Conceptualising and Working with 'Psychosis' in

Assertive Outreach Teams: A Grounded Theory Study

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Contents

List of Appendices and Addenda

Appendix A   Data Extraction Tables for Literature Review

Appendix B   Statement of Epistemelogical Position

Appendix C   Ethical Approval

Appendix D   Participant Information Sheets and Consent Forms

Appendix E   Interview Guide

Appendix F   Example of Initial Coding

Appendix G   Example of a Memo

Appendix H   Additional Quotations

Appendix I   Chronology of Research Process

Appendix J   BJCP Guidelines for Publication

Addendum   Interview Transcripts

List of Figures

List of Tables

Target Journals

Literature Review - British Journal of Clinical Psychology

Empirical Piece: Psychosis - Psychological, Social and Integrative Approaches

Acknowledgements

Thesis Abstract

Part One: Literature Review

Purpose: To determine current opinions amongst mental health professionals regarding the aetiology of 'schizophrenia'

Method: Literature searches were conducted using online databases. Search terms included: *schizophrenia, psychosis, cause, etiology, aetiology, beliefs, causal, explanatory models, conceptual models, causal beliefs, psychologists, nurses, psychiatrists, staff, professionals, workers*.

Results: Thirteen relevant studies were identified: 11 cross-sectional surveys, 1 quasi-experimental design, 1 peer-professional autobiographical account.

Conclusions: The majority of health professionals favoured biological aetiology. Aetiological beliefs are related to preferred management strategies. Biological aetiological beliefs are amenable to change through the use of a training programme.

Part Two: Research Report

Objectives: To explore 1) What understanding staff members have of possible causes of clients' unusual experiences and distress? 2) What approach do staff members take in promoting recovery and how is this related to their construction of 'psychosis'? 3) How are differences in opinions about treatment and recovery negotiated between clients and staff or between the individual staff member and the team?

Method: Semi-structured interviews were conducted with eight mental health professionals working in four separate Assertive Outreach teams, spanning two regions of the East Midlands. Interview data was analysed using grounded theory methodology.

Results: A model was developed based on two continuums between the core categories of 'expert position', 'being with' and 'dependence', 'independence'. Four contributory categories 'conceptualisation of mental health difficulties', focus of recovery', 'risk and responsibility' and 'team/organizational factors' influence the position that professionals.

Conclusions: Professionals' approaches to understanding and working with people experiencing mental distress are context-dependent. Biomedical conceptualisation tends to be associated more frequently with the 'Expert Position', but other factors such as risk and resource limitations can also move professionals towards this way of working.

Part Three: Critical Appraisal

This is a reflective account of the research process and some of the challenges encountered.

Part One:

Literature Review

What Beliefs do Mental Health Professionals Hold about the Aetiology of 'Schizophrenia'?

Abstract

Purpose: To determine current opinions amongst mental health professionals regarding the aetiology of 'schizophrenia'

Method: Literature searches were conducted using the online databases PsychInfo, Scopus, Medline and ISI Web of Knowledge. The words '*schizophrenia*' and '*psychosis*' were combined with a range of other search terms either within titles or keywords: *cause, etiology, aetiology, beliefs, causal, explanatory models, conceptual models, causal beliefs, psychologists, nurses, psychiatrists, staff, professionals, workers*.

Results: Thirteen relevant studies were identified, eleven of which were cross-sectional surveys, one a quasi-experimental design examining the effects of a training programme on aetiological beliefs and the final study was a peer-professional autobiographical account.

Conclusions: The majority of health professionals favour biological causation, but tend to hold multifactorial beliefs, which is suggestive of a stress-diathesis model. There are cultural differences between professionals, with French psychiatrists, for instance, favouring psychodynamic theories more highly than the British. Aetiological beliefs are related to preferred management strategies. Biological aetiological beliefs are amenable to change through the use of a training programme.

1   Introduction

The term 'schizophrenia', meaning 'splitting of psychic functions' was introduced by Swiss psychiatrist Bleuler in 1911 (Hunter & Woodruff, 2005) to describe a group of diseases with variable course and outcome, characterised by loosening of associations, blunt or incongruent affect, ambivalence and autism (the 4 'A's) (Tandon, Nasrallah & Keshavan, 2009). Schneider (1959) defined 11 first-rank symptoms which included hallucinations, delusions and thinking errors. Bleuler's 4 'A's have now been broadly subsumed into diagnostic classification in the ICD-10 (WHO, 1992) and DSM-IV (APA, 1994) as 'negative symptoms' of schizophrenia whilst Schneider's first rank symptoms have come to be referred to as 'positive symptoms' (Tandon *et al.* 2009).

According to recent NICE (2009, p.4) guidelines:

"Schizophrenia is a major psychiatric disorder, or cluster of disorders, characterised by psychotic symptoms that alter a person's perception, thoughts, affect, and behaviour."

Despite a vast amount of research, no definitive aetiology has yet been established and lifetime prevalence remains at approximately 1%. Twin studies and adoption studies have indicated a possible genetic susceptibility, brain scanning has identified differences in brain structures between 'schizophrenics' and controls, whilst biochemical research has implicated the neurotransmitter dopamine, which is targeted by anti-psychotic medication (Tandon *et al.* 2009). Psychological factors such as cognitive dysfunction, personality factors, high expressed emotion (Tandon *et al.* 2009), urban environments and socioeconomic deprivation (Jones, 2001) and abuse, particularly in childhood (Read, Van Os, Morrison & Ross, 2005) have also been implicated. Some favour a stress-diathesis model of aetiology which incorporates an underlying biogenetic or cognitive vulnerability, with psychosocial stressors as triggering factors (Garety, Kuipers, Fowler & Bebbington, 2001).

There is wide heterogeneity in presentation, course and outcome for people diagnosed with schizophrenia and given the failure to establish a definitive aetiology, it has been proposed that reconceptualisation is necessary. Tandon *et al.* (2009) suggest that rather than a single disease entity it should be replaced by a classification based upon clinical dimensions. Bentall (2006) argues that there is no clear distinction between 'normal' and 'psychotic' experience, but that it is a continuum. Delusion, for instance may result from "*rational attempts to explain anomalous experiences*" (p.225). He advocates for the abandoning of psychiatric diagnosis althogether in favour of a 'complaints-oriented' approach, which would encourage professionals to explore individual service-users' experiences and the meaning they attach to them.

The importance of understanding service-users' explanatory models has been discussed by Bhui & Bhugra (2002) and is highlighted in the National Institute for Health and Clinical Excellence (NICE) (2009) schizophrenia guidelines. Research has shown that service-users and their relatives tend to hold multifactorial causal beliefs in relation to their mental health difficulties, which incorporate a variety of psychosocial factors (Holzinger, Reinhold, Lindenbach, Peitscheleit & Angermeyer, 2003; Read, Haslam, Sayce & Davies, 2006). There is evidence to suggest that service-users are more satisfied with their treatment when their clinician shares their model of understanding (Callan & Littlewood, 1998; McCabe & Priebe, 2004). A preliminary search of the literature could not identify any existing reviews examining the current beliefs held by clinicians in regards to the aetioligy of 'schizophrenia'. A review has been conducted in order to summarise the current thinking on this issue amongst mental health professionals.

2   Method

Literature searches were conducted using the online databases PsychInfo, Scopus, Medline and ISI Web of Knowledge, between February and May 2011. Table 1 shows the combinations of search terms entered into each database:

Search Term 1	Search Term 2	Search Term 1	Search Term 2
Staff		Assertive Outreach	
Staff Understanding		Assertive Outreach	+ Mental Health
Community		Team Approach	
Nurses			
Social Workers			
Psychiatrists			
Psychologists	+ Schizophrenia		
Professionals			
Cause			
Causal Models			
Causal Beliefs	+ Psychosis		
Aetiology			
Etiology			
Explanatory Models			
Conceptual Models			
Assertive Outreach			
Workers			

Table 1: Search Terms

An initial scoping search of the literature, plus later citation searches of selected review papers revealed very few studies published prior to 1990 which addressed the review question. Two studies conducted by Gallagher (1977) and Gallagher, Jones and Barakat (1987) examined the attitudes of American Psychiatrists to seventeen different aetiological theories of schizophrenia. In the 1977 study, no significant difference was found between ratings given for biogenic and environmental theories. In the more recent (1987) study, the picture had changed dramatically with the gap between ratings of biogenic and environmental theories widening significantly. The five top ranked theories were: polygenetic heredity, biochemical imbalance, neural defects, recessive gene and metabolic dysfunction − all biogenic theories. Gallagher, Jones and Barakat (1987) concluded that these findings

indicated a shift in aetiological beliefs amongst the psychiatric profession over the decade towards a "combination" or stress-diathesis model of schizophrenia in which environmental stressors can trigger the disorder in those with an underlying biogenetic vulnerability.

Over recent decades there have been significant advances in biogenetic research techniques, in particular neuroimaging, with the introduction of functional Magnetic Resonance Imaging (fMRI)[1] in the 1990s. Earlier family interaction theories such as the "double-bind" theory proposed by Bateson, Jackson, Hayley and Weakland (1956), have declined in popularity as they have come to be viewed as quite blaming on the part of the family and there is a lack of consistent empirical evidence of their validity.

The aim of this review was to assess the *current* aetiological beliefs views of mental health professionals, therefore the evidence that there had been significant shifts in thinking by the late 1980s, added to the increased focus on neuroimaging and biogenetic research over the last two decades, resulted in a decision to include only studies written or published from 1990 onwards. In addition, the NHS and Community Care Act came into force in 1990, introducing internal markets and an emphasis on a move away from long-term institutional care. Studies preceding this are unlikely to be so relevant to the current NHS context.

Two professionals working in the field were consulted for search terms and obtaining additional material, this resulted in one unpublished study being included in the review. Once relevant papers identified by the searches and from personal contact had been obtained, further searches were undertaken of the references from each study and online citation searches were completed using Scopus and PsychInfo. All papers (except Midkiff, 2006 – unpublished), were accessed electronically. Due to the small number studies meeting the

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[1] FMRI is a technique for measuring brain activity by detecting the changes in blood oxygenation and flow that occur in response to neural activity.

search criteria it was not possible to select papers on the basis of methodological quality, therefore the potential shortcomings of the available studies will be discussed.

Titles and abstracts of articles found by the searches were scanned for relevance and full articles were then retrieved. To be included in the review studies had to:

- Be published/written from 1990 onwards in English.

- Include primary research.

- Be from peer-reviewed journals or grey literature if judged relevant and valid (i.e. well-designed/informative unpublished research studies.)

- Include samples of qualified mental health professionals working within formal inpatient or community health services.

- Focus partially or entirely on aetiological beliefs about schizophrenia/psychosis/severe mental illness.

Studies were excluded if they:

- Included only student, service-user or lay samples

- Focused only on general "mental illness"

- Included only non-professionally trained staff working within informal services.

Throughout this paper the terms 'schizophrenia', 'illness', 'disorder' and 'patient' will be used where it is the language of the papers being reviewed. This does not imply that the author of this review accepts the biomedical construction of schizophrenia. This is a topic of much debate, as highlighted previously.

A total of thirteen studies were selected for inclusion in the review. Summaries of methodology and findings, including levels of significance, are included in data extraction tables in appendix A. Eleven of the studies were cross-sectional surveys, one (Midkiff, 2006) utilised a quasi-experimental approach and one (Chadwick, 2007) was an autobiographical account by a peer-professional.

3.1   Psychologists

Only one study examined the beliefs of psychologists as a distinct group. Gallager, Gernez and Baker (1991) surveyed a sample of 150 graduate psychologists from the UK and Republic of Ireland. They suggested that many psychologists were reluctant to work with people diagnosed with schizophrenia and that this may be related to four false beliefs, set out by Bellack (1986, in Gallagher *et al.* 1991):

- There is doubt about the validity of the schizophrenia concept.

- Schizophrenia is biologically determined.

- The condition is adequately treated with medication.

- It is too serious a complaint to be amenable to psychological/behavioural intervention.

Half of the participants believed that schizophrenia is a valid construct, whilst a third disagreed. In relation to aetiology, two thirds of participants endorsed the involvement of genetics in the development of schizophrenia. The vast majority did not agree that schizophrenia is adequately treated with medication and felt that it was not too severe a condition for psychologists to work with, indicating a role for psychological intervention.

This study is very basic; there is no exploration of other causal beliefs and no analysis conducted to examine relationships between the factors. It was also stated in the introduction

that it intended to identify at what point in psychologists' careers beliefs were formed but this did not seem to be addressed in the results.

The notion that 'schizophrenia is a valid construct' is highly debatable, therefore to label it a 'false belief' seems to be an enigma. This study was conducted twenty years ago, however, so debates around the concept and the role of psychologists in working with people with a diagnosis of schizophrenia may have moved on considerably, as highlighted in a more recent BPS publication (Kinderman & Cooke (eds.) 2000).

3.2   Psychiatrists

Three studies utilised postal questionnaires to determine the beliefs of practicing psychiatrists. Cape and Daniel (1994) surveyed 119 psychiatrists in a single region of the UK, using a 45-item questionnaire to ascertain their beliefs about the aetiology of schizophrenia, the factors they considered most useful in diagnosis, their management preferences and beliefs about prognosis. Using principle components analysis, they separated aetiological items into three factors: psychosocial (primarily related to family dynamics), biological and life events. They found that participants were significantly more likely to rate genetic predisposition and neurotransmitter dysfunction than psychosocial factors or life events, and rated life events as significantly more important than psychosocial factors. Childhood experiences, expressed emotion, substance misuse, stress, personality, neurodevelopmental disorder, institutionalisation, iatrogenicity, incest and age were also cited by a small number of participants. Interestingly participants over 45 years old were more likely to rate psychosocial factors as important – the authors speculate that this could be due to changes in the nature of psychiatry training over time, or changes in beliefs that occur with greater experience.

Those giving psychosocial factors aetiological importance were more likely to rate psychological interventions as useful and less likely to rate medication, whilst biological aetiological beliefs were related to perceived usefulness of medication. Those rating stressful life events as key to aetiology found both approaches useful. Psychiatrists favouring psychosocial aetiology thought fewer patients would need to be on medication for life and were more likely to rate social support and nature of onset as important in predicting prognosis. Those favouring biological aetiology thought more patients would be on medication for life and also rated onset as important for predicting prognosis. 85% of participants thought that schizophrenia is a heterogenous rather than a unitary disorder.

In a more recent study, Baille, McCabe and Priebe (2009) surveyed 154 British consultant psychiatrists regarding aetiological beliefs about depression and schizophrenia and opinions on individual variability in aetiology. An open question sought opinions on the importance of asking clients about their understanding of their difficulties. Findings indicated that eight psychosocial factors were seen as significantly more important in the development of depression than schizophrenia. 'Effects of physical illness (including pregnancy)' was the only biological factor to be considered more significant for depression than schizophrenia. Conversely, four biological factors were considered significantly more important in the aetiology of schizophrenia (see appendix A).

Participants believed that aetiological factors vary significantly more among patients presenting with depression than schizophrenia. They also thought it was significantly more important to ask the patients with a diagnosis of depression their understanding of their illness than those with schizophrenia. Developing an individual treatment plan in collaboration with the patient was seen as significantly more important for patients with depression than schizophrenia. Influencing the therapeutic relationship in its own right (rather than a means of treatment adherence) was seen as significantly more important for

patients with schizophrenia than depression, this is related to trying to understand the meaning that patients attach to their psychotic experiences.

Van Os, Galdos, Lewis, Borgeois & Mann, (1993) compared the views of 69 French and 92 British Psychiatrists in terms of aetiological beliefs and preferences for diagnostic and management strategies. French psychiatrists tended only to diagnose schizophrenia in patients aged under 45 years and with poor prognosis, whereas the British sample diagnosed late onset schizophrenia and included those with both bad and good prognoses.

In terms of aetiology, French psychiatrists seemed to be influenced far more by psychodynamic theories and rated family dynamics and parental factors as significantly more influential in the development of schizophrenia than British psychiatrists. The British sample tended to be more heavily influenced by behavioural and biological theory, rating biological predisposition, neurodevelopmental factors and aetiological heterogeneity significantly more highly than their French counterparts. The findings are in keeping with the previous two studies, in that British psychiatrists tended to favour biogenetic aetiology.

Preferred management strategies tended to link with aetiological beliefs to some extent, with French psychiatrists having a stronger belief in the usefulness of psychoanalytic psychotherapy and recognition of unconscious processes. They also favoured combination drug therapy which is generally viewed sceptically in Britain.

3.3   Nurses

Two studies of the beliefs of Turkish nurses were identified and one study in Italy comparing the beliefs of nurses to those of psychiatrists and relatives of people diagnosed with schizophrenia. Eker and Arkar (1991) surveyed 91 female nurses working in two general hospitals. They used two case vignettes of patients with 'paranoid schizophrenia' and 'anxiety, neurosis/depression' to elicit beliefs about causation, therapy, prognosis and desire

for social distance. They found that nurses believed in both organic (structure of the brain and nervous system) and psychological (past or present life conditions, relationships and occupational problems) causation and thought both psychotherapy and drug treatments could be useful. Overall psychological causes and psychotherapy were rated more highly than organic causation and drug treatment.

The 'paranoid schizophrenia' vignette attracted statistically higher ratings for perception of mental illness, greater expectations of emotional burden, physical burden and influence on one's own mental health and greater desire for social distance than the 'anxiety, neurosis/depression' case. The authors did not separate out different components of aetiological beliefs, asking only about organic versus psychological causation and findings are not presented clearly which makes it difficult to compare the results for the two vignettes. The sample is made up of nurses with mixed clinical experience, so not all will have had psychiatric experience, there is no differentiation in this regard.

Kukulu and Ergün (2007) conducted a questionnaire survey of 543 nurses working in psychiatric services across a total of 39 hospitals in Turkey, to gauge their attitudes and opinions regarding people with a diagnosis of schizophrenia. They found that 93.2% perceived schizophrenia to be an illness present from birth and 51.4% believed it is caused by social problems. Only a small proportion of nurses agreed that schizophrenia is a state of excessive sadness or a state not an illness. Almost all of the sample believed it is an illness and that people with this diagnosis are mental patients. A little under half believed it is a state of emotional weakness. Three quarters believed that people with schizophrenia are aggressive and 80.7% believed they are unable to make correct decisions about their own lives. These findings are quite concerning as they suggest that nurses held quite negative beliefs towards patients with this diagnosis and their ability to make informed decisions.

Beliefs about prognosis were also fairly negative, with the vast majority believing that people will not fully recover. Nurses believed in treatment with medication but acknowledged that there can be serious side effects and believed them to be addictive. Just under a third of the sample believed that social problems had to be resolved before schizophrenia could be overcome and 43% thought it could be treated by psychotherapy. Unfortunately the findings of this study are only presented as percentages, there are no statistical analyses which means that it is impossible to determine the relationships between factors.

Magliano et al. (2004a) conducted a survey, using the Opinions about Mental Illness Questionnaire (QO) across 30 mental health services in Italy, to compare beliefs held by 190 psychiatric nurses, 110 psychiatrists and 709 key relatives of people with a diagnosis of schizophrenia. They found that nurses held similar beliefs to psychiatrists in relation to the aetiology of schizophrenia. The causal factors most frequently cited by these groups were heredity, stress, substance misuse and family conflict. Relatives were statistically less likely to cite heredity, misuse of alcohol or family conflicts than professionals. Nurses and psychiatrists were more optimistic about patients' ability to work than relatives and were more likely to state that people keep aloof from patients with schizophrenia than relatives. Almost a third of nurses and relatives believed people with schizophrenia are unpredictable, compared to 2% of psychiatrists. Nurses also held beliefs on civil rights that were more similar to relatives than psychiatrists. Linear regression analysis was conducted to determine the relationship between factors but unfortunately causal beliefs were not included in this so it is not possible to explore the relationship between beliefs about aetiology, social functioning and civil rights.

3.4 Comparisons between professionals and other groups.

Four studies were identified that compared the beliefs of mixed samples of mental health professionals with other stakeholder groups. In a variation of the study discussed above, Magliano et al (2004b) compared data from 709 key relatives with that of a mixed sample of 465 professionals and 714 lay respondents. They hypothesised that the public and relatives would share causal beliefs which would differ from those of professionals. Their findings showed, however, that the lay respondents held aetiological beliefs that were more similar to those of professionals than those of relatives.

Heredity was cited significantly more often by professionals and psychological trauma, stress and incorrect therapy more frequently cited by lay respondents. Three quarters of professionals and only one quarter of relatives believed both psychosocial and biological factors were involved. Approximately a third of lay respondents and 20% of professionals cited only biological causal factors as opposed to over two-thirds of relatives. Relatives were significantly less likely than the other two groups to cite family conflict or substance misuse as relevant. Professionals and lay respondents held more similar beliefs in regards to medical treatment, social competence and civil rights than relatives. Lay respondents were the most positive about the possibility of recovery, followed by relatives, with only 2% of professionals believing patients could make a full recovery.

There are some difficulties in making comparisons between groups using the QO because the versions written for professionals (QO-P) and the general public (QO-GP) utilise case vignettes, whereas the family version (QO-F) requires relatives to think about their family member, which is a specific rather than general example and therefore may yield different responses. This issue is highlighted by Magliano *et al.* (2004b).

Grausgruber, Meise, Katschnig, Schöny and Fleishhacker (2006) compared the beliefs of a large representative population sample of Austrians, 137 mental health patients' relatives and 460 non-medical mental health professionals (including nurses). They found that professionals appeared to have multi-factorial understandings, being fairly evenly distributed between psychosocial and genetic factors and were least likely to cite 'weak character' as relevant. The public and relatives cited genetic factors more frequently than professionals. Relatives cited occupational stress and nervous strain significantly more frequently than the other two groups. Professionals and relatives held similar beliefs in regards to unhappy family situation and serious life events with both groups citing head injuries less frequently than public.

In this professional sample, which does not include psychiatrists, there is less preference towards a biological aetiological model. This may be a cultural variation, however, as no other studies from Austria were identified with which to compare. Professionals and relatives were more optimistic about treatability than the public whilst professionals were least likely and the public most likely to perceive people with schizophrenia as dangerous. Staff and relatives were generally more likely to be accepting of people with this diagnosis than the public.

Two further studies compared the views of professionals with other groups in the United States. Marshall, Soloman, Steber and Mannion (2003) conducted a questionnaire survey with 48 providers and 39 family members. This study did not focus exclusively on schizophrenia, but more broadly on the issue of 'severe mental health', which is a term usually used to encompass the psychotic disorders (e.g. schizophrenia, bipolar disorder). Providers were much more likely to cite family environment, family communication, behaviour of family members and family criticism, hostility and over-involvement (high expressed emotion) as causal factors in the development of severe mental illness than family

members, with the latter being cited by almost all of the provider sample. Unfortunately statistical comparisons were not reported, therefore it is not possible to determine whether these differences are significant, although they appear to be fairly large (see appendix A).

A large majority of providers agreed that severe mental illness is biologically based, with family members and providers rating this factor similarly. Provider beliefs in family causation were significantly related to being white, female and having a higher level of education. Belief in family causation amongst providers was significantly related to providers having less contact with families, whilst in the family group, beliefs in family causation were significantly associated with negative experiences with providers. The samples in this study are relatively small and the professional backgrounds of those included in the provider sample are not reported so it is difficult to make comparisons with the findings of other studies or to predict whether these results are generalisable to other settings.

The final comparative study, conducted in North Carolina by Van Dorn, Swanson, Elbogen and Swatz (2005), compared the beliefs of 85 clinical psychiatric staff with those of 56 lay respondents, 83 family members of patients with a schizophrenia diagnosis and 104 mental health service consumers with a DSM-IV schizophrenia-related diagnosis. Participants were presented with a case vignette and then either participated in a structured interview (public, family, consumers) or completed a questionnaire (clinicians). All groups strongly endorsed chemical imbalance as a causative factor at rates at or approaching 100%, although the consumer group were significantly less likely to cite this as relevant. The vast majority of clinicians strongly endorsed genes and inheritance as a key causal factor at rates significantly higher than the other groups. Approximately two thirds of clinicians cited stressful circumstances as relevant, with 18% citing upbringing and a small minority citing God's will and bad character.

Non-biomedical causal factors were endorsed significantly more frequently by family, public and consumers than clinicians. Family and consumers were significantly more likely to endorse bad character and upbringing as relevant, whilst clinicians and the public cited God's will significantly less frequently than the other two groups. Consumers were more likely to rate stress as a key causative factor than clinicians. These finding show a strong preference for biogenetic aetiology amongst clinicians, with stress possibly being a secondary factor, consistent with a stress-diathesis model. They also indicate that clinicians' aetiological beliefs differ significantly from those of other groups, in particular consumers and family members.

3.5 Changing Beliefs

Midkiff (2006) designed a three-hour training programme which aimed to encourage professionals to think more critically about existing research evidence and the influence of psychiatry and pharmaceutical companies in setting the research agenda and promoting biological models of causation for mental health difficulties, including schizophrenia. The study was quasi-experimental in design, with a non-matched student control group. The experimental group consisted of 76 mental health professionals, over half of which were psychologists, the rest being social workers, counsellors or other (non-specified) mental health professionals. A Strength of Beliefs Scale (SOBS) was administered prior to and following participation in the training programme to measure change in beliefs. In line with her prediction, she found that professionals tended towards biological causal beliefs prior to training.

Following training, beliefs in biological causation significantly declined, both generally and in relation to specific disorders including schizophrenia. Pharmaceutical workshops were viewed as significantly less useful following training and there was a highly significant

change in participants' beliefs regarding the validity of empirical evidence for biological causation, with professionals taking a more sceptical view after training. No such changes were observed in the control group.

3.6   An Insider's Perspective

Peer-professional accounts provide a unique and valuable perspective on the nature of psychotic experiences, the effects of being diagnosed with a severe mental illness and the process of recovery. Chadwick (2007) has written an analytical, reflective account of his experience of 'schizophrenia', from the perspective of being both a service-user and a professional psychologist. He attributes his difficulties to a combination of cognitive factors and "brain hardware malfunction". He identifies pre-disposing cognitive and affective factors including difficulties with attention, high cortical arousal, poor context processing, poor impulse control and mental state regulation. These difficulties, combined with sustained experiences of bullying, stigmatisation and abuse, resulted in social isolation and a pattern of downward social drift.

Chadwick links the experience of marginalisation to the development of feelings of paranoia, leading onto ideas of reference, perceived external locus of control, beliefs of persecution and magical thinking, exacerbated by confirmation bias. In his view, there is not a clear distinction between the content of 'normal' and 'psychotic' beliefs, but rather the distinction is in the manner in which the beliefs are held – it is the loss of the ability to critically reflect on one's thoughts that differentiates them. He found that acceptance of illness and medication, in combination with changes in his self-concept and social scenario were key to his recovery. This is an individual perspective, however, and other peer-professionals (e.g. May) have found that illness acceptance and medication have not been helpful in the process of recovery. Chadwick believes that psychosis can be triggered by

abuse and stigmatisation in those who have "biochemical, psychological and intrapsychic susceptibilities", which fits with a diathesis-stress model.

4   Discussion

Studies of British psychiatrists indicated a preference for biological aetiology in schizophrenia, in contrast to other mental health difficulties such as depression. Aetiological beliefs can bear a significant relationship to preferred management strategies with those psychiatrists favouring biological aetiology tending to rate antipsychotic medication as useful whereas those prioritising psychosocial aetiology were more likely to view psychological intervention positively. Aetiological beliefs and preferred management strategies can be influenced by culture and context, with psychoanalytical work having had a considerably stronger influence on psychiatry in France than Britain.

Magliano *et al* (2004a) found that Italian psychiatrists and nurses favoured heredity, with stress, substance misuse and family conflict also being fairly frequently endorsed. Kukulu and Ergün's (2007) study of Turkish nurses found a similar pattern with almost all believing that schizophrenia is an illness present at birth, although approximately half also implicated social problems. This suggests a belief in a diathesis-stress model of aetiology. Eker and Arkar (1991) did not find a preference for organic over psychological aetiology in their study, possibly because their sample did not consist exclusively of nurses with psychiatric experience.

Professionals in Magliano *et al*'s (2004b) study in Italy and both of the American studies (Marshall *et al*. 2003 & Van Dorn *et al*. 2005) tended to endorse primarily biological aetiology with psychosocial factors as secondary, again suggestive of a stress-diathesis model. Relatives also tended to endorse biological causation, but were far less likely than professionals to cite family issues as relevant to the development of schizophrenia. For relatives, a belief that biology or general life stressors rather than family issues are key aetiological factors may serve a protective function. Marshall *et al*. (2003) found that

28

providers' beliefs in family causation were linked to reduced contact with families and to more negative consumer experiences. Working with families is recommended within NICE schizophrenia guidelines (NICE, 2009) so if generalisable, this pattern of beliefs could negatively affect clinical practice and engagement between professionals and families. Other research corroborates the finding that differences in beliefs between professionals and relatives can result in conflict and affect patients' compliance with interventions (Jorm, Korten, Jacomb, Rodgers & Pollitt, 1997, Caldwell & Jorm, 2001).

Gallagher *et al.* (1991) and Midkiff's (2006) research indicates that even psychologists and non-medical professionals tend to believe that biology has a role to play. Midkiff's study, however, shows that aetiological beliefs are not fixed and are amenable to change in response to new learning experiences. Post-training measures were only completed once, immediately following the training programme, so it is not clear whether these changes were sustained over time.

Many psychiatrists viewed 'schizophrenia' as a heterogenous disorder. There was considerable disparity in approach to diagnosis, with general clinical impression being perceived as more useful than diagnostic manuals. Diagnosis is not a purely objective process, rather the *"quality of interaction between doctor and patient"* (Cape & Daniel 1994) is important and there were considerable cultural differences in approach to diagnosis. This suggests that 'schizophrenia' is not a stable, objective concept but is open to subjectivity and interpretation, making diagnosis unreliable. Clinical research into schizophrenia is often based upon samples of participants deemed to fit DSM-IV or ICD-10 criteria, these groups may not necessarily be comparable to patients receiving a diagnosis in clinical practice, making research findings of questionable validity.

As a peer professional, Chadwick (2007) bridged the divide between service-users and professionals. He states that by conceptualising their patients' difficulties in organic, objective terms, professionals (particularly psychiatrists) fail to understand their subjective, heartfelt experience, resulting in them feeling alienated and not listened to.

A thorough search of the existing literature revealed a disappointingly small number of studies on this topic, some of which were of questionable quality with few statistical analyses of findings and poorly presented data. Given the relationship between clinicians' aetiological beliefs and preferred management approaches and the link between shared explanatory models and patient satisfaction, the need for further research into the beliefs of mental health professionals is indicated.

4.1   Further Research

Cross-sectional surveys are useful for exploring the opinions held by a specific sample within a particular timeframe and context, but cannot determine change over time. Longitudinal studies would be useful to monitor change in staff beliefs to see whether greater exposure to mental health service-users results in individual psychosocial factors being taken into account to a greater extent or whether exposure to the pervading biomedical model within cements beliefs about biological aetiology.

Quantitative studies force participants to choose from a range of pre-specified responses, so the data obtained is reductionist. Qualitative research with specific groups or teams of professionals would allow for more in-depth exploration of ideas and, depending upon the method of analysis employed, the construction of theories and models or a comprehensive understanding of particular phenomenon or experience.

A small number of studies have indicated beneficial results in using psychological formulations to modify staff perceptions of service-users, (Berry, Barrowclough & Wearden,

2008; Summers, 2006).   There is a need to extend this research, perhaps utilising a quasi-experimental design, similar to that of Midkiff (2006), to look at whether staff beliefs, can be modified and whether change is sustained over time.

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Part Two:

Research Report

Conceptualising and Working with 'Psychosis' in

Assertive Outreach Teams: a Grounded Theory Study

Abstract

Objectives: The three key questions which this study aims to address are:

1) What understanding do staff members have of possible causes of clients' unusual experiences and distress ('psychosis')?

2) What approach do staff members take in promoting recovery and how is this related to their construction of 'psychosis'?

3) How are differences in opinions about treatment and recovery negotiated between clients and staff or between the individual staff member and the team?

Method: Semi-structured interviews were conducted with eight mental health professionals working in four separate Assertive Outreach teams, spanning two regions of the East Midlands. Interview data was analysed using a grounded theory approach.

Results: A model was developed based on two continuums between the core categories of 'expert position', 'being with' and 'dependence', 'independence'. Four contributory categories 'conceptualisation of mental health difficulties', focus of recovery', 'risk and responsibility' and 'team/organizational factors' influence the position that professionals take in different contexts.

Conclusions: Professionals' approaches to understanding and working with people experiencing mental distress are not static but context-dependent and influenced by several factors. A more biomedical conceptualisation tends to be associated more frequently with the 'Expert Position', but other factors such as risk and resource limitations can also move professionals towards this way of working.

1   Introduction

1.1   *The Contested Conceptualisation of unusual experiences*

The term 'psychosis' encompasses a range of experiences including hearing voices, seeing, feeling or smelling things that others cannot perceive and holding unusual beliefs. Many people have unusual experiences at some time in their lives without meeting the diagnostic criteria for a 'mental illness' or coming into contact with mental health services. It is estimated, for instance, that as many as one in ten of the general population may hear voices (Tien, 1991, as cited in Kinderman & Cooke, 2000). The cultural framework of the person experiencing voices can influence the level of distress e.g. voices may be interpreted as a positive experience if perceived as being spiritual in nature. In the UK mental health services are dominated by a biomedical model. Many people who present to services reporting unusual experiences will be assessed by a psychiatrist and receive a diagnostic label such as 'schizophrenia'. Approximately 1 in 100 people receive each such diagnosis in their lifetime (Kinderman & Cooke, 2000).

There has, however, been a well documented critique of diagnosis in recent years, which argues that categories of mental illness are often poorly defined; diagnosis does not accurately predict prognosis, what might help and aetiology are not fully understood (Kinderman & Cooke, 2000). Diagnostic criteria have been refined over time, but even using the DSM-IV (APA, 1994) diagnosis is often subjective and unreliable which makes inclusion criteria for research studies extremely variable (Read, Mosher & Bentall, 2004). Furthermore, even with modern-day psychiatric diagnostic criteria, there is a spectrum of unusual experiences and changes in affect that can come under the umbrella of 'psychotic experience' and each combination will be unique to the individual. Despite these criticisms, diagnosis is routinely used and accepted as legitimate in mental health services. A new

version of the Diagnostic and Statistical Manual (DSM V) is currently under development and receives wide support from psychiatric and some psychological quarters.

Much evidence now supports the idea that 'psychotic' experiences are likely to result from a complex interaction between social, psychological and biological factors. Factors such as poverty, family environment, social exclusion, experiences of trauma, abuse or racism appear to be causally related to a person having distressing, unusual experiences (Kinderman & Cooke; 2000, Johnstone, 1999). Psychosocial factors are also extremely important in determining the outcome for an individual. One of the single most protective factors in maintaining recovery and social functioning, for instance, is employment (Kinderman & Cooke, 2000). The home environment and support networks that a person has are also extremely significant in relation to outcome. Individuals who return to highly critical or overprotective (high expressed emotion) families tend to have a worse prognosis and higher chance of relapse than those whose families are supportive, calm and tolerant (low expressed emotion) (Kinderman & Cooke, 2000).

1.2   Complexity and competing interventions

In mental health services, the first-line treatment of choice for distressed individuals with unusual experiences still tends to be biomedical. The more recent guidelines for 'schizophrenia' (NICE 2009) do, however, recommend access to psychological interventions including CBT, art therapy and family interventions. The importance of maintaining hope and optimism for recovery is highlighted along with the necessity to engage in person-centred care, taking account of cultural and ethnic differences and collaborative working relationships between staff, service-users and carers.

The guidelines stipulate that service-users should be fully informed of the costs and benefits of using psychiatric medication and their decisions respected. They still, however,

rely on psychiatric diagnosis and advocate pharmaceutical treatment as one of the main coping strategies in the management of these difficulties. It is stipulated that social issues should be addressed by staff, but do not emphasise how social factors may be linked causally to the onset of unusual experiences (Bentall & Fernyhough, 2008).

Given the contested nature of conceptualisations of 'psychosis' and the range of interventions, it would seem vital for services to work collaboratively with clients and to help individuals to make sense of their experiences in a meaningful way. This involves taking into consideration family history (biological, psychological and social), past experiences, cultural and ethnic beliefs and individual interpretations.

The BPS (Kinderman & Cooke, 2000) recommends that services adopt a holistic approach, which recognises that the individual is the 'expert' on their own experiences and should be listened to. In many cases, non-compliance with medication is not an irrational or 'psychotic' decision, but a reasoned choice. Many psycho-active medications, whilst helpful for a percentage of service-users, have little or no therapeutic benefit for some and can have extremely unpleasant negative effects, some of which are difficult or impossible to reverse (e.g. tardive dyskinesia) or in a small minority of users, potentially fatal (e.g. neuroleptic malignant syndrome) (Kinderman & Cooke, 2000; Moncrieff, 2008).

1.3   Negotiation of contested conceptualisations of 'psychosis'

Bhui and Bhugra (2002) explained how using an ethnographic approach to elicit explanatory models of illness from patients can help clinicians understand how patients attempt to construct meaning of their 'illness' from an individual perspective. Research has shown that patients are more satisfied with their treatment when their clinician shares their model of understanding (Callan & Littlewood, 1998; McCabe & Priebe, 2004).

41

A brief review of existing literature by the current author found that people with a diagnosis of 'schizophrenia' often hold multi-factorial models of causation in relation to their difficulties and that these factors are predominantly psychosocial in nature. A review of the existing literature relating to staff beliefs suggested that professionals tend to prioritise the biomedical model of aetiology, but few studies have investigated this topic. Given the relationship between clinicians' aetiological beliefs and preferred management approaches and the link between shared explanatory models and patient satisfaction, the need for further research into the beliefs of mental health professionals is indicated.

1.4   Conceptualising and Working with 'Psychosis' in Assertive Outreach Teams

Assertive Outreach (AO) teams were set up across the UK in response to Labour Government reforms of mental health services. The model was based upon the Assertive Community Treatment approach which had been found to improve outcomes for people in the United States who had severe mental health problems (Schneider, Brandon, Wooff, Carpenter & Paxton, 2006). The "Mental Health Policy Implementation Guide" (Department of Health (DoH), 2001) specified that AO teams should be set up nationally to provide a service for adults aged 18-65 years with:

- a severe and persistent mental disorder (e.g. schizophrenia, major affective disorders)

- high service use including repeated inpatient admissions

- difficulty maintaining contact with services

- Multiple complex needs (e.g. history of violence or persistent offending, risk of self-harm or neglect, previous poor treatment response, dual diagnosis[2], recent detention under the Mental Health Act (1983), unstable accommodation or homelessness.)

Assertive Outreach Teams were to be made up of a variety of professionals including Occupational Therapists (OTs), Community Psychiatric Nurses (CPNs), Social Workers and

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[2] Of substance misuse and serious mental illness.

Psychologists, in addition to a Team Leader and regular input from a psychiatrist who should be well embedded in the team. The services were to provide a comprehensive package of care aimed at improving engagement with services, reducing hospital admissions or length of stay, increasing stability in the lives of service-users and carers, improving social functioning and being cost effective (DoH, 2001). By September 2003 approximately 236 AO teams had been set up around the country.

The current study aimed to integrate some of the ideas discussed above regarding cause of and recovery from 'psychosis', in order to look at how staff in multi-disciplinary AO teams conceptualise psychosis and how their understanding informs their practice. Examining the extent to which staff attempt to elicit clients' understanding of their difficulties and paths to recovery and how approaches are negotiated allowed the construction of a theory about how teams operate and the working relationships between staff and service-users.

2   Method

2.1   *The Research Questions*

The three key questions which this study aimed to address were:

- What understanding do staff members have of possible causes of clients' unusual experiences and distress ('psychosis')?

- What approach do staff members take in promoting recovery and how is this related to their construction of 'psychosis'?

- How are differences in opinions about treatment and recovery negotiated between clients and staff or between the individual staff member and the team?

2.2   Design

The existing literature identified on staff beliefs was comprised predominantly of quantitative studies. It was decided that the current study would be exploratory in nature, therefore a qualitative approach would be most appropriate. Data was gathered through the use of semi-structured interviews which elicited in-depth information and enabled exploration of concepts and experiences. Interview data was then analysed using Grounded Theory methodology which involves the construction of theory derived from the data through a process of creating theoretical categories and constant comparative analysis (Charmaz, 2006). This research was conducted within a 'Contextualist' epistemological framework (Madill, Jordan & Shirley, 2000) (See appendix B).

The aim was to derive theory from interview data rather than imposing previously derived categories. It was important, therefore, not to assume a particular model of understanding or to impose concepts upon participants by use of particular terminology. For this reason, the use of psychiatric diagnostic labels by the interviewer was avoided as far as possible during the interviews in order to allow interviewees to use their own words and concepts.

2.3   Procedure

2.3.1   Recruitment

Ethical approval to conduct the research within the NHS was applied for and granted by Research Ethics Committee via Proportionate Review on 22nd March 2010 (appendix C). Approval was also sought from and granted by Research and Development departments in three NHS Mental Health Services Trusts in one region of the UK. The study was open to all mental health professionals and support workers working in Assertive Outreach teams across these Trusts. In order to be eligible for inclusion they were required to be having frequent, direct clinical contact with service-users who have had or are having unusual experiences (psychosis). The only exclusion criteria was any language barrier or sensory impairment which would hinder the individual from participating in a interview in spoken English, as time and budgetary constraints did not allow for the employment of interpreters.

The researcher liaised with team leaders to deliver a short presentation about the study to four of the Assertive Outreach teams at multi-disciplinary team meetings. Following the presentation written information was given to team members, including the Participant Information Sheet (appendix D) and they were invited to complete and return a Demographic Information and Expression of Interest form if they were willing to be interviewed. In one region it was not possible to arrange to present the study in person, so the information and forms were circulated via using email, via the team manager. Demographic information was required in order to facilitate theoretical sampling.

In total nineteen staff members volunteered to participate in the study. Two volunteers were Team Leaders, one working across two city teams, the other in a city team in another area which was not represented in the selected research sample. Two Nurses volunteered from one county team, four from another. In the city teams, one team generated five volunteers including three Nurses, a Peer Support Worker and a Support Worker; the

other team generated six volunteers including three nurses, a social worker, an Occupational Therapist and a Consultant Psychiatrist. Twelve volunteers were of White British origin, two Black African, one Black Caribbean, one Irish, one Chinese, one British Indian and one mixed White and Black African background. The representation of different professions and ethnic groups within the pool of volunteers broadly reflects the make-up of the AO teams as a whole, with the majority being of White British origin and from nursing backgrounds. Volunteers had between six months and forty years of experience in their professions.

2.3.2 Sampling

The participants were selected initially through purposive sampling which aimed to select participants across different teams and professional backgrounds. After the first three interviews had been conducted, theoretical sampling was used in order to try to select cases which might add to or challenge the emerging theory.

The first two interviewees were known to have key roles in promoting recovery within their teams and the third was a Social Worker. In discussion with research supervisors it was felt that their views would be different to many of the other team members who did not hold these roles. The fourth participant was chosen as a Team Leader and Social Worker and the researcher felt that this might offer a different perspective to other team members. The fifth participant was chosen as a representative of the nursing staff, not holding an additional recovery role. Participants six and eight were chosen as representatives of nursing staff from another region, in order to look at whether they held similar or different perspectives to previous participants. Participant seven was chosen to represent a medical perspective as a Psychiatrist who works closely with but is not embedded in an Assertive Outreach Team. In selecting participants other demographic factors were also considered in order to ensure a mix of genders, ethnicities and experience.

2.3.3   Participants

The eight participants were all clinical staff working closely with or embedded within four separate Assertive Outreach (AO) teams in one region of England. These teams were comprised primarily of Community Psychiatric Nurses and Support Workers, although two teams included Social Workers and one an Occupational Therapist. The teams all also receive input from Psychiatrists and Clinical Psychologists.   Two of the teams worked within inner cities with significant ethnic-minority populations and high incidence of social deprivation. The other two teams worked across wider county areas, encompassing both urban and rural districts, with predominantly White British populations and mixed socioeconomic profiles.

A list of participants and their demographic information is presented in Table 1. In order to maintain the anonymity of quotations used, they are not presented in participant order.

Gender	Self-Defined Ethnicity	Professional Group	Number of Years in Profession	Number of Years with the Team
F	White British	Nurse	8	3.5
F	White British	Social Worker	5	5
F	British African/Caribbean	Nurse	29.5	6
M	White British	Nurse	21	9.5
M	British Indian	Psychiatrist	20	10
M	White British	Social Worker	5	5
F	Black African	Nurse	3.5	1
M	White British	Nurse	40	7

Table 2: Demographic Information of Participants

2.3.4 Interviews

A semi-structured interview guide was constructed for the purpose of this study. A copy of this, showing possible areas of questioning can be found in appendix E. This was flexible and evolved based upon areas uncovered during earlier interviews. The guide covered three key areas:

- Ideas around causes of mental distress

- Ideas around treatment and what helps/hinders recovery

- How approaches are negotiated with clients and within the team.

The questions in the guide were not necessarily asked in chronological order, however, or adhered to word for word. Instead the guide was used at each interview purely as a prompt for the interviewer to ensure that all key areas of interest had been covered. In all interviews, additional follow-up questions were asked to pick up on areas of interest in interviewees responses for instance to request elaboration or clarify meaning.

As key themes began to emerge throughout the interviews, these were picked up on and later interviewees were asked some more specific questions, for instance in regards to risk assessment and tolerance, attitudes towards Community Treatment Orders (CTOs)[3] or perceived differences between services that AO could offer in comparison to other teams. Other themes and areas of interest which were pursued in later interviews included opinions on medication use and withdrawal, ideas about the concept of insight and the possible functions of certain 'psychotic symptoms' for the service user. In some interviews, certain topics around service provision and resource issues were also pursued, including discussing

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[3] This is a section of the Mental Health Act 1983/2007 that allows patients with a mental disorder to be discharged from hospital into the community subject to certain conditions. For instance they are mantatorily required to see their Responsible Clinician when asked and may additionally be required to accept medication and keep regular appointments with their care co-ordinator and/or psychiatrist. Failure to comply with conditions can result in a compulsory recall to hospital for up to 72 hours for assessment.

the proposed dissolution of the teams in one area. The interviewer tried to use neutral, non-medical language at the beginning of the interviews, but would then pick up on the terminology used by the interviewee, for instance terms such as 'illness', 'insight' or 'symptoms' in order to facilitate mutual understanding.

Interviews were arranged individually at a time and location convenient to each interviewee. They were conducted in private rooms and recorded using a digital audio recording device. Interviewees were given the opportunity to ask questions prior to commencing the interview and were required to sign a consent form. Interviews lasted approximately 50-65 minutes.

2.3.5 Transcribing

Ideally Charmaz (2003a; 2006) recommends that researchers should complete all transcriptions in person in order to thoroughly immerse themselves in the interview data, however due to time constraints it was not feasible to do this. The researcher conducted all eight interviews in person and transcribed the first three in order to begin to get a feel for the data. The remaining five interviews were sent on audio CDs to a professional Business Administrator who signed a confidentiality agreement. Transcriptions were returned via email in password-protected files and were then thoroughly checked by the researcher by listening to the audio recordings in conjunction with reading through the transcripts in order to pick up any errors in transcription and to allow the researcher to be immersed in the data as much as possible. Interview transcripts are bound as an addendum to this thesis along with a guide to transcript conventions.

2.4 Data Analysis

There are many variations on Grounded Theory analysis. Earlier approaches (e.g. Glaser & Stauss, 1967 cited in Charmaz, 2006; Strauss & Corbin, 1998) operate within a more

positivist epistemology, highlighting the need for maintaining an objective stance in order to discover the reality of what is in the data. Charmaz takes a different approach, stating that "We *construct* our grounded theories through our past and present involvements and interactions with people, perspectives, and research practices" (Charmaz, 2006, p.10). She believes that rather than discovering reality within the data, grounded theory "offers an *interpretive* portrayal of the studied world, not an exact picture of it" (Charmaz, 2006, p.10). This approach sits more comfortably with the Contextualist epistemology adopted in this study and therefore this was the key text used to guide the data analysis. Figure 1 illustrates the hierarchical nature of the analysis, although in reality, constant comparison leads to frequent revisions and therefore it is not an entirely linear process.
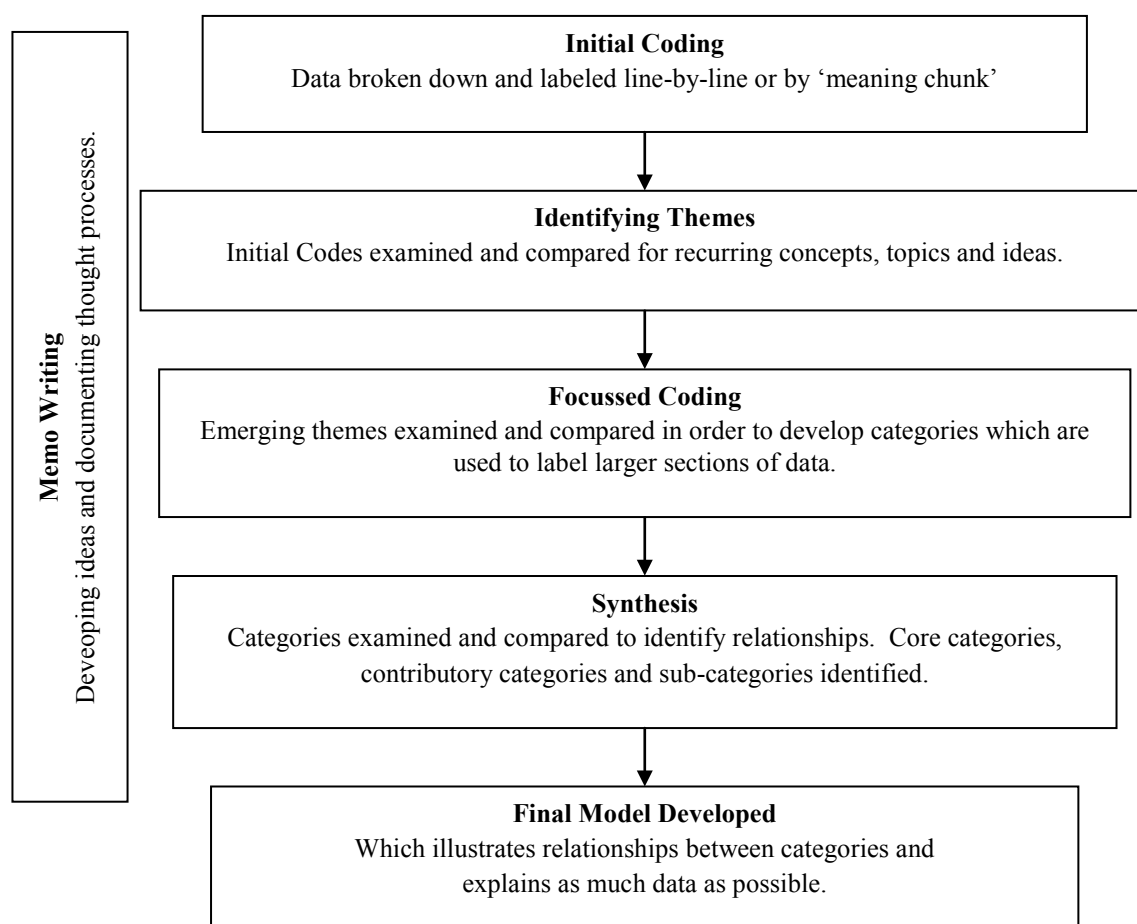

Figure 1: Process of Analysis

2.4.1 Initial Coding

The first stage of the analysis involved examining the data closely and coding each line or 'meaning chunk' (sentence or concept) by giving it a label. The idea of coding in this way is to open up the data and allow the researcher to begin to ask questions of it, allowing ideas to emerge. Charmaz (2006) recommends that initial codes should "stick closely to the data" and that where possible active codes should be used. The aim at this stage is to code fairly quickly and to constantly compare new codes with previous ones. This process can shed light on emerging themes and identify areas to explore in subsequent interviews. An example of initial coding can be seen in appendix F.

2.4.2 Focused Coding

Themes were identified by examining the initial codes to find recurring ideas, topics or concepts within the data. The emerging themes were then closely examined and compared in order to allow the development of a number of categories which seemed to explain significant ideas or concepts within the data. The interview transcripts were then coded using the category labels as applied to larger sections of data (e.g. several lines or a paragraph).

2.4.3 Synthesis

The final stage of analysis involved identifying core categories which were able to explain the majority of the data and developing a model to depict the relationships between categories. By careful examination of the focused codes, a number of contributory categories and subcategories were identified. Any focused codes which were not well supported by the data were subsumed, where possible, as part of a contributory or sub-category or, where they seemed of limited relevance, were eliminated from the final model. In this way a model was developed which attempts to offer one possible way of understanding the complex interactions between staff members' beliefs and practices. Figure 1 illustrates this process as

a flow diagram, although in reality this is not a linear process as the model is constantly being revised by the addition of new data and constant comparative analysis.

2.4.4 Memo writing

Memos were written throughout the research process to capture the thought processes behind decisions that were made, initial reflections on interviews and the ideas that developed throughout the analysis. An example is included in appendix F.

2.5 Enhancing Quality

Samples of two pages of interview data from two separate interviews were rated by one research supervisor and a fellow Trainee Clinical Psychologist who was also involved in conducting a Grounded Theory study. In accordance with the contextualist epistemological position, as described by Madill *et al.* (2000), the purpose of triangulation was completeness, rather than convergence; i.e. to see whether different raters might enrich the emerging theory by offering additional perspectives that had not been considered by the researcher. The coding applied by all three raters was in fact very similar. Having the additional ratings, however, did help to clarify some of the emerging themes (recurring initial codes), in particular themes relation to 'imposition' on service users as opposed to 'prioritising the client's perspective' which became key elements of the core categories of 'Expert Position' and 'Being With'.

Towards the end of data collection a peer supervision session was held where the initial process model was presented and discussed. This allowed alternative ideas and suggestions to be made and raised questions which, upon later reflection, were significant in deciding whether it was necessary to significantly revise the model. Throughout the process of analysis regular research team meetings were held with both supervisors. These meetings were vitally important for the development of the final process model as they enabled

alternative interpretations to be proposed and discussed and challenging questions to be asked. The final process model does not therefore represent the interpretation of a single researcher, but incorporates ideas generated during discussions with peers and supervisors and is therefore likely to be a valid representation of the data.

2.6   *Revising the Model*

Towards the end of data collection an emerging model was taking shape which depicted a linear process. An attempt was made to begin writing up the findings and describing the relationships between categories, however, as the write-up progressed it became clear that the linear model could not account for the complexity of the data. Upon further reflection, it became clear that the categories that had been developed roughly mapped onto the interview questions asked and therefore the model had been imposed upon rather than being grounded in the data. It was not possible to 'fit' participants' responses into set categories as they often made contradicting statements or stated that they shifted position in different contexts. Discussions in research meetings generated the idea of using polarities to better illustrate these phenomenon. It was then necessary to return to an earlier stage of analysis in order to develop new categories and a model which more accurately portrayed the data. This was extremely time-consuming, therefore restricted the time available to interview additional participants, resulting in a final sample size that was slightly smaller than initially anticipated.

3   Results

3.1   The Process Model

In trying to capture the complexity of human understandings and interactions it was not possible to represent the findings in terms of mutually exclusive categories and a linear process. Individuals held seemingly contradictory beliefs or sometimes behaved in ways which did not seem to fit with their ideals. Instead the model depicts a fluid conceptualisation comprised of two sets of intersecting polarities or Core Categories: Expert Position/Being With and Independence/Dependency. In between the polarities is a continuum of possible positions. Participants tend to more frequently position themselves at particular points on the continuums but then shift to different positions in different contexts, depending upon a variety of influencing factors – the Contributory Categories. Contributory categories are interrelated but for diagrammatical simplicity this has not been illustrated in figure 2.

Key for Figure 2: The Process Model

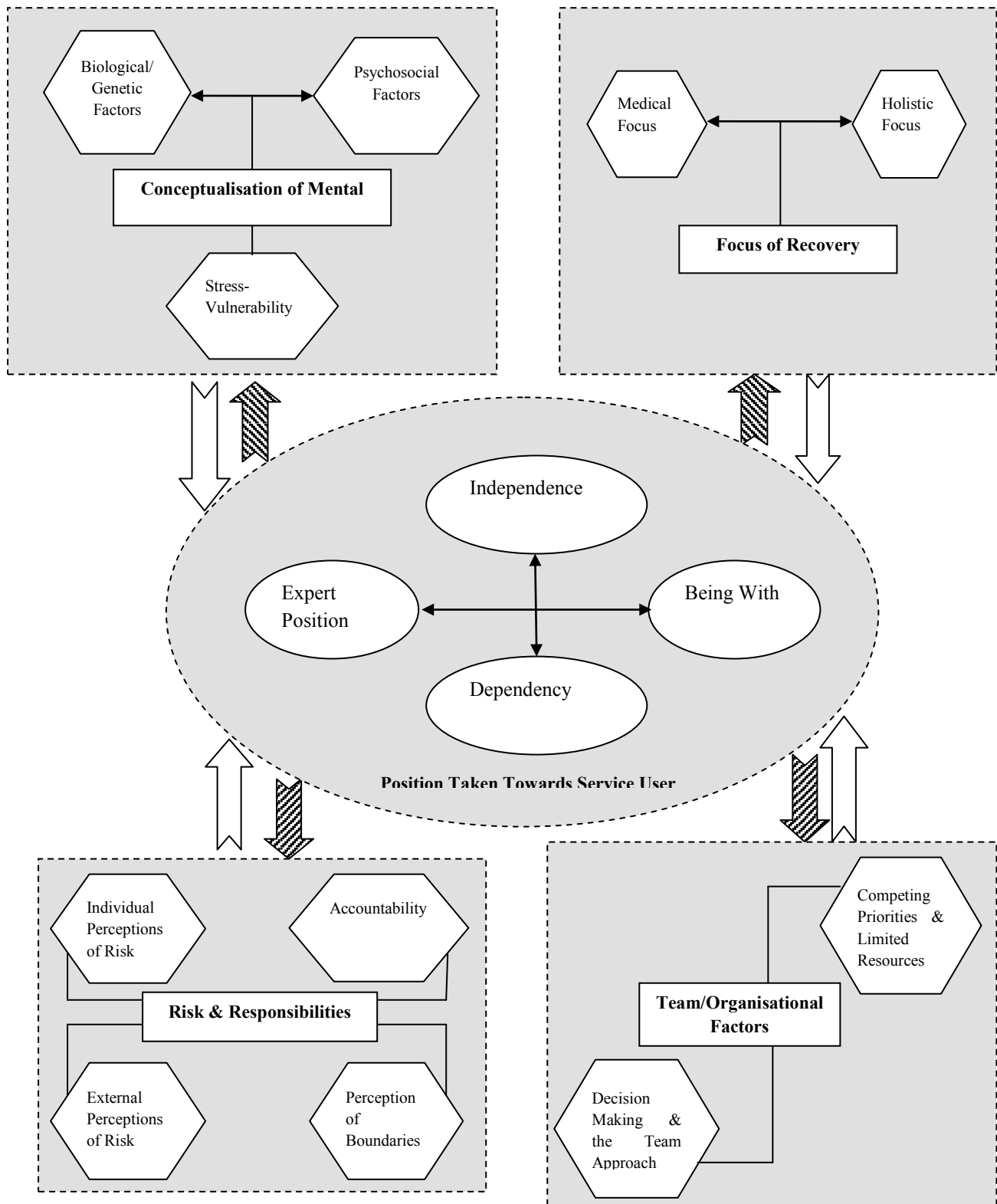|	
⬭ Core Categories	⬭ Core Category Sub-Model
▭ Contributory Categories	▭ Contributory Category Sub-Model
⬡ Sub-categories	— Contribution to category
↔ Continuum of possible positions	⟹ Influence of Context & Understanding on Position Taken
⟹ Influence of Position Taken on Understanding	
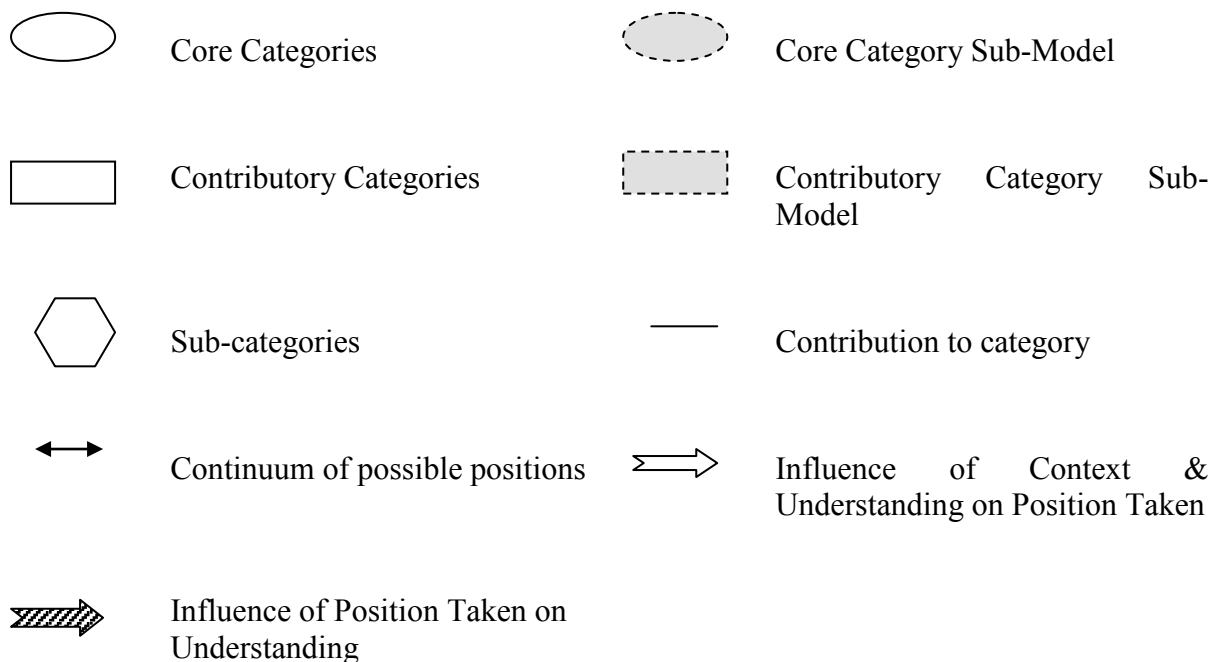
Figure 2: The Process Model

3.2 The Core Categories

3.2.1 Expert Position

The 'Expert Position' is one in which the professional is perceived as holding the knowledge and expertise, therefore the service-user's freedom of choice and sense of autonomy may be restricted at times if it is thought that it is in their best interests.

"...it's fair to say that they've been referred to us for a particular reason which is that they're not accepting, well for lack of a better term, or whatever treatment is offered to them so then there is obviously a limit to how much choice and freedom they can have." (P7, 143)

The 'expert position' is more likely to be adopted when professionals are positioned further towards a biogenetic conceptualisation of mental health difficulties because this is linked to a more positivist tradition in that it assumes there is a true 'reality' which is separate from psychotic experiences. There are diagnosable mental illnesses and evidence-based treatment approaches that can be drawn upon in order to 'treat' the symptoms that service-users are experiencing. Service-users who do not agree with the position of the professional may be considered as lacking 'insight' into their condition or situation and this can be perceived as a barrier to working with them.

"non-acceptance that there is a problem is a barrier as well because then whatever interventions you are suggesting which might be useful, if there is non-acceptance of them, due to lack of insight or whatever things, then that is a barrier." (P7, 514)

When a service-user resists intervention, whether medical or psychosocial in nature, they may be perceived by the professional as 'difficult' to work with.

"I think anyone who's kind of got zero motivation to want to [laugh] change anything in their lives is <u>extremely</u> difficult to work with unless all you want to do is maintain them…" (P2, 544)

When working from an 'expert position' the professional may impose treatments or interventions upon service-users for paternalistic reasons, or because of the limitations of the system they are working in. The nature of the AO client group is such that they have a history of reluctance to engage with mental health services. Unless the professionals' support comes to be viewed as valuable and welcomed by the service-user then their very presence will represent a degree of imposition.

"because actually right at the beginning we're bringing people into a service and going 'we're taking away some of your choices or we're imposing things on you' and I think that's a key feature of services" (P3, 233)

Some participants tended to more frequently position themselves in the 'expert position', whereas others did not find this a instinctive position to adopt but had to shift towards this way of working at times in order to minimise risks to the service-user and others or because of organisational pressures and resource limitations.

"I've said 'look actually I'm really concerned and and if things don't start to change, if if you're not able or gonna take medication I think we probably will be calling a Mental Health Act assessment because, actually I'm really worried [laugh] about you, and for <u>these</u> reasons' and having to be really open and honest…" (P3, 278)

3.2.2   Being With

'Being with' is the opposing position to the 'expert position'. This involves working with service-users in a non-hierarchical, collaborative and client-centred way. The professional

attempts to understand and empathise with service-user's experiences and beliefs and work from their perspective.

"...it's really important to listen to the service user's perspective on why they have mental health issues if they feel they <u>do</u>... and to work with that rather than to try and necessarily impose your view of of why that is..." (P3, 68)

At this end of the continuum, the service-users' wishes are paramount, they are able to make informed choices about their care and positive risk-taking is encouraged. The service-user is viewed as an expert in their own experience and the professional works in partnership with them (*1 – appendix H).

"...I think social work you sort of start from, the whole training's about like you know the service user's the expert and you're there to listen to them..." (P3, 585)

The focus of 'being with' is on having a therapeutic relationship with somebody to support them through difficult times without necessarily having any immediate answers or solutions for their problems.

"...a lot of what I do is just spending time with people who are distressed and not having an answer to that just, there I think there's something valuable about just spending time with people at that point because, and just making them aware that they're not completely alone..." (P3, 678)

'Being with' is associated with a social constructionist rather than a positivist approach to knowledge. Multiple perspectives can be tolerated and explored as there is an acceptance that meaning is individually constructed.

"I think the thing you just have to remember there is that we're not talking about my <u>perception </u>of something we're talking about an individual's perception..." (P1, 129)

Service-users are encouraged to find answers for themselves (*2) and supported to take their desired course of action wherever possible.

"I'm there I'm there for the client not for anything else, it's <u>not</u> my agenda it's <u>their</u> agenda"(P1, 739)

Participants who believed that there may be more than one legitimate way of perceiving the World tended to take a more questioning approach in terms language and formulating people's beliefs and experiences. Some did use terms such as 'ill' or 'insight' but were aware that this terminology was contentious (*3).

"Erm in terms of service-users across Assertive Outreach er insight appears to be quite a big issue. Erm I think you know it, it's a bit contentious of how important insight is..." (P4, 173)

Whilst some professionals want to generally position themselves towards this end of the continuum, others shift towards this way of working in certain contexts. The AO model, for instance incorporates a focus on relationship building and engagement, so professionals may adopt a more client-centred approach in order to facilitate this.

"...you just have to be more <u>open</u> and really <u>supportive</u> and, in terms of their needs and to improve the engagement and build the trust." (P5, 118)

There are limitations to simply 'being with' service-users and understanding their perspective. Unusual beliefs were accepted when they were judged by professionals to be benign.

"I don't think that it's for me to impose my view [laugh] of the World on them in that context because it doesn't cause them any particular harm, it's something they've lived with for a very long time..." (P3, 106)

Where professionals judged an unusual belief to be distressing for the service user or maladaptive, however, they would shift away from simply 'being with' by offering alternative perspectives.

"...saying 'I don't believe this is real' is sometimes helpful if there's kind of an element of distress and, and being upset..." (P3, 101)

3.2.3   Dependency

In this context 'dependency' is a state in which the service-user is over-reliant on the AO service, or a particular aspect of its provision (e.g. medication or relationship with care-coordinator). Whilst service-users are required to remain under the care of services they are inevitably dependent to some extent on the treatment or support provided.

Dependency may sometimes be associated with compliance which may be functional to the service, and may even be valued in some contexts. Service-users are required to engage with professionals and comply with interventions and treatment regimes. When a service-user's mental health is perceived to be unstable, too much independence may be perceived as a risk and provoke anxiety in professionals. It is more difficult to monitor service-users' level of functioning and current state of mental health if they cannot meet and engage with them on a regular basis.

"...we're always a bit kind of twitchy if folks are withdrawn and are not seeing services. I can't really see how that can ever be a particularly be a good sign, even though if they're just themselves they might find that they've actually, that's actually fine to be doing so." (P4, 358)

At other times, however, a high level of dependency can have a negative impact on the service, resulting in increased professional burden and workload. It may impede a service-

user's recovery because they feel unable to move away from services and lack confidence in forming relationships and engaging in activities in the wider community.

Service-users may become too dependent because professionals take a paternalistic stance, doing things for their service-users as they do not believe that they have the capacity to do things for themselves, which can be disempowering.

"I had one of my clients and I'll think well I'll make the appointment for them because I know they're not going to do it." (P6, 200)

Dependency can also occur because service-users come to highly value the relationship they have with the professional and feel that they do not want to lose the human contact, particularly if their social network is very limited.

"I've befriended them so much ... there's a problem with over-engaging as well because they become too dependent on you and you lose track of what you're trying to achieve..." (P8, 112)

3.2.4   Independence

At this end of the continuum, service-users are encouraged to make decisions about their treatment and other aspects of their life. The goal is for them to progress to a point where intervention from specialist services can be reduced or withdrawn altogether. This involves supporting people to connect with the wider community.

"...it's about saying well you know there is a, there is a wider world out of there and er that's where we see your recovery as being er kind of ultimately located and that's where we want to get you, get you to, and that's very much part of our work as a, as a community team." (P4, 62)

Independence means not only having the opportunity to be autonomous in your decision-making, but also taking responsibility for the outcomes of those decisions – making an informed choice. Certain contextual conditions may need to be met in order for professionals to feel comfortable promoting independence and autonomy.

"...as long as it's <u>legal</u> and all the rest of it [laugh] and they've <u>thought</u> it through and you're kind of um happy that they're making an <u>informed</u> choice they've <u>got</u> capacity, they kind of <u>know</u> what they're doing they <u>know</u> what the possible outcome could be if it all went a bit pear-shaped and they're willing to kind of, <u>work</u> with that then <u>yes</u> I think I probably would work with them like that..." (P2, 210)

For some professionals the emphasis is on giving the service-user a degree of control or ownership and empowering them to make their own choices. For others, having firm boundaries in place and a clear remit is necessary in order to encourage service-users to take responsibility for their own lives.

"I take my clients out for lunch but they pay their bit and I pay for my bit. I think that's <u>fair</u>." (P5, 237)

3.3   Contributory Categories

3.3.1   Conceptualisation of mental health difficulties

All participants disclosed multi-factorial explanations of mental health difficulties, incorporating a variety of biological/genetic and psychosocial factors, therefore in figure 2 this category is again depicted as a continuum of possible positions. Figure 2 also illustrates that participants all alluded directly or indirectly to a stress-vulnerability model in which the vulnerability may be either genetic/biological or psychosocial in nature according to their position.

3.3.1.1   Biological/Genetic Factors

Participants who positioned themselves at this end of the continuum described service-users as 'having' diagnosable mental illnesses such as 'schizophrenia' and 'bipolar disorder' which resulted from biological factors, were potentially heritable and/or involved a chemical imbalance in the brain which could be corrected through the use of psychiatric medication. They recognised that diagnoses were sometimes less than exact and could change over time depending upon different doctors' perspectives and new research, but it was felt that diagnostic labels were necessary and useful, providing a common language (*4). It was thought that service-users found diagnoses aversive primarily because of the stigma associated with serious mental illness.

"...the consultant can't just change the diagnosis to suit the client's needs because it's a legal document erm and we go by the ICD diag, diagnostic book..." (P5, 49)

The professional is positioned as the 'expert' therefore service-users who did not believe that they had a mental health problem were perceived as lacking 'insight'. (*5).

"...the majority of them don't agree that they've got a problem. Their, you know, insight isn't the, isn't the best erm, with these type of illnesses." (P6, 37)

Delusions and hallucinations were viewed as 'symptoms' and although professionals demonstrated sympathy for those experiencing them they did not tend to reflect a great deal on their nature or the functions that they might serve. The treatment agenda is generally 'expert' led, aiming to minimise or eradicate symptoms and psycho-education is viewed as important in order to help the service-user to understand and accept their mental health difficulties.

"...you make the most of that opportunity and you know just educate her a bit more on taking her medication and why things are what they are in your life..." (P5, 114)

63

3.3.1.2   Psychosocial Factors

Participants commonly cited several psychosocial factors which were seen to contribute to the development of mental health difficulties, including substance misuse[4] (cited by all), early life experiences, trauma, isolation, marginalisation, lack of positive relationships and living in unsafe/unhealthy environments. Those who constructed mental health difficulties as primarily psychosocial in origin were more likely to reflect on the nature and function of unusual experiences such as delusions or hallucinations rather than viewing them purely as symptoms of an illness.

"I think, for a lot of them as well, like the psychosis, the delusions can be <u>protective</u> cos the reality is really just so <u>bad</u> really. I think a lot of them if they just <u>stood</u> there and thought 'is this <u>it</u>?' it could be quite, such a <u>devastating</u> kind of thing to have to think about." (P2, 345)

Those who tended to be positioned towards this end of the continuum were more skeptical about the utility of diagnostic labels, viewing them as ambiguous, irrelevant, over-used and a barrier to understanding the person and their difficulties as a whole. Although it was accepted by some that diagnostic labels could have some utility in terms of planning care and predicting timescales for recovery (*6), it was felt that they were generally unhelpful. (*7).

"I think schizophrenia is an overused and blanket diagnosis that is almost meaningless because of that." (P2, 506)

At this end of the continuum multiple perspectives are tolerated, therefore non-acceptance or lack of 'insight' was not perceived as a barrier to exploring people's beliefs and histories

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[4] Substance misuse may have both a biochemical and psychosocial influence depending upon conceptualisation

(*8). There is more utility in exploring how people make individual sense of the World, positioning professionals more towards 'being with'.

"we don't know exactly what's going on and actually in some ways it doesn't matter it's about people's own ability to make sense of the World, and to manage that…" (P3, 85)

3.3.1.3 Stress-Vulnerability Model

All participants alluded directly or indirectly to a stress-vulnerability model, whereby individuals have an underlying propensity for developing mental health difficulties, but social and environmental stressors can act as triggers. For those generally positioned towards the biogenetic end of the continuum, the vulnerability was perceived as genetic/biological in origin (*9):

"I mean personally, I believe that it's something that's in you that's, it's going to come out at some time or other and maybe drugs or environmental factors and stresses bring it out sooner than, than it normally would…" (P6, 16)

Whilst those more often positioned towards the psychosocial end of the continuum were more skeptical about the evidence for genetic heritability and believed that vulnerability is more about resilience; the ability to cope with stress and to problem-solve, which is learnt through previous life experiences (*10).

"I mean I guess that there are statistics aren't there to say that it is genetic to a certain extent but I think it's from my own, the way they adapt to life is generally about what they've learnt in their childhood…" (P8, 223)

In the latter position anybody may have the potential to develop mental health difficulties if exposed to a certain set of circumstances; it is about psychological thresholds as opposed to being due to biogenetic susceptibility (*11).

3.3.2   Focus of recovery

Figure 3 illustrates that, as with 'conceptualisation', participants described multi-factorial models of recovery and mentioned a variety of medical and psychosocial factors that may enhance or inhibit service-users' progress.

3.3.2.1   Medical Focus

At this end of the continuum, participants tended to view psychiatric medication as a key component of treatment; necessary to create a stable foundation on which to base other interventions. This makes sense if mental health difficulties are viewed as resulting from a chemical imbalance in the brain (*12) or conceptualised as having parallels with physical illness.

"...if you totally subscribe to the model of mental health as an <u>illness</u> and you can have treatment, then I suppose it's hard to kind of say 'well we'll just let people <u>not</u> have that treatment'..." (P3, 360)

This tends to be associated with a biogenetic conceptualisation in which the key factors in recovery are good medication concordance, acceptance of illness and engagement with mental health services. Recovery was generally described in terms of observable and/or quantifiable factors, such as whether a service-user was engaging with activities in the community, whether they appeared to be exhibiting fewer symptoms and whether they had required a hospital admission.

"I mean we have to do as part of the care programme approach we do the HONOS, the Health of Nation Outcome Scales. We also do the I forget the name now, the engagement scale as well, the AO, whatever, the engagement scale which perhaps we do at the outset and then later on to see how well people are either engaging or not with the team..." (P7, 532)

66

Service-users' perspectives on progress would be taken into account to some extent, but the professional's judgement was given priority, therefore this approach to assessing recovery is more in line with the 'expert position'. It was seen as probable that service-users would remain under the care of mental health services, even if discharged from AO

"...very rarely people who we see move out of services..." (P6, 78)

Withdrawal of medication was seen as an unrealistic goal for most service-users.

"...I think it would be cruel to support them to come off it because you know, you know erm that the sort of depths that can deteriorate to." (P6, 496)

This end of the continuum then offers less hope of recovering a 'normal' life and is more likely to result in 'dependency' on medication and services.

3.3.2.2   Holistic Focus

There was a great deal of consensus amongst participants in terms of the remit of AO and what it should offer. Participants were aware that service-users referred to AO had often had negative experiences with mental health services and were reluctant to engage. In AO it was important to work in a different way from other services, not simply focusing on mental health but addressing other practical and social needs such as housing, benefits, social inclusion, employment and education. Participants talked about "being useful" to service-users in a way that other services had not been, for instance carrying out practical tasks like shopping and decorating.

"I think AO's much more good, much more effective at sort of negotiating with people to kind of try and make the services useful to them in a way that actually has meaning for them..." (P3, 713)

Those who tended to position themselves more often towards this end of the continuum viewed medication as just one component of the management strategy, to be used if and when it was helpful for the service-user (e.g. to enhance coping ability or to avert a crisis.) Other means of support were seen as equally if not more valuable (*13). Medication was perceived as not eliminating all symptoms and being *"helpful"* and *"destructive"* or *"distressing"* (P3, 410).

"I'm not a great fan of medication or whatever but I mean it does play a part with some people..." (P2, 134)

In AO, smaller caseloads and a lack of time restrictions, allowed for long-term, more flexible working and greater continuity. Staff were able to spend more time getting to know their service-users and responding to them in creative ways, allowing them greater choice, control and independence. Whilst in some contexts, a focus on medication compliance can result in staff adopting the 'expert position' and imposing treatments or interventions, the AO approach can also encourage a shift towards a more holistic focus of recovery.

"We're not just there to enforce medication, to enforce depot injection. They want to know that you know we'll be there to support them through difficult times so we do a lot of social stuff like shopping, benefits..." (P5, 152)

In assessing recovery, those more frequently positioned at this end of the continuum used language which indicated that they were connecting with the service-users' subjective experience, raising concepts such as 'self-esteem', 'confidence' and 'self-worth'.

"...having a purpose in life, um feeling just useful and loved and wanted..." (P2, 326)

There was a recognition that service-users may have a different view from professionals about what was important to them in their recovery. This links back to the

concept of tolerating multiple perspectives and 'being with' the service user in understanding how they make sense of the World (*14).

There was more optimism about the prospect of people becoming more independent, withdrawing from medication and moving out of services, even if this was viewed as a very long-term goal. Recovery was seen as being located in the wider World.

"...we're very much working to a recovery model which is about erm, supporting people to kind of move through services to a point in which they hopefully don't need services at all..." (P4, 147)

3.3.2.3   Individual perceptions of risk

Some participants highlighted the statutory duties that the AO service has to protect the safety of service-users and the public. Whether or not a service-user is allowed to take a course of action depends upon whether the likely costs are judged by the professionals working with them to be too high to justify the risk and what support networks they have in the community.

"...in terms of kind of taking risks we would be erm more sort of likely to take risk given that there's a kind of wider network out there to support them. If somebody's very isolated that makes us kind of less likely to sort of do things really." (P4, 376)

Some team members are more willing to allow clients to take therapeutic risks than others, providing that they feel the service-user is making an informed choice.

"...the other option is what he's choosing and if that's what he wants to do then we need to go with that and he might just need to go through that for a period of time, to see if it does make a difference, and we just have to make sure that we monitor it..." (P1, 474)

For those who seemed more comfortable accepting a certain level of risk, there was a perception that AO has a generally higher tolerance of risk than other services and will enable service-users to remain in the community even when they reach a point at which other services may have called for a Mental Health Act assessment. This is partly due to the more flexible working patterns of AO and the ability to provide more intensive support at home. Hospital admission tended to be viewed as a negative experience which offers little therapeutic benefit.

Other participants tended to adhere more rigidly to policies and guidelines in assessing acceptable levels of risk.

"...being a multi-disciplinary team and in terms of risk assessment, some people just brush it aside and say 'oh it's so and so, that's normal' and I'm thinking well, if its risk situation at the moment in the Trust, we don't tolerate any risk, any abuse..." (P5, 252)

Therapeutic risk-taking is about allowing service-users to have more control over their lives and enabling them to make decisions; a client-centred approach in line with 'being with' and encouraging 'independence'. Risk-averse practice results in professionals moving towards the 'expert position', restricting service-users' choices and being more willing to impose treatment if it is seen to be in the service-users' best interests.

Professionals working in AO cannot escape from the reality that risk management is part of their role. For those who positioned themselves more frequently towards 'being with' this can pose dilemmas and a need to be open and honest with service-users about their dual role (*15).

"On one hand it's like you know lots of recovery stuff, work with Strengths Agenda; on the other hand it's like risk is, is perfectly kind of, it trumps those things..." (P4, 438)

3.3.2.4   Accountability

For some mental health professionals statutory obligations are made more explicit due to the role that they hold, for instance being the Responsible Clinician (RC). An awareness of legal accountability for service-users' behaviour encouraged more cautious and risk-averse practice.

"...given the role that we have, perhaps more so, so when for example things do go wrong we are asked to you know provide reports and get involved in enquiries or you know go to court and things like that..." (P7, 478)

Where professionals perceived a lack of support from their organisation in the event of an adverse incident, novel or innovative practices may be restricted. Several participants highlighted the need to document discussions and decision-making in order to have a clear record in case of being held accountable in the event of an incident.

"...there is still that feeling that you're not gonna get the support that you would want to occur. You will there will always be someone wrong, there will always be somebody scapegoated..." (P1, 782)

Some participants highlighted the need to be accountable to service-users when, for instance, the decision to call a Mental Health Act Assessment has been imposed. The professional may want to 'be with' the service-user through this distressing experience but are aware that the service-user may then perceive them as being one of the 'experts' imposing treatment or hospital admission, therefore the therapeutic relationship could be damaged. Moving towards 'being with' the service user and engaging in open discussion after the crisis can help to rebuilt trust and repair damaged relationships.

3.3.2.5 *Perception of Boundaries*

Participants differed greatly in terms of their perception of boundaries. Having rigid boundaries protects the needs of the service and organisation as well as the individual professional. It may lead to promoting 'independence' to some extent as the service-user is less likely to become over-reliant on the service, but it could also lead to adopting the 'expert position' and imposing treatments/interventions on clients due to risk-averse practice.

"...we get certain staff who are saying, 'oh come on, let's go and do this' and when you think, 'no we <u>shouldn't</u> be jumping, you know saying how high shall we jump' cos at the end of the day, we should have boundaries..." (P5, 287)

Having permeable boundaries leads to a more flexible approach in line with the 'being with' end of the continuum, but also risks fostering 'dependency' through over-engagement if the boundary between being friend and professional becomes blurred. This could place unrealistic burdens on the professional and the team.

3.3.2.6 *External Perceptions of Risk*

Several participants described how those who work with mental health service-users develop a greater tolerance of behaviour that does not conform to social norms than the general public. The media often portrays people with a diagnosis of 'schizophrenia' as potentially dangerous and a risk to others whereas for professionals, particularly those positioned more towards 'being with', the service-user is an individual who has the right to express themselves in different ways.

"The general public's tolerance is basically 'they're doing something wrong they're as mad as a hatter admit them' whereas for us it may often be a fact of saying 'well no not necessarily the person is just expressing their <u>belief</u>..." (P1, 509)

Professionals may be compelled impose restrictions/interventions on service-users under pressure from other members of the public or organisations (*16). The possibility of being held accountable for not acting quickly enough to prevent an adverse incident creates pressure to intervene and impose restrictions/interventions in order to reduce risk.

A number of participants talked about external pressure from inpatient wards or rehab units to impose Community Treatment Orders (CTOs) on service-users upon discharge to the AO team. Some participants felt that CTOs are sometimes seen by colleagues as an easy option.

"...sometimes people want to use them maybe too readily and it's almost like 'let's have a CTO and then um we don't have to bother having any medication conversations with the person working with them about anything, cos they're on a CTO and that's it job done'" (P2, 259)

None of the research sample believed that CTOs are necessary or beneficial for the majority of service-users. The preferred approach was to establish a voluntary agreement about treatment/intervention rather than imposing a CTO immediately which may hinder the development of a therapeutic relationship. The majority of participants felt that there were ethical questions about imposing treatment but some also felt that the orders did not carry enough powers of enforcement to make them useful.

"...if you've got someone that's, say they're on a depot medication or even on tablets and they're refusing it, no matter what treatment order they're on, erm how are you going to get it into them?" (P6, 453)

3.3.3 Team/Organisational Factors

3.3.3.1 Competing priorities and limited resources

Whilst AO provides a more flexible and intensive service than other teams, there are still limitations in terms of numbers of staff and working hours. Competing priorities, such as organisational requirements for documentation and paperwork, take time away from direct client-work. In reality service-users have limited choice over many aspects of their care, e.g. who becomes their care-coordinator.

"...that's just the way it is because we have limited resources and people have caseloads and actually we have to allocate it on the basis of who's got space..." (P3, 231)

Staff shortages and unpredictable workloads can impact on the level of care and support that people receive so that sometimes there is little space to engage in preventative work or "being with" service-users and instead it is a case of *"firefighting"(P1, 678)*. Under these circumstances people can become wary of over-committing themselves.

"...you <u>never</u> know what's gonna happen. If that intensity's gonna increase in two or three weeks' time and you've committed yourself to extra stuff, they you're running a very thin <u>line</u>..." (P1, 712)

Team make-up is variable but the majority of AO staff were from nursing backgrounds. This led to a feeling that AO staff had to wear many hats, becoming a *"multi-task professional"* (P1, 279), engaging in work that would not normally fall within their professional remit.

"It seems to have its advantages when it's all nurse, a lot of nurse led really but there are lots of disadvantages with lots of social sort of interaction that you need to do as well so you tend to be the social worker as well..." (P8, 149)

Having a dedicated team consultant psychiatrist and extended, more flexible working hours enabled crises to be managed more often within the team. Teams which operated more limited working hours had to rely on support from the Crisis Team which meant imposition on service-users as they have to deal with unfamiliar professionals at a time of distress.

3.3.3.2 *Decision-making and the team approach*

All participants felt that the team approach was valuable, providing an opportunity to listen to different perspectives and find creative solutions, particularly when a team member felt stuck, or uncertain how to proceed with a service-user. It was acknowledged by several participants that there are very different perspectives within the teams, but usually they could reach a consensus or majority decision through negotiation and compromise. Participants felt that even if there were no new suggestions or ideas the team would sometimes acknowledge that they had done everything they possibly could, which was reassuring for them as care-coordinator.

Participants described a hierarchy in decision-making with. In most cases decisions about a service-user's care lie with their care-coordinator, but where the team cannot reach a consensus or it is perceived that the risk or continuing a course of action is too high the team leader or responsible clinician may choose to over-rule the care-coordinator.

"... as the team manager they might intervene and actually say 'no I don't think this is an acceptable level of risk'" (P3, 498)

In some contexts this hierarchy was more readily accepted, particularly where a professional perceives themselves as being lower down the hierarchy, or where they can accept the reasoning behind the final decision.

"I've had a situation whereby I didn't agree with a certain decision and I just documented that my opinion <u>was</u> however the responsible clinician didn't think that was necessary so that's how you resolve it. At the end of the day, doctors have the utmost, final word." (P5, 330)

Others felt more able to challenge the decisions of those higher up the hierarchy, either due to the strength of their beliefs or because they held a relatively powerful role (e.g. being an Approved Mental Health Professional). Taking a more challenging approach was more in line with 'being with' and promoting 'independence' as the focus was more often on advocating for the service-users' choices.

"...I have to agree it's right, so ... normally I try and persuade people around to my view as well because it's better if you can try and get a consensus that you know, we should be trying this..." (P3, 631)

3.4   Potential Outcomes

Adopting the 'Expert Position' may sometimes be beneficial for service-users as it allows them to adopt a passive role as a recipient of care. It allows professionals to retain control over and to manage risk. In the long-term, however, it could result in the service-user feeling dependent upon services or feeling disempowered and unheard. They may choose to withhold information about their experiences or their intentions to stop taking medication because they do not feel their choices will be respected and they fear compulsory intervention. 'Being with' places the service-user as an equal, giving credibility to their individual expertise and experiences. It leaves the professional in a somewhat less powerful position, having to relinquish some control and open up to new possibilities and understandings. The aim is to enable to service-user to develop their sense of self-efficacy and promote greater dependence. The boundary between 'helper' and 'friend' needs to be

maintained, however, otherwise the service-user may become dependent upon the relationship.

4   Discussion

4.1   The Process Model

The aim of the process model was to capture the different approaches professionals take in conceptualising mental distress and unusual experiences and illustrate the relationship between conceptualisation and ideas about prognosis and recovery.   Issues of risk and responsibility along with team and organisational factors all have an impact on the decision-making processes that play out between staff and service-users and between professionals within the team.

4.1.1   The Core Categories

4.1.1.1   Expert Position versus Being With

The model presents a continuum of possible positions that can be adopted when working with service-users which are linked to beliefs about the location and validity of 'knowledge'.   In the 'expert position' the professional is assumed to possess superior knowledge and skills which can be applied in order to understand and find solutions to the service-user's difficulties.   Professionals may demonstrate empathy and respect for the service-user, but the agenda is led by the professional, therefore the balance of power is unequal.

Davis, Day and Bidmead (2002) highlight some of the shortcomings of adopting the 'expert position' in helping relationships.   Firstly the service-user controls the information that is shared with the professional and their cooperation is vital – they are more likely to pursue objectives that they are in agreement with.   Secondly there may not be any immediate solutions to presenting problems and thirdly that the service-user (and their support network) are key to the success of implementing management strategies.   If the professional takes a lead role, successes may be attributed to professional expertise rather than to the efforts of the

service-user. This may lead to feelings of disempowerment and dependency, or result in non-compliance with treatments or interventions and potentially disengagement. Research in AO has shown that disengagement is often associated with lack of active participation and poor therapeutic relationships, with power issues being pertinent. (Priebe, Watts, Chase & Matanov, 2005).

'Being with' incorporates many of the elements of the 'Partnership Model' proposed by Davis, Day and Bidmead (2002) which highlights the importance of working together, power sharing and negotiating in the helping relationship. The professional and service-user are viewed as having equally valued and complementary expertise which can be pooled in order to find solutions. The relationship is one in which the service-user feels listened to and involved and provides a positive model of relating which can then be generalised to other situations.

The notion of "withness" is well documented within literature in the field of family therapy and has evolved through the work of Tom Anderson (Anderson, 1987, 1990, 1992. Anderson & Goolishan, 1988 cited in Seikkula & Olson, 2003). Hoffman (cited in Anderson & Gehart, 2006) states that:

"Instead of the "expert" individual being assigned the most influence in this activity, as usually happens in psychotherapy, a "withness" conversation allows voices to emerge that have often been stifled or withheld."

Priebe *et al*. (2005) found that key factors influencing service-user engagement with AO were time and commitment of staff, willingness to listen and a focus on social support and engagement without a focus on medication. Service-users highlighted the importance of being seen as more than an "illness on legs", having their experiences listened to and being active participants in decision-making. In keeping with this, participants in the current study

viewed smaller caseloads, flexible working hours and non-time-limited interventions as key to the success of developing therapeutic relationships with service-users. They also talked about focussing on the person and their needs as a whole and being useful to the service-user in a variety of emotional and practical ways, rather than concentrating entirely on mental health issues and medication. These were the factors that were identified as making AO different to other mainstream mental health services.

4.1.1.2   Independence versus Dependency

Service-users are inevitably dependent upon the services provided by AO to some degree, whether it be in terms of receiving their prescribed medication or practical support from their care-coordinator to go shopping, attend appointments or fill in benefit applications. Even if the service-user is receiving limited input from the team, they live with the knowledge that the professionals within the service have the power to override their choice and autonomy by calling a Mental Health Act Assessment which may result in hospitalisation or the imposition of a CTO, if it is felt that they are not engaging appropriately with the service and may pose a risk to themselves or others.

Dependency is more likely to occur when professionals adopt a paternalistic approach in which they make decisions in the service-users best interests rather than encouraging them to be active participants in their recovery. Working from the 'expert position' service-users' ideas and experiences may remain unheard or be dismissed as 'psychotic' or resulting from their lack of insight. Service-users may become passive recipients of care and even come to adopt a 'mentally ill' lifestyle in which their social network consists almost exclusively of other mental health service-users and they become trapped in the benefits system. This situation may be exacerbated by lack of motivation and energy – sometimes viewed as 'negative symptoms' of 'schizophrenia'. An alternative explanation, put forward by several participants, is that issues such as social stigma, poverty, isolation and the traumatic

experience of mental distress itself can lead to service-users losing their confidence and self-esteem and feeling hopeless about their future. This can be exacerbated by the sometimes unpleasant side-effects of antipsychotic medication.

Professionals in AO work with the same service-users for extended periods of time and build trusting therapeutic relationships. Some participants highlighted the difficulty of maintaining the boundary between being a friend and a professional, which may be more difficult when working from a collaborative position in which the relationship is one of partnership. Whilst developing a good relationship is important, this should provide a model for the service-user to draw upon. In order to encourage greater independence from services it is necessary for the professional to facilitate the expansion of a service-user's social network. This may include working with them to overcome barriers such as anxiety and lack of confidence.

For some participants, firm boundaries were seen as necessary for encouraging independence. It was mentioned that some service-users, particularly those with 'personality disorder' can be manipulative and try to draw staff into doing things for them. Working from the 'expert position' the professional's role was perceived as teaching service-users how to behave in more socially acceptable ways and take responsibility for their actions. Working from the position of 'being with' an alternative approach would be to understand the needs that the service-user is communicating through this behaviour.

There is a need to find a middle-ground between paternalism and a laissez-faire approach in which service-users may be left to deal with the consequences of their action/inaction - the latter approach being somewhat punitive. In order to promote recovery, service-users should be enabled to make informed choices and be active participants in their care – this involves exploring options and potential outcomes, with support from staff to

81

overcome challenges. Research in AO has shown that a desire to be an independent person and a difficulty in accepting the patient role is a factor in disengagement from services (Priebe *et al*. 2005). Service-users may be less likely to disengage if they are equal partners in the helping relationship and feel that they are listened to and their individual expertise is valued.

In reality 'no man is an island' – rather we are all interdependent on other people, systems or organisations. The goal of recovery, therefore, is not complete independence but to become interdependent on social networks or organisations outside statutory mental health services. This might mean having regular access to a GP, support groups such as the Hearing Voices Network or other sources of social interaction including family and friendships, voluntary work, paid employment or education.

4.1.2   The Contributory Categories

A number of key factors emerged which influenced the position that professionals took in various contexts. It was clear from the interviews that some participants preferred to view themselves as practicing in a manner in keeping with the 'being with' end of the continuum. Under some circumstances, however, they feel they have to move further towards the 'expert model', persuading service-users to accept medication or intervention, or indeed remove their autonomy by calling a Mental Health Act assessment. This shift in position was usually associated with perceived level of risk.

Action may be taken because it is felt that it is in the service-user's best interests, or because of the fear of being held accountable by the organisation or the public if things went wrong. Working within a system in which risk minimisation is a key priority and the fear of litigation and negative media publicity is ever present, results in professionals feeling under pressure to take action in order to avert potential crises. This can result in ethical dilemmas

for staff, particularly those who prefer to work on a collaborative way with service-users. At times the power to make these decisions may be removed from the care-coordinator if it is deemed by a professional further up the hierarchy (e.g. Responsible Clinician, Team Leader) that they have underestimated the risk or are placing too great a pressure on the service by their preferred course of action.

Organisational factors and limited resources push professionals further towards the 'expert position'. Working collaboratively may take a great deal of time and also places greater emotional demands on the professional. Focusing on medical aspects of recovery is potentially easier from a service point of view as it is possible to look at measurable outcomes such as engagement, medication compliance and symptomology. It is more difficult to evaluate qualitative benefits gained from a collaborative, therapeutic relationship and a sense of personal autonomy. In some ways, it may be beneficial to services for service-users to remain 'dependent' where this equates to compliance. Encouraging greater independence may present challenges and necessitate greater resources being expended initially, but could result in a requirement for less statutory involvement in the long-term.

When mental distress is conceptualised as resulting from diagnosable mental illnesses, resulting primarily from biogenetic factors, expert medical 'knowledge' is prioritised above individual explanatory models. Professionals perceive their role as being one of 'educating' the service-user about their 'illness' and the exacerbating factors in their lives. Lack of 'insight' is perceived as a potential barrier to exploring ideas and possibilities. Medication is perceived as the key component of treatment and there is generally less optimism about the possibility of recovery.

Conceptualising mental distress from a more constructionist perspective, incorporating a complex and interacting range of psychosocial factors, allows different ideas to co-exist.

This concept may feel threatening for some professionals as it blurs the distinction between 'normal' and 'psychotic' experience and between the mentally 'ill' and the 'healthy'. Whilst all participants described biopsychosocial models, there was great variation in the weight that participants gave to various aetiological factors, thereby positioning them at different points on the continuum.

4.2   Clinical Implications

The NICE (2009) updated guidelines for Schizophrenia highlight the importance of maintaining hope for recovery and adopting a person-centred approach in which service-users are able to make informed choices. They also stipulate that professionals should use explanatory models with service-users which take into account different cultural and ethnic beliefs about the causes of "abnormal mental states". It would seem vital that professionals make every attempt to elicit these beliefs when working with service-users and their families, regardless of ethnic background, because if ideas and interventions offered by services do not fit with service-users' frameworks of understanding there is more likely to be resistance and non-engagement.

Clinical Psychologists are a scarce resource within AO services and there was a mindset amongst some participants that service-users need to be 'psychologically minded' or stable in order to benefit from psychological input. Psychologists can play a significant role in encouraging reflective practice within teams and enabling staff to develop shared formulations (Berry, 2008) both as a team and in collaboration with clients. Service-users' expertise could be utilised more widely in talking to professionals about the experience of mental distress or working as peer-professionals within teams, which would help to break down the 'us and them' dichotomy.

Developing good communication and being open minded to ideas and transparent about options available is more likely to result in service-users being honest with services rather than disengaging or withholding information. A collaborative approach in which the service-user is an active participant allows for ideas to be discussed and plans to be developed that are in line with the service-users goals and therefore more likely to be adhered to.

Lack of 'insight' should not be a barrier to exploring service-users' perspectives, even when it appears that their explanations are incoherent or confused. Use of person-centred approaches (Freeth, 2007) and the Open Dialogue approach pioneered in Lapland (Seikkula, Alakare & Aaltonen, 2001, Sekkula & Olson, 2003, Seikkula, Aaltonen, Alakare *et al*, 2006) have demonstrated how alternative approaches to the 'expert position' or 'psychoeducation' approach can allow connections to be made with people even during an acute episode of 'psychosis'. This fits with the idea of 'being with' service-users at times of distress, helping them to make sense of their experiences and find answers, with support from professionals and key members of their social network.

The AO team approach has many benefits. Smaller caseloads and more flexible working hours allow for the development of therapeutic relationships with service-users and a more holistic approach to recovery and greater continuity of care. Having a range of professionals with different perspectives within the team allows for different ideas and perspectives to be shared. The team approach provides checks and balances to individuals' practice with shared decision-making.

The current context within the NHS of mental health clustering and payment by results with a focus on efficiency and cost-savings is threatening the existence of AO services. This was highlighted by two participants whose teams are being disbanded with AO workers being

subsumed into Community Mental Health Teams. Such a move is likely to result in higher caseloads and a greater pressure on resources, making it more difficult to work in practical, creative or innovative ways. The loss of the team approach could potentially be detrimental, leaving staff feeling unsupported and losing their distinct AO identity and remit. There is a risk that short-term cost-saving initiatives will have long-term detrimental effects on AO service-users who have previously disengaged from mainstream mental health services which have failed to meet their needs.

All participants highlighted difficulties with diagnosis, including the stigma attached to mental health labels, in particular 'schizophrenia'. Several participants highlighted the ambiguous nature of diagnoses which are subjective and often overused. In recent years there has been much debate about the validity and utility of categorical diagnostic systems within the area of mental health. Due to the heterogenous nature of presentations and prognoses in'schizophrenia', many believe that rather than a single diagnosable condition it is better understood in terms of a 'Needs Based Approach' incorporating individual precipitating factors (Alanen, 2009) or a 'complaint-oriented approach' (Bentall, 2006) as there is far more valid research evidence to explain the aetiology of specific experiences such as hallucinations and delusions than 'schizophrenia' as single 'illness'.

4.3   Methodological Critique

The sample size of eight participants included in this study is small but adequate for the methodology. Logistical issues including the time taken to obtain the necessary Ethics Committee and Trust Research and Development approvals, added to the time constraints of the doctoral training programme restricted the number of participants that could be interviewed and the amount of data that could be analysed within the timescale. The decision to reanalyse the data to develop a revised process model also meant that more time was spent

on analysis at the expense of conducting further interviews. It may have been useful to have explored aspects of the model in more detail with a greater number of participants, possibly including those from different professional or ethnic backgrounds, however, the themes that emerged from the analysis were well supported by the data.

The aim of the grounded theory approach is to achieve theoretical saturation and there is good reason to believe that saturation, or at the very least theoretical sufficiency, was achieved in this study as by the eighth interview the data was primarily adding to the existing categories rather than generating any significantly different ideas or themes. During the process of analysis additional themes emerged but it was felt that there was not enough data to support these as independent categories. Where this was the case either the themes were excluded from the final model, or in most cases it was decided that they could be subsumed as elements of larger, better supported categories.

Initially purposive and later theoretical sampling, were used to ensure that the sample was relatively diverse. Participants came from both genders and a range of ethnic and professional backgrounds. They held different professional roles within the teams including Responsible Clinician, Approved Mental Health Professional and a Team Leader – the remainder of the sample all had roles as care-coordinator, with some holding additional roles as Recovery Champions. Participants had volunteered to participate, therefore there may have been an element of selection bias with certain groups choosing to exclude themselves, for this reason it cannot assumed that the views represented in the sample were representative of all AO staff. Despite this possible bias the sample included participants from four separate teams across two NHS Trusts covering different geographical areas.

It is likely that the main themes identified by the research would be common to all AO teams although the relationships between categories may vary and there may be additional

local influences which were not identified in this study. AO teams offer community-based interventions and work with a specific client group with severe mental health difficulties, complex needs and a history of difficulty in engaging with services. Working in this context is likely to influence staff perceptions of service-users and conceptualisation of psychosis, in term of for instance their beliefs about the possibility of recovery, the emphasis put on relationship building and practical support and their beliefs about client autonomy. It is not possible, therefore, to generalise these findings to other mental health services which have a different remit and admission criteria.

The interviews generated data which was sufficient to construct an answer to the first two research questions, regarding what understanding staff members have about possible causes of clients' experiences and distress, what approaches they take in promoting recovery and how this is related to their understanding. The third research question related to how approaches to treatment and recovery are negotiated between staff and clients and within the team. Unfortunately the interview data did not really provide enough detail in this area, particularly in relation to how approaches are negotiated within the team. The model does encompass some reference to these processes in terms of how staff members perceive themselves as part of a hierarchy, to what degree they are willing to advocate for clients and whether their focus is on empowering clients to make choices or attempting to encourage compliance. In order to look at these aspects in more detail, however, it might be more effective to use alternative research methods (e.g. observation) as what is reported by interviewees is an interpretation and therefore may not accurately reflect the underlying processes of which they may not be fully aware.

The quality of the analysis was enhanced through the process of constant comparison. Care was taken to ensure that the final model stayed as close to the data as possible, although any representation is of course a particular interpretation and will have been influenced by the

researcher's conceptual models and theoretical background. Samples of data from two separate interviews were coded (initial coding) by an additional two raters – one peer who was external to the research team and one research supervisor. The results of these analyses were compared with the researcher's own ratings to determine whether any additional themes had been identified. The additional ratings were in actual fact very similar to that of the researcher and the ideas raised in these could be incorporated into the existing themes. A reflexive journal was kept throughout the process of interviewing and analysis in which significant thoughts and ideas were noted in the form of memos (see appendix G). This helped to keep track of the thought processes behind the emerging model.

4.4   Future Research

A review of the literature revealed that there has been very little research into the conceptual models that professionals in mental health services use to understand mental distress and unusual experiences so the current study was of an explorative nature. Further qualitative research could examine in greater detail where professionals' beliefs have come from, how they change over time with experience or further training. There may be different ways of working and influences on practice in other NHS Trusts or in other teams. It would be interesting to conduct further research with AO teams in other regions of the UK and to explore whether staff members in teams with different remits, composition and client groups (e.g. Community Mental Health Teams (CMHTs), Early Intervention in Psychosis (EIP) teams, Rehab and Recovery teams or staff on inpatient or forensic units) have similar or different conceptualisations of psychosis and how this influences practice in these contexts.

It would be interesting to follow up staff whose AO teams have been disbanded to discover whether their concerns regarding quality and continuity of care and the loss of AO identity and the team approach have in fact proved to be a reality. Research with AO service-

users to explore their experiences of organisational change and its impact on their care would also be valuable. Research with service-users could also examine their experiences of working with professionals and the benefits and disadvantages of the 'expert position' and 'being with' from their perspective and how this relates to feelings of greater independence or dependency. In order to answer the third research question more thoroughly, using an observational method would be a more effective way of eliciting information about interactions and processes. This could be done by sitting in on team case discussions or by observing interactions between staff members and clients.

4.5   Conclusions

There are many different ways of conceptualising mental distress. The predominance of the biomedical model in UK mental health services privileges 'expert' medical knowledge above the subjective experiences of service-users. By being open to listening to and considering the alternative perspectives mental health professionals can allow themselves to develop greater understanding and collaborative relationships with service-users, resulting in better therapeutic relationships, greater levels of transparency, self-efficacy and independence.

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91

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Part Three:

Critical Appraisal

My Research Journey

This was my first experience of conducting qualitative research and it has been at times fascinating and satisfying, but also sometimes infuriating and confusing. In this section I will discuss the research journey I have been though and some of the issues and experiences I have encountered on the way.

Deciding on a Methodology

At the start of the research process, there was much deliberation about which methodology would be most appropriate for the research topic. Interpretive Phenomenological Analysis (IPA) was considered as a strong possibility, but after much indecision, it was decided, in discussion with my research supervisors, that the aim of the project was to look at processes rather than individual experiences. It was decided, therefore, that grounded theory would be the most appropriate approach to take.

Conducting the Interviews

The skills that I have developed throughout clinical psychology training put me in good stead for conducting research interviews. I was able to actively listen to participants and to follow up on points of interest. I found the process of interviewing extremely enjoyable and was keen to note down ideas and reflections that occurred to me after each one. The difficulty I had was that I found I had a tendency to leap to conclusions about the themes that were emerging, based upon my overall impressions of the interview. In grounded theory analysis it is important to try not to allow your preconceptions to overly influence the analysis, but to fragment the data and to use that as the basis for developing themes and categories.

Working from a contextualist (Madill, Jordan & Shirley, 2000) epistemological framework however, it was important for me to recognise the influence of my own preconceptions and my status as a trainee clinical psychologist within the interviews. I noted with interest that the majority of participants talked about carrying out psychological interventions, such as CBT and told me that they found psychology input to the teams useful. I found myself wondering to what extent my profession was influencing their responses and whether if I had been interviewing them as a student nurse or trainee psychiatrist the interviews may have evolved differently. This was particularly the case when I interviewed a psychiatrist, who explained to me that all psychiatrists have to undertake supervised psychodynamic and CBT therapy as part of their training, in order to be allowed to qualify. He also seemed to be quite guarded with his language at times and non-commital, talking in generalities rather than stating his own opinion. I wondered why he felt it necessary to explain this to me. I also became aware of my own preconceptions because I had expected him to take a very biomedical approach and found myself surprised that the interview took a different turn. At one point I began to feel as if I was interrogating him, which, upon reflection, may have been the result of the transference in the room as I believe he was quite anxious and possibly slightly defensive.

Some interviews seemed to flow brilliantly and I found them really stimulating, but with others it was more stilted and I found myself becoming a little bored at some points. Reflecting afterwards I realised that the interviews that were more difficult were generally those with a more biomedical focus in which the participants did not seem to reflect a great deal on their understandings and practice. I think this is probably because their conceptualisations were at odds with mine and no matter how hard I tried to remain as neutral as possible and not to overly interpret what was being said it was difficult to stop myself from doing so.

Charmaz (2006) recommends that researchers transcribe their interviews personally to allow themselves to become immersed in the data. I completed the transcriptions for the first three interviews myself but found this to be an incredibly tedious and time consuming business. I have family commitments, which along with the commitments of the training course meant that it was simply not realistic for me to complete the transcriptions of all eight interviews. I have to admit to some feelings of relief when I made the decision to pay to have the remaining interviews transcribed. I think in many ways this was beneficial to my analysis, because instead of becoming frustrated by the tedium of transcribing, I was able to simply enjoy the data.

During the analysis stage I believe I did become fully immersed in the data. I completed the initial coding, then went back to do the focused coding and through the process of constant comparison between and within interviews I came to remember almost exactly where pertinent quotes were and in which interviews. I managed to develop a process model which seemed to make a great deal of sense to me and proudly took my diagram into peer supervision, explaining my model to fellow trainees. It all seemed to make sense and fit the data. The difficulty came when I tried to write up my findings. My initial model was a linear one, and although it seemed to fit the main themes that had emerged, there were so many discrepancies and inconsistencies within the data that I could not possibly write it up in a way that would be true to my data – I would be forcing data into categories rather than allowing the categories to emerge from the data.

After much soul searching and discussions with supervisors, I came to the realisation that my original categories had been broadly based upon preconceived ideas set out in the interview guide. This did not accurately reflect the reality of my findings, which were complex and could not be shoe-horned into a linear process model. I had to go back to my

data and painstakingly reanalyse every page, developing new categories and identifying quotes to back them up. A new model finally emerged which allowed for inconsistencies and changes in position and reflected the processes that I had identified far more accurately.

Writing up my Findings

This again proved to be an arduous and frustrating process. I had so many ideas that I wanted to get across that I struggled to be selective. After having spent so much time collecting and analysing the data it seemed to be a shame to leave out elements that I thought were interesting or relevant. It proved impossible to be all inclusive within the word limit imposed however, so I had to review my model a number of times. Initially I started off with seven contributory categories, but after much deliberation I finally decided to merge 'Assertive Outreach Model' into the category of 'Team/Organisational Factors', two categories merged to become 'Focus of Recovery' and 'Tolerance of Multiple Perspectives' became an element of 'Being With', rather than a distinct category. Initially the 'Expert Position' category had been labeled 'Imposing' but after careful consideration I realised that 'Imposing' was actually an element of a broader concept so the category which was renamed the 'Expert Position'.

Whilst writing the findings I again found it difficult to remain objective. I could not help myself siding somewhat with the position of 'Being With' as it fits more comfortably with the position we work from as psychologists, in terms of collaboration and understanding service-users' perspectives. I do not think I have managed to achieve a completely balanced presentation of findings, but according to Glaser and Strauss (as cited in Rennie, 2000), this is acceptable provided that the theory is accountable to the information. I believe I have accurately reflected the views that were presented by my participants, although it is only one interpretation of the data. Giddens (1976), (as cited in Rennie, 2000) refers to a "*double hermeneutic*" in social science research, in other words, interview data is an interpretation of

the pre-interpreted world. Interview participants choose how to represent their experiences and decide what to disclose or withhold, therefore what they present to the interviewer is their individual interpretation of events. I found it difficult to steer clear of using language and terminology indicative of a positivist epistemology, but this was essential as I aimed to describe a model in which participants move between different positions in different contexts, rather than adhering to fixed beliefs and approaches.

Developing Knowledge in the Topic Area

In searching for literature relevant for my research and literature review I have retrieved a huge number of articles on the topic of psychosis. I have become intrigued with different approaches to making sense of unusual experiences, the experiences that may lead people to develop mental distress and different ways of working with such difficulties. I was particularly interested to read about the Open Dialogue approach which was pioneered in Lapland, because it illustrates a model of working which is so far removed from the biomedical model of services dominant in the UK. I found myself feeling quite frustrated with the restrictions of the NHS model and wondering why more egalitarian, innovative practices cannot be adopted here. It seems that the NHS is heading more and more towards putting people into diagnostic boxes, with the introduction of mental health clustering. The focus on 'quick-fixes' such as manualised CBT therapy and drug treatments seems to me to be very short-termist. There were so many good elements cited by participants in relation to the Assertive Outreach model, that it seems a shame that the creative, flexible approaches and practical social support cannot be extended and enhanced with a greater focus on the use of psychological formulations and partnership working. Rather the current NHS climate is resulting in the disbanding of teams and greater pressure on resources. I feel that what service-users really need is time and understanding, but this is sorely lacking within many mental health services. The concept of 'insight' also frustrates me as it seems to invalidate

the service-user's perspective. Rather than dismissing 'psychotic' ideas and understandings, the 'Open Dialogue' approach advocates that those ideas should be heard and that by helping people to make sense of their thoughts and ideas they can find a way out of their confusion.

Challenges and Limitations

There were delays at certain points in the research process. Firstly it took several months to gain R&D approval from one NHS Trust which delayed the interviews as this was the key research site as my field supervisor had easy access to the teams in that region. The second delay came with the difficulties in analysing my results. The fact that I had to go back to the drawing board and completely restart the analysis meant that the whole process took much longer than expected and necessitated me requesting an extension on the deadline. Having never conducted qualitative research before I think I had underestimated the time involved in trawling though so much data and allowing the ideas to form into a cohesive model.

Ideally I would have liked to have included a couple more participants in the study, I was originally hoping to do ten interviews. Due to the other commitments and the delay in obtaining the R&D approval, however, this just was not realistic. I do genuinely believe, however, that more interviews would in all probability have just served to validate the model as I think it unlikely that any significantly different themes would have emerged. I am satisfied that, if not theoretical saturation, I at least managed to reach theoretical sufficiency with there being adequate data to support each category and no vitally important elements that are not captured by the model (in my opinion). I had hoped that there would have been more time for peer supervision, but unfortunately due to pressures of the course and geographical location this did not come to fruition. We did have one peer supervision session in which I discussed my first process model and I did get samples of data coded by a fellow trainee and a supervisor which has hopefully enhanced the validity of the analysis somewhat.

In Conclusion

This has, without doubt, been the most all consuming academic exercise I have ever engaged in. It has been educational, enlightening, satisfying but also incredibly exhausting and frustrating at times. I am still left with the feeling that with more time I could have refined things still further, but there has to be a deadline. I hope that this research contributes something valuable to the field – it has certainly been a learning experience for me. I would like to have an opportunity to conduct qualitative research again in the future, however maybe under less pressured circumstances. It would be interesting to extend this research to teams in other NHS Trusts to see if the findings are replicated.

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Appendix A: Data Extraction Tables for Literature Review

Study	Type/Design and measures	Participants	Aims	Analysis	Main findings

Baille, McCabe & Priebe (2009) UK	• Cross-sectional survey - random sample • Postal questionnaire adapted from Angermeyer & Klusmann (1998) • Piloted locally • 19 putative aetiological factors rated on 5 point likert scales from '1=definitely not a cause to 5= definitely a cause. Also rated for how much they vary between patients. • Open question on how important it is to ask patients about their understanding of their illness.	• 335 consultant psychiatrists selected from register of RCP – every 5th member – sent questionnaire. • 154 returned questionnaires. • Average age 47 yrs. • 17.5 yrs average post qualification. • 69.6% male. • 76.6% white, 15.5% Asian, 1.9% black, 3.9% other ethnic background, 1.9% not stated.	• To identify the views of practicing British psychiatrists on the aetiology of schizophrenia and depression, the variation of aetiological factors from patient to patient and the importance of asking patients about their understanding.	• Percentages • Chi-squared analysis • Independent samples t-tests • Content analysis of answers to open question	• 8 psychosocial factors viewed as sig. more important in depression than schizophrenia: recent life events/loss , relationship difficulties, parenting style, childhood factors (inc. neglect and abuse), social isolation, abnormal/thinking errors and lifestyle (all $p<0.001$) and general stress of modern life ($p=0.009$) • 1 biological factor more important n depression: the effects of physical illness (inc. pregnancy) $p<0.001$. • Four biological factors viewed as sig. more important in schizophrenia than depression: genetics ($p<0.001$), biochemical abnormalities and neurotransmitter dysfunction ($p=0.001$), prenatal factors ($p<0.001$) and perinatal trauma ($p<0.001$). • Aetiological factors thought to vary more among patients with depression than schizophrenia ($p<0.001$) • It was thought to be significantly more important to ask patients with a diagnosis of depression their understanding of their illness than those with schizophrenia ($p=0.008$) **Reasons for discussing understanding** • Developing an individual treatment plan in collaboration with patient (49.6% dep. v 36.4% Sz, $p=0.03$) • Shared model ensuring treatment adherence (20.9% v 28.7%, ns.) • Influence prognosis (8.2% v 8.5% ns) • Influence therapeutic relationship in its own right (11.2% dep. v 25.6% Sz, $p=0.002$)
Study	**Type/Design and measures**	**Participants**	**Aims**	**Analysis**	**Main findings**

| Baille, McCabe & Priebe (2009) | - Assessment, insight and psychological mindedness (10.4% v 15.5%, ns)
- Gain a shared formulation (21.6% v 14%, ns)
- For education purposes (13.4% v 12.4%, ns) |
| Cont. | |

Study	Type/Design and measures	Participants	Aims	Analysis	Main findings

| Cape & Daniel (1994)

UK | • Cross-sectional survey
• Postal questionnaire
• 45 questions covering: demographics, approach to diagnosis, importance of various aetiological factors, approaches to management, importance of various prognostic indicators and further comments.
• Yes/No responses and 5 point likert scales.
• Completed anonymously – requested not to discuss with colleagues prior to completion.
• Questionnaire piloted on 25 senior psychiatrists. | • 119 psychiatrists.
• Members of the RCP employed by South West Regional Health Authority.
• 74% male
• 64% <45yrs
• 15.4 yrs mean experience
• 77% Consultant or academic equivalent.
• 58% General adult, 19% child & adolescent, 1% LD, 7% psycho-geriatrics, 3% drug/alcohol, 2.5% forensic, 1% psychotherapy. | To investigate 3 key areas:

• How do clinical psychiatrists diagnose and manage patients with schizophrenia?
• What are their beliefs about aetiology and prognosis?
• Do their beliefs influence practice in a clinical setting? | • Principle Components Analysis (parametric and non-parametric)
• Wilcoxon test
• **Aetiology**: PCA revealed 3 factors:
-*Psychosocial* (38.3% variance): schism & skew (.88), schizophrenogenic mother (.87), double bind (.85), fragmented family communication (.79) and scapegoating (.75).
-*Biological* (15.5% variance): brain pathology (.68), neurotransmitter dysfunction (.64), genetic predisposition (.63), virus (.63).
-*Live events* (single item - 10% variance). | **Diagnosis**

• General clinical impression sig. most useful (p<0.0001).
• Schneider's 1st rank symptoms sig. more useful than ICD-9 or DSM-III (p<0.0001).
• So sig. diff between ICD & DSM.
• 9% thought schizophrenia is a unitary disorder, 85% thought it is a heterogeneous group of disorders, 6% don't know.
• 14 thought longitudinal view is important in diagnosing.
• 13 thought relatives' or informants' histories are important.
• Feighner's criteria, concrete thinking, mood and family dynamics also mentioned.
Aetiology

• Genetic predisposition and neurotransmitter dysfunction had sig. higher ratings than psychosocial factors or life events (p<0.0001).
• Life events sig. higher than psychosocial factors (p<0.0001).
• Psychiatrists >45yrs and with more experience more likely to rate psychosocial factors.
• Those giving biological aetiology found Schneider's 1st rank symptoms useful (p<0.006).
• 7 cited childhood experiences, 4 expressed emotion, 4 substance misuse, 4 stress and 2 personality. 1 each also cited neurodevelopmental disorder, institutionalisation, iatrogenicity, incest and age. |

Study	Type/Design and measures	Participants	Aims	Analysis	Main findings

| Cape & Daniel (1994)

Cont. | • **Prognostic Indicators**: PCA revealed 4 factors: *-Personal Effectiveness* (26.2% variance): premorbid personality (.82), employment record (.76), ability to form stable relationships (.68). *-Social Support* (12.4% variance): family psychiatric history (.77), support services available (.64), family relationships (.60). *-Clinical Characteristics* (11.8% variance): response to drug treatment (.73), previous psychiatric history (.68), signs & symptoms on presentation (.68) *-Onset* (9.1% variance): acuteness of onset (.85), age at onset (.69). -Presence of structural brain pathology did not load onto any factor. | **Management**

• Oral and depot antipsychotics rated sig. more highly than other interventions (p<0.01).
• Respondents rating psychosocial aetiology more likely to rate psychological treatments as useful (p<0.008) and less likely to rate medication useful (p<0.002)
• Those giving biological aetiology importance rated medical management more useful (p<0.04).
• Those giving life events important found both strategies useful.
• Female psychiatrists less likely to find medical management useful (p<0.03).
• Those preferring psychosocial aetiology thought fewer patients would be on medication for life (p<0.02) whilst those preferring biological aetiology thought more would (p<0.001).
• Those giving psychosocial aetiology more likely to rate social support (p<0.001) and onset (p<0.004) prognostically important.
• Onset also important for those giving biological aetiology (p<0.03).

Prognostic Indicators

• Response to drug treatment only item to be sig. more important (p<0.01).
• More experienced psychiatrists gave more importance to clinical characteristics (p<0.03) and less to personal effectiveness (p<0.02).
• Women more likely to rate clinical characteristics as important (p<0.006) Those rating personal effectiveness (p<0.03) and illness characteristics (p<0.001) more important were more likely to rate medical management useful. |

Study	Type/Design and measures	Participants	Aims	Analysis	Main findings
Chadwick (2007) UK	• Peer-professional, first-person autobiographical account	• Professional psychologist • Experienced psychosis after qualification (1979)	• To straddle the gap between "sane" and "insane" • Combine objective and subjective knowledge. • Focus on phenomenology.	• Reflective and analytical account of own experiences.	• Predisposing factors: pre-existing cognitive and affective factors, attentional style, high cortical arousal and poor context processing. • Poor impulse control and mental state regulation. • Cross-generational genetics and social learning effects. • Exacerbated by sustained bullying, stigmatization and abuse at school and in community – being a 'transvestite' in Glasgow. • Downward social drift. • Social exclusion and marginalisation resulting in paranoia and leading to ideas of reference, external locus of control and magical thinking, feelings of persecution and confirmation bias. • Cognitive and brain hardware malfunction. • Recovery aided by haloperidol medication supported by changes in self-concept and social scenario.

Study	Type/Design and measures	Participants	Aims	Analysis	Main findings
Eker & Arkar (1991) Turkey	• Cross-sectional survey • Star case vignettes illustrating 'paranoid schizophrenia' and 'anxiety, neurosis/ depression' (from Erinosho & Ayorinde, 1978). • Questionnaire including demographics, cause, treatment and prognosis, social distance scale (adapted from Norman & Malla, 1983) and emotional burden.	• 91 female nurses from 2 general hospitals in Izmir. • Mean age 26.26 yrs • Mean number of depts. worked in 2.52. • Mean experience 6.91 yrs. • 79% resident in city, 18% town, 3% village. • 39% married. • 40% University educated.	• To examine the attitudes of experienced Turkish nurses towards causation, therapy and prognosis, social distance, expected emotional and physical burden and expected influence on one's own mental health. • To identify predictor variables – social and professional background.	• Pairwise t-tests of attitudes. • Multiple regression analysis for predictor variables.	• Nurses accepted both psychological and organic causation and both psychotherapy and drug treatment. • Probability of recovery was rated highly. • Psychological causes and psychotherapy rated more highly than organic causation and drug treatment. • Statistically sig. tendency to perceive mental illness, greater expectations of emotional burden, physical burden, influence on one's own mental health and greater social distance in case of 'paranoid schizophrenia' than 'anxiety/neurosis depression' ($p<0.001$ for all except influence on own health $p<0.02$). • Being a university graduate was sig. related to lower acceptance of psychotherapy as useful and lower perceived chances of recovery ($p<0.05$). • Age was positively related to desire for social distance ($p<0.05$). • Years of experience and experience of different fields of medicine were not significant predictors of attitude.

Study	Type/Design and measures	Participants	Aims	Analysis	Main findings
Gallagher, Gernez & Baker (1991) UK & Republic of Ireland.	• Questionnaire made up of 18 distracter items from Reda & Mahoney (1984) "Cognitive therapies: Recent developments in theory, research and Practice" and 4 target items. • Rated on 7 point likert scales – 1=strongly agree to 7=strongly disagree	• 150 graduate psychologists, eligible for BPS or PSI membership. • Resident in UK or Republic of Ireland. • 45 Clinical Psychologists (CP) in adults psychology, 44 CP not in adult psychiatry, 61 not CPs.	To test Bellack's (1986) 4 false beliefs: • Schizophrenia is a valid construct. • Genetics probably plays a minimal role in the determination of schizophrenia. • Schizophrenia is adequately treated with medication. • Schizophrenia is too severe a condition for psychologists to work with. • It also aimed to identify when in their training beliefs were formed.	• Findings presented as bar charts illustrating the percentages of each answer given. • No statistical analyses presented although claims no significant difference between groups.	• 50% agreed schizophrenia is a valid construct, 33% disagreed, 17% uncertain. • Approx 66% disagreed that genetics play a minimal role, 23% agreed, 10% unsure. • 11% agreed schizophrenia is adequately treated with medication (1% strongly), 7 % uncertain, 91% disagreed. • 4% agreed schizophrenia too severe to work with, 5% neutral, 91% disagreed (57% strongly)

Study	Type/Design and measures	Participants	Aims	Analysis	Main findings
Grausgruber, Meise, Katschnig et al. (2006) Austria	• Cross sectional survey • Between groups design • Structured interviews for public • Postal questionnaires for relatives and health professionals • Case vignettes	• Representative population sample 1042 Austrians aged 16+ yrs • Quota sampling by gender, age, profession, population, size of residence & geographical region. • 137 relatives of people suffering from mental illness. • 460 non-medical mental health professionals inc. psychiatric nurses, social workers, psychologists, physiotherapists and occupational therapists.	• Provide baseline info on attitudes and social distance to schizophrenia in order to allow evaluation of countrywide anti-stigma programme. • To enable focus groups to be established. • To determine opinions about cause, success of treatment, dangerousness and in which situations respondents envisage having contact with schizophrenic patients.	• Factor analysis on causal attribution scale revealed 4 dimensions: Stress, genetics, social factors and personality. • Pearson's Chi Square • OLS Regression analysis • Analyses of internal consistency of social distance scale (Guttman and Mokken) and reliability analysis (Kuder-Richardson formula): 0.75 public, 0.66 staff.	• Significant differences between groups in causal attributions. • Lay public most likely to cite genes (44%), serious life events (34.6%) and head injuries (27.7%) and nervous strain (24.4%) • Relatives most frequently cited nervous strain (47.2%), occupational stress (40.5%), genes (36.2%), unhappy family situation (28.6%) and serious life events (25.2%). • Professionals more evenly distributed: Unhappy family situation (30.7%), nervous strain (26.3%), genes (26.4%), and serious life events (24.7%). Least likely to cite weak character (2.2%). Multi-causal understandings. • Professionals and relatives twice as likely to believe in treatability than lay public (P<0.001) • Approx 50% public, 33% relatives & 25% staff believed people with schizophrenia are more dangerous than the general public.

Study	Type/Design and measures	Participants	Aims	Analysis	Main findings
Kukulu & Ergün (2007) Turkey	• Cross-sectional questionnaire survey. • Demographic data. • Questions on aetiology, treatment, diagnosis and social distance towards people diagnosed with schizophrenia. • Questionnaires distributed and collected by researcher but completed anonymously.	• 543 nurses working in psychiatric services: 164 in University hospitals, 358 in psychiatric hospitals and psychiatric wards, 21 in training and research hospitals. • Age 21-59 yrs, mean 32.3 yrs. • 73.7% married • 16.2% had completed a 4 yr university nursing training programme or higher. • 64.1% had <10 yrs experience. • 82.5% from nuclear families. • 8% family psychiatric history.	• To evaluate the attitudes and opinions of nurses who work on psychiatric wards in Turkey concerning individuals who are diagnosed with schizophrenia.	• Results presented as percentages with no statistical comparisons.	• **Aetiology**: 1.8% believed schizophrenia is contagious, 93.2% believed it is an illness present from birth, 51.4% believed it is caused by social problems. • **Social Distance**: 31.9% agreed people with schizophrenia should not be allowed to move freely in society, 56.7% agreed they could work with somebody with schizophrenia, 6.1% agreed they could marry someone with schizophrenia, 42.9% agreed it wouldn't bother them to have a neighbour with schizophrenia, 63.2% agreed they would not rent their home to someone with schizophrenia. • **Diagnosis:** 16.8% agreed schizophrenia is a state of excessive sadness, 76% agreed people with schizophrenia are aggressive, 80.7% agreed people diagnosed with schizophrenia are not able to make correct decisions about their lives, 96.1% agreed it is an illness, 93.2% agreed people with this diagnosis are mental patients, 6.4% agreed it is a state not an illness, 47% agreed it is a state of emotional weakness. • **Treatment:** 19.5% agreed a change in environment plays an important role in overcoming schizophrenia, 84.3% agreed people will never fully recover, 2.6% agreed religious leaders can help people overcome schizophrenia, 31.3% agreed it cannot be overcome until social problems are resolved, 87.3% agreed t is an illness treatable by medication, 42.5% agreed it is an illness treatable with psychotherapy, 93.7% agreed medications used to treat it can have serious side effects, 95% agreed medications used to treat schizophrenia are addictive.

Study	Type/Design and measures	Participants	Aims	Analysis	Main findings
Magliano, De Rosa, Fiorillo et al. (2004) Italy	• Cross-sectional survey • Between groups design • Ad hoc demographic schedule • Pattern of Care schedule (PCS) on interventions received • Questionnaire on the Opinions about Mental Illness (QO) for relatives (QO-F) and professionals (QO-P, vignette version) • Face to face administration	• 30 Italian MH services • 709 key relatives of people with a DSM-IV diagnosis of schizophrenia – 29% male, mean age 57.1 yrs. • 190 psychiatric nurses, working in service >1yr – 42% male, mean age 43.2 yrs. • 110 psychiatrists, working in service >1yr, 57% male, mean age 44.4yrs. • Professionals significantly younger, had higher levels of education and more frequently male than relatives (p<0.0001)	To test 2 hypotheses: • That nurses agree with psychiatrists but not relatives concerning factors involved in development of schizophrenia. • That nurses are more similar to relatives than psychiatrists in beliefs about patients' ability to perform occupational and social role and acknowledgement of civil rights.	• Chi square • Man-Whitney U • ANOVA with LSD post-hoc comparisons where relevant. • Kruskal-Wallis ANOVA for diffs in social functioning and civil rights subscales.	• Nurses agreed with psychiatrists and differed from relatives re causal factors. • Nurses & psychiatrists most frequently cited heredity (74% & 75%), stress (53% & 66%) and family conflicts (48% & 46%) • Relatives most frequently cited stress (46%), psychological trauma (36%) & love breakdown (30%). • Nurses more similar to psychiatrists in beliefs about ability to work (77% & 79%) than relatives (56%) and that people with schizophrenia keep aloof from others (87%, 96%, 56%). • Nurses agreed with relatives on unpredictability (31% & 35%) (psychiatrists 2%) • No groups thought people should be treated in an asylum. • Nurses beliefs on civil rights more similar to relatives than psychiatrists.

Study	Type/Design and measures	Participants	Aims	Analysis	Main findings
Magliano, Fiorillo, De Rosa et al. (2004) Italy	• Cross–sectional survey • Between groups design • QO-F, QO-P & QO-GP (general public) • QO-P & QO-GP inc. Case vignette of patient meeting ICD-10 criteria for schizophrenia.	• 30 Italian areas • 714 lay respondents (36% male, mean age 41.8, 11% university degree) • 465 professionals in service >1 yr (42% male, 43% nurses, 25% psychiatrists, 11% psychologists & sociologists, 9% social workers, 7% occupational therapists, 5% auxiliary/admin. Mean age 43.5 yrs, 49% university degree) • 709 key relatives of patients with schizophrenia (29% male, mean age 57.1 yrs, 7% university degree.)	• To compare beliefs about causes, treatments and psychosocial consequences of schizophrenia. **Hypotheses** • Professionals would have most positive attitudes towards schizophrenia followed by relatives then public. • Public and relatives would share beliefs about causal factors and would differ from professionals. • Awareness of diagnosis would be associated with more pessimism re social and personal limitations. • Younger and more educated participants would more frequently acknowledge civil rights and social competence of patients.	• Chi Square & ANOVA • Kruskal Wallis ANOVA to test sample differences. • Multiple regression • Statistical significance: $p < 0.01$ univariate analyses, $p < 0.05$ multivariate analyses.	• 73% relatives acknowledged diagnosis of schizophrenia in their family member. • 21% public and 74% professionals identified schizophrenia in case vignette. • Public and professionals held similar causal beliefs. Public more frequently cited psychological trauma, stress and incorrect therapy ($p < 0.0001$). Professionals more frequently cited heredity ($p < 0.0001$). • 73% professionals and 25% relatives believed in both biological and psychosocial causality. 34% public, 20% professionals and 68% relatives mentioned biological factors only ($p < 0.0001$). • 25% public, 28% professionals and 48% relatives believed in usefulness of medication ($p < 0001$) • 58% public, 44% professionals and 46% relatives believed in usefulness of psychosocial interventions ($p < 0.0001$). • 35% public, 2% professionals and 17% relatives believed in complete recovery ($p < 0.0001$).

Study	Type/Design and measures	Participants	Aims	Analysis	Main findings
Magliano, Fiorillo, De Rosa et al. (2004) Cont.					• Public and professionals similar about capability to work. • Public differed on opinions about unpredictability and use of asylums (more frequently endorsed) • Public and professionals similar in opinions on civil rights. • 19% public, 17% professionals and 49% relatives believed patients should not have children.

Study	Type/Design and measures	Participants	Aims	Analysis	Main findings

| Marshall, Soloman, Steber & Mannion (2003)

US | • Cross-sectional
• Questionnaire survey
• Distributed by post and through focus groups
• Questions relating to beliefs about cause, family's prior experience with mental health services and provider contact with families, rated on 5 point likert scales. | • 48 providers, 39 family members.
• 44% providers had worked in mental health for 11 years or more. 46% reported daily/weekly family contact.
• 77% family were parents of adults with severe mental illness.
• 33% family had participated in educational programmes aimed at families of persons with a mental illness, 59% had participated in a support group.
• Both providers and family members were predominantly white (81.3% & 79.5%), female (64.6% & 76.9%) and well educated (College 39.6% & 33.3% and graduate/professional 60.4% and 23.1%). | To investigate 2 key research questions:

• To what extent are provider's experiences working in mental health and their contact with family members associated with their beliefs regarding the causes of mental illness, when controlling for race, gender and education?
• To what extent are family members' previous experiences with providers and their participation in support and educational groups associated with their beliefs regarding the causes of mental illness, when controlling for race, gender and education? | • Principle components analysis of items on causal beliefs.
• Descriptive analysis.
• Hierarchical linear regression analysis. | **Family Experiences**:

• 51% family members disagreed that providers had given them as much info as needed (35.9% agree, 12.8% unsure.
• 64.1% agreed that they sometimes providers did not understand the problems they faced in caring for someone with mental illness (10.3% disagree, 25.6% unsure).
• 41% disagreed that providers are responsive to their needs (35.9% agree, 23.1% unsure).
Causal Beliefs:

• 29% providers and 5.1% family agreed family environment could cause mental illness.
• 27.1% providers and 15.4% family believed family communication is a factor.
• 43.8% providers and 23.1% family agreed behaviour of family members can cause mental illness.
• 93.8% providers and 66.7% family believed family criticism, hostility and over involvement could result in hospitalisation.
• 89.6% providers and 92.3% family believed severe mental illness is biologically based.
Provider Factors

• Beliefs in family causation sig. associated with less contact with families (p=0.006).
• Yrs of experience not sig. associated with beliefs in family causation.
• Family causation beliefs associated with providers who were white (p=0.000), female (p=0.000) and more education (p=0.016). |

Study	Type/Design and measures	Participants	Aims	Analysis	Main findings
Marshall, Soloman, Steber & Mannion (2003)					• Beliefs in biological causation not sig. related to contact with families, yrs experience or sociodemographic variables **Family Factors**
Cont.					• Beliefs in family causation sig. associated with negative experiences with providers (P=0.041). • Participation in support groups or educational programmes not sig. associated with family causation beliefs. • Biological causation beliefs not sig. associated with experiences with providers, participation in groups or sociodemographic variables.

Study	Type/Design and measures	Participants	Aims	Analysis	Main findings
Midkiff (2006) US	• Quasi-experimental with non-matched controls. • Repeated measures design. • 3 hours training programme including critique of studies supporting biological causation of mental health disorders, highlighting influence of psychiatry and pharmaceutical industry. • Pre & post training questionnaire survey. • 38-item Strength of Beliefs Questionnaire (SOBS), 6 point likert scales.	• **Treatment Group:** 76 mental health professionals aged 18-63+ yrs, 52% male, 78% with masters degree or higher. 59.2% psychologists, 14.5% social workers, 15.8% counsellors, 10.5% other. • **Controls:** 26 undergrad and postgrad students participating in an advanced statistics class. Aged 18-44 yrs, 20% male.	**Hypotheses** • MHPs' reported strength of belief regarding the aetiology of many mental health disorders tends towards the biologically based. • MHPs' reported strength of belief re aetiology is amenable to change as the result of a 3 hour training programme. • Change in belief of biological causation is associates with change in belief in 5 domains: guild, pharmaceutical, layperson, HMO/insurance & empirical.	• Paired t-tests (2-tailed) for pre-post comparisons • Linear regressions to compare change in domains with strength of belief in biological causation after controlling for demographics. • Sig. $p<0.05$	• 22 items indicated significant change in thinking post-training. • There was a significant decrease in beliefs of biological causation post training. Sig. for empirical ($p<0.001$), pharmaceutical ($p<0.001$), perceptions of HMO industry influence $p=0.015$. No sig. Change in layperson's preference. • The belief that schizophrenia is a biological disorder significantly decreased post-training ($p<0.01$). • Beliefs about biological causation in ADHD, anxiety, depression, also sig. declined. • Beliefs that mental illness is caused by biology rather than poorly learnt coping skills sig. declined ($p<0.01$). • Belief in research inc. twin studies, evidence of biological abnormalties such as chemical imbalance, brain lesions or genetics, identifying a specific gene, brain chemicals as evidence of biological illness sig. declined post training. • Beliefs that pharmaceutical workshops seen as less helpful post training ($p<0.01$). • No change in control group. • Multiple regression showed HMO and layperson domains non.sig. • Empirical domain had greatest influence ($r=.530$, $p<0.001$) • Age, sex and education not sig. predictors of strength of beliefs. • Psychologists seen as best placed to diagnose and treat (above psychiatrists and counsellors) post training. Sig. decline in belief in psychiatrists' role in diagnosis & treatment. ($p<0.01$).

Study	Type/Design and measures	Participants	Aims	Analysis	Main findings
Van Dorn, Swanson, Elbogen & Swartz (2005) US	• Cross-sectional survey • Between groups design • Vignette of "Mr Smith" who has schizophrenia • Structured interviews with consumers, family members and general public • Self-administered questionnaires for clinicians • Likert scales • Short Portable Mental Status Questionnaire (SPMSQ) for consumers. • $25 payments for public/family/ consumers • $50 payment for clinicians • Insight & treatment attitudes questionnaire for consumers.	• North Carolina • 104 adults (18+) with DSM-IV diagnosis of schizophrenia, schizoaffective disorder or schizophreniform disorder, able to give informed consent, scoring <4 errors on SPMSQ when used. 54.8% male, mean age 43.94, 73.08% African American, 11.55 mean yrs education. • 83 family members of patients with schizophrenia. 59% relatives of consumer participants, 41% recruited through advertising. 25.3% male, mean age 54.38, 59.04% African American, 13.39 mean yrs ed.	To investigate 3 key questions: • Are there stakeholder differences in the belief that "Mr Smith" is likely to be violent? • Are there differences between stakeholder groups in the desire for social distance? • Are there differences in perceived cause of "Mr Smith's" mental illness?	• ANOVA and Scheffé follow up tests for group differences.	• Consumers sig. more likely to endorse likelihood of violence than clinicians (63% & 30%). Family 46%, public 50%. • No sig. diffs in desire for social distance: public 44%, consumers 33%, family 35%, clinicians 36%. • Causal factors: Chemical imbalance most frequently endorsed – public 100%, consumers 89.4%, family 93.9%, clinicians 97.6%. • Clinician ratings: Bad character – 1.22%, chemical imbalance – 97.6%, way he was raised – 18.3%, stressful circumstances – 67%, genetic or inherited problem – 96.3%, God's will – 6.9%. • Consumers significantly less likely than clinicians to endorse chemical imbalance. • Consumers (84.6%) sig more likely to endorse stressful circs than clinicians. • Clinicians sig. more likely to endorse genetics than other groups. • Non-biomedical factors more often endorsed by consumers, family and public than clinicians • Consumers 53.8%) and family (30.1%) sig. more likely to endorse bad character than clinicians.

Study	Type/Design and measures	Participants	Aims	Analysis	Main findings
Van Dorn, Swanson, Elbogen & Swartz (2005) Cont.		• 85 clinical staff (psychiatrists, clinical social workers and case managers) selected from staff rostas of health centres and psychiatric units and private psychiatrists. 40% male, mean age 44.46, 23.53% African American, 12.85 yrs average experience, 51.75% with MD. • 56 members of general public from list of research volunteers at Duke University Medical Centre and local advertising. 48.21% male, mean age 37.84, 26.79% African American, 15.54 mean yrs ed.			• Consumers sig. more likely to endorse upbringing (66.3%) than other groups, clinicians least likely. • Clinicians (6.9%) and public (23.7%) sig. less likely to endorse God's will than consumers 42.5%. Family (27.8%) sig. more likely to endorse than clinicians. • Correlation between perceptions of violence and desire for social distance (0.21, p<0.001). • Consumers significantly more likely than clinicians to predict 'Mr Smith' would be violent (p<0.005). • 36% clinicians somewhat or very likely to desire social distance. No sig diffs between groups.

Study	Type/Design and measures	Participants	Aims	Analysis	Main findings
Van Os, Galdos, Lewis et al. (1993) UK & France	• Epidemiological study - 1st admission data for schizophrenia under ICD (UK) or INSERM (France), 1973-1982 • Cross-sectional postal questionnaire survey – 38 questions rated with 7 point likert scales. • Translated into English and French • Between groups design	• 92 practicing UK psychiatrists randomly selected from 1985 membership of RCP. • 69 practicing psychiatrists randomly selected from 1990 list of the Département Régional des Affaires Sanitaires et Sociales de l'Aquitaine (SW France). • Child psychiatrists excluded.	• To compare the incidence of schizophrenia in France and UK as recorded by national statistics on hospital admissions. • To compare the concept (aetiology, diagnosis and management) of schizophrenia in France and UK.	• Adjusted age rates by indirect standardisation with UK as standard to calculate ratio of observed to expected events in France. • t-tests • Chi square	• Higher incidence in France before age 45 but lower after 45 esp. for women. • Sharp increase in incidence after 65 yrs in UK, fall in rates in France. • Overall rates rising in France over period, esp. in men, falling in UK. • 22% French psychiatrists seen a patient with schizophrenia in last 6 months, 8% in UK. • French psychiatrists reserve diagnosis for disorders with onset before 45 yrs, chronic course, poor outcome, dissociation and discordance key symptoms. • UK psychiatrists include late onset and good outcome as well as delusional disorders. • Preference for diagnostic manual: DSM-III = 79% UK, 44% France ICD-9 = 72% UK, 11% France INSERM = 2% UK, 35% France Other = 5% UK, 10% France Manuals not useful = 12% UK, 43% France • Aetiology: UK higher ratings for biological predisposition, neurodevelopmental, aetiological heterogeneity. French higher ratings for family dynamics and parental factors – psychodynamically oriented.

Appendix B: Statement of Epistemology

This research was conducted within a 'Contextualist' epistemological framework as described by Madill, Jordan & Shirley (2000). This is the position that *"knowledge is local, provisional and situation dependent"* (Madill *et al*, 2000). In practice, this means that knowledge obtained using this methodology is influenced by factors such as the cultural meaning systems that are shared by researcher and participant, situational factors and individual characteristics of interviewer and interviewee (e.g. profession, gender, age, ethnicity).

Appendix C: Ethical Approval

NHS

National Research Ethics Service

22 March 2010

Mrs Claire Broomhead
Trainee Clinical Psychologist

Dear Mrs Broomhead,

Study Title:	**The Construction of 'Psychosis' in Assertive Outreach Teams: an exploratory study of staff members' understanding of psychosis and how approaches to intervention are negotiated within the team and between staff and clients.**
REC reference:	10/H0408/26
Protocol number:	5

The Proportionate Review Sub-committee of the [   ] Research Ethics Committee 2 Research Ethics Committee reviewed the above application at the meeting held on 22 March 2010.

Ethical opinion

The members of the Committee present gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below.

Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

For NHS research sites only, management permission for research ("R&D approval") should be obtained from the relevant care organisation(s) in accordance with NHS research governance arrangements. Guidance on applying for NHS permission for research is

available in the Integrated Research Application System or at http://www.rdforum.nhs.uk. Where the only involvement of the NHS organisation is as a Participant Identification Centre, management permission for research is not required but the R&D office should be notified of the study. Guidance should be sought from the R&D office where necessary.

Sponsors are not required to notify the Committee of approvals from host organisations.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

The documents reviewed and approved at the meeting were:

Document	Version	Date
Covering Letter		04 March 2010
REC application	36532/102527/1/430	01 March 2010
Protocol	5	28 February 2010
Investigator CV		01 March 2010
Investigator CV: Academic Supervisor		
Investigator CV: Key Investigator		28 January 2010
Interview Schedules/Topic Guides: Draft	5	28 February 2010
Participant Information Sheet	5	28 February 2010
Participant Consent Form	6	16 March 2010
Expression of Interest and Demographic Information Form	5	28 February 2010
Summary/Synopsis: Flow Chart	5	28 February 2010
Presentation Handouts		04 March 2010
Referees or other scientific critique report		07 December 2009
Service User Reference Group (SURG) Evaluation of Trainee Research		

Membership of the Proportionate Review Sub-Committee

The members of the Sub-Committee who were present at the meeting are listed on the attached sheet.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Now that you have completed the application process please visit the National Research Ethics Service website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

Research Ethics Committee 2

Attendance at PRS Sub-Committee of the REC meeting on 22 March 2010

Committee Members:

Name	Profession	Present	Notes
	Consultant Paediatric Oncologist	Yes	
	Health Services Researcher	Yes	
	P.P.I Member	Yes	
	Lay Member	Yes	

Also in attendance:

Name	Position (or reason for attending)
	Committee Co-ordinator
	Proportionate Review Coordinator – observing

cxxxi

- Notifying substantial amendments
- Adding new sites and investigators
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.
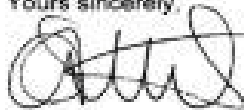
We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nres.npsa.nhs.uk

10/H0408/26	Please quote this number on all correspondence

With the Committee's best wishes for the success of this project

Yours sincerely,

Enclosures: *List of names and professions of members who were present at the meeting and those who submitted written comments*

"After ethical review – guidance for researchers"

Copy to: *Sponsor / R&D office for NHS care organisation at lead site -*

Appendix D: Participant Information Sheet and Consent Form

Participant Information Sheet

Researcher

Claire Broomhead, Trainee Clinical Psychologist.

I am inviting you to take part in a research study that I am undertaking as part of my training in Clinical Psychology. Before you decide to participate it is important for you to understand what it will involve. Please take time to read the following information carefully. If you have any questions or require any additional information please feel free to ask. If you choose to participate you are free to change your mind at any point up until the analysis has been completed and the findings are being written up. If you choose to withdraw before this point any information relating to you, including any interview data, will be removed from the study.

Title of Study
The construction of 'psychosis' in Assertive Outreach Teams: An exploratory study of staff members' understanding of the concept of 'psychosis' and how approaches to intervention are negotiated within the team and between staff and clients.

Introduction

Assertive Outreach teams work with service-users who have experienced a range of significant mental health difficulties. This study aims to find out how staff, working in these teams, understand their clients' experiences and how their understanding informs their practice.

What are the benefits of the study?

The study will give staff the opportunity to think about and discuss their understanding of mental health difficulties and the ways in which they work with clients. The findings of the study can be fed back to the teams and disseminated more widely through publications in peer reviewed journals. This will provide the basis for discussions within mental health services about models of understanding and ways of working as well as opening up possible areas for future research.

What happens if I agree to take part?

I will contact you to arrange a date, time and location for the interview that is convenient for you. Immediately prior to the interview you will be asked to read and sign a 'Briefing and Consent' form to say that you have agreed to take part and that you agree to the interview being audio-recorded. This is only to ensure that I have acted properly in asking you to take part. It is not a contract and you still have the right to change your mind at any time. It is estimated that interviews will last between 45 to 60 minutes although you can stop at any time you wish. Please note there are no right or wrong answers; it is your views that are important for this study. With your consent the interview will be digitally recorded and typed up so that I can be accurate in representing your views. It is likely that some of the

interviews will be typed up by a paid transcriber who is a member of NHS administrative staff, is used to dealing with sensitive information and has signed a confidentiality agreement. The transcriber will not be given any of your personal details. It is possible that following the first interview you may be contacted to participate in a second interview later on in the study, lasting approximately 30-45 minutes. You are under no obligation whatsoever to attend a second interview.

Do I have to take part?

No. It is entirely optional and deciding not to participate or withdrawing will have no consequences for your future career.

Will anyone else be told what I said in my interview if I take part?

Information from your interview will **not** be discussed with other staff from the Assertive Outreach Team. Your participation will not affect your employment – team leaders will not be informed which members of staff have volunteered or been selected for interview.
Once the interview is typed up I may require some assistance with analysis from my supervisors at the University of Leicester and may take some sections of anonymised information to discuss with other trainees in my cohort who are conducting similar research. Your name and personal details will not be used during these discussions and so will not be linkable to your transcript. Nobody outside the research team (myself and my supervisors) will have access to your personal information.

The only circumstance when I would be required to inform someone else about something said in your interview would be if it led me to believe that you or another person was at significant risk from harm. In this case I would inform you that I needed to share this information with my supervisors and take appropriate action (e.g. contacting your line manager or signposting you to sources of support).

Will my taking part in this study be kept confidential?

Yes. Utmost care will be taken in order to ensure your anonymity. Back-ups of audio recordings will be stored in password-protected files on the University of Leicester secure network until the study has been completed and written up for publication when they will be deleted. Once the interview has been stored in this way and transcribed the recording will be erased from the digital recorder. No personal information will be held on computer. Demographic information will be held in a password-protected file and the anonymised transcription of your interview will be password protected and identified only by a participant number. The computer on which this information is stored will also be password protected - meaning that only I will be able to access it. Your name and personal details will not be mentioned anywhere in the study in order to protect your identity. Direct quotations may be used in the write-up but where necessary minor details will be omitted or altered to ensure your anonymity whilst preserving the meaning of what you said. Copies of transcriptions and demographic information will be stored securely by the University of Leicester for 5 years following the completion of the study.

What are the possible disadvantages and risks I should know about before I take part?

If you find that you feel upset in any way during the interview then I will stop and ask you whether or not you would like to take a break, or stop altogether. You will decide whether or not you want to continue with the interview. If you feel you need to discuss any issues that arise in more detail, with your permission, I can liaise with your line manager and/or my research supervisors and signpost you to appropriate sources of support.

What will happen to the results of the study?

The results will be written up as a thesis which will be submitted to the University of Leicester as part of the requirements to gain a Doctorate in Clinical Psychology. They may also be published in a relevant journal. A summary of findings will be presented to all the Assertive Outreach teams involved in the study and may be sent to relevant service-user organisations and published in Trust magazines.

Conclusion

Thank you for taking the time to read this information sheet. I will be contacting you shortly to ask whether you are still interested in participating in this study. If you would like to take part we can then arrange a suitable date, time and location for the interview. You can change your mind and withdraw at any time, up until the analysis has been completed and I am writing up the findings. Withdrawal or refusal to participate will not affect your employment in any way.

Contact Details

<div align="center">

Claire Broomhead (Chief Investigator)
Trainee Clinical Psychologist,

</div>

Dr Jon Crossley (Academic Supervisor)   **Dr Steven Coles (Field Supervisor)**
Clinical Tutor   Clinical Psychologist

Centre:

Participant Identification Number:

CONSENT FORM

Title of Project: The construction of 'psychosis' in Assertive Outreach Teams: An exploratory study of staff members' understanding of the concept of 'psychosis' and how approaches to intervention are negotiated within the team and between staff and clients.

Name of Researcher: Claire Broomhead, Trainee Clinical Psychologist

Please initial box

1. I confirm that I have read and understand the information sheet dated 28/02/10 (version 5) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, up until the data has been analysed and findings are being written up, without giving any reason and without my employment or legal rights being affected. ☐

3. I understand that I am entitled to request a copy of my interview transcript and will be informed of the findings of the study. ☐

4. I consent to my interview being digitally audio-recorded. ☐

5. I consent to my interview being transcribed by a paid member of staff who has signed a confidentiality agreement (optional). ☐

6. I agree to take part in the above study. ☐

_____ ___/___/___ _____
Name of Participant   Date   Signature

_____ ___/___/___ _____
Name of Person Taking Consent   Date   Signature

Appendix E: Interview Guide

1)   Can you tell me a bit about the service-users you work with and the types of mental health difficulties they have experienced?

2)   Broadly speaking, what do you believe helps your clients?

3)   What do you believe is unhelpful?

4)   Outside of mental health services what do you believe is helpful and unhelpful in enabling your clients to make progress?

5)   How would you describe your approach in working with clients?

6)   Do you feel that the approach you take differs from other members of your team in any way and if so, how?

7)   If a client has different views to you about what might help them to recover, how would you address this with the client and what would be likely to happen – give an example if possible?

8)   What would happen if there were different opinions within the team about how to work with a service-user – give an example if possible?

9)   What do you believe causes the mental health difficulties of the service-users that you work with?

10)   To what extent do you talk to your clients about what they believe caused their difficulties and how does this inform your approach to working with them?

11)   What would you do if there were discrepancies between your understanding of their difficulties and theirs?

12)   Within the team context, are innovative or different approaches encouraged and if so, how?

Appendix F: Example of Initial Coding

I: So are there ever times when perhaps there's differences of opinion within the team as to what the best course of action with a particular SU would be and how how would that be handled?	
P: Yeah, um, I mean I think ideally there should <u>always</u> be some debate (laugh) about how a situation's handled cos then cos that's the kind of point of the team approach isn't it to kind of think a bit more creatively? Um, and I think, I think I'm lucky in that the team is very, is on the whole very supportive of each other so even though we have quite different perspectives and different approaches, there's quite a lot of sort of mutual respect within the team, um, which is helpful, um and then I think, the sort of really controversial decisions we tend to kind of hammer out in sort of group supervision where we have a facilitator, or in the end I guess that's the role of the kind of Team Leader or clinical lead to say 'actually in this case I think we should take this action', but I think we're careful to make sure that everybody has an opportunity to sort of say their opinion, and and I think that on	Debate being useful

Team approach facilitating creative thinking

Team being generally supportive

Having different perspectives and approaches

Mutual respect for each other

Group supervision as a forum for debating controversial decisions |

the <u>whole</u>, weight would be given to the care coordinator's view cos obviously	Having a facilitator Team leader/clinical lead making ultimate decisions Everybody able to voice opinion Care-co view carrying most weight

Appendix G: Example Memo

Memo   6/4/11

Different perceptions of clients. Some
seen as distressed, having different
perceptions of the world & challenging/
Sense having more about them.
Some see them as 'difficult'
or on the manipulative side,
pushing boundaries.
Contradiction → well enough to
be in community so not unwell
& know what they're doing.
So why disregard their views/
decisions on treatment?

& Competing priorities — balancing the needs
of the SU + needs of the team.

Doing   Being with.
to   Good relationship
↓   collaboration
↓ Affects the   But risk of
team.   dependency,
Less risk/uncertainty   overinvolvement,
more efficient use of   burn-out.
resources.
But → effects on relationship.

Appendix H: Additional Quotes

*1   *"I think um, people generally have <u>better</u> knowledge about what's <u>happened</u> to them um, I mean it's ok for us to have <u>theories</u>..." (P2, 54)*

*2   *"I think people need to find the answers <u>themselves</u> and I I think we can help in that process on people finding answers but I don't think we should actually <u>give</u> them the answer, really." (P2, 112)*

*3   *"Whether or not it's helpful to say that and 'I think you're act you're distressed and perhaps you're ill at the moment' although saying 'you're ill' is kind of a complicated thing..." (P3, 99)*

*4   *"...if I hear that this person has say diagnosis of schizophrenia then I expect loosely certain things..... I think that is useful as er a synopsis of what the problem may be..." (P7, 493)*

*5   *"a <u>lot</u> of the ones who I see are like 'well there's nothing wrong with me anyway'. You know and you can explore well why do you think you have this medication? Why do you think that we come and see you?" (P6, 41)*

*6   *"If somebody's got a diagnosis of, pretty heavy diagnosis, then its, it's clearly going to take er, you know a lot, maybe take a lot longer for those sort of circumstances to sort of, to, to settle really." (P4, 505)*

*7   *"...I think it's a millstone round people's necks really. I think it's, you know, it's very clumsy, the language is very sort of, I grimace really..." (P4, 549)*

*8   *"...do a timeline really and look at the significant things that have happened in their life and how that's changed their views and thinking and what, how they dealt with it. Whether that's led to, I mean a lot of, a lot of paranoia really starts off with some*

really quite genuine erm things that have happened to them and it just gets out of context…" (P8, 206)

*9 *"There is some evidence to say, especially schizophrenia that if a child is born to parents with schizophrenia, the chances are that they're more, fifty percent more likely to have schizophrenia if it runs in the family so there is that family genetics I think and then there's probably biological aspects to the whole thing" (P5, 66)*

*10 *"I'm not convinced that it it's necessarily a kind of genetic thing er I think it's really there's a lot of evidence to suggest that that doesn't really give a very clear explanation of why people develop mental distress um, and I think it it makes more sense to me to think about um people's life experiences…" (P3, 25)*

*11 *"...my life experiences are different to somebody else's. Err you could argue that the two of us have a higher threshold than somebody with mental health problems because we're not deemed as having a mental health problem…" (P1, 133)*

*12 *"I would perhaps suspect that all these factors then cause a chemical imbalances which we hope to correct by means of medication…" (P7, 84)*

*13 *"taking someone to the cinema, cos that then gives them something to chat to somebody else about, is actually really positive cos, and can be much more therapeutic than taking your olanzapine that day..." (P3, 721)*

*14 *"...we place lots of value on that but for the service user they might say 'well … I'm not bothered. Why should I care that I've been to the cinema twice, you know for the first time in twenty years …. I'd actually rather not have this horrible medication that I hate, or that I don't think I need'." (P3, 550)*

*15   *"...I think it's really important as well that although that with people that I'm as honest as possible with the service-users about my role, so that whilst on the one hand I'm there to support people completely and sort of respect their choices and enable them to be as empowered as possible and do all of that, my job is also to you know minimise their risks..." (P3, 389)*

*16   *"...we might sometimes get a 'phone call maybe from housing or from a family member saying 'oh so and so's doing this and they're bler bler' you know and we're kind of oo we didn't think it was that bad [laugh] um and I think it's because our tolerance levels go up a little bit about people's behaviour..." (P2, 387)*

Appendix I: Chronology of Research Process

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┌─────────────────────────────────────────────┐
│          Ethical Approval (22/3/10)          │
└─────────────────────────────────────────────┘
                      │
                      ▼
┌───────────────────────────────────────────────────────────────────┐
│ Researcher meets with Assertive Outreach Team Leaders to discuss    │
│ study and arrange to meet teams.                                    │
└───────────────────────────────────────────────────────────────────┘
                      │
                      ▼
┌───────────────────────────────────────────────────────────────────┐
│ Researcher presents study to teams, gives out presentation handouts │
│ and 'Expression of Interest & Demographic Information forms'.        │
└───────────────────────────────────────────────────────────────────┘
                      │
                      ▼
┌───────────────────────────────────────────────────────────────────┐
│ Staff return 'Expression of Interest & Demographic Information       │
│ forms' to Chief Investigator                                        │
└───────────────────────────────────────────────────────────────────┘
                      │
                      ▼
┌───────────────────────────────────────────────────────────────────┐
│ Researcher selects participants in collaboration with research      │
│ supervisors and contacts them to ascertain their interest.          │
│ Participant information sheet sent out to potential interviewee.     │
└───────────────────────────────────────────────────────────────────┘
                      │
                      ▼
┌───────────────────────────────────────────────────────────────────┐
│ CI contacts potential interviewee to answer any questions and       │
│ arrange suitable time/date/location for interview.                  │
└───────────────────────────────────────────────────────────────────┘
                      │
                      ▼
┌───────────────────────────────────────────────────────────────────┐
│ Interviewee reads and signs 'Briefing and Consent form' and         │
│ participates in 50-60 minute semi-structured interview which is      │
│ digitally audio-recorded.                                           │
└───────────────────────────────────────────────────────────────────┘
                      │
                      ▼
┌───────────────────────────────────────────────────────────────────┐
│ Transcription and initial analysis of data using a constant         │
│ comparative technique. Themes emerging from previous interviews      │
│ will inform selection of further participants and subsequent        │
│ interview schedules                                                 │
└───────────────────────────────────────────────────────────────────┘
                      │
                      ▼
┌───────────────────────────────────────────────────────────────────┐
│ As the data collection and parallel analysis proceeds the           │
│ generation of core categories and theory becomes possible           │
└───────────────────────────────────────────────────────────────────┘
                      │
                      ▼
┌───────────────────────────────────────────────────────────────────┐
│ Writing up including reference to any pre-existing literature that   │
│ has relevance. Submission 25th May 2011.                            │
└───────────────────────────────────────────────────────────────────┘
                      │
                      ▼
┌───────────────────────────────────────────────────────────────────┐
│ Dissemination of findings to the supporting services. Wider         │
│ dissemination via poster presentations, possible publications and   │
│ summaries to service-user organisations and Trust magazines/        │
│ websites.                                                           │
└───────────────────────────────────────────────────────────────────┘
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British Journal of Clinical Psychology

British Journal of Clinical Psychology

Top Author Guidelines

The British Journal of Clinical Psychology publishes original contributions to scientific knowledge in clinical psychology. This includes descriptive comparisons, as well as studies of the assessment, aetiology and treatment of people with a wide range of psychological problems in all age groups and settings. The level of analysis of studies ranges from biological influences on individual behaviour through to studies of psychological interventions and treatments on individuals, dyads, families and groups, to investigations of the relationships between explicitly social and psychological levels of analysis.

The following types of paper are invited:

• Papers reporting original empirical investigations

• Theoretical papers, provided that these are sufficiently related to the empirical data

• Review articles which need not be exhaustive but which should give an interpretation of the state of the research in a given field and, where appropriate, identify its clinical implications

• Brief reports and comments

1. Circulation

The circulation of the Journal is worldwide. Papers are invited and encouraged from authors throughout the world.

2. Length

Papers should normally be no more than 5000 words (excluding abstract, reference list, tables and figures), although the Editor retains discretion to publish papers beyond this length in cases where the clear and concise expression of the scientific content requires greater length.

3. Submission and reviewing

All manuscripts must be submitted via http://www.editorialmanager.com/bjcp/. The Journal operates a policy of anonymous peer review.

4. Manuscript requirements

• Contributions must be typed in double spacing with wide margins. All sheets must be numbered.

• Tables should be typed in double spacing, each on a separate page with a self-explanatory title. Tables should be comprehensible without reference to the text. They should be placed at the end of the manuscript with their approximate locations indicated in the text.

• Figures can be included at the end of the document or attached as separate files, carefully labelled in initial capital/lower case lettering with symbols in a form consistent with text use. Unnecessary background patterns, lines and shading should be avoided. Captions should be listed on a separate sheet. The resolution of digital images must be at least 300 dpi.

• For articles containing original scientific research, a structured abstract of up to 250 words should be included with the headings: Objectives, Design, Methods, Results, Conclusions. Review articles should use these headings: Purpose, Methods, Results, Conclusions.

• For reference citations, please use APA style. Particular care should be taken to ensure that references are accurate and complete. Give all journal titles in full.

• SI units must be used for all measurements, rounded off to practical values if appropriate, with the imperial equivalent in parentheses.

• In normal circumstances, effect size should be incorporated.

• Authors are requested to avoid the use of sexist language.

• Authors are responsible for acquiring written permission to publish lengthy quotations, illustrations, etc. for which they do not own copyright. For guidelines on editorial style, please consult the APA Publication Manualpublished by the American Psychological Association.

5. Brief reports and comments

These allow publication of research studies and theoretical, critical or review comments with an essential contribution to make. They should be limited to 2000 words, including references. The abstract should not exceed 120 words and should be structured under these headings: Objective, Method, Results, Conclusions. There should be no more than one table or figure, which should only be included if it conveys information more efficiently than the text. Title, author name and address are not included in the word limit.

6. Supporting Information

BJC is happy to accept articles with supporting information supplied for online only publication. This may include appendices, supplementary figures, sound files, videoclips etc. These will be posted on Wiley Online Library with the article. The print version will have a note indicating that extra material is available online. Please indicate clearly on submission which material is for online only publication. Please note that extra online only material is published as supplied by the author in the same file format and is not copyedited or typeset. Further information about this service can be found at http://authorservices.wiley.com/bauthor/suppmat.asp

7. Copyright

Authors will be required to assign copyright to The British Psychological Society. Copyright assignment is a condition of publication and papers will not be passed to the publisher for production unless copyright has been assigned. To assist authors an appropriate copyright assignment form will be supplied by the editorial office and is also available on the journal's website at http://www.blackwellpublishing.com/pdf/CTA_BPS.pdf. Government employees in both the US and the UK need to complete the Author Warranty sections, although copyright in such cases does not need to be assigned.

8. Colour illustrations

Colour illustrations can be accepted for publication online. These would be reproduced in greyscale in the print version. If authors would like these figures to be reproduced in colour in print at their expense they should request this by completing a Colour Work Agreement form upon acceptance of the paper. A copy of the Colour Work Agreement form can be downloaded **here**.

9. Pre-submission English-language editing

Authors for whom English is a second language may choose to have their manuscript professionally edited before submission to improve the English. A list of independent suppliers of editing services can be found athttp://authorservices.wiley.com/bauthor/english_language.asp. All services are paid for and arranged by the author, and use of one of these services does not guarantee acceptance or preference for publication.

10. Author Services

Author Services enables authors to track their article - once it has been accepted - through the production process to publication online and in print. Authors can check the status of their articles online and choose to receive automated e-mails at key stages of production. The author will receive an e-mail with a unique link that enables them to register and have their article automatically added to the system. Please ensure that a complete e-mail address is provided when submitting the manuscript. Visithttp://authorservices.wiley.com/bauthor/ for more details on online production tracking and for a wealth of resources including FAQs and tips on article preparation, submission and more.

11. The Later Stages

The corresponding author will receive an email alert containing a link to a web site. A working e-mail address must therefore be provided for the corresponding author. The proof can be downloaded as a PDF (portable document format) file from this site. Acrobat Reader will be required in order to read this file. This software can be downloaded (free of charge) from the following web site:http://www.adobe.com/products/acrobat/readstep2.html.

This will enable the file to be opened, read on screen and annotated direct in the PDF. Corrections can also be supplied by hard copy if preferred. Further instructions will be sent with the proof. Hard copy proofs will be posted if no e-mail address is available. Excessive changes made by the author in the proofs, excluding typesetting errors, will be charged separately.

12. Early View

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Further information about the process of peer review and production can be found in this document: What happens to my paper?

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