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Qualitative psychology in the real world: the utility of template analysis

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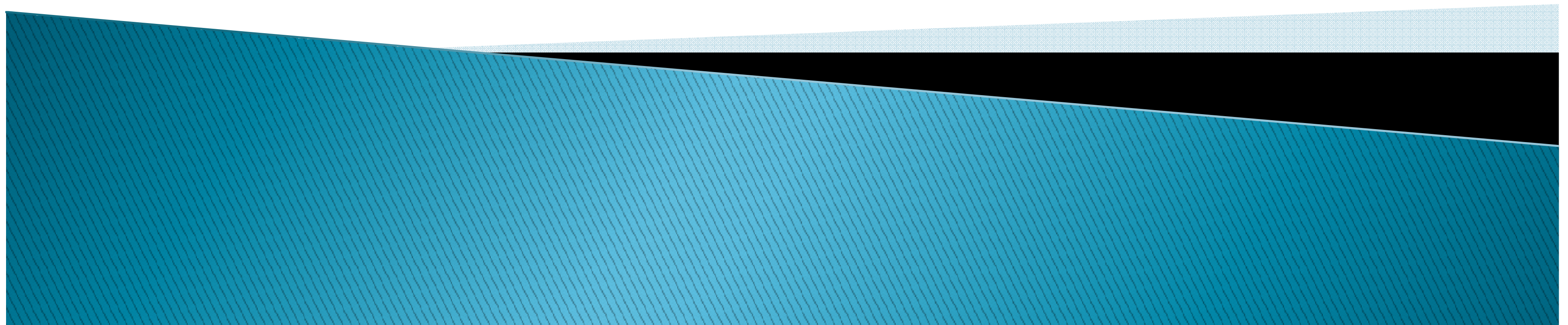
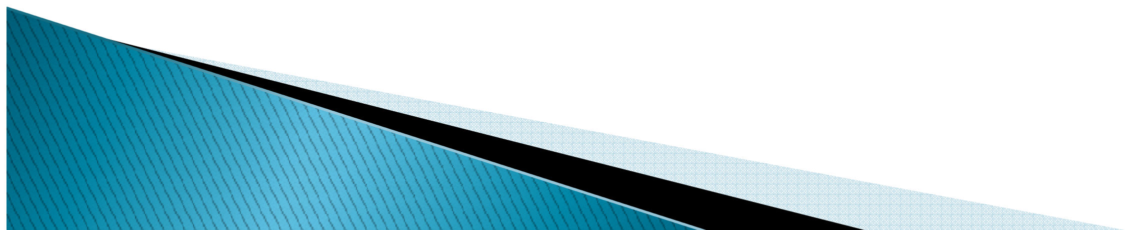


What is ‘applied’ (qualitative) psychology?

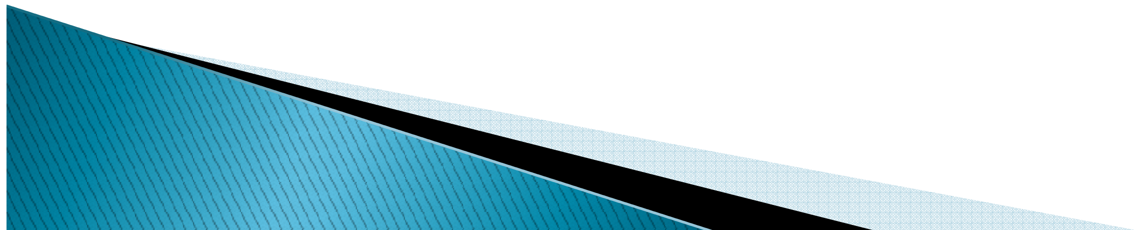
- The application of psychological knowledge to solve practical problems in ‘real world’ settings
- Dichotomy between ‘pure’ and ‘applied’ research is problematic for qualitative psychologists
- An alternative conceptualisation: dimension spanning the ‘academic’ to the ‘hands on’



What is template analysis?

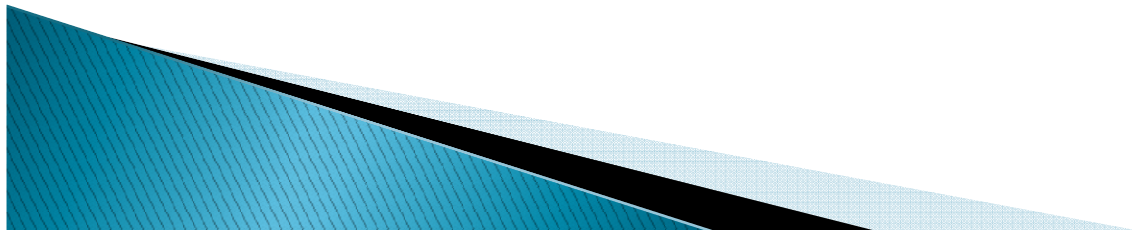
- A technique for the thematic ordering and analysis of qualitative data

- Can be used with a variety of data collection methods



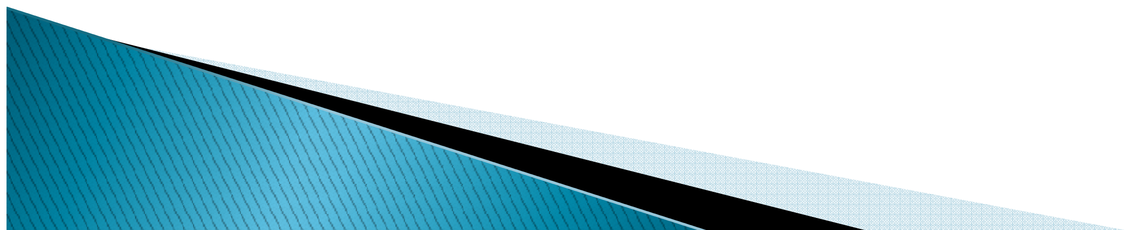
Why use template analysis?

- Epistemological flexibility
- Procedural flexibility
- A priori codes
- Larger data sets



Examples of research using template analysis

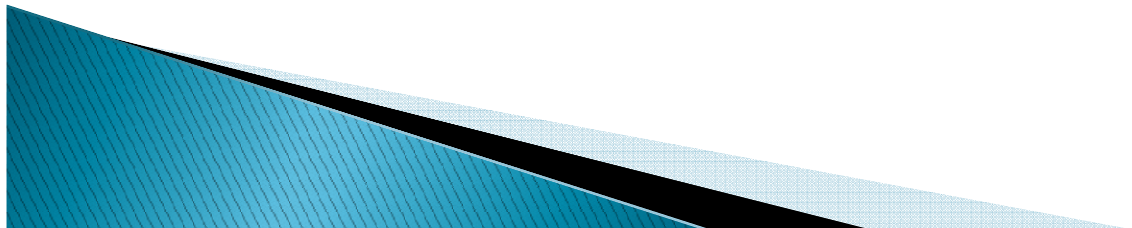
- Collaborative working between healthcare professionals
- Impact of family members on back pain disability



Example 1: Unpicking the Threads

- University of Huddersfield research project funded by Macmillan Cancer Support (expected end date May 2012)

- Research Team: Professor Nigel King, Ms Jane Melvin, Dr Jo Brooks, Dr David Wilde, Ms Alison Bravington

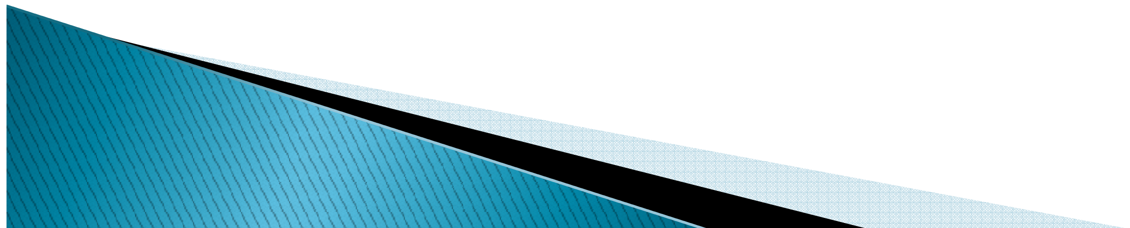


Research Aims

- To examine how specialist and generalist nurses work with each other and with other professionals, carers and patients in providing supportive and palliative care to cancer patients

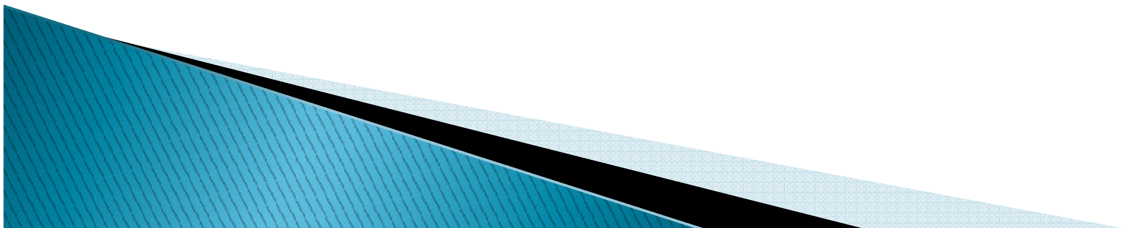
  - Comparisons between cancer and long-term condition patients

  - Implications for practice & service development

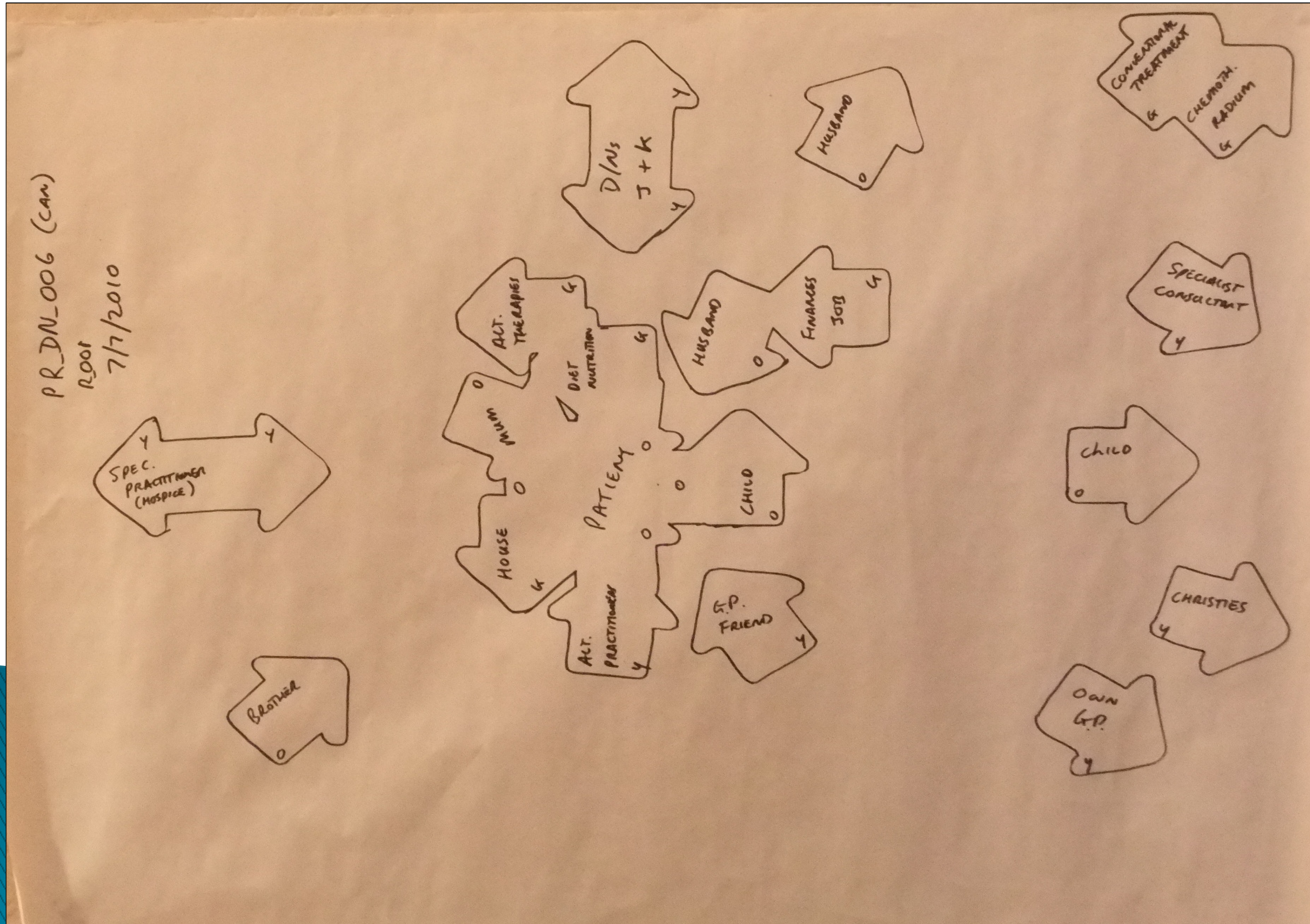


Methods

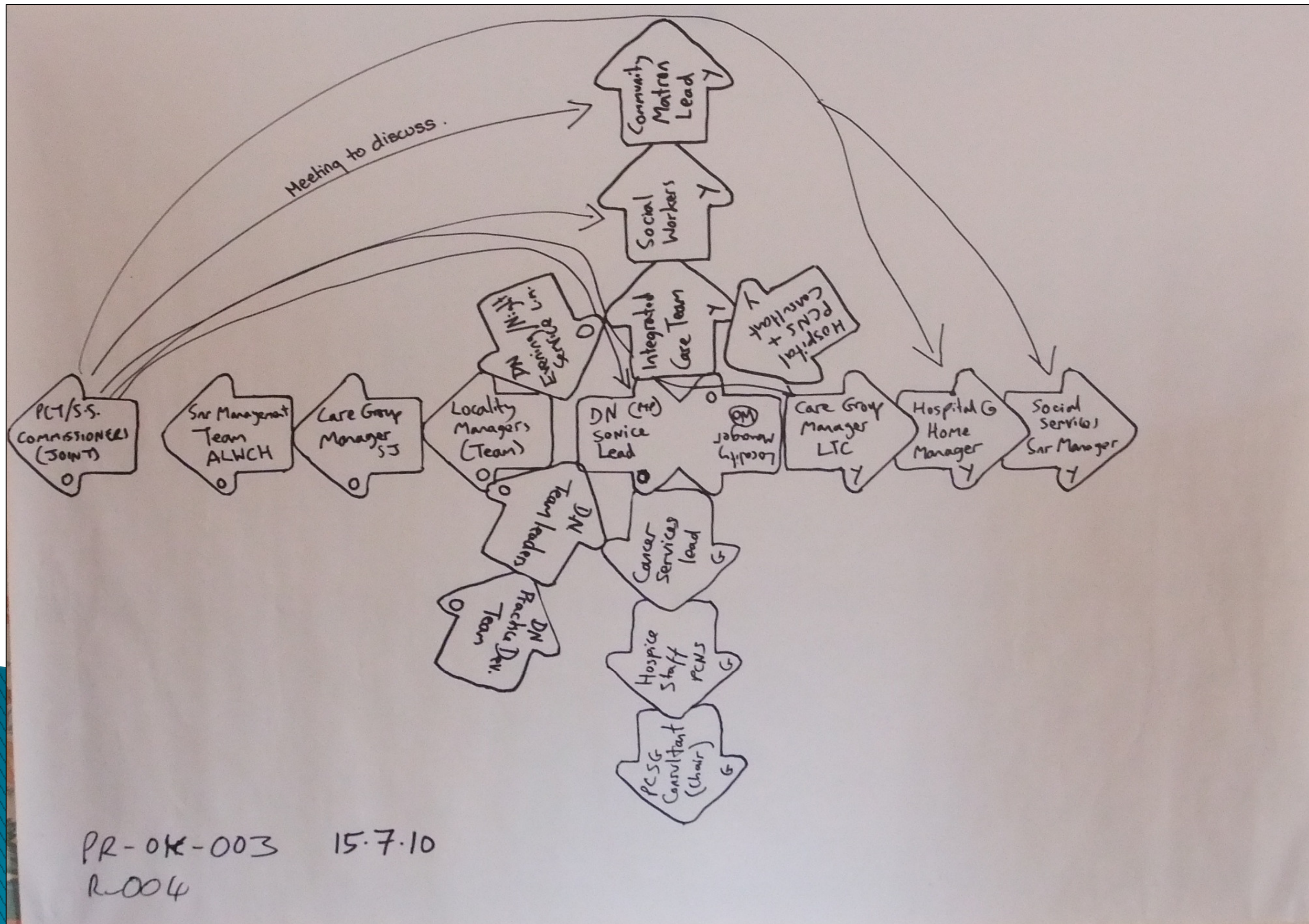
- ‘Pictor’ technique
- More than 70 interview participants covering a variety of professional roles, plus patient and carers



UTT Project: Pictor Chart: District Nurse

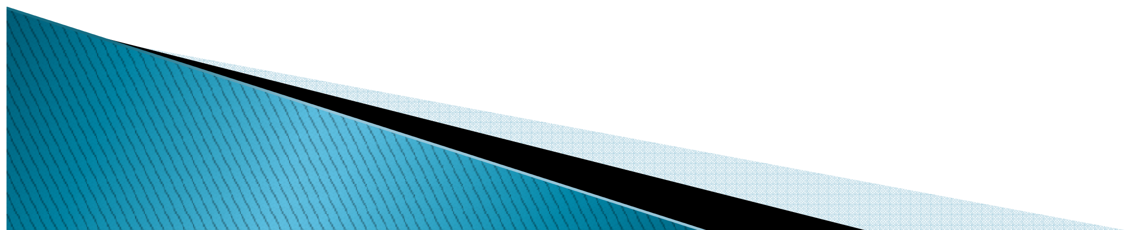


UTT Project: Pictor Chart: Key Stakeholder



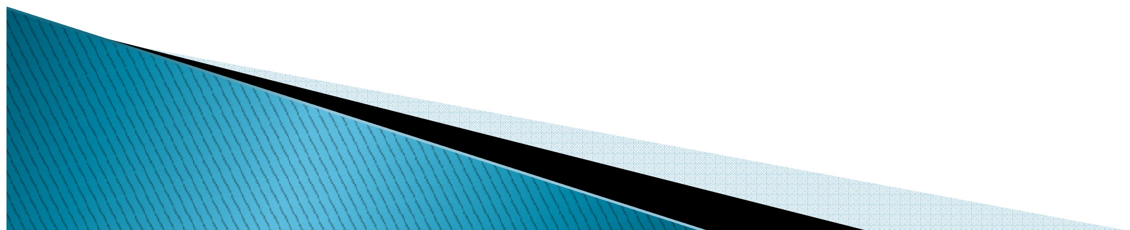
Version 1 template (Jan 2011)

- 1. Survivorship *(5)*
- 2. Comparisons between cancer and LTC *(2)*
- 3. Organisational change *(2)*
- 4. Roles and perception of roles *(3)*
- 5. Relationships and collaborative working *(3)*
- 6. Workload issues *(1)*



Version 8 (Jan 2012)

- 1. What affects collaborative working? *(4)*
- 2. Condition specific involvement *(3)*
- 3. Survivorship *(4)*
- 4. Current NHS reorganisation *(4)*



1. Survivorship

1.1 Understanding of the concept

1.1.1 Patient perceptions of survivorship

1.2 Whose responsibility is it?

1.3 Early intervention?

1.4 End of life vs. survivorship

1.5 Practices to support 'survivors'

2. Comparisons between cancer and LTC

2.1 DN's re. LTC – short term problem solving; Cancer – longer term, more emotional support [role perception]

2.2 LTC's more unpredictable than cancer

3. Organisational change

3.1 Process of managing change

3.1.1 Need for liason at different levels

3.2 Impact of NHS changes

3.2.1 Fragmentation

4. Roles and perception of roles

4.1 Perceptions of CM role

4.1.1 Long term monitoring

4.2 Perceptions of GP role

4.2.1 GPs – curative/ medical models

4.2.2 GPs respond to financial incentives

4.2.3 GPs see selves as independent of NHS

4.2.4 GPs role in palliative/ supportive care

4.2.4.1 QOF – more GP focus on palliative care

4.2.4.2 GPs pass palliative care to nurses

4.3 Perceptions of DN role

4.3.1DN's task focused 2

5. Relationships and collaborative working

5.1 Relationships amongst nursing groups

5.1.1 Work as integrated team

5.2 Relationships between nurses and other professionals

5.2.1 Nurses and GPs

5.2.1.1 GPs difficult to work with

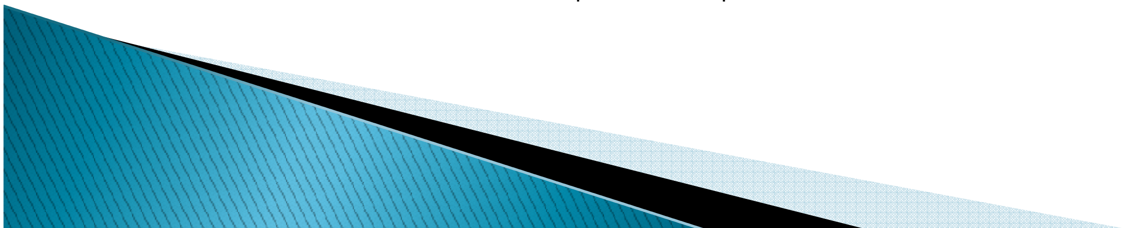
5.2.2 Health and social care – working together?

5.3 Relationships between organisations

5.3.1 Influences (interpersonal; intergroup; structural; geographical)

6. Workload issues

6.1 More palliative LTC patients nursed at home



1. What affects collaborative working?

1.1 Role definitions and distinctions
- 1.1.1 Inter- professional understanding
  - 1.1.1.1 Level of understanding
    - 1.1.1.1.1 Clear understanding of professional role
    - 1.1.1.1.2 Poor understanding of professional role
  - 1.1.1.2 Managing boundaries and defining territory
    - 1.1.1.2.1 Role flexibility
    - 1.1.1.2.2 Role duplication
- 1.1.2 Understanding of own professional role
- 1.1.3 Organisational definitions of role

1.2 Collaborative working practices and systems
- 1.2.1 Access to information and information exchange
  - 1.2.1.1 Facilitators
    - 1.2.1.1.1 Inter-professional meetings
      - 1.2.1.1.1.1 GSF
      - 1.2.1.1.1.2 Other inter-professional meetings
    - 1.2.1.1.2 Information sharing initiatives
      - 1.2.1.1.2.1 Roles/ posts facilitating information exchange *(e.g. liaison DNs)*
      - 1.2.1.1.2.2 Specific schemes *(e.g. 'Good to talk' sessions)*
    - 1.2.1.1.3 Good procedural and case record information available *(e.g. EoL drug info sheets)*
    - 1.2.1.1.4 Effective use of IT systems
    - 1.2.1.1.5 Joint visits
  - 1.2.1.2 Inhibitors
    - 1.2.1.2.1 IT system problems
    - 1.2.1.2.2 Failure to pass on information
    - 1.2.1.2.3 Lack of knowledge about available resources
    - 1.2.1.2.4 Boundary issues in information exchange
  - 1.2.1.3 Inequities in access to information

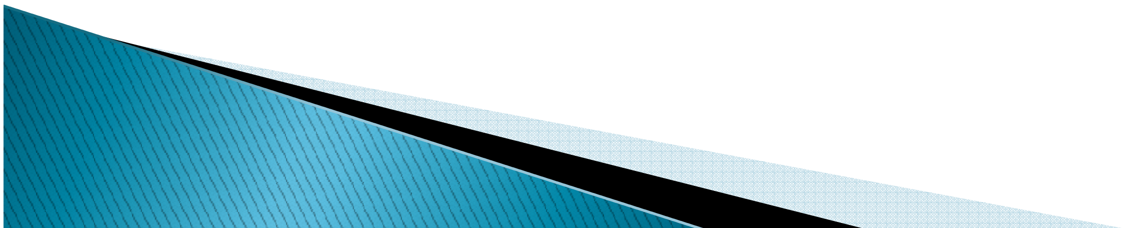
.

- 1.2.2 How to manage the co-ordination of different professional groups working together on a case?
  - 1.2.2.1 Extent of integration between different teams and services
  - 1.2.2.2 Challenges for managing the co-ordination of services
    - 1.2.2.2.1 boundary issues
    - 1.2.2.2.2 cross sector issues
    - 1.2.2.2.3 'too many cooks'
      - 1.2.2.2.3.1 managerial
      - 1.2.2.2.3.2 sheer number of different services
- 1.2.3 Resource issues that affect collaborative working
  - 1.2.3.1 Workload issues that affect collaborative working
  - 1.2.3.2 Financial resource issues that affect collaborative working

.

1.3 Impact of intra-team dynamics on collaborative working

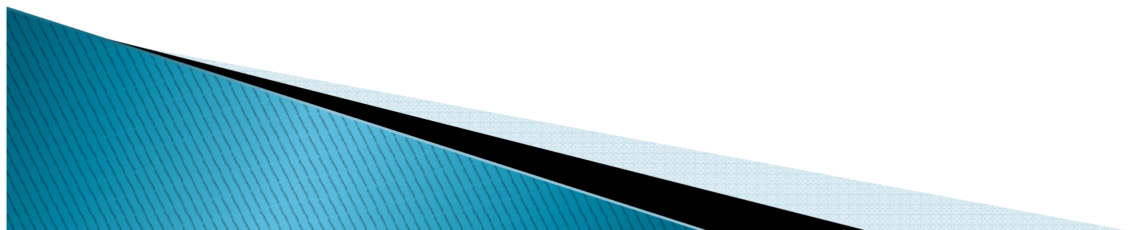
1.4 Impact of inter-personal relationships on collaborative working
- 1.4.1 Longevity of relationship
- 1.4.2 'Stepping on toes' (role overlap)
- 1.4.3 Respect
- 1.4.4 Making an effort
- 1.4.5 Shared job history
- 1.4.6 Accessibility and availability
- 1.4.7 Personal chemistry



Example 2: Significant others and work participation outcomes in back pain

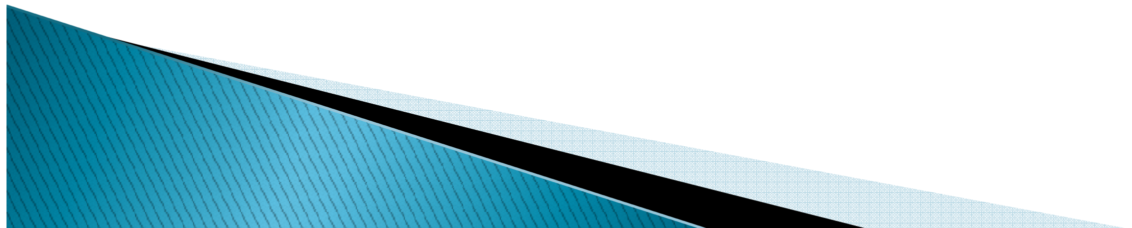
- University of Huddersfield research project funded by the Bupa Foundation (project completed March 2012)

- Research Team: Dr Jo Brooks, Dr Serena McCluskey, Professor Nigel King, Dr Dimple Vyas, Professor Kim Burton



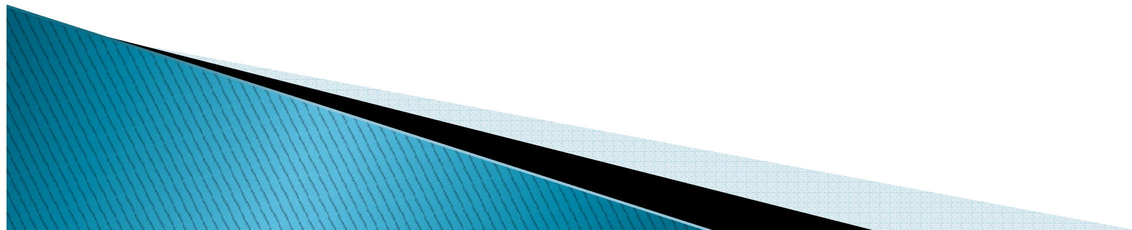
Research Aims

- Qualitative exploration of the illness perceptions/ beliefs/ cognitions of back pain patients <u>and</u> their 'significant others'
- Exploratory study comparing dyads on the basis of work participation outcomes

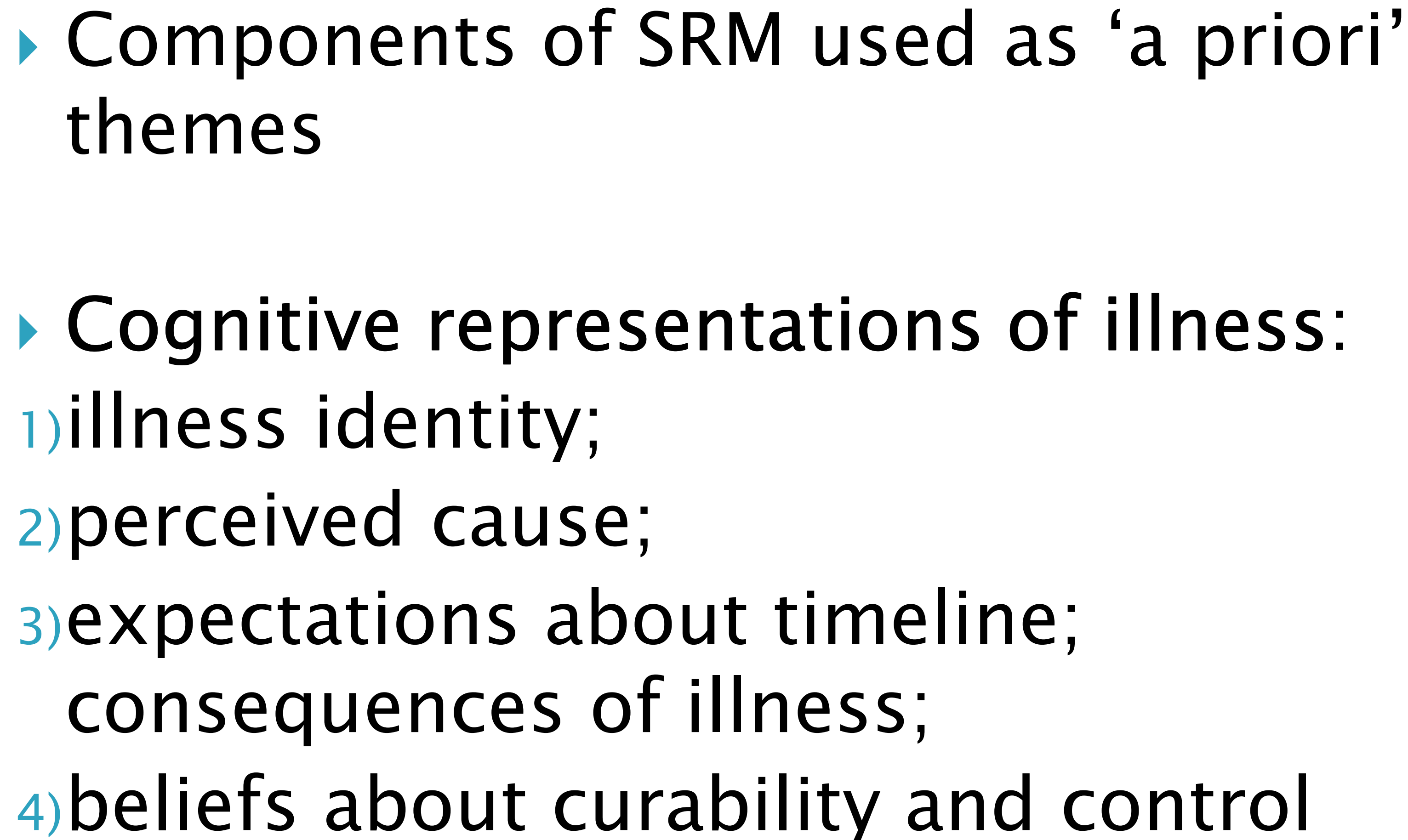


Methods

- Semi structured interviews based on Self-Regulatory Model (SRM)
- Conducted separately with patients and their nominated significant other (N = 18)



Analysis



- Components of SRM used as ‘a priori’ themes

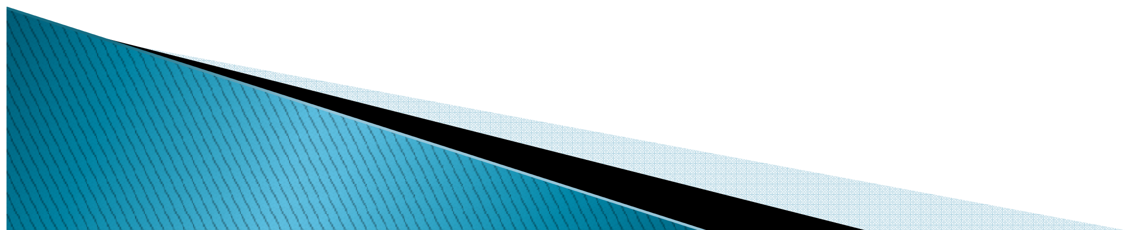
- Cognitive representations of illness:

1) illness identity;
2) perceived cause;
3) expectations about timeline; consequences of illness;
4) beliefs about curability and control

- Emotional representations of illness:

1) emotional representations;
2) (2) illness coherence

- Plus emergent top-level themes
- patient identity;
- impact on and influence of significant others

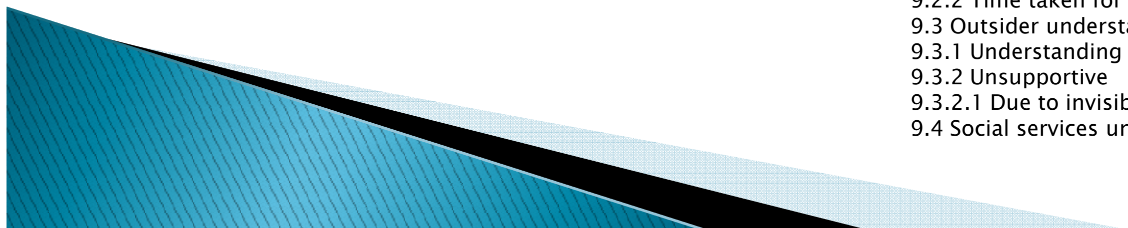


1. Illness identity
1.1 Specific label attributed to condition
1.2 Symptoms
    1.2.1 New onset symptoms
    1.2.2 Previously experienced symptoms
    1.2.3 Pain
        1.2.3.1 Constant
    1.2.4 Symptoms come and go
1.3 Co-morbidities

2. Beliefs about causality
2.1 Beliefs about triggers
2.2 Cause unknown
2.3 Outside sources used to back up causal explanations
2.4 Work as causal

3. Expectations about timeline
3.1. Chronicity (through experience)
3.2 Acute
3.3 Cyclical
3.4 Degenerative

4. Consequences of illness
4.1 Future consequences
    4.1.1 Potential future consequences
    4.1.2 Expected future consequences
4.2 Work
    4.2.1 Adjustments/ flexibility at work
4.3 Sleep
4.4. Things can do
4.4.1 Positive developments skills resulting from condition
4.5 Impact on everyday activities



5. Beliefs about curability and management
5.1 Pain relief
    5.1.1 Medication
        5.1.1.1 Dissatisfaction with
            5.1.1.1.1 not a cure
            5.1.1.1.2 side effects
        5.1.1.2 Would like more
    5.1.2 Injections
        5.1.2.1 Less effective over time
5.2 Surgery
    5.2.1 Last resort/ risks
5.3 Self management
    5.3.1 Just carry on
        5.3.1.1 Takes mind off
    5.3.2 Keep mobile
    5.3.3 Equipment
    5.3.4 Weight issues
        5.3.4.1 Exercise
5.4 Not possible to control/ manage
5.5 Treatment expectations
5.6 Alternative therapies
5.7 Physiotherapy

6. Emotional representations (emotional responses generated by condition)
6.1 SO
6.2 Pat
6.2.1 Antidepressants

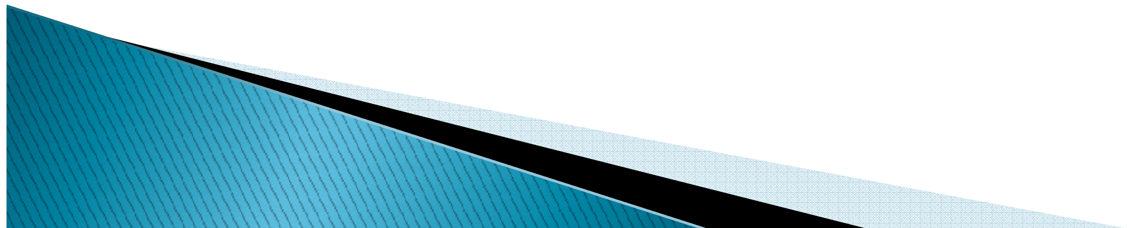
7. Patient identity
7.1 Being a fighter
7.2 Removing blame
7.3 Co-morbidities
7.4 SO as ‘true witness’ to ‘real’ patient
7.5 Patient as victim

8. Impact on and influence of SO
8.1 Fears of future dependency
8.2 Routine dependency
8.2.1 Normalising dependency

9. Illness coherence
9.1 Understanding of the dyad
9.1.1 Shared understanding
9.1.2 Differing models
9.2 Professional (medical) understanding of condition
9.2.1 Pat or SO as more expert
9.2.2 Time taken for medical treatment
9.3 Outsider understanding
9.3.1 Understanding through personal experience
9.3.2 Unsupportive
9.3.2.1 Due to invisibility
9.4 Social services understanding

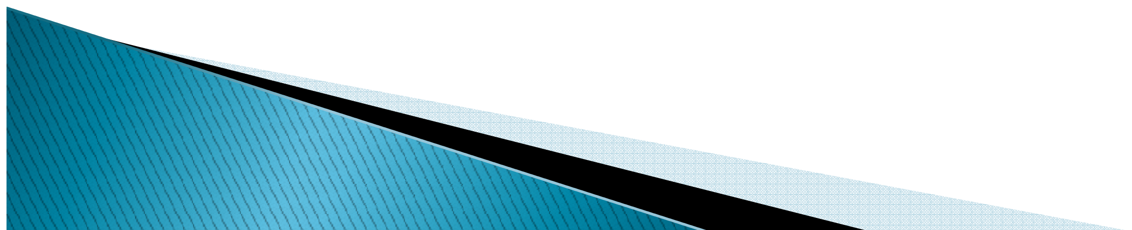
Write up and conclusions

- Treatment expectations
- Impact on patient activities (including employment)
- Patient identity
- Research report available at: http://eprints.hud.ac.uk/13217



Conclusions

- Flexible but structured approach
- Conducive to group analysis
- Use of an initial template and a priori codes
- Size of data set



Acknowledgements

- Ms Jane Melvin, Dr David Wilde, Ms Alison Bravington

- Dr Serena McCluskey, Professor Kim Burton, Dr Dimple Vyas

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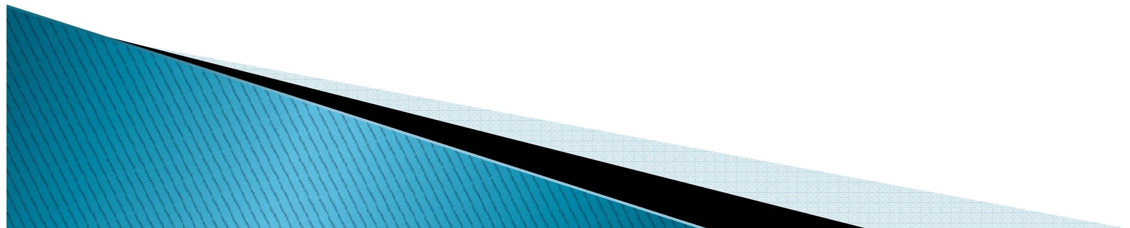
BupaFoundation The Medical Research Charity



Further information

- King, 2012

- Template analysis website:
www2.hud.ac.uk/hhs/research/template_analysis/index.htm

Or please get in touch:
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