid up 23 hours a day on the bed we are getting to be responsible for ourselves." (P3, M). A flattened hierarchy (with its emphasis on a shared distribution of power), paired with a sense of connection among the group (specifically, collective concern), encourages a "…collective therapeutic responsibility for other group members…" (C5, A). Collective concern could also encourage engagement through the desire to inspire others, "I want to improve so that they can see that there is hope for them as well." (C5, M); or through fear of being judged negatively for not engaging, "…another big thing was that people were worried about you…I think it helps you think again before you do anything, and also the fact that you've got to tell them." (C5, M).

Taking responsibility meant demonstrably engaging in therapeutic discussion with the group. A perceived lack of engagement could result in open challenge, "Tessa, states in a soft, reassuring voice, 'I would love more chances to talk with you'. She goes on to say about how Julie 'just sits in the lounge doing nothing. I really don't feel that is helpful'." (C7, A&M). Not only did non-engagement represent a lack of responsibility to themselves and to the group, it appeared to represent a threat to the perceived safety of the collective therapeutic environment, "Participants voiced their concerns that the fakers interrupted therapeutic progression for those with genuine aims." (P4, A). Engaging in therapeutic discussion meant that "…one is expected to expose one's past…" (P2, A) and, the act of doing so could leave an individual feeling vulnerable, "offloading emotional baggage leaves you feeling

childlike…afraid and scared" (P4, M). The therapeutic environment helped to facilitate vulnerability through fostering trust within the group. For example, displays of collective concern contributed to an environment where DTC members could trust that demonstrations of vulnerability would be actively supported by the group:

> Within the Faswell's small groups the attentiveness of residents to each other, as well as the concern residents would show each other, was clearly apparent from both the frequency with which residents would very often voluntarily disclose intimate details about themselves to the group, and the way in which group members would seek actively to respond to another's disclosures. (C6, A)

The act of "reciprocal self-disclosure" (C10, A) creates a mutual experience that connects group members, further enhancing the connection between them, "…it was the act of disclosing, rather than the specific character of the experience being disclosed that seemed to resonate with others and encourage further sharing." (C10, A). These mutual acts also reinforce the operational elements of the DTC by modelling the safety of boundaries (e.g. confidentiality), and by engendering a sense of equality within the group (as all members will have occupied the vulnerable position). Those who do not engage in self-disclosure remove themselves from the flattened hierarchy by refusing to enter the equal position of vulnerability, creating a sense of difference that also undermines the sense of connection among the group. Indeed, a DTC member commented, "How can I trust them if it's not equal?" (P4, M).

Discussion

I aimed to explore how the therapeutic environment of a DTC is experienced in both community and prison settings. Findings indicated that the experience of the DTC

environment was broadly similar for the two settings under review. For both settings, operational elements of a DTC contributed to a sense of safety, equality and responsibility among group members. The operational elements also reflected a general adherence to the DTC model, e.g. democratic decision-making and a flattened hierarchy have long been considered crucial (Jones, 1956; Rapoport, 1960). Whilst the participants in paper seven reported on elements that were indicative of a flattened hierarchy (e.g. shared responsibility and a sense of equality), the author drew on her observations of the DTC to suggest that power dynamics within DTCs may be better understood as being fluid, e.g. with greater tenure comes greater status. A shared sense of connection and collective concern were also prominent across the two settings, displaying clear overlap with CofC core standard nine (to share responsibility for the safety of one another), which itself would be supported by the operational element of safety through boundaries (Royal College of Psychiatrists, n.d.-b). A shared sense of connection was also cultivated through recognition of mutual negative experiences, be they historical (e.g. trauma and/or offence history), or in the present (e.g. mutual experience of the challenges associated with DTC membership). The operational elements of a DTC, coupled with a shared sense of connection, appeared to contribute to a DTC environment that facilitated therapeutic engagement by promoting responsibility, engendering trust, and supporting members to feel safe enough to allow their vulnerabilities to show. Reciprocal self-disclosure was a mutual experience that could further connect group members through mutual displays of vulnerability. Mutual displays of vulnerability reinforced the sense of equal distribution of power within the group, and modelled the continued safety provided by DTC boundaries (e.g. confidentiality), further enhancing the operational elements of the DTC. Figure two visually depicts the proposed relationship between themes.

[Figure two near here]

The presence of broadly similar experiences across DTC settings, despite existing reports of a conflict between the inherent need for security regulations within prison organisations, and the democratic decision-making processes that are a key component of the DTC approach (Lees et al., 1999), was surprising. Both Lees and colleagues, and I, compared prison DTCs with their counterparts in the community to contrast the extent to which the former could create an environment that engenders democracy. Whilst members of prison DTCs also drew comparisons to evaluate the democratic nature of the DTC environment within which they were located, their point of comparison was with mainstream prison services. By referring back to the hierarchical nature of the mainstream prison services from which the DTC members came, the prison DTC environment could still be experienced, and described, as a democratic one, despite the presence of security constraints that might limit members' influence over how the DTC functions (Leggett & Hirons, 2007). Just as members of a prison DTC had referred back to previous experiences of care (e.g. mainstream prisons) to evaluate their experience of the DTC environment, so did the community DTC members, who instead drew comparisons with previous experiences of mental health services.

A prominent feature of the synthesis was the development of a shared sense of connection, typified by a collective concern between DTC members. Baumeister and Leary's (1995) belongingness hypothesis posits that humans have an innate, pervasive motivation to form and maintain a degree of stable, positive, relationships. According to their hypothesis, four elements are required to satisfy one's sense of belongingness: (i) frequent interactions; (ii) that are stable over time; (iii) ideally, pleasant; and (iv) characterized by reciprocal concern. It has been proposed that cultivating, and harnessing, belongingness, are essential to the success of DTCs (Haigh, 2013). The findings of the thematic synthesis lend support to the

perspective that belongingness, as formulated by Baumeister and Leary, was a feature of the DTC experience, irrespective of DTC setting. The presence of frequent (element one), and stable (element two), interactions can be inferred from participants' lengthy membership periods to an intervention that inherently involves discussion between members. Participants' descriptions of collective concern and care show clear overlap with element four, reciprocal concern. Moreover, the atmosphere of collective concern ensured that whilst interactions between members may be challenging, they were experienced as supportive and in their best interests (i.e. element three). This resembles Clarke, Winship, Clarke and Manning's (2017) reflection that though compassion in DTCs can appear to be tough, acts of confrontation are done with a caring intent.

Whilst Baumeister and Leary note that shared negative experience can promote social bonding, they do not specify how this might relate to their proposed elements of belongingness. For the participants in the reviewed papers, recognition of mutual negative experience helped them to feel understood, and that they were not alone. The importance of shared lived-experience has also been underscored by clients in mental health services who have reported that experts-by-experience helped them to feel better understood (Paulson et al., 1999; Coatsworth-Puspoky, Forchuk, & Ward Griffin, 2006), and accepted (Sells, Davidson, Jewell, Falzer, & Rowe, 2006). In an experimental study that induced the experience of physical pain among strangers, Bastian, Jetten and Ferris (2014) found that shared experience of pain can act as a "social glue" between strangers, promoting bonding and co-operative behaviour. Consequently, mutual negative experience (e.g. historical trauma) appears to include a perception of understanding the hardships that another person has experienced, and of having one's hardships be understood by others, leading to co-operation between parties to alleviate recognized suffering. The mutual recognition of

hardship, and the incentive to co-operate with others to alleviate that hardship, most closely resembles the belongingness element of reciprocal concern.

Pearce and Pickard (2012) have proposed that there are at least two key components that underpin the effectiveness of TCs: the promotion of belongingness, and the promotion of responsible agency (the authors describe the latter as the capacity to reflect on one's behaviour, decide on a change, commit to that change, and to see that change through). Pearce and Pickard contend that belongingness promotes responsible agency via a boost to self-esteem. They argue that improvements to self-esteem increase an individual's belief that they are worthy of care, which then allows them to commit to making a change (i.e. responsible agency). Findings from this review offer a degree of support to these proposals. Not only was belongingness a prominent positive feature of the experience of the DTC environment (i.e. connecting with others), DTC members commented on how the operational elements of a DTC contributed to that belongingness. For example, DTC members described the importance of frequent interactions over an extended period of time in permitting them to recognize collective concern. The reciprocal concern that is apparent in belonging appeared to promote a sense of responsible agency by encouraging one to make demonstrable changes so that it might then inspire their peers; or because non-engagement could lead to challenge from respected peers. The importance of trust as a precondition for that engagement was also underscored by DTC members, such that an absence of trust would lead to a perception that the environment was unsafe and this would inhibit the motivation to display one's vulnerabilities during discussion. Self-esteem was not a feature of this review; however, the review was concerned with how the environment of a DTC is experienced, and how that might contribute to engagement, rather than the experience of engagement itself. See figure three for a visual depiction of the integration between thematic synthesis themes and Pearce and Pickard's proposals around belongingness, self-esteem and responsible agency.

[Figure three near here]

Clinical implications

None of the reviewed papers specified whether the DTCs under investigation had undergone CofC accreditation prior to study commencement. Nevertheless, experiences were broadly similar across all 10 papers, supporting the underlying idea behind CofC accreditation that different DTCs can, and do, share similar characteristics. Consistency was also inferred from the frequency of CofC core standards that were apparent across the papers, e.g. standard three (members are encouraged to form relationships with each other) and standard nine (shared responsibility for each other's safety) (Royal College of Psychiatrists, n.d.-b). Thus, it appears that a minimum standard of delivery can be achieved across the DTC landscape, without the need to implement a prescriptive treatment manual. To continue to ensure a consistent delivery of TC practice, new and existing TCs may find it helpful to audit their community against the CofC core standards, or to apply for formal accreditation.

The importance of connection through mutual negative experience in building a connection/belongingness, trust and safety was underscored by members of both community, and prison, DTCs. However, facilitators working in prison DTCs should be especially mindful of how members' offence histories might overlap with other members' trauma histories. Such a scenario could lead to a complex display of transference, and countertransference, where one member occupies the role of abuser, and another the role of abused. Both offenders and victims experience increased risk of shame following the occurrence of an offence (Andrews, Brewin, Rose, & Kirk, 2000; Feiring, Taska, & Lewis, 2002; Tangney, Stuewig, & Hafez, 2011), and this might be re-experienced in the DTC.

Shame can predict depressive symptoms, eating-related difficulties, post-traumatic stress disorder and self-injury (Cândea & Szentagotai, 2013). For offenders, specifically, shame has been linked to outcomes that are contrary to the public interest, e.g. recidivism (Tangney et al., 2011). Supporting a dialogue between the two parties, within the safe boundaries of the DTC, could resemble the restorative justice technique of victim-offender mediation (VOM). A review of three decades of VOM research concluded that the vast majority of persons who take part in VOM report the experience to be helpful, with the process often resulting in lower levels of offending (Umbreit, Coates, & Vos, 2004). For the individual in the abuser-position, the intention should be to move away from shame and instead foster constructive feelings of guilt through supportive reflection on the negative consequences of their behaviour (Tangney et al., 2011). The person in the abused position should be supported to feel empowered by taking an active role in the process, which should include sharing information around victimisation and receiving information about the offensive act (Choi, Green, & Kapp, 2010). DTCs that attempt to incorporate aspects of VOM may wish to revisit their agreed boundaries after such interactions, so that members can continue to feel safe and accepted.

It has been said that the challenging nature of the interpersonal work of DTCs can lead to feelings of failure, rejection, punishment, self-criticism and self-blame (Pearce & Pickard, 2012). That collective concern most frequently occurred in response to displays of distress and/or challenge suggests that connection/belongingness has an important part to play in buffering against these challenging emotions. Given the democratic nature of DTCs, it may prove helpful to have transparent discussions about the importance of belongingness, including regular check-ins with members' personal sense of connection/belongingness to the group. This would allow the group to actively monitor itself and to offer timely support that might boost belongingness for those that are feeling depleted.

Strengths, limitations and future research

To my knowledge, there are no qualitative syntheses pertaining to the experience of DTC membership, within the journal literature. Hence, the thematic synthesis has provided an essential summary of what is known about how the DTC environment is experienced in both community and prison settings. Moreover, by explicitly comparing and contrasting the experience of DTC membership across two fundamentally different settings, the review has begun to address what connects the relatively heterogeneous TC landscape. The review findings are useful for the development and maintenance of DTCs, whether in community or prison setting, in terms of identifying those factors that are important to creating a therapeutic environment that promotes engagement. The review has also added to the literature on belongingness by suggesting that mutual negative experience (e.g. historical trauma) appears to include a perception of understanding the hardships that another person has experienced, and of having one's hardships be understood by others, leading to reciprocal concern (or, co-operation) between parties.

Numerous limitations have been identified. The CASP tool was used, by me, to appraise the quality of the papers under review. The inclusion of a second CASP assessor would have allowed for comparisons of interrater agreement (Gisev, Pharm, Bell, & Chen, 2013), which may have increased the trustworthiness of the final CASP ratings. There was a paucity of qualitative research available for review. To gather as much data as possible, no restrictions were placed on year of publication; however, just 10 qualitative papers were identified and these were spread across a period of 31 years. By not imposing a limit on publication year, there is a risk that some of the reported experiences may not be relevant to contemporary DTCs. Another consequence of the broad search strategy was that little consensus existed among the research aims of the 10 papers (see table three). Therefore, the selection of illustrative quotes was more greatly influenced by how closely a paper's aims

overlapped with the stated aims of the review, rather than the relative quality of the paper itself. Despite attempts to disperse power among the DTC, facilitators remain an important part of how DTCs function; yet, their experiences were not included in the thematic synthesis. Future research may wish to consider how DTC facilitators experience the therapeutic environment of DTCs which, when considered alongside the present review, would provide a multi-stakeholder account on the experience of the DTC environment. Another limitation is that the experience of sustained therapeutic engagement, and the processes of change involved, have not been addressed. Future reviews may wish to specifically explore the experience of therapeutic engagement in both community and prison DTCs.

Conclusion

The aim of the thematic synthesis was to explore how the therapeutic environment of a DTC is experienced in both community and prison settings. Findings indicated that the experience of the DTC environment was broadly similar for both settings. Specifically, the operational elements of a DTC, coupled with a sense of connection/belongingness within the group, appeared to contribute to a DTC environment that facilitated therapeutic engagement by promoting responsibility, engendering trust, and supporting members to feel safe enough to allow their vulnerabilities to show.

Acknowledgements

This study did not require funding, nor did it require ethical approval.

Disclosure of interest

I report no conflict of interest.

References

Aiyegbusi, A., & Kelly, D. (2015). 'This is the pain I feel!' Projection and emotional pain in the nurse–patient relationship with people diagnosed with personality disorders in forensic and specialist personality disorder services: findings from a mixed methods study. *Psychoanalytic psychotherapy*, *29*(3), 276-294.

Akerman, G. (2019). Communal living as the agent of change. *The Wiley international handbook of correctional psychology*, 590-602.

Akerman, G., & Geraghty, K. A. (2016). An exploration of clients' experiences of group therapy. *Therapeutic Communities: The International Journal of Therapeutic Communities*.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.).

Andrews, B., Brewin, C. R., Rose, S., & Kirk, M. (2000). Predicting PTSD symptoms in victims of violent crime: The role of shame, anger, and childhood abuse. *Journal of abnormal psychology*, *109*(1), 69.

Atkins, S., Lewin, S., Smith, H., Engel, M., Fretheim, A., & Volmink, J. (2008). Conducting a meta-ethnography of qualitative literature: lessons learnt. *BMC medical research methodology*, *8*(1), 1-10.

Bach, B., & First, M. B. (2018). Application of the ICD-11 classification of personality disorders. *BMC psychiatry*, *18*(1), 1-14.

Barr, W., Kirkcaldy, A., Horne, A., Hodge, S., Hellin, K., & Göpfert, M. (2010). Quantitative findings from a mixed methods evaluation of once-weekly therapeutic community day

services for people with personality disorder. *Journal of Mental Health*, *19*(5), 412-421.

Bastian, B., Jetten, J., & Ferris, L. J. (2014). Pain as social glue: Shared pain increases cooperation. *Psychological science*, *25*(11), 2079-2085.

Baumeister, R. F., & Leary, M. R. (1995). The need to belong: desire for interpersonal attachments as a fundamental human motivation. *Psychological bulletin*, *117*(3), 497.

Britten, N., Campbell, R., Pope, C., Donovan, J., Morgan, M., & Pill, R. (2002). Using meta ethnography to synthesise qualitative research: a worked example. *Journal of health services research & policy*, *7*(4), 209-215.

Cândea, D., & Szentagotai, A. (2013). Shame and psychopathology: From research to clinical practice. *Journal of cognitive and behavioural psychotherapies*, *13*(1), 101-113.

Capone, G., Schroder, T., Clarke, S., & Braham, L. (2016). Outcomes of therapeutic community treatment for personality disorder. *Therapeutic Communities: The International Journal of Therapeutic Communities*.

Chiesa, M., Fonagy, P., Holmes, J., & Drahorad, C. (2004). Residential versus community treatment of personality disorders: a comparative study of three treatment programs. *American Journal of psychiatry*, *161*(8), 1463-1470.

Choi, J. J., Green, D. L., & Kapp, S. A. (2010). Victimization, victims' needs, and empowerment in victim offender mediation. *International Review of Victimology*, *17*(3), 267-290.

Clarke, J. M. (2017). The case for “fluid” hierarchies in therapeutic communities. *Therapeutic Communities: The International Journal of Therapeutic Communities*.

Clarke, J. M., & Waring, J. (2018). The transformative role of interaction rituals within therapeutic communities. *Sociology of health & illness*, *40*(8), 1277-1293.

Clarke, S., Winship, G., Clarke, J. and Manning, N. (2017). Therapeutic Communities. In M. Parker (Eds.), *Psychiatric and Mental Health Nursing: The Craft of Caring* (pp. 631-640). Routledge.

Coatsworth-Puspoky, R., Forchuk, C., & Ward-Griffin, C. (2006). Peer support relationships: An unexplored interpersonal process in mental health. *Journal of Psychiatric and Mental Health Nursing*.

Coid, J., Yang, M., Tyrer, P., Roberts, A., & Ullrich, S. (2006). Prevalence and correlates of personality disorder in Great Britain. *The British journal of psychiatry*, *188*(5), 423-431.

Cooke, A., Smith, D., & Booth, A. (2012). Beyond PICO: the SPIDER tool for qualitative evidence synthesis. *Qualitative health research*, *22*(10), 1435-1443.

Critical Appraisal Skills Programme. (2018). *CASP Qualitative Checklist.* https://casp-uk.net/wp-content/uploads/2018/01/CASP-Qualitative-Checklist-2018.pdf

Dale, O., Sethi, F., Stanton, C., Evans, S., Barnicot, K., Sedgwick, R., Goldsack, S., Doran, M., Shoolbred, L., Samele, C., Urquia, N., Haigh, R., & Moran, P. (2017). Personality disorder services in England: findings from a national survey. *BJPsych bulletin*, *41*(5), 247-253.

Dietz, E. F., O'Connell, D. J., & Scarpitti, F. R. (2003). Therapeutic communities and prison management: An examination of the effects of operating an in-prison therapeutic community on levels of institutional disorder. *International journal of offender therapy and comparative criminology*, *47*(2), 210-223.

Dolan, R. (2017). HMP Grendon therapeutic community: the residents' perspective of the process of change. *Therapeutic Communities: The International Journal of Therapeutic Communities*.

Feiring, C., Taska, L., & Lewis, M. (2002). Adjustment following sexual abuse discovery: The role of shame and attributional style. *Developmental psychology*, *38*(1), 79.

Gisev, N., Bell, J. S., & Chen, T. F. (2013). Interrater agreement and interrater reliability: key concepts, approaches, and applications. *Research in Social and Administrative Pharmacy*, *9*(3), 330-338.

Haigh, R. (2013). The quintessence of a therapeutic environment. *Therapeutic Communities: The International Journal of Therapeutic Communities*.

Hodge, S., Barr, W., Göpfert, M., Hellin, K., Horne, A., & Kirkcaldy, A. (2010). Qualitative findings from a mixed methods evaluation of once-weekly therapeutic community day services for people with personality disorder. *Journal of Mental Health*, *19*(1), 43-51.

World Health Organization. (2019). *International statistical classification of diseases and related health problems* (11th ed.). https://icd.who.int/

Jones, M. (1956). The concept of a therapeutic community. *American Journal of Psychiatry*, *112*(8), 647-650.

Lees, J., Manning, N., & Rawlings, B. (1999). *Therapeutic community effectiveness: A systematic international review of therapeutic community treatment for people with personality disorders and mentally disordered offenders*. NHS Centre for Reviews and Dissemination, University of York.

Leggett, K., & Hirons, B. (2007). Security and Dynamic Security in a Therapeutic Community Prison. In M. Parker (Eds.), *Dynamic Security: the Democratic therapeutic Community in Prison* (pp. 232-241). Jessica Kingsley Publishers.

Lord, A. J., Field, S., & Smith, I. C. (2017). The experiences of staff who support people with intellectual disability on issues about death, dying and bereavement: a metasynthesis. *Journal of Applied Research in Intellectual Disabilities*, *30*(6), 1007-1021.

Magor-Blatch, L., Bhullar, N., Thomson, B., & Thorsteinsson, E. (2014). A systematic review of studies examining effectiveness of therapeutic communities. *Therapeutic Communities: The International Journal of Therapeutic Communities*.

Malivert, M., Fatséas, M., Denis, C., Langlois, E., & Auriacombe, M. (2012). Effectiveness of therapeutic communities: a systematic review. *European addiction research*, *18*(1), 1-11.

McKeganey, N. P., & Bloor, M. J. (1987). Teamwork, information control and therapeutic effectiveness: a tale of two therapeutic communities. *Sociology of health & illness*, *9*(2), 154-178.

Miller, S., Sees, C., & Brown, J. (2006). Key aspects of psychological change in residents of a prison therapeutic community: A focus group approach. *The Howard Journal of Criminal Justice*, *45*(2), 116-128.

Murphy, E., Dingwall, R., Greatbatch, D., Parker, S., & Watson, P. (1998). Qualitative research methods in health technology assessment: a review of the literature. *Health technology assessment*, *2*(16), 1-275.

National Institute for Mental Health in England. (2003). *Personality disorder: No longer a diagnosis of exclusion.* National Health Service. http://personalitydisorder.org.uk/wp-content/uploads/2015/04/PD-No-longer-a-diagnosis-of-exclusion.pdf

Paulson, R., Herinckx, H., Demmler, J., Clarke, G., Cutler, D., & Birecree, E. (1999). Comparing practice patterns of consumer and non-consumer mental health service providers. *Community mental health journal*, *35*(3), 251-269.

Pearce, S., & Autrique, A. (2010). On the need for randomized trials of therapeutic community approaches. *Therapeutic Communities*, *31*(4), 338-355.

Pearce, S., & Haigh, R. (2017). *The theory and practice of democratic therapeutic community treatment*. Jessica Kingsley Publishers.

Pearce, S., & Pickard, H. (2012). How therapeutic communities work: Specific factors related to positive outcome. *International Journal of Social Psychiatry*, *59*(7), 636-645.

Pearce, S., Scott, L., Attwood, G., Saunders, K., Dean, M., De Ridder, R., Galea, D., Konstantinidou, H., & Crawford, M. (2017). Democratic therapeutic community treatment for personality disorder: randomized controlled trial. *The British Journal of Psychiatry*, *210*(2), 149-156.

Pocnet, C., Antonietti, J. P., Handschin, P., Massoudi, K., & Rossier, J. (2018). The many faces of personality: The DSM-5 dimensional and categorical models and the five-factor model. *Personality and Individual Differences*, *121*, 11-18.

Rapoport, R. N. (1960). Community as Doctor. London. *Tavistock Publications*, *92*, 143.

Roberts, J. (1997). How to recognize a therapeutic community. *Prison Service Journal*, 4-7.

Sells, D., Davidson, L., Jewell, C., Falzer, P., & Rowe, M. (2006). The treatment relationship in peer-based and regular case management for clients with severe mental illness. *Psychiatric services*, *57*(8), 1179-1184.

Ross, G. E., & Auty, J. M. (2018). The experience of change in a prison therapeutic community: An interpretative phenomenological analysis. *Therapeutic Communities: The International Journal of Therapeutic Communities*.

Royal College of Psychiatrists. (n.d.-a). *Community of Communities Member Directory 2019-2020* [Brochure]. https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/quality-networks/therapeutic-communities-c-of-c/cofc-member-directory-2019-2020--pdf.pdf?sfvrsn=d3196af7_4

Royal College of Psychiatrists. (n.d.-b). *Community of Communities Process Document 2019-2020* [Brochure]. https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/quality-networks/therapeutic-communities-c-of-c/cofc-process-document-2019-2020.pdf?sfvrsn=77daf685_4

Tangney, J. P., Stuewig, J., & Hafez, L. (2011). Shame, guilt, and remorse: Implications for offender populations. *Journal of Forensic Psychiatry & Psychology*, *22*(5), 706-723.

Thomas, J., & Harden, A. (2008). Methods for the thematic synthesis of qualitative research in systematic reviews. *BMC medical research methodology*, *8*(1), 1-10.

Tong, A., Flemming, K., McInnes, E., Oliver, S., & Craig, J. (2012). Enhancing transparency in reporting the synthesis of qualitative research: ENTREQ. *BMC medical research methodology*, *12*(1), 1-8.

Umbreit, M. S., Coates, R. B., & Vos, B. (2004). Victim-offender mediation: Three decades of practice and research. *Conflict Resolution Quarterly*, *22*(1-2), 279-303.

Vanderplasschen, W., Colpaert, K., Autrique, M., Rapp, R. C., Pearce, S., Broekaert, E., & Vandevelde, S. (2013). Therapeutic communities for addictions: a review of their effectiveness from a recovery-oriented perspective. *The Scientific World Journal*, *2013*.

Vanderplasschen, W., Vandevelde, S., & Broekaert, E. (2014). *Therapeutic communities for treating addictions in Europe. Evidence, current practices and future challenges*. European Monitoring Centre for Drugs and Drug Addiction.

Waldram, J. B., & Wong, S. (1995). Group therapy of Aboriginal offenders in a Canadian forensic psychiatric facility. *American Indian and Alaska Native Mental Health Research*, *6*(2), 34-56.

Walsh, D., & Downe, S. (2005). Meta-synthesis method for qualitative research: a literature review. *Journal of advanced nursing*, *50*(2), 204-211.

Table 1

Free-Text Search Terms Utilized in the Systematic Literature Search Strategy

SPIDER heading	Search domain	Free-text search terms
S – sample	Adults with a diagnosis of personality disorder	"personality disorder"
PI – phenomena of interest	Democratic therapeutic communities	"therapeutic communit*" or "milieu therapy" or "therapeutic milieu"
D – design	Qualitative research	qualitative* OR interview* OR "focus group*" OR Phenomeno* OR IPA OR "interpretative phenomenological" OR "case stud*" OR observ* OR "grounded theory" OR narrative OR thematic OR theme OR themes OR experienc* OR "content analysis" OR ethnolog* OR "conversation analysis" OR views OR attitude* OR Percept*

Table 2

Quality Appraisal of Studies Included in the Thematic Synthesis

CASP checklist item	Study number									
	1	2	3	4	5	6	7	8	9	10
Research setting (Community [C], or Prison [P])	P	P	P	P	C	C	C	P	C	C
Was there a clear statement of the aims of the research? (Y/N)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Is a qualitative methodology appropriate? (Y/N)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Was the research design appropriate to address the aims of the research? (1-3)	3	2	2	3	2	2	2	3	2	3
Was the recruitment strategy appropriate to the aims of the research? (1-3)	1	2	3	3	3	2	2	3	3	2
Was the data collected in a way that addressed the research issue? (1-3)	2	1	3	3	2	1	2	3	2	2
Has the relationship between researcher and participants been adequately considered? (1-3)	1	2	1	2	2	2	1	2	1	1
Have ethical issues been taken into consideration? (1-3)	3	1	3	1	2	1	2	2	2	2
Was the data analysis sufficiently rigorous? (1-3)	1	1	2	2	2	1	2	2	2	3
Is there a clear statement of findings? (1-3)	2	2	2	3	3	2	2	3	2	3
How valuable is the research? (1-3)	2	2	3	2	2	1	2	2	2	3
Total CASP score (out of 24)	15	13	19	19	18	12	15	20	16	19

Note. Papers rated for each CASP item as either weak (1), moderate (2), or strong (3).

Table 3

Key Characteristics of Reviewed Studies

Study Number	Author & year of publication	Research aim(s)	Sample description	Data collection strategy	Method of data analysis	Country
1	Akerman & Geraghty (2016)	To explore how residents within a prison-based TC cope with the material that they are exposed to during membership.	10 adult offenders, residing at HMP Grendon.	One focus group facilitated by two therapists from the prison wing (one of whom was the primary author).	Thematic analysis, conducted at the semantic level.	England.
2	Waldram & Wong (1995)	To assess the effects of culture on treatment for Aboriginal offenders.	Over the 5-week research period, the number of Aboriginal offenders fluctuated between 7-9.	Observations of large group therapy meetings, and repeated semi-structured interviews with individual offenders.	Not stated.	Canada.
3	Dolan (2017)	To identify the factors that contribute to change at HMP Grendon TC from the perspective of the residents. Specifically, what aspects are perceived as the most important and why?	65 adult offenders total, 36 of whom took part in the qualitative arm of the study.	Mixed methods: Questionnaires, followed by Qualitative Interviews.	Framework analysis.	England.

Study Number	Author & year of publication	Research aim(s)	Sample description	Data collection strategy	Method of data analysis	Country
4	Miller, Sees & Brown (2006)	What are key components and significant events of therapeutic change, as experienced by TC members?	27 adult offenders.	Four focus groups.	A two-stage process: (1) "mechanical" organising of data into themes; and (2) "interpretative" coding of the segments and identification of patterns between and within those codes	England.
5	Hodge et al., (2010)	To examine service users' experiences of being a member of a one-day TC.	23 service users, 8 former service users, 4 service user consultants, 7 staff and 9 referrers.	Semi-structured interviews, conducted twice (where possible), with the second approx. 12-months after the first.	Thematic analysis.	England.
6	McKeganey & Bloor (1987)	To map differences in the extent, and occurrence, of therapeutic work between a residential TC in England, and a day TC in Scotland.	Data collected over a 3-month period at the residential TC, at which time there were 18 residents. Data collected over a 4-month	Participant observation, unstructured interviews and audio recording.	Not stated, though the authors described implementing member checking to establish "consensual agreements".	England and Scotland.

Study Number	Author & year of publication	Research aim(s)	Sample description	Data collection strategy	Method of data analysis	Country
			period at day TC, at which time there were approximately 30 patients.			
7	Clarke (2017)	To explore how TC client members negotiate and enforce community expectations (through an analysis of power within everyday interactions outside of structured therapy).	Research conducted at 2 DTCs across a period of 12 months. Exact number of participants not specified.	Narrative ethnography approach, consisting of 746 hours of participant observation, 21 narrative interviews with clients and 7 semi-structured interviews.	Thematic analysis.	England.
8	Ross & Auty (2018)	To explore the experience of making psychological changes from the perspective of TC graduates.	5 adult offenders at HMP Gartree who had completed their TC treatment.	Semi-structured interviews.	Interpretative phenomenological analysis.	England.
9	Aiyegbusi & Kelly (2015)	To establish nurse and resident experiences of the nurse-patient relationship in TC and secure mental health settings.	12 nurses (Delphi study); 13 nurses (interview only); and 12 in-patients (focus group only).	Sequential mixed method study, integrating quantitative Delphi study data with qualitative interviews and focus groups.	Framework analysis.	England.
10	Clarke & Waring (2018)	To explore how negative emotions in situations outside of formal therapy	Research conducted at 2 DTCs across a	Narrative ethnography approach, consisting of 746 hours of participant	Thematic analysis.	England.

Study Number	Author & year of publication	Research aim(s)	Sample description	Data collection strategy	Method of data analysis	Country
		can be transformed into positive emotions and facilitate personal changes.	period of 12 months. Exact number of participants not specified.	observation, 21 narrative interviews with clients and 7 semi-structured interviews.		

Figure 1

Flow Chart Depicting the Systematic Search Process

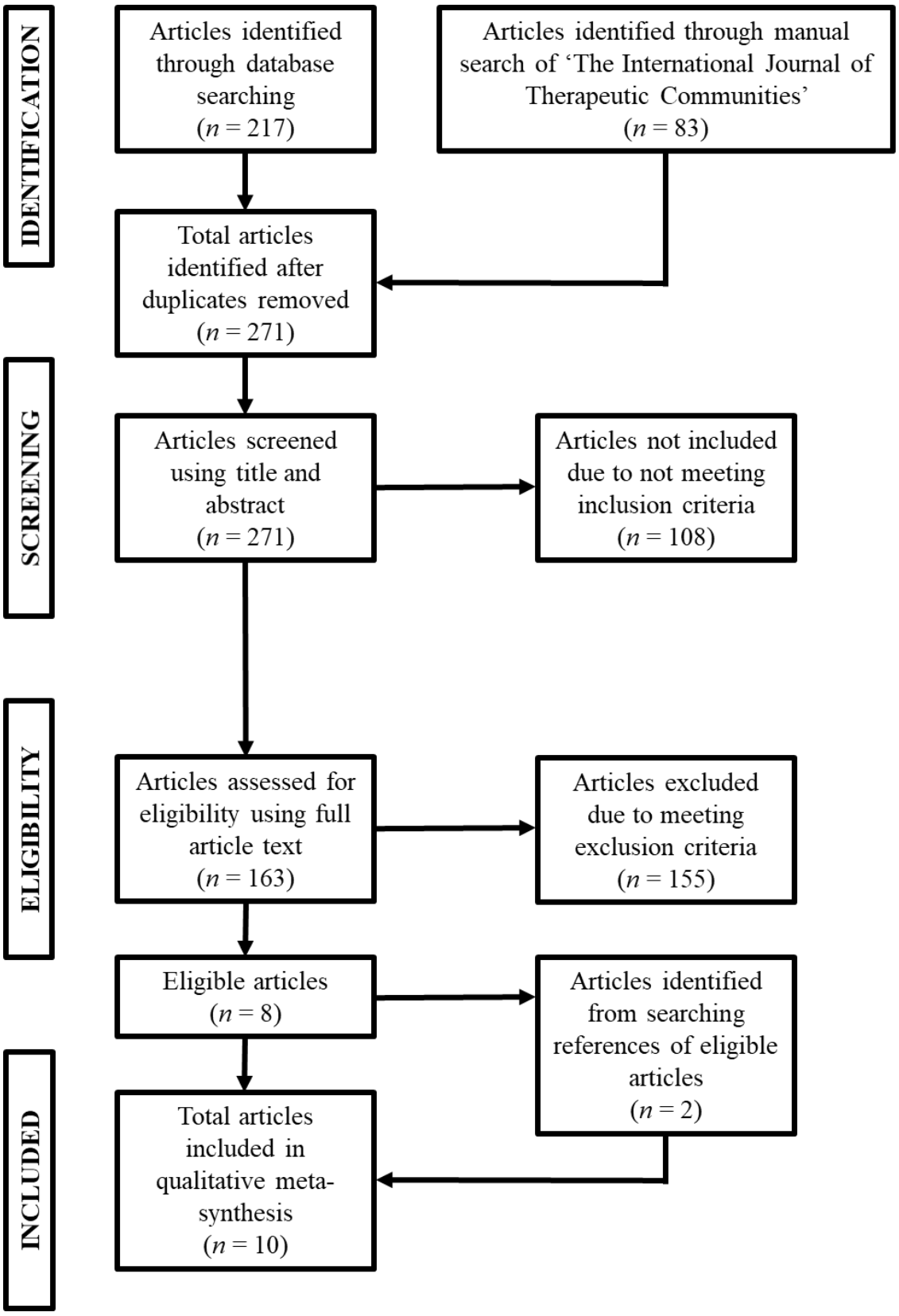


Figure 2

Relationship Between Thematic Synthesis Themes

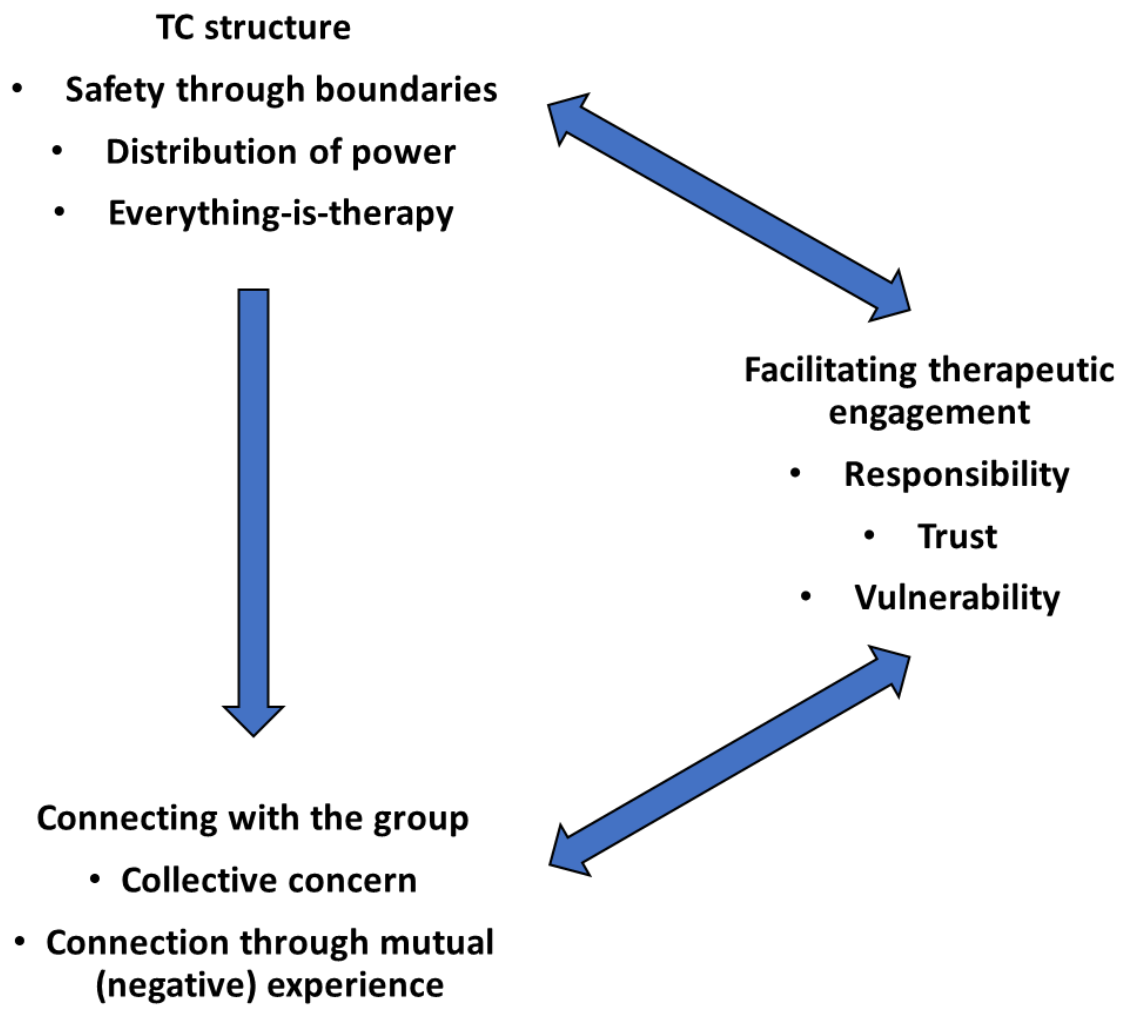
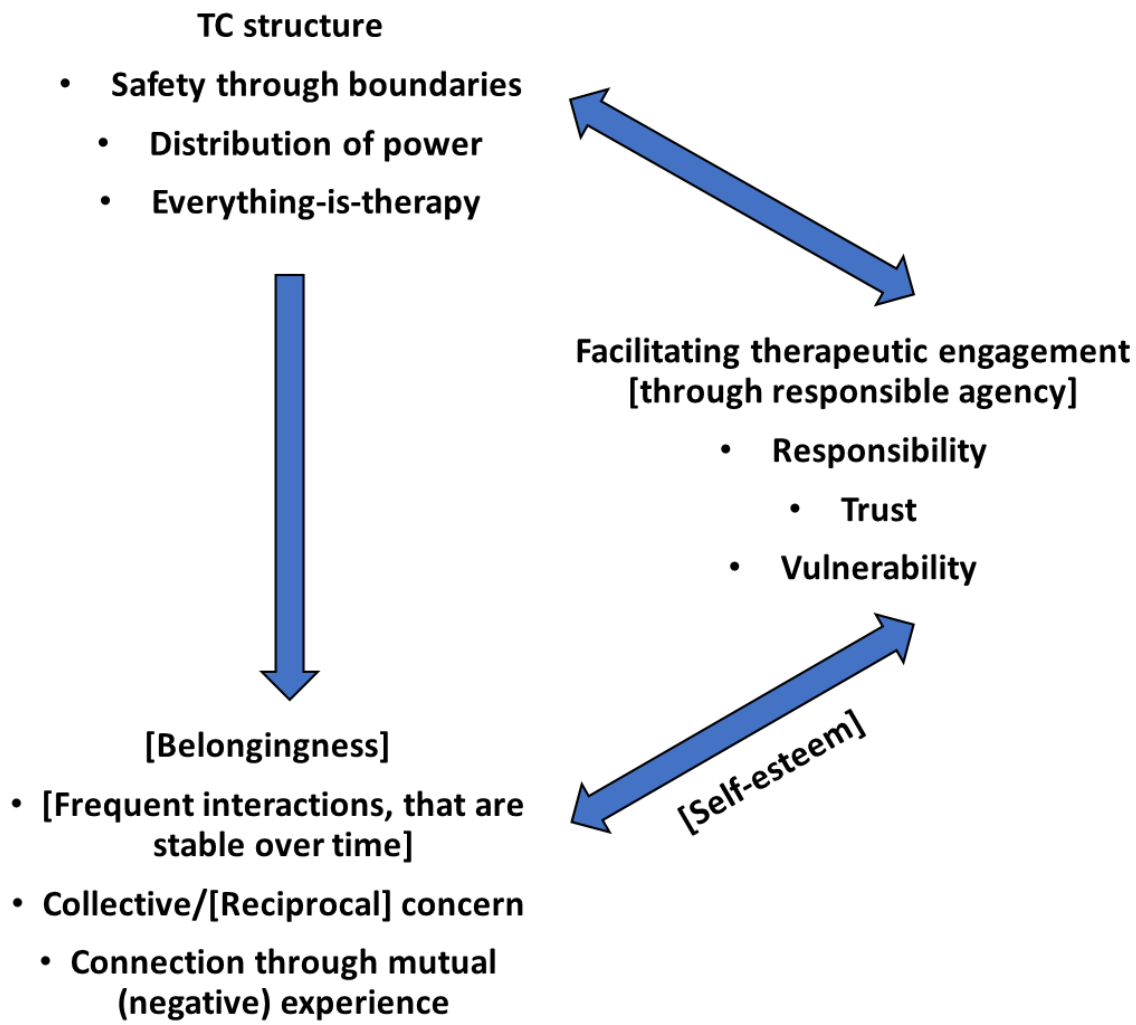


Figure 3

Integrating Thematic Synthesis Themes with Pearce and Pickard's Proposals (2012)



Note. Pearce and Pickard's (2012) proposals are included in square brackets, to help differentiate from the thematic synthesis themes

Appendices

Appendix A

Community of communities' core standards

	Core Standards
CS1	There is a clear Therapeutic Community model of practice that is consistently applied across the service
CS2	Community Members are aware of the expectations of Community Membership
CS3	Community Members are encouraged to form a relationship with the Community and with each other as a significant part of Community life
CS4	Community Members work together to review, set and maintain Community rules and boundaries
CS5	There is a structured timetable of activities that reflects the needs of Community Members
CS6	All behaviour and emotional expression are open to discussion within the Community
CS7	Community Members take part in the day to day running of the community
CS8	Everything that happens in the Community is treated as a learning opportunity
CS9	Community Members share responsibility for the emotional and physical safety of each other
CS10	Community Members are active in the personal development of each other

*table taken verbatim from Community of Communities Process Document 2019-2020

Appendix B

Enhancing transparency in reporting the synthesis of qualitative research: the ENTREQ statement

No	Item	Guide and description	Location in paper
1.	Aim	State the research question the synthesis addresses.	Pg. 5
2.	Synthesis methodology	Identify the synthesis methodology or theoretical framework which underpins the synthesis and describe the rationale for choice of methodology (e.g. meta-ethnography, thematic synthesis, critical interpretive synthesis, grounded theory synthesis, realist synthesis, meta-aggregation, meta-study, framework synthesis).	Pg. 11
3.	Approach to searching	Indicate whether the search was pre-planned (comprehensive search strategies to seek all available studies) or iterative (to seek all available concepts until they theoretical saturation is achieved).	Pg. 6
4.	Inclusion criteria	Specify the inclusion/exclusion criteria (e.g. in terms of population, language, year limits, type of publication, study type).	Pg. 8-9
5.	Data sources	Describe the information sources used (e.g. electronic databases (MEDLINE, EMBASE, CINAHL, psycINFO, Econlit), grey literature databases (digital thesis, policy reports), relevant organisational websites, experts, information specialists, generic web searches (Google Scholar) hand searching, reference lists) and when the searches conducted; provide the rationale for using the data sources.	Pg. 6
6.	Electronic search strategy	Describe the literature search (e.g. provide electronic search strategies with population terms, clinical or health topic terms, experiential or social phenomena related terms, filters for qualitative research, and search limits).	Pg. 6-7
7.	Study screening methods	Describe the process of study screening and sifting (e.g. title, abstract and full text review, number of independent reviewers who screened studies).	Pg. 8
8.	Study characteristics	Present the characteristics of the included studies (e.g. year of publication, country, population, number of participants, data collection, methodology, analysis, research questions).	Pg. 11-12 & Pg. 39-42
9.	Study selection results	Identify the number of studies screened and provide reasons for study exclusion (e.g., for comprehensive searching, provide numbers of studies screened and reasons for exclusion indicated in a figure/flowchart; for iterative searching describe reasons for study exclusion and inclusion based on modifications to the research question and/or contribution to theory development).	Pg. 6-9 & Pg. 43

No	Item	Guide and description	Location in paper
10.	Rationale for appraisal	Describe the rationale and approach used to appraise the included studies or selected findings (e.g. assessment of conduct (validity and robustness), assessment of reporting (transparency), assessment of content and utility of the findings).	Pg. 10 & Pg. 38
11.	Appraisal items	State the tools, frameworks and criteria used to appraise the studies or selected findings (e.g. Existing tools: CASP, QARI, COREQ, Mays and Pope [25]; reviewer developed tools; describe the domains assessed: research team, study design, data analysis and interpretations, reporting).	Pg. 10 & Pg. 38
12.	Appraisal process	Indicate whether the appraisal was conducted independently by more than one reviewer and if consensus was required.	Pg. 10
13.	Appraisal results	Present results of the quality assessment and indicate which articles, if any, were weighted/excluded based on the assessment and give the rationale.	Pg. 10 & Pg. 38
14.	Data extraction	Indicate which sections of the primary studies were analysed and how were the data extracted from the primary studies? (e.g. all text under the headings “results /conclusions” were extracted electronically and entered into a computer software).	Pg. 11
15.	Software	State the computer software used, if any.	Pg. 11
16.	Number of reviewers	Identify who was involved in coding and analysis.	Pg. 11
17.	Coding	Describe the process for coding of data (e.g. line by line coding to search for concepts).	Pg. 11
18.	Study comparison	Describe how were comparisons made within and across studies (e.g. subsequent studies were coded into pre-existing concepts, and new concepts were created when deemed necessary).	Pg. 11
19.	Derivation of themes	Explain whether the process of deriving the themes or constructs was inductive or deductive.	Pg. 11
20.	Quotations	Provide quotations from the primary studies to illustrate themes/constructs and identify whether the quotations were participant quotations or the author’s interpretation.	Pg. 13-20
21.	Synthesis output	Present rich, compelling and useful results that go beyond a summary of the primary studies (e.g. new interpretation, models of evidence, conceptual models, analytical framework, development of a new theory or construct).	Pg. 21-28

Appendix C

Thematic grid charting the progression from paper-specific concepts, to analytic themes

Concepts / Codes	Descriptive themes	Analytic themes
Treating others with respect; Ground rules; Absences; Refraining from self-harm; Community values; Safe environment	Boundaries: boundaries helped the community to feel safe and clearly indicated what was expected of each other.	Operational elements of a democratic therapeutic community: a sense of safety, and equality, was created through democratic decision-making – including democratically-agreed boundaries – and a flattened hierarchy. For community-based environments, fluid working meant that everything within the community could be considered therapeutic.
Power dynamics; Group votes; Jobs & Responsibilities; Open communication; Relationships with others	Democratic working: members were included in how the community operates and were supported to feel equal to the staff/each other.	
Informal time; Carry over of conversations; Activities; Different types of meetings; Mealtimes; Smoking breaks	Informal working: essential therapeutic work often took place outside of formal meetings.	
Reciprocal self-disclosure; Similar life experiences; Shared experiences; Seeing oneself in others; Feeling understood; Not feeling alone/different	Connecting with others: community members felt connected to, and understood by, one another.	Connecting with the group: a therapeutic environment typified by strong bonds and collective concern. Community members (including staff) felt connected with one another, and understood, often through mutual life experiences, or through mutual engagement in the community.
Collective concern; Collective care; Attentiveness; Working together; Encouragement; Validation; Non-judgemental; Friendships	Collective care: a tangible sense of care for one another within the group. Often, this included supporting one another's progress.	
Responsibility for actions; Accountability to others; Commitment; Motivation to change; Asserting needs; Setting an example	Responsibility: taking responsibility for one's actions, and for improving one's situation. Holding a responsibility to the community.	Facilitating therapeutic engagement: the therapeutic environment facilitated engagement by promoting responsibility for oneself and to the community. Responsibility was demonstrated by engaging in community discussions, which required speakers to be vulnerable. The therapeutic environment helped to facilitate vulnerability through fostering trust within the group.
Trust; Solidarity; Safety; Inclusivity; Sharing information; Trust takes time; Mistrust of others	Trust: feeling safe that others would not judge or degrade them. Trust took time to build and members could start from a position of mistrust	
Feeling exposed; Letting yourself go; Facing reality; Learning to share; Talking openly; Feedback; Offloading emotions	Vulnerability: the capacity to be vulnerable through self-disclosure, and receipt of feedback.	

Note. Concepts/Codes column represents indicative examples from the dataset, rather than all possible concepts/codes pertaining to a particular descriptive theme.

Appendix D

Journal of Mental Health notes for contributors

Preparing Your Paper

Review article

- Should be written with the following elements in the following order: Title page (to be uploaded separately and must not appear on the Main Document); Abstract (Background, Aims, Methods, Results, Conclusions); Keywords; Main text introduction; Materials and methods; Results; Discussion; Acknowledgments; Declaration of interest statement; References (in the correct format); Appendices (where appropriate - to be uploaded separately); Table(s) and caption(s) (on individual pages) - to be uploaded separately; Figures and figure captions (as a list) - to be uploaded separately.
- Should be no more than 6000 (excluding abstracts, tables and references) words
- Should contain an unstructured abstract of 200 words.
- Should contain between 3 and 7 keywords. Read making your article more discoverable, including information on choosing a title and search engine optimization.
- When submitting a Review, please confirm that your manuscript is a systematic review and include a statement that researchers have followed the PRISMA guidance – if this is not the case, please say why.
- Please confirm whether the review protocol has been published on Prospero and provide a date of registration – if this is not the case, please say why.
- Manuscripts are limited to a maximum of 4 tables and 2 figures to be uploaded separately – please advise where in your manuscript these are to be located.
- Please ensure that author details are not on the Main Document.
- Please ensure that author details are not included in the file name.

- Participants: language must be in the style of the APA. Our policy therefore is to refer to study participants as opposed to patients or subjects.
- Please note we do not accept pdfs. Please save your documents in the .doc format. in the .doc format.

Style Guidelines

Please refer to these quick style guidelines [found at: Taylor & Francis manuscript layout guide | Author services (taylorandfrancis.com)] when preparing your paper, rather than any published articles or a sample copy.

Any spelling style is acceptable so long as it is consistent within the manuscript.

Please use double quotation marks, except where "a quotation is 'within' a quotation".

Please note that long quotations should be indented without quotation marks.

Formatting and Templates

Papers may be submitted in Word format. Figures should be saved separately from the text. To assist you in preparing your paper, we provide formatting template(s).

References

Please use this reference guide when preparing your paper [link to APA referencing guide]. An EndNote output style is also available to assist you.

Chapter 2 Democratic therapeutic communities and the experience of belongingness: a qualitative exploration

Background: Democratic therapeutic communities (DTCs) are a group intervention, primarily offered to persons in receipt of a personality disorder diagnosis. Within DTCs, belongingness is thought to be an essential driver of therapeutic change. This research sought to explore how belongingness is experienced at the time of DTC membership; and, what happens to one's sense of belongingness, following discharge. Methods: Individual semi-structured interviews were completed with seven former DTC members. Interview transcripts were analysed using thematic analysis. Results: Four analytic themes were developed: (i) belonging and trust; (ii) spectrum of connection; (iii) being yourself; and (iv) ensuring belonging after membership. Conclusions: Findings indicated that belongingness is a persistent feature of the DTC journey, beginning with an initial stage based on recognition of shared suffering before progressing to a second, deeper stage, predicated on joint participation in the therapeutic process. Former DTC members can sustain a sense belonging to DTCs by maintaining friendships from their respective DTC, revisiting cherished memories, retaining mementos and/or via occupation/study within the field of DTCs, or mental health.

Keywords: therapeutic communities; personality disorder; belongingness; self-concept; self-esteem.

Therapeutic communities (TCs) have been defined as 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" (Roberts, 1997, p. 4). That is, the group itself is considered to be the primary driver behind beneficial outcomes for TC members (Magor-Blatch, Bhullar, Thomson, & Thorsteinsson, 2014). Historically, democratic therapeutic

communities (DTCs) have been the dominant model of TC in the United Kingdom (UK) (Lees, Manning, & Rawlings, 1999). DTCs primarily offer support for difficulties relating to personality disorders, drawing on psychoanalytic theory, within an environment that emphasizes democracy between group members and staff (Akerman, 2019).

The evidence base for DTCs can be described as modest but encouraging. A meta-analysis concerning the effectiveness of DTCs indicated a positive effect, with an odds-ratio of 0.695, and an upper 95% confidence interval of 0.769 (Lees et al., 1999). DTCs have been demonstrated to: be cost-effective (Davies, Campling, & Ryan, 1999); lead to significantly better outcomes than a general psychiatric group (Chiesa, Fonagy Holmes, & Drahorad, 2004); significantly improve mental health and social functioning (Barr et al., 2010); significantly improve scores on measures of violence risk, and psychological symptoms (Wilson, Freestone, Taylor, Blazey, & Hardman, 2014); and lead to improvements at 24-month follow-up on measures of aggression, self-harm and satisfaction with care, when compared to treatment as usual (Pearce et al., 2017). Nevertheless, some have argued that the method requires more clarity (Veale, Gilbert, Wheatley, & Naismith, 2015).

An enduring description of the workings of a TC described four key elements – democratisation, permissiveness, reality confrontation and communalism (Rapoport, 1960). Though Rapoport's themes remain well-cited, Haigh (2013) argues that to apply them to modern TCs – which bear little resemblance to traditional services – would be "tokenistic". Pearce and Haigh (2017) contend that there are four specific processes through which change occurs in DTCs: belongingness; social learning; responsible agency; and, the development of narrative. Of these drivers, Haigh (2013) asserts that belongingness is leveraged first (i.e. at the point of induction), to support the early development of secure attachments.

Baumeister and Leary (1995) formulated belongingness[2] as "the combination of frequent interaction plus persistent caring" (1995, p.497). The authors proposed that the motivation to belong is innate, fundamental and pervasive. They continued that belongingness requires four elements: (1) frequent interactions; (2) that are, ideally, pleasant; (3) involving relationships that are characterized by both reciprocal concern; and, (4) stability over time (table 1 depicts how the DTC model promotes these four elements). One's sense of belonging has been linked to the development of one's identity and sense of self (Friedman, 2007). A high sense of belonging can predict happiness (Leung, Kier, Fung, Fung, & Sproule, 2013) and has been associated with fewer physical health problems (Begen & Turner-Cobb, 2012). A low sense of belonging has been linked to an increased likelihood of suicidal thoughts / history of suicide attempts (Hatcher & Stubbersfield, 2013); an increased risk of symptoms consistent with depression (Hagerty & Williams, 1999; Cockshaw, Schochet, & Obst, 2013); and threats to self-esteem (Leary, Cottrell, & Phillips, 2001; Knowles, Lucas, Molden, Gardner, & Dean, 2010).

Reflecting on DTCs, Pearce and Pickard (2012) have proposed that belongingness improves self-esteem, which allows an individual to begin to believe that they are worthy of care, leading to motivation to take the effortful steps towards change (i.e. responsible agency). The need to seek/maintain a sense of belonging can encourage change in and of itself, via conformity to democratically agreed boundaries (Veale et al., 2015). Boundaries are strictly adhered to as part of the DTC model; whilst violations of those boundaries are expected to be explored within the group and, where necessary, assigned a democratically agreed consequence (Pearce & Haigh, 2017). Pearce and Pickard (2012) mused that the threat

[2] Baumeister and Leary use the terms belongingness, and belonging, interchangeably. This thesis follows their precedent by applying the two terms interchangeably.

of consequences comes with plausible risks for DTC members: (i) of feeling like they have failed to meet expectations; (ii) of feeling rejected/punished; and (iii) as a consequence of the former two points, a risk of self-criticism, self-blame and loss of hope. Nevertheless, the authors concluded that such risks are unlikely as belongingness facilitates an environment of compassion, which serves to mitigate the risks associated with consequences.

Meanwhile, some have accused DTC practice of unhelpfully drawing on belonging, noting how social conformity can be encouraged to deleterious ends (Veale et al., 2015). Pearce and Haigh (2017) acknowledged that a DTC member may conform to group norms without insight as to why a given behaviour might be deemed problematic. Pearce and Pickard (2012) contend that individual agency is always maintained as membership status is voluntary; yet, this ignores the likelihood that one's membership status is itself open to influence by the need to belong. DTCs primarily work with persons who have received a diagnosis of personality disorder, some of whom are thought to be particularly sensitive to feelings of both "thwarted belongingness" (i.e. a sense of alienation) (Silva, Ribeiro, & Joiner, 2015), and social rejection (Dixon-Gordon, Gratz, Breetz, & Tull, 2013).

Though the DTC method explicitly aims to cultivate a sense of belonging between community members, advocates for the TC method have called for research to investigate whether or not the beneficial effects from TC membership extend to the wider community once treatment concludes (Pearce & Pickard, 2012). However, achieving a sense of belongingness outside of the DTC may be particularly problematic due to satiation effects – once the need to belong has been satisfied through a minimum number of quality social contacts, the motivation to acquire further social bonds is diminished (Baumeister & Leary, 1995). Thus, for the duration of DTC membership, an individual's need to belong may be satiated by the DTC itself, leading to a decrease in motivation to establish a sense of belongingness outside of the group. Upon discharge, relationships formed within the DTC

could become severed, leading to a sudden reduction in belongingness. The individual would be tasked with establishing meaningful social bonds (potentially, from scratch) to replace those that they had lost upon departing the DTC – albeit, with a new set of skills and social expectations that they could be expected to have acquired from their time in the DTC.

The following project aimed to explore the role that belongingness plays within DTCs by drawing on first-hand accounts of former DTC members. To accomplish that aim I proposed two research questions: (1) how is belongingness experienced at the time of DTC membership; and (2) what becomes of that belongingness following a discharge?

Method

Design

The research followed a qualitative design. The consolidated criteria for reporting qualitative research checklist (COREQ) (Tong, Sainsbury, & Craig, 2007) was used as a reference to help guide the written report (see table two). Individual semi-structured interviews were conducted with seven purposively sampled former DTC members, to gain first-hand accounts that explore the experience of belongingness prior to DTC membership, during DTC membership, and in the time following discharge. No one refused to take part/dropped out.

Participants

Inclusion criteria for participants were: (i) be over the age of 18; (ii) be an English speaker; (iii) been an active member of a DTC; and (iv) been a member of their respective DTC for at least one month. Participants were sampled via a combination of targeted online advertisement and participant snowballing. A short advertisement was posted on Twitter,

requesting interested parties to contact me for further information. Once an individual had signalled their interest in taking part, I screened them against the inclusion criteria. Snowballing was raised during the screening process, with participants asked to forward a copy of the participant information sheet / twitter link to suitable parties.

Data saturation has regularly been positioned as key to establishing a trustworthy analysis (Fusch & Ness, 2015). However, no agreed method of establishing data saturation exists (Francis et al., 2010). Corbin and Strauss (2015) note that the pursuit of data and, with it, new insights, could go on forever. They add that the pursuit of an endpoint, at which, nothing new can be added to the analysis, is not practical when balanced with the finite resources and deadlines that constrain researchers. Following reports that 6-12 participants are generally required to reach data saturation in qualitative research (Guest, Bunce, & Johnson, 2006; Ando, Cousins, & Young, 2014) an initial recruitment target of six participants was established. Following Braun and Clarke's thematic analysis approach (2006), data saturation was taken to be the point at which further coding/refinement added nothing "substantial". The application of a semi-structured interview guide was assumed to contribute to achieving data saturation at a relatively early stage, owing to each participant receiving similar questions (Guest et al., 2006). I felt that interview seven indicated that point at which data saturation had occurred.

Participant characteristics

Table three displays participant demographics. Five participants identified as female, one as male, and one as other[3]. Participants' age at the point of joining their respective DTC

[3] I felt that using the gender pronouns, he/she, and, him/her, for those participants who identified as male/female would possibly draw attention to the one individual who stated a

ranged from 24-54 years, with an average of 32.6 years. Participants were asked to briefly summarize the difficulties that they presented with at the point of joining their respective DTC. All of the participants responded by listing mental health diagnoses. Sam (all participants were assigned a pseudonym) was the only participant not to list a diagnosis of personality disorder. Three participants reported to be in receipt of diagnoses of both depression, and anxiety. Six of the participants joined their respective DTC within the last decade. Year of entry ranged from 2002-2019, with an average entry of 2014. One participant attended a residential DTC whilst another attended an inpatient DTC, the remaining five attended day DTCs. Day DTC attendance ranged from 1-4 days per week, with an average weekly attendance of two days. All but one participant experienced a planned discharge. For those participants that experienced a planned discharge, duration of membership ranged from 12-24 months, with an average of 16 months. At the time of interview, time since discharge (whether planned, or unplanned) ranged from 1-17 years, with an average of 5 years.

Procedure

Upon contacting me for further information, participants were emailed a participant information sheet. Owing to COVID-19 social distancing measures, I conducted semi-structured interviews remotely. The date, time and method of interview (i.e. videoconferencing/telephone) were negotiated with participants. Participants were informed of the limits to confidentiality and their right to withdraw. With consent, interviews were audio recorded, and transcribed, by me. No other persons were present at any of the interviews.

---

preference for gender-neutral pronouns. Thus, I decided to treat all participants equally by using gender-neutral pronouns throughout.

To prompt discussions that would capture data pertinent to the research questions, a semi-structured interview guide was developed (see Appendix A for interview guide). Prior to designing the interview guide I met with the DTC Umbrella Group – a peer-support network comprised of representatives from DTC's that were situated across the North West of England – to explore what the stakeholders believed would be important areas to discuss at interview. Brief field notes were written onto the interview guide throughout each respective interview. Interview duration ranged from 63-73 minutes, with an average of 68 minutes.

Analysis

Data was analysed using thematic analysis. The thematic analysis was conducted from a "contextualist" position (Madill, Jordan, & Shirley, 2000). Contextualism assumes that whilst objects exist independently of human beings, those objects are assigned meaning through people and those meanings must be understood within their specific societal, cultural, temporal and/or physical contexts (Madill et al., 2000).

Braun and Clarke's (2006) thematic analysis was followed throughout. After familiarising myself with the data by conducting and transcribing each interview, I coded each interview, line-by-line, for "interesting" features pertaining to the research questions. Coding was completed systematically across the entire dataset. Once all codes had been developed, I analysed them to see how specific configurations of codes might combine to create broader themes that begun to capture meaningful patterns of response across the data set. Themes (and sub-themes) were reviewed in two stages: (1) do the individual codes form a coherent pattern within the theme?; and, (2) do the themes accurately reflect patterns of meaning across the entire dataset? Once the themes had been developed, each theme was analysed to produce a coherent narrative that captured both the value of each theme individually, and, when taken together, as an overarching story of the data. Themes were

given names, and extracts were located within the data which accurately reflected theme content. To audit the analysis (Larkin & Thompson, 2012), drafts were iteratively reviewed by my research supervisors. The following example illustrates how supervisor feedback could move the analysis from broad observations to nuanced detail. In an early draft of the analysis the theme, "Being yourself", represented that participants began to accept themselves, generally. Supervisors highlighted how a supporting quote from Karen explicitly stated that she belonged in her body. This observation prompted me to review the theme, leading to the observation that participants grew to accept, and express themselves, in mind and in body.

About the researcher

I had no direct experience of having been a member of, facilitated or observed a DTC. Having engaged with the literature I approached the research interviews as a critical outsider, rather than a passionate insider (the latter was how I had come to view advocates of the DTC approach). I was honest with each participant about my lack of direct experience with the DTC model and I encouraged that interviews be viewed as a co-construction. What had felt like abstract, cold concepts in the literature (e.g. reality confrontation, boundaries and a flattened hierarchy) became warmer and more relatable when understood through participants' vivid and emotive first-hand accounts. Consequently, I recognised a personal shift from critical outsider (i.e. do DTCs work?), to curious investigator (i.e. *how* do DTCs work?). I also noticed that I made frequent use of reflective summaries throughout the first interview (Rogers & Farson, 1957) – a habit from clinical interviewing, rather than a conscious decision driven by the research. My primary concerns were that a clinical approach to research interviewing could: (i) remind participants of difficult experiences with mental health services; and (ii) may not yield information pertinent to the research questions. I

approached all subsequent research interviews with the mantra, “how does this question relate to belongingness and/or the experience of DTC membership?”.

Ethics

Given the online recruitment strategy, there was a potential that interest in the project could considerably outweigh the target sample range of 6-12 participants. It was made explicit in both the online advertisement, and the participant information sheet, that I intended to recruit a maximum of 12 persons. Participants were informed that the internet/telecommunications could not be guaranteed to be completely secure and were offered the option of withdrawing from the research. Ensuring confidentiality within participants’ chosen interview location was also discussed extensively with each individual participant. Participants were informed that data would be stored securely (and anonymously) for a period of 10 years before being destroyed. Ethical approval for the project was obtained from Lancaster University’s Faculty of Health and Medicine Research Ethics Committee.

Results

Four themes were identified across the seven interviews: (i) belonging and trust; (ii) a spectrum of connection; (iii) beginning to accept yourself; and (iv) ensuring belonging after membership. All seven participants contributed to each of the themes. Table four displays a thematic grid charting the progression from coding, to subthemes, to themes. All four themes will be presented, in turn, with supporting quotations (taken from across all seven interviews). To provide important context to the findings, I will first describe how the participants conceptualized belonging.

There were two prominent features when participants discussed the meaning of belonging. First, participants described a "connection" (Karen; Heather; Sam; Marguerite; Sophie; Emily) between oneself and someone, or something, else, "In some ways it's kinda like a bit of a label that you label on yourself to say that you do feel like you're connected to somebody, or something." (Sophie). Second, participants described feeling "accepted" (Heather; Sam; Gordon; Emily) by others, or receiving "acceptance" (Karen; Sam; Gordon), as a product of that connection, "I suppose, I kind of generally always seen it as a sense of, sort of safety and community, in terms of being accepted by others, for the person I am." (Sam).

Belonging and trust

Recalling their experiences prior to joining their respective DTC, all seven participants described feeling unsatisfied with the level of belonging in their lives:

> …I think I did want to belong to a group of people I was at school with. I was at a boarding school. Outside boarding school there was never anyone to belong to, when I was at home. I got rejected so many times that after that, by the time I got to 13, I'd made up my mind, for self-preservation reasons, that I'm not gonna get hurt anymore by other people. I'm gonna tell myself that I don't want to belong, and I'm gonna live like that. And then I found reasons to attach to it, later, from the age of 13 onwards, of being the 'individual' is more important. But if I'm being totally honest it was probably because I didn't want to be hurt anymore by being rejected. (Gordon)

Gordon's experience of seeking belonging, only to feel rejection, was typical of participants' pre-DTC belonging narratives. Gordon's self-preservation strategy was to reject others before

they had the opportunity to reject them – to reject the very idea of belonging by asserting one's individuality. By contrast, Heather described a history of subverting their individuality in order to be accepted, "It was more about me becoming what was expected, rather than necessarily belonging to who I am…". Heather points to a conditional acceptance afforded to them by adherence to a set of pre-existing conditions for belonging. Nevertheless, that conditional acceptance remained tinged with the pain of rejection as Heather was unable to be themself in those relationships. The implication is that in order to feel that one truly belongs, one's self-concept (i.e. who one perceives themself to be) must align with the belongingness conditions of the group.

Entering a DTC was positioned as something that triggered old wounds relating to rejection and challenged participants' existing coping strategies, resulting in an initial sense of mistrust. Returning to Heather's previous experience of conditional acceptance, Heather recalled that they initially believed that to belong in a DTC would mean, "losing yourself within the collective". That is, Heather's sense of who they perceived themself to be would be lost among the noise of the collective voice. One inference would be that Heather could not trust that their individual needs would be recognized, and met, among a backdrop of potentially competing demands.

To facilitate belonging, participants spoke of having to build up a sense of trust. Emily described trust as, "…the precondition of belonging, [that] allows the therapy to happen." Experiences of building trust within a DTC were a prominent feature of all seven interviews, and those experiences appeared to converge around four distinct ideas: (i) being handed responsibility for how the DTC functions; (ii) acting with transparency; (iii) recognition of joint participation; and (iv) role modelling. Emily illustrated a number of these ideas:

> So I think that the fact that it is so open, and transparent, and requires full participation, and everyone to vote unanimously for anything to be passed, allows you to build that trust before you have that connection. Because there's no room for people to be deceitful, or to hurt you, without it being questioned, because it's all about accountability. And that accountability facilitates trust, which then leads to belonging.

Emily's extract shows how votes represent a concrete means of handing responsibility over to DTC members. The requirement for a unanimous vote reflects joint participation; full participation is essential, and each individual voice is important. Votes also help to convey transparency, in that members must make their vote known, and that vote is open to exploration from the group. Working together to govern their respective DTC, and doing so with transparency, allowed the group to decide on their own conditions for belonging, promoting accountability to one another, and building trust.

In terms of role modelling, DTCs were described as being "generational" (Heather), in that there is a constant turnover of membership. For newer members, trust is built when more experienced peers role model the conditions, and successes, of the DTC, "And now, being with them, they're telling their stories as well. They're telling their emotions and you're kinda learning, 'This is an okay thing to do. I'm okay at doing this. I can finally do this'." (Sophie). Here, Sophie benefited from observing the telling of stories in a supportive arena, building trust within themself that they could follow suit. When Sophie follows the model set by others, the sharing of stories becomes a reciprocal act that unites members together. As a member progresses along their DTC journey, they begin to take on more responsibility for role modelling to less-tenured members, continuing the generational cycle of DTC membership.

A spectrum of connection

Reflecting on their early experiences within their respective DTCs, all seven participants described developing a swift connection with fellow members that was based upon what Emily described as a recognition of "shared suffering" (i.e. similarities in terms of mental health diagnoses/experiences). The significance of recognising shared suffering was that the inductee could expose their vulnerabilities (reinforcing transparency within the group), based upon a trust that their fellow members would not be shocked, and may understand both the historical context, and current presentation of, their difficulties:

> So there was always that fear. And it was a constant barrier. And when I got to the TC there was, I didn't have to hide anything anymore…If I was upset I could actually talk to people. And it wasn't just that. It was people could understand back cos they've had similar problems. They've had similar feelings. They've all got a PD [personality disorder] diagnosis there anyway. So they kind of understand the emotional crap that goes on in your head. (Sophie)

Whilst establishing an initial connection predicated on shared suffering was felt to be important, six of the participants felt that to truly belong you had to shift towards what they considered to be a deeper connection that was built upon a recognition of joint participation with the DTC process. Participation was described as "hard work" (Karen; Marguerite; Gordon), which involved "showing kind of the parts of them that it's uncomfortable to kind of have seen" (Heather). Participants described receiving, and providing, challenging feedback that allowed them to "develop a new level of meaning" (Marguerite). Joint participation facilitated individuals to form a "reciprocated relationship" (Sam) with others,

as members were felt to be "working alongside each other…[and] caring for each other" (Gordon). Sam was the only participant who felt that their connection remained at the level of shared suffering:

> We had the same kind of, you know, similar experiences, in terms of trauma etc., but just very different ways of expressing that…I know that at times I'd be so kind of rigidly perfectionist with what I was doing that I would be very closed. I wouldn't talk. I wouldn't kind of get involved. I don't know. To me this seemed like something [that] was observable but just wasn't interpreted in a way that would have perhaps been more helpful to me. And I think to some extent I would sometimes feel a bit of resentment that it wasn't noticed as being a problem when other people's problems were kind of being almost immediately picked up on.

For Sam, a recognition of their shared suffering did not translate into an understanding of their present difficulties, and how those difficulties were expressed. With the expression of their difficulties going unrecognized, Sam was not privy to the challenge and care received by more overtly expressive members. Consequently, Sam did not perceive their relationship to the group to be a reciprocal one, leading to resentment and, at times, a reluctance to engage, "I could acknowledge that I was kind of just shutting down and choosing to not get involved at times".

Being yourself

Participants reported that feeling accepted by others within the DTC allowed them to both accept and express themselves, in mind and in body:

> …belonging and being accepted meant that I started to belong and accept myself. Like, I belonged in my body, which I'd never really sort of had a positive relationship with before. And I started, like, I started to dye my hair when I was there, for a start. That was one of the things I did, to just be, like, 'you know, actually, this is who I am', and whatever. (Karen)

In the context of a history characterized by overt rejection, or conditional acceptance that was dependent on covert subjugation of one's identity, Karen highlights how feeling safe enough to be themself was a new and profound experience. Karen's dyeing of their hair was both a demonstrable display of their self-concept, and a display of their trust in their fellow DTC members that the latter would continue to accept them following such a display. Thus, feeling acceptance from their peers appeared to free participants from fears of rejection. Participants trusted that they could behave in a manner that was congruent with their self-concept, without fear of a reprisal.

Karen continued to explain the importance of being oneself, in relation to their sense of belonging to the DTC, "…you could only really belong as well if you were really being yourself. People would see right through you if you were not being yourself." This extract, which was emblematic of the views expressed across many of the interviews, highlights how having the trust, and confidence, to express oneself conveys authenticity and transparency to the other members of the DTC, which further enhances the trust that exists among them.

Feeling accepted by others also enhanced one's capacity for self-reflection and insight. Compared to their experiences prior to joining the DTC, participants felt that their time in the DTC had enabled them to explore who they were, and what their needs and values were:

> And again part of that is the person I was, and learning, and what my community was, and not forcing myself on to things that I didn't really, that didn't really ring true with me. Which I think I'd been trying to do for years before that. I'd been trying to put myself in moulds that I don't belong in. (Karen)

Here, Karen recontextualizes their unsatisfactory history of belonging by suggesting that a motivation to experience belonging, coupled with a lack of personal insight into their personal needs and values, meant that they had attempted to belong in places that had not fit with their self-concept. From these insights, Karen asserts that she can be more selective in terms of where she attempts to satisfy their belonging. Again, the implication is that belonging comes with conditions attached, and part of the success of belonging is ensuring that one's self-concept is congruent with those conditions.

Ensuring belonging after membership

Following their departure from the DTC, participants spoke of making space for belonging in both their existing relationships (e.g. family, friends, workplace, religious), and when forming new ones. Participants created space for belonging by drawing on concrete skills (e.g. boundary-setting) and/or personal insights (e.g. reflections on self-concept) that they had gained from their participation in the DTC:

> Yeah, I think I have more boundaries in my relationships, which is healthy. I don't think I was very good at communicating what I needed, and what I wanted, and what I would not accept, in my relationships, previously...I don't think there was much distinction between I, and someone else, in my previous relationships. Like, my identity was defined by them, in some ways. So when

> they left, I felt I'd lost part of myself. Whereas now, I feel I have more boundaries between myself and other people. (Emily)

The above extract neatly captures participants' self-reported belongingness journeys. Participants entered their respective DTCs with unsatisfactory experiences of belonging that were often predicated on a failure to meet the conditions that had been set by others, or a subjugation of their self-concept in order to meet those conditions. On their journey through the DTC, participants learned not only to explore their self-concept (e.g. their needs and values), but they also learned the means by which they could safely express themselves (e.g. through boundary-setting and transparency). Upon leaving their respective DTCs, participants were better able to identify those persons/groups/places that were aligned with their self-concept. Moreover, they were able to assert themselves in existing relationships (e.g. families).

Six participants described the importance of maintaining a connection to DTCs following discharge. Participants spoke of maintaining a connection to their specific DTC through revisiting fond memories, retaining physical mementos (e.g. a photograph or therapeutic document), and continuing friendships that had been established within the DTC:

> …so in terms of belonging I haven't ever quite let go of it, that is there still, for me. And actually the people there, the therapists are different now. So for me, in my head, it's the same therapists there. Just like when you look back to your family growing up, those key people are there, aren't they, as if they are still there…So in my imaginings, in my head, I still belong to the TC that was there when I was there. (Marguerite)

For Marguerite, though there is an acceptance that the physical properties of the DTC may have changed, their particular time in the DTC has been preserved in memory, and this is enough to maintain a sense of belonging. Marguerite continued:

> So we all shape the TC that we're in. And if we've been in a TC, little bits of us will be there still. So, you know, when you're thinking about belonging, I think there's never a complete disconnect, is there?

Above, Marguerite establishes the bi-directional nature of continued belonging to their particular DTC. The DTC may live on in the memories of former members, but former members also leave an indelible footprint on the history of that particular DTC. The idea of leaving a legacy links in with the generational role modelling aspects of DTCs – even after individual memberships come to an end, the influence of past members can still be felt.

Many of the participants also maintained a broader connection to DTCs, such as working, studying or conducting research in the sphere of mental health, as illustrated by Heather, "…I became quite part of a wider network of people who had left therapeutic communities, I've stayed in touch with the therapeutic community world – that's the world I work in now."

Sam was the only participant who did not comment on the importance of maintaining a connection to DTCs. Sam was also the only participant who felt that their DTC membership had not progressed to a deeper connection that was built upon joint participation. Sam reported that their membership included periods where they felt on the periphery, misunderstood, and resentful. Thus, when compared to the experiences of the other six participants, Sam's incentive to maintain a connection with the DTC was likely diminished. Nevertheless, one could consider that voluntary participation in this project represents a reflection of all seven participants' continued connection to the world of DTCs.

Discussion

This project explored how belongingness is experienced at the time of DTC membership; and, what becomes of that belongingness following discharge. Findings indicated that belongingness was a persistent feature of participants' DTC journeys. Participants reported a swift progression from fear and mistrust to an initial stage of belonging based on recognition of shared suffering. Building trust helped to facilitate belonging by reducing fears of rejection. DTCs enhanced trust by encouraging members to set, and monitor, democratically agreed boundaries (i.e. conditions for belonging). Where participants felt satisfied with the conditions for belonging, they reported to fully engage with the DTC process, leading to a second (and deeper) stage of belonging that was predicated on joint participation. Feeling accepted by their peers allowed participants to begin to explore, accept and express themselves, imbuing interactions with authenticity and transparency. For participants who experienced joint participation, a sense of belonging to their DTC was maintained via continued friendships from their respective DTC, revisiting cherished memories, retaining mementos and/or by means of occupation/study within the field of DTCs, or mental health. All participants spoke of having acquired personal insights, and tangible skills, that had assisted them with making space for belonging in their post-discharge relationships. Figure one depicts these findings in a proposed model charting the course of DTC-related belongingness.

In the introduction I raised three potential challenges with leveraging belongingness within DTCs: (1) belongingness might coerce conformity; (2) members may experience difficult emotions in receipt of consequences for non-compliance; and (3) that discharge could sever existing ties to the DTC, resulting in a diminished sense of belonging and a need to establish meaningful connections elsewhere. These challenges were largely absent from participants' narratives. Rather than viewing themselves as coerced passengers, the majority

of participants positioned themselves as active agents who grasped responsibility for how their respective DTCs were governed. Just one participant reported receiving a democratically assigned consequence for non-compliance. Whilst that participant felt supported throughout the consequence process, the absence of consequences within the other six interviews suggests that the sample may have been skewed. Consequently, findings from this project cannot be said to support, or disconfirm, Pearce and Pickard's (2012) assertions that belongingness may mitigate the potential risks associated with consequences. Though discharge marked the point at which participants no longer attended their respective DTC, the majority of participants described how their sense of belonging had continued on with them. Some of the means by which participants continued to feel a sense of belonging following the loss of their DTC membership status showed parallels with how the bereaved maintain a continuing bond with the departed, such as revisiting cherished memories and retaining physical mementos (Root & Exline, 2014). In pursuing occupation/study that is related to their experiences within the DTC, former DTC members are able to maintain their sense of connection by integrating those experiences into their sense of professional identity (Jones & Pietilä, 2020). All of the participants felt more skilled in navigating existing relationships, and in selecting new relationships that were best suited to their self-concept.

Participants' fears around rejection, and the swift development of an initial stage of belonging that would support them to begin to trust others, supports Haigh's (2013) perspective that belonging is linked to the attachment phase of early TC membership. However, participants were clear that a sense of belonging based on shared suffering alone was not enough to sustain a satisfactory connection with others over the course of DTC membership. Participants described that as they became more active in their DTC, the connection with their peers shifted to one based on joint participation, where members were observed to be working hard, together, to the betterment of everyone. Baumeister and Leary

(1995) contend that reciprocal relationships are a key component of belonging and these findings confirm that a belonging based on shared suffering may be reciprocal insofar as participants reported the presence of similar historical events. In the long-term, participants felt more satisfied with their level of belonging when they observed actions that were reciprocated in the present, via active participation. Thus, rather than being specific to the initial attachment phase of joining a DTC, belonging can be considered as a shifting component that requires continuous reinforcement throughout membership.

It has been hypothesized that TCs enhance belongingness which, in turn, boosts self-esteem, which is then harnessed to develop responsible agency (Pearce & Pickard, 2012). Participants' responses lend support to the presence of all three components. As a primary focus of the research, belonging was a recurring feature throughout the analysis. Responsible agency was another prominent feature, exemplified by participants' descriptions of accepting responsibility for how their respective DTC functioned, conducting themselves with transparency and role modelling DTC processes to others. Though the concept of self-esteem was not referenced by name, participants' descriptions of accepting, exploring, and expressing their self-concept, convey that they began to value themselves enough to warrant such acts of self-care. Moreover, the sociometer theory of self-esteem proposes that an individual's self-esteem represents a subjective assessment of the degree to which they feel included, or excluded, by valued others (Leary, Terdal, Tambor, & Downs, 1995). This hypothesis is satisfied by participants' assertions that peer-approval was a fundamental pre-requisite for their subsequent acts of self-care.

Findings from this project elaborate on Pearce and Pickard's (2012) hypothesis with the explicit suggestion that belongingness, responsible agency and self-esteem form an interactive triad (B-RA-SE triad, depicted in figure two), with respect to how TCs operate. I have already highlighted how belonging (via peer approval) contributed to improved self-

esteem. In the absence of fears of rejection, and with improved self-esteem, participants felt comfortable to be themselves, imbuing their interactions with authenticity and trustworthiness; thus, looping back to reinforce belongingness. Self-esteem contributed to responsible agency as participants began to believe that they were worthy of help, were free to explore their personal needs, and felt able to pursue those needs within a supportive environment. The reciprocity evident in responsible agency – every vote that is offered, every reflection shared and each act of role modelling serves to help others, as well as the individual – benefits belonging as peers perceive the individual as caring about, and contributing to, their improved well-being. Responsible agency, via those improvements in belonging, strengthens peer-approval which then leads to enhanced self-esteem. Finally, there was an indication that belonging might contribute to a degree of responsible agency in the absence of improved self-esteem. First, participants spoke of taking responsibility in the first weeks of membership (e.g. completing a commitment statement or being involved in voting procedures) despite lingering fears around rejection and a tendency towards mistrust. Second, Sam, who felt a partial acceptance from their DTC, demonstrated a degree of participation with the DTC process – they attended regularly, were respectful of their peers, and completed the treatment period.

A key finding is that belongingness comes with conditions attached, and the success of one's sense of belonging is, in part, dictated by aligning one's self-concept to relationships with similar belongingness conditions. The idea that belongingness could be conditional is consistent with Rogers' (1959) view that interpersonal acceptance can be perceived by an individual as either conditional, or unconditional. Performance against belongingness conditions would seemingly influence one's status as insider, or outsider; and, the outcome of such an evaluation could impact the frequency and stability of one's future interactions (two of the four elements required for belonging). For example, several participants explained how

repeated attempts of self-harm would violate DTC boundaries (i.e. belongingness conditions) and could lead to an individual receiving a temporary/permanent discharge, halting one's capacity for interaction with the group. Moreover, a misalignment between one's self-concept, and the belongingness conditions of the group, could increase the likelihood of one's needs going unmet. In relationships such as this, where an individual perceives that they are giving more than they receive (i.e. when the relationship is not considered reciprocal), there is an increased risk of loneliness (Buunk & Prins, 1998) and a reduced motivation for social interaction (Gang & Stukas, 2015). For example, Sam described loneliness, resentment and a reduced motivation to engage with others in response to his distress going unmet. However, Sam's withdrawal may have been perceived as non-participation by the group, rather than a sign of distress. From either perspective, both parties may have perceived a lack of reciprocity and, consequently, the sense of belonging between the two suffered.

Clinical implications

There are two essential clinical implications to be inferred from these findings: (1) belongingness should be considered as a shifting, malleable component of the DTC intervention that has the potential to perpetually strengthen relationships throughout a given membership period; and (2) belonging is conditional, and those conditions should be monitored regularly by the group to ensure that all members feel a sense of alignment with them.

Most DTCs include a preparatory group where potential members are guided through a process of "deep consent" (Pearce & Haigh, 2017, p. 192). The preparatory group includes learning about the importance of regular attendance, acclimatising to group participation, and attending visits to a prospective DTC. Upon joining a DTC, new members should be handed

a welcome booklet that provides an explanation of the therapeutic model (Pearce & Haigh, 2017). In addition, the Community of Communities (CofC) core standards (Royal College of Psychiatrists, n.d.) hint at the importance of belongingness, and the associated conditions for DTC membership, noting how members are encouraged to: form relationships; share responsibility for each other's safety; set and review boundaries; and be aware of community expectations. Yet, despite an alleged deep consent process, a purported welcome booklet and the CofC core standards, many of the participants expressed that their research interview had been the *first* occasion where they had consciously considered the role that belongingness had played in their DTC journey. This implies that whilst the *experience* of belongingness had been an important feature of their journey, the *concept* of belongingness had not. Omitting to overtly discuss belongingness, and to share the responsibility for monitoring it, suggests that a truly transparent discussion of the therapeutic model has not taken place and raises concerns with regards to how "deep" the consent process is.

Given the importance of aligning one's self-concept with the belongingness conditions of the group, persons who are considering joining a DTC should be made aware of the existing conditions for belonging at the preparatory group, prior to their decision to join. Again, Pearce and Pickard (2012) note that, when considering applicants to the DTC, existing members are only likely to approve those persons whom the group feel are best-suited to belong. Discussing the matter openly affords tenured DTC members the opportunity to explicitly role model the importance of belonging to potential recruits, supporting all involved to make a more informed, and transparent, decision. Dropouts are commonplace within TCs (Lees, Manning, & Rawlings, 2004) and explicit discussion of the group's existing conditions for belonging may help to reduce the potential for dropout at a later date.

Findings from this research indicate that members of a DTC should be entrusted to devise, label and monitor the group's belongingness conditions as this would help to build

trust, and that trust would further enhance belongingness within the group. To some extent, this may well occur, in the guise of "boundary setting". Again, I suggest being transparent about how boundaries relate to belonging, to underscore their importance and to flatten the hierarchy. Moreover, were all members to actively participate in the process of discussing belongingness, this would be an observable marker of joint participation (which could further improve belongingness for DTC members). Regularly reviewing the belongingness conditions of the group would also provide a non-judgemental platform for raising concerns about one's personal sense of belongingness, affording the group further avenues to acknowledge and accommodate the diverse needs of their community. Members who are more likely to passively withdraw at times of distress may particularly benefit from regular belongingness check-ins. Again, these active steps may help to reduce the potential for future dropout.

Strengths, limitations and future research

With these findings I have established that belonging is an important aspect throughout DTC membership (and beyond), and that one's belongingness status is conditional. The DTC landscape has been described as strikingly heterogeneous and the demographics of the interviewed participants reflect that heterogeneity. The consistency of these findings brings some common understanding to that landscape, supporting the notion that though DTCs may hold demographic differences, they may share many core ingredients. Nevertheless, the findings presented here should be interpreted with caution. Memories can be altered, distorted, fabricated or suppressed in an effort to support an individual's current goals, self-image and self-beliefs – termed, *coherence* (Conway, 2005). Therefore, the interviews reflect a collection of memories that support participants' self-concept at the time of interview, rather than an objective reflection of their experience at the time of DTC

membership. Dropout from DTCs is commonplace, with a completion rate of 9-56%, depending on the intended length of treatment (Malivert, Fatséas, Denis, Langlois, Auriacombe, 2012). Yet, six of the seven participants completed their course of DTC treatment, suggesting that the sample may not be representative of all persons who join a DTC.

Ideas for future research include testing the validity of either of the two proposed models, within DTC settings: (i) the model depicting the course of DTC-related belongingness; and/or (ii) the BR-A-SE triad. Alternatively, Pearce and Pickard (2012) have stated that TCs are uniquely placed in the manner that they leverage belongingness to therapeutic effect. Researchers may choose to explore this assertion by observing whether the proposed models apply to other group mental health interventions. Dialectical behaviour therapy may prove most appropriate as, like DTCs, the intervention is considered to be of primary benefit to persons with a diagnosis of personality disorder (Dimeff & Linehan, 2001), and emerging evidence supports its effectiveness in treatment for such individuals (Feigenbaum, 2007; O'Connell & Dowling, 2014). The findings of this paper share many similarities with Dagaz's (2012) qualitative exploration of high school marching band membership – Dagaz noted that participants felt accepted by their peers and developed a connection to their community that was built upon joint participation, which engendered trust between members and contributed to participants' self-confidence. The similarities between the two sets of experiences are particularly interesting when contrasted against the differences between the two groups, in terms of their setting and their aims. Consequently, it may be worth exploring the model depicting the course of DTC-related belongingness in non-therapeutic groups, also.

Conclusion

This project aimed to explore both how belongingness is experienced at the time of DTC membership; and, what becomes of that belongingness following discharge. Findings indicated that belongingness was a persistent feature of participants' DTC journeys, beginning with an initial stage based on recognition of shared suffering before progressing to a second, deeper stage, predicated on joint participation in the therapeutic process. For participants who experienced joint participation, a sense of belonging to their DTC was maintained via continued friendships from their respective DTC, revisiting cherished memories, retaining mementos and/or by means of occupation/study within the field of DTCs, or mental health, generally. All participants spoke of having acquired personal insights, and tangible skills, that had assisted them with making space for belonging in their post-discharge relationships.

Acknowledgements

This study did not require funding.

Disclosure of interest

I report no conflict of interest.

References

Akerman, G. (2019). Communal living as the agent of change. *The Wiley international handbook of correctional psychology*, 590-602.

Ando, H., Cousins, R., & Young, C. (2014). Achieving saturation in thematic analysis: Development and refinement of a codebook. *Comprehensive Psychology*, *3*, 03-CP.

Barr, W., Kirkcaldy, A., Horne, A., Hodge, S., Hellin, K., & Göpfert, M. (2010). Quantitative findings from a mixed methods evaluation of once-weekly therapeutic community day services for people with personality disorder. *Journal of Mental Health*, *19*(5), 412-421.

Baumeister, R. F., & Leary, M. R. (1995). The need to belong: desire for interpersonal attachments as a fundamental human motivation. *Psychological bulletin*, *117*(3), 497.

Begen, F. M., & Turner-Cobb, J. M. (2012). The need to belong and symptoms of acute physical health in early adolescence. *Journal of Health Psychology*, *17*(6), 907-916.

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

Buunk, B. P., & Prins, K. S. (1998). Loneliness, exchange orientation, and reciprocity in friendships. *Personal Relationships*, *5*(1), 1-14.

Chiesa, M., Fonagy, P., Holmes, J., & Drahorad, C. (2004). Residential versus community treatment of personality disorders: a comparative study of three treatment programs. *American Journal of psychiatry*, *161*(8), 1463-1470.

Cockshaw, W. D., Shochet, I. M., & Obst, P. L. (2013). General belongingness, workplace belongingness, and depressive symptoms. *Journal of Community & Applied Social Psychology*, *23*(3), 240-251.

Conway, M. A. (2005). Memory and the self. *Journal of memory and language*, *53*(4), 594-628.

Corbin, J., & Strauss, A. (2015). *Basics of qualitative research: Techniques and procedures for developing grounded theory*. Sage publications.

Dagaz, M. C. (2012). Learning from the band: Trust, acceptance, and self-confidence. *Journal of Contemporary Ethnography*, *41*(4), 432-461.

Davies, S., Campling, P., & Ryan, K. (1999). Therapeutic community provision at regional and district levels. *Psychiatric Bulletin*, *23*(2), 79-83.

Dimeff, L., & Linehan, M. M. (2001). Dialectical behaviour therapy in a nutshell. *The California Psychologist*, *34*(3), 10-13.

Feigenbaum, J. (2007). Dialectical behaviour therapy: An increasing evidence base. *Journal of Mental Health*, *16*(1), 51-68.

Francis, J. J., Johnston, M., Robertson, C., Glidewell, L., Entwistle, V., Eccles, M. P., & Grimshaw, J. M. (2010). What is an adequate sample size? Operationalising data saturation for theory-based interview studies. *Psychology and health*, *25*(10), 1229-1245.

Friedman, R. L. (2007). Widening the therapeutic lens: Sense of belonging as an integral dimension of the human experience. *Dissertation Abstracts International: Section B: Sciences and Engineering*, *68*(5-B), 3394.

Fusch, P. I., & Ness, L. R. (2015). Are we there yet? Data saturation in qualitative research. *The qualitative report*, *20*(9), 1408.

Gang, G. C. A., & Stukas, A. A. (2015). The effects of reciprocity, type of relationship, and culture on relationship processes. *Jurnal Psikologi Malaysia*, *29*(2).

Gratz, K. L., Dixon-Gordon, K. L., Breetz, A., & Tull, M. (2013). A laboratory-based examination of responses to social rejection in borderline personality disorder: The mediating role of emotion dysregulation. *Journal of personality disorders*, *27*(2), 157-171.

Guest, G., Bunce, A., & Johnson, L. (2006). How many interviews are enough? An experiment with data saturation and variability. *Field methods*, *18*(1), 59-82.

Hagerty, B. M., & Williams, A. (1999). The effects of sense of belonging, social support, conflict, and loneliness on depression. *Nursing research*, *48*(4), 215-219.

Haigh, R. (2013). The quintessence of a therapeutic environment. *Therapeutic Communities: The International Journal of Therapeutic Communities*.

Hatcher, S., & Stubbersfield, O. (2013). Sense of belonging and suicide: a systematic review. *The Canadian Journal of Psychiatry*, *58*(7), 432-436.

Jones, M., & Pietilä, I. (2020). Personal perspectives on patient and public involvement–stories about becoming and being an expert by experience. *Sociology of health & illness*, *42*(4), 809-824.

Knowles, M. L., Lucas, G. M., Molden, D. C., Gardner, W. L., & Dean, K. K. (2010). There's no substitute for belonging: Self-affirmation following social and non-social threats. *Personality and Social Psychology Bulletin*, *36*(2), 173-186.

Larkin, M., & Thompson, A. R. (2012). Interpretative phenomenological analysis in mental health and psychotherapy research. *Qualitative research methods in mental health and psychotherapy*, 101-116.

Leary, M. R., Cottrell, C. A., & Phillips, M. (2001). Deconfounding the effects of dominance and social acceptance on self-esteem. *Journal of personality and social psychology*, *81*(5), 898.

Leary, M. R., Tambor, E. S., Terdal, S. K., & Downs, D. L. (1995). Self-esteem as an interpersonal monitor: The sociometer hypothesis. *Journal of personality and social psychology*, *68*(3), 518.

Lees, J., Manning, N., & Rawlings, B. (1999). *Therapeutic community effectiveness: A systematic international review of therapeutic community treatment for people with personality disorders and mentally disordered offenders*. NHS Centre for Reviews and Dissemination, University of York.

Lees, J., Manning, N., & Rawlings, B. (2004). A culture of enquiry: Research evidence and the therapeutic community. *Psychiatric Quarterly*, *75*(3), 279-294.

Leung, A., Kier, C., Fung, T., Fung, L., & Sproule, R. (2013). The Exploration of Happiness. In A. Delle Fave (Eds.), *The Exploration of Happiness: Present and Future Perspectives* (pp. 247-267). Springer.

Madill, A., Jordan, A., & Shirley, C. (2000). Objectivity and reliability in qualitative analysis: Realist, contextualist and radical constructionist epistemologies. *British journal of psychology*, *91*(1), 1-20.

Magor-Blatch, L., Bhullar, N., Thomson, B., & Thorsteinsson, E. (2014). A systematic review of studies examining effectiveness of therapeutic communities. *Therapeutic Communities: The International Journal of Therapeutic Communities*.

Malivert, M., Fatséas, M., Denis, C., Langlois, E., & Auriacombe, M. (2012). Effectiveness of therapeutic communities: a systematic review. *European addiction research*, *18*(1), 1-11.

O'Connell, B., & Dowling, M. (2014). Dialectical behaviour therapy (DBT) in the treatment of borderline personality disorder. *Journal of psychiatric and mental health nursing*, *21*(6), 518-525.

Pearce, S., & Haigh, R. (2017). *The theory and practice of democratic therapeutic community treatment*. Jessica Kingsley Publishers.

Pearce, S., & Pickard, H. (2012). How therapeutic communities work: Specific factors related to positive outcome. *International Journal of Social Psychiatry*, *59*(7), 636-645.

Pearce, S., Scott, L., Attwood, G., Saunders, K., Dean, M., De Ridder, R., Galea, D., Konstantinidou, H., & Crawford, M. (2017). Democratic therapeutic community treatment for personality disorder: randomized controlled trial. *The British Journal of Psychiatry*, *210*(2), 149-156.

Powell, J. L., & Drucker, A. D. (1997). The role of peer conformity in the decision to ride with an intoxicated driver. *Journal of Alcohol and Drug Education*, *43*(1), 1.

Rapoport, R. N. (1960). *Community as Doctor*. Tavistock Publications.

Roberts, J. (1997). How to recognize a therapeutic community. *Prison Service Journal*, 4-7.

Rogers, C. (1959). A Theory of Therapy, Personality, and Interpersonal Relationships, as Developed in the Client-Centred Framework. In S. Kock (Eds.), *Psychology: A Study of a Science* (pp. 184-256). McGraw-Hill.

Rogers, C. R., & Farson, R. E. (1957). *Active listening.* Retrieved from https://www.virtualmediationlab.com/wp-content/uploads/2012/08/active_listening.pdf

Root, B. L., & Exline, J. J. (2014). The role of continuing bonds in coping with grief: Overview and future directions. *Death Studies*, *38*(1), 1-8.

Royal College of Psychiatrists. (n.d.). *Community of Communities Process Document 2019-2020* [Brochure]. https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/quality-networks/therapeutic-communities-c-of-c/cofc-process-document-2019-2020.pdf?sfvrsn=77daf685_4

Silva, C., Ribeiro, J. D., & Joiner, T. E. (2015). Mental disorders and thwarted belongingness, perceived burdensomeness, and acquired capability for suicide. *Psychiatry Research*, *226*(1), 316-327.

Tong, A., Sainsbury, P., & Craig, J. (2007). Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International journal for quality in health care*, *19*(6), 349-357.

Veale, D., Gilbert, P., Wheatley, J., & Naismith, I. (2015). A new therapeutic community: Development of a compassion-focussed and contextual behavioural environment. *Clinical psychology & psychotherapy*, *22*(4), 285-303.

Wilson, K., Freestone, M., Taylor, C., Blazey, F., & Hardman, F. (2014). Effectiveness of modified therapeutic community treatment within a medium-secure service for personality-disordered offenders. *The Journal of Forensic Psychiatry & Psychology*, *25*(3), 243-261.

Table 1

How DTC Practices Promote Belongingness Within the Group

Proposed element for promoting belongingness (Baumeister & Leary, 1995)	Associated practices within DTCs (Pearce & Haigh, 2017)
Frequent interactions	Regular group meetings – minimum once per week. Ideal membership size of at least 10 persons.
Pleasant interactions	The group sets clear boundaries and rules about what behaviour is permissible. Democratically assigned consequences can deter behaviour that might disturb the group.
Reciprocal concern	Explicit expectation on members and staff to hold mutual care and concern for each other.
Stability over time	DTCs are a medium to long-term intervention – membership lasts up to 18 months. Strict adherence to attendance ensures that group composition is stable.

Table 2

Consolidated Criteria for Reporting Qualitative Research Checklist

No	Item	Guide questions / description	Page number
Domain 1: Research team and reflexivity			
Personal characteristics			
1.	Interviewer	Which author/s conducted the interview or focus group?	7-8
2.	Credentials	What were the researcher's credentials? E.g. PhD, MD	9
3.	Occupation	What was their occupation at the time of the study?	9
4.	Gender	Was the researcher male or female?	9
5.	Experience and training	What experience or training did the researcher have?	9
Relationship with participants			
6.	Relationship established	Was a relationship established prior to study commencement?	9
7.	Participant knowledge of the interviewer	What did the participants know about the researcher? E.g. personal goals, reasons for doing the research	9-10
8.	Interviewer characteristics	What characteristics were reported about the interviewer/facilitator? E.g. bias, assumptions, reasons and interests in the research topic	9-10
Domain 2: Study design			
Theoretical framework			
9.	Methodological orientation and theory	What methodological orientation was stated to underpin the study? E.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis	8-9
Participant selection			
10.	Sampling	How were participants selected? E.g. purposive, convenience, consecutive, snowball	5-6
11.	Method of approach	How were participants approached? E.g. face-to-face, telephone, mail, email	7-8
12.	Sample size	How many participants were in the study?	5-6
13.	Non-participation	How many people refused to participate or dropped out? Reasons?	5
Setting			
14.	Setting of data collection	Where was the data collected? E.g. home, clinic, workplace	7
15.	Presence of non-participants	Was anyone else present besides the participants and researchers?	8
16.	Description of sample	What are the important characteristics of the sample? E.g. demographic data, date	6-7

No	Item	Guide questions / description	Page number
Data collection			
17.	Interview guide	Were questions, prompts, guides provided by the authors? Was it pilot tested?	8
18.	Repeat interviews	Were repeat interviews carried out? If yes, how many?	N/A
19.	Audio recording	Did the research use audio or visual recording to collect the data?	8
20.	Field notes	Were field notes made during and/or after the interview or focus group?	8
21.	Duration	What was the duration of the interviews or focus group?	8
22.	Data saturation	Was data saturation discussed?	5-6
23.	Transcripts returned	Were transcripts returned to participants for comment and/or correction?	N/A
Domain 3: Analysis and findings			
Data analysis			
24.	Number of data coders	How many data coders coded the data?	8-9
25.	Description of the coding tree	Did authors provide a description of the coding tree?	41-42
26.	Derivation of themes	Were themes identified in advance or derived from the data?	8-9
27.	Software	What software, if applicable, was used to manage the data?	8-9
28.	Participant checking	Did participants provide feedback on the findings?	N/A
Reporting			
29.	Quotations presented	Were participant quotations presented to illustrate the themes/findings? Was each quotation identified? E.g. participants number	10-19
30.	Data and findings consistent	Was there consistency between the data presented and the findings?	10-19
31.	Clarity of major themes	Were major themes clearly presented in the findings?	10-19
32.	Clarity of minor themes	Is there a description of diverse cases or discussion of minor themes?	10-19

Note. Table adapted from Tong, Sainsbury and Craig (2007) to include a column for the corresponding page number

Table 3

Participant Demographics

Participant	Gender	Presenting difficulty (as described by the participant)	Age at membership	Type of DTC	Location of DTC	Year of entry to DTC	Duration of membership	Completed treatment	Years since discharge
Karen	Female	Borderline personality disorder; Post-traumatic stress disorder; Eating Disorder, Self-harm and attempts to end life	28	Inpatient DTC	Yorkshire and the Humber	2016	12 months	Yes	3
Heather	Female	Borderline personality disorder; Generalized anxiety disorder; Depression	29	Residential DTC	North West / West Midlands	2002	12 months	Yes	17
Sam	Other	Complex post-traumatic stress disorder; Risk-to-self	25	Day DTC (1-day p/w)	Undisclosed	2015	18 months	Yes	4
Marguerite	Female	Personality disorder; Complex trauma	44	Day DTC (3-days p/w)	South East	2012	12 months	Yes	7
Gordon	Male	Risk-to-self; Depression; Anxiety - Assigned	54	Day DTC (1-day p/w)	South East	2018	18 months	Yes	1

Participant	Gender	Presenting difficulty (as described by the participant)	Age at membership	Type of DTC	Location of DTC	Year of entry to DTC	Duration of membership	Completed treatment	Years since discharge
		a diagnosis of borderline personality disorder which they reported was a necessary means to accessing the DTC service							
Sophie	Female	Emotionally unstable personality disorder; Episodes of psychosis during previous inpatient stays	24	Day DTC (4-days p/w)	East Midlands	2016	24 months	Yes	2
Emily	Female	Risk-to-self; Recovering anorexic; Depression; Anxiety; Emotionally unstable personality disorder (participant 7 did not agree with this diagnosis as they reported that they	24	Day DTC (1-day p/w)	North West	2019	3 months	No - Unplanned discharge. Reported that they were unable to secure the required time away from work in order to continue their	1

Participant	Gender	Presenting difficulty (as described by the participant)	Age at membership	Type of DTC	Location of DTC	Year of entry to DTC	Duration of membership	Completed treatment	Years since discharge
		had not been seen by the diagnostician)						attendance at sessions	

Table 4

Thematic Grid Charting the Progression from Coding, to Themes (and Sub-Themes)

Initial codes	Sub themes	Themes
Belonging is challenging; Belonging is conditional; Fear of losing individuality; Fear of needs going unmet; Fear of stigma / rejection; Little incentive to belong; Unsatisfactory prior experiences of belonging.	Mistrust: inductees enter their respective DTC with a sense of mistrust and fear, owing to a history of rejection and unsatisfactory experiences of belonging.	Belonging and trust: belonging cannot exist in a DTC without trust. DTC members often report a history of attempting to meet conditions of belonging that have been set by others, leading to unsatisfactory connections. DTCs allow the group to define their own conditions for belonging by handing members responsibility for how the DTC functions (e.g. boundary-setting), facilitating trust between its members.
Belonging is conditional; DTCs are generational; Given responsibility; Reciprocated relationships; Role modelling; Transparency.	Building Trust: trust helps to overcome initial fears and facilitate belonging. Trust is developed through being handed responsibility; transparency; reciprocated relationships; and role modelling.	
Being vulnerable; Feeling understood; History of service use; Shared diagnoses; Shared suffering; Shared trauma.	Connection through diagnosis / mental health: upon entry to a DTC, an initial connection is established based on a recognition of shared suffering.	A spectrum of connection: a connection must progress from recognition of shared suffering, to recognition of joint participation, for one to feel as though they truly belong within a DTC, and to reap the associated benefits (e.g. mutual care).
Being vulnerable; Engagement is hard work; Mutual care; Reciprocated relationships; Use of feedback/challenge.	Connection through positive experience of DTC engagement: over time, members' connections deepen as they jointly engage in transparent, and challenging, conversations. Joint participation involves mutual care and illustrates the reciprocated nature of relationships.	
Asserting needs; Belonging is conditional; Identification of needs; Self-acceptance.	No subtheme	Being yourself: feeling accepted from the members of the DTC allows an individual to begin to explore, accept and express themself, leading to the development of personal insights concerning one's self-concept.

Initial codes	Sub themes	Themes
Asserting needs in existing relationships; Belonging is conditional; Establishing new connections; Increase in belonging outside of DTC.	Making space for belonging: awareness of one's needs allows former DTC members to assert those needs in existing relationships, and to identify new relationships that would meet those needs.	Ensuring belonging after DTC: members leave their DTC with an appreciation of the personal significance that belonging holds for them. Former DTC members ensure belonging by recognising their conditions for belonging and asserting these. Persons who have a positive experience of DTC membership find ways to maintain their sense of connection to their respective DTC.
DTC mementos; Positive memories of DTC; Sustaining friendships after DTC; Taking part in DTC research; Working in mental health.	Maintaining connection to DTCs: former DTC members maintain a connection to their respective DTC via friendships, memories, mementos and occupation.	

Figure 1

Model Depicting the Course of DTC-Related Belongingness

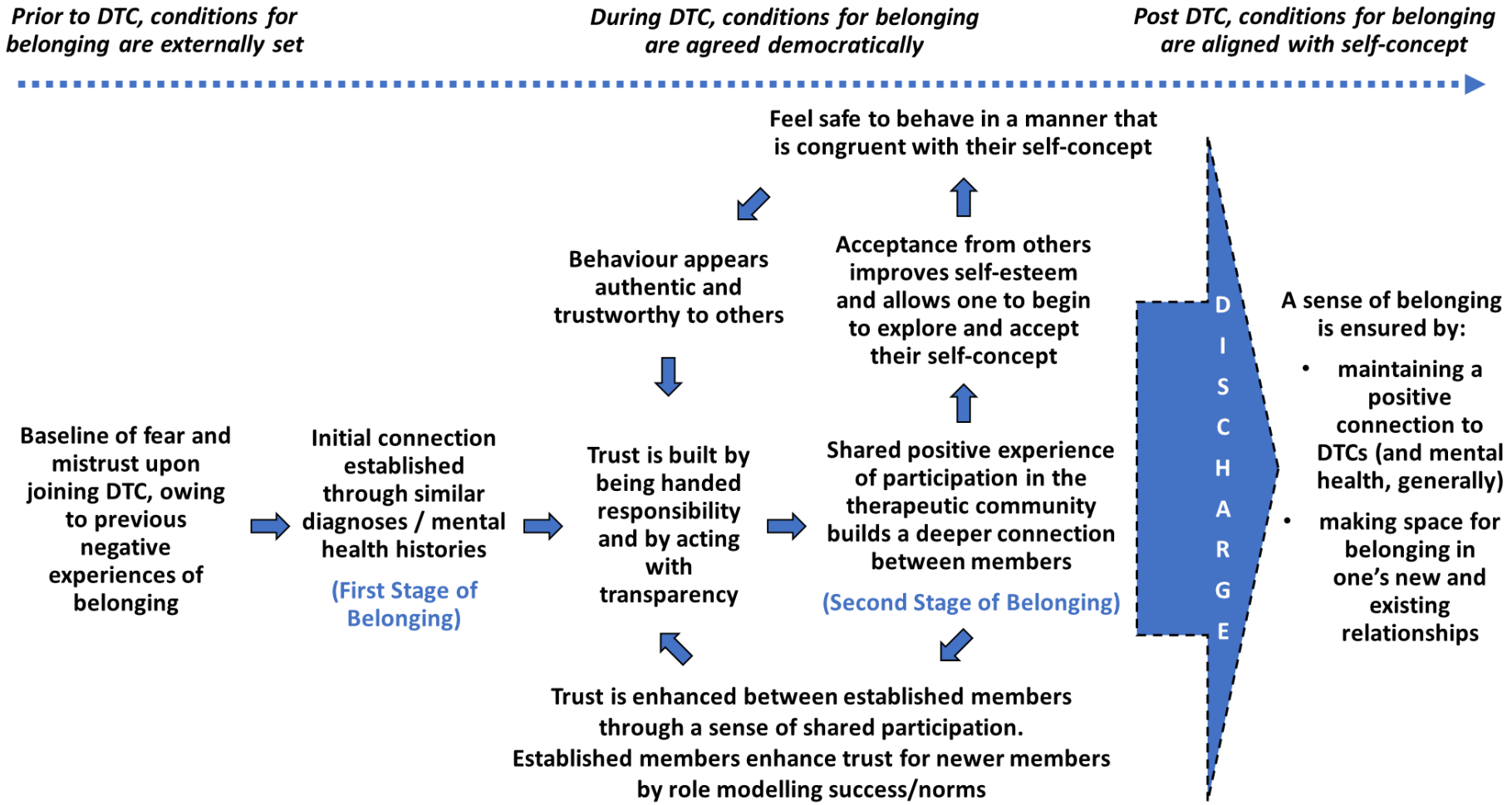


Figure 2

The Belonging, Responsible Agency, Self-esteem [B-RA-SE] triad.

Note. Informed by Pearce and Pickard (2012)

Appendix

Appendix A

Interview guide

Belonging:

- **What does belonging mean to you?**

  Prompt: Are there any groups / connections / relationships that you feel you belong to?

- **Think back to before you were a member of a democratic therapeutic community. What did belonging mean to you back then?**

Belonging to a democratic therapeutic community:

- **What did it mean to be a member of a democratic therapeutic community?**

  Prompt: did you feel that you belonged to the group?

- **What helped you to develop a sense of belonging to the group?**

  Prompt: Was there a time where you felt that you belonged to the group the most?

  Prompt: Did any specific practices within the group enhance your sense of belonging?

- **What were the benefits of feeling a sense of belonging to the group?**

  Prompt: Benefits to their mental health difficulties?

  Prompt: Benefits to existing relationships / groups?

- **What were the challenges to your sense of belonging to the group?**

  Prompt: Were there times where you felt that you did not belong to the group?

  Prompt: Did any specific practices within the group challenge your sense of belonging?

  Prompt: Suspension of the group, e.g. due to coronavirus?

Belonging following discharge:

- **Were there any changes to your sense of belonging once your time in the group came to an end?**

  Prompt: What were your expectations & how did they compare to reality?

- **How is your sense of belonging now?**

  Prompt: What has been your sense of belonging since the lockdown and social distancing?

  Prompt: How might your sense of belonging have been different if you had not been a member of the group?

  Prompt: What is your hope for building/maintaining relationships?

Appendix B

Psychotherapy Research Notes for Contributors

Preparing your paper

All authors submitting to medicine, biomedicine, health sciences, allied and public health journals should conform to the Uniform Requirements for Manuscripts Submitted to Biomedical Journals, prepared by the International Committee of Medical Journal Editors (ICMJE).

Structure

Authors will need to include a separate 2-3 sentence summary labelled "Clinical or Methodological Significance of this Article" and should also include a word count with their article.

Word limits

Manuscripts reporting results of quantitative or qualitative research generally should not exceed 35 double-spaced pages (including cover page, abstract, text, references, tables, and figures), with margins of at least 1 inch on all sides and a 12-point font. Concise manuscripts are favoured over lengthier manuscripts, as long as quality is not compromised in abbreviating a paper. For manuscripts that exceed these page guidelines, authors must provide a rationale in their cover letter to justify the length of their paper. Papers that do not conform to these guidelines will be returned to authors without a peer review.

Style guidelines

Please use APA (American Psychological Association) style guidelines when preparing your paper, rather than any published articles or a sample copy.

Please use American, British-ize spelling style consistently throughout your manuscript.

Please use double quotation marks, except where "a quotation is 'within' a quotation". Note that long quotations should be indented without quotation marks.

Formatting and templates

Papers may be submitted in any standard format, including Word and LaTeX. Figures should be saved separately from the text.

References

All submitted manuscripts should conform to the current APA (American Psychological Association) style. Please use this reference style guide when preparing your paper. An EndNote output style is also available to assist you.

Using Third-Party Material in your Paper

You must obtain the necessary permission to reuse third-party material in your article. The use of short extracts of text and some other types of material is usually permitted, on a limited basis, for the purposes of criticism and review without securing formal permission. If you wish to include any material in your paper for which you do not hold copyright, and which is not covered by this informal agreement, you will need to obtain written permission from the copyright owner prior to submission. More information on requesting permission to reproduce work(s) under copyright.

Disclosure Statement

Please include a disclosure statement, using the subheading “Disclosure of interest.” If you have no interests to declare, please state this (suggested wording: The authors report no conflict of interest). For all NIH/Wellcome-funded papers, the grant number(s) must be included in the declaration of interest statement. Read more on declaring conflicts of interest.

Consent

All authors are required to follow the ICMJE requirements on privacy and informed consent from patients and study participants. Please confirm that any patient, service user, or participant (or that person's parent or legal guardian) in any research, experiment, or clinical trial described in your paper has given written consent to the inclusion of material pertaining to themselves, that they acknowledge that they cannot be identified via the paper; and that you have fully anonymized them. Where someone is deceased, please ensure you have written consent from the family or estate. Authors may use this Patient Consent Form, which should be completed, saved, and sent to the journal if requested.

Chapter 3 Critical Appraisal

The purpose of the research paper was to explore the experience of belongingness during, and after, democratic therapeutic community (DTC) membership. Findings from the research indicated that belonging was a persistent feature of the DTC experience. Participants reported entering their respective DTCs with fears of rejection and a mistrust of others, but these soon gave way to an initial stage of belonging that was predicated on a recognition of shared suffering. Trust was enhanced among DTC members by encouraging them to set, and monitor, democratically agreed boundaries (i.e. conditions for belonging). Over time, those participants who reported satisfaction with the conditions for belonging described a deeper commitment to the DTC, and their sense of belonging shifted to a connection predicated on joint participation in the community (i.e. the second stage of belonging in DTCs). A sense of acceptance from their peers supported these participants to explore, accept and express themselves with greater freedom. For those participants who reported experiencing the second stage of belonging, a sense of belonging was ensured after discharge by maintaining friendships from the DTC, retaining mementos, revisiting cherished memories and/or via occupation/study within the field of DTCs/mental health. Irrespective of the stage of belonging that was experienced, participants described obtaining personal insights, and practical skills, that had supported them to make space for belonging in their post-discharge relationships. Two models were produced from the analysis of the interviews: (i) a model depicting the course of DTC-related belongingness (see figure one); and (ii) the belongingness, responsible agency and self-esteem triad (B-RA-SE triad, depicted in figure two).

The search for a DTC 'recipe'

In the research paper I asserted that the consistency of the findings – despite the heterogeneity of the participants – had brought a degree of common understanding to what could be considered a diverse DTC landscape. Establishing a common understanding is particularly important as some have argued that the therapeutic community (TC) method, in general, requires more clarity (Veale, Gilbert, Wheatley, & Naismith, 2015).

The first true TCs are believed to have arisen during World War Two (WW2), in part, as a wartime effort to rehabilitate shell-shocked soldiers so that they could return to duty (Whiteley, 2004). Thus, the foundations of the TC approach reside in a practical effort to maximize military resources, rather than in a well-developed psychological theory. What has followed has been a series of post-hoc efforts to describe how TCs work, beginning with Rapoport's proposed four key elements of a TC – democratisation, permissiveness, reality confrontation and communalism (Rapoport, 1960). Rapoport's elements have remained heavily cited, despite claims that they may not be applicable to modern TCs (Haigh, 2013). More recently, Pearce and Pickard (2012) have proposed two specific therapeutic factors related to positive outcomes in TCs: (i) promotion of a sense of belongingness; and, (ii) the capacity for responsible agency. Whether it is Rapoport's elements, or Pearce and Pickard's therapeutic factors, I contend that both represent important observable phenomena within TCs, generally; rather than a detailed description of the therapeutic process. An appropriate metaphor would be that Rapoport's elements represent the ingredients contained within a meal, rather than a description of the recipe that led to that meal – the ingredients are recognisable to taste, but there remains uncertainty about how to prepare those ingredients to result in the desired effect. Sticking with the recipe metaphor, Pearce and Pickard (2012) suggest a small portion of the recipe by hypothesising a therapeutic process whereby TCs enhance belongingness which, in turn, boosts self-esteem, which is then harnessed to develop

responsible agency. However, Pearce and Pickard do not elaborate further on this proposal, nor do they offer any support from research specifically designed to investigate whether such a process is present in the experience of DTC membership. The key strength of the research paper is that not only have oft cited ingredients of the DTC approach been reported in participants' experiences (e.g. a flattened (or possibly fluid) hierarchy, democracy, belonging, responsible agency, role-modelling etc.), but those ingredients have now been presented in two clear models (i.e. recipes).

Haigh (2013) had previously hypothesized a developmental progression through therapeutic environments (such as DTCs) and, until the research paper presented here, Haigh's paper represented the closest recipe for how DTCs work. However, the models presented within the research paper challenge the notion that members' DTC journeys correspond to a developmental process, whereby one moves neatly from one stage to another. For example, findings from the research paper indicate that a culture of belonging (as Haigh describes it in his article) is not only important at the initial engagement phase of treatment (as Haigh proposed). Rather, an individual's sense of belonging can deepen, or lessen, throughout their membership period. The research paper also suggests that belonging in DTCs exists along two stages: the first stage is predicated on a recognition of shared suffering; whilst the second (and deeper) stage is based on acknowledgement of joint participation. Haigh also posits that involvement, and agency, represent the penultimate and final stages of the developmental sequence, respectively. However, Pearce and Pickard (2012) note that one's status as a DTC member is, in part, a reflection of one's *choice* to be a member. That is, the decision to choose to join a DTC represents a degree of agency, prior to the establishment of any attachment to the group (with attachment proposed to be the first of Haigh's developmental stages). The models proposed from the research paper suggest that involvement, and responsible agency, co-occur throughout a DTC membership period, as

involvement inherently requires agency (i.e. choice), e.g. choosing to join the DTC; involving oneself in voting procedures; choosing to share stories (and be vulnerable, in the process); and, choosing to offer feedback to others.

Sticking with the recipe metaphor, the thematic synthesis paper resulted in another model designed to demystify the process by which DTCs lead to positive outcomes. The pooled data for the thematic synthesis could be considered to be even more heterogeneous than that of the research paper as the former compared, and contrasted, the experience of community DTC members, with that of prison-based DTC members. Again, however, the consistency of the findings reported in the thematic synthesis represents a major strength of that paper. Moreover, there appears to be consistency across the three models, with many of the same ingredients captured in all three, e.g. belongingness, responsible agency and self-esteem. These similarities should be interpreted with caution as each paper was designed, implemented, analysed and written by me, meaning one piece of research may have influenced the other, and vice versa. Yet, belongingness, self-esteem and responsible agency are thought to be universal human experiences. The desire for belongingness has been described as innate to all humans and is proposed to date back tens of thousands of years as a means of ensuring survival in harsh conditions (Baumeister & Leary, 1995). Self-esteem has been shown to function similarly in Eastern samples as in Western ones (Brown, Cai, Oakes, & Deng, 2009; Cai, Wu, & Brown, 2009). Moreover, a cross-cultural study involving participants from North America, South America, East Asia and South Asia, concluded that the majority of participants from each region believed that the universe is indeterministic (Sarkissian, Chatterjee, De Brigard, Knobe, Nichols, & Sirker, 2010) – that is, our universe is not predetermined and people are active agents within it. Thus, we might reasonably expect to find these three phenomena among many walks of life / narratives. Nevertheless, to limit the potential for cross-influencing, I engaged in qualitative “bracketing” of information.

Existential bracketing

There remains debate over the definition and implementation of bracketing in qualitative research (Tufford & Newman, 2012). Gearing (2004) developed a typology of bracketing in research and, the approach used across both the research and thematic synthesis papers aligns most closely with Gearing's "existential bracketing". Existential bracketing pertains to the researcher's efforts to set aside suppositions concerning research propositions, and theories, only. From an existential bracketing perspective, suppositions about the larger world/environment cannot be bracketed, nor can the researcher's personal assumptions and consciousness. Crucial to the existential bracketing perspective is setting conditions that allow for the investigation of a phenomenon's lived experience. By acknowledging the importance of individual meanings, and the context-bound nature of knowledge production, existential bracketing is consistent with the ontological minimal-hermeneutic-realism and epistemological relativity that underpins the thesis.

For each paper, existential bracketing began at the literature review and research question development phase. One can limit the impact of research propositions and theories by tempering the pursuit of knowledge prior to data gathering and analysis (Chan, Fung, & Chien, 2013). The literature reviews that contributed to the research questions in the two respective papers were intended to stoke curiosity in the world of DTCs and, to justify the pursuit of the research questions with a rationale. Existential bracketing continued through the data gathering phase of each paper. For the research paper, a semi-structured interview guide was applied with the intention of focusing the interviewees on the area of interest (i.e. belongingness), whilst giving respondents the freedom to discuss what the phenomenon meant to them and their experience of life in a DTC (Chan et al., 2013). For example, rather than work from the theoretical definition of belongingness, the first question was to ask each participant what belongingness meant *to them*. When selecting papers for the thematic

synthesis, the aim was to limit the constraints of research propositions, and theories, by implementing broad inclusion criteria.

Through the data analysis phase, existential bracketing was applied much the same in both papers. Data analysis was conducted inductively, meaning the analysis was completed without a pre-existing coding frame or particular analytic preconceptions (Braun & Clarke, 2006). For the thematic synthesis paper, a sense of connection appeared to be a recurring theme. Hence, it was particularly difficult to bracket away prior reading around belongingness that had informed the introduction for the research paper. A number of steps were applied to assist with the inductive analysis of both papers. Data collection and analysis were completed for the thematic synthesis prior to collecting data and conducting the subsequent analysis for the research paper. Initial coding remained close to the wording of the original data and, in most cases, this meant using truncated quotes. As analysis moved from coding to the more interpretive matter of theme production, I would ask myself, "has this come from the data?". Answering this question meant going back to the data to find quotes that supported the proposed themes. Copies of the analysis were shared with two research supervisors and their feedback helped to reflect further on areas where suppositions concerning research propositions, and theories, may have occurred. For both papers, existential bracketing ended at the discussion phase, so that the respective analyses could be explored within the wider research context.

The existential bracketing steps outlined above should engender a degree of confidence in the extent to which the respective analyses can be said to have arose from their individual data, rather than an amalgam of the two.

Relationship between the proposed models

It would appear that a limitation with applying existential bracketing both within, and between, the two thesis papers, is that three separate models have been proposed to help understand the experience of DTC membership. In essence, two discrete analyses have been favoured, to the detriment of arriving at a cohesive whole. However, such a conclusion would be misleading. The two models from the research paper intentionally observe belongingness from different perspectives. The model depicting the course of DTC-related belongingness presents a roadmap for how belongingness develops, and shifts, over the course of a DTC membership period. In this model, belongingness takes centre stage. By contrast, the B-RA-SE triad focuses on the relationship between three therapeutic factors that are thought to pervade the DTC journey (rather than dissect the journey itself). In the B-RA-SE triad, belongingness is positioned equally alongside self-esteem and responsible agency. Thus, the two models from the research paper were never intended to form a cohesive whole and, instead, should be viewed as complementary.

Despite bracketing, the model depicting the relationship between themes from the thematic synthesis paper shares key similarities with the B-RA-SE triad. As detailed earlier, many of the core elements across the models are thought to be universal to the human experience, which could account for some of the observed similarity. The thematic synthesis model depicted three core themes: TC structure; connecting with the group; and facilitating therapeutic engagement. I propose that connecting with the group, and therapeutic engagement, are wholly captured by the B-RA-SE triad under the headings of "belongingness", and "responsible agency". I have already argued in the thematic synthesis paper that the theme of connecting with the group appeared to be a lay representation of the belongingness hypothesis. With respect to the therapeutic engagement theme, this shows clear overlap with how responsible agency is depicted in the B-RA-SE triad, insofar as the latter involves the demonstrable act of accepting the responsibility to participate in the DTC.

The theme of therapeutic community structure was not present in the B-RA-SE triad; thus, I have proposed an integrative model of the two (see figures three and four). In the integrative model, just as with the thematic synthesis model, I maintain that the DTC structure both contributes to, and is informed by, belongingness and responsible agency. Yet, in the integrative model, I depict the DTC structure as the specific methods (e.g. distribution of power, importance of boundaries etc.) that envelop the therapeutic processes that occur within the DTC. Thus, the DTC structure can be considered relatively constant – these are the recognized methods of a DTC, from beginning, to end. By contrast, the B-RA-SE triad represents a fluid therapeutic process that is both informed by, and a contributor to, those DTC methods. Future research may wish to explore the integrative model with DTC members/former members, in greater detail.

The three phases of DTCs

It is recommended that DTC membership is preceded by a preparatory group and followed by a discharge group (Pearce & Haigh, 2017). Preparatory groups typically meet for two hours per week, for a period of 12 months, with the aim of preparing prospective members for the main treatment phase through careful use of assessment, practical planning and, in some cases, commitment to a treatment contract. By contrast, discharge groups seek to support DTC members to manage the losses associated with leaving, and to re-establish social networks outside of the DTC. Sandwiched between the two is the main treatment phase of DTC membership. The treatment phase typically lasts between 12-18 months and consists of community meetings, formal therapy groups, activity groups and informal time (Pearce & Haigh, 2017).

A limitation of the research is that the interview guide focused primarily on the experience of participation in the active DTC treatment phase, only. The semi-structured nature of the interviews allowed for organic conversations about pre and post groups to emerge, but the guide did not actively pursue those conversations. Therefore, the proposed models can only account for what occurs at the main treatment phase of DTC membership. Only a few participants referred to their pre and/or post groups. Such absences may reflect that membership to the core treatment phase of the DTC was the most salient part of their stories; however, it would undoubtedly reflect the contents of the interview guide, too. For those participants who did discuss pre and/or post groups, there was considerable variability in how those groups operated. For example, Sophie noted how their discharge group lasted for 24 months, whereas Karen stated that theirs lasted for half of that, at 12 months. There were also variations in how many people attended, how frequently the group met, and the geographical location of each group. It should be noted that, prior to commencing an interview, I clarified that the questions would pertain to the core treatment phase of DTC membership, unless otherwise stated.

Exploring the research models in either/both the pre and post DTC groups would offer an interesting area for future research. Capturing the bookends to the core treatment phase of the DTC group would offer an account that captures the entirety of what could be considered the full DTC journey. It could be particularly interesting to observe how belongingness operates in the discharge group, as the process model suggests that, upon leaving the DTC, former members should be better placed to make space for belonging in their relationships. Moreover, the discharge group represents a new set of people to form relationships with and, it would be interesting to observe whether participants entered that group with the same fears around rejection with which they entered the core treatment group.

Methodological considerations from the empirical paper

Though thematic analysis was ultimately used to analyse participants' interview transcripts, alternative approaches were considered – namely, interpretative phenomenological analysis (IPA) and grounded theory.

Research questions concerned with individual experiences, and the meanings attached to them, are well suited to an IPA inquiry (Pietkiewicz & Smith, 2014). The successful application of IPA assumes a relatively high degree of similarity among participants (Pietkiewicz & Smith, 2014), so that individual participant themes can subsequently be translated across participants. However, participant demographics varied considerably (see table three of the empirical paper), suggesting that their experiences may be too dissimilar to successfully translate within an IPA approach.

Grounded theory is primarily concerned with the actions people take, and the meanings behind such actions (Thornberg & Charmaz, 2014). The application of grounded theory has been described as a "time-consuming and long process" (Backman & Kyngäs, 1999, p. 152). Backman and Kyngäs contend that grounded theory is particularly laborious for those new to the method, noting that a compromise must be sought between the demands of the approach and the resources available to the novice researcher. Having weighed the intricate, time-intensive demands of the grounded theory approach against my personal resources, I felt that I could not do justice to the approach and, ultimately, the analysis would suffer. Specifically, I would qualify as a novice grounded theory researcher, working independently, with a total of six months separating the ethics submission date from and the final day of clinical training.

In contrast to IPA and grounded theory, thematic analysis offered an inductive means of exploring participants' experiences, whilst being flexible in terms of both

ontological/epistemological assumptions and sample characteristics (Braun & Clarke, 2006). Indeed, the purpose of a thematic analysis is not necessarily to produce a robust theory; thus, the method may not involve some of the more time-consuming aspects associated with a successful grounded theory, such as purposively sampling participants to address conceptual and/or theoretical gaps within one's emerging theory (Timonen, Foley, & Conlon, 2018).

The spectre of COVID-19

Originally, face-to-face interviews were to be conducted with participants. However, owing to the COVID-19 pandemic, these were removed and, instead, remote means of interviewing were planned. The primary reason behind the change in interview mode was to protect myself, the participants and our local communities from possible COVID-19 transmission. Moreover, given that I could not account for when the next COVID-19 lockdown might occur, sticking exclusively to remote interviewing would also eliminate the need to modify my approach midway through data collection.

From a methodological standpoint, the research satisfied Farooq and De Villiers (2017) five suitability criteria for remote interviewing in qualitative research. Specifically, (1) contextual data was not necessary for the collection of spoken-word data; (2) the target population can be expected to be reasonably experienced with using a telephone / the internet as 95% of UK households own at least one mobile phone (O'Dea, 2020) and 95% of adults aged 16-74 in the UK use the internet regularly (Office for National Statistics, 2019); (3) at the time of the interviews I was confident using the telephone/videoconferencing as I had been facilitating clinical work via these technologies for the previous six months; (4) I could offer participants the choice of internet or telephone interviews (rather than deciding for

them); and (5) facilitating remote interviews was manageable within the £0.00 budget of the project.

Much of the literature concerned with the quality of data obtained from remotely facilitated qualitative interviews has focused on the use of telephones. In part, this discrepancy may be due to the relatively recent emergence of videoconferencing software (e.g. Skype was launched in 2003 and Microsoft Teams was launched in 2017) comparative to the invention of the home telephone (which was patented in 1876). In her review of the literature concerning telephone facilitated qualitative interviews, Novick (2008, p. 397) concluded, "there is little evidence that data loss or distortion occurs, or that interpretation or quality of findings is compromised when interview data are collected by telephone". For the purpose of collecting spoken data only, differences between the mode of interview may be a question of attending to different cues, rather than an absence of cues altogether. For example, Lechuga (2012) posits that whilst visual cues (e.g. facial expressions, body language) may be absent from the telephone interview, researchers can nevertheless recognise the opportunity for prompting/probing by attending to "aural cues", e.g. long pauses, hesitations and volume/tone of voice. Similarly, rather than using a visible nod to display interest and encourage further talk, the interviewer may turn to strategic utterances, e.g. "umm" or "ahh" (Holt, 2010). Indeed, these were practices that I had been implementing in my clinical work for the previous six months so I felt comfortable drawing on them during the research interviews. The average interview duration for the project was 68 minutes, suggesting that the interviews were not unduly short and that participants were forthcoming with their data.

In terms of the present project, my sense was that remote interviewing benefited the project in numerous ways. For example, participants were afforded flexibility in terms of time, date and location that the interview would take place (Cachia & Millward, 2011) and I

was able to sample from a wider geographical area than I had originally envisioned (Cachia & Millward, 2011). Weller (2017) has evidenced that the physical absence of the interviewer can reduce the sense of pressure and potential embarrassment on the part of the interviewee, leading to an increase in interviewee confidence and safety. Thus, my physical absence may have helped participants to feel comfortable to share information that they may not have offered had the interview been conducted in person. Moreover, given that the UK had been through a lockdown and longstanding social distancing measures well before the commencement of the research interviews, it is possible that the participants may have been more adept and comfortable with remote means of communicating than they otherwise would have been had the pandemic not been present.

On the topic of COVID-19 more specifically, I decided not to address the pandemic directly in the interviews and, instead, opted to preserve the original interview agenda. Consequently, COVID-19 was largely absent from participants' narratives. Whilst I felt I did not have the time to pivot the project too drastically, there are a couple of interesting ideas that researchers may wish to pursue in the future. For example, I am aware that a number of DTCs have moved to either an online, or telephone, medium. Research may wish to consider how the experience of belongingness was impacted by the transition from face-to-face DTC work, to a remote means of working.

Conclusion

Much of the literature on the inner workings of DTCs have been limited to post-hoc speculations on observable ingredients. Whilst Haigh (2013) appears to have come closest to positing a recipe for the therapeutic process of DTCs, the research from this thesis challenges Haigh's developmental conceptualisation. This thesis proposes two complementary recipes: (i) the model depicting the course of DTC-related belongingness; and (ii) an integrative

model combining the findings from the thematic synthesis with the B-RA-SE triad of the research paper. The consistency of the findings across the thesis, as a whole, offers a degree of common understanding to what has long been considered a diverse DTC landscape.

References

Backman, K., & Kyngäs, H. A. (1999). Challenges of the grounded theory approach to a novice researcher. Nursing & health sciences, 1(3), 147-153.

Baumeister, R. F., & Leary, M. R. (1995). The need to belong: desire for interpersonal attachments as a fundamental human motivation. *Psychological bulletin*, *117*(3), 497.

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

Brown, J. D., Cai, H., Oakes, M. A., & Deng, C. (2009). Cultural similarities in self-esteem functioning: East is East and West is West, but sometimes the twain do meet. *Journal of Cross-Cultural Psychology*, *40*(1), 140-157.

Cachia, M., & Millward, L. (2011). The telephone medium and semi-structured interviews: a complementary fit. *Qualitative Research in Organizations and Management: An International Journal*.

Cai, H., Wu, Q., & Brown, J. D. (2009). Is self-esteem a universal need? Evidence from The People's Republic of China. *Asian Journal of Social Psychology*, *12*(2), 104-120.

Chan, Z. C., Fung, Y. L., & Chien, W. T. (2013). Bracketing in phenomenology: Only undertaken in the data collection and analysis process. *The qualitative report*, *18*(30), 1-9.

Clarke, S., Winship, G., Clarke, J., & Manning, N. (2017). Therapeutic Communities. In M. Parker (Eds.), *Psychiatric and Mental Health Nursing: The Craft of Caring* (pp. 631-640). Routledge.

Farooq, M. B., & De Villiers, C. (2017). Telephonic qualitative research interviews: When to consider them and how to do them. *Meditari Accountancy Research*, *25*(2), 291 - 316.

Gearing, R. E. (2004). Bracketing in research: A typology. *Qualitative health research*, *14*(10), 1429-1452.

Haigh, R. (2013). The quintessence of a therapeutic environment. *Therapeutic Communities: The International Journal of Therapeutic Communities*.

Holt, A. (2010). Using the telephone for narrative interviewing: a research note. *Qualitative research*, *10*(1), 113-121.

Lechuga, V. M. (2012). Exploring culture from a distance: The utility of telephone interviews in qualitative research. *International Journal of Qualitative Studies in Education*, *25*(3), 251-268.

Novick, G. (2008). Is there a bias against telephone interviews in qualitative research?. *Research in nursing & health*, *31*(4), 391-398.

O'Dea, S. (2020, August 31). *UK households: ownership of mobile telephones 1996-2018.* Statista. https://www.statista.com/statistics/289167/mobile-phone-penetration-in-the-uk/#statisticContainer

Office for National Statistics. (2019, May 24). *Internet Users, UK: 2019.* https://www.ons.gov.uk/businessindustryandtrade/itandinternetindustry/bulletins/internetusers/2019

Pearce, S., & Haigh, R. (2017). *The theory and practice of democratic therapeutic community treatment*. Jessica Kingsley Publishers.

Pearce, S., & Pickard, H. (2012). How therapeutic communities work: Specific factors related to positive outcome. *International Journal of Social Psychiatry*, *59*(7), 636-645.

Pietkiewicz, I., & Smith, J. A. (2014). A practical guide to using interpretative phenomenological analysis in qualitative research psychology. *Psychological journal*, *20*(1), 7-14.

Rapoport, R. N. (1960). *Community as Doctor*. Tavistock Publications.

Sarkissian, H., Chatterjee, A., De Brigard, F., Knobe, J., Nichols, S., & Sirker, S. (2010). Is belief in free will a cultural universal?. *Mind & Language*, *25*(3), 346-358.

Timonen, V., Foley, G., & Conlon, C. (2018). Challenges when using grounded theory: A pragmatic introduction to doing GT research. International Journal of Qualitative Methods, 17(1), 1-10.

Thornberg, R., & Charmaz, K. (2014). Grounded Theory. In S. D. Lapan, M. T. Quartaroli & F. J. Riemer (Eds.), *Qualitative Research: An Introduction to Methods and Designs* (pp. 41-68). Jossey-Bass.

Tufford, L., & Newman, P. (2012). Bracketing in qualitative research. *Qualitative social work*, *11*(1), 80-96.

Veale, D., Gilbert, P., Wheatley, J., & Naismith, I. (2015). A new therapeutic community: Development of a compassion-focussed and contextual behavioural environment. *Clinical psychology & psychotherapy*, *22*(4), 285-303.

Weller, S. (2017). Using internet video calls in qualitative (longitudinal) interviews: Some implications for rapport. *International Journal of Social Research Methodology*, *20*(6), 613-625.

Whiteley, S. (2004). The evolution of the therapeutic community. *Psychiatric Quarterly*, *75*(3), 233-248.

Figure 1

Model Depicting the Course of DTC-Related Belongingness

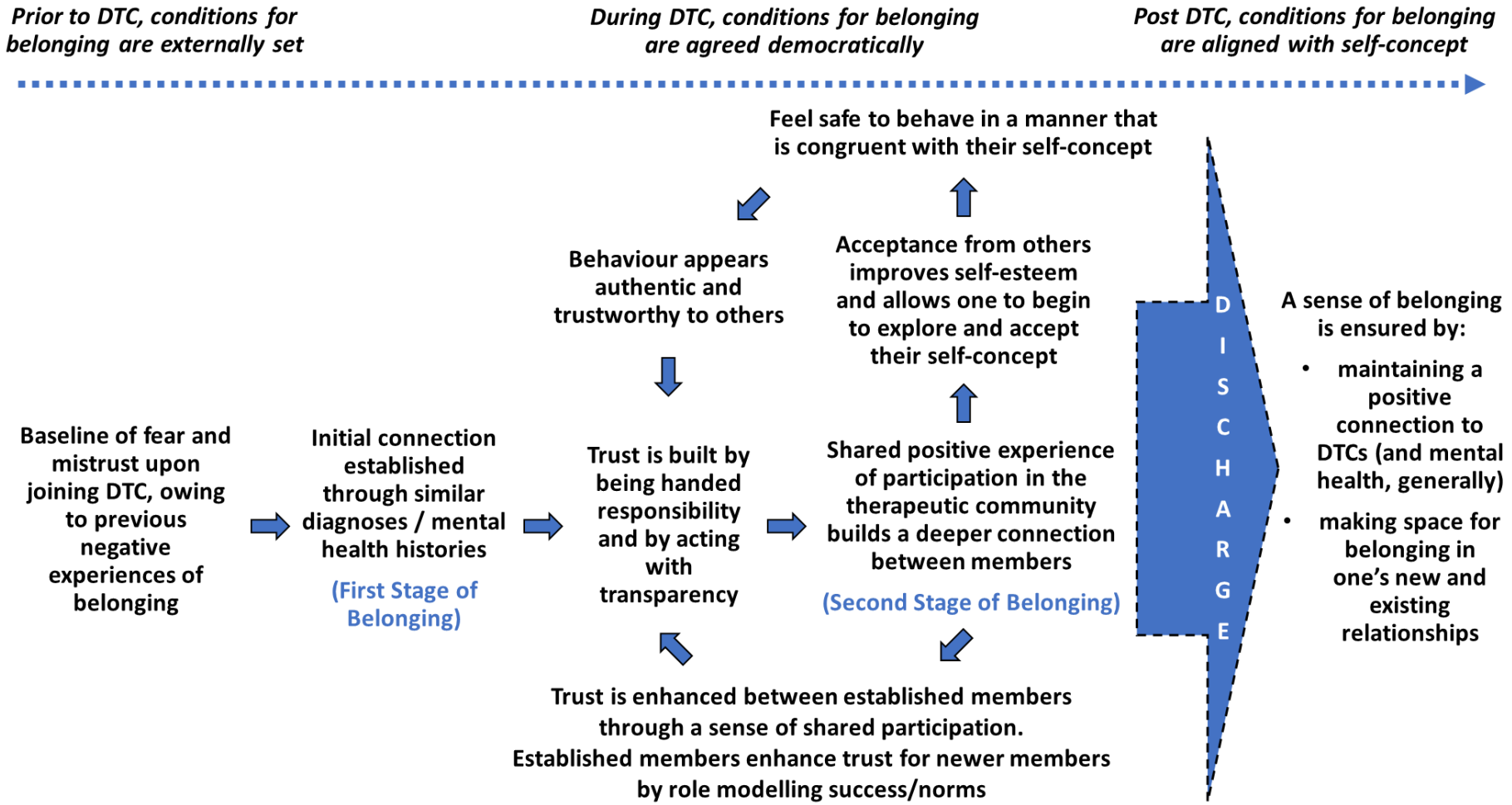


Figure 2

The Belonging, Responsible Agency, Self-esteem [B-RA-SE] triad

Note. Informed by Pearce and Pickard (2012)

Figure 3

Integrative Model (Basic)

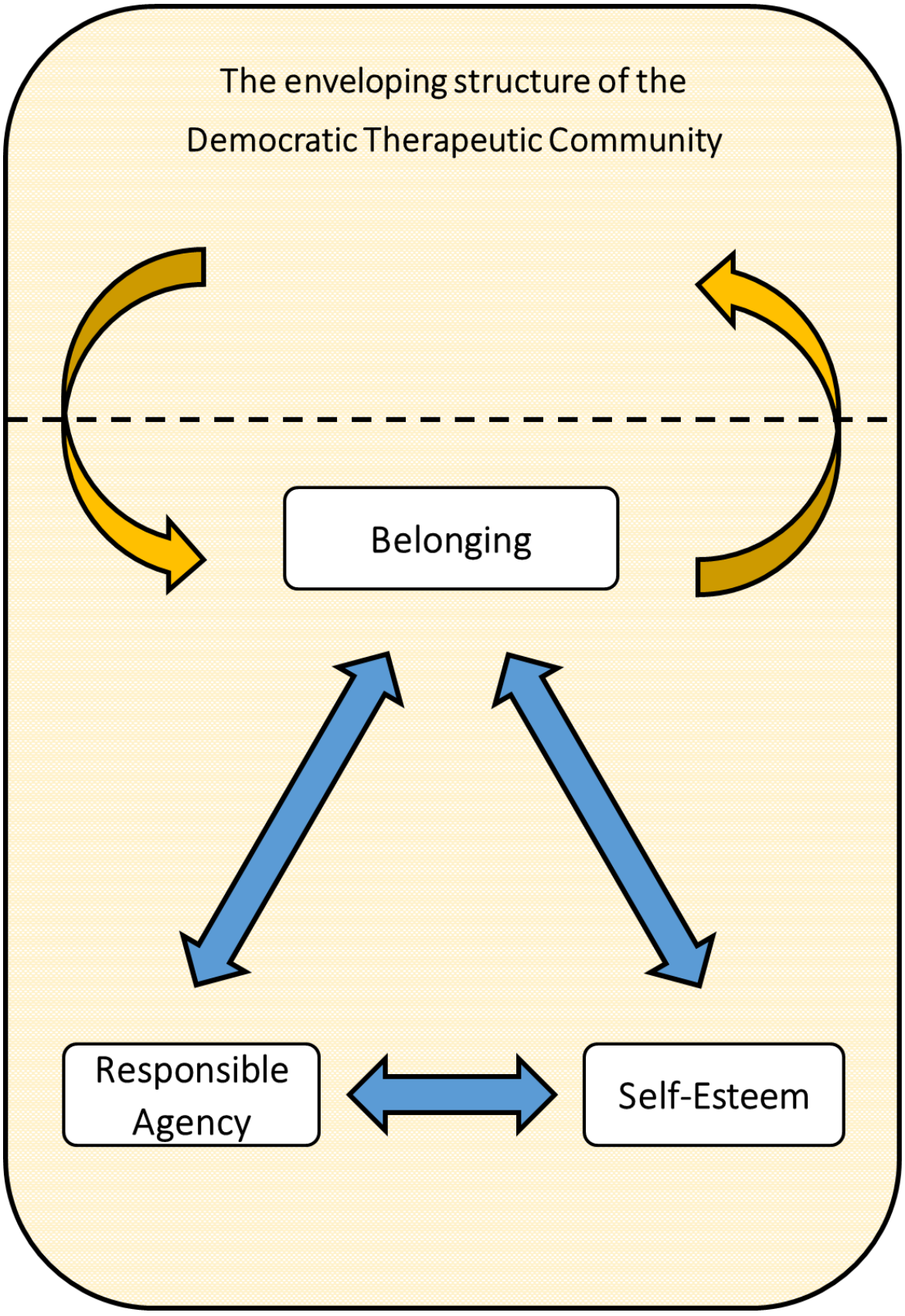
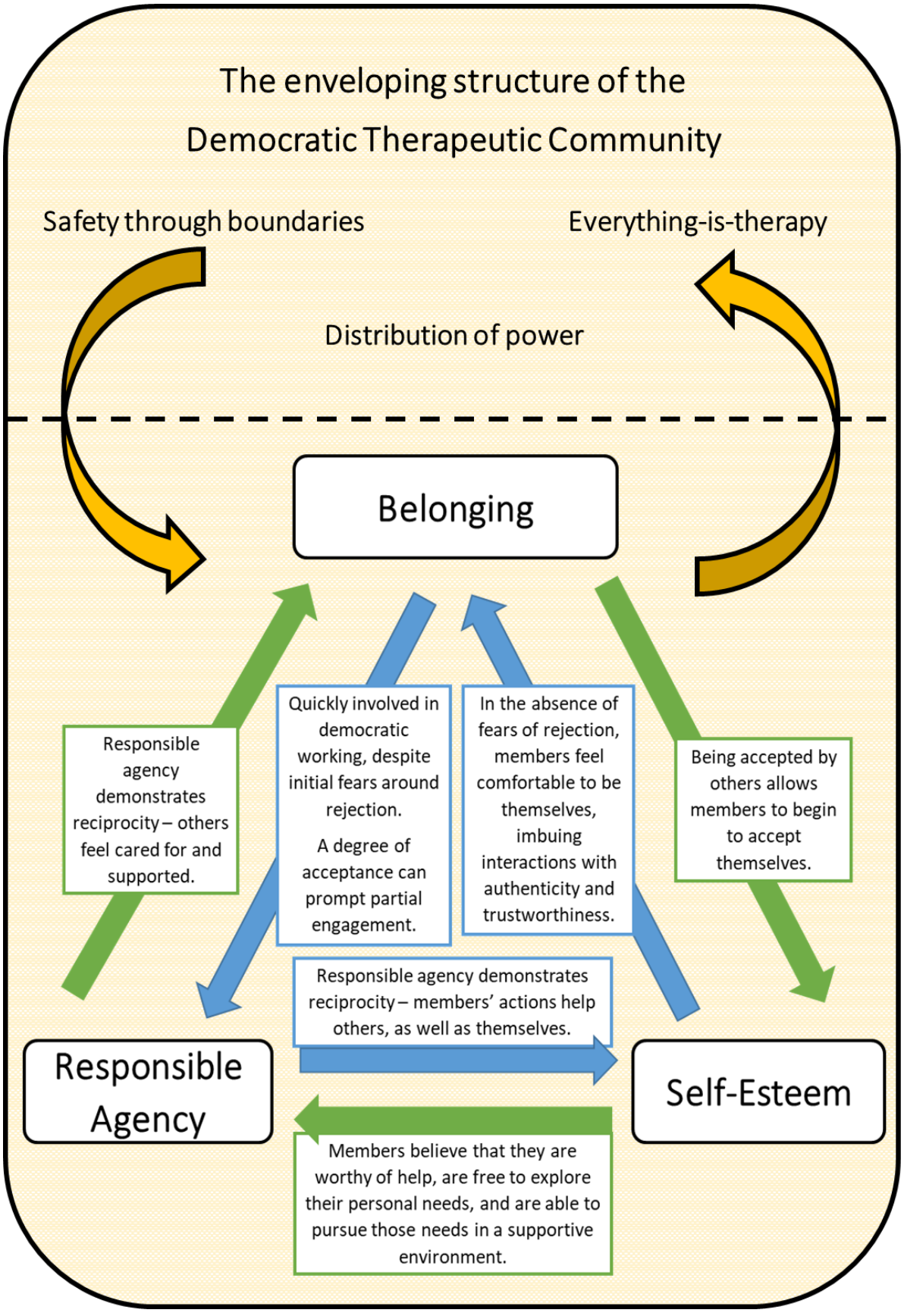


Figure 4

Integrative Model (Detailed)



Chapter 4 Ethics Proposal

Faculty of Health and Medicine Research Ethics Committee (FHMREC)

Lancaster University

Application for Ethical Approval for Research

for additional advice on completing this form, hover cursor over 'guidance'.

Guidance on completing this form is also available as a word document

Title of Project Democratic Therapeutic Communities and the Experience of Belongingness

Name of applicant/researcher: Adam Pitt

ACP ID number (if applicable)*: **Funding source (if applicable)**

Grant code (if applicable):

***If your project has *not* been costed on ACP, you will also need to complete the Governance Checklist [link].**

Type of study

☐ Involves existing documents/data only, or the evaluation of an existing project with no direct contact with human participants. **Complete sections one, *two* and four of this form**

☒ Includes *direct* involvement by human subjects. **Complete sections one, *three* and four of this form**

SECTION ONE

1. Appointment/position held by applicant and Division within FHM DClinPsy Trainee – Division of Health Research

2. Contact information for applicant:

E-mail: a.pitt@lancaster.ac.uk **Telephone**: [PERSONAL INFORMATION REDACTED] (please give a number on which you can be contacted at short notice)

Address: [PERSONAL INFORMATION REDACTED]

3. **Names and appointments of all members of the research team (including degree where applicable)**

Dr Suzanne Hodge – Lecturer in Health Research, research supervisor.

Dr James Kelly – Lecturer in Research Methods, research supervisor.

Dr Gill Aspin – Clinical Psychologist (Pennine Care NHS Foundation Trust), field supervisor.

3. If this is a student project, please indicate what type of project by marking the relevant box/deleting as appropriate: (please note that UG and taught masters projects should complete **FHMREC form UG-tPG**, following the procedures set out on the FHMREC website

PG Diploma ☐ Masters by research ☐ PhD Thesis ☐ PhD Pall. Care ☐

PhD Pub. Health ☐ PhD Org. Health & Well Being ☐ PhD Mental Health ☐ MD ☐

DClinPsy SRP ☐ [if SRP Service Evaluation, please also indicate here: ☐] DClinPsy Thesis ☒

4. Project supervisor(s), if different from applicant:

Dr Suzanne Hodge – Division of Health Research, Lancaster University, Furness Building, Lancaster, LA1 4YG

Dr James Kelly – Division of Health Research, Lancaster University, Furness Building, Lancaster, LA1 4YG

Dr Gill Aspin – Hollins House, Marple, Stockport, SK6 6BA.

5. **Appointment held by supervisor(s) and institution(s) where based (if applicable)**:

Lecturer in health research (Dr Hodge), lecturer in research methods (Dr Kelly) and highly specialist clinical psychologist (Dr Aspin).

SECTION TWO

Complete this section if your project involves existing documents/data only, or the evaluation of an existing project with no direct contact with human participants

1. Anticipated project dates (month and year)
Start date: End date:

2. Please state the aims and objectives of the project (no more than 150 words, in lay-person's language):

Data Management

For additional guidance on data management, please go to Research Data Management *webpage, or email the RDM support email:* rdm@lancaster.ac.uk

3. Please describe briefly the data or records to be studied, or the evaluation to be undertaken.

4a. How will any data or records be obtained?

4b. Will you be gathering data from websites, discussion forums and on-line 'chat-rooms'

4c. If yes, where relevant has permission / agreement been secured from the website moderator?

4d. If you are only using those sites that are open access and do not require registration, have you made your intentions clear to other site users?

4e. If no, please give your reasons

5. What plans are in place for the storage, back-up, security and documentation of data (electronic, digital, paper, etc)? Note who will be responsible for deleting the data at the end of the storage period. Please ensure that your plans comply with General Data Protection Regulation (GDPR) and the (UK) Data Protection Act 2018.

6a. Is the secondary data you will be using in the public domain?

6b. If NO, please indicate the original purpose for which the data was collected, and comment on whether consent was gathered for additional later use of the data.

Please answer the following question *only* if you have not completed a Data Management Plan for an external funder

7a. How will you share and preserve the data underpinning your publications for at least 10 years e.g. PURE?

7b. Are there any restrictions on sharing your data?

8. Confidentiality and Anonymity

a. Will you take the necessary steps to assure the anonymity of subjects, including in subsequent publications?

b. How will the confidentiality and anonymity of participants who provided the original data be maintained?

9. What are the plans for dissemination of findings from the research?

10. What other ethical considerations (if any), not previously noted on this application, do you think there are in the proposed study? How will these issues be addressed?

SECTION THREE

Complete this section if your project includes *direct* involvement by human subjects

1. Summary of research protocol in lay terms (indicative maximum length 150 words):

The belongingness hypothesis posits that humans have an innate, fundamental and pervasive motivation to form and maintain positive interpersonal relationships. Low belongingness has been linked to an increased risk of mental health difficulties and heart disease. In contrast, high belongingness has been linked to a decrease in health problems and increases in positive emotions. Democratic therapeutic communities (DTCs) are an intervention for persons with a diagnosis of personality disorder. In DTCs, the group is considered to be the primary driver of therapeutic change,

and belongingness is specifically leveraged to encourage adherence to group norms. The following qualitative project utilizes semi-structured interviews, conducted remotely with former DTC members, to gain first-hand accounts that explore their experience of belongingness prior to, during, and after DTC membership. Data will be analysed inductively using thematic analysis and findings would contribute to the literature concerning how DTCs work.

2. **Anticipated project dates (month and year only**)

Start date: 22.06.2020 End date: 31.08.2020

Data Collection and Management

For additional guidance on data management, please go to Research Data Management *webpage, or email the RDM support email:* rdm@lancaster.ac.uk

3. Please describe the sample of participants to be studied (including maximum & minimum number, age, gender):

The following inclusion criteria should engender itself to capturing a broad range of responses and experiences from former DTC members:

(i) be over the age of 18;

(ii) be an English speaker (due to funding limitations the use of an interpreter/translation service cannot be facilitated; however, DTCs normally require that members possess good English-speaking skills from the outset);

(iii) have been an active member of a DTC at any stage in their life; and

(iv) have been a member of their respective DTC for a period of at least one month (preferably, the final sample will be comprized of a range of membership periods, allowing for different accounts of belongingness across membership lifespans).

Criteria 3 and 4 have been selected to ensure a degree of exposure to the DTC environment; therefore, providing participants with a body of experience to draw upon at interview. Similarly, participants will be excluded from the project if they are currently a member of a DTC as they will not be able to comment on the experience of belongingness after DTC membership ends.

4. How will participants be recruited and from where? Be as specific as possible. Ensure that you provide the *full versions* of all recruitment materials you intend to use with this application (e.g. adverts, flyers, posters).

Participants will be recruited online using principally, but not exclusively, Twitter, Facebook and Reddit platforms. Personal accounts will not be used at any stage of the recruitment process. Where possible, appropriate persons/organisations with existing accounts will be asked to advertise the study poster

on my behalf by attaching it as a picture in a social media post. For example, the Lancaster University DClinPsy Twitter account has agreed to post a picture of the advertisement poster using their Twitter Handle. I will search Facebook for appropriate groups that are relevant to my target population (e.g. mental health, personality disorder, democratic therapeutic communities) and ask administrative users within those groups to post a picture of the advertisement poster. I will follow a similar method on Reddit as that proposed for Facebook. Where an account is required to help facilitate the recruitment process (e.g. a Reddit/Facebook account from which to contact relevant administrative members in appropriately themed groups) a new account will be created with the sole purpose of facilitating recruitment for the project. Appropriate organisations, advocacy groups and charities (e.g. for people who have a diagnosis of/presentation consistent with personality disorder; for democratic therapeutic communities) will be approached directly to assist with recruitment by displaying the advertisement poster on an appropriate digital platform, or by retweeting/linking to existing advertisements elsewhere. Organisations include but are not limited to: The Consortium for Therapeutic Communities; The Royal Collage of Psychiatrists Community of Communities; and the Democratic Therapeutic Community Umbrella Group (a peer-support network for 6 democratic therapeutic communities across the North-West of England). Once an advertisement has been placed on a given platform it becomes publicly available – anyone will be able to post, tweet, retweet or otherwise share the advertisement once it is in the public domain. Snowballing will be encouraged on the poster itself, at initial approach from an interested party, and again on debrief after the interview.

Participants who contact Adam Pitt about taking part in the project will be screened, by Adam, against the inclusion/exclusion criteria outlined in question 3. During screening, participants will also be asked whether they know of anyone else who would also satisfy the inclusion criteria for the project and who might feasibly want to take part (i.e. snowballing sampling). Where a participant indicates that they know of another person(s) who may be interested in taking part, that participant would be asked to forward a copy of the participant information sheet to the potential interested parties and instruct them to contact Adam Pitt if they would like to learn more about the project.

Adam Pitt will aim to recruit 6-12 participants for the project, a range which falls squarely within the recommended 6-12 participants that are generally required to reach data saturation in qualitative research (Guest, Bunce & Johnson, 2006). Given the combination of a potentially wide-reaching online recruitment strategy and, the relatively small sampling targets, there is a potential that interest in the project could considerably outweigh the target numbers. As a research team, we are particularly mindful that turning away potential participants could be experienced as rejecting, especially if, as suspected, many of the former DTC members might perceive that they have experienced rejections already in their lives. To help manage the expectations of potential participants, both the advertisement and the participant information sheet will make explicit that we intend to recruit a maximum of 12 persons. The participant information sheet will also make explicit that we intend to recruit on a first-come-first-served basis, to illustrate to interested parties that they will not undergo a weighting process whereby one person's involvement is deemed to be more (or less) important than someone else's. Once the maximum number of 12 participants have been recruited, a message will be uploaded to the respective social media outlets, explaining that recruitment has ceased and thanking everyone for their interest in the project.

5. Briefly describe your data collection and analysis methods, and the rationale for their use.

The project follows a qualitative design whereby Adam Pitt will facilitate semi-structured interviews to capture data from participants. The semi-structured interview guide has been developed with key stakeholders (e.g. experts by experience, NHS therapists, third sector therapists) Owing to government mandated social distancing measures, these interviews will be conducted remotely, using either video-conferencing software (I will recommend Microsoft Teams; however, I will aim to be flexible where participants explicitly request an alternative, e.g. Skype) or telephone. Interviews are expected to last approximately 45-60 minutes and they will be audio recorded (using a digital recording device, placed beside the laptop speaker – see question 7 for further details), and transcribed, by Adam Pitt. Consent will be established at the start of an audio recording (see response to question 9 for further details around consent).

Research questions concerned with individual experiences, and the meanings attached to them, are well suited to an interpretative phenomenological analysis (IPA) (Pietkiewicz & Smith, 2014). An advantage of IPA is that an individual participant's experiences are first interpreted in isolation from the overall sample, meaning that the interpretation of one person's experience is less likely to be influenced by the interpretation of another account. However, the application of IPA assumes a relatively high degree of similarity among participants (Pietkiewicz & Smith, 2014), so that individual participant themes can subsequently be translated across participants. In contrast, the proposed sample for this project is expected to be somewhat diverse (e.g. differing lengths of membership to the DTC; differing length of time since leaving the DTC; differing gender; differing age; differing reason for referral), which would likely pose difficulties with translating themes across participants (i.e. their accounts would be too dissimilar). Therefore, data will be analysed using an inductive thematic analysis as this method is more flexible in terms of sample characteristics (Braun & Clarke, 2006) whilst still allowing the research team to focus on the experiential aspects of participants' accounts. The analysis will be conducted from a 'contextualist' position (Madill, Jordan & Shirley, 2000) which assumes that meanings must be understood within their cultural and physical environments (Larkin, Watts & Clifton, 2006). Contextualism integrates ontological minimal-hermeneutic-realism (i.e. 'things' exist, but their meanings are generated by people) and epistemological relativity (i.e. the production of knowledge is bound by historical and social contexts) (Larkin, Watts & Clifton, 2006).

6. What plan is in place for the storage, back-up, security and documentation of data (electronic, digital, paper, etc.)? Note who will be responsible for deleting the data at the end of the storage period. Please ensure that your plans comply with General Data Protection Regulation (GDPR) and the (UK) Data Protection Act 2018.

As the research is being conducted remotely, the use of 'hard copy' documents are not anticipated. Recorded interviews will be transcribed (by me – no independent transcribers will be used) on Microsoft Word and data will be made anonymous. Transcribed files will be password protected and will be stored on Adam Pitt's password protected personal file space on the Lancaster University server, where it can be accessed from home via VPN. Similarly, transcripts will be coded and analysed electronically, and stored on Adam Pitt's protected personal file space on the Lancaster University

server. Finally, it will be necessary to store participant contact details (specifically, email addresses and telephone numbers) in order to arrange their respective remote interviews and, at a later date, to provide them with a summary of the findings of the research. Contact details will be stored electronically across two separate Microsoft Word documents. The first document will include participants' email and telephone details, and each participant will be assigned a unique identification code. The second document will contain a key, matching each individual code with the participants' name. Both documents will be assigned a unique password. The two documents will be stored on Adam Pitt's protected personal file space on the Lancaster University server. Upon receiving a "pass" mark from Lancaster University, participants will be emailed a summary of the research findings, after which the two documents pertaining to participant contact details will then be deleted. Storing data/documents on personal file space on the Lancaster University server (to be accessed from home via VPN) is consistent with the Lancaster University DClinPsy policy for 'storing data during a research study'.

Following submission of the project for assessment (approx. November 2020), audio recorded consent files, anonymized transcripts, and coded data produced as part of the thematic analysis will be encrypted and transferred securely to the DClinPsy Research Co-ordinator who will save the files in password-protected file space on the university server, to be stored for a period of 10 years (providing scope for the project to be re-drafted and submitted for publication, following its assessment as part of the Clinical Psychology programme). Data will be transferred electronically using a secure method that is supported by the University. The DClinPsy admin team will have responsibility for deleting the audio recorded consent files, anonymized transcripts, and coded data following the 10-year storage period. The above approach is consistent with the Lancaster University DClinPsy policy for 'transferring research data for long-term storage'.

7. Will audio or video recording take place? ☐ no ☒ audio ☐ video

a. Please confirm that portable devices (laptop, USB drive etc) will be encrypted where they are used for identifiable data. If it is not possible to encrypt your portable devices, please comment on the steps you will take to protect the data.

Whilst video-conferencing software will be utilized, including those that permit the recording of sessions, the research team have no analytic purpose for visual data. Thus, the research team felt that it would be unethical to collect visual information pertaining to participants – information that is not needed for the purpose of the research – if it was possible to collect the audio data alone. Therefore, to limit the information held about participants, interviews will be audio recorded using a digital recording device (supplied by Lancaster University) that will be placed in close proximity to the speakers of the electronic device being used for the interview (e.g. a laptop or a mobile telephone). No video recording will take place. Unfortunately, the digital recording device is not encrypted. Following an interview, audio recorded data will be transferred from the digital recording device to Adam Pitt's password protected personal file space on the Lancaster University server (estimated to be within 24 hours following the completion of an interview), where it can be accessed from home via VPN. Once an audio file has been successfully transferred from the digital recording

device, to the Lancaster University server, it will immediately be deleted from the digital recording device. It is estimated that the absolute maximum storage space required for the audio files will be no more than 1.2 gigabytes (1 audio file is estimated to be no more than 100 megabytes, with a maximum of 12 audio files).

b What arrangements have been made for audio/video data storage? At what point in the research will tapes/digital recordings/files be destroyed?

Both audio recorded interview data and audio recorded consent files will be stored on Adam Pitt's password protected personal file space on the Lancaster University server, where it can be accessed from home via VPN. Audio recorded consent files will be deleted from Adam Pitt's personal file space once they have been transferred to the DClinPsy Research Co-ordinator (Sarah Heard), where they will be stored for a period of 10 years. In case of queries raised by examiners that would require access to the original audio data, audio recorded interview data will only be deleted following the receipt of a "pass" mark from examiners (approximately, December 2020).

Please answer the following questions *only* if you have not completed a Data Management Plan for an external funder

8a. How will you share and preserve the data underpinning your publications for at least 10 years e.g. PURE?

All relevant files with documentation will be transferred to the DClinPsy Research Co-ordinator who will save the files in password-protected file space on the university server, to be stored for a period of 10 years. Data will be transferred electronically using a secure method that is supported by the University. The DClinPsy admin team will have responsibility for deleting the audio recorded consent files, anonymized transcripts, and coded data following the 10-year storage period.

8b. Are there any restrictions on sharing your data ?

Due to the small sample size, even after full anonymization there is a small risk that participants can be identified. Therefore, supporting data will only be shared on request. Access will be granted on a case by case basis by the Faculty of Health and Medicine.

9. Consent
a. Will you take all necessary steps to obtain the voluntary and informed consent of the prospective participant(s) or, in the case of individual(s) not capable of giving informed consent, the permission of a legally authorized representative in accordance with applicable law? yes

b. Detail the procedure you will use for obtaining consent?

Consent will be established by Adam Pitt, immediately before the commencement of an interview. Owing to government mandated social distancing measures, consent will be recorded as a separate

audio file, prior to the commencement of an interview (i.e. the audio file will act as evidence of consent). Establishing consent via audio file was felt to be the most efficient, inclusive and safe approach. Specifically, establishing consent via audio file would be less time consuming then emailing a consent form, asking that person to sign that consent form, then returning the completed consent form to me. Moreover, it is possible that not all participants would have access to the appropriate hardware to print and return a hard copy of the consent form. Without the necessary hardware, the research team/participants would be reliant upon the postal service for exchanging hard copies of written consent forms. However, reliance on the postal service would require the research team, and participants, to put themselves at an increased risk of contracting COVID-19, when compared to establishing consent via audio recording within the seclusion of one's home (i.e. by visiting a local post office, the research team/participants are likely to encounter other members of the public and this could compromise social distancing measures).

As part of the recruitment process, all eligible participants will receive a participant information sheet prior to scheduling an interview. On the day of, but prior to commencement of, the interview, Adam Pitt will revisit the participant information sheet and offer the participant an opportunity to ask any questions. Having revisited the information sheet, the consent form will be read aloud by Adam Pitt, with consent sought from the participant for each individual item contained within the document. Time for questions will be allocated and the interview will not proceed until the participant is happy to do so.

10. What discomfort (including psychological e.g. distressing or sensitive topics), inconvenience or danger could be caused by participation in the project? Please indicate plans to address these potential risks. State the timescales within which participants may withdraw from the study, noting your reasons.

Although the interview questions are not thought to be intrusive in nature, there always remains the possibility that a topic discussed within an interview might inadvertently cause distress to a participant. For example, explicit discussion around belonging may conjure up difficult experiences where the participant felt as though they did not belong. Indeed, given the current COVID-19 pandemic, and the limitations imposed on our social lives, what it means to belong may have taken on new meanings or significance. Prior to commencing an interview, all participants will be informed of their right to stop the interview at any moment, to choose not to answer any given question, and to receive a full debrief at the end of their interview. Where participants appear to display signs of distress during the interview, Adam Pitt will pause the interview and ask the participant whether they would like to continue, or whether they would like to take a break (or cease the interview outright and withdraw from the study). Numerous resources (that are intended for use in the event of distress) are provided on both the participant information sheet, and on the debrief sheet. These resources include local charities and NHS crisis hotlines (e.g. Samaritans, Sane Line, Shout, '111', emergency services).

Participants may withdraw from the study at any time but, due to the anonymous transcription and thematic analysis processes which follow the interview, it may not be possible to remove their data beyond 2 weeks following their interview date. After this time, whilst every effort will be made to

remove their data, it may not be possible. Participants' right to withdraw will be clearly detailed on the participant information sheet.

11. What potential risks may exist for the researcher(s)? Please indicate plans to address such risks (for example, noting the support available to you; counselling considerations arising from the sensitive or distressing nature of the research/topic; details of the lone worker plan you will follow, and the steps you will take).

Potential risks to members of the research team are expected to be low as all correspondence with participants will take place remotely. The research team will utilize a designated research mobile phone (supplied by Lancaster University) for all telephone communications with participants. Similarly, the research team will use their Lancaster University email accounts for exchanging email communication with participants. As stated earlier, social media accounts will be set up specifically for advertising the project, rather than relying on personal accounts.

12. Whilst we do not generally expect direct benefits to participants as a result of this research, please state here any that result from completion of the study.

Although participants may find participating interesting, there are no direct benefits, or payment, for taking part. Following the dissemination of findings back to the DTC Umbrella Group it is possible that changes will then be implemented which may then improve the DTC environment for future members.

13. Details of any incentives/payments (including out-of-pocket expenses) made to participants:

Not applicable.

14. Confidentiality and Anonymity

a. Will you take the necessary steps to assure the anonymity of subjects, including in subsequent publications? yes

b. Please include details of how the confidentiality and anonymity of participants will be ensured, and the limits to confidentiality.

All interviews will be conducted remotely, either via telephone, or via video-conferencing software. Microsoft Teams will be recommended for video-conferencing interviews as this would be the most secure means of communication. For Microsoft Teams interviews, Adam Pitt will use his Lancaster University account. Where a participant explicitly requests an alternative to Microsoft Teams (e.g. Skype), a new account will be created for the sole purpose of facilitating correspondence/interviews for the research project. If a participant states a preference for utilising an alternative to Microsoft Teams, such as Skype, the participant will be informed that the alternative software cannot be guaranteed to be a completely secure means of communication and they will be offered the option of withdrawing from the study. When arranging the interview, Adam Pitt will suggest that participants establish a private, quiet location in which to conduct the interview – this might include conducting the interview at a specific time/date. To help safeguard any potential children/young persons from being exposed to potentially distressing information, participants who live with children/young

persons will specifically be asked to arrange their interview for a time/location where children will not be within earshot of the interview. On the day of the interview Adam Pitt will ask the participant to consider their immediate environment, and whether others might overhear the content of the interview. Where others might hear the content of our conversation, Adam Pitt will make it explicit that confidentiality cannot be guaranteed under such circumstances and Adam Pitt will suggest identifying a more appropriate environment/day/time for the interview to take place. Nevertheless, it is anticipated that some participants might be happy to proceed with the interview, despite another adult being able to hear the conversation (e.g. a partner). Where a participant would be happy to proceed with the interview, despite the presence of another adult, Adam Pitt will again remind the participant that this would mean that their conversation could not be guaranteed to be confidential. For his part, Adam Pitt will conduct the interviews at his home, in a private, quiet room, free from possible interruptions.

Prior to commencing an interview, participants will be informed of the limits to confidentiality. Specifically, it will be made explicit to each participant that should they reveal any information that suggests that an individual (including the participant) is presently/has been placed at risk of harm, or details of a past/future crime are revealed, Adam Pitt would have to share that information. In the first instance, Adam Pitt would share the information with his supervisors Dr Aspin (field supervisor) and Dr Hodge (research supervisor) and Dr Kelly (research supervisor and practicing clinical psychologist within the NHS). Following our discussion, an appropriate action plan would be devised.

Interview data will be audio recorded and will be transcribed by Adam Pitt. Transcriptions will be made anonymous, substituting participant names for pseudonyms, and identifiable information for generic alternatives. Anonymous quotes from the interview transcripts will be utilized in the written report of the project (e.g. thesis) to support the analytic narrative.

15. If relevant, describe the involvement of your target participant group in the *design and conduct* of your research.

Prior to the design of the project, the DTC Umbrella Group had discussed the idea of conducting a piece of research in the area of belonging. The Umbrella Group is attended by paid staff only, a number of whom are experts-by-experience (i.e. they have previously been members of a DTC and are now part of the paid workforce that facilitate DTCs). Adam Pitt has met with the Umbrella Group on a couple of occasions throughout the design of the current project. Specifically, the Umbrella Group have offered feedback on the relevance of the proposed research, ideal sample sizes, how to access participants, maintaining the safety of participants/the research team, topics for the interview schedule and dissemination strategies.

16. What are the plans for dissemination of findings from the research? If you are a student, include here your thesis.

As research supervisors, Dr Suzanne Hodge and Dr James Kelly will be permitted access to the research data so that technical and/or ethical issues that may arise during the project can be managed,

collaboratively. Foremost, the findings of the project will be disseminated as a third-year thesis, as per DClinPsy training. Following the receipt of a "pass" mark from Lancaster University, findings from the project will be summarized (anonymously) in writing and emailed to all individual participants, and to the DTC Umbrella Group who helped design the project. Where they feel that it would be helpful, Adam Pitt may remotely present the findings at a meeting of the DTC Umbrella Group. Results of the research may be submitted for publication in an academic/professional journal.

17. What particular ethical considerations, not previously noted on this application, do you think there are in the proposed study? Are there any matters about which you wish to seek guidance from the FHMREC?

The present project has had to be amended due to the COVID-19 lockdown and associated social distancing measures. The original project aimed to recruit NHS patients, who were currently a member of a DTC, for a face-to-face interview about belongingness. As such, the research team had already established links with 3 DTCs in the North West that were happy to support participant recruitment. Given the shared decision-making nature of DTCs, it was necessary that each DTC have an open debate, involving all of their respective members, as to whether they would be interested in supporting recruitment to the study. Given that those discussions have already taken place, those 3 DTCs, and their respective members, may be under the expectation that the original project is intended to go ahead. Indeed, prior to the COVID-19 lockdown, a few members from the respective DTCs had already contacted Adam Pitt to signal their interest in taking part. The research team believe that, ethically, those persons who have already contacted Adam Pitt, and the 3 DTCs that had been willing to support recruitment to the project, should be informed of the changes to the project, why those changes have been necessary, and where they can learn more about the amended project (i.e. signposting to the project Twitter handle / Facebook page).

SECTION FOUR: signature

Applicant electronic signature: Adam Pitt Date 13.05.2020

Student applicants: please tick to confirm that your supervisor has reviewed your application, and that they are happy for the application to proceed to ethical review ☒

Project Supervisor name (if applicable): Dr Suzanne Hodge Date application discussed 20.05.20

Submission Guidance

1. **Submit your FHMREC application <u>by email</u> to Becky Case (**fhmresearchsupport@lancaster.ac.uk) as two separate documents:
    i. **FHMREC application form.**
    Before submitting, ensure all guidance comments are hidden by going into 'Review' in the menu above then choosing *show markup>balloons>show all revisions in line.*

ii. **Supporting materials.**
Collate the **following materials for your study, if relevant, into a single word document:**

a. **Your full research proposal (background, literature review, methodology/methods, ethical considerations).**
b. Advertising materials (posters, e-mails)
c. Letters/emails of invitation to participate
d. Participant information sheets
e. Consent forms
f. Questionnaires, surveys, demographic sheets
g. Interview schedules, interview question guides, focus group scripts
h. Debriefing sheets, resource lists

Please note that you DO NOT need to submit pre-existing measures or handbooks which support your work, but which cannot be amended following ethical review. These should simply be referred to in your application form.

2. Submission deadlines:

i. Projects including direct involvement of human subjects **[section 3 of the form was completed]**. The *electronic* version of your application should be submitted to Becky Case **by the committee deadline date.** Committee meeting dates and application submission dates are listed on the FHMREC website. Prior to the FHMREC meeting you may be contacted by the lead reviewer for further clarification of your application. Please ensure you are available to attend the committee meeting (either in person or via telephone) on the day that your application is considered, if required to do so.

ii. The following projects will normally be dealt with via chair's action, and may be submitted at any time. **[Section 3 of the form has *not* been completed, and is not required].** Those involving:

a. existing documents/data only;
b. the evaluation of an existing project with no direct contact with human participants;
c. service evaluations.

3. <u>You must submit this application from your Lancaster University email address, and copy your supervisor in to the email in which you submit this application</u>

Appendices

Appendix A

Research Protocol

Doctorate in Clinical Psychology | Lancaster University

Thesis

Research Protocol: Version 0.1

Democratic Therapeutic Communities and the Experience of Belongingness

Lancaster University

Doctorate in Clinical Psychology

Applicants

Student researcher

Mr Adam Pitt, Clinical Psychology Doctoral Student, Division of Health Research, Lancaster University, Furness Building, Lancaster, LA1 4YX

Tel: [PERSONAL INFORMATION REDACTED] Email: a.pitt@lancaster.ac.uk

Research supervisors

Dr Suzanne Hodge (principal investigator) & Dr James Kelly, Division of Health Research, Lancaster University, Furness Building, LA1 4YG

Tel: 01524 592712 Email: s.hodge@lancaster.ac.uk

Tel: 01524 593535 Email: j.a.kelly@lancaster.ac.uk

Field supervisor

Dr Gill Aspin, Highly Specialist Clinical Psychologist, Hollins House, Marple, Stockport, SK6 6BA

Tel: 0161 716 2070 Email: g.aspin@nhs.net

Introduction

Evolutionary psychologists and anthropologists have argued that, in early societies, individuals would be more likely to survive and procreate if they belonged to a group than if they were alone (Buss & Kendrick, 1998). Building upon this perspective, Baumeister and Leary (1995) developed the belongingness hypothesis: humans have an innate, fundamental and pervasive motivation to form and maintain some degree of stable, positive, interpersonal relationships. Thus, belongingness can be defined as 'the need to be and perception of being involved with others…which contributes to one's sense of connectedness (being part of, feeling accepted, and fitting in), and esteem (being cared about, valued and respected by others)…' (Somers, 1999, p.16). Indeed, a high sense of belongingness can predict happiness (Leung, Kier, Fung, Fung & Sproule, 2013) and has been associated with fewer physical health problems (Begen & Turner-Cobb, 2012). By contrast, a low sense of belongingness has been linked to an increased likelihood of suicidal thoughts / history of suicide attempts (Hatcher & Stubbersfield, 2013), increased risk of depressive symptoms (Cockshaw, Schochet & Obst, 2013), and threats to self-esteem (Knowles, Lucas, Molden, Gardner & Dean, 2010). Nevertheless, the need to belong remains an under-researched area within psychology (Rokach, 2011).

Therapeutic communities (TCs) have been defined as 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). Therapeutic communities have been applied to numerous populations (e.g. children and young people, adult mental health, persons with a diagnosis of learning disability) and settings (e.g. hospital, community (both residential and non-residential) and secure settings). Democratic therapeutic communities (DTCs) are the dominant model of therapeutic community within the UK (Lees, Manning & Rawlings, 1999). DTCs are a medium to long-term intervention for difficulties consistent with personality

disorder (Pearce & Haigh, 2017). Typically, DTCs meet a minimum of once per week (usually from 9am-5pm) and have a membership size of at least 10 persons. The relationships between members, and the interactions that take place within the community, are considered to be where much of the therapy happens (Pearce & Haigh, 2017). An average day in a DTC might include various administrative and reflective meetings, small group work (including activities of daily living, socialising activities, and therapeutic group work), and unstructured 'down time' (Pearce & Haigh, 2017).

From a clinical perspective, a successful therapeutic relationship between therapist and client likely provides some degree of belongingness. In his seminal work on the therapeutic alliance, Bordin (1979) posits that establishing a bond between therapist and client (i.e. a connection to another person) is a key component of the therapeutic relationship. Moreover, the therapeutic relationship reportedly accounts for 22% of client outcome (Martin, Garske, & Davis, 2000), irrespective of the therapeutic model used (Fluckiger et al., 2012). However, whilst a strong therapeutic relationship is an important feature of many psychological interventions, Pearce and Pickard (2013) contend that therapeutic communities represent a cauldron where belongingness can actively be promoted between the peers within the group, as well as with the therapist-facilitators. Drawing on work which indicated that mutual concern among peers fosters hope in a manner that care displayed from a professional does not (Van Ryzin, Gravely, & Roseth, 2009), Pearce and Pickard position peer belongingness as an important and unique feature of therapeutic communities. It has been claimed that therapeutic communities actively encourage peer belongingness by deliberately aiming for social cohesion among their members, believing that the sum of individual experiences contributes to the well-being of the group (Haigh, 2013). Indeed, social expectations and peer pressures that arise from therapeutic communities may serve to encourage normative health behaviours (Cohen, 2004), such as regular exercise, positive sleep hygiene and a balanced diet. Yet, to encourage peer

responsibility to the group, therapeutic communities also advocate practices such as suspension of privileges and early discharge, which may serve to decrease belongingness by engendering feelings of rejection and loneliness (Pearce & Pickard, 2013). Thus, within DTCs may be leveraged both as reward, and as punishment (Baumeister & Leary, 1995), indicating the possibility for considerable variation in how belongingness is experienced among members. Moreover, questions remain as to how DTC members experience belongingness outside of the therapeutic communities themselves, such as following discharge. For example, do members develop skills in DTCs that better enable them to cultivate a sense of belonging to other groups, whether they be pre-existing relationships (e.g. familial and/or friends), or more recent (e.g. starting a new job)?

The following project aims to utilize qualitative research methods to gain first-hand accounts that explore the experience of belongingness among former members of DTCs, including how belongingness is understood outside of the therapeutic community environment. Findings from this project would contribute to the literature concerning how therapeutic communities work, providing commissioners with new information to aid them in the allocation of funds to services, and supporting potential DTC members to make informed decisions with regards to their mental health treatment.

Method

Design

In contrast to traditional hypothesis testing, a key aim of this project is to provide participants with an opportunity to discuss and explore, in detail, their experience of belongingness within, and beyond, the environment of a DTC. With that aim in mind, a qualitative approach will be utilized as this allows for rich and detailed accounts of individual experience (Braun & Clarke, 2014).

Participants

Participants will be recruited online using principally, but not exclusively, Twitter, Facebook and Reddit platforms. Personal accounts will not be used at any stage of the recruitment process. Where possible, appropriate persons/organisations with existing accounts will be asked to advertise the study poster on my behalf by attaching it as a picture in a social media post. For example, the Lancaster University DClinPsy Twitter account has agreed to post a picture of the advertisement poster using their Twitter Handle. I will search Facebook for appropriate groups that are relevant to my target population (e.g. mental health, personality disorder, democratic therapeutic communities) and ask administrative users within those groups to post a picture of the advertisement poster. I will follow a similar method on Reddit as that proposed for Facebook. Where an account is required to help facilitate the recruitment process (e.g. a Reddit/Facebook account from which to contact relevant administrative members in appropriately themed groups) a new account will be created with the sole purpose of facilitating recruitment for the project. Appropriate organisations, advocacy groups and charities (e.g. for people who have a diagnosis of/presentation consistent with personality disorder; for democratic therapeutic communities) will be approached directly to assist with recruitment by displaying the advertisement poster on an appropriate digital platform, or by retweeting/linking to existing advertisements elsewhere. Organisations include but are not limited to: The Consortium for Therapeutic Communities; The Royal Collage of Psychiatrists Community of Communities; and the Democratic Therapeutic Community Umbrella Group (a peer-support network for 6 democratic therapeutic communities across the North-West of England). Once an advertisement has been placed on a given platform it becomes publicly available – anyone will be able to post, tweet, retweet or otherwise share the advertisement once it is in the public domain. Snowballing will be encouraged on the poster itself, at initial approach from an interested party, and again on debrief after the interview.

Once an individual has signalled their interest in taking part, they will be screened by Adam Pitt to ensure that they meet a non-exhaustive set of inclusion criteria for the project. The inclusion/exclusion criteria are:

i. Must be over the age of 18;
ii. Must be an English speaker (due to lack of translation facility);
iii. Must have been an active member of a DTC at any stage in their life; and
iv. Must have been a member of their respective DTC for a period of at least one month (preferably, the final sample will be comprised of a range of DTC membership periods, allowing for different accounts of belongingness across membership lifespans).

Due to funding limitations the use of an interpreter (or translation service) cannot be facilitated. Thus, criterion 2 represents a necessity of budget constraints. Criteria 3 and 4 have been selected to ensure a degree of exposure to the specific environments that are under investigation; therefore, providing participants with a body of experience to draw upon at interview.

During screening, participants will also be asked whether they know of anyone else who would also satisfy the inclusion criteria for the project and who might feasibly want to take part (i.e. snowballing sampling). Where a participant indicates that they know of another person(s) who may be interested in taking part, that participant would be asked to forward a copy of the participant information sheet to the potential interested parties and instruct them to contact Adam Pitt if they would like to learn more about the project.

The researcher will aim to recruit 6-12 participants, a range which falls squarely within the recommended 6-12 participants that are generally required to reach data saturation in qualitative research (Guest, Bunce & Johnson, 2006). Given the combination of a potentially wide-reaching online recruitment strategy and, the relatively small sampling targets, there is a potential that interest in the project could considerably outweigh the target numbers. As a

research team, we are particularly mindful that turning away potential participants could be experienced as rejecting, especially if, as suspected, many of the former DTC members might perceive that they have experienced rejections already in their lives. To help manage the expectations of potential participants, both the advertisement and the participant information sheet will make explicit that we intend to recruit a maximum of 12 persons. The participant information sheet will also make explicit that we intend to recruit on a first-come-first-served basis, to illustrate to interested parties that they will not undergo a weighting process whereby one person's involvement is deemed to be more (or less) important than someone else's. Once the maximum number of 12 participants have been recruited, a message will be uploaded to the respective social media outlets, explaining that recruitment has ceased and thanking everyone for their interest in the project.

Reporting on extensive participant demographics will be avoided as, with an intended sample of this size, the anonymity of participants could be jeopardized (Morse, 2008). Specific participant demographics to be included in the final report will include reason for joining the DTC, length of duration in the DTC, gender and age.

Proposed Materials

Adam Pitt designed a semi-structured interview schedule to help ensure that discussions yield data that is relevant to the research questions. Prior to designing the interview schedule, Adam Pitt met with the DTC Umbrella Group to discuss what the representatives believed would be important areas to include as part of the schedule.

Procedure

Adam Pitt will facilitate semi-structured interviews to capture data from participants. Qualitative interviews offer the researcher an opportunity to use discourse to access the

thoughts, feelings and experiences of another individual (Rubin & Rubin, 2011). Moreover, qualitative interviews have frequently been used in the therapeutic community literature (e.g. Chen, Elisha, Timor & Ronel, 2016; Stevens, 2013; Possick, & Itszik 2018). Owing to government mandated social distancing measures, these interviews will be conducted remotely, using either video-conferencing software (I will propose Microsoft Teams; however, I will aim to be flexible where participants themselves request an alternative, e.g. Skype) or telephone. Interviews are expected to last approximately 45 minutes, to an hour and they will be audio recorded and transcribed by Adam Pitt. Consent will be established by Adam Pitt, immediately before the commencement of an interview. Owing to government mandated social distancing measures, consent will be recorded on a separate audio file, prior to the commencement of the interview (i.e. the audio file will act as evidence of consent). Establishing consent via audio file was felt to be the most inclusive approach, and the best way to maintain public safety. Specifically, it is possible that not all participants would have access to the appropriate hardware to print and return a hard copy of the consent form. Without the necessary hardware, the research team/participants would be reliant upon the postal service for exchanging hard copies of written consent forms. However, reliance on the postal service would require the research team, and participants, to put themselves at an increased risk of contracting COVID-19, when compared to establishing consent via audio recording within the seclusion of one's home (i.e. by visiting a local post office, the research team/participants are likely to encounter other members of the public and this could compromise social distancing measures).

As the interviews will be conducted remotely, it will be necessary to store participant contact details (specifically, email addresses and telephone numbers) in order to arrange their respective interviews and, at a later date, to provide them with a summary of the findings of the research. Contact details will be stored electronically across two separate Microsoft Word documents. The first document will include participants' email and telephone details, and each

participant will be assigned a unique identification code. The second document will contain a key, matching each individual code with the participants' name. Both documents will be assigned a unique password. The two documents will be stored on Adam Pitt's protected personal file space on the Lancaster University server. Upon receiving a "pass" mark from Lancaster University, participants will be emailed a summary of the research findings, after which the two documents pertaining to participant contact details will then be deleted.

As part of the recruitment process, all eligible participants will receive a participant information sheet prior to any agreed contact from Adam Pitt to arrange an interview. On the day of, but prior to commencement of, the interview, Adam Pitt will revisit the participant information sheet and offer the participant an opportunity to ask any questions about the project. Adam Pitt will be clear that participants may withdraw from the study at any time, but due to the anonymous transcription and thematic analysis processes which follow the interview, it may not be possible to remove their data beyond 2 weeks following their interview date. After this time, whilst every effort will be made to remove their data, it may not be possible. Next, the consent form will be read aloud by Adam Pitt, with consent sought from the participant for each individual item contained within the document. No time limit will be imposed on the process detailed above and participants will be made aware that they are free to ask questions at any time. The interview will not proceed until the participant is happy to do so.

Whilst most video-conferencing software permit the recording of sessions, the research team have no analytic purpose for visual data. Thus, the research team felt that it would be unethical to collect visual information pertaining to participants – information that is not needed for the purpose of the research – if it was possible to collect the audio data alone. Therefore, to limit the information held about participants, interviews will be audio recorded using a digital recording device (supplied by Lancaster University) that will be placed in close

proximity to the speakers of the electronic device being used for the interview (e.g. a laptop or a mobile telephone). No video recording will take place. Following an interview, both audio recorded consent files and audio recorded interview data will be transferred from the digital recording device to Adam Pitt's password protected personal file space on the Lancaster University server (estimated to be within 24 hours following the completion of an interview), where it can be accessed from home via VPN. Once an audio consent/interview file has been successfully transferred from the digital recording device, to the Lancaster University server, it will be deleted from the digital recording device. Audio recorded interview files that are stored on the Lancaster University server will be transcribed by Adam Pitt. Transcriptions will be anonymous, substituting participant names for pseudonyms, and identifiable information for generic alternatives. Anonymized transcripts will be password protected. In case of queries raised by examiners that would require access to the original audio data, all audio recoded interview files will only be deleted from the secure Lancaster University server following the receipt of a "pass" mark from examiners (approximately December 2020). As research supervisors, Dr Suzanne Hodge and Dr James Kelly will also be permitted access to the research data so that technical and/or ethical issues that may arise during the project can be managed collaboratively.

Following submission of the project for assessment (approx. November 2020), audio recoded consent files, anonymized transcripts, and coded data produced as part of the thematic analysis will be encrypted and transferred securely to the DClinPsy Research Co-ordinator who will save the files in password-protected file space on the university server, to be stored for a period of 10 years (providing scope for the project to be re-drafted and submitted for publication, following its assessment as part of the Clinical Psychology programme). Data will be transferred electronically using a secure method that is supported by the University. Following the data transfer the original documents will be deleted from Adam Pitt's password

protected personal file space on the Lancaster University server. The DClinPsy admin team will have responsibility for deleting the digital consent forms, anonymized transcripts, and coded data following the 10-year storage period.

Proposed Analysis

Research questions concerned with individual experiences, and the meanings attached to them, are well suited to an interpretative phenomenological analysis (IPA) (Pietkiewicz & Smith, 2014). An advantage of IPA is that an individual participant's experiences are first interpreted in isolation from the overall sample, meaning that the interpretation of one person's experience is less likely to be influenced by the interpretation of another account. However, the application of IPA assumes a relatively high degree of similarity among participants (Pietkiewicz & Smith, 2014), so that individual participant themes can subsequently be translated across participants. In contrast, the proposed sample for this project is expected to be somewhat diverse (e.g. differing lengths of membership to a DTC; differing length of time since leaving the DTC; differing gender; differing age; differing reason for referral), which would likely pose difficulties with translating themes across participants (i.e. their accounts would be too dissimilar). Therefore, data will be analysed using an inductive thematic analysis as this method is more flexible in terms of sample characteristics (Braun & Clarke, 2006) whilst still allowing the research team to focus on the experiential aspects of participants' accounts.

The analysis will be conducted from a 'contextualist' position (Madill, Jordan & Shirley, 2000) which assumes that meanings must be understood within their cultural and physical environments (Larkin, Watts & Clifton, 2006). Contextualism integrates ontological minimal-hermeneutic-realism (i.e. 'things' exist, but their meanings are generated by people) and epistemological relativity (i.e. the production of knowledge is bound by historical and social contexts) (Larkin, Watts & Clifton, 2006).

The proposed analysis strategy has been informed by thematic analysis guidelines (Braun & Clarke, 2006). Each interview will be coded, line-by-line, for "interesting" features pertaining to the research questions. Coding will be completed systematically across the entire dataset. Once all codes have been developed, they will be analysed to see how specific configurations of codes might combine to create broader themes that capture meaningful patterns of response across the data set. Themes (and sub-themes) will be reviewed in two stages: (1) do the individual codes form a coherent pattern within the theme?; and, (2) do the themes accurately reflect patterns of meaning across the entire dataset? Once the themes have been developed, each theme will be analysed to produce a coherent narrative that captures both the value of each theme individually, and, when taken together, as an overarching story of the data. Themes will be given names, and extracts will be located within the data which accurately reflected theme content.

To improve analytical rigour, two processes will be followed throughout the analysis. First, to minimize the contamination of participants' own experiences and meanings, Adam Pitt will reflexively monitor his own assumptions and beliefs so that he can make efforts to consciously remove these from the analysis (Larkin & Thompson, 2012). Second, to audit the analysis (Larkin & Thompson, 2012), Dr Suzanne Hodge and/or Dr James Kelly (research supervisors for the project) will check coding and theme development periodically.

Practical Issues

Potential risks to members of the research team are expected to be low as all correspondence with participants will take place remotely. The research team will utilize a designated research mobile phone (supplied by Lancaster University) for all telephone communications with participants. Similarly, the research team will use their Lancaster University email accounts for exchanging email communication with participants. As stated earlier, social media accounts

will be set up specifically for advertising the project, rather than relying on personal accounts. The proposed online and snowballing recruitment strategy is not expected to incur any significant costs.

As noted, all interviews will be conducted remotely, either via telephone, or via video-conferencing software. Microsoft Teams will be recommended for video-conferencing interviews as this would be the most secure means of communication. For Microsoft Teams interviews, Adam Pitt will use his Lancaster University account. Where a participant explicitly requests an alternative to Microsoft Teams (e.g. Skype), a new account will be created for the sole purpose of facilitating correspondence/interviews for the research project. If a participant states a preference for utilising an alternative to Microsoft Teams, such as Skype, the participant will be informed that the alternative software cannot be guaranteed to be a completely secure means of communication and they will be offered the option of withdrawing from the study. When arranging the interview, Adam Pitt will suggest that participants establish a private, quiet location in which to conduct the interview – this might include conducting the interview at a specific time/date. To help safeguard any potential children/young persons from being exposed to potentially distressing information, participants who live with children/young persons will specifically be asked to arrange their interview for a time/location where children will not be within earshot of the interview. On the day of the interview Adam Pitt will ask the participant to consider their immediate environment, and whether others might overhear the content of the interview. Where others might hear the content of our conversation, Adam Pitt will make it explicit that confidentiality cannot be guaranteed under such circumstances and Adam Pitt will suggest identifying a more appropriate environment/day/time for the interview to take place. Nevertheless, it is anticipated that some participants might be happy to proceed with the interview, despite another adult being able to hear the conversation (e.g. a partner). Where a participant would be happy to proceed with the interview, despite the presence of another adult,

Adam Pitt will again remind the participant that this would mean that their conversation could not be guaranteed to be confidential. For his part, Adam Pitt will conduct the interviews at his home, in a private, quiet room, free from possible interruptions.

Issues around data storage have already been discussed under the 'Procedure' heading.

Ethical Concerns

Prior to commencing an interview, participants will be informed of the limits to confidentiality. Specifically, it will be made explicit to each participant that should they reveal any information that suggests that an individual (including the participant) is presently/has been placed at risk of harm, or details of a past/future crime are revealed, Adam Pitt would have to share that information. In the first instance, Adam Pitt would share the information with his supervisors Dr Aspin (field supervisor) and Dr Hodge and Dr Kelly (research supervisors). Following our discussion, an appropriate action plan would be devised.

The ethics of turning away large numbers of potential participants has been noted and discussed under the 'participants' subheading; thus, they will not be repeated here.

The present project has had to be amended due to the COVID-19 lockdown and associated social distancing measures. The original project aimed to recruit NHS patients, who were currently a member of a DTC, for a face-to-face interview about belongingness. As such, the research team had already established links with 3 DTCs in the North West that were happy to support participant recruitment. Given the shared decision-making nature of DTCs, it was necessary that each DTC have an open debate, involving all of their respective members, as to whether they would be interested in supporting recruitment to the study. Given that those discussions have already taken place, those 3 DTCs, and their respective members, may be under the expectation that the original project is intended to go ahead. Indeed, prior to the COVID-19 lockdown, a few members from the respective DTCs had already contacted Adam

Pitt to signal their interest in taking part. The research team believe that, ethically, those persons who have already contacted Adam Pitt, and the 3 DTCs that had been willing to support recruitment to the project, should be informed of the changes to the project, why those changes have been necessary, and where they can learn more about the amended project (i.e. signposting to the project Twitter handle / Facebook page). Given the current social distancing measures, the research team proposes to send an email to each of the 3 respective DTCs, summarising the above, for them to disseminate appropriately among their members. For those persons that contacted Adam Pitt directly, we propose to send them an individual email which would also explain that we will delete their original correspondence, so that no information continues to be held about them.

Timescale

The following timetable is based on estimations and is intended to provide a rough guide rather than a strict 'recipe' that must be adhered to.

- Develop research protocol and materials (e.g. semi-structured interview, participant information sheet, consent forms etc.), submit for ethical approval – May 2020.
- Refine research protocol based on feedback from FHMREC; submit for ethical approval – May-June 2020.
- Recruit participants, conduct interviews and transcribe audio data – June-August 2020.
- Complete thematic analysis of transcripts – September 2020.
- Finalize draft prior to submission for supervisor feedback – October 2020.
- Incorporate supervisor feedback and submit final thesis to Lancaster University as per training requirements – November 2020.
- Feedback a summary to the DTC Umbrella Group and provide individual summaries for each participant – January 2021.

References

Baumeister, R. F., & Leary, M. R. (1995). The need to belong: desire for interpersonal attachments as a fundamental human motivation. *Psychological bulletin*, *117*(3), 497.

Begen, F. M., & Turner-Cobb, J. M. (2012). The need to belong and symptoms of acute physical health in early adolescence. Journal of health psychology, 17(6), 907-916.

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

Braun, V., & Clarke, V. (2014). What can "thematic analysis" offer health and wellbeing researchers?. *International journal of qualitative studies on health and well-being, 9*.

Buss, D. M., & Kenrick, D. T. (1998). Evolutionary social psychology.

Chen, G., Elisha, E., Timor, U., & Ronel, N. (2016). Why do adolescents drop out of a therapeutic community for people with drug addiction?. Journal of Child & Adolescent Substance Abuse, 25(1), 65-77.

Cockshaw, W. D., Shochet, I. M., & Obst, P. L. (2013). General belongingness, workplace belongingness, and depressive symptoms. Journal of Community & Applied Social Psychology, 23(3), 240-251.

Cohen, S. (2004). Social relationships and health. American psychologist, 59(8), 676.

Guest, G., Bunce, A., & Johnson, L. (2006). How many interviews are enough? An experiment with data saturation and variability. *Field methods, 18*(1), 59-82.

Haigh, R. (2013). The quintessence of a therapeutic environment. Therapeutic Communities: The International Journal of Therapeutic Communities, 34(1), 6-15.

Hatcher, S., & Stubbersfield, O. (2013). Sense of belonging and suicide: a systematic review. The Canadian Journal of Psychiatry, 58(7), 432-436.

Knowles, M. L., Lucas, G. M., Molden, D. C., Gardner, W. L., & Dean, K. K. (2010). There's no substitute for belonging: Self-affirmation following social and nonsocial threats. Personality and Social Psychology Bulletin, 36(2), 173-186.

Larkin, M. & Thompson, A. R. (2012). Interpretative Phenomenological Analysis in Mental Health and Psychotherapy Research. In D. Harper & A.R. Thompson (Eds.), Q*ualitative research methods in mental health and psychotherapy: A guide for students and practitioners* (pp. 101-116). Chichester, West Sussex: John Wiley & Sons, Ltd.

Larkin, M., Watts, S., & Clifton, E. (2006). Giving voice and making sense in interpretative phenomenological analysis. *Qualitative research in psychology*, *3*(2), 102-120.

Lees, J., Manning, N., & Rawlings, B. (1999). Therapeutic community effectiveness: A systematic international review of therapeutic community treatment for people with personality disorders and mentally disordered offenders.

Leung, A., Kier, C., Fung, T., Fung, L., & Sproule, R. (2013). Searching for happiness: The importance of social capital. In The exploration of happiness (pp. 247-267). Springer, Dordrecht.

Madill, A., Jordan, A., & Shirley, C. (2000). Objectivity and reliability in qualitative analysis: Realist, contextualist and radical constructionist epistemologies. *British journal of psychology*, *91*(1), 1-20.

McElvaney, R., & Tatlow-Golden, M. (2016). A traumatized and traumatising system: Professionals' experiences in meeting the mental health needs of young people in the care and youth justice systems in Ireland. *Children and Youth Services Review, 65*, 62-69.

Morse, J. M. (2008). "What's your favorite color?" Reporting Irrelevant Demographics in Qualitative Research. *Qualitative Health Research, 18*(3), 299-300.

Pearce, S., & Haigh, R. (2017). A Handbook of Democratic Therapeutic Community Theory and Practice.

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

Pearce, S., Scott, L., Attwood, G., Saunders, K., Dean, M., De Ridder, R., Galea, D., Konstantinidou, H., & Crawford, M. (2017). Democratic therapeutic community treatment for personality disorder: randomized controlled trial. The British Journal of Psychiatry, 210(2), 149-156.

Pietkiewicz, I., & Smith, J. A. (2014). A practical guide to using interpretative phenomenological analysis in qualitative research psychology. Psychological Journal, 20(1), 7-14.

Possick, C., & Itzick, M. (2018). Women's Experience of Drug Abuse Treatment in a Mixed-Gender Therapeutic Community. *Affilia, 33*(4), 493-508.

Roberts, J. (1997). How to recognize a therapeutic community. Prison Service Journal, 4-7.

Rokach, A. (2011). From loneliness to belonging: A review. *Psychology Journal*, *8*(2), 70-81.

Rubin, H., & Rubin, I. (2012). *Qualitative interviewing: The art of hearing data (3rd ed.)*. Thousand Oaks: SAGE.

Sacks, J. Y., Sacks, S., McKendrick, K., Banks, S., Schoeneberger, M., Hamilton, Z., Stommel, J., & Shoemaker, J. (2008). Prison therapeutic community treatment for female offenders: Profiles and preliminary findings for mental health and other variables (crime, substance use and HIV risk). Journal of Offender Rehabilitation, 46(3-4), 233-261.

Smith, J.A., Flowers, P. & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, research, practice*. London: Sage.

Stevens, A. (2013). The ‘Meanings’ of Female Staff in Male Therapeutic Community Prisons: Gender as Symbolism and Specialism. The Howard Journal of Criminal Justice, 52(5), 479-497.

Vanderplasschen, W., Colpaert, K., Autrique, M., Rapp, R. C., Pearce, S., Broekaert, E., & Vandevelde, S. (2013). Therapeutic communities for addictions: a review of their effectiveness from a recovery-oriented perspective. The Scientific World Journal, 2013.

Van Ryzin, M. J., Gravely, A. A., & Roseth, C. J. (2009). Autonomy, belongingness, and engagement in school as contributors to adolescent psychological well-being. Journal of youth and adolescence, 38(1), 1-12.

Appendix B

Advertising Materials

Recruitment poster (to be disseminated primarily on social media platforms)

WOULD YOU LIKE TO TAKE PART IN SOME RESEARCH?

Doctorate in Clinical Psychology | Lancaster University

CAN YOU HELP?

1. Are you over the age of 18?
2. Have you spent at least one month as a member of a democratic therapeutic community?
3. Has your membership now finished?

IF YOU ANSWERED YES TO ALL 3 QUESTIONS I WOULD BE VERY GRATEFUL TO HEAR FROM YOU

WHAT WOULD YOU BE ASKED TO DO?

- Take part in an interview where we will discuss your experience of belonging to a democratic therapeutic community.
- The interview will last approximately 45-60 minutes and will take place over the telephone or by using Microsoft Teams.
- Participation is voluntary and will be completely anonymous.
- I am hoping to interview 6-12 people.

PLEASE FORWARD THIS ADVTERISMENT TO OTHERS WHO MIGHT BE INTERESTETED IN THE RESARCH.

My name is Adam and this research is being conducted as part of my training to become a clinical psychologist.

If you would like more information about the research, or if you would like to take part, please contact me at: a.pitt@lancaster.ac.uk

Appendix C

Participant Information Sheet

Democratic Therapeutic Communities and the Experience of Belongingness

My name is Adam Pitt and I am conducting this project as a trainee on the Doctorate in Clinical Psychology programme at Lancaster University, Lancaster, United Kingdom.

What is the research about?

It has been suggested that people have a natural desire to seek out relationships with others – to feel a sense of 'belonging'. The desire to belong is thought to be an important part of how democratic therapeutic communities work. We want to explore how belonging is experienced, and understood, by former members of democratic therapeutic communities. This project could help us to better understand how democratic therapeutic communities work.

Who can take part?

If you used to be a member of a democratic therapeutic community, are over the age of 18 and are an English speaker we would like to hear from you. We will be looking to recruit a maximum of 12 people to take part in the project, on a first-come-first-served basis.

Do I have to take part?

No. It's completely up to you to decide whether or not you take part. If you *do* decide to take part, you are free to opt out at any time by informing Adam Pitt. If you choose to withdraw after 2 weeks from the interview date, your data may have been anonymized, analysed (to develop 'themes' that interpret what has been said in the interview), and incorporated into the report. Therefore, it might not be possible for your data to be withdrawn after 2 weeks from your interview date. Nevertheless, every attempt will be made to remove your data, up to the point of analytic theme production.

What will I be asked to do if I take part?

If you decide you would like to take part, you would be asked to participate in a one-time semi-structured interview with Adam Pitt. To help maintain social distancing, the interviews will take place either over telephone or with a webcam – a digital recording device will be used to capture the audio from your interview (no video recorders will be used). Interviews will take place at a time and date that has been agreed in conversation with you. Given the confidential nature of research interviews, and to ensure the quality of the audio recording, it is suggested that the interview take place in a private, quiet location. We recommend using Microsoft Teams for video interviews as this is the most secure method available to us. However, if you would prefer to use an alternative, such as Skype, we can try to arrange this, but we would be unable to guarantee that it would be a completely secure

means of communication. It is expected that interviews will last approximately 45 to 60 minutes. With your permission, the interview will be audio recorded for the purposes of transcription at a later date.

Will my data be identifiable?

Your participation will be treated confidentially and your data will be made anonymous. The data collected for this project will be stored securely and only members of the research team conducting this project will have access to this data:

- Audio recordings will be transferred from the digital recording device to Adam Pitt's password protected personal file space on the Lancaster University server (estimated to be within 24 hours following the completion of an interview). Once an audio file has been successfully transferred from the digital recording device, to the Lancaster University server, it will be deleted from the digital recording device.
- Audio recordings will be transcribed (i.e. typed and stored electronically on a computer) within a period of 2 weeks following the interview date. The typed version of your interview will be made anonymous by removing any identifying information, including your name. Anonymized direct quotations from your interview may be used in the reports or publications from this project, so your name will not be attached to them.
- Your personal data (i.e. contact details) will remain on a password protected file that is separate to your anonymized transcript. Your contact details will be deleted once a summary of the project findings has been sent to you (approximately Winter 2020/21).
- After the project has been submitted for academic assessment, the research co-ordinator at Lancaster University will transfer the audio consent forms and anonymized transcripts to storage on password-protected file space on the Lancaster University server for a period of up to 10 years. Once stored, the DClinPsy admin team will be responsible for the data.
- In case of queries raised by examiners, audio recorded interviews will only be deleted from the secure Lancaster University server following the receipt of a "pass" mark from examiners (approximately winter 2020/21).

There are some limits to confidentiality: if what is said in the interview makes me think that you, or someone else, is at significant risk of harm, I will have to break confidentiality and speak to a member of staff about this. In some circumstances, I might have to share your information with other appropriate parties. For example, I might have to contact the police if you report that a crime has been committed. In any case, the purpose of sharing your information would be to ensure that all efforts have been made to try and keep people safe. If possible, I will tell you if I have to share your information. Additionally, as stated earlier, the internet/telephone lines cannot be guaranteed to be 100% secure.

Lancaster University will be the data controller for any personal information collected as part of this study. Under the GDPR you have certain rights when personal data is collected about you. You have the right to access any personal data held about you, to object to the processing of your personal information, to rectify personal data if it is inaccurate, the right to have data about you erased and, depending on the circumstances, the right to data portability. Please be aware that many of these

rights are not absolute and only apply in certain circumstances. If you would like to know more about your rights in relation to your personal data, please speak to the researcher on your particular study.

For further information about how Lancaster University processes personal data for research purposes, and your data rights, please visit our webpage: www.lancaster.ac.uk/research/data-protection

What will happen to the results?

The results will be summarized and reported for the purposes of doctoral training. During the winter of 2020/21, anonymous, generalized findings will be reported back to the 'Umbrella Group' (a peer-support network comprised of 6 democratic therapeutic communities throughout the North West of England) so that they may be used for the benefit of local democratic therapeutic communities.

Following the receipt of a "pass" mark from examiners, the report may be redrafted and submitted for publication in a peer-reviewed journal.

Are there any risks to taking part in the project?

There are no risks anticipated with participating in this project. However, if you experience any distress following participation you are encouraged to inform Adam Pitt and contact the resources detailed in the next section.

Resources in the event of distress

Should you feel distressed either as a result of taking part, or in the future, the following resources may be of assistance.

- 'Samaritans' provide a listening service during times of distress. Tel: 116 123
- 'Sane Line' aim to improve the quality of life for anyone affected by their mental health. Tel: 020 3805 1790
- 'Shout' is a free text messaging service for people who are in crisis. Text 'Shout' to 85258.
- You may also find it helpful to contact the NHS on '111'; or, if you feel that you are in crisis and your safety cannot be guaranteed, you may wish to contact the emergency services on '999'.

Are there any benefits to taking part?

Although you may find participating interesting, there are no direct benefits in taking part.

Who has reviewed the project?

This study has been reviewed by the Doctorate in Clinical Psychology and approved by the Faculty of Health and Medicine Research Ethics Committee at Lancaster University.

Where can I obtain further information about the project if I need it?

If you have any questions about the project, please contact Adam Pitt:

Mr Adam Pitt

Candidate on the Lancaster University Doctorate in Clinical Psychology

Division of Health Research, Lancaster University, Furness Building, Lancaster, LA1 4YX

Tel: 07508 375 645

Email: a.pitt@lancaster.ac.uk

Dr Suzanne Hodge (Chief Investigator)
Lecturer in Research Methods
Division of Health Research
Lancaster University
Furness Building
Lancaster
LA1 4YG
Tel: 01524 592712
Email: s.hodge@lancaster.ac.uk

Dr James Kelly (Research Supervisor)
Lecturer in Research Methods
Division of Health Research
Lancaster University
Furness Building
Lancaster
LA1 4YG
Tel: 01524 593535
Email: j.a.kelly@lancaster.ac.uk

Dr Gill Aspin (Field Supervisor)
Clinical Psychologist / Lead Clinician
Delamere resource Centre
45 Delamere St
Crewe
Cheshire
CW1 2ER
Tel: 07342 081891
Email: g.aspin@nhs.net

Complaints

If you wish to make a complaint or raise concerns about any aspect of this project, and do not want to speak to one of the research team, you can contact:

Professor Bill Sellwood

Programme Director

Department of Health Research

Lancaster University

Furness Building

Lancaster

LA1 4YX

Tel: 01524 593998

Email: b.sellwood@lancaster.ac.uk

If you wish to speak to someone outside of the Lancaster University Doctorate Programme, you may also contact:

Professor Roger Pickup

Associate Dean for Research

Faculty of Health and Medicine

(Division of Biomedical and Life Sciences)

Lancaster University

Lancaster

LA1 4YG

Tel: +44 (0)1524 593746

Email: r.pickup@lancaster.ac.uk

Thank you for taking the time to read this information sheet.

Appendix D

Consent Form

Study Title: *Democratic Therapeutic Communities and the Experience of Belongingness*

We are asking if you would like to take part in a project concerning how belonging is experienced, and understood, by former members of democratic therapeutic communities. Before you consent to participating in the project we ask that you read the participant information sheet and mark each box

Statements of taking part in the project	Please **INITIAL** each statement
1. I confirm that I have read the information sheet and fully understand what is expected of me within this project.	
2. I confirm that I have had the opportunity to ask any questions and to have them answered.	
3. I understand that my interview will be audio recorded only (i.e. no video recording will take place), and then made into an anonymized written transcript.	
4. I understand that audio recordings will be kept until Adam Pitt receives a "pass" mark from examiners (approximately winter 2021).	
5. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, and without my legal rights being affected.	
6. If I choose to withdraw after 2 weeks from the interview date, I understand that my data may have been anonymized and incorporated into themes, therefore, it might not be possible for my data to be withdrawn. Nevertheless, every attempt will be made to extract my data, up to the point of theme production.	
7. I understand that the information from my interview will be pooled with other participants' responses, anonymized and may be published.	
8. I consent to information and quotations from my interview being used in reports, conferences and training events.	
9. I understand that Adam Pitt will discuss data with their supervisor(s) as needed.	
10. I understand that any information I give will remain confidential and anonymous unless that information suggests that an individual is presently/has been placed at risk of harm, or a crime has/will be committed, in which case the interviewer (Adam Pitt) will need to share this information with his supervisor(s).	
11. I consent to Lancaster University keeping written transcriptions of the interview for 10 years after the study has finished.	
12. I consent to take part in the above study.	

below with your initials if you agree. If you have any questions or queries before signing the consent form please speak to Adam Pitt.

Name of Participant: _____ Signature: _____ Date:_____

Name of Researcher: _____ Signature: _____ Date: _____

Appendix E

Interview Guide

Belonging:

- **What does belonging mean to you?**

  Prompt: Are there any groups / connections / relationships that you feel you belong to?
- **Think back to before you were a member of a democratic therapeutic community. What did belonging mean to you back then?**

Belonging to a democratic therapeutic community:

- **What did it mean to be a member of a democratic therapeutic community?**

  Prompt: did you feel that you belonged to the group?
- **What helped you to develop a sense of belonging to the group?**

  Prompt: Was there a time where you felt that you belonged to the group the most?

  Prompt: Did any specific practices within the group enhance your sense of belonging?
- **What were the benefits of feeling a sense of belonging to the group?**

  Prompt: Benefits to their mental health difficulties?

  Prompt: Benefits to existing relationships / groups?
- **What were the challenges to your sense of belonging to the group?**

  Prompt: Were there times where you felt that you did not belong to the group?

  Prompt: Did any specific practices within the group challenge your sense of belonging?

  Prompt: Suspension of the group, e.g. due to coronavirus?

Belonging in the wider context:

- **Were there any changes to your sense of belonging once your time in the group came to an end?**

  Prompt: What were your expectations & how did they compare to reality?
- **How is your sense of belonging now?**

  Prompt: What has been your sense of belonging since the lockdown and social distancing?

Prompt: How might your sense of belonging have been different if you had not been a member of the group?

Prompt: What is your hope for building/maintaining relationships?

Appendix F

Debrief Sheet

Study Title: *Democratic Therapeutic Communities and the Experience of Belongingness*

On behalf of myself and the research team, I want to thank you for taking part in our project. How do you feel following our interview together?

What is the project about?

The purpose of this project is to better understand how belonging is experienced, and understood, by former members of democratic therapeutic communities. It is hoped that findings from this project could help us to gain a greater understanding of how democratic therapeutic communities work.

How will my data be used?

- Audio recordings will be transferred from the recording device to Adam Pitt's password protected personal file space on the Lancaster University server (estimated to be within 24 hours of when the recording took place). Once an audio file has been successfully transferred to the Lancaster University server it will be deleted from the audio recording device.
- Audio recordings will be transcribed (i.e. typed & stored on a computer) during Summer 2020.
- Your personal data (i.e. contact details) will remain on a password protected file that is separate to your anonymized transcript. Your contact details will be deleted once a summary of the project findings has been sent to you (approximately Winter 2020/21).
- After the project has been submitted for academic assessment, the research co-ordinator at Lancaster University will store the audio consent forms and anonymized transcripts on password-protected file space on the Lancaster University server for a period of up to 10 years.
- In case of queries raised by examiners, audio recorded interviews will only be deleted from the secure Lancaster University server following the receipt of a "pass" mark from examiners (approximately winter 2020/21).
- The results will be summarized and reported for the purposes of doctoral training. During the winter of 2020/21, anonymous, generalized findings will be reported back to the 'Umbrella Group' – a peer-support network comprised of democratic therapeutic communities situated throughout the North West of England - so that they may be used for the benefit of local democratic therapeutic communities.
- Following the receipt of a "pass" mark from examiners, the report may be redrafted and submitted for publication in a peer-reviewed journal

Resources in the event of distress

The following resources may be helpful if you begin to feel distressed as a result of taking part.

- 'Samaritans' provide a listening service during times of distress. Tel: 116 123
- 'Sane Line' aim to improve the quality of life for anyone affected by their mental health. Tel: 020 3805 1790

- ‘Shout’ is a free text messaging service for people who are in crisis. Text ‘Shout’ to 85258.
- You may also find it helpful to contact the NHS on ‘111’; or, if you feel that you are in crisis and your safety cannot be guaranteed, you may wish to contact the emergency services on ‘999’.

Chapter 5 Appendices not covered elsewhere

Appendix A

Letter Confirming Ethical Approval

Applicant: Adam Pitt
Supervisor: Dr Susanne Hodges

Department: DHR

FHMREC Reference: FHMREC19107

23 July 2020

Re: FHMREC19107
Democratic Therapeutic Communities and the Experience of Belongingness

Dear Adam Pitt,

Thank you for submitting your research ethics application for the above project for review by the **Faculty of Health and Medicine Research Ethics Committee (FHMREC)**. The application was recommended for approval by FHMREC, and on behalf of the Chair of the Committee, I can confirm that approval has been granted for this research project.

As principal investigator your responsibilities include:

- ensuring that (where applicable) all the necessary legal and regulatory requirementsin order to conduct the research are met, and the necessary licenses and approvals have been obtained;
- reporting any ethics-related issues that occur during the course of the research or arising from the research to the Research Ethics Officer at the email address below (e.g. unforeseen ethical issues, complaints about the conduct of the research, adversereactions such as extreme distress);
- submitting details of proposed substantive amendments to the protocol to theResearch Ethics Officer for approval.

Please contact me if you have any queries or require further

information.Email:- fhmresearchsupport@lancaster.ac.uk

Yours sincerely,

Dr. Elisabeth Suri-Payer,
Interim Research Ethics Officer, Secretary to FHMREC.

Appendix B

Word Count for Each Component of the Thesis

Table 1

Word Count for Main Text

Component	Word Count
Abstract	298
Literature Review	7,990
Research Paper	7,998
Critical Appraisal	3,989
Ethics Proposal	5,676
Total	25,951

Table 2

Word Count for Additional Material

Component	Word Count
Tables	2,338
Figures	1,033
References	3,389
Appendices	10,995
Total	17,509