A Qualitative Study Investigating the Effects of Being Detained under the Mental Health Act (1983) on an Individual’s Identity

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*A Qualitative Study Investigating the Effects of Being Detained under a Section of the Mental Health Act (1983) On an Individual’s Identity.*
This portfolio contains a selection of work completed during the PsychD in Clinical Psychology training course.

**Volume I** contains (i) the academic dossier, consisting of two essays, three Problem Based Learning accounts, and two case discussion group process accounts summaries; (ii) the clinical dossier, containing summaries of the five placements, and the five case report summaries; (iii) the research dossier, comprising the research logbook, the service related research project completed in year one, the abstract of the qualitative research project completed in year two and the major research project completed in years two and three.

**Volume II** of the portfolio comprises the clinical dossier containing the five case reports and two case discussion group process accounts in full, and the placement contract, logbooks and evaluation forms. Due to the confidential nature of the clinical material, this volume will be kept within the Clinical Psychology department of the University of Surrey.

The work presented in this portfolio reflects the range of client groups, presenting problems and psychological approaches covered during the course. Within each dossier, the work is presented in the order in which it was completed to illustrate the development of my clinical, academic and research skills during the period of training.

Identifying details have been changed or removed in this portfolio in order to maintain confidentiality and anonymity.
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The members of my case discussion group have not only been instrumental in helping me manage the stresses of the course but have also been five wonderful friends who have been there for me throughout. Thank you. A special thanks to Marie V and Marie T who have always been the other end of the phone (often several times a day) to support me.

My final and most important thanks go to my family and to my husband, Terry, who kept me grounded in life outside of the course, and who has been through this journey with me.
OVERVIEW OF THE ACADEMIC DOSSIER

This dossier consists of the two essays written during the first two years of the PsychD training course, the three Problem Based Learning accounts and summaries of the two case discussion group process accounts. The case discussion group process accounts can be found in full in Volume II of the portfolio.
ADULT MENTAL HEALTH ESSAY

TO WHAT EXTENT IS MEMBERSHIP OF AN ETHNIC MINORITY GROUP (IN THE UK) INFLUENTIAL IN THE PROCESS OF DIAGNOSIS AND TREATMENT OF PSYCHOSIS

Year One
Introduction

This title produces a number of interesting questions from the onset. What is an ‘ethnic minority group’ and what is ‘psychosis’ are perhaps the most obvious questions provoked. In answering the first of these questions the term ‘ethnicity’ has to be explored.

What is an Ethnic Minority Group?

The word ethnic stems from the Greek word ‘ethnos’ which means nation and the term ‘ethnic minority’ is defined in the Oxford English Reference Dictionary (Pearsall & Trumble, 1996) as ‘a (usually identifiable) group differentiated from the main population of a community by racial origin or cultural background’. This definition highlights the overlap of the term ethnicity with ‘race’ and culture and the difficulties in separating these terms not only in literature but in everyday language usage. This definition also holds two conflicting ideas about ethnicity that is present in some of the literature. That is the difference between a definition of ethnicity that suggests that it consists of fixed cultural characteristics (‘essential’ ethnicity), which can include concepts of ‘race’, and one where a person’s ethnicity can be seen as being fluid and open to change depending on the situation the person is in (Smaje, 1995). In the context of the United Kingdom (UK) ethnic minority groups are usually identified as being any person that is not British and ‘white’ (British White is the ethnic majority according to the Office for National Statistics (ONS), 2001 Census (cited at http://www.statistics.gov.uk)), which suggest nationality and skin pigmentation are the important differentials. In this essay, the main ethnic minority group referred to will be people who are African-Caribbean who reside in the UK. In using the term African-Caribbean I am describing people who are also referred to as Black Caribbean (the term used in the 2001 Census). I have chosen to use the term African-Caribbean as it is the most widely used term in the literature to describe this ethnic group and I have chosen to mainly focus on this population because in the context of not only mental health issues but particularly psychosis there is a significant amount of literature in relation to African-Caribbean people. I have also decided to discuss African-Caribbean people because of my previous work experience in psychiatric
hospitals where the most prevalent ethnic minority group were African-Caribbean people and because of my current place of residence, which is in an area of the UK where the highest concentration of African-Caribbean people live, 12.6 per cent of the local population (ONS, 1991 Census). It is therefore this ethnic minority group that I have had most contact with personally and professionally and this is in many ways what drew me to this essay.

With this said it is important to note the limitations in defining an ethnic minority group in terms of African-Caribbean descent. Not only does this form of grouping not make explicit some key components of ethnicity such as religion, language and culture (Smaje, 1995) but it includes such a vast range of peoples who have descended from a large geographical area. It also suggests a degree of homogeneity which is not necessarily present. Dimensions such as class, sexuality, gender and age are not specified in this categorisation and are significant variables when discussing the process of diagnosis and treatment of psychosis.

The title of this essay also specifies ‘membership of an ethnic minority group’. How one becomes a member of a group is also a complex matter in terms of ethnicity and there is often a meaningful differentiation between whether you internally identify yourself within a particular ethnic group (i.e. choose yourself the ethnic group you belong to) or, whether you are externally identified as being a member of an ethnic group. Mason (1990) labels these two processes by dividing ethnicity into ethnicity as identity and ethnicity as category. With most of the research referred to in this essay membership of an ethnic grouping is defined by participants’ selection of an ethnic group and suggests ethnic identity, though due to the limited categories available in most ethnicity monitoring forms there is limited choice to how an individual identifies their ethnicity.

Taking into account the limitations of ethnicity data it is still important to have some understanding of how much of a minority group African-Caribbeans are. In the April 2001 Census it was recorded that the size of the minority ethnic population in the United Kingdom was 4.6 million or 7.9 per cent of the total population (ONS). 12.2 per cent of the minority ethnic population identified themselves as Black Caribbean.
The Office for National Statistics also recorded that 61 per cent of Black Caribbeans lived in London. The high proportion of Black Caribbeans living in London is an important statistic to consider when thinking of the social environment that members of minority ethnic groups are living in.

It is also important to note my perspective in this essay as a person that is part of the ethnic ‘majority’ in the UK, being British and white. In writing this essay I have recognised my own anxieties in discussing issues surrounding ethnicity; my concerns about my own assumptions and that my own ethnicity might provide me with some automatic limitations in writing about the influence of being a member of an ethnic minority group in the UK. These reflections on a personal level mirror some of the apprehensions I have experienced amongst mental health professionals in discussing issues about ethnicity, which in turn I feel may narrow the debate about the influence of ethnicity in the provision of mental health services.

**What is Psychosis?**

Psychosis is defined as a severe mental disorder in which thinking and emotion are so impaired that the individual is seriously out of contact with reality (Davison & Neale, 1998). In psychotic illnesses individuals can experience delusions and hallucinations. The diagnosis of schizophrenia is most commonly referred to when discussing psychosis in this essay as it is the most common form of psychotic illness mentioned in the literature. Psychotic illness are thought to affect about one person in 250 (Melzter *et al*., 1995, cited in Culley & Dyson, 2001) and about one person in a hundred is likely to receive a diagnosis of schizophrenia in their lifetime (British Psychological Society (BPS), 2000).

Psychosis or psychotic illnesses are usually diagnosed by Psychiatrists. There are many pathways to being seen by a Psychiatrist which include being referred by a General Practitioner (GP), being referred by other mental health professionals, and through the forensic services. It is also important to note that there are many people who have experiences of psychosis who do not come in contact with the mental health services (BPS, 2000). For a person to be diagnosed with a psychotic illness in the UK
they have to meet certain diagnostic criteria that are defined by the International Classification of Diseases, edition 10 (ICD-10). The validity and reliability of the diagnostic systems have often been challenged, with particular questioning of the reliability of the diagnosis of schizophrenia which has been shown to be inconsistently diagnosed from practitioner to practitioner and from country to country (Beck et al, 1962, Blashfield, 1973). This has made research in to the influence of ethnicity on diagnosis even harder to ascertain.

The treatment of psychosis includes psychiatric medication and psychological therapies. The most researched and thus common form of psychological therapy for psychosis is cognitive-behavioural therapy (BPS, 2000).

**Does being an African-Caribbean in the UK influence the process of diagnosis of psychosis?**

Since the 1960s there have been reports of higher than expected rates of schizophrenia among African-Caribbean people living in England when compared to the white population (Sharpley, 2001). African-Caribbean people are typically reported to be three to five times more likely than white people to be admitted to hospital with a diagnosis of schizophrenia (Cochrane & Bal, 1989; Littlewood & Lipsedge, 1988). What does this mean? Is there an increased prevalence of psychosis among African-Caribbean people or is there some form of bias in the process of diagnosis?

Earlier research in the 1980s typically looked at hospital admission and treatment rates when investigating the relationship between ethnicity and psychosis (Cochrane & Bal, 1989; Harrison et al., 1988; Littlewood & Lipsedge, 1988; McGovern & Cope, 1987). There were many limitations to these studies which included; lack of data on the proportion of ethnic minority groups in the UK (the first Census to include data on ethnicity was in 1991); inconsistencies between Psychiatrists in diagnosing schizophrenia; and ethnicity being categorised by place of birth and therefore excluding African-Caribbean people born in the UK (Sharpley, 2001). It has also been argued that by using data on hospital admission and treatment rates, what is being investigated is the expression of an illness in forms of symptoms which brings the
individual in contact with services rather than the illness itself (Blane et al. 1996, cited in Iley & Nazroo, 2001). Data on hospital admission rates excludes people with psychosis that are in the community and not receiving hospital treatment and Sashidharan and Francis (1993) have argued that admission data may reflect health professionals' views as much as disease prevalence. Despite these limitations, the conclusions to these studies spurred a wave of interest into investigating whether there was some form of 'ethnic vulnerability' to schizophrenia (Sashidharan & Francis, 1993).

So does being an African-Caribbean mean that you have an increased vulnerability to schizophrenia, or psychosis in general, and therefore are more likely to be diagnosed with schizophrenia? There have been several hypotheses trying to explain an 'ethnic vulnerability' to schizophrenia. These hypotheses have included investigating whether African-Caribbean people have an increased 'biological' risk to schizophrenia. This form of investigations has produced little supporting evidence (Iley & Nazroo, 2001) and research by Hickling and Rodgers-Johnson (1995) indicates that in the Caribbean (Jamaica) first contact treatment rates for people of African ethnic background are not elevated above first contact rates for the White population of the UK, suggesting that there is no genetic predisposition for schizophrenia in African-Caribbean people. This form of ‘biological’ argument has some resonance with earlier hypotheses linking ‘race’ to intelligence. Other explanations of ‘ethnic vulnerability’ have included other biological hypotheses (e.g. prenatal and perinatal complications, excessive cannabis use); social hypotheses (African-Caribbean people are more likely to live in inner cities, to experience racism, social disadvantage etc.); and psychological hypotheses (African-Caribbean people more likely to make external attributions), all of which are discussed in Sharpley et al. (2001) review of the ‘excess’ of psychosis among the African-Caribbean population in England.

When first researching the literature for this essay I became easily embroiled in trying to understand the various hypotheses above and the suggested increased rates of schizophrenia among African-Caribbean people in the UK, without questioning these reportedly elevated rates. The validity of these findings of elevated rates was initially questioned after examining research conducted in the community rather than in
hospital settings (Nazroo, 1997; Sproston & Nazroo, 2000). Sproston & Nazroo’s community based study, Ethnic Minority Psychiatric Illness Rates in the Community, indicated that prevalence of psychotic illnesses amongst the African-Caribbean population in the community was not as elevated as previously suggested by research which focused on hospital admission rates. Their results indicated that Africa-Caribbean people had a twofold higher rate of prevalence of psychotic illness in the community compared with the White group, and that this difference was only statistically significant for women. This study and the Fourth National Survey of Ethnic Minorities (Nazroo, 1997) concluded that rates of psychotic illnesses in the community for Black Caribbean were not particularly elevated among men, the young or ‘non-migrant’ people, which has been suggested by studies that have focused on treatment rates (Cochrane & Bal, 1989). By questioning the assumption that there are elevated prevalence rates of psychosis amongst African-Caribbean people in the UK, more questions have arisen about the process of diagnosis and whether there is some form of bias in the process. I believe that my own development of thought has been reflected in the literature where authors (Littelwood & Lipsedge, 1988; Sashidharan, 1993; Nazroo 1997) have challenged the validity of earlier research and questioned whether psychiatry and mental health services are accurately diagnosing psychosis in African-Caribbean people and whether at some institutional level this population are at a disadvantage. So why would the diagnosis process not be as valid for African-Caribbean people?

First of all the whole concept of diagnosis needs to be challenged. Using the term diagnosis immediately presumes that mental health difficulties are conceptualised in the same model that physical illnesses are. It presumes that something is identified as ‘ill’ about an individual and therefore is given a label (diagnosis) which indicates possible aetiology, what treatments are effective and what the probable prognosis is. Unfortunately (or not) mental health diagnoses are not able to suggest specific effective treatments or predict prognosis (BPS, 2000). This model of mental health is a Western construction and is the backbone to psychiatry and to clinical psychology. How do non-Western cultures relate to this model of mental health? Some non-Western cultures do not see the need to treat symptoms of mental illness and to extract these behaviours from the self (exorcistic) but to process the symptoms and to
integrate them with the self as they may be potentially helpful (endorcistic) (Levi-Strauss, 1955, cited in Lemma, 1996). This lack of identification of symptoms as a 'problem' could result in people of non-Western thinking, feeling less inhibited about expressing their symptoms and thus more likely to be diagnosed as having schizophrenia. Kleinman (1987) described the rigid application of diagnostic criteria, based on one model of mental illness from one culture to another for whom it lacks any coherence, as a 'category fallacy'. Kleinman reported that this 'category fallacy' obscures ethnic differences in the experience of illness.

While reflecting on the conceptualisation of mental health in the UK and the issues above, I was struck by how the title to this essay could be seen as ethnocentric and by discussing psychosis in terms of diagnosis and treatment could already identify a conceptualisation of psychosis that may be at odds with how people from ethnic minority groups conceptualise it.

However, the above challenges to the validity of the diagnosis of psychotic illnesses as applied to people from non-western cultures does not explain why increased rates of schizophrenia are being diagnosed in second and third generation African-Caribbean people whose cultural belief may be 'westernised' and why there is not the same significant elevated rates of people being admitted to hospital with a diagnosis of schizophrenia from other ethnic minority groups (Nazroo, 1997). Another active component of the process of diagnosis to be addressed is the role of the Psychiatrist. Do Psychiatrists have some stereotypical view of African-Caribbean people that influence the diagnosis? Do Psychiatrists misinterpret what African-Caribbean people are expressing more than people from other ethnic groups? These questions are difficult to investigate because of fears individuals may have in being seen as prejudicial. These fears may result in individuals having a defensive position in reporting their views, that is what people say and what people do are often quite different (Chakraborty & McKenzie, 2002). An example of the potential for prejudicial or biased diagnosis is the elevated rates of diagnosis of 'cannabis induced psychosis' reported in the 1980s among African-Caribbean people which has since been discredited (Littlewood & Lipsedge, 1982). This over-diagnosis of cannabis
induced psychosis indicates a period when stereotypical views about African-Caribbean people may have affected psychiatrists’ choice of diagnosis.

Fernando (1995, pp. 32) discusses the role of professionals in assessments and how these may be biased,

...assessments usually fail to allow for ideologies about life, approaches to life’s problems, beliefs and feelings that come from non-Western cultures, mainly because training (of professionals) is of Western culture... stereotypical assumptions about black people play a big part in assessments that professionals make.

The stereotypical assumptions that he refers to are those that are particularly evident in media representations of black males as violent and dangerous which is demonstrated in the rating by Psychiatrists of black male clients as potentially more violent than white clients (Lewis, Croft-Jeffreys, & David, 1990).

Whilst thinking of racial stereotyping I was reminded of when I worked in a secure psychiatric hospital in North London. In this job I had the opportunity to observe one of the client’s court trial at the Old Bailey Law Courts. This client was of mixed British and African (Somali) ethnic background and the psychiatric nurse, who stood next to him, in the dock, was of African descent and had much darker skin pigment. One of the offences that the client was accused of was of causing grievous bodily harm to a cocaine dealer. Whilst observing the trial in the public gallery one morning there were some school children also watching the trial, who presumed that the psychiatric nurse was the accused (the client) because he looked “seriously mean” which “he would need to be to beat up a cocaine dealer.” Reflecting on this I believe that the psychiatric nurse’s darker skin pigment had an influence on the school children’s impression of him. This reflection made me question how prevalent racial stereotyping was. Do we question enough whether we, as mental health professionals, have a degree of racial stereotyping and whether if we do it influences our care towards clients? I am left questioning myself as to whether I at some intrinsic level make assumptions about clients because of their ethnicity.
Diagnosis of schizophrenia and the choice of treatment are also dependent on the degree of severity of the symptoms presented. One factor that may influence this is the stage in the illness that a person first contacts mental health services. If a person accesses services later on in the course of their illness, when symptoms are likely to be more severe, then it should follow that they are more likely to receive a diagnosis of schizophrenia. The Department of Health document, 'Inside Outside: Improving Mental Health Services for Black and Minority Ethnic Communities in England' (March 2003b), have reported that Black and ethnic minority people have problems in accessing services, have cultural and language barriers in assessments and have lower GP involvement in care. These factors could have a significant influence on the process of diagnosis. If there are barriers for African-Caribbean people in seeking help then they are going to go longer without treatment, will not receive early interventions and will therefore be more likely to experience deterioration in their mental health. This would suggest that when they do access services, they will be more likely to receive a diagnosis as their symptoms will be more pronounced. The difference pathways to care that are experienced by people from different ethnic groups is an important aspect when considering the treatment that people receive and it is this area that we will now turn to.

**Does being an African-Caribbean influence the process of treatment of psychosis?**

The Department of Health's (DOH) document, 'Delivering Race Equality: A Framework for Action' (2003a) has highlighted some of the issues surrounding pathways to care for African-Caribbean people. These include African-Caribbean people having an increased risk of following aversive pathways into specialist mental health care (Sashidharan, 1993), with treatment delay being a particularly significant factor. The reasons for treatment delay could be due to the role of the GP. It has also been noted in the DOH's, 'Delivering Race Equality' document that GPs are less likely to feel involved in the care of Black and minority ethnic clients with severe mental illness and that they experience increased difficulties diagnosing mental health problems in African-Caribbean people. Lack of GP involvement is strongly associated with police involvement and compulsory admissions to mental health service (DOH,
African-Caribbean people are more likely than non-Black clients to be in contact with the police or prison services before admission and to be admitted to hospital under a section of the Mental Health Act (Audini & Elliot, 2002). So it appears that being an African-Caribbean in the UK has some influence on how you access services, but how does this more 'aversive' pathway effect the treatment that is received? Accessing mental health services through compulsory admissions, either through the criminal justice system or through civil Mental Health Act sections, suggests that in African-Caribbean people crises are not being anticipated and that there is a reduced chance of preventing the development or relapse of mental illness. As well as more aggressive pathways to care African-Caribbean people have also been reported to receive more aggressive treatment such as; ECT, high dosage drug treatment and being less likely to receive psychotherapy. (DOH, 2003b, McKenzie et al, 1995).

Is the difference in African-Caribbean people's experience of mental health services related to the perception of African-Caribbean people by mental health professionals? Harrison et al. (1989) reported that African-Caribbean people were more likely to have been aggressive at the time of admission (which could be due to increased likelihood of compulsory admission) and once admitted staff were more likely to perceive them as potentially dangerous both to themselves and others. If African-Caribbean people were perceived as more dangerous then this would also have an impact on risk assessments and the amount of restrictions they have in their freedom whilst in hospital.

From what has been described above it would appear that African-Caribbean people are more likely to have a negative experience of mental health services. This could result in African-Caribbean service users being more reluctant to access services, as they perceive them as harmful. The consequence of this could be that this population would not receive support (from mental health services) for the mental health difficulties they may be experiencing, which could result in an increased risk of their difficulties escalating to a crisis point. This would lead in some cases to increased risk of self harm or harm to others which would further reinforces mental health professionals (and the public's) views that African-Caribbean people are more at risk...
and therefore need more ‘severe’ treatment pathways. This feedback loop has been described as ‘circles of fear’ (Breaking the Circles of Fear, The Sainsbury Centre for Mental Health, 2002). It is this circle of fear that appears to have a significant influence on the relationship between African-Caribbean people and mental health services and is thus influential on the process of treatment.

As mentioned above African-Caribbean people are less likely to receive psychotherapy as a form of treatment. Though this is the case, it is worth exploring how being an African-Caribbean may influence psychological treatment of psychosis as this is becoming more of a recognised form of treatment for psychosis amongst mental health services (BPS, 2000). It is also worth exploring how this relationship of fear between the African-Caribbean service user and the mental health services may effect psychological treatment.

**Psychological Treatment**

The therapeutic relationship between client and therapist has been suggested as one of the key indicators of therapeutic outcome (Greben, 1981). How does ethnicity affect the therapeutic relationship, especially if there is a relationship of fear between the African-Caribbean service user and mental health services? Looking at my own experience of working with clients from different ethnic backgrounds I am curious to explore whether a client’s ethnicity has affected my ability to build a collaborative relationship in therapy. I immediately want to deny that I have any pre-conceived judgements about a client before I hear their narrative, but I have to be open to the idea that at some implicit level I may make assumptions about a client’s life based on their ethnicity. When I was working in a psychiatric hospital in North London the majority of the clients I did substance misuse work with were from an ethnic minority background and more often than not came from families that were socio-economically disadvantaged. I remember starting some psycho-educational work with a middle class white British client who came from Dorset and being conscious that I was more curious about how his life had developed and resulted in him having a forensic and psychiatric history which included heavy substance misuse, than I was of client’s from ethnic minority backgrounds. Somehow it was more ‘surprising’ that his life had taken
this route. This suggests to me that I thought it was more of the ‘norm’ for non-white clients to experience difficulties in their lives that resulted in contact with forensic and mental health services.

Cognitive-behavioural therapy (CBT) is more frequently used with clients with psychosis than any other psychological therapy (BPS, 2000). Kinderman and Bentall’s (1996) cognitive model of psychosis identifies a client’s attributional style (how individuals explain their own and others’ behaviour) as being an important factor in the development of paranoia and persecutory delusions, in that there is an exaggerated external attributional (other-blaming) bias. Does being an African-Caribbean in the UK, where you may have an increased chance of experiencing discrimination and racism, effect your attributional style, and if so how can this be used to help with formulation in therapy? I am aware that by exploring the association between ethnicity and particular thinking styles in order to aid formulation that there is a risk of bringing assumptions to therapy. To de-tangle this it is important to emphasise that it is not a person’s ethnicity that causes a more external attributional style but others’ reaction to a person’s ethnicity that can cause a person to have more negative experiences of social interactions which could affect their beliefs and cognitions. Therefore when working therapeutically with a client from an ethnic minority group, it would seem to be important to be mindful of their experiences of discrimination and racism and how those experiences could have affected their beliefs and thinking styles, in relation not only to their symptoms but to the therapeutic relationship also.

Beliefs are not only affected by experiences but also by one’s cultural identity, which might be important to consider when choosing an appropriate form of therapy, for example the choice of individual or family therapy. There may be a need with some client’s from ethnic minority groups, whose cultural identification may be more collectivist than individualistic, to conceptualise their experiences more systemically than individually.

Whilst exploring issues of culture and other influences arising from working with African-Caribbean clients that could affect the therapeutic process, the limitations of defining a group of individuals by such a limited definition of ethnicity becomes
apparent. Issues such as religion, gender, sexuality, to name just a few, become aspects of ethnicity that need to be identified in order to address how they influence the therapeutic process. It is also recognised the significant influence of cultural beliefs and that by identifying an individual as an African-Caribbean one is not specifying whether the individual has migrated to the UK in his/her lifetime, or their parents/grandparents etc., and what cultural beliefs that individual identifies with. When working with an African-Caribbean client, as with working with any other client, there is a need to formulate the client’s presenting difficulties from their own framework/perspective, recognising how you, the therapist, (with your own ethnicity) fits into that framework.

**Discussion and Conclusion**

Throughout the essay I feel there has been a conflict not only in the literature but in my own understanding of the research findings between the need to recognise the importance of ethnicity in the diagnosis and treatment of psychosis and the recognition that by even just identifying and categorising a person’s ethnicity this can lead to assumptions being made. This conflict is captured succinctly by A. Ivey, M. Ivey and L. Simek-Morgan (1997):

> When cultural differences are overemphasized, the result is a stereotyped, exclusionary, politicized, and antagonistic perspective. When cultural similarities are overemphasized, the result can be the exploitation of less powerful by more powerful groups and a pretense of a melting pot environment that disregards essential features of cultural identity.

Though this quote is focusing on culture rather than ethnicity, I believe that it has equal significance when discussing ethnicity, especially as the division between the two are at times indistinct.

With these difficulties said, I believe that being a member of an ethnic minority group in the UK quite clearly and significantly influences the process of diagnosis and treatment of psychosis. These influences appear to be to the extent that there is an
identified dysfunctional relationship between mental health services and the African-Caribbean community. This dysfunctional relationship needs to be addressed not only at an organisational level but also at an individual one, with mental health professionals reflecting on their own potential assumptions, stereotypical views and understanding of the role of ethnicity in their practice.

In writing this essay I have recognised the lack of clarity in the use of the term ethnicity and how often culture and ‘race’ become key factors. Why African-Caribbean people should have such different experiences of mental health services to other ethnic minority groups suggests to me that stereotypical views about African-Caribbean people are highly influential in the process and treatment of psychosis. Where these views come from can be a huge topic of discussion and one that this essay hasn’t the space to address, though it can be speculated that the history of African colonialisation and the impact of the slave trade have left particular historical impressions of this population that has on some levels been ingrained into British society and into the institutions of psychiatry and clinical psychology. These impressions also appear to be fuelled by the media, a culture of fear and blame and a need to identify the ‘other’ in order to strengthen one’s own place in society. In exploring these thoughts I am ponderous about whether the recent world events that appear to have increasingly marginalised the Muslim community and associated members of this community with feelings of fear, might result in this minority ethnic group having similar experiences of the mental health services in the future.
References


SUPERVISION IS SEEN AS AN IMPORTANT PART OF A PSYCHOLOGIST'S PERSONAL AND PROFESSIONAL DEVELOPMENT, YET MENTAL HEALTH PROFESSIONALS ARE SOMEWHAT AMBIVALENT. CRITICALLY DISCUSS YOUR OWN SUPERVISION EXPERIENCE AGAINST TWO THEORETICAL FRAMEWORKS OF YOUR CHOICE, FOCUSING ON SUPERVISION AND LEARNING, AND ETHICAL ISSUES INCLUDING WORKING WITH DIFFERENCE.

Year Two
When I first read through the Professional Issues essay titles I felt uninspired. What had enticed me into Clinical Psychology was primarily the therapeutic relationship, and though professional issues had filtered in and guided my work they have tended not to have been an area of passion. When re-reading the titles I was struck by this title’s comment about mental health professionals’ ambivalence towards supervision, because it reminded me of the beginning stages of my career, as a rehabilitation assistant, when I felt this ambivalence, and now how I almost take for granted my weekly discussions with my supervisor as they are so integral to my development and practice. Through researching this essay I am have become further appreciative of the dynamics of the supervisory relationship, more aware of my development as a supervisee and what some of my future learning needs are. Through my knowledge of supervision frameworks, time spent on reflecting on previous supervisory experiences, and my study of learning itself, I am more able to utilise the supervision I have now. I think this will have a significant impact on any future supervisory role I may have. The more I learnt for this essay, the more passionate I feel about the topic, and the more I understand why I chose this essay.

Introduction

To introduce the topic I will start by providing a brief overview of supervision and in particular the process of learning within supervision and some of the ethical issues that arise in supervision. Through looking at these areas some of the reasons why mental health professionals may be ambivalent towards supervision may become apparent. I will then position myself within the essay by introducing my previous experiences of supervision.

1 Throughout this essay I will write in the first person in order to include my reflections on the topic and to recognise my part in the process.

2 The literature reviewed to inform this essay was mainly based on supervision processes in clinical psychology, psychotherapy and counselling psychology. I have decided to look at individual clinical supervision (which excludes group, peer, and research supervision amongst others) and have focused on models/theories that explore the development of the supervisee (not the supervisor), and the supervisory process.
A brief overview of supervision

The word 'supervision' originates from Latin ('super' meaning over and 'videre' to see), and means to oversee (already hinting at power differential). The Department of Health (1993, cited in Fleming & Steen, 2004, p. 15) define supervision as

a formal process of professional support and learning which enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance consumer protection and safety of care in complex clinical situations.

This definition includes concepts of accountability and quality control, concepts that have become increasingly important in the delivery of health care and have in turn provoked some of the more recent (since the 1980s) interest in supervision and recognition of its importance in the development and regulation of mental health professionals. Supervision is an integral part of mental health professionals’ training and Continuing Professional Development (CPD). CPD has been a key driving force behind NHS strategy over recent years (Division of Clinical Psychology, 2005), and supervision as part of CPD has received more attention, including guidelines on how it should be implemented (British Psychological Society, 2002). With this attempt to regulate supervision in an era of evidence-based practice, there is an increased need to investigate the evidence for the effectiveness of supervision and a more informed understanding behind the supervision process. Previous research into supervision has been heavily criticised for methodological flaws (Russel, Crimmings & Lent, 1984; Ellis, Ladany, Krenge & Schult, 1996) including difficulties with the internal and external validity of studies. This questionability surrounding the evidence may also provoke some mental health professionals’ ambivalence towards supervision as they may be left unclear of whether supervision is actually an effective use of their time.

A brief overview of the process of learning within supervision

Figure 1 is a model that I have developed to illustrate some of the factors that are involved in the process of learning within supervision. The aim of including this
model is to highlight the multi-faceted nature of the learning process in supervision and the requirements of the supervisor and supervisee in order for optimum learning to occur. The model highlights the demands on both the supervisee and the supervisor and therefore the potentially overwhelming tasks that mental health professionals may feel are involved in the process. The figure includes information discussed by Milne & Westerman (2001) about the roles that the supervisor and the supervisee need to undertake to facilitate learning and also highlights how this process occurs via the supervisory relationship. It also includes other supervisor/supervisee tasks that are important to learning and other models (Kolb, 1984) that are informative in our understanding of the learning process. I have also included in the figure factors that might influence the supervisor/supervisee's knowledge or ability to use these tasks (these are shown by arrows into the two text boxes). For example, a supervisor's previous experiences of being supervised will affect their method of supervising. When discussing two supervision frameworks later and in particular the process of learning within these frameworks, I will be doing so in the context of my understanding of learning within supervision, as illustrated by Figure 1.

A brief overview of ethical issues relating to supervision

Ethical issues within supervision are somewhat similar to those that occur within a therapeutic relationship and include issues of confidentiality, dual relationships and abuse of power. Within supervision, there is a risk that supervision can be seen as therapy for the supervisee, especially as parallel processes may arise within the relationship to those that occur between the supervisee (therapist) and client. On reflection, it is difficult to know when it is appropriate to disclose personal information to a supervisor, and what one expects from the supervisor in response. I feel that this often reflects difficulties in exploring issues of counter-transference and
LEARNING IN SUPERVISION

SUPERVISOR’S FACILITATION OF LEARNING:
- Managing the learning environment
- Listening
- Supporting
- Summarising
- Feedback
- Gathering information
- Checking theoretical knowledge base
- Challenging
- Informing/educating
- Guided experiential learning (modelling, role playing, etc.)
- Self-disclosing
- Disagreeing
- Observing.
- Guiding useful reading.
- Modelling a reflective stance.

Previous experiences of being supervised

Knowledge of learning theories/processes

Knowledge of own learning needs

Learning interface via the SUPERVISORY RELATIONSHIP

SUPERVISEE’S LEARNING TASKS
- Experiential Learning Cycle (Kolb, 1984)
  - Concrete Experiencing
  - Reflective Observation
  - Abstract Conceptualisation Theory
  - Active Experimentation
- Bringing information to the supervision
- Observing supervisor.
- A reflective stance characterised by:
  - intention, active inquiry, openness and vulnerability (Neufeldt, Kano & Nelson, 1996)

Trust policies/ BPS guidelines

Personality factors e.g. openness

Supervisor’s prior experiences of being supervised

Figure 1: Adapted from Milne & Westerman (2001)
differentiating feelings that are provoked from work with a client and from your own personal issues.

Ethical issues that surround supervision include whether it is ethical for a supervisor to be supervising without the appropriate training and evaluation, yet how many supervisors are knowledgeable of supervisory models and are using them to inform supervision? One of the assumptions within supervision is that supervisors are competent not only as supervisors but as therapists themselves, and is this a valid assumption? Also the evidence for the effectiveness of supervision is not conclusive, yet it is integral to the training of mental health professionals.

When discussing difference within supervision I will mainly be referring to cultural differences, as defined by Ryde (2000, p. 39) as

> different explicit and implicit assumptions and values that influence the behaviour and social artefacts of different groups.

It is important to consider that in supervision it is not only difference between the supervisor and supervisee that needs to be considered but also difference with the client. Exploring working with difference in supervision is an ethical issue as it is often through difference that individuals have perceived power and therefore the opportunity to abuse this power, whether consciously or unconsciously.

Figure 2: Complex power dynamics in cross-cultural supervision (Ryde, 2000)
Figure 2 illustrates three types of power that are inherent within supervision. Role power indicates the power that is linked to the position within supervision, (e.g. role of supervisor); cultural power indicates the power of the dominant cultural group (e.g. British white middle class heterosexual); individual power indicates the power of the individual’s personality. Within cultural power the effect of society, and the cultural context that supervision is taking place within is important to note. I am presently on placement where I am working with people with learning disabilities and have become acutely aware of how, via the media in particular, they have significantly reduced cultural power.

Within supervision it is important to address the power dynamics between the three individuals involved but that often takes a secure supervisory relationship and an ability to know our own assumptions and to be able to challenge them. I will therefore conclude this introductory section by informing the reader of my previous experiences of supervision.

An overview of my experiences of supervision

My first experience of supervision was when I was a rehabilitation assistant. In my eighteen months there, I had supervision twice, both times being a rather tokenistic exercise, and one that I did not find helpful. As an assistant and trainee psychologist, I have experienced weekly supervision with six different supervisors who have a range of theoretical and cultural backgrounds. I have never had a discussion with a supervisor about what model/theory of supervision informs their practice or what learning styles I prefer. There have been many differences and power differentials between myself and supervisors. My evaluation of supervision has been very much orientated around the supervisory relationship and feeling secure enough in our relationship to receive challenges without defence.

In terms of my assumptions about supervision, I am acutely aware of the evaluative nature of supervision, as presently I am in training. With this comes awareness of the supervisor’s role power, and my assumption that they are more powerful than me. In terms of cultural power, I am British, female, white, middle-class and heterosexual. I
have had male and female supervisors and some supervisors have been members of cultural minority groups. On reflection there have been multiple levels of power imbalances between me and previous supervisors. The time spent thinking about this essay has provided me with a forum to explore my own power within supervision and how I have experienced difference within supervision. I feel it is important to know your own role, cultural and individual power so that when you feel defensive you do not fall back on any prejudiced power resources.

I will now move on to discuss two supervision frameworks focusing on the issues introduced above. I will explain each framework whilst intertwining my reflections of my supervision experiences along side focusing on ethical issues and learning within the framework.

**Hawkins & Shohet's Seven-eyed Supervisor Model (2000)**

**Model content and reflections**

Hawkins and Shohet's model (2000) describes four elements within supervision: a supervisor, a supervisee (therapist), a client and a work context. Hawkins and Shohet describe the actual process of supervision as involving two interlocking systems: the therapy system and the supervision system, which can at times parallel each other. They go on to describe how the supervision system oversees the therapy system via two supervision styles: one through the supervisee and supervisor reflecting together on therapy sessions; and a second through how that therapy experience is reflected in the here and now experiences of the supervision process. These two styles contain three modes of supervision each that are categorised in Table 1, which also contains a separate seventh mode, which focuses on the wider context within which supervision occurs.
Table 1: Seven modes of supervision.

<table>
<thead>
<tr>
<th>Supervision style through reflection on therapy session</th>
<th>Supervision style though reflection on here and now experiences of the supervision process.</th>
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</thead>
<tbody>
<tr>
<td>Mode 1: Session content</td>
<td>Mode 4: Internal experience of supervisee</td>
</tr>
<tr>
<td>Mode 2: Supervisee's strategies and interventions</td>
<td>Mode 5: Supervisory relationship</td>
</tr>
<tr>
<td>Mode 3: Therapy process and relationship</td>
<td>Mode 6: Internal experience of supervisor</td>
</tr>
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<td>Mode 7: Wider context.</td>
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**Mode 1: Session content.**

This mode of supervision contains the 're-telling' of the therapy session to the supervisor, including discussions about what aspects of the therapy the supervisee felt unsure of. Hawkins and Shohet describe the importance of staying with the feelings of not knowing as is defends against premature theorising and interpreting. When I was at the beginning of my career as a supervisee, the fear that my supervisor would realise I did not know what had happened in the session was intense. I clearly remember sitting with a client, and feeling clueless about what I was possibly trying to assess and what my intervention was. Yet in supervision, I did not portray this or the feelings of helplessness and hopelessness I had. There is a desperate need to 'know' when you feel you are being 'overseen'. I feel this has blurred my ability to relay to previous supervisors what it was like to be in a room with a client. Through vulnerability and uncertainty one remains more open to learning and more able to consider a range of possibilities. Neufeldt, Karno & Nelson (1996) describe openness and vulnerability as two dimensions to a reflective stance (see Figure 1) where openness is an ability to be able to hold in mind a variety of interpretations and where vulnerability is the readiness to experiment with a new ideas. This therefore allows for the active experimentation (Mode 2), a component of Kolb's Experiential Learning Cycle (1984) which will be described below.

This mode also discusses the need to describe the client, which Hawkins and Shohet describe as requiring, 'the clear focus of a portrait painter' (p. 72). This analogy helps to highlight the individuality and therefore biases that come with describing a client,
as every portrait painter portrays their subject from a different perspective. This reminds me of a client I worked with, and had discussed with my supervisor several times before they saw them for the first time. When they did my supervisor was struck by how different their fantasy of the client had been. Somehow, the portrait I had painted had not only been affected by my perspective and portrayal but by the perspective my supervisor viewed it from. Hawkins & Shohet describe the metaphor of an ‘ideological editor’, where our beliefs and assumptions shape how we describe the client. I have rarely discussed with supervisors how my beliefs and assumptions shape my portrayal of a client or reflected on some of my own cultural assumptions within supervision, though the culture of a client has often been discussed. Our understanding of the client’s beliefs and cultural system may affect our interpretations of their behaviour in a session (Ryde, 2000). For example, minimal eye contact could be interpreted by the therapist as defensive, but could be a culturally specific behaviour (e.g. being disrespectful).

**Mode 2: Focusing on strategies and interventions**

This mode focuses on the strategies and interventions that were implemented, what they were and what could have been done differently to improve them. Yet again, this takes a deal of honesty from the supervisee. Nondisclosures are important to consider in this mode and how honest supervisees are to supervisors about any misguided interventions. Ladany, Hill, Corbett and Nutt (1996) report that in their study of supervisee nondisclosures that most supervisees (97.2%) do withhold information from their supervisors, which include clinical mistakes. One reason for nondisclosure is deference to the supervisor and suggests that power imbalances that are not addressed within supervision and poor supervisory relationships may contribute to nondisclosures. Ladany *et al.* suggest that this may be addressed by supervisor’s modelling disclosure in supervision, allowing supervisees to feel safe to disclose their own mistakes.

Planning of interventions can include generating ideas through brainstorming. I have experienced that this aspect takes creativity and confidence. One technique I have used with a supervisor that I found helpful was role-play where I ‘played’ the client.
This allowed me to change my role position and to use my knowledge and intuition about a client to predict how the client may react to an intervention. I felt that why this worked so well was because many of my responses were automatic and therefore relied on some unconscious knowing of the client.

This mode's reflection on past and future interventions and Mode 1's focus on the content of supervision can be conceptualised within the Kolb's Experiential Learning Cycle (1984), see Figure 3.

**Figure 3: Kolb's Experiential Learning Cycle (1984).**
Mode 3: Focusing on the therapy relationship

This mode focuses on the conscious and unconscious interaction between therapist and client. The task is to listen to the ‘unheard’ voice of the client, to bring them into the supervision room, and to make them heard. I have focused on this mode in particular when there have been engagement issues and even after a client has disengaged, it has been useful to explore the client’s feelings about the therapeutic relationship and what the client might have been communicating at the time that I might have been unable to hear. Within this mode it is important to consider the differences within the therapist (supervisee) and client and how these differences may be affecting the relationship and the delegation of power within the relationship. If the therapist is perceived as powerful by the client (whether through role, cultural or individual differences that are loaded in the therapist’s favour), then it may be difficult for the client to disclose any dissatisfaction with the relationship and to communicate honestly with the therapist. This can also work the other way, where the client is perceived as having more power. When I started training as a Clinical Psychologist and met my first client, who had panic disorder, I was struck by my own feelings of anxiety and how this client who was male, older and wearing a suit (fitting in to my cultural assumptions that middle aged businessmen are powerful) made me feel de-skilled and powerless.

Mode 4: Focusing on the supervisee’s process

This mode explores the supervisee’s internal processes and how they may be impacting on therapy. Whenever I think about countertransference issues I hear the argument for personal therapy. Is it unethical to work through issues of countertransference – to tease apart what is yours and what is theirs – when you haven’t thoroughly explored and identified your own personal conflicts? When I have explored my own feelings within supervision I have nearly always felt confused about what to disclose to a supervisor. Last year I felt intense irritation within the countertransference. At one point, I had a thought cross my mind within a session that this client made me want to poke my eyes out. I told my supervisor and it instigated a discussion about my difficulties bearing witness to the client’s social isolation and
about his need to test my commitment to him. Could I still stay in the room and empathise with him when I felt such irritation by him. I feel that without discussing this openly with my supervisor I would have been unable to have contained my own emotions and to have learnt what they may have been communicating to me about the client. The ability to focus on supervisee’s processes within supervision could also safeguard against the development of feelings that might make a supervisee vulnerable to developing a dual relationship or crossing boundaries with a client, and therefore might safeguard against unethical practice.

A supervisee’s cultural background might affect their ability to disclose information. Different cultures and different family backgrounds have different beliefs about disclosure of personal information. This is also important to consider with regards to the client. Whether our cultural beliefs affect our feelings for the client, and vice versa, is an important aspect to reflect on. How do our assumptions affect how we feel towards a client?

**Mode 5: Focusing on the supervisory relationship.**

This mode includes the impact of the client on the supervisory relationship and how the supervisory relationship may parallel the therapeutic relationship. I worked with a client with bulimia, who when she entered the session, made me feel like she was vomiting her emotions onto me. When I introduced the client’s background information to my supervisor and re-told the session, my supervisor commented on how he felt like I was purging the client’s story. This has made me think of what we can learn from how we narrate a client’s story but also how we can unconsciously transfer to our supervisor the impact of being with a client. How the supervisor responds in the supervisory relationship can model to the supervisee how to deal with conflict or other difficulties within the supervisory relationship, but also the therapeutic relationship. This modelling has been an important part of my learning experience.
Mode 6: Focusing on supervisor's own process

This mode focuses on how the supervisor is affected by the therapeutic work. With the example above my supervisor also felt like he had been purged onto. This mode connects the supervisor to the client and can provide an opportunity to think how a supervisor's beliefs and culture may impact on the work with the client. I have worked with few supervisors who have shared their emotional reaction to the client or to the supervision, and it is only more recent ones who have included this within my supervision. I am curious whether that was due to the psychodynamic leaning that those supervisors have, or because my development as a supervisee has resulted in supervisors later in my career feeling able to include this within supervision.

Mode 7: Focusing on the wider context.

In this mode there is a focus on wider contextual issues which includes the organisations where the therapy and supervision take place, and also the professional body that the supervisor and supervisee are members of. It is important to consider organisational policies and professional standards and how they impact on the therapeutic work and safeguard ethical practice. In my supervision the impact of the multi-disciplinary team I have been working with has often entered the supervision discussion, including how the client may be impacting on the team dynamic and vice versa. The culture of a team or an organisation can have powerful effects on the therapeutic work and on the supervision process, and can unconsciously affect how we conceptualise a client. In a culture where risk issues are paramount, such as a forensic unit, emotive language can often be used to describe a client and can infiltrate a supervisee's and supervisor's presumptions about a client.

Working within a team or organisation often complicates issues of confidentiality within therapy and within supervision. Who needs to know what? These are important issues that need honest discussions early on with the client, the supervisor and the team involved.
Stoltenberg and Delworth’s Integrated Developmental Model (1987)\(^3\).

This model is developmental in that it tries to describe the process that occurs for a novice supervisee to progress to a masterful one. I have found that this model does relate to my experiences of being on a journey and developing skills as a therapist and supervisee. Stoltenberg and Delworth also describe the model being an active-organism model where knowledge or reality is constructed by the individual and where the individual is viewed as emerging and moving towards a goal. I find it hopeful and achievable to have a goal to aim for, but in the era of CPD I believe that the goal is more an illusion that a reality and that the finishing line is continually at least one step ahead. Stoltenberg and Delworth describe the supervisee as developing in terms of three basic structures: self and other awareness, motivation and autonomy over four developmental stages (see Table 3). The progression of the supervisee occurs across eight domains relevant to professional development, and development of these domains can occur at different times, therefore a supervisee could be at stage three of development for one domain and stage one for another. Table 2 identifies the basic structures of development and the professional domains.

<table>
<thead>
<tr>
<th>Basic Structures in the Progression of a Supervisee</th>
<th>Domains to Professional Development of a Supervisee</th>
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</thead>
<tbody>
<tr>
<td>1. Self and other awareness</td>
<td>1. Intervention skills competence</td>
</tr>
<tr>
<td>2. Motivation</td>
<td>2. Assessment techniques</td>
</tr>
<tr>
<td>3. Autonomy</td>
<td>3. Interpersonal assessment</td>
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<td>4. Client conceptualisation</td>
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<td>5. Individual differences</td>
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<td>6. Theoretical orientation</td>
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<td></td>
<td>7. Treatment goals and plans</td>
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<td>8. Professional ethics</td>
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Table 2: Aspects of the Integrated Developmental Model.

\(^3\) Stoltenberg and Delworth have developed the model further since the 1987 version (Stoltenberg et al. 1998, cited in Fleming & Steen, 2004), though I will critically discuss my supervision experiences in relation to their 1987 version as there is more extensive reading around this earlier model which does not appear to significantly differ from the later model.
I find it hard to quickly relate my experiences of progressing as a supervisee in terms of these basic structures and find the domains more accessible in terms of monitoring my progress probably because they relate more to the core competencies that trainee clinical psychologists need to obtain.

Stoltenberg and Delworth described the development through the stages and report that this is done so through Piaget's (1970, cited in Stoltenberg & Delworth, 1987) constructs of assimilation and accommodation. These concepts on how we integrate new knowledge have helped me to conceptualise why some information is harder to learn that others, why at times I feel resistant to concepts and why it takes me a bit longer to adjust to new information. When changing supervisors I have at times found it especially difficult to add new constructs into my knowledge base that conflict with old ones, and at an emotional level it is hard to accommodate a new supervisor and what they have to offer, when attachments to previous supervisors are still strong. Stoltenberg and Delworth also report that supervisees can regress in the stages when faced with new tasks, which does reflect my experiences of working with a new client group where I felt that the level of development I had achieved suddenly receded and though I wasn’t back at square one it did make me feel de-skilled for a period.

| Stage 1: | Supervisee is dependent and self centred though has limited awareness of self and others. Motivation and anxiety are high with supervisee being self-conscious and anxious about being evaluated. Need a supervisor to be containing and provide structure. |
| Stage 2: | Supervisee fluctuates been dependency and autonomy, from being over-confident to over-whelmed. They are client-centred and are more identified with the client. They have acquired a certain level of skill across the domains but do not have the theoretical base to understand the process behind the skills. Supervisory relationship is more turbulent and motivation is challenged. |
| Stage 3: | Supervisee has conditional dependency on the supervisor depending on the situation – with clients in crises will become dependent – though their belief in their autonomy is not easily threatened. There is self and other awareness and the supervisee is able to focus on process issues. Supervisee is more aware of their strengths and weaknesses and has more stable motivation. |
| Stage 4 (Level 3 integrated): | Supervisee does not have further structural changes in this stage but there is integration across domains of their skills. They have autonomy and can consider process issues within a context. |
Table 3: The developmental stages.

Table 3 describes the characteristics of the developmental stages and I will now relate my experiences to the changes in the three basic structures.

Self and Other Awareness

I am able to recognise how these stages of development relate to my experiences, especially with the change of focus from self, to client, and then to process issues. The shift to being able to focus on process issues has felt like quite a sudden leap in development for me and one that has opened the doors to new areas of learning (the reflective stance aspect of Figure 1). I feel this is reflected in the type of literature that I have been reading and that has been recommended by supervisors. I do feel that as a supervisee my awareness of my self, the client and the interactions between us has been hugely dependent on the theoretical orientation of my supervisor and therefore has changed with different supervisors, rather than being solely related to my level of development.

Motivation

I have also experienced the fluctuations in motivation though not as described by this model. I believe that this model does exclude so many other factors that affect motivation apart from the development of the supervisee such as personal factors, the systems and organisations they are working in, the quality of the supervisory relationship and the therapeutic relationships with clients. My motivations have been severely battered when feeling stuck with particular clients, when my personal life has become more demanding, when I have worked in a very dysfunctional multi-disciplinary team and where my relationship with my supervisor was distant and superficial.
Autonomy

My dependence on my supervisor has also been affected by many other factors. Ironically, I have been more autonomous as an assistant psychologist than as a trainee psychologist and I think that this may be due to supervisors of trainee psychologists being monitored by the university. I reflect back on situations where I was more independent of my supervisor and wonder about the ethical issues of being too autonomous without being adequately contained by a supervisor.

Conclusion

Both models have enhanced my understanding of my experiences as a supervisee. Hawkins and Shohet's (2000) model has helped me to conceptualise some of the process issues involved in supervision and the Integrated Developmental Model (Stoltenberg & Delworth, 1987) has informed my understanding of the different aspects there are to supervisee development. My reflections appeared to relate more easily to a process model and have made me aware of areas I want to work on in future supervision, in particular identifying parallel process issues and exploring more honestly with my supervisor our relationship. Though both models have been informative they both had limitations, though when any generalised theory is related to individual experiences this must nearly always be the case.

This essay has also made me curious about supervision in the clinical psychology training courses and whether it would be useful for supervision to be more effectively evaluated through specific assessment tools as well as through self-reports. This may help with the quality control of supervisors and identify areas to work on for the supervisor and supervisee. It would also be beneficial if supervision contracts contained more process issues (such as the need to focus on difference and power within the supervision relationship), the supervision frameworks that would inform supervision, and a more explicit documentation of the developmental level of the supervisee at the beginning of the supervisory relationship.
Finally, I began this essay by stating that when first reading the Professional Issues essay titles I was left uninspired and now I end it informing the reader of the development I have made through researching and writing this essay which has left me curious about my future journey as a supervisee and inspired to discover more about the supervision process.
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Problem Based Learning Reflective Account 1

The Relationship to Change.

Year One
My reflective journal started after the first Problem Based Learning (PBL) group that I attended. The entry is short but full of feelings of anxiety and confusion, it included: “After the group I was left with feelings of panic and confusion and feeling that I should sit back and observe and learn more before I contribute”. These feelings of anxiety and uncertainty have diminished and I now feel ‘safe’ in the group. That is I feel I have a role and an identity in the group that is welcomed by others. The PBL exercise provided us individual group members with a reason to explore each others way of working and interacting. The presentation gave us a sense of camaraderie; our nerves, our excitement, our sense of achievement and relief were shared and consumed. For a short while, we understood each other’s experience of a moment – we understood a fraction of each other’s stories. There were other benefits from participating in the PBL exercise but I feel that the formation of the group, that will share further experiences over the next three years, will be the most beneficial.

In this reflection I am going to share my thoughts about ‘the relationship to change’ that have developed since the presentation because of my three months in placement. I will write down my thoughts in the chronological order that they developed, in order to give the reader a sense of my development over the last three months.

An area where I was not expecting such an obvious awareness of change and which as a PBL group we didn’t explore, was the change in role for the therapist between the assessment sessions and the first intervention session. I am aware that some approaches or therapists make less of a distinct differentiation between these two stages but as a new trainee with ‘concrete’ session plans I felt a sudden shift when working with a client between how they and I experienced my role in the different stages. Maybe this change in role between what I felt was as an active, reflective listener (in assessment) to someone who had a direction in the session and a model to socialise the client to, amongst other things, (in intervention) was particularly striking to me because of my change from being a trainee in induction who role plays, to a
trainee who is suddenly in a ‘live’ role with ‘live’ clients. The anxieties I was feeling with this change were similar to the anxieties and pressure I felt being suddenly in the room with a client where I had to ‘do’ something in the intervention stage rather than listen and understand in the assessment stage.

Over the last two months I have been working with a client with panic disorder. This work has led me to contemplate this client’s fear of change and what makes an individual feel safe enough to risk change? Whilst thinking this I am aware how in the PBL presentations there were a lot of discussion about motivation to change and the stages of change (Prochaska & DiClemente 1992). When thinking of helping a client move from one stage to another (e.g. contemplation to action) as a therapist am I thinking, “look things are obviously pretty crap for you now, anything has got to be better than this”? But through reflection I go beyond this thought and realise it is not about how bad things are for the client that is going to motivate their change, but what they will gain from risking change that will be important to them, that will motivate. Miller & Rollnick (2002, pp. 12) report:

Intrinsic motivation for change arises in an accepting, empowering atmosphere that makes it safe for the person to explore the possibly painful present in relation to what is wanted and valued.

I have found it helpful whilst working with clients to contemplate the benefits of change rather than the costs of not.

With the client with panic disorder he felt ‘stuck’ but at the same time feared change. He ultimately feared dying. It was interesting that in our PBL group we did not discuss ageing or death when discussing our relationship to change. In the past three months clients’ anxiety about their own or other’s death has been a salient factor in their presenting difficulties. Society pushes us to reject ageing, to feel ashamed of looking or being old, and to try any magic potion to stop the inevitable change happening. Death is hidden away. I have seen one dead body in my whole life. Doesn’t this societal approach to aging and death increase the fear of the unknown? Do my own anxieties about death and society’s stance make it harder to work with a
client about their own anxieties? I have included a picture of van Gogh’s Two Cut Sunflowers (1887), (Appendix 1) as these two pictures struck me as being a visualisation of death anxiety. That all things living, will age and wither and die is inevitable, this constant change towards an end is frightening and these dying sunflowers represent to me this anxiety. How to work with clients with this anxiety is challenging because it forces us to face some of our own existential fears. In our PBL group when discussing our relationship to change we discussed our changing roles in the Psychology profession, our experiences of change in the group, our expectation of change in a therapeutic setting but not our own life span development. When thinking of my relationship to change it is in a temporal context and therefore it is inevitable to discuss my own ageing.

This constant process of change is relevant in the therapeutic relationship and is what I have reflected on since starting my placement. Barry Mason (1993) talks about the benefits of being in a therapeutic relationship where there is constant change as this allows for continual exploration and curiosity. He discusses the dangers of being certain and being closed to change. I have found that this is reassuring as a first year trainee because I have experienced that each session with a client adds another aspect to the formulation and the initial desire to have a complete static formulation to work from is replaced by an appreciation of the changing formulation.

The constancy of change also affects individual’s narratives. How I interpret and relay a memory of when I first went to boarding school changes with whom I am talking to and with my development. The original event can never be truthfully replayed because through time my memory of the event has constantly evolved. This I have found important to consider in the therapeutic relationship because it encouraged me to look at how a narrative is told as much as what the narrative is about. In supervision, though the content of the client’s narrative is explored and valued, I have found that the most powerful discussions have been around the client’s way of telling their story. For example after two sessions with a client who suffers from bulimia nervosa and two supervision sessions it became noticeable that I was relaying the content of the client’s narrative as she did in the session to my supervisor. I was ‘purging’ the client’s story onto my supervisor and I was projecting onto him some of the feelings
she projected onto me. Reflecting on this in supervision was helpful in understanding how overwhelmed the client felt.

With memories constantly changing in meaning it makes the ‘live’ therapeutic relationship invaluable as a source of information about a client’s present conflicts. The changes in the therapeutic relationship are a means of accessing the changes that are being experienced by the client. This is one way of trying to evaluate how or if a client is changing but I have found it difficult in the last three months to measure such change. The changes in the therapeutic relationship, when reflected on in supervision have helped assess the client’s change but there is an anxiety in me to be able to know quantifiably what change has happened and when there is enough change. Somehow the measures that are used, (e.g. Beck’s Anxiety Inventory etc.) don’t seem to give justice to the changes that are happening for the client. When we are talking about changes in the client, are we talking about cognitive, emotional, physical, behavioural changes? A combination of all or some of these? I feel that there are changes taking place that are incredibly difficult to verbalise let alone report on in a letter to the client’s referrer. It is like van Gogh’s cut sunflowers, they represent something to me that I find hard to verbalise, though I tried in order to communicate to you (the reader) what they mean. To you they will probably not symbolise or provoke the same feelings that they did to me. Even the feelings and thoughts they provoked in me as a teenager are different from the ones they provoked now at this stage in my life. So not only is the experience of change different from one individual to the next, but also from one time period to the next. How can I, as a therapist report on and measure a client’s change, and recognise when there has been enough change? Can a client recognise their own changes, when they feel they have changed enough?

This anxiety about measuring change is also present in my own changing process as a trainee and has been discussed as a PBL group. I feel that we are all noticing the changes in each other, as we do with clients, but because the changes are not happening in units but on a continuum, the change is harder to monitor. As a trainee, can I recognise my own development? One of the advantages of the PBL process was that it gives us a benchmark of where we started. The PBL groups provide us with a forum to notice others’ change and to have reflected back to us our own. The
reflective journals also provide us with a way of being able to see our own change. I am amazed by my changing views on the reflective journal. Its use to me has changed significantly in the last few months. I feel that the PBL exercise has provided me with the opportunity to reflect and to explore why there is a need to reflect and what the benefits of reflections could be.

It is my reflections on reflections that I would like to conclude with as I feel that my changing thoughts on reflective practice has been a helpful part of the PBL exercise. I am not stable. I am constantly receiving information, processing it and ejecting it. I am in a constant state of flux, and thus who I am from one moment (though essentially may be the same) is different from another moment. In order to understand how I am changing and how these changes effect me as a professional I need space to recognise the changes and the impact they have. Before this exercise the importance of understanding the need to reflect was not evident to me in such a 'real' way as it is now. Last night on the train home from placement, I wrote in my reflective journal. I began by writing about the group I am presently facilitating, it then developed into a discussion of the feelings I experienced in the group and an exploration as to why I am having these feelings. The time writing my reflective journal provided me with the space to detangle the emotions, to explore possible reasons for them and ultimately to explore the clients experiences. That is a significant change from my earlier entries and I feel pleased that I am able to recognise that change and appreciate it.
References


Appendix 1

'Two Cut Sunflowers'
Vincent van Gogh
Paris, August-September 1887
Oil on canvas, 43.2 x 61 cm
Problem Based Learning Reflective Account 2

Child Protection, Domestic Violence, Parenting, and Learning Disabilities

Year Two
Beginning to Confront Initial Anxieties.

I am presently on placement in a Community Team for People with Learning Disabilities. Previous to this I have had no professional experience of people with learning disabilities and minimal personal experience. My only personal experience is a memory of a boy I knew when I was a child. His mother played tennis with mine and in the school holidays we sometimes played together. He was described by my mother’s friends, in lowered voices, as being “difficult” and “slow”, and his mother was always discussed in sympathetic terms. It is only in the past few months when reflecting on my personal experience of people with learning disabilities that I asked my mother about him, and she told me he had learning disabilities and is still living at home with his mother causing “trouble”. What stands out in my memories of playing with him was being scared of him because I did not know how to be with him. I believe that some of this fear has stayed with me and that with the PBL task and the beginning of my learning disability placement this fear re-surfaced. In this reflective account I want to address some of mine and the group’s anxieties about the PBL task and how this was managed; the changes in my anxieties since working with people with learning disabilities; and my present thoughts on the task.

The task and the anxieties it caused.

The task was essentially to explore the risks to three-year-old female twins who were presently in short term foster care if they returned home to their natural parents. Our conclusions were presented to fellow trainees, facilitators, supervisors and course team members. The twins’ parents, Mr & Mrs Stride were described as living in conditions of deep poverty, with Mrs Stride reported to have mild learning disabilities and Mr Stride described as having attended a special needs school, and with a history of Mr Stride physically assaulting Mrs Stride during disagreements which the twins have witnessed. Mr Stride’s parents are supportive, though Mrs Stride has no contact with her parents. Mrs Stride has two older children who are living with adoptive families. Social Services are concerned about physical neglect of the children’s needs and it is reported that there have been many attempts to try and support the Stride family. It is noted that Mr and Mrs Stride feel desperate about the situation and want
their children home with them. As a psychologist we have been asked to conduct a risk assessment by the children's Guardian.

This PBL task was given to us before we had started our placement with people with learning disabilities or with children and families, and it triggered many thoughts - "Was this an indication of what was ahead?", "Would we have to conduct assessments that would decide the risk to children of staying with their parents?", "Would I have to get involved in something like this?", "I know nothing about people with learning disabilities, I know nothing about children, and I am beginning to feel I know nothing about psychology", "Not only does this task make me feel powerless and stupid but it has been forced on us at a time when we have research proposals to submit, when a new placement is beginning and when quite frankly I do not have time to think about this pointless PBL task". These were not just my thoughts but thoughts that were voiced in the group. How as a group could we contain our anxieties and dispel our fears? Well, initially we avoided work on the task, termed by Bion (1961) as basic assumption mentality. We had a basic assumption of fight-flight (Bion, 1961) that is we attacked the perceived enemy, which was the course team, for demanding this task of us. We spent a significant amount of the earlier sessions protesting about the unfairness of it all. This protest helped us to avoid the painful reality of working with the Strides and with exploring our fears about our future placement and future clients we would have to work with. We avoided the emotional content of the task and I feel that this was reflected in our presentation, that role-played a formal court procedure and that involved us as group members presenting individually. It was a very fragmented presentation for a cohesive group such as ours. Once in one of the group sessions a group member voiced how the task was making her feel anxious and distressed about what it would be like to have her child removed from her care. As a group, we ignored this. We muttered polite responses and moved on. We are not usually like this as a group. We are well established and typically sensitive and responsive, but this time we swept her emotions under the carpet. Upon reflection I feel we did her a disservice to protect ourselves from recognising our own anxieties about working with the Strides.
Our presentation was well received, though I feel it was a superficial academic presentation to a situation, which we felt unable to fully explore. Would the group's response to the task be mirrored in a 'real' situation? Do we use defences to avoid addressing our own anxieties when working with clients in painful situations? If so how does that affect our practice?

*My thoughts since having worked with people with learning disabilities.*

What struck me about working with people with learning disabilities is how provocative it has been. To be honest, my assumption was that people with learning disabilities would be more 'different' from me than 'similar', and that somehow this difference would provoke less of a countertransference reaction, than maybe working with other client groups. The assumption being that difference would provide a safety barrier and protect me from some of the emotional aspects of working with people with learning disabilities. This is not what I have experienced. Loss and resilience have been central themes throughout my placement. These themes have struck at core feelings within me. The fear of loss, abandonment and separation and an overwhelming existential fear, I believe are dominant in the human psyche and these fears are continually being defended against. Working with people, whose very existence can be challenged before birth and whose worth is portrayed as being less than others (e.g. in the media recently it was reported that a mother killed her severely disabled son, was found guilty of manslaughter but received no custodial sentence, which was condoned because of the sympathies towards the mother – but does this also portray a message that this man’s life was somehow of less worth?) has provoked questions within me of my own worth and meaning, my judgements of how I value others and my own existential fears. Yalom (1980) identified four existential ultimate concerns – death, freedom, isolation and meaninglessness. These four concerns are consistently brought to the foreground when working with people with learning disability and are therefore harder to defend against within ourselves.

These reflections have made me consider the relevance of these issues to the Strides and whether their case history began to provoke feelings within the group that we were not ready or able to fully consider.
Present thoughts on the task

When I re-visited the Strides I was aware that the aspect of learning disabilities seemed less prominent than when I initially addressed the task. For one, I am much more aware how vague the term is. What does it mean that Mrs Stride has been ‘described’ as having ‘mild’ learning disabilities, and can we make any assumptions about Mr. Stride because he attended a school for children with special educational needs? These terms seem to have become more meaningless to me, and I believe that it is because I am now more aware how the ‘diagnosis’ of learning disabilities is only a small proportion of who people with learning disabilities are. It actually tells me very little about an individual’s difficulties and even less about whom they are as individuals, let alone how they are as parents.

The ripple affect of having learning disabilities seems to play a greater importance in the risk issues surrounding the Strides being parents, than the fact that they have learning disabilities (though it is unclear whether Mr Stride does). These ripple affects, include issues such as; the impact of Mrs Stride having learning disabilities on her own parents attachment to her; her experience of being raised in the Looked After Children system on her model of parenting; the potential economic consequences of having learning disabilities; the potential of a reduced support system to help them care for children; and the increased vulnerability of being in abusive relationships. These ripples could be present in people without learning disabilities as well and I believe that these consequences are not inevitable and that there is the possibility of having a system that works towards reducing the negative impact of having learning disabilities.

Conclusion

As a group we concluded in our presentation that the twins should not return to the care of their parents but be placed for adoption. This decision was made because it was felt that there were not adequate resources available to give Mr and Mrs Stride the long-term support that they need to reduce the potential risks to the children, such as neglect and abuse. I have continually questioned whether this is still my view and
whether at some level I am colluding with the prejudices against the Stride family by allowing lack of resources to be a reason to expose another generation to the rippling social affects of learning disabilities that are not inevitable. At the same time I fear that the ‘reality’ of the current service provision for Mr. and Mrs Stride is not adequate to protect the children from the risks, so presently there needs to be unnecessary removal of children to protect them. This is a frustrating situation to be in, and a potentially harmful one for the professional as well as the client, ‘A sense of responsibility without adequate authority and power to achieve outcomes often leads to work-related stress and eventually burn-out’ (Obholzer, 1994, p.43).

After word

This reflective account has been deeply difficult to write because I am presently experiencing a loss. I have been in a dilemma about at what level I should convey this to the reader and at what level this personal experience has impacted on my ability to write this account. On reflection I feel it highlights the complexities that surround the relationship between our personal and professional identities. It also makes me consider the need for reflection to have a relationship with action and not to be purely a tokenistic endeavour. By this I mean, through reflection I have noticed how my present feelings of loss may make me particularly sensitive to the theme of loss in the Strides, then maybe if I was the psychologist asked to write a risk assessment for the Court then I would need to consider my professional competence at the moment to do this. Reflection needs to inform practice and to help health professionals’ contain the emotional consequences that are often involved with working with individuals that are often in pain. There is such a temptation to avoid ‘admitting’ to these emotional consequences, to the potential fears and anxieties surrounding working with the Strides, but it is vital that we should reflect on such feelings because our defences are often likely to impact on our client work. These defences can include, ‘depersonalising relations with patients by treating them as objects ... [and] avoiding seeing common elements between themselves [staff] and the patients’ (Roberts, 1994, p. 79). Writing reflective accounts helps to provide health professionals with alternative structures to contain our anxieties and is thus vital to competent and empathic practice.
References


Problem Based Learning Reflective Account 3

Working with older people.

Year Three
Maintaining hope and adapting to change.

We have completed our last Problem Based Learning (PBL) presentation and are now just left with this, our reflective account about the experience. As I reflect on the case of Mr. Khan and his family (see appendix 1), I am reminded of many clients from my older people placement and the common threads to their experiences. I am then left with what the first PBL started, the relationship to change, and what I have come to realise is the importance of maintaining hope with the patient (I deliberately use the word ‘patient’ to highlight the origins of the word as coming from the Latin *pati* ‘to suffer’ and to recognise the pain felt by the patient). When I talk of hope I do not mean the hope that the difficulties experienced will not be dementia, or hope that a cure will be found, or that somehow it will all go away; but the hope that with the building of a empathic, curious and honest therapeutic relationship there will be the chance that the individual will be able to tolerate the anxiety of change (whether that be conscious or unconscious) and will consequently be able to adapt.

**Maintaining hope**

Since doing the PBL task I have been on placement working with older people. The experiences of Mr. Khan and his family are not unique. The older people I have worked with have had to deal with grief, family disharmony, changes in functioning, and the question of who is going to be there for them. In addition, cultural aspects that were present with Mr. Khan have been reflected in most of the clients I have seen. For example, where someone who was born in the 1930s is adapting to a different culture in the 2000s, with children who are behaving in ways that are different from what they understand, and where they have to adjust to societal changes or live in a culture different from the one they originated.

On occasion in therapy sessions with older people, I have been overcome with feelings of inevitability and hopelessness, which at times has led me to feebly reassure or suggest superficial practical suggestions to clients in a way that is contrary to my usual therapeutic style. In the session, there seems an almost noticeable embarrassment between the client and me and I sense that they feel a need to play
along with me and murmur polite niceties about the helpfulness of my reassurance or suggestion, whilst we both recognise the game we are both playing. I have reflected upon these feelings and in doing so have come back to Casement's (1985) description of "unconscious hope". In this, he describes the importance of being able to 'just' tolerate the clients' despair, and in so doing provide the client with an unconscious sense of hope. So in sessions with clients, I sit and I listen and I recognise the pain they feel, and I don't flee in fear towards reassurance mode but 'just' tolerate that pain. In this small action I feel I allow space for an honest and hopeful exchange where implicitly I am letting the client know that I recognise the pain for what it is, I do not minimise or dismiss it, and I can stay with it without it destroying me, therefore giving them hope that they will be able tolerate it too.

The ability to work with individuals who are coping with intra-psychic or interpersonal changes, who may be in a position where they feel hopeless, relies not just on the Clinical Psychologist theoretical knowledge but also on the Clinical Psychologist as a person. Almond (2003) argues that theory is only one factor that the therapist uses to inform technique and that there are many other factors that the therapist uses to understand, formulate and act, such as personal interpretation of received theory, personal motivations and so on.

The holding function of theory

Almond (2003) also discusses the role of theory in containing the therapist. Indeed theory provides sense making, guidance, and support. In our group's PBL presentation we focused on the literature, in understanding information about what services would be available in Pakistan and in the UK, and other groups' presentations did appear heavily influenced by ideas of differential diagnoses and assessment. Indeed, I have noticed that in older people services there appears to be a heavy medical model influence and a focus on diagnoses and subsequent management or treatment. I wonder if this, in part, helps to contain professionals, clients, and relatives' anxieties about age, loss, and death. Whether there is a need to have definite diagnoses, in firm treatment guidelines, in order to provide sense making, guidance, and support. This may be especially the case with older people as it is an area in mental health where
you know, due to your inevitably ageing, you may have to face some of the challenges your client faces (if you live long enough). Do we all at some level look upon Mr. Khan’s case and wonder if this is what is ahead for us, a debate about whether we are depressed or suffering from dementia? Is it naïve to think we can work with individuals who are in situations where they need help and not be aware of our own vulnerabilities? In order for our own anxieties not to impact on our work with the client and for us to remain hopeful with our clients we have to be able to reflect on these anxieties and to contain them, whether that be in supervision, with the help of theory or in personal therapy.

Adapting to change

The first PBL task we had to complete was on the ‘relationship to change’. In my PBL reflective account, I discuss individuals’ fear of change and particularly fear of ageing and death. Yet again, I am brought back to how individuals, such as Mr. Khan, adapt to change. Mr. Khan, a Muslim originally from Pakistan, disowned his daughter for marrying a European. His wife died nine months ago and it has recently been reported he is having difficulties with his short-term memory and with caring for himself. While these are just snippets of information about Mr. Khan that highlight some of the changes in Mr. Khan’s life, as with other older people I am currently working with, individuals’ ability to manage such changes seem fundamentally linked to their psychological well-being.

In working therapeutically with clients, I often feel there is an emphasis to move the client forward, to see some evidence of internal change, and an organisational and individual frustration when progress seems limited or indeed non-existent. When asked recently by my supervisor, what my anxiety was with a particular client, I responded that I was anxious that therapy would not be effective, and at times with that client, I have felt myself almost pushing ideas on to them. At these times I have reflected on David Mearns’ (1994) discussion about self-concept change in the client and the risk of the therapist forsaking a person-centred framework in order to ‘move the client on’ by any means, when they are faced by periods of ‘stuckness’ or even regression in the therapy. If in sessions, I as the therapist, become too directive in a
‘desperate need’ to be effective, I try to recognise that I am trying to take control of the client’s internal change, and potentially enhancing their sense of loss of control over external events and feelings of helplessness.

A new type of ending

On my older adult placement, a client who had begun to attend a group I facilitated died due to physical health problems. This is the first time since I began training that a client of mine had died, and this has made me think of a different type of ending with a client, one that is not therapist or client initiated. I felt left with a sense of powerlessness and confusion. I felt stupefied, left with no real understanding of what it meant for this client to die, or almost an unfairness that we had been interrupted working together on something. Endings are caused by many different reasons and lead to different reactions. Working with older people has led me to face a new type of ending and one that draws on my own personal beliefs about death, integrating the professional and personal once again.

In our PBL exercise, we explored Islamic beliefs about deaths and the mourning process, but interestingly we did not share our own beliefs and how this influences our work with clients who are facing bereavement or their own death. Peter Speck (1994) discusses working with dying people and that professionals can use the work-role to maintain an unconscious fantasy that death happens only to clients. Maybe our reluctance to discuss our own belief system served to prevent us identifying with Mr. Khan. Furthermore, on placement with older people the need to maintain a professional identity may serve to protect us from identifying with the client and having to face our own anxieties about past and future losses, to a greater degree than other placements.

The group processes

This PBL task I feel was probably the least impacting, both emotionally and practically, on the group. I feel we approached this task in a systematic way and in a manner to complete what we needed to do as quickly and efficiently as possible. This is probably
partly due to other demands placed on us, reflecting the need to prioritise work demands as a Clinical Psychologist working in the NHS would need to do so. I feel as a group we were able to do this task effectively because we could rely on each other to fulfil their obligation and to do what needed to be done. One of the comments about our presentation was that it did not appear that there was equal participation amongst members. Interestingly, I feel it is our growth as a group that allowed that to happen. ‘Behind the scenes’ we were all contributing and feeding the information to those that were presenting the information. This reminds me of multi-disciplinary teams (MDT) where in a case review which is usually chaired by the psychiatrist (especially it appears in older people services), it may appear to the client and their family that the power and the knowledge rests with that chairperson, when in reality many members of the MDT have provided that person with the information.

As a group we also did not explore what it meant for this to be our last PBL task, maybe because we were swept up in the need to complete the task rather than the process of completion. The ending of our group I feel needs to be explored as we approach the final months of training and what it might mean to form new groups, maybe with other members from different professional roles. It may be beneficial for us to think of how we can take this learning approach forward with us, and how we may want to adapt the problem-based learning method to fit into a new organisation with new members.

Concluding remarks.

I have wanted this reflective account to not only include reflections about the PBL process but also to provide you, the reader, with more of a sense of me, as a Clinical Psychologist. As I am (too quickly) approaching the end of training, who I am as a Clinical Psychologist, including my individual style of being with a client is clearer to me. With this said, I feel I am on the beginning of a journey where I understand where my starting point is and am hopeful about my ability to adapt to the changes ahead, as I grow older in professional role, whether those be more on a macro level (such as the difficulties in the current NHS climate) or a micro level (e.g. a moment of emotional connection with a client that causes change in me).
REFERENCES.


APPENDIX 1

Title: Working with Older People

Problem Based Learning Exercise

The Problem

Mr. Khan's youngest daughter, Maya has contacted Social Services about her father's health. She is concerned about her father who has been suffering from short-term memory problems. He has been leaving the kettle on and saucepans on the stove to boil dry. He has been neglecting himself and his physical health is deteriorating. He has lost some weight and he has been eating out-of-date food.

Maya, the youngest daughter is urging Social Services to do something and also asking her older sister, Shazia to return from Pakistan to help sort out a solution for their father's care.

Some Background Information

Mr. Khan is 72 years old. He migrated to the UK from Pakistan in his mid 30's. He is a retired bus driver. He learned English after coming to the UK.

His wife died of cancer 9 months ago. Mrs Khan did not speak English and spoke only Urdu. She was primarily a home maker, working occasionally as a private dress maker.

Mr & Mrs. Khan have 2 daughters Shazia and Maya. Both daughters were born in the UK and have had English education. The eldest daughter, Shazia had an arranged marriage in Pakistan where she lives with her family. Her husband is a shop-keeper. They have 3 children. Shazia's eldest son Imran is currently contemplating coming to the UK to University.

Maya, the younger daughter married a European and was disowned by the family. She had no contact with her father till her mother passed away 9 months ago. Maya and her husband have no children. She is University educated. She and her husband are both journalists and fairly mobile, travelling 3-4 days a week throughout Europe and sometimes at short notice.

Mr and Mrs Khan were both religious and had links with the Muslim community. However, Mr Khan fell out with the mosque about they way they responded to his wife's death. He has stopped going to the local Mosque but continues to pray at home.

Prompt Questions

...something about who speaks English, who speaks Urdu and who speaks both?
...something about the rift with the community in the Mosque and the potential for mediation?
...something about understanding religious faith and appropriate culturally sensitive solutions?
...something about grief and mourning – individual, family and community based?
...something about impact of migration and loyalties to country of origin and host country?
...something about the possibility of going back to country of origin?
...something about appropriate residential care and relationships with staff and other residents?
...something about assessments, short term memory, self-care and differential diagnosis?
...something about assessing risk to self?
...something about relationship with social services and other professional systems?
...something about the role of the Psychologist, MDT, etc?

Date: 16th May 2006
SUMMARY OF CASE DISCUSSION GROUP PROCESS ACCOUNT (1)

This process account examined the purpose of the case discussion group. In particular, the role of reflection in a group format was explored with thoughts that the space to reflect on our practice and to hear others’ reflections on their practice, aided the development of our ‘internal supervisor’ (Casement, 1985). The work of Bion (1961) in the examination of the purpose of the group was explored. With development of the group, I felt its purpose changed, becoming more creative with increased safety. However, it seemed there was also a healthy sense of ‘paranoia’ in the group, which provided an awareness of self and group monitoring of practice.

This account also explored what affected the group and the effects it had. Included in these reflections was the diversity of the group members and our facilitator’s reminders to attend to the “unheard voices”. Through bringing our clients into the group discussion, we added to the diversity of the group, with clients becoming ‘members’ of the group at times. The impact on the group of the Course Team and the society we are embedded in was also discussed. The group’s ability to influence was reflected upon, including its effect on us as practitioners, our clients, and our supervisors.

My experiences of the group was also focused on in this account. I have found it difficult, at times, in the group to listen. I have also been curious how other members of the group views of me may have changed over time. Finally, in this account I discuss the future of the group in relation to our ability to feel secure ending this group with our current facilitator and welcoming further development.

References


SUMMARY OF CASE DISCUSSION GROUP PROCESS ACCOUNT (2)

This account focused on how we coped with some of the changes that occurred. On a group level, our ability to absorb a new member and to lose members without fear of losing 'group character' (Bion, 1961) was reflected on.

Other changes to the group included that this year the clients felt less dominant in the group, with more focus on how we were managing both professionally and personally, and a greater need for emotional support. This year's group also felt less 'playful', explorative and creative and with this, I felt that group morale was challenged. However, this demoralisation did not spiral out of control (into a 'demoralisation trap', Hinshelwood, 1997) which was felt to be due to our belief in the group's effectiveness.

There felt a greater need for the group to contain us this year. In my mind, the group's ability to receive a member's anxieties, to hold and reflect on them without instantaneously acting on them, has provided members with an opportunity to learn and to grow. The group's ability to contain has been vital, as without it the group would have become fragmented and fractured.

My individual experiences in the group were also reflected on and my increased security within the group. The account ended with thoughts about the future of the group. The most fundamental change ahead that was discussed was the termination of the group. My account concluded with the hope that each of us will be able to 'surrender our need for the analyst [group] to act as a container' (Bateman & Holmes, 1995, p. 179) and that we can internalise the containing and reflective function of the group, so that we will move forward with all we have learnt.

References


OVERVIEW OF THE CLINICAL DOSSIER

This dossier consists of summaries of each of the five placements completed during the three years of training. It also includes summaries of the five case reports, which are contained in full in the confidential Volume II of the portfolio. The case reports were written during the three years of training: two were written on the yearlong Adult Mental Health placement and one from the People with Learning Disabilities, Child and Family, and Older People placements. These documents represent the psychological assessments and interventions undertaken on these placements and are presented in the order the placements were undertaken.
SUMMARY OF PLACEMENT EXPERIENCE

Adult Mental Health Placement

Dates: November 2004 to September 2005
Setting: Psychological Therapies Service, Community Mental Health Team (CMHT), Day Hospital.

Summary of experience:
Experience was gained in a variety of settings on this placement. Individual assessment and therapy was predominantly done in the Psychological Therapies Service; group work at the Day Hospital; and joint working and attendance of team meetings at the CMHT. Individual work was approached mainly from an integrative theoretical stance, with emphasis on cognitive-behavioural therapy and an exploration of relevant psychodynamic processes in supervision. As well as individual work, I co-facilitated a ‘Managing Your Mood Group’ with a Community Psychiatric Nurse. The evaluation of the outcome of this group was presented to the Day Hospital’s multi-disciplinary team (MDT). Other experiences included conducting joint assessments in the community with a social worker; observing a staff support group facilitated by my supervisor on an inpatient ward and conducting individual therapy with a patient on a continuing care ward in the community. Clients I worked with ranged in age from 19 to 54 years, and presented with various psychological difficulties including: OCD, depression, hearing voices, PTSD, paranoia, panic disorder and life adjustment issues as a consequence of having multiple sclerosis. A range of neuropsychological and psychometric assessments were undertaken, with reports written and feedback disseminated to the client and the necessary professionals. During this placement a service-related research project investigating referrers’ perceptions of Clinical Psychologists was undertaken.

Learning Disabilities Placement:

Dates: October 2005 to March 2006
Setting: Community Team for Adults with Learning Disabilities

Summary of experience:
This placement provided experience of working with adults with learning disabilities, their families and staff groups in Day Hospitals, outpatients, and in residential homes. Individual therapy was undertaken using cognitive-behaviour therapy and brief
psychodynamic therapy. Assessment and intervention was undertaken with clients with autistic spectrum disorders, dementia, Down's syndrome, and cerebral palsy who displayed a range of psychological difficulties including 'challenging behaviour', depression, self-harm and bereavement issues. Experience was also gained of working with clients from diverse ethnic, cultural and religious backgrounds (including working with an interpreter). Detailed assessments were undertaken on this placement including the use of neuropsychological assessments and functional analysis of behaviour. This placement also provided the opportunity to attend weekly psychotherapy supervision groups, where I presented two clinical cases to the group.

Children and Family Placement:
Dates: April 2006 to September 2006
Setting: Child and Adolescent Mental Health Services (CAMHS)
Summary of experience:
This placement provided the opportunity to work using cognitive-behavioural, behavioural and systemic therapy with children and their families. Assessment and intervention was undertaken with a range of children, from 4 to 14 years old, from diverse ethnic and religious backgrounds, and who presented with a range of behavioural, emotional and learning difficulties (including self-harm, dog phobia, needle phobia and depression). Several neuropsychological assessments were undertaken including a detailed cognitive, personal and social assessment of a 10 year old girl with Foetal Sodium Valproate Syndrome who was also a Fragile X carrier. Functional analyses were undertaken at schools, and findings presented in school meetings. There was also opportunity to observe members of the MDT, including observing family therapy sessions, deliberate self-harm assessment on a medical inpatient ward, and undertaking joint assessments. A re-referral audit was also undertaken on this placement and the findings presented to the MDT.

Older People Placement:
Dates: October 2006 to September 2007 (split year long)
Setting: Community Mental Health Team for Older People
Summary of experience:
This placement has provided me with the opportunity of working with older people in various settings including: inpatient wards, clients' homes, outpatient settings and
residential homes. I have undertaken individual and group therapy (‘Dementia Support Group’ co-facilitated with an Occupational Therapist and a ‘Therapeutic Support Group’ co-facilitated with the Lead Clinical Psychologist) with clients ranging in age and psychological difficulties (including depression, persecutory thinking, and anxiety). Assessments and interventions have mainly been approached using an integrative framework, encompassing cognitive-behavioural, systemic and psychodynamic theories. Several neuropsychological assessments have been undertaken with a wide range of assessment tools (e.g. CAMCOG, WAIS-III, WMS-III, BADS etc.), with reports written and feedback given to referrers and clients. MDT meetings have been attended and a talk on ‘The emotional impact of working with older people’ presented to the team.

**Specialist Psychotherapy Placement:**

**Dates:** October 2006 to September 2007 (split yearlong)

**Setting:** Psychotherapy Department

**Summary of experience:**

This placement has provided an in-depth opportunity to experience working solely within a psychodynamic model. Long-term individual therapy (year long) has been undertaken with a female patient presenting with depression. This therapy has increased from once weekly to twice weekly providing an opportunity for myself and the client to experience the process of more intensive therapy. Shorter-term therapy has also been undertaken with other patients. Experience of attending group supervision of the Intensive Outreach Project (which includes individual, group and psychodrama therapy), has provided the opportunity to engage in detailed psychodynamic formulations of patients with more severe psychological difficulties. Psychodynamic assessments undertaken by psychotherapists have also been regularly observed.
COGNITIVE-BEHAVIOURAL THERAPY WITH A 38-YEAR-OLD MAN PRESENTING WITH PANIC DISORDER AND AGORAPHOBIA

Referral

Mr. Tim Smith, a 38-year-old white Scottish male, was referred to the Psychology Service by his General Practitioner (GP) who reported that he had been having panic attacks for the last couple of years.

Presenting Problem

Tim reported that he had been experiencing feelings of panic when going on busy trains and general feelings of anxiety surrounding his overall health. He reported that these problems started about two years ago. Tim stated that he coped with the feelings of panic by avoiding situations, such as going on trains and tubes.

Assessment and Background Information

Two face-to-face clinical assessments were conducted with Tim, which were structured around a cognitive-behavioural assessment format. Assessment information was also gained from the Psychology Service's Information Questionnaire and from the Clinical Outcome in Routine Evaluation (CORE) Outcome Measure.

In the assessment, Tim reported that his father was an alcoholic and his mother has always being anxious and unwell and was diagnosed with Parkinson’s Disease about ten years ago. Tim reported that he fears taking lots of pills like his mother and that he used to be worried that he would think himself into an illness.

Tim reported that he and his partner of four years, Sue, have not had an active sexual life for about two years and that this is mainly due to his lack of sexual interest in her.
Tim reported that his first panic attack occurred about two years ago when he was on a tube in London. He described that he continued having panic attacks and that he developed thoughts that something was physically wrong with him, which made him feel generally anxious about his health. He also began to avoid situations where he thought he would have a panic attack (including trains, lifts and any space where he feels trapped). Tim’s goal of therapy was to be able to use the train and tubes again.

There was no history of risk in Tim’s background and in the assessment sessions there was no indication of any risk issues.

**Formulation**

It appears that after Tim’s initial panic attack he became anxious about having another attack and therefore restricted his lifestyle to minimise the risk. His avoidance of situations and his continual worry about having another attack seemed to result in his fears being maintained, with increased vigilance to his physical symptoms and increased general anxiety levels. Tim’s panic attacks could be conceptualised using Clark’s (1986) (cited in Wells, 1997) vicious cycle model, which includes maintenance factors and highlights the role of catastrophic misinterpretations of physical or cognitive symptoms in feeding into the anxiety levels which ultimately reach a level where a panic attack is experienced.

The trigger to Tim’s panic attacks appears to be his attention to his somatic sensations. Tim may have learnt to be more alert to his somatic sensations than other people due to his mother’s perpetual health problems throughout his life and in particular early fears of ‘thinking yourself ill’. These experiences may have resulted in Tim becoming hyper-vigilant to his physical health and being pre-disposed to being anxious about unexplained physical symptoms such as those he experienced in his first panic attack.

Tim’s difficulties with his sexual relationship with Sue could be a precipitating factor to his panic attacks, as this increased tension could have resulted in Tim experiencing higher than normal levels of anxiety.
Tim’s goal of therapy, to be able to go on train and tubes, was specific, as was his wish to have a brief intervention. It was decided that due to the discrete presentation of his difficulties six sessions of cognitive-behavioural therapy (CBT) would be offered with a review to assess whether more sessions were needed.

**Intervention**

Intervention was informed by Wells’ (1997) comprehensive account of CBT for Panic Disorder and Clark *et al.’s* (1989) Oxford-based Cognitive Therapy Package. This has been evaluated as a highly effective treatment for panic disorder (see Clark, 1996 for a review).

Two assessment and six intervention sessions were completed within a CBT framework. Therapy focused on socialising Tim to Clark’s model of panic, on normalising anxiety and identifying Tim’s misinterpretations of bodily sensations whilst experiencing anxiety. Tim was asked to complete a hierarchy that rated situations in order of how anxiety-provoking he believed them to be and homework then consisted of testing out these situations, starting at the least anxiety-provoking. The role of avoidance, safety behaviours, and anticipatory anxiety were also explored.

In the sessions, Tim also discussed his relationship with Sue his partner and his parents; in particular his anger and frustrations at his current situation and his difficulties in expressing his emotions to Sue.

In further sessions a more in-depth formulation of the predisposing and precipitating factors to Tim’s development of panic attacks was explored in particular his current relationship situations and his earlier experiences with his mother and father.

**Outcome**

Tim completed therapy with a reduced CORE score, (with a lower score in the “Problems” dimension) with it moving to a score that is representative of the general
population. Tim also reported in the final session that he was able to go on trains and that he was planning a trip to London where he was intending to travel on the tube.

Tim finished CBT reporting his symptoms had improved with a psychological understanding of his difficulties.

**Critical Evaluation:**

On reflection, I feel that it would have been beneficial to have used a specific measure of panic to monitor Tim’s progress. Wells (1997) also suggests follow-up sessions as part of the relapse prevention strategy, which could have been helpful with Tim.

I feel the main success of the therapeutic work with Tim was in providing him with a space where he felt listened to, thus enabling him to enter into a collaborative relationship. This, I feel, allowed him to explore a conceptualisation of his psychological difficulties and be supported to challenge some of his beliefs.

**References**


ADULT MENTAL HEALTH CASE REPORT 2 SUMMARY

COGNITIVE-BEHAVIOURAL THERAPY WITH A 28-YEAR-OLD WOMAN PRESENTING WITH OBSESSIVE-COMPULSIVE DISORDER (OCD)

Referral

Mrs. Jane Law was referred to the Psychology Service by her Psychiatrist who reported that she suffers from anxiety and “obsessive-compulsive type behaviour”. He reported “…she cleans things obsessively and worries that her children may pick up germs”.

Presenting Problem

Jane reported that her difficulties started after the birth of her first child, Ben, four years ago. She stated that currently her OCD involves checking and cleaning; that she spends thirty minutes checking before going to bed or leaving the house and that she washes her hands between thirty to fifty times per day. Jane also reported that she avoids situations or doing things that she knows will cause her to have intrusive thoughts, such as using a public toilet. Jane stated that she fears contaminating herself or her children, and that she fears hurting them or herself.

Assessment and Background Information

Two face-to-face clinical assessments were conducted with Jane, which were structured around a cognitive-behavioural framework. Information was also gained from the Clark – Beck Obsessive-Compulsive Inventory (Clark & Beck, 2004).

Jane reported that when she was three years old her brother, George, was born. George spent a significant amount of his first two years in hospital and Jane reported that her mother spent a considerable amount of her time with George in hospital.
Jane described her mother as having had depression and being a “hard person to live with”. She reported her mother has a degree of OCD and worries a lot. Jane also reported that her mother was frequently packing her bags telling her that she was leaving.

There was no history of risk in Jane’s background and in the assessment session there was no indication of any potential risk issues.

**Formulation**

The CBT model for OCD (Salkovskis *et al.*, 1998), which includes the role of elevated responsibility and the concept of thought-action fusion (Wells, 1997) was used to inform the formulation.

Jane reported having obsessional thoughts regarding the safety of her loved ones and herself, which causes her to feel anxious. To reduce this anxiety she engages in compulsions in an attempt to feel safe. It is her appraisal of these intrusive thoughts, her belief that by having these thoughts she is responsible for preventing harm happening, that causes her to feel anxious and to check and clean. Jane’s engagement in compulsive behaviours, maintains her OCD, preventing disconfirmation of her beliefs.

It is hypothesised that Jane’s early experiences of separation from her mother when her brother was in hospital and her mother’s recurrent threat to leave during her childhood caused Jane to be vulnerable to fears of loss and separation. Jane’s early experiences could have resulted in her forming beliefs that those she loves could leave her and that nothing is secure and safe leading to assumptions that she is responsible and needs to keep those she loves safe and with her. These assumptions appeared to have been triggered with the birth of her son, maybe because of the ‘vulnerability’ of a newborn and the responsibility ofparenthood.
**Intervention**

Jane has completed two assessment sessions and ten intervention sessions and due to developments in the formulation of her difficulties, therapy has been extended for a further four sessions to explore endings in more detail. At the time of writing this report, she has had two of the four additional sessions.

The ten intervention sessions were conducted in a CBT framework, though increasingly throughout the progress of therapy discussions in supervision and in sessions were informed by other psychological theoretical approaches, particularly attachment theory and systemic theory.

Intervention sessions focused on socialising Jane to Clark’s (2004) model of OCD, on normalising anxiety and identifying Jane’s appraisals of her obsessions. Jane very quickly identified her elevated feelings of responsibility to her loved ones and her fears of vulnerability and separations. Jane was able to challenge some of her dysfunctional appraisals of her obsessions, (her beliefs in thought-event fusion, her elevated sense of responsibility, and her catastrophising) through thought records and behavioural experiments. Jane was also able to expose herself to a hierarchy of anxiety-provoking situations. Jane engaged in relapse prevention work, which looked at the cost and benefits of life without OCD, identified situations where she may be vulnerable to lapses and potential coping strategies to deal with these high-risk situations.

With the reduction in her anxiety symptoms, Jane’s anger towards her mother began to be expressed. With the development of therapy if was explored with Jane her ‘family script’ (Vetere & Dallos, 2003) for expressing anger, and her separation anxieties due to an insecure attachment base (Bowlby, 1998) during childhood was explored with her.
**Outcome**

Jane has yet to complete therapy, though completed the Clark-Beck Obsessive-Compulsive Inventory on the tenth session, which indicated a reduction from her initial score, though still remains in the ‘Severe Clinical’ range. Her Compulsions subscale dropped from the ‘Severe Clinical’ range to the ‘Mild and Moderate Clinical’

Jane reports that she has a greater understanding of her difficulties, which has helped to challenge them. She also describes less fear that her children will learn the same family script that she has. Jane reports that her checking and cleaning have significantly reduced, but that they are still present to a degree.

**Critical Evaluation**

The most significant criticism of the work undertaken was the lack of ‘evidence’ that integrating other approaches after ten sessions of CBT would be effective. In response to this, I suggest that through adapting the intervention based on the individual client’s presentation I am contributing to my practice-based evidence rather than following evidence-based practice. I do feel through exploring her family scripts and the discussions on issues of attachment, that Jane was able to come to a more in-depth understanding of her difficulties. I think that this further work was possible due to the cognitive and behavioural strategies that she had already implemented which had given her a sense of empowerment and hope and which resulted in the development of a secure therapeutic relationship.

**References**


PEOPLE WITH LEARNING DISABILITIES CASE REPORT SUMMARY

BRIEF BEREAVEMENT FOCUSED THERAPY WITH A 32-YEAR-OLD MAN WITH A DIAGNOSIS OF DOWN'S SYNDROME.

Referral

Mr. Roberts, a 32-year-old man diagnosed with Down’s syndrome was referred to the Psychology Service, as he and his mother were distressed about an incident where Mr. Roberts refused to board a plane.

Presenting Problem

Mr. Roberts reported that his refusal to board the airplane was due to seeing his late father’s face in the sky. Mr. Roberts has flown frequently before his father’s death and has never had any previous difficulties.

Assessment and Background Information

The initial assessment included discussions with the Community Team; attendance of a network meeting; an interview with Mr. Roberts; and the reading of Mr. Roberts’ health and social services files.

Mr. Roberts is described as having ‘moderate learning disabilities’ and presented as having some comprehension difficulties, though these difficulties did not prevent him from being able to express his thoughts and feelings well.

Mr. Roberts has several medical conditions and he reports that he has been told before that he might ‘drop down dead’ at any moment because of the difficulties with his heart. Mr. Roberts also believes that if he has an operation on his heart he will die.

Mr. Roberts’ father died in August 2002 whilst in hospital. Mr. Roberts and his mother believe that his father died due to MRSA and Mr. Roberts blames the cleaner
at the hospital. Mr. Robert’s reports that after his father died he watched a nurse wash him.

**Formulation**

The formulation is informed by Malan’s (2001) Triangle of Conflict and Worden’s (2001) Tasks of Mourning. Mr. Roberts’ difficulty in talking about his father and his frequent expression of anger surrounding loss rather than sadness might suggest that he is having difficulties in experiencing the pain of the loss of his father. It is hypothesised, that the incident where Mr. Roberts saw his father in the sky whilst on the airplane was an example of his ‘unmanifested’ grief expressing itself and the beginning of his inability to suppress his grief any longer.

Worden also reports that a grief reaction is more likely to be complicated if there have been multiple losses in a person’s history. Mr. Roberts’ experiences of having a learning disability may have resulted in multiple experiences of loss (Davies, 1999). Mr. Roberts’ cognitive and communication difficulties may have made the concepts of death harder to understand and the expression of his feelings more difficult, which may have also made progressing through the grieving process more problematic.

Mr. Roberts’ expression of anger could be understood as a defence against his feelings of sadness and be conceptualised using Malan’s Triangle of Conflict. It is hypothesised that Mr. Roberts has anxiety about expressing his sadness. Sinason (1992) theorises that some people with learning disabilities ‘fake cheerfulness’ as others close to them cannot bear their grief and so they encourage happiness. The loss of his father could also have triggered thoughts about his own mortality, and this could have increased his anxiety having to defend against this with denial of the sadness surrounding loss.
**Intervention**

Mr. Roberts attended 11 sessions in total, their focus divided up into three areas: facilitation of sadness regarding the death of his father; the use of the therapeutic relationship; and psycho-education of death concepts.

Mr. Roberts' anxiety about expressing his sadness, which seemed to focus on what others' would think, and the role of his anger, were discussed. Mr. Roberts described sadness as being a pain and it was apparent in our earlier sessions that Mr. Roberts was resistant to expressing sadness often talking about how angry he felt about someone else.

Mr. Roberts compiled a memory book of his father using a picture book. It also appeared that he was remembering the dead traumatic image of his father, which seems to have been 'stuck' in his mind because of watching his dead father being washed. This was the image that Mr. Roberts’ saw in the sky. Due to this, it was decided that Mr. Roberts’ would bring in some images of his father when alive, which he had so far avoided looking at since his death. It was thought that by bringing these 'linking objects' into the sessions it would help Mr. Roberts access his sadness.

Within the therapeutic relationship, I tried to provide Mr. Roberts with a space where he could express his sadness without fearing rejection or of being overwhelmed by his sadness. I was also aware in the sessions that breaks in therapy might provoke feelings in Mr. Roberts and that by exploring the transference relationship this may help reflect on his past and current relationships.

Mr. Roberts was given a questionnaire to explore his understanding of death, which indicated he had a relatively robust concept of death.

**Outcome**

Mr. Roberts reported in the last session that he felt less angry and more able to feel sad about the death of his father. His mother also reported that he requested to visit his
father’s grave, which was something he had not wanted to do previously. Mr. Roberts’ reported he still did not want to go on an airplane in the future. It appears that his concept of his father being in the sky did not change and that he still wanted to avoid flying.

Critical Evaluation

The therapy failed to address his avoidance of boarding airplanes and it may be beneficial if more direct work is done to address this. It is felt the work we did together allowed Mr. Roberts a safe contained space where he was able to begin to get in touch with his sadness and seemed to provide him with a ‘positive’ experience of ending and loss.

References


A NEUROPSYCHOLOGICAL ASSESSMENT OF A 10-YEAR-OLD GIRL WITH FOETAL SODIUM VALPROATE SYNDROME WHO IS A CARRIER OF THE FRAGILE X GENE.

Referral

Ruby Beccles is a 10-year-old white British girl, who was referred to the Child and Adolescent Mental Health Service because of concerns about her social communication skills.

History of Presenting Problem

Ruby’s parents report that they noticed delay in her achievement of developmental milestones and that she had only minimal speech at two years.

In terms of her social development, Ruby’s parents reported that she did participate in some symbolic and pretend play when younger, though she has always appeared to have difficulties understanding jokes or metaphors. She is also reported to be socially inappropriate at times. Ruby has been reported to have friends but to seem to prefer spending time with adults and tends to play by herself at school break time.

In a statement of educational needs, which Ruby received when she was four years old, she was described as having ‘mild general delay’ with the main area of concern being her speech and language development. However, it also noted that she had made good progress with her learning and has acquired many age appropriate skills.

Ruby was diagnosed with Foetal Sodium Valproate Syndrome (FSVS) when she was three years old. Ruby’s parents have also recently been told that she is a carrier of the Fragile X gene. Ruby has no psychiatric history and there is no report of any obsessions or unusual behaviours.
Hypotheses

It is hypothesised that Ruby will display difficulties with her verbal cognitive abilities predominantly due to reported language difficulties and her FSVS. Furthermore, Ruby may also display some other cognitive difficulties due to the combination of this syndrome with her being a Fragile X carrier, which could include difficulties with executive functioning skills. It is envisaged that any learning difficulties identified will be more likely to correlate with a profile attributable to her FSVS (because Ruby received her fragile X chromosome from her father, which indicates she is less likely to have reduced cognitive performance (Dykens, 1994). Therefore, it is hypothesised that her Verbal IQ will be lower than her Performance, rather than the Fragile X profile where there are weaknesses in nonverbal cognitive abilities.

It is also hypothesised that her cognitive profile will not be ‘typical’ of a profile for someone with autism (Performance IQ elevated) as from the developmental and social history there are indications that Ruby’s presentation is not in line with an Autistic Spectrum Disorder (ASD).

The final hypothesis is that Ruby will display difficulties in her personal and social skills, in particular those that rely heavily on language, executive functioning skills, or motor skills.

Presentation

Ruby was pleasant, motivated, and co-operative throughout the assessment sessions. Ruby’s eye contact was normal and there were no unusual behaviours observed. She used gesticulation to help her to communicate and possibly to compensate for some of her language difficulties.

From observations of Ruby’s performance on this occasion it is felt that a reliable estimate of her abilities has been obtained.
Findings

Cognitive Functioning

Ruby’s scores on the Wechsler Intelligence Scale for Children – Third Edition UK were significantly scattered and indicate that she has an uneven cognitive profile. There is a significant range of subtest scores within the verbal subscale, which means that a Verbal IQ score cannot be computed. Ruby’s verbal subtest scores (except for one which was in the ‘Average’ range) fell in the ‘Low Average’ or ‘Low’ range. Ruby’s Performance IQ fell in the ‘Average’ range. Ruby’s scores on the Wechsler Objective Reading Dimensions were in the ‘Average’ range. Ruby’s scores on the Delis-Kaplan Executive Function System indicate that the subtests that do not rely on language are in the average range.

Personal and Social Functioning

Ruby’s profile on the subdomains of the Daily Living Skills, Socialisation and Motor Skills Domains of the Vineland Adaptive Behaviour Scale, are all varied. Her scores on the Daily Living Skills subdomains indicate she may be able to do some complex daily living skills tasks though still finds it difficult to do some of the more fundamental ones.

Discussion

Ruby’s varied profile, where she displays strengths in skills that do not depend on language, indicate that she does not have general learning difficulties. There are indications that are contrary to an ASD in Ruby’s developmental and social history, as well as from her behaviour during assessment and the responses to the Vineland Adaptive Behaviour Scale. Ruby’s cognitive profile is more consistent with a ‘typical’ profile of FSVS rather than Fragile X Syndrome as her Performance IQ is in the ‘Average’ range. In addition, there is no evidence of global executive functioning difficulties (indicated in people with Fragile X Syndrome) as her higher-level cognitive skills that are not dependent on language are in the average range.
Recommendations

It is recommended that Ruby receive the added support to learn skills in identified areas of cognitive, social, and personal difficulty. Ruby’s non-verbal cognitive skills are an area of strength and therefore the use of pictorial aids, such as pictures and diagrams could be used to promote her learning.

It is also important to note that Ruby’s varied profile means that she may give others a mixed and possibly confusing message about her abilities, with others underestimating or overestimating her abilities. It is therefore recommended to check whether Ruby is able to undertake various tasks, she is given, and to support her build her skills in areas of difficulty using a graded step-by-step approach.

Critique

On reflection I am questioning the benefit of attributing Ruby’s difficulties to FSVS or/and being a carrier of the Fragile X gene (unless used for research purposes), which was one of the referral questions, as I wonder what use this information provides as finding the aetiology will not inform treatment. I hope to inform my future practice by holding in mind the need to be questioning why referral questions are being asked and how the answers will benefit the client and those that support them.

References

OLDER PEOPLE CASE REPORT SUMMARY

INTEGRATIVE THERAPY WITH A 74-YEAR-OLD WOMAN PRESENTING WITH DEPRESSION AND PERSECUTORY THOUGHTS

Referral

Mrs. Barbara Marsh, a 74-year-old white British female, was internally referred to the Psychology Service by the Community Mental Health Team for Older People due to her low mood and beliefs that her son's partner was moving her belongings.

Presenting Problem

Mrs. Marsh lives with her son Bill, his partner Dawn and their son. Since her husband’s death, Mrs. Marsh reports that she believes that Dawn moves her belongings “to wind her up” and that Dawn wants her to leave the family home. This has caused difficulties within the family.

Assessment and Background Information

Mrs. Marsh was assessed over three sessions, which were structured around an integrative approach. The assessment procedure was approached with recourse to three theoretical traditions in the following way: the exploration of Mrs. Marsh’s current difficulties was done from a predominantly cognitive orientation; Mrs. Marsh’s reported difficulties were causing difficulties with family relationships and therefore the systems around her were assessed; finally in the assessment session issues of transference and countertransference were attended to.

Mrs. Marsh was diagnosed with Hereditary Spastic Paraplegia (HSP) at three years of age. At the time of diagnosis, her mother left the family, which Mrs. Marsh believes was because of her disability. From three to ten years of age Mrs. Marsh lived with foster parents as her father was in military service. At ten years of age, Mrs. Marsh’s father returned from military service and Mrs. Marsh went to live with him, his new
wife, and her children. Mrs. Marsh describes life at home as difficult, experiencing sexual abuse from her father.

Mrs. Marsh has three children who all have HSP. Mrs. Marsh reports having a happy and supportive marriage. Mr. Marsh died in 2005 and his death came as a great shock to Mrs. Marsh, who did not have a chance to say goodbye to him.

**Formulation**

Mrs. Marsh’s early experiences of broken insecure attachments with her mother and father may have caused her to have beliefs that there is something wrong with her that causes others to leave her or to mistreat her. This would have been reinforced by her disability where she describes experiencing stigma from others, including her belief that her mother left her due to her disability. Mrs. Marsh also reports feeling guilty that she has passed on to her children her disability further causing her to have negative thoughts about herself.

Mrs. Marsh’s marriage appears to have given her an experience of a secure attachment that has allowed her to challenge her negative self-beliefs. It is possible that the experience of the loss of her husband has caused earlier beliefs about her, others, and the world that are focused on issues of abandonment, low self-esteem, and insecurity to resurface. This could have resulted in her low mood and beliefs that others are doing things to cause her difficulties. It is also reported that persecutory thoughts can be used as a defence against feelings of low self-esteem, as the threat is made external rather than internal (Bentall, 2001).

**Intervention**

Mrs. Marsh attended nine psychology sessions. Mrs. Marsh worked cognitively, challenging some of her negative thinking and identifying alternative thoughts. Mrs. Marsh was also able to recognise the impact of her early life experiences on her current low self-esteem and her ability to make negative assumptions about others’ intentions. In discussing some of her experiences Mrs. Marsh seemed to re-narrate her
story from one of self-blame, through to anger and other blame and then to sadness and acceptance. She reported that discussing her past provided validation for her feelings and also an opportunity to see herself as a ‘survivor’ rather than someone who was weak and flawed. In two of the sessions, Mrs. Marsh’s son, Bill, joined us, in order to provide a forum where they could discuss their difficulties in a contained safe space. They worked together on making a contract that was aimed at reducing family tensions.

During the therapy, it became noticeable that Mrs. Marsh was experiencing some difficulties with her memory and therefore a brief cognitive screening assessment was undertaken, which indicated that Mrs. Marsh did appear to suffer from cognitive functioning difficulties. Mrs. Marsh was informed of this and that it may be useful for her to be referred to a psychiatrist for further investigations. Mrs. Marsh denied she had any cognitive problems. Following the session where Mrs. Marsh was informed of her results, Mrs. Marsh cancelled her next therapy appointment reporting that she no longer wished to continue as she felt focusing on her problems was only making her more upset.

It possible that Mrs. Marsh’s memory difficulties were a significant contributing factor to her persecutory thoughts, though it is hypothesised that her explanation for her belongings being moved focused on others’ wish to cause her distress, may have been the result of her earlier experiences and core beliefs as mentioned above.

**Outcome**

Mrs. Marsh was assessed using the Clinical Outcome of Routine Evaluation, pre and post therapy, which indicated that Mrs. Marsh’s scores fell from being representative of a clinical population to being representative of the general population. At the end of therapy Mrs Marsh also reported that she felt “less to blame for her problems” since receiving therapy. So though it appears as if therapy did not reduce Mrs. Marsh’s persecutory thoughts Mrs. Marsh seems less distressed by these thoughts and to see them less as a direct attack on her self. This in turned appeared to alleviate family tensions slightly.
Critical Evaluation:

It may have been more appropriate if another psychologist assessed Mrs. Marsh's cognitive abilities, so that there may have had less impact on the therapeutic process. However, this may have caused a delay in her assessment and at the time, it was thought that Mrs. Marsh might have benefited more from being assessed by someone she had developed a therapeutic relationship with. These reflections on Mrs. Marsh's disengagement following cognitive assessment will be used to inform future practice, in particular when and who assess someone.

References

OVERVIEW OF THE RESEARCH DOSSIER

This dossier consists of the research log checklist, which summarises the research skills and experiences gained during clinical training; the Service Related Research Project completed during year one; the abstract of the qualitative research project completed in year two; and the Major Research Project completed during years two and three.
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SERVICE RELATED RESEARCH PROJECT

A Postal Survey Study Focusing on Four Groups of Potential Referrers within a Discrete Locality Area.

Year One

The name of the service and any details that would enable the identification of the service has been removed to ensure anonymity.
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Abstract

Background:
Previous literature and Trust consultation papers suggest that there is some confusion regarding the roles Clinical Psychologists undertake, which is compounded by there being multiple referral groups.

Aims:
The aims of this study were: to explore and compare referrers' perceptions and prioritisation of the roles of Clinical Psychologists; to explore referrers' understanding of the therapies they perceive as being most needed by clients and what psychological difficulties clients are most commonly referred for; and to explore reasons why referrers might not refer a client to Clinical Psychology.

Method:
Four referrer groups were identified and participants were sent a questionnaire devised for the purpose of this study. 32% of participants returned their questionnaire. The data was analysed using descriptive and non-parametric analyses.

Results:
There was no significant difference between referrer groups' perception of the roles undertaken by Clinical Psychologists. Research and audit work was perceived by respondents as being of limited importance in the role of Clinical Psychologists. Direct work\(^4\) was prioritised by referrers over indirect work\(^5\) and research and audit. Cognitive-behavioural therapy was rated the psychological therapy most in need by referrers and anxiety disorders were the most common form of psychological difficulty that referrers' reported they referred for. Service related issues\(^6\) were the most common reasons referrers did not refer clients to Clinical Psychologists.

---

\(^4\) Assessment, individual intervention and group work.

\(^5\) Consultation, supervision and education and training.

\(^6\) Includes waiting lists and lack of psychologists.
Conclusion:
These results are discussed in relation to the implications for the Psychology service and the profession of Clinical Psychology and a number of suggestions for future research are made.
Acknowledgements

I would like to thank my University and Placement Supervisors for all their support and advice. I would also like to thank the participants of this project who took the time to fill in the questionnaire in an environment where time is precious.
Introduction

The structure of the service provided by Adult Mental Health (AMH) Clinical Psychologists has undergone a period of change in recent years. Clinical Psychologists increasingly find themselves working within Psychological Therapies Services and Community Mental Health Teams (CMHTs). Psychological Therapies Services were developed to co-ordinate the range of psychological therapies that are provided by a variety of disciplines at various sector levels. It has been suggested that the multi-disciplinary approach to psychological therapies has the potential to cause some confusion in understanding the roles of Clinical Psychologists (NHS Trust consultation paper, 2004). This may be compounded by the fact that Clinical Psychologists have different roles within Psychological Therapies and CMHTs and are therefore receiving referrals from multiple referrers. It would appear that as well as role confusion for clinical psychologists, there is lack of clarity as to which service is most appropriate for patients and the qualifications of some of the psychological therapists that are referred to (NHS Trust consultation paper, 2004; Sibbald, Addington-Hall, Brenneman & Freeling, 1993). It is thought more open communication with referrers about the roles undertaken by Clinical Psychologists and the roles referrers expect them to undertake, will allow for greater role clarity which will hopefully improve service efficiency, which is especially important in any limited resourced service.

Previous literature has looked specifically at GPs' perspectives on the role of Clinical Psychologists (Elphick 2004, Medlik 1987, 1999) and given the changing structure of Clinical Psychology there is a need to reassess these perspectives as well as assess the perspectives of other referrers. Elphick (2004) concluded that GPs did not consider Clinical Psychologists role in primary care to involve the education, training and supervision of other primary care staff, though they were aware of the skills Clinical Psychologists have to offer in psychological assessment, consultation and running groups. It would be interesting to see if GPs' perceptions have changed.

Ross & Hardy (1999) noted that GPs are put off referring to Psychology Services because of long waiting lists and inaccessible services. Whether this is still the case
would be of interest as it is likely to affect those who are being referred to Clinical Psychology and may account for why some individuals’ needs might not be met. Ross & Hardy also note that GPs’ explanations to the client about the referral to Clinical Psychology are important in the development of clients’ expectations and consequently psychology service uptake. Furthermore Garfield (1986) reports that if an individual’s expectation of psychological therapy is incongruent with its actual practice they may be discouraged from continuing with treatment. Therefore GPs’ or referrers’ understanding of the role of the Clinical Psychologists could be critical to clients’ engagement in therapy.

Aims

1. To explore and compare referrers’ perceptions of the role of Clinical Psychologists.
2. To identify the roles of Clinical Psychologists that referrers’ would wish to prioritise in the context of limited resources.
3. To explore referrers’ understanding of the therapies they perceive as being most needed by clients and what psychological difficulties clients are most commonly referred for.
4. Explore reasons why referrers might not refer a client with psychological difficulties to Clinical Psychologists.
Method

Participants:

Referrer groups were identified through discussion with the Professional Lead of Psychology AMH and selected from a discrete Trust locality. They were grouped into four categories:

1. GP surgeries \( (n^7 = 113) \)
2. Four CMHTs \( (n = 64) \)
3. Two Day Hospitals \( (n = 14) \)
4. Managed Counselling Service (MCS) \( (n = 15) \)

Total number of potential participants (staff referrers) was 206. The manager of the inpatient wards was contacted regarding involvement in the study but due to the team’s workload declined participation.

Participants from three of these groups were identified by contacting the Team Managers, informing them of the study and gaining consent to write to team members. The Primary Care Trust (PCT) Clinical Lead was similarly contacted and provided the GP list.

\(^7 n = \text{number of potential participants (staff referrers)}\)
Response Rate:

The response rate for each of the four groups of referrers is shown in Table 1. Of the 206 questionnaires sent out, 66 responded (32% of total sample).

Table 1: Response rate.

<table>
<thead>
<tr>
<th>Group</th>
<th>Number of staff</th>
<th>Number returned</th>
<th>% returned</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP</td>
<td>113</td>
<td>39</td>
<td>33%</td>
</tr>
<tr>
<td>CMHT</td>
<td>64</td>
<td>12</td>
<td>17%</td>
</tr>
<tr>
<td>MCS</td>
<td>15</td>
<td>6</td>
<td>33%</td>
</tr>
<tr>
<td>DH</td>
<td>14</td>
<td>9</td>
<td>64%</td>
</tr>
<tr>
<td>TOTAL :</td>
<td>206</td>
<td>66</td>
<td>32%</td>
</tr>
</tbody>
</table>

Development of Questionnaire:

A non-standardised Questionnaire (see Appendix 1) was devised for the purpose of this postal survey, to elicit quantifiable data. Previous Questionnaires used by Medlik (1999) and Elphick (2004) in related projects provided ideas for development of the questionnaire and the Professional Lead of Psychology AMH, senior clinicians of the PCT and the Head of the Managed Counselling Service (MCS) were consulted. The Questionnaires were printed on eye-catching bright yellow paper in an attempt to increase response rate. Participants were asked to identify which referral group they belonged to but were otherwise anonymous. The Questionnaires were posted to the four groups of participants with a covering letter (see Appendix 2) explaining the research project and a return envelope. Participants were informed in the covering letter that by returning the Questionnaire it was assumed that consent was given.

This study was approved by the Local Research and Ethics Committee (see Appendix 3) and the Research and Development Committee (see Appendix 4).
The findings of the study will be disseminated at the Psychology Service Team Meeting and a detailed summary will be distributed to the four different Referral Groups that participated in the study.

**Analyses**

The Questionnaires provided quantitative data, which was analysed using the Statistical Package for Social Sciences software. Descriptive and non-parametric analyses were used to describe responses to the questions asked. For Questions 5 and 6 on the questionnaire containing qualitative responses, the responses were categorised so that frequencies and themes could be obtained. For question 5, Diagnostic and Statistical Manual of Mental Disorders Fourth Edition (DSM-IV) categories were used to group diagnostic responses. These categorisations were reviewed by two qualified psychologists and given that there were only a few discrepancies between items (89.3% and 77% agreement with DSM-IV categories; 74.4% agreement with each other) it was decided that such categories were suitable (see Appendix 5 for categorisation). The responses to Question 6 were also categorised into themes (see Appendix 6).
Results

For the purpose of this report only those results directly relevant to the aims of the study will be discussed here.

What does the role of a Clinical Psychologist include?

While 33% of Managed Counselling members reported that they thought the role of Clinical Psychologists included audit, (this was the lowest percentage and the only one below 50%) it appeared that all other Referrer Groups thought that Clinical Psychologists' role should include assessment, individual intervention, group work, education and training, being supervised, supervising others, consultation, research and audit, with few identifying 'other' categories (highest 17% for CMHT members) as being important to the role. Though all referral groups had a majority of members (over 50%) reporting that research was a role, there were some differences across referral groups with a range between 75% of CMHT members and 54% of GPs. The role of audit had the largest range between referral groups with 67% of CMHT members reporting it was a role and only 33% of Managed Counselling members. (See Appendix 7 for the full results). Despite this range for the roles of audit and research, there was no significant difference between referrer groups' perception of the roles undertaken by Clinical Psychologists.

\textsuperscript{8} Kruskal Wallis test used.
Figure 1 categorises these roles into direct work\textsuperscript{9}, indirect work\textsuperscript{10} and research and audit work. It shows how research and audit were thought, by the least percentage of referrers, as being included in the role of a Clinical Psychologist.

\textbf{Figure 1. Q7: What do you perceive the role of a Clinical Psychologist includes?}

\begin{figure}
\centering
\includegraphics[width=\textwidth]{figure1.png}
\caption{Q7: What do you perceive the role of a Clinical Psychologist includes?}
\end{figure}

\textsuperscript{9} Direct work includes assessment, individual intervention and group work.
\textsuperscript{10} Indirect work includes consultation, supervision and education and training.
Prioritisation of roles:

Figure 2 indicates that in the context of limited resources the majority of all the Referrer Groups prioritise the role of direct work, then indirect work followed by research and audit work. Direct work would seem equally prioritised across all Referrer Groups, whilst indirect work is prioritised by CMHT and Day Hospital members and research and audit work mostly by Managed Counselling Service members. Referrer groups showed a significance difference in their prioritisation of only two of the roles; supervising others ($p = 0.011)^{11}$ and being supervised ($p = 0.031)^{12}$. GPs prioritised the roles of being supervised and supervising others the least; being supervised was prioritised by Managed Counselling Service members the most and the role of supervising others by CMHT members the most.

![Figure 2: Q8 Which roles do you think should be prioritised?](image)

---

11 Kruskal Wallis test used.
12 Kruskal Wallis test used.
A need for different therapies:

Table 2: Referrer groups rated need for different psychological therapies, (need was rated 1 to 10; 1 = not in need, 10 = a very high need)

<table>
<thead>
<tr>
<th></th>
<th>CMHT</th>
<th>GP</th>
<th>MCS</th>
<th>DH</th>
</tr>
</thead>
<tbody>
<tr>
<td>CBT</td>
<td>8.8*</td>
<td>8.7</td>
<td>8</td>
<td>8.4</td>
</tr>
<tr>
<td>Family Work</td>
<td>6.7</td>
<td>7.6*</td>
<td>6.2</td>
<td>3.4</td>
</tr>
<tr>
<td>Psychodynamic</td>
<td>6.4*</td>
<td>5.5</td>
<td>5.2</td>
<td>4.2</td>
</tr>
<tr>
<td>Behavioural</td>
<td>5.8</td>
<td>5.8</td>
<td>5.4</td>
<td>6*</td>
</tr>
<tr>
<td>Integrative</td>
<td>5.6</td>
<td>4.5</td>
<td>7*</td>
<td>4.13</td>
</tr>
</tbody>
</table>

* = The highest rated need amongst the referrer groups.

Table 2 indicates that all Referrer Groups rated cognitive-behavioural therapy (CBT) in most need out of all the therapies on offer with a generally consistent rating (range 8 to 8.8). In looking at other therapies family therapy was seen as the most in need by GPs; psychodynamic therapy was rated most in need by CMHT members; behavioural therapy was rated most in need by Day Hospital members and integrative therapy was rated most in need by Managed Counselling members. When the average rated needs across the Referral Groups were ranked it demonstrated that CBT was thought the most in need (8.5) with the other therapeutic approaches showing very similar rated need; family work (5.98), behavioural therapy (5.75), psychodynamic (5.32) and integrative (5.31). There was no significant difference¹³ between referrer groups rated need of the five different psychological therapies.

¹³ Kruskal Wallis test used.
Types of psychological difficulty referred:

Figure 3 shows that anxiety disorders are noticeably the most common form of difficulty reported to be referred to Clinical Psychologists by referrers (93%). This is followed by the 'Other' category (61%) which relate to the DSM-IV category of ‘Other conditions that may be a focus of Clinical Attention’ and includes relational problems and problems related to abuse or neglect (see Appendix 6); then Mood Disorders (48%), followed by Eating Disorders (29%).

![Figure 3. Q5: What forms of psychological difficulties do you refer to Clinical Psychologists?](image-url)
Reasons for not referring:
Table 3 shows the response of referrers to Question 6, 'Are there any reasons why you might not refer a client who has psychological difficulties to a Clinical Psychologist?' The responses were categorised into the four areas below (see Appendix 6).

**Table 3: Reasons why referrers do not refer.**

<table>
<thead>
<tr>
<th>Are there any reasons why you might not refer to a Clinical Psychologist?</th>
<th>Percentage of Referrers</th>
</tr>
</thead>
<tbody>
<tr>
<td>No reasons</td>
<td>7.1%</td>
</tr>
<tr>
<td>Due to Service related issues</td>
<td>75%</td>
</tr>
<tr>
<td>Due to Client issues</td>
<td>32.1%</td>
</tr>
<tr>
<td>Refer for other treatment instead</td>
<td>5.4%</td>
</tr>
</tbody>
</table>
Figure 4 shows how these responses were divided amongst the different Referrer Groups. ‘Service related issues’ were the largest percentage response for GPs, Managed Counselling Service members and Day Hospital members and this was the only response that all Referral Groups included. The same percentages of CMHT members (45%) do not refer a client because of ‘service related issues’ and ‘client related issues’. ‘Client related issues’ is the only category that showed a significant different between referral groups (p= 0.012)\(^{14}\) though ‘service related issues’ approaches significance (p= 0.071)\(^{15}\).

**Figure 4. Q6: Are there any reasons why you might not refer a client who has psychological difficulties to a Clinical Psychologist?**

<table>
<thead>
<tr>
<th>Reason</th>
<th>CMHT</th>
<th>GP</th>
<th>MCS</th>
<th>DH</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Reason</td>
<td>100</td>
<td>90</td>
<td>80</td>
<td>0</td>
</tr>
<tr>
<td>Service related issues</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Client related issues</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Referred for other treatment</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

\(^{14}\) Kruskal Wallis test used.

\(^{15}\) Kruskal Wallis test used.
Discussion

The overall response rate to this postal survey was 32%, with CMHT members having the lowest response rate (18.8%), this may reflect some of the historic and recent difficulties between CMHTs and psychologists; including the lack of Clinical Psychologists currently in post and the difficulties in integrating Clinical Psychologists within the team.

The aims of this study were achieved and will be discussed below along with the implications for the service and for Clinical Psychology as a profession:

1. **To explore and compare the perceptions of the roles of Clinical Psychologists by referrers.**

Referrers perceive the role of Clinical Psychologists to include direct work, indirect work and research and audit work and therefore appear to have an understanding of the diversity of Clinical Psychologists' role. However, research and audit work was perceived by all referrer groups as comparatively marginal to the role of Clinical Psychologists (with audit being a perceived role by only 33% of Managed Counselling members). However, there was no statistical difference between referrer groups' perceptions of the role of Clinical Psychologists.

This is a change from Elphick's (2004) findings where GPs did not consider Clinical Psychologists' role to involve education, training and supervision and suggests there has been an improvement in GPs knowledge of the role of Clinical Psychologists. This may suggest recent service management changes have brought about beneficial effects.

2. **To identify the roles of Clinical Psychologists that referrers would wish to prioritise in the context of limited resources.**

Priorities were consistent across referrer groups with the roles of assessment and individual intervention being prioritised by most. CMHT referrer group prioritised indirect work the most which could reflect their appreciation of Clinical Psychologists roles within a team, such as supervision, training and consultation. Research and audit are prioritised the least by all referral groups (which could be one reason why there
was a low response rate from this study) and could be due to pressures of long waiting lists and the need to ensure that service users have their psychological needs addressed, resulting in research and audit being marginalised in this context. As doctorate level research is a core skill for Clinical Psychologists it may be beneficial if this role was highlighted by the Psychology Service and the Clinical Psychology profession in general, with the benefits of evidence-based practice for clients and services promoted.

3. To explore referrers' understanding of the therapies they perceive as being most needed by clients and what psychological difficulties clients are most commonly referred for.

Cognitive-behavioural therapy (CBT) was rated the most in need, with other therapies being rated almost equally in need by referrers. This is perhaps unsurprising due to the National Institute of Clinical Excellence guidelines for mental health disorders which promote the implementation of CBT and the development of CBT in the context of a strong research commitment, "a factor that might be relevant to its current status" (Roth & Fonagy, 1996, pg. 41). It was also noted whilst entering data from this question that there was often a query over what some of the other therapies were, this highlights that referrers' knowledge of what other therapies entail may be limited. This could effect their explanation to the client which might impact on clients' knowledge about the forms of psychological therapies available and potentially their motivation to attend therapy (Garfield 1986) as well as their ability to make informed choices. It is therefore important to provide clarity regarding the different psychological therapies available and what they involve.

Results from this study show that anxiety disorders were reported the most by referrers as the most common form of psychological difficulties that are being referred to Clinical Psychologists. Interestingly no referrers reported that they referred clients with psychosis and this may be because of beliefs that psychological intervention is not appropriate for this or related difficulties. The Psychology Service needs to increase awareness amongst referrers about the range of difficulties that can benefit from psychological intervention.
4. Explore reasons why referrers might not refer a client with psychological difficulties to Clinical Psychologists.

The results of why referrers may not refer a client with psychological difficulties to a Clinical Psychologist supports Ross & Hardy’s (1999) finding that GPs are often put off by service-related issues, such as long waiting lists and inaccessible services and suggests that service-related issues will be the most common reason why referrers do not refer to Clinical Psychologists. Service-related issues was the majority response for all the Referrer Groups apart from CMHT members who reported that client related issues were an equally thought reason not to refer. This study confirms the negative impact that long waiting lists and the perception of an under resourced psychology service has for both referrers and prospective service users, and suggests that when the psychology service expands (in numbers of Clinical Psychologists in post and accessibility), that it will be important to inform other services.

This study also shows that about a third of referrers returning this questionnaire are not referring clients because of client related issues. These include issues associated with risk, substance misuse and personality disorder (see Appendix 5). These issues might not necessarily be reasons perceived by Clinical Psychologists for not accepting a referral, and therefore informing referrers about therapeutic access and exclusion criteria appears to be needed.

Limitations and recommendations:

There were several limitations to this study the most significant being the lack of homogeneity within a Referrer Group with members having different occupations and probably quite different interests and abilities in managing psychological need themselves. There was no means in this study to control for this variability or other issues of diversity. Future research into this area might explore how these variables could be controlled more effectively. Another limitation was the lack of a pilot study which would have addressed the confusion stemming from the question 2 and 3, ‘How many hours per week do you estimate a Clinical Psychologist has available for face-to-face/indirect work with your referrals?’ From the responses it seemed unclear what was meant by ‘your referrals’, whether it was an individuals or the Referrer Group as a whole.
It is thought future investigations could undertake some qualitative research exploring referrers’ perception of the role of Clinical Psychologists, this could also explore referrers’ understanding of the different psychological therapies that Clinical Psychologists are implementing, and how this impacts on future psychological work with clients. This could be explored within focus groups where a more in-depth understanding of the perceptions of referrers and more knowledge about the heterogeneity of the participants could be acquired.

Finally, it is acknowledged the low response rate, and the limitations of this study, mean that results should be interpreted with some caution and that there is a clear need for further exploration of these important issues.
References


Appendix 1

Referrers perception and prioritisation of the roles undertaken by Clinical Psychologists working with adults in a Mental Health setting.

Please indicate which referrer group you belong to by ticking the appropriate box below:

CMHT ☐  Managed Counselling Service ☐
GP Surgery ☐  Day Hospital ☐

1) Do you have a Clinical Psychologist working in your team/surgery?
   Yes ☐  No ☐
   If yes, how many days or half days per week do they work for your team/surgery? __________________ days per week.

2) How many hours per week do you estimate a Clinical Psychologist has available for face-to-face work with your referrals?
   ___________________________ hours per week.

3) How many hours per week do you estimate a Clinical Psychologist has available for indirect work (e.g. report writing, supervision, teaching) regarding your referrals?
   ___________________________ hours per week.
4) How would you rate the need for the following types of therapy? (Rank from 1 – 10, with 1 = not in need and 10 = a very high need)

<table>
<thead>
<tr>
<th>Rank need (1 – 10)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitive Behavioural Therapy</td>
</tr>
<tr>
<td>Family Work</td>
</tr>
<tr>
<td>Psychodynamic Therapy (Insight Orientated Therapy)</td>
</tr>
<tr>
<td>Behavioural Therapy</td>
</tr>
<tr>
<td>Integrative Therapy</td>
</tr>
<tr>
<td>Others (please specify):</td>
</tr>
</tbody>
</table>

5) Please list the 5 most common forms of psychological difficulties that you refer to Clinical Psychologists?

1. ____________________________________________
2. ____________________________________________
3. ____________________________________________
4. ____________________________________________
5. ____________________________________________

6) Are there any reasons why you might not refer a client who has psychological difficulties to a Clinical Psychologist?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
7) Please can you list what you perceive the role of a Clinical Psychologist includes by ticking the appropriate boxes below?

<table>
<thead>
<tr>
<th>The role includes:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment</td>
</tr>
<tr>
<td>Intervention with individuals</td>
</tr>
<tr>
<td>Group Work</td>
</tr>
<tr>
<td>Education and Training of others</td>
</tr>
<tr>
<td>Supervision of others</td>
</tr>
<tr>
<td>Being supervised</td>
</tr>
<tr>
<td>Consultation work</td>
</tr>
<tr>
<td>Research</td>
</tr>
<tr>
<td>Audit</td>
</tr>
<tr>
<td>Others (please specify):</td>
</tr>
</tbody>
</table>

8) Please could you complete the table below (ticking the boxes) by indicating which roles you believe should be prioritised.

<table>
<thead>
<tr>
<th>Should be prioritised</th>
<th>Less of a priority</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment</td>
<td></td>
</tr>
<tr>
<td>Intervention with individuals</td>
<td></td>
</tr>
<tr>
<td>Group Work</td>
<td></td>
</tr>
<tr>
<td>Education and Training of others</td>
<td></td>
</tr>
<tr>
<td>Supervision of others</td>
<td></td>
</tr>
<tr>
<td>Being supervised</td>
<td></td>
</tr>
<tr>
<td>Consultation work</td>
<td></td>
</tr>
<tr>
<td>Research</td>
<td></td>
</tr>
<tr>
<td>Audit</td>
<td></td>
</tr>
<tr>
<td>Others (please specify):</td>
<td></td>
</tr>
</tbody>
</table>
9) If you had 27 hours to allocate per week to the roles below, how would you do so? E.g. 3 hours on role 1, 1 hour on role 2 etc.

1. Assessment ____________________ hours
2. Individual intervention ____________________ hours
3. Group Work ____________________ hours
4. Training & Education ____________________ hours
5. Consultation ____________________ hours
6. Supervision ____________________ hours
7. Research ____________________ hours
8. Audit ____________________ hours
9. Other (please specify) ____________________ hours

THANK YOU FOR YOUR TIME

Please return this questionnaire by sending it in the return envelope provided to and placing it in internal mail.
Dear Colleague,

I am a first year trainee Clinical Psychologist studying at University of Surrey. I am presently on placement at [location], supervised by Dr. [supervisor], the Professional Lead for [specialization]. As part of my Service Related Research Project I am investigating referrers' perception and prioritisation of the roles undertaken by Clinical Psychologists working with adults in a Mental Health setting. It is thought that this information will help inform Clinical Psychologists as to how other professionals understand their roles and the perceived priorities in an environment where there are limited resources. By gathering information about your understanding of Clinical Psychologists' roles, this study is aiming to improve the relationship between potentially multiple referrers and a Clinical Psychologist. I will provide a summary of this research for all the professional groups that have been invited to take part and the Clinical Psychology Service. I will also feed back a summary of the conclusions from this study to the Psychological Therapies Working Party.

In order to make the findings meaningful for the locality I would appreciate your time to complete this questionnaire study. I have enclosed a copy of the questionnaire and would appreciate you returning it to me in the envelope provided via internal mail. I am aware of the constraints on everyone's time and have paid attention to this in the design of the questionnaire, which should take no more than about 10 – 15 minutes to complete. Please could you return the questionnaire as soon as possible and within a month of receiving it. By completing and returning the questionnaire it will be assumed that you are consenting to participating in this study.

If you have any questions regarding this study please contact me on the number above. I am at the service between Wednesday and Friday.

Thank you again for your time.

Yours sincerely,

Trainee Clinical Psychologist
Appendix 3

16 April 2005

Dear ...

Full title of study: Referrers perception and prioritisation of the roles undertaken by Clinical Psychologists working with adults in a Mental Health setting.

REC reference number: 7...
Protocol number: 2

Thank you for your letter of 18 March 2005, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.

The Committee has designated this study as having "no local investigators". There is no requirement for other Local Research Ethics Committees to be informed or for site-specific assessment to be carried out at each site.

Conditions of approval

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

<table>
<thead>
<tr>
<th>Document Type:</th>
<th>Version:</th>
<th>Dated:</th>
<th>Date Received:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Application Parts A &amp; B only</td>
<td>2</td>
<td>18/03/2005</td>
<td>30/03/2005</td>
</tr>
</tbody>
</table>
Management approval

You should arrange for all relevant NHS care organisations to be notified that the research will be taking place, and provide a copy of the REC application, the protocol and this letter.

All researchers and research collaborators who will be participating in the research must obtain management approval from the relevant care organisation before commencing any research procedures. Where a substantive contract is not held with the care organisation, it may be necessary for an honorary contract to be issued before approval for the research can be given.

Notification of other bodies

The Committee Administrator will notify the research sponsor that the study has a favourable ethical opinion.

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.

Please quote this number on all correspondence

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

Yours sincerely

Enclosures

Standard approval conditions
Appendix 4

Mrs ID: Referenda perception and prioritisation of the roles undertaken by Clinical Psychologists.

Further to my letter of the 15th March 2005. The Chairman on behalf of the RAMC has considered your response to the issues raised by the committee's initial review. The documents considered were as follows:
*NHS REC form parts A, B, C, and D (signed and dated 24/03/05)
*Copy of protocol (no version control noted)
*Copy of lay summary (no version control noted)
*Copy of questionnaire (version 1 dated 25/02/05)
*Copy of REC approval letter (signed and dated 16/04/05)

I am pleased to inform you that this study has now been approved by 'Chairman's action', and so may proceed. This approval is valid in the following organisations:

- Your RAMC approval is valid providing you comply with the conditions set out below.
  1. You commence your research within one year of the date of this letter. If you do not begin your work within this time, you will be required to resubmit your application to the committee.
  2. You notify the RAMC by contacting me, should you deviate or make any changes to the study protocol.
  3. You send the RAMC by contacting me, if significant developments occur as the study progresses, whether in relation to the safety of individuals or to scientific direction.
  4. You complete and return the standard annual self-report study monitoring form when requested to do so at the end of each financial year. Failure to do this will result in the suspension of RAMC approval.
  5. You comply fully with the Department of Health Research Governance Framework, and in particular that you ensure that you are aware of and fully discharge your responsibilities in respect to Data Protection, Health and Safety, financial probity, ethics and scientific quality. You should refer in particular to Sections 3.5 and 3.6 of the Research Governance Framework.

Please contact the Consortium Office if you wish this approval to be extended to cover other Consortium Organisations; such an extension will usually be agreed on the same day. We also have reciprocal arrangements for recognition of Research Governance approval with some other NHS Organisations; such an extension can usually be arranged within five working days.

Please note that if your work involves NHS Trust, this approval means that you now have your Research Passport.

Good luck with your work.

04 May 2005

Service Related Research Project.
Yours sincerely

Research Governance Assistant
Appendix 5: Categorisation for responses to Question 5: Please list the 5 most common forms of psychological difficulties that you refer to Clinical Psychologists?

Mood Disorders: Depression Bipolar

Impulse-control Disorders: Gambling

Anxiety Disorders: Panic PTSD Generalised Anxiety OCD Anxiety Phobias

Somatoform Disorders: Psychosomatic problems

Dissociative Disorders: Dissociative disorder

Personality Disorders: Personality disorder

Eating Disorders: Eating disorders

Substance-related Disorders: Addictions

Other conditions that may be a focus of Clinical Attention:

Others:
Stress Negative/irrational thinking Unresolved psychological issues Emotion Sadness Personal status difficulties
Appendix 6

Categorisation of responses for Question 6: Are there any reasons why you might not refer a client who has psychological difficulties to a Clinical Psychologist?

Service related issues:

- Waiting list
- No psychologist
- Won't be seen
- Inconsistency of practitioner
- Negative view of psychologist
- Not able to do so
- Lack of specialist services
- Lack of evidence of effectiveness of psychological therapies

Client related issues:

- Client doesn't want to.
- Substance misuse
- Personality disorder
- Too unwell
- Risk
- Too depressed to manage therapy

No reason:

- No

Referred for other treatments:

- Responds to medications
- Refer to counselling
- Manage myself
### Table 3: Referrer groups perception of the role of Clinical Psychologist.

<table>
<thead>
<tr>
<th>Percentage of group members that thought the role was included.</th>
<th>CMHT</th>
<th>GP</th>
<th>MCS</th>
<th>DH</th>
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<tr>
<td>Assessment</td>
<td>100%</td>
<td>97%</td>
<td>100%</td>
<td>89%</td>
</tr>
<tr>
<td>Individual Intervention</td>
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<td>100%</td>
<td>100%</td>
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<td>84%</td>
<td>83%</td>
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<td>Education &amp; Training</td>
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<td>81%</td>
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<td>78%</td>
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<td>Being Supervised</td>
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<td>70%</td>
<td>83%</td>
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<td>54%</td>
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<tr>
<td>Audit</td>
<td>67%</td>
<td>62%</td>
<td>33%</td>
<td>56%</td>
</tr>
<tr>
<td>Others</td>
<td>17%</td>
<td>8%</td>
<td>1%</td>
<td>0%</td>
</tr>
</tbody>
</table>
Dear Katherine

I am writing to you formally to say thank you for sending me the final copy of your service related research report, as well as the summary report that has certainly been disseminated across the teams here in the area.

I understand that you need confirmation of this for your portfolio. I do hope my email is acceptable and I attach your original email from 2005! I cannot believe you are now coming to the end of your training, and I wish you only the very best of wishes post-qualification!

You were a pleasure to have had here on placement, please let me know if you need anything else.

Yours sincerely
A discourse analysis of UK national daily newspapers' representations of 'paedophiles'  

Background:  
Print media is believed to be significantly influential on the public's moral position (Farrow & Brien, 2005), their perceptions of 'paedophiles' (Gavin, 2005) and the public's views on how 'paedophiles' should be treated by the judicial system (Sprott & Doob, 1997). This treatment has appeared to focus on incarceration and little attention paid to rehabilitation of offenders or whether this is effective in preventing re-offending.

Aims:  
The aims of this research are to explore media constructions of 'paedophiles' focusing on constructions of the 'nature' and 'origins' of 'paedophilia' and tracing implications for the rehabilitation of 'paedophiles'.

Method:  
Print media in the form of newspaper articles were used to examine the research question. A selection of 'popular', 'mid market', and 'quality' newspapers, published over three weeks from 30th January to 18th February 2006 were analysed using discourse analysis (Potter & Wetherell, 1987). This method was used to examine how the media used language to construct 'paedophiles', to identify the functions these constructions performed, and to consider how these functions are achieved (Coyle, 2006).

Results:  
Forty-two newspaper articles were used in the analysis, and the majority of these were found in the 'popular' press, especially 'The Sun'. The main themes that emerged were: the depersonalised construction of the 'paedophile' (with an emphasis on the inherently evil and inhuman nature of the 'paedophile' emphasised); the blaming and positioning of responsibility for offending (emphasising the responsibility of professionals to prevent offending); and the context of child protection and rehabilitation (emphasis placed on custodial sentences rather than rehabilitation).
Discussion:
The practical and theoretical implications of these findings were discussed (including the construction of ‘paedophiles’ effecting their motivation to seek help and its role on the maintenance of ‘paedophilic’ behaviour), as well as the limitations of the study.

References:


MAJOR RESEARCH PROJECT

A QUALITATIVE STUDY INVESTIGATING THE EFFECTS OF BEING DETAINED UNDER A SECTION OF THE MENTAL HEALTH ACT (1983) ON AN INDIVIDUAL'S IDENTITY

Year Three
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1. ABSTRACT

There have been few studies that have investigated the experiences of individuals who have been detained under the Mental Health Act (MHA) (Ross, 2003), though compulsory admission to a psychiatric hospital has increased by fifty percent in the last decade (Laurence, 2003). Studies that have explored the effects of being detained suggest that; individuals feel they are not being respected as a human being, experience reduction in self-esteem, and changes in self-concept (Beveridge, 1998; Hughes et al., 2007; Olofsson & Jacobsson, 2001; Rooney et al., 1996).

This study aims to explore specifically how the process of being detained under the MHA affects an individual’s identity. Ten participants who had been detained under the MHA were interviewed. Participants were asked in the interview about the impact of being detained on how they saw themselves, how they managed any changes in their identity and what they would have liked to have been different about their experiences. The interviews were transcribed and analysed using Interpretative Phenomenological Analysis. Six main themes emerged from the analysis and these suggest that participants’ experiences of being detained under the MHA caused sudden and sometimes permanent life and identity changes, caused feelings of distinctiveness and powerlessness, affected their self-worth, resulted in a sense that their identity was not complete, and resulted in the use of coping strategies.

These findings suggested that the experiences of being detained under the MHA could be conceptualised as a threat to an individual’s identity (as defined by Breakwell, 1986). The clinical and theoretical implications of this are discussed, with particular regard to the further development of Identity Process Theory (Breakwell, 1986, 1996).
2. INTRODUCTION

The experience of being an inpatient on a psychiatric ward has been a research focus for many decades, with Goffman's influential work, 'Asylums' dating back to 1961 (Goffman, 1961, reprinted in 1986). However, there have been relatively few research studies directly investigating the subjective experiences of individuals who have been compulsory admitted to a psychiatric hospital (Ross, 2003). In the studies that have been conducted, it has been noted that individuals report that such experiences have an impact on aspects of their identity, such as loss of self-esteem and feelings of control, though these were not explicitly explored (Barnes et al., 2000; Beveridge, 1998; Olofsson & Jacobsson, 2001; Rooney et al., 1996). This study aims to explore further the impact of being detained under the Mental Health Act (MHA) (1983), specifically looking at potential effects on an individual's identity. Such a focus appears to be particularly relevant in the current climate of increasing detentions under the MHA (Laurance, 2003; The Information Centre, 2007) and with the potential increase in compulsory powers given the proposed changes in mental health legislation (Dillon-Hooper, 2006).

This introductory section aims to provide an overview of the MHA; outline the relevant literature that guided the development of the research questions; and orientate the reader to the concept of identity used in this research study.

2.1 Mental Health Legislation

2.1.1 The Mental Health Act (1983)

The MHA (1983) is the current legislation that outlines provisions for the compulsory detention and treatment in hospital of individuals with a 'mental disorder' (Her Majesty's Stationary Office [HMSO], 1983, reprinted in 1999). The term mental disorder is broadly defined in the legislation as including individuals with 'mental illness'; individuals with 'mental impairment' ("a state of arrested or incomplete development of mind which includes severe or significant impairment of intelligence and social functioning"); individuals with 'psychopathic disorder' ("a persistent
disorder or disability of mind which results in abnormally aggressive or seriously irresponsible conduct”); and “any other disorder or disability of the mind” (HMSO, 1999, p. 1). It is of note that while the Act provides legal definitions for the terms ‘mental impairment’, and ‘psychopathic disorder’, it does not with regard to ‘mental illness’, (instead relying on clinical judgements) and this is the most common form of ‘mental disorder’ under which individuals are detained (Information Centre, 2007). The Act stipulates that an individual can be formally detained if they suffer from a mental disorder to a nature or degree, which makes medical treatment in hospital appropriate and is in the interest of their own health and safety, or for the protection of others (HMSO, 1999). The MHA also contains a ‘treatability’ criterion, where the mental disorder that an individual is suffering from must be seen as treatable for them to be able to be detained. This ‘treatability’ criterion has become a particular area of attention in recently proposed Draft Mental Health Bills (Department of Health [DOH], 2002, 2004, and 2006), which have included suggestions for its removal. The proposed reforms to the MHA will be discussed in more detail below.

The MHA is divided into ten parts including: the application of the Act (Part I); compulsory admission to hospital and guardianship (Part II); patients concerned in criminal proceedings or under sentence (Part III); consent to treatment (Part IV) and the management of property and affairs of patients (Part VII).

This study focuses on Part II of the MHA, concerned with civil detentions, which does not include court disposals or prison transfers (covered in Part III). It is felt that individuals detained under such a forensic section are likely to have had another detention experience (due to criminal behaviour), as well as that of being detained under the MHA, which could confuse the research focus.

Part II describes detailed requirements for the use of compulsory admission procedures, and sets out arrangements for the discharge of patients (Butler, 1983). It has numerous sections; with sections 2 and 3 the most commonly enacted (The Information Centre, 2007). Section 2 describes the requirement for a period of assessment, which can last up to 28 days, and section 3 describes the provisions for
treatment that can initially last for six months, with the possibility of multiple one-year extensions.

The use of mental health legislation by mental health services has substantially increased over the past two decades (Laurance, 2003). In the last decade, there has been a 7% increase in total involuntary hospital admissions under the MHA, with 94% of all involuntary admissions being under Part II of the Act (The Information Centre, 2007). Court and prison disposal admissions (Part III of the Act) represent virtually all remaining involuntary admissions. This high proportion of Part II admissions and the rise in the number of individuals being detained under the MHA suggests that this study's focus has increasing clinical and service delivery relevance.

2.1.2 Reforming the Mental Health Act

It has been argued that subsequent to media interest (over the last decade) in perceived failures in community care there has been an apparent need for the government to restore public confidence in mental health services and in particular, their ability to protect the public from people with mental health problems who present a 'danger to others' (Laurance, 2002). The government's response has been to propose reforms to mental health services (Laurance, 2002), with the publication of two key documents, 'Modernising the Mental Health Services' (DOH, 1998) and the 'National Service Framework for Mental Health' (DOH, 1999), which led to the White Paper, 'Reforming the Mental Health Act' (DOH, 2000). The government also suggested such reforms were required to support community based services (particularly Assertive Outreach Teams), and meet the need to bring mental health legislation in line with the Human Rights Act (DOH, 2000).

Following the White Paper a Draft Mental Health Bill (DOH, 2002) was presented with the intention of generating a new MHA. This Bill was strongly opposed by mental health campaigners and professionals because of its perceived expansion of compulsory powers, including the removal of the 'treatability test' and the introduction of compulsory community treatment orders (to enforce treatment compliance in community settings). The Sainsbury Centre for Mental Health (SCMH)
(2003) described the proposals as having provoked an almost "universally hostile response", reporting the proposed reforms as "draconian", "unworkable", and "impracticable" (p.2). Such opposition resulted in a second (DOH, 2004) and then a third Bill (DOH, 2006) - the third Bill intending to amend the current MHA rather than create a new MHA. Both these subsequent Bills also received strong opposition and criticism, and in March 2007 the government announced it would introduce a shorter piece of legislation that would amend the current MHA in November 2007. This legislation again looks likely to remove the ‘treatability test’ (replaced by a wider concept of ‘appropriate treatment’) and the right to independent advocacy, as well as introduce ‘supervised’ community treatment (which replace community treatment orders, and will be restricted to individuals who have already been detained as inpatients under the MHA) (Dillon-Hooper, 2006). Consequently there is still much hostility to the legislation, with fears that with the increase in compulsory powers, individuals’ rights could be compromised and people could be left unsupported without independent advocates (Dillon-Hooper, 2006).

I will now provide an overview of previous research on the effects of being detained under the MHA, with a focus on how this literature informed the development of the research questions for this study.

2.2 Literature Review

Before considering the findings of previous research, I feel it is important to set the political context within which some of the research was undertaken. In the 1970s (primarily in the USA though also in the UK) there was a difference of opinion between psychiatrists and civil libertarians as to the treatment of those deemed ‘mentally ill’. The psychiatrists tended to display a more ‘paternalistic’ attitude

---

16 It is noted that this review will include literature from a number of countries. This breadth is due to the minimal amount of published research found in the UK, and while it is recognised that there may be a number of cultural and legal differences to the context of the research discussed, it is felt that such research is still likely to provide a valuable insight into some of the effects of being detained on individuals and thus is of relevance to my research focus.
towards treatment issues, arguing for the benefits of being detained involuntary to a psychiatric hospital. On the other hand, the civil libertarians viewed involuntary admission as punitive and an attack on an individual’s freedom. Each side of the debate contested with the other, often using research that focused on opposing findings from involuntary psychiatric patients’ views of their admission (Edelsohn & Hiday, 1990). Consequently, there was often a significant political agenda behind such research depending on its socio-political leanings. In the review that follows such alternate agendas are worth bearing in mind.

2.2.1 Early exploration of the effects of being detained.

There have been relatively few studies exploring the effects of being detained (Ross, 2003). One of the earliest works in this area was by the sociologist Ervin Goffman, who in his book ‘Asylums’ (Goffman, 1991), examined the experiences of individuals who were unwillingly hospitalised.

In this work Goffman identified that an individual’s experience of being a ‘mental patient’ in a psychiatric institution was likely to impact on their self-concept and on their judgements of themselves in relation to others. Goffman contrasted a ‘mental patient’s’ situation before they entered hospital, where they had relationships and rights, with a situation where they experienced severe restrictions in both as a consequence of their admission. He said of being admitted, “[The detainee] typically begins with the experience of abandonment, disloyalty, and embitterment” (Goffman, 1991, p.125).

Goffman also pointed to the need for the ‘mental patient’ to change their present and past views of themselves, in order to make sense of their admission to hospital. This, he suggests involves believing the construction of their case history, as presented to them by mental health professionals, that they were/are ‘sick’. Goffman highlights that the construction of the mental patient’s identity starts to become the concern of others and consequently is out of a patient’s control, “...having one’s past mistakes and present progress under constant moral review” (Goffman, 1991, p. 151). He goes
on to argue that society’s construction of the mental patient is one of “not having a viable self” (p. 152), which is likely to be threatening to the individual’s self-concept.

It seems therefore from Goffman’s early work that being admitted unwillingly to hospital has the potential to have a number of effects on an individual’s identity. These include changes in both the perception of self and relationships with others; one’s sense of control; and one’s self-worth. While such findings have been substantiated by subsequent research, particularly qualitative studies (which will be discussed later in section 2.4.3), there is a body of research which has questioned Goffman’s findings and this will now be considered.

2.2.2 Following Goffman

In contrast to Goffman’s conclusions there have been several quantitative studies that have indicated that the majority of individuals detained under the MHA have viewed their experiences either neutrally or positively (Adams & Hafner, 1991; Gove & Fain, 1977; Rooney et al., 1996; Toews, et al., 1981). Gove & Fain concluded that there was no significant difference between the experiences of voluntary and involuntary patients, with both types of patient tending to have a favourable evaluation of their hospital experience and that “there is nothing intrinsic in the commitment process that is seriously debilitating and therefore it is a reasonable course of action” (Gove & Fain, 1977, p. 675). However, the study can be criticised methodologically as its findings were based on dichotomous question responses, which might make any differences involuntary and involuntary patients’ experiences harder to detect.

Twenty years after Gove and Fain’s study, which took place in the United States, Rooney et al. (1996) also compared voluntary and involuntary patients admitted to hospitals in Ireland. They concluded that in general involuntary patients viewed their admission neutrally and that over time patients showed a change of attitude to their detention from one that was initially negative to one that was increasingly more positive. Other studies (Allen & Barton, 1976; Kane et al., 1983; Toews et al. 1984; Toews et al., 1986) have also noted this change in attitude over time. Although Rooney et al.’s (1996) study concludes that the majority of involuntary patients
viewed their experiences neutrally; they also note that a substantial minority (34%) viewed it negatively, with particularly negative views regarding the hospital (54% of involuntary patients comparing it to being in prison). Other quantitative studies (Adams & Hafner, 1991; Toews, et al., 1981) have supported this finding, concluding that patients have more positive attitudes towards being detained than negative ones. A few studies have also highlighted that the majority of involuntary patients felt that their detention had been necessary for their treatment (Rooney et al., 1996; Toews, et al., 1981; Toews et al., 1986) and that individuals with ‘treatment experience’ (though it is unclear what is included in this experience) are in favour of compulsory hospital admission as a treatment option (Lauber et al., 2000).

While the studies above seem to construct a more positive picture of the potential experience of involuntary detention to that suggested by Goffman, they provide little indication of whether individuals experience being detained as having an effect on their identity, seeming to focus more on views of ‘satisfaction’ as an outcome measure. Further studies that highlight the more potentially complex effects of detention on the individual and that have been more influential in the development of this study’s research questions will now be reviewed.

2.2.3 Literature that guided the development of this study’s research questions.

Shannon’s (1976) research investigating the experiences of patients who felt coerced into treatment was one of the earliest undertaken. While it did not necessarily differentiate between voluntary and involuntary patients, it reported that patients who “felt coerced” were less likely than other patients; to expect that staff would be helpful, to believe that they needed and would receive treatment, and to think that a hospital was the “right place” for them. Instead, they were more likely to be angry about being physically controlled, to feel deceived, to be brought to hospital by the police, and denied any say about what was happening to them. Such reports of negative affect have been supported and expanded by other studies that have looked specifically at the experiences of being detained under the MHA (Beveridge, 1998; Hesford, 1992, as cited in Ross, 2003; Hughes et al., 2007; McKenna et al. 1999;
Hesford (1992, as cited in Ross, 2003) reported that the feelings associated with being detained under the MHA are feelings of unworthiness, vulnerability, humiliation, fear, anger, hatred, fatalism, negativism, and lack of control. This study has been supported by McKenna et al. (1999) whose quantitative study (undertaken in New Zealand) concluded that individuals detained under the MHA feel loss of autonomy, perceive hospitalisation as coercive and have a perception of "threat" and "force" with accompanying feelings of anger (p. 150). Indeed Morrison et al.'s (1999) study highlights the potential psychological difficulties that can arise from these emotive experiences, arguing that all psychiatric admissions are likely to be associated with pervasive distress and that a number of individuals show clinically significant symptoms of Post Traumatic Stress Disorder. Though this study was based on a small sample size (34 participants), it does raise the question of whether involuntary admission has the potential not only to cause distress but also to contribute to further mental health issues.

Other quantitative studies found that large proportions of involuntary patients reported; reductions in self-esteem, a crisis of identity due to being judged insane, feeling perceived as unfit to function in society, and feelings of frustration, bewilderment, and anger because of their detention (Beveridge, 1998, & Rooney et al., 1996). The finding of feeling perceived as socially 'unfit' has been supported by Lauber et al. (2000). He suggests that there may be an increased risk of stigmatisation as a consequence of being admitted to hospital for treatment, with individuals more likely to be identified as mentally ill in their social context. Each further admission may increase the risk of being identified as mentally ill, and the subsequent stigmatisation and devaluation of the individual (Wahl, 1999).

One of the few qualitative reports directly investigating the experience of being detained (Barnes et al, 2000) reports that participants describe a pervasive loss of control, especially over decision-making. It also suggests participants felt a sense of infantilisation, anger, punishment, labelling, loss of self-esteem and confidence, and
that detention can damage an individual’s capacity to trust others. However, this study also reported that the experience of being detained promoted self-reflection and self-awareness – both possible positive outcomes of the detention process. A further qualitative study, conducted in Sweden by Olofsson and Jacobsson (2001), found that detained individuals experienced feelings of dehumanisation and not being involved in their own care. They reported that participants felt that they were not capable, nor worthy, and that they had been changed into “another type” of person as a result of their detention (p.362). The experience of being changed into ‘another type’ of person because of detention, was further explored in a UK qualitative study (Thornhill et al, 2004) where participants’ described “wanting to escape from the identity of a chronic psychiatric patient” (p.188). Furthermore, the most recent known qualitative study exploring the experience of individuals detained under the MHA (Hughes et al., 2007) appears to support many of the above findings with participants descriptions of negative changes in self-concept, loss of identity, disruptions to relationships, and added difficulties in recovery as a consequence of detention.

While one has to be careful with generalising the findings of the above qualitative studies, they do appear to build on each other, seeming to present a broad understanding of some of the potential effects of detention on identity. These effects seem to include loss of self-esteem, loss of self-efficacy, and reduction of self-worth with negative evaluation of the new identity, and resulting negative affect. Given that Markowitz (2001) describes self-concept as one of the key elements to recovery, such findings seem likely to have significant clinical and service delivery implications.

It is of note that while many of the studies discussed so far take an endorsing or critical stance on detention (possibly reflecting the social-political influences commented on earlier), Johansson and Lundman’s (2002) qualitative study highlights a more complex picture. Here it is suggested that an individual’s experience of involuntary psychiatric care is likely to have features of both support (including experiences of being respected and cared for) and violation (including experiences of not being listened to, dehumanisation, and loss of integrity) as occurring whilst detained under the MHA.
While the above literature in many ways guided the development of this study’s research questions, it was also felt that service users’ perspectives should be taken on board as suggested by Faulkner and Thomas (2002). This is also in line with the government’s National Service Framework for Mental Health (DOH, 1999) where service user involvement in the planning and delivery of care is one of the key principles. Consequently, I will now look at a number of service user perspectives that influenced the development of this study’s research questions.

_Service Users’ Perspectives._

Since the 1980s there has been an increase in the number of published accounts by service users on their experiences of being detained under the MHA. In reviewing such accounts, which seem predominately negative, a number of potential effects of detention on an individual’s identity can be identified. Ronald Bassman (2001, p. 36) reported that, “When you become a mental patient, you are no longer regarded as a whole person with an individual mix of strengths and weaknesses”. He went on to describe his experience of being a ‘mental patient’ to include: a belief that recovery is rare and therefore that his situation was hopeless; and a belief that there were negative consequences to him showing emotions – “if you are laughing too happily, you are manic and need to be sedated” (Bassman, 2001, p. 40). Furthermore, in The Sainsbury Centre for Mental Health’s report (SCMH, 1998), an individual who was detained is quoted as saying “... [You are] not cared for in hospitals as individuals”. This seems similar to King (2006), who said of their experience, “The one thing about being sectioned is that you are a non-person”, and Rose (2000) who described feeling “scrutinised like a specimen rather than being a human being” (p.8) during her period of detention. It appears that such accounts highlight the potentially negative and dehumanising aspects of the detention experience.

These views from service users appear to substantiate some of the studies findings (particularly the qualitative studies) discussed above, and suggest that issues of identity are relevant in the experience of being detained under the MHA. I will now turn my attention to the concept of ‘identity’ as used in this study.
2.3 Identity Process Theory

Breakwell’s Identity Process Theory (IPT) (1986, 1996) has provided a context to the term ‘identity’ for this study, and an overview of this theory and its relevance to this study will be outlined.

IPT describes identity from a social psychological viewpoint:

“Identity is treated as a dynamic social product, residing in psychological processes, which cannot be understood except in relation to its social context and historical perspective.” (Breakwell, 1986, p. 9)

This viewpoint is particularly relevant to the area under investigation because of its integration of the psychological and social.

IPT describes identity as having two levels – its structure and its processes. The structure of identity is seen to be a dynamic social product and consists of a content and a value dimension. The content dimension consists of the social and personal characteristics of an individual which taken together make them unique (e.g. group membership and personal values) (Breakwell, 1986, 1987). This integration of personal and social identity appears in line with some of the experiences of individuals who have been detained under the MHA described in the literature above – where an individual’s social position as a detained psychiatric patient appears closely intertwined with aspects of personal identity, such as their emotions and attitudes (e.g. Barnes et al, 2000; Bassman, 2001; Olofsson & Jacobsson, 2001). Each element in the content dimension is described as having a negative or positive value attached, and these values comprise the value dimension (Breakwell, 1986). The value dimension is dynamic, so for example, changes in an individual’s position within a social system (e.g. being detained) will cause re-evaluation of the value of particular identity elements. This could be related to Bassman’s (2001) experience, as described in the literature review above, where laughing (which could be positively valued as being happy in one social system) became negatively valued as a sign of mania once he became a “mental patient” (p. 40).
Breakwell argues that the processes of assimilation-accommodation and evaluation regulate the structure of identity. These processes consist of the absorption of new components into the identity structure; the accommodation of the existing structure; and the allocation of meaning and value to identity contents (Breakwell, 1986). IPT reports that these processes are guided and motivated by at least four identity principles that are relevant in western industrialised cultures, though Breakwell reports that this is not an exhaustive list (Breakwell, 1987, 1993). The four principles identified are continuity, distinctiveness, self-esteem, and self-efficacy.

The continuity principle requires that any changes in identity between the past and present is perceived to be congruent with the development of identity, and that there is subjective consistency in how individuals see themselves. The distinctiveness principle is a motivational tendency towards establishing and maintaining a sense of differentiation from others (Vignoles et al., 2000) and recognises that individual and group distinctiveness may both be valued within the identity of an individual. Breakwell (1987) also highlighted that the distinctiveness principle may be culturally dependent and specific to individualistic cultures. The self-esteem principle motivates the need to achieve a personal judgement of worthiness (self-esteem is essentially evaluative and refers to the extent we like and approve of ourselves). The efficacy principle motivates one to maintain feelings of competence and self-control over one's life (self-efficacy being the belief that one can perform desired behaviours effectively (Bandura, 1997)). Loss of self-esteem and self-efficacy have been reported in the literature review (Barnes et al., 2000; Beveridge, 1998; Olofsson & Jacobsson, 2001) and suggest that challenges to these principles may be particularly relevant to individuals who have been detained.

Breakwell, (1986, 1993) goes on to define a threat to identity occurring when the processes of identity are unable to comply with the principles of identity, and that this is a subjective experience. IPT's provision of a framework for understanding 'threatened identities' appeared relevant to this study where some of the experiences of being detained under the MHA, as explored in the literature review, could be conceptualised as having the potential to be a threat to identity.
Breakwell (1986) identified three types of coping strategies that are used to remove or modify a threat to identity: *intra-psychic, interpersonal,* and *intergroup.* Breakwell specifies that what constitutes a coping strategy is “anything the individual believes to be done in order to expunge threat” (1986, p. 78), and therefore the outcome of the strategy, whether it fails or not, is not what defines it. *Intra-psychic* coping strategies operate at the level of emotions and cognitions and include deflection (e.g. denial and fantasy) and acceptance (e.g. compromising and change) strategies. *Interpersonal* coping strategies rely upon changing relationships with others in order to cope with the threat (e.g. isolation and compliance) and *intergroup* strategies can include group action (e.g. service-user groups) and the use of multiple group membership to shield against threat. It is thought that how individuals, who are detained under the MHA, cope with any perceived threat to their identity could have specific clinical relevance, as strategies such as isolation and denial could be conceived as further adding to an individual’s mental health difficulties.

### 2.4 Research Aims and Questions

The aim of this study is to gain an understanding of how individuals make sense of their experiences of being detained under the MHA. In particular, how they perceive the effect of these experiences on their identity. The study aimed to answer the following research questions:

- To what extent, and in what ways, do individuals believe that their experience of being detained under the MHA has impacted on their identity?
- To what extent, and in what ways, do individuals believe that their experience of being detained under the MHA has threatened their identity (in relation to self-esteem, self-efficacy, continuity, and distinctiveness)?
- To what extent, and in what ways, might an individual cope with any perceived threat to their identity due to being detained under the MHA?
3. **METHOD**

3.1 **Qualitative Analysis and the choice of Interpretative Phenomenological Analysis (IPA)**

As this study is concerned with understanding the uniqueness and particularity of human experience a qualitative methodology has been chosen (Lyons, 2000). This approach also seems evidenced as appropriate by the literature review above as previous studies have highlighted the complexity and variety of individuals’ experiences of being detained under the MHA. I believe that a quantitative method might struggle to capture the intricacies of any such experiences due to its focus upon the reduction of data into categorical units (Smith *et al.*, 1995). Furthermore, it has been suggested that a qualitative approach is able to manage and make sense of contradictory and diverse data (Willig, 2001), and therefore such an approach would seem most relevant to the current study where the literature review has emphasised the differing nature of previous findings.

3.1.1 **Interpretative Phenomenological Analysis**

It is thought that the qualitative approach of Interpretative Phenomenological Analysis (IPA) was particularly relevant to this study. The main aim of IPA is to analyse individuals’ phenomenological accounts of their experiences, believing that these experiences are unique and valuable, whilst recognising the subjectivity of the analyses (Smith *et al.*, 1999). IPA is particularly useful when the topic being researched is complex, novel or about process issues (Smith & Osborn, 2003). Due to IPA’s focus on how individuals make sense of personal experience it has also been described as being congruent with patient-centred research (Brocki & Wearden, 2006).

IPA would allow for a focused exploration of an individual’s phenomenological account of their experience of being detained under the MHA. In turn, it was hoped that this would allow for investigation of individuals’ perceptions of their identity and their accounts of whether this was ‘threatened’ by the process of being detained, rather
that due to any mental health difficulties they had at the time. It is individuals’
discrimination of the origin of the effect on their identity that will be relevant. Indeed
Smith (2004) has tentatively suggested that a core construct to emerge from IPA
studies has been one of identity.

The choice of IPA has also been influenced by my own beliefs and construction of the
world. IPA’s theoretical and epistemological position (see below) is aligned to my
own as a clinician, with its recognition that meanings are negotiated with a social
context (Smith, 1995) whilst assuming that an individual’s description of an
experience has some relationship to their internal or psychological reality.

Other qualitative methods, such as Discourse Analysis (Potter & Wetherell, 1987) and
Grounded Theory (Glasser & Strauss, 1967) were considered less appropriate in
approaching the research questions. Discourse analysis relates to a social
constructionist epistemology and is less congruent with this study’s aim to gain an
understanding of participants’ underlying beliefs about their experiences. Grounded
Theory is recognised to share many features with IPA (Willig, 2001), although IPA is
acknowledged to have more of a focus on an individual’s psychological worlds
(Willig, 2001) which would appear more relevant to the present study.

The theoretical and epistemological position of IPA

IPA is phenomenological in that it attempts to understand individuals’ perceptions of
phenomena and is interpretative or hermeneutic in that it recognises the role of the
researcher in making sense of experience (Smith, 2004). The role of the researcher is
affected by how they construct and make sense of their world, which means that there
is not a neutral relationship between subject and object (Richardson, 1996). IPA has
also been described as falling between two theoretical positions: one where there is a
belief that individuals’ accounts are seen as factual records that indicate a ‘reality’;
and another where individuals’ accounts have no relation to the external or internal
world. IPA lies between these positions, where there is recognition that individuals’
accounts are mediated through language, culture and political interests, whilst
acknowledging that there is ‘psychological reality’, where an individual’s account
does represent an expression of their inner world (Smith, 1995). This position has often meant that IPA has been described as coming from a critical realist epistemology (Coyle, 2006).

3.2 Sampling

A sample size of ten was chosen for this study. This number is in line with that recommended by Smith et al (1999) in order to allow for an in-depth analysis of the data whilst not causing the researcher to be overwhelmed by too much material. Sampling was purposive in order to gain a relatively homogenous sample. The topic being investigated (the experience of being detained under a civil section of the MHA) defined the boundaries of the relevant sample.

3.3 Participants

3.3.1 Recruitment

Ten participants were recruited by liaising with the MHA Administrator of the local NHS Trust where the research was taking place. The MHA Administrator dealt directly with my field supervisor, because of his role as a local clinician (a requirement for ethical approval). The MHA Administrator provided a list of possible participants who had been detained under the MHA and were under the clinical care of local mental health teams.

My field supervisor contacted the clinical care team to determine if a possible participant was suitable to participate in the study (see the inclusion/exclusion criteria). The identified suitable participants were then approached by a clinical care team member, given a Participation Information Sheet (Appendix 1), and asked if they were interested in participating in the study. If so, the clinical care team member asked permission from them to be contacted by myself by phone or letter (depending on their preference) in order to arrange a meeting. They were then sent a letter

17 A total of 13 potential participants were approached, 10 consented to participate, three declined for reasons unspecified by the member of their clinical care team.
confirming the meeting time and a Consent Form (Appendix 2). They were also offered an opportunity to meet to discuss the project in person if they preferred – though no one accepted this offer. Participants were given the choice of where they wanted to meet: eight of the ten decided to meet at their home; one at the base of their Community Mental Health Team; and one at their office. The NHS Trust’s Lone Working Policy was implemented to ensure the researcher’s safety.

3.3.2 Contextualising Participants

Table 1 below, presents the biographical data of the participants in order to provide some understanding of their life circumstances and their experiences of being detained under the MHA\textsuperscript{18}. The ten participants were all detained under the MHA within the last eight years. The duration of detention ranged from two weeks to six months. Participants ranged from being detained only once to “numerous” occasions.

\textsuperscript{18} Participants were given a short form to complete regarding biographical data before the interview started (Appendix 3).
<table>
<thead>
<tr>
<th>Participant</th>
<th>Sex</th>
<th>Age</th>
<th>Ethnicity</th>
<th>Employment Status</th>
<th>Personal situation</th>
<th>Diagnoses (participants words)</th>
<th>Number of times detained under the MHA</th>
<th>Sections of the MHA detained under</th>
<th>Length of time detained under the MHA (approximately)</th>
<th>Time since last detained under MHA (approximately)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ann</td>
<td>F</td>
<td>51</td>
<td>White British</td>
<td>Not presently employed</td>
<td>Married</td>
<td>Bipolar affective disorder</td>
<td>2</td>
<td>Section 3</td>
<td>1) 5 months 2) 6 months</td>
<td>3 years</td>
</tr>
<tr>
<td>Claire</td>
<td>F</td>
<td>30</td>
<td>White British</td>
<td>Employed</td>
<td>Single</td>
<td>Schizo-affective disorder</td>
<td>4</td>
<td>Section 3</td>
<td>1) 2 months 2) 3 months 3) 3 months 4) 2 months</td>
<td>3 years</td>
</tr>
<tr>
<td>Margaret</td>
<td>F</td>
<td>49</td>
<td>White British</td>
<td>Not presently employed</td>
<td>Single</td>
<td>Psychotic depression</td>
<td>1</td>
<td>Section 2</td>
<td>1) 3 weeks</td>
<td>2 years</td>
</tr>
<tr>
<td>Pamela</td>
<td>F</td>
<td>44</td>
<td>White British</td>
<td>Not presently employed</td>
<td>Divorced</td>
<td>Bipolar and Schizo-affective disorder</td>
<td>3</td>
<td>Sections 2 and 3</td>
<td>1) 6 months 2) 3 months 3) 3 months</td>
<td>2 years</td>
</tr>
<tr>
<td>George</td>
<td>M</td>
<td>48</td>
<td>White British</td>
<td>Not presently employed</td>
<td>Married</td>
<td>Bipolar affective disorder</td>
<td>1</td>
<td>Section 2</td>
<td>1) 2 months</td>
<td>3 years</td>
</tr>
<tr>
<td>Peter</td>
<td>M</td>
<td>61</td>
<td>White British</td>
<td>Not presently employed</td>
<td>Single</td>
<td>Schizophrenia, Obsessional neurosis and Psychosis</td>
<td>“Numerous”</td>
<td>Sections 2 and 3</td>
<td>Not recorded</td>
<td>1 year</td>
</tr>
<tr>
<td>Kate</td>
<td>F</td>
<td>44</td>
<td>White British</td>
<td>Not presently employed</td>
<td>Divorced</td>
<td>Bipolar affective disorder</td>
<td>8</td>
<td>Sections 2 and 3</td>
<td>1) 6 months 8) 2 months</td>
<td>4 years</td>
</tr>
<tr>
<td>Laura</td>
<td>F</td>
<td>47</td>
<td>White British</td>
<td>Employed</td>
<td>Married</td>
<td>Bipolar affective disorder</td>
<td>2</td>
<td>Section 2</td>
<td>1) 2 weeks 2) 3 weeks</td>
<td>1 year</td>
</tr>
<tr>
<td>Gemma</td>
<td>F</td>
<td>38</td>
<td>White British</td>
<td>Not presently employed</td>
<td>Single</td>
<td>Bipolar affective disorder</td>
<td>1</td>
<td>Section 3</td>
<td>1) 6 weeks</td>
<td>3 years</td>
</tr>
<tr>
<td>Francesca</td>
<td>F</td>
<td>55</td>
<td>White British</td>
<td>Not presently employed</td>
<td>Married</td>
<td>Bipolar affective disorder</td>
<td>2</td>
<td>Section 3</td>
<td>1) 4 months 2) 2 months</td>
<td>8 years</td>
</tr>
</tbody>
</table>
3.3.3 Inclusion and exclusion criteria

Participants were included in the study if:

- they had experience of being detained under a civil section of the MHA (1983) in the last ten years (a time-period suggested by Hughes et al., (2007) as being appropriate after consultation with a service user organisation)
- they consented to participate.

Participants were excluded from the study if:

- there were any risk concerns identified by their care team.
- they were currently experiencing an acute episode of mental illness.
- they had been detained under a forensic section of the Mental Health Act (it was thought that the process of detention under a forensic section had the potential to add another experience of detention that could confuse the topic under discussion).
- they had been discharged from a section of the MHA in the last 6 months (due to concerns that recall or reflection on the experiences might be too distressing).

3.4 Researcher

Qualitative researchers aim to acknowledge, describe and “bracket” their prior observations, knowledge and values (Ponterotto, 2005) as it is maintained that they cannot be differentiated from the research process, and need to be kept in mind in order recognise their role in the construction and expression of participants’ “lived experience”. While the knowledge I obtained prior to data collection has been outlined in the Introduction, it is also noted that this study particularly foregrounds Identity Process Theory (Breakwell, 1986; 1996), which has been used as a framework throughout the development of the interview schedule and data analysis. Such theoretical foregrounding has been described as a more a priori theoretically
committed approach (Storey, 2007) and has been used in previous IPA studies (Coyle & Rafalin, 2000; Turner & Coyle, 2000). With this said, there has also been an effort not to force theoretical constructs onto the data, especially at the initial stage of analysis, and to allow new concepts to emerge, in line with the inductive approach of IPA.

My previous clinical experiences of working with patients who have been detained under the MHA may have led me to assume that the experience of detention is an acutely disturbing and unsettling one. In turn, this may have resulted in me believing that individuals would report significant negative experiences of detention with consequent negative impact on their identity. With such potential biases recognised, I also note that I have had relatively limited contact with patients after discharge from section, and consequently feel I have fewer assumptions about how individuals would perceive their experiences after they have had time to reflect.

3.5 Procedure

3.5.1 Semi-structured Interview and Data collection

Smith and Eatough (2006) note that semi-structured interviews are the most common form of data collection in IPA studies. The aim of a semi-structured interview is to explore the topic under investigation in a way that allows the participant to bring to the interview novel and interesting material whilst providing enough guidance to ensure that the topic of focus is addressed.

The development of the interview schedule for this study was informed both by the literature review and by my university and field supervisors (Appendix 4). Furthermore, a number of service users were consulted in its development.

The interview schedule was designed to specifically answer the research questions, whilst trying to be as open as possible. Therefore, open-ended and non-directive questions were asked to allow the participant breadth and depth in their responses. With this said if a participant responded to a question with little information, there
were a number of prompt questions to encourage discussion. The interview schedule was divided into three sections: the process of being detained under the MHA (the day of admission); time spent in hospital whilst detained; and experiences since discharge. In each section there was firstly a focus on gaining a general understanding of participants’ experiences, then a more detailed investigation of: whether at that time there were any changes in how participants saw themselves; how participants managed any of these changes; and in what ways participants would have wanted their experiences to have been different.

For example, the questions relevant to identity began with a general question, and then included further prompt questions that were informed by the principles of Identity Process Theory (Breakwell, 1986, 1996) (self-esteem, self-efficacy, continuity and distinctiveness). These prompt questions were used if they were thought to be needed to promote discussion. By beginning with a more general question, it was also hoped this would allow participants to describe other aspects to identity that they felt were relevant that are not addressed in Identity Process Theory. An example of one of these questions with prompts is shown below:

Did the experience of being admitted to a hospital under a section effect how you saw yourself at the time?

- Did it affect your level of self-esteem? How you felt about yourself?
- Did it make you feel that you were different from others?
- Was there a sudden change in how you saw yourself?
- Did it change how you viewed your abilities to control situations?

The interviews lasted between thirty and ninety minutes, with most of the interviews lasting approximately an hour. The interviews were audiotaped and then transcribed verbatim.
3.6 **Analysis**

The data was analysed by myself and reviewed by my two supervisors and by a peer qualitative analysis group. Some participants also reviewed a summary of the themes that emerged from the analyses in order to assess participant validation of the findings.

Throughout the analysis I aimed to intertwine into the text evidence of the participant’s sense-making and my own sense-making as a researcher, whilst making transparent the differentiation between what belongs to the participants and what is my interpretation. If appropriate, I also attempted to consider the participant’s experiences and my interpretation of it within the framework of Breakwell’s Identity Process Theory. Breakwell’s theory takes a social psychological view of identity, which appears to be in line with the epistemology of IPA where there is recognition of a ‘psychological reality’ mediated within an external world.

3.6.1 **Stages of Analysis**

Smith has reported that his guidelines to IPA analysis are flexible and are likely to need adapting to an individual researcher’s way of working (Smith *et al.*, 1999). Throughout the analytic procedure, the research questions were a primary focus, though as suggested by Willig (2001) areas of interest outside the research questions were still allowed for. The analytic process took the following form:

- After all the interviews had been transcribed, the one deemed the ‘richest’ by its relevance to the research topic was identified. A detailed reading and re-reading of this transcript generated an overall perspective of the material and all initial thoughts and comments relating to the research questions were noted in the left-hand margin.

- The right-hand margin was then used to document any initial sub-themes that arose from the left hand margin notes. These sub-themes aimed to capture the content of the data in a thematic label. The sub-themes identified were continually checked against the data to ensure that all interpretation stemmed from the participant’s own words (see Appendix 5 for an analysed transcript).
Through re-reading these sub-themes were then further evaluated, refined and condensed and those that had weak evidence were 'pruned'- though it should be noted that the relevance of a sub-theme was not necessarily decided by the frequency of its occurrence alone, but also because of its 'richness'.

Connections between sub-themes were then identified and sub-themes were clustered together to give a main theme. This was given a descriptive label that conveyed the concepts of the sub-themes it contained.

A summary table of sub-themes and main themes from the first transcript was then produced with quotes.

This process was then repeated for one other transcript, the one deemed the second richest, with emergent sub-themes and main themes identified.

Areas of convergence and divergence of the sub-themes and main themes of the two transcripts analysed were identified and a summary table produced.

The rest of the transcripts were then read and re-read in detail and the summary table from the first two interviews was used to begin analysis of the remaining transcripts in the same manner, though new themes could be added, or present ones elaborated or pruned.

After all the transcripts were analysed I went back to earlier transcripts to check whether themes that were added in later transcripts were supported.

Finally, a list of main themes was identified with their constituent sub-themes and quotes from the transcripts, which aimed to capture the essence of the participants’ experiences.

3.7 Ethical considerations

Consideration was given to the possible effect on the participants of discussing potentially distressing memories. Participants were recipients of ongoing clinical care from mental health services who were aware of their participation and the potential need to provide support. Informed written consent was obtained from all participants and it was emphasised that neither participation nor non-participation would affect their clinical care. All participants were offered the opportunity to contact the researcher within one month of participation should they need to discuss any issues that arose, though none did. At the end of the interview schedule, the participants were
asked what they felt about being interviewed on the topic, so that any distress could be identified and managed.

The interviews with the participants were audio taped for which written consent was obtained. All data was anonymised and treated as confidential material. The study was reviewed and approved by the Local NHS and University of Surrey Ethics Committees, and by the local Research and Development Consortium (Appendix 6).

3.8 Evaluation of Qualitative Studies:

Elliot et al. (1999) suggest a number of criteria that are applicable to both qualitative and quantitative research and further criteria that are unique to qualitative research. Elliot et al. (2000) have located their criteria within a phenomenological-hermeneutic tradition (Willig, 2001), making them appropriate for IPA analysis

3.8.1 Elliot, et al’s (1999) guidelines that are unique to qualitative research

Owning one’s perspective:
This guideline highlights the need for the researcher to specify their values, interests, and assumptions and how they may have influenced the research process. In section 3.5, I have discussed my prior knowledge, observations, personal values, and biases and have attempted to describe how these factors may have influenced the research process in a transparent manner.

Situating the sample:
In an attempt to provide the reader with an understanding of the relevance of this study’s findings to other individuals and situations, I have described some of the characteristics of the participants in section 3.4.2.

Grounding in examples:
In the ‘Results’ section I have aimed to ground the analyses in data by providing numerous direct quotes from transcripts. It is also hoped that the analysis of the data and interpretations made are transparent to the reader by the clarity of the ‘Results’
section. Included in the appendices is a transcript that has been analysed (Appendix 5) in order to give the reader a further understanding of the analytic procedure involved and a table of the participants whose descriptions contributed to the development of subthemes (Appendix 9).

**Providing credibility checks:**
A summary of the themes were sent to the participants who consented to being involved in this process, asking them to provide feedback (Appendix 7). Two of the ten participants provided feedback (Appendix 8), which overall suggests a high degree of fit between the suggested themes and participants’ experiences.

A further credibility check was achieved by having a supervisor and a peer qualitative analysis group monitor the research and analytic process. This involved them reading a transcript and providing comments on what areas of interest arose for them, remarking on whether the themes appeared to be of good fit and were grounded in the data, and to note any themes they thought were missing.

**Coherence:**
This guideline highlights the need to represent the findings in a manner that is coherent and structured, allowing the reader to understand the integration of the data whilst still conveying the nuances. I have sought to meet this criterion by providing main and subthemes in the results, noting the overlap between themes and between participants’ accounts, whilst reporting areas of difference.

**Accomplishing general versus specific research tasks:**
A specific task of this study was to investigate a small sample of individuals’ experiences of being detained under the MHA, and how they perceived this to affect their identity. It is recognised that the ten participants in this study represent only a small sample of individuals who have experienced being detained under the MHA, and it does not aim to represent a more generalised sample. However, it aims to provide a more in-depth understanding of the phenomenon and its links to psychological theory.
Resonating with the readers:
This study aims to be presented in a manner that provides the reader with an increased understanding and interest in the experiences of individuals who have been detained under the MHA and the impact this may have on their identity.

4. RESULTS

How does being detained under a section of the Mental Health Act affect an individual’s identity?

Six main themes emerged from the data that are relevant to the above research question, each with several subthemes (see Table 2).

Table 2

<table>
<thead>
<tr>
<th>Main Theme</th>
<th>Subthemes</th>
</tr>
</thead>
</table>
| 1) Life changes          | i) Rupture: permanent and sudden change to life situation.  
                            | ii) A new identity trajectory  
                            | iii) Loss of stability        |
| 2) Distinctiveness       | i) Being perceived and treated as different.  
                            | ii) Seeing self as different  |
                            | iii) Group distinctiveness    |
| 3) Powerlessness         | i) Lack of understanding in the process  
                            | ii) Control and power being taken away  
                            | iii) Long-term effects on self-efficacy |
| 4) Self-worth            | i) Devaluing and dehumanising experience  
                            | ii) Negative evaluation of self  
                            | iii) Positive changes in self  |
| 5) Identity not complete | i) Something being taken away  
                            | ii) Feeling lacking            |
| 6) Coping                | i) Distraction and avoidance  
                            | ii) Acceptance                |
                            | iii) Agency                   |

19 See Appendix 9 for a summary table of the number of participants whose descriptions were included in the subthemes.
4.1 Life changes

A main theme that emerged was a general perception that there had been sudden changes in participants’ life situation. This appeared to sometimes result in participants’ views of themselves changing either at the time of detention or since discharge. This also seemed to cause changed perceptions of their future life and in particular its stability. These subthemes are discussed below:

4.1.1 Ruptures: permanent and sudden changes in life situation

Many of the participants describe being detained under the MHA as causing a sudden change in their life. For example, two of the participants, Pamela and George, reported feeling that they were in a “different world” (Pamela) or a world that had “been turned on its head” (George). This seems to indicate a sense of disorientation where their whole life situation had become unfamiliar. Another participant, Kate, described being detained under the MHA as: “the rug being pulled up from under my foot”, suggesting her experiences also contained an unexpected and destabilising quality. Ann’s description of being detained as a “dramatic event” that “equates to nearly losing my life” also highlights the powerful impact being detained under the MHA had on her life. The descriptions above appear to suggest that not only is being detained under the MHA a sudden event but one that causes a sense of rupture in some of the participants “normal” life and environment.

Ann goes on to describe this “dramatic” experience as having a sense of permanency about it, as if her change in life circumstance has had such an impact that she can never return to her pre-detention situation.

Ann:  
"It impacts so much on you and I think it is such a drastic event that it will never leave you. Never [...] it sort of taints you."

Claire’s account is more specific in that what changed in her life when she was detained was the amount of control she had.
Claire: “I never knew that something like this could be forced upon me, I never knew that I would be in a situation where matters were taken out of my hands [...] Like anybody you do have a certain amount of control don’t you before things for whatever reason are taken away from you, and that’s quite hard to come to terms with.”

Claire seems to describe a sense of surprise that she could be placed in a situation where control was taken away from her; a situation she never considered could happen before she had been detained under the MHA. This surprise is similar to George and Pamela’s disorientation with regard to their description of being in an unfamiliar situation, both suggesting feelings of confusion and bafflement at the experience. Rooney et al.’s (1996) quantitative study also reported that involuntary patients described feelings of bewilderment at the time of detention.

Although Claire appears to report surprise at having to “come to terms with” a situation where control is taken away from her she differs from Ann’s description of it being a “dramatic event”:

Claire: “I wouldn’t say it was dramatic, it felt like it at the time, but not looking back, you know there are far worse things that can happen to you.”

It appears that Claire, when looking back on the experience, finds comfort in comparing her experiences with other possible worse ones. Claire, who is the youngest of the participants, highlights in her interview her need to “move on with life” and not “to be a victim”, and her reflection that “there are far worse things that can happen to you” could be a way of helping her to “move on”.

4.1.2 A new identity trajectory

Some participants also describe the experience of being detained under the MHA, and the consequent rupture in their life situation as resulting in a new life and a new
identity. Pamela describes herself as not being the “same” as before and her life not being one “you thought you were going to have”, as though the “different world” she entered when detained under the MHA (4.1.1) has resulted in her expected identity and life path being interrupted and resulting in a new unplanned trajectory. This could be understood in terms of Breakwell’s (1986) concept of the principle of continuity (as referred to in the ‘Introduction’): participants’ descriptions of their experiences could be conceptualised as a discontinuity of identity before and after being detained.

Francesca describes this new identity trajectory resulting in her not being able to be the person she was before she was detained under the MHA, as if there was no going back and no returning to the original trajectory. Olofsson and Jacobsson’s (2001) stated that participants in their study described being changed into another type of person, which appears similar to Francesca’s experience.

Francesca: “I lost the person who I was before I was sectioned. The person who I was when I was working and everything was going okay, wasn’t the same person who was in hospital [...] so it does make you think and look at yourself, and think what if that hadn’t happened where would I be in my life [...] no I’m not the same person”.

This appears to leave Francesca wondering “what if” and where she would be in her life if she had not had the experience. This seems similar to Laura’s comment that “if I hadn’t been sectioned I don’t know what I would have been doing”.

4.1.3. Loss of stability

Many participants describe “an awareness” (Claire) that their life situation could suddenly change again in the future leaving them feeling like “you can’t really control your life” (Ann) and that “you just haven’t got any control over your future really” (Pamela). These quotes not only appear to describe feelings of loss of stability but also loss of control over life, which is explored further in 4.3.4. Two participants explicitly identify an awareness of the possibility of being detained again in the future (Kate
reports feeling she is “at risk of being admitted again” in the future and Margaret describes feeling “vulnerable” to “having something like that happen”). Claire identifies this threat to her sense of stability as coming from her social worker, in that “she [social worker] could just whip me in there”. This could result in Claire finding it difficult to trust others, which has been reported by Barnes et al. (2000) as a theme to their qualitative study.

Claire’s goes on to highlight this sense of lack of control over her future:

Claire: “I’m always aware, there’s an awareness now that things might not be like they are forever, and there might be a situation I can’t control something or be responsible for something myself [...] I’ve learnt that what’s yours now today might be totally different tomorrow, you might be in a totally different situation. You have to be grateful for the fact that what you have, the person you are and the person you have that’s yours, just be grateful for it because it can be taken away from you, and that’s what happens. [...] I thought I was completely untouchable that nobody could mess with anything that I thought about or anything I wanted to do. Which is a bit arrogant really but that’s how it was”.

This account also includes awareness about future identity instability in that “the person you are”, the thoughts you have, the things you wanted to do, your identity, “can be taken away from you”. There appears to be a realisation that how she sees herself is open to change again in the future and therefore is not a stable construct.

4.2 Distinctiveness

A second main theme that emerged was one of distinctiveness, and consisted of three subthemes: being perceived and treated by others as different; seeing self as different from others; and being a member of a distinctive group.
4.2.1 Being perceived and treated as different

Most of the participants described feeling as though others perceived them and treated them differently during or after being detained under the MHA. Some of the participants reported feeling that since being detained other people saw them as someone who was dangerous.

Claire: “I thought people were scared of me, they didn’t want to speak to me, they didn’t want to approach me, all that sort of thing”.

Margaret also describes feeling that because she had been “put under section” people would think differently of her, as there must be a “serious reason behind it”, which was either that “you’re going to hurt yourself or someone else”. Her account is similar to Claire’s in that Margaret also felt people treated her differently, with a “bit more suspicion”.

Francesca goes further in her account, describing the emotional impact this has on her when she is perceived as “dangerous” by others.

Francesca: “I can remember asking my sister why I was sectioned, and she said it was for my own safety because it did bother me that maybe people thought I was dangerous to others. But it did bother me that people might think that I had a section because I was a danger to others. And it especially bothered me, that they’d think that I was a danger to him [her son].”

Francesca’s focus on being “especially bothered” by how others viewed her as dangerous, compared to Margaret and Claire’s accounts, might be linked to Francesca losing custody of her son when she was sectioned under the MHA, and having to fight for access rights after she was discharged. In these circumstances the emotional impact of others thinking she “was a danger to him [her son]” may have been greater because of the consequences it meant in terms of her ability to see her son.
Some of the participants identified the other people that perceived them as dangerous being mental health professionals, who then treated them differently because of this perception. Margaret acknowledges that even though she felt that she “would never hurt anyone else” or kill herself, that the “professionals saw it differently”. Kate goes on to describe a nurse’s perception of her as dangerous, with the nurse saying to her: “if I let you go out with me you might kill me”, appearing to result in her being treated with caution.

Laura’s account slightly differs from the other participants’ accounts in that she describes being viewed differently during the process of being detained under the MHA:

Laura: “I didn’t think I needed to be treated as inhumanely as I was, because I wasn’t aggressive, I wasn’t causing them any trouble, you know, I didn’t need to be treated like that.”

Laura describes the police treating her in an “inhumane” way because of what seems to be her belief that they may have viewed her as “aggressive”. Laura’s account of being detained by the police as a traumatic experience was still emotionally upsetting for her, which was evident in the interview when she cried when recalling what she describes as her maltreatment by the police. For Laura this especially salient experience appears to have contributed to her comparing her mental health history of being detained under the MHA to a criminal record where others would judge her differently because of it.

Laura: “When I started to become well it’s a huge stigma to know that you’ve been sectioned, it’s like having a criminal record, only worse in a sense. I mean, no matter what I do, it will always be on my record that I’ve been sectioned, so I would think in some situations, let’s say I was a witness or something in court or some other situation, my reliability would probably always be questioned.”
George also describes believing he would be treated differently in the future; he felt that it would happen if he returned to work because he would be going back with “a label saying I had been sectioned”. This is similar to Laura’s description of “being sectioned” as a “black mark”.

Gemma, like Laura, experienced police involvement in the process of being detained under the MHA. She described remembering at the time feeling the experience was “horrendous” because she felt that due to the police involvement other members of the public saw her as “abnormal” and “sticking out”. Therefore, Gemma appears to feel a sense of distinctiveness from the police being involved in the process.

4.2.2 Seeing self as different

Pamela and Gemma appeared to “resign” (Pamela) themselves at the time of being detained under the MHA to being “different” (Pamela) and seemed to take on professionals’ perceptions of them as “dangerous to themselves or others” (Gemma) and “out of control” (Pamela). As mentioned above (4.21), Gemma’s experience of the police involvement in the MHA detention process was observed by members of the public, whom she believed saw her as “abnormal”. This could have resulted in her being more likely to internalise the view that she is “dangerous” as it appeared to be reinforced by others (members of the public and the police) apart from mental health professionals. Pamela and Gemma’s apparent internalisation of the views of professionals, and/or members of the public, seems to support the symbolic interactionist premise (Blumer, 1969). This premise argues that how we see ourselves is derived from ongoing social interactions (Charon, 1995), with the taking on of others’ perspective and that it is not entirely idiosyncratic (Willig, 2001).

Ann describes the feeling that she is different, or that she is not “normal like everybody else” making her feel that she is “set apart”, which she finds “isolating”. Claire also appears to feel that she is unique because when she compares herself to others she finds that nobody else she knows has had the experience she has: “I thought ‘oh god I don’t know anybody who has had this happen to them’...”.
Margaret described a different experience where she did not internalise others’ image of her:

Margaret: "No I didn’t think I was nuts, no I thought I had let things really get to me and I had sort of run myself down. Not eating and sleeping properly and things like that. But err no I didn’t see myself as nuts at the time."

She describes having a different understanding of what was happening to her, where instead of taking on a perception of herself as “nuts” which she appears to feel others identified her as, she describes a feeling of being under stress and external factors affecting her rather than it being something internal.

4.2.3 Group distinctiveness

Another subtheme that emerged from the data was a sense of the participants as seeing themselves as members of a group, and that this group was distinct.

Peter’s describes “patients” distinctiveness as their uniqueness in having nothing at all to them, as if their distinction is in their emptiness compared to other people.

Peter: “Of course the way I see myself as opposed to the way some other people see me. Other people presume that the patients have no identity at all, that they have no emotions, no personality, no rights, no nothing in a way. It’s surprising for them when they do show some characteristics. That’s the opinion of some.”

Peter lives in residential care where he is still very much identified as a “patient”, which could explain why his account is more focused on how others view “patients” in general and less about others’ perceptions when they know that he has been detained under the MHA.
In George’s account below, he appears to be describing his move to a new social category of individuals who were detained under the MHA, as if he has moved from an ‘ingroup’ to an ‘outgroup’.

George: “... the fact is I am a police officer, I’ve dealt with a number of people being sectioned, basically you are one of them.’

Researcher: ‘And what did being ‘one of them’ mean to you?’

George: ‘Well I suppose being a nutter’

Tajfel (1978) social identity theory describes individuals’ motivation to categorise people into ‘outgroups’ (different from self) and ‘ingroups’ (including the self) in order to achieve a feeling of positive group distinctiveness. It could be interpreted that George previous conceptualisation of himself being in the ‘ingroup’ as a police officer has been challenged, as he is now identified in the ‘outgroup’ as “one of them”. This seems, initially at least, to result in a feeling of negative group distinctiveness (“being a nutter”).

Ann compared the group of detained individuals to mental health professionals, leaving her feeling that her group was “abnormal” compared to them who she describes as “normal”. Claire differs from Ann and George in that she compares the group of detained individuals to other patients who were in hospital voluntarily.

Claire: “There is two kinds of camps isn’t there, I suppose there are the people that are under section, there’s the other ones that aren’t on a section”.

Pamela takes this difference further by suggesting that being a member of the “club of people who are sectioned”, not only made them “join forces” but also gave them a sense of positive uniqueness where they were “exclusive” and “higher up the hierarchy of the hospital”, which feels like having “a badge of honour”. Pamela’s comparison of herself to others could be conceptualised in terms of a downward social comparison, where one compares oneself to less fortunate others which can increase one’s own self-esteem (Dovidio et al., 2000). In Pamela’s account, it seems she feels
fortunate being in the “exclusive” “club”, which may be because of what seems to be the added status of being an involuntary patient. Downward social comparisons have also been reported to regulate negative emotion following threat (Wills, 1981).

Breakwell (1986) describes the need to feel distinct and unique from others as one of the prime motivational principles in identity process theory, which guides and motivates the processes shaping identity. It appears that Pamela’s example above of being in a distinct group provides her with a positive sense of uniqueness and differentiation from others, which may give her some protection from feeling her identity is threatened in the social context she is in.

4.3 Powerlessness

All of the participants described feelings of powerlessness related to their experiences of being detained under the MHA. This third main theme consisted of three subthemes: lack of understanding in the process of being detained under the MHA; control and power being taken away; and long-term effects on self-efficacy.

4.3.1 Lack of understanding in the process

A majority of the participants described a lack of understanding in the process of being detained under the MHA. For example: Pamela describes not understanding “what was happening at all […] I had no idea what was going on”; Gemma reports that she “didn’t really understand sectioning” and that she had not “even heard of the word”; and George goes on further to describe being “scared” because of “not understanding” and “not having the knowledge”. This lack of understanding could be conceptualised in terms of powerlessness as participants lack of knowledge may result in increased dependence on professionals who have the knowledge, and could lead to a minimal ability to influence the situation they are in. This appears similar to Hesford (1992, as cited in Ross, 2003) and Hughes et al’s (2007) studies that report feelings of lack of control associated with being detained under the MHA. Gemma attributes this lack of understanding to nobody explaining to her what was happening:
Gemma: "... nobody explained. It was almost like they sort of... obviously thought, 'well you are quite poorly we’ll give you something to calm you down with and then take you to [psychiatric hospital] but we can’t actually talk to you'...”

Laura compared the lack of explanation to what you are told if you are arrested, feeling that less is explained to you when you are “sectioned”:

Laura: "I mean I think... nobody actually explains what the rules are. I mean if you are a mental patient for the first time, you’re sectioned, it’s not like anybody tells you, I mean if you get arrested, they read you your rights, when you are sectioned nobody sits down and explains what your rights are and what they are not and what you can do.”

Laura has previously compared her experience of being detained under the MHA to having a criminal record and to being a criminal (4.21) and the continuation of this comparison to being arrested is linked to her traumatic and salient experience of the police’s involvement in her detention under the MHA.

Pamela, Laura, and Peter all identified how this lack of understanding about the process of being detained was more of an issue the first time they were detained. For example Pamela, reports: “I suppose the more time you are sectioned the more times you know the system [...] I didn’t know what was going on the first time, the second and third time I did”. This suggests that participants may experience greater feelings of powerlessness during their first experience of being detained under the MHA.

4.3.2 Control and power being taken away

A common subtheme that ran through all of the participants’ accounts was one of control and power being taken away from them whilst being detained under the MHA (this was also seen in the loss of stability subtheme (4.13)). Many of the participants
describe control over decision making being taken away. For example, Gemma reports, “I didn’t have to make any conscious decisions about anything”. This appears to be similar to Barnes et al.’s (2000) qualitative report where participants who had been detained under the MHA describe a pervasive loss of control, especially over decision-making. Feeling part of the decision-making process is reported to help patients perceive ‘procedural justice’ and minimise the experience and perception of coercion (Lidz et al., 1995).

For Claire this level of control infiltrated even more internally than it appeared to for other participants:

Claire: “You don’t feel in control of what you are... even what you are thinking in a way, because they have seized all of that”.

Peter and Laura describe power and control being taken away in terms of not having “any rights at all” (Peter) or having “less rights than if you were a criminal which I’m not sure is right” (Laura). Laura again goes on to compare her level of control over her freedom with that of a “criminal”, appearing to feel it is unjust as she has not committed a crime and that there is no certainty of being released:

Laura: “... knowing that I haven’t actually committed any kind of crime, and yet I can have my liberty removed completely without any recourse to justice, well for sometime anyway. You know if you are a criminal and you go and punch somebody or do something then you go to a police station, you can have a solicitor and you will probably be released within twenty-four hours”.

For Laura what perhaps would normally be a ‘downward comparison’ to a criminal, has now become an ‘upward comparison’ where she is worse off in terms of her level of control than a criminal.
Some participants describe the negative affect (Kate: “demeaned” and “unhappy”), resulting from feelings of powerlessness and the “vulnerable and weakened position” (Claire) they are placed in because of their perception that their control has been taken away. This appears to be consistent with Bandura’s (1997) review of self-efficacy, which describes loss of self-efficacy leading to negative effect.

Below, Claire likens this power and control being taken away from her to being “taken back” to the position of a child, as if her identity has regressed to a previous one where she is not responsible and does not have to make any decisions.

Claire: “Well in a way you feel, it’s a regressive thing, [...] because you have all your responsibilities taken away, you don’t have to make any decisions, nothing like that, and you do go to almost a childlike state [...] because you are kind of involuntarily taken back to being about nine years old”.

The descriptions of powerlessness above also fit with Breakwell’s (1993) self-efficacy principle in Identity Process Theory, which refers to the motivation to maintain feelings of competence and control. These descriptions of loss of self-efficacy constitute a threatened identity.

In contrast to some participants’ reports, Pamela, describes a different experience where control being taken away from her as a “good thing” and that she “needed to be controlled”. This appears in line with Pamela’s earlier description of seeming to internalise professionals’ view of her as “out of control” (3.22), which could therefore cause her to feel that it would be positive if control were taken away from her.

4.3.3 Long-term effects on self-efficacy

The third subtheme relates to participants’ reports about their present and future perceptions of the level of control they have over their life.
As mentioned in the previous subtheme of loss of stability (4.1.3) participants describe being aware that they are at "risk of being detained again" (Kate).

Margaret: "I suppose it has made me feel a bit, you know, how vulnerable we can be really sometimes to being sectioned, or to having something like that happen to us".

For Kate and Margaret, not only does this "risk" potential mean a loss of stability over their future but also the possibility of being placed in a "powerless" (Kate) position where they do not "have much control at all" (Margaret).

Ann reports that it now feels "like you can't control life" and that she is "less in control", rather than a future situation where control could be lost. Ann's more continual feelings of loss of control could be related to her description in the interview of taking an overdose less than a year ago, directly relating this to what she describes as the "dramatic" experience of being detained (4.1.1). Pamela also describes perceiving at the time of interview that she does not have any control over the future, which prevents her making any plans ("we don't have plans beyond tomorrow"; "your future's totally forgotten"), as if she has become aware of the futility of it. The concept of self-efficacy (Bandura, 1997) seems particularly relevant here, in that participants' belief in their ability to influence action has been threatened by their experience of being detained under the MHA.

Claire goes further in describing this "awareness" of the fragility of the level of control she has as changing her perception of herself as someone who is "untouchable":

Claire: "There's an awareness now that things might not be like they are forever, and there might be a situation where I can't control something or be responsible for something myself, so there's always that, there's always that kind of thing in my head that says actually even though you feel that you are in control of this situation you might not be for whatever reason [...] Just to
know that I'm not an all encompassing entity that is totally autonomous where as before I did think that. I thought I was completely untouchable that nobody could ever mess with anything that I thought about or anything I wanted to do.”

The impact on Claire of this experience of control being taken away is not solely related to self-perception, as she also describes it affecting her relationships with others:

Claire: “I felt like I couldn’t open up anymore with anybody because as soon as that happened somebody would take control, take charge and I’d be off again, you know, taken back”.

4.4 Self-worth

A fourth main theme that emerged from the data was one of self-worth, where a majority of the participants reported feelings of low worth and value because of their experiences of being detained under the MHA. These feelings of low self-worth were for some participants temporary, with them reporting a more positive evaluation of self at the time of the interview. This main theme consists of three subthemes: devaluing and dehumanising experience, negative evaluation of self and positive changes in self-esteem.

4.4.1 Devaluing and dehumanising experience

A majority of participants reported general feelings of being devalued and degraded due to their experiences of being detained under the MHA. The experience of being detained is described as being “completely demeaning” (Ann) and “degrading” (Laura); and that being “sectioned was humiliating” (Pamela). Ann describes this “demeaning” experience as making her feel like a “low life”, whilst Kate experienced it as “soul destroying”, as if the very essence of whom she is was obliterated.
Ann describes feeling that it dehumanised her ("you haven’t got your liberty... and it dehumanises you"), as if one’s full humanity is questioned ("[you are] just sort of less of a human being"). Ann’s feelings of being “less of a human being” relates to her experience of being detained as one that “equates to nearly losing my life” (4.1.1).

The descriptions of dehumanisation appear to be in line with the findings of Olofsson and Jacobsson (2001) who described the core theme of individuals’ experiences of being detained under the MHA as one where they felt they were not respected as human beings. Ann appears to be taking this sense of dehumanisation further in that not only is the experience dehumanising but also more specifically that it is the consequences of others’ actions that dehumanises her: “like they [mental health professionals] are dealing with animals”. This appears similar to Laura’s description of being treated “inhumanely”.

Ann also describes the importance her lack of freedom has in affecting her feeling of not having a “true life”. It is as if her basic human right to freedom is taken away, making her feel less than human.

Ann: “... because it’s not life, it is not true life being locked on a ward all day [...] your rights as a human being or as an individual are no longer yours... it’s just awful, dreadful”.

Previously (4.3.2) Peter’s and Laura’s descriptions of having reduced rights were described as power and control being taken away, whereas in Ann’s quote above the impact of her restricted liberty appears to be more indicative of a dehumanising experience with the potential to effect feelings of self-worth.

Laura’s account below also describes her concerns that her status as a citizen may have changed because of being detained under the MHA. She links this potential challenge to her “civil liberties” being because she is in a “different league”, as if she is identifiable as being beyond the remits of full civil rights.
Laura: “I think there are some things as a human being, my civil liberties may have changed as a result of being sectioned. I'm not sure I can serve on a jury. I'm not sure I can adopt. And I'm not sure that it wouldn't be used against me as a credible witness or something like that. So those are the things that concern me about being sectioned as opposed to having being admitted voluntarily. Because the good and the great go to hospital voluntarily, being sectioned puts you in a different league I think, where you aren't even capable of making a decision for yourself, it has to be made for you.”

This subtheme of dehumanisation and devaluation could also be conceptualised in terms of the participants feeling stigmatised, which has been described as having:

“a social identity, or membership in some social category, that raises doubts about one’s full humanity: one is devalued, spoiled or flawed in the eyes of others” (Crocker & Quinn, 2000, p. 153).

A previous study by Toews, et al., (1981) noted that the majority of participants who had been detained under the MHA reported that there was an additional stigma to being involuntarily committed.

4.4.2 Negative evaluation of self

Another subtheme that emerged from participants’ accounts was their experiences of being detained under the MHA resulting in them making negative judgments about themselves. A previous subtheme (4.2.2) of “seeing self as different” touched upon some participants’ experience of being detained under the MHA resulting in them seeing themselves as out of control or abnormal, which overlaps with this subtheme. Here there appears more of a focus on negative evaluation of self rather than setting them apart from others in some way.
As with previous subthemes, there was often a comparison to feelings of criminality and punishment. For example, Ann describes feeling she “had done something wrong” that she had been “locked up for”. With Ann’s account, she appears to be describing feeling she has done “wrong” whereas Claire appears to interpret this feeling of having been punished to mean that there was something internally wrong with her, as if she was wrong:

Claire: “... how I looked at a lot of it was a punishment [...] I’m being punished because I was naughty [...] I did feel innately bad [...] I did sort of feel like I was a deeply flawed or bad person.”

Pamela, Francesca, and George also describe the sense that being detained under the MHA reflected negatively on them and being “ashamed” (Francesca) and “embarrassed” (Pamela) if others knew. George describes the need for legislation, resulting in loss of self-worth, which also seemed to lead to a reduction in his confidence. Loss of confidence is also a theme that emerged from Barnes et al. (2000) and Hughes et al. (2007) studies.

George: “Yeah I am pretty disappointed with myself to say the least I think. You know you let every one down. I think my confidence was shattered, and I think it still is shattered [...] I felt really bad about myself to be true [...] I feel ashamed, of the fact that I didn’t go as a voluntary patient initially, that they had to use the legislation to get me to do something, is a bit of like being on the other side of the fence when it comes to being a police officer. Therefore being dealt with by the legislation I suppose I felt bad and ashamed that they had to resort to it”.

George again refers to identifying himself in a new social category, “being on the other side of the fence”, where he seems to see himself in a distinct group (4.2.4) that he appears to judge negatively as it makes him ashamed of himself. His negative feelings about legislation being needed also appears to encompass feeling ashamed of
his loss of self-efficacy, which has been previously noted as causing him to feel “scared” (4.3.1).

Breakwell’s (1986) Identity Process Theory may also be helpful in providing a framework for these accounts, where participants appear to be experiencing reduced self-worth due to negative evaluations of self. The need to feel positively evaluated is identified as being a desirable identity state (Breakwell, 1986, p. 24) and it appears that for some participants their self-worth is threatened. Previous studies have also reported that individuals who are detained under the MHA have a greater reduction in self-esteem to voluntary patients (Rooney et al., 1996).

Peter and Laura’s accounts differ from the other participants in that they appear not to feel that being detained under the MHA effected how they saw themselves (Laura: “… the sectioning itself was more about the loss of freedom than it was about how I perceived myself”) or lower their self-esteem (Peter: “I would have to say I have more self-esteem now than before”). Laura does go on to say that, the “degradation” and “humiliation” that she experienced had more of an effect on her after she was discharged from hospital and when her “mania” receded.

Laura: “… and all that’s happened to you during the manic phase, you know the degradation and the humiliation, and try and deal with all of that, that then is when your self-esteem goes really really down the pan […] the mania, it’s like you can do anything, ‘I’ve got the power, I’m fantastic’, even being in hospital is fantastic. It protects you from that till afterwards. And afterwards the fact that you’ve been sectioned…”

This could be interpreted as suggesting that the “mania” helped to defend against negative evaluation of self and to cope with the experiences whilst initially detained.
4.4.3 Positive changes in views of self

Some participants described a positive change in how they viewed themselves. It appears that for some participants the period during and shortly after being detained had a temporary negative impact on self-evaluation (as discussed above) which with time and reflection changed. Claire describes a belief that she has “learnt a lot” from her experiences and this has made her more “self-aware” and “in touch” with herself, and a “bit more human”. This appears similar to the findings of Barnes et al’s (2000), which reported that the experience of being detained promoted self-reflection and self-awareness in some of their participants.

Francesca also reports in her account what appear more positive self-evaluations, describing herself as more empathic and understanding of other people:

Francesca: “I suppose I have to be quite thankful that I have survived these experiences. I feel it’s maybe improved the person I was because I’m much more tolerant, accepting of other people’s disability, especially mental health, which perhaps I wouldn’t have been before [...] its probably changed me for the better, I am more open minded I think than perhaps people that haven’t gone through that experience, and more understanding of people because I’ve been through such a lot myself”.

Both Claire and Francesca appear to be describing positive changes in their views of themselves. These changes could be understood in terms of ‘temporal comparisons’ where individuals compare their current selves to how they were at different points in time in the past (Dinos et al., 2005). Here Claire and Francesca appear to be involved in downward past comparisons, (where they derogate past selves; Dinos et al., 2005) which may help them to see their present selves more positively.

Francesca and Kate also report feelings of pride or “awe” (Kate) and increased respect for themselves because of their ability to survive, as “not everybody survives” (Kate) being detained under the MHA. Francesca’s account also describes feeling pride that
she not only survived her experiences, but that she did so when her family members did not believe in her and had given up on her:

Francesca: “I really believe when I was sectioned for the first time, that my husband and his family thought it was the asylum days, that I would never come out, I really think they believed that. It was with great joy and pride that I survived that and proved them wrong, that not only did I come out but held down full time work and bought my own flat and survived”.

4.5 **Identity not complete**

The fifth theme that emerged from the data describes a feeling reported by participants of a lack of wholeness to their identity. This theme consists of two subthemes: something being taken away and something lacking. Initially these themes were thought to be part of some of the subthemes above, though on reflection it was felt, through my ‘interpretive lens’ that the participants were describing something qualitatively different, a more generalised sense that their identity as a complete entity had been changed.

4.5.1 **Something being taken away**

Several of the participants described a sense that something, some unspecific intrinsic part of them had been taken away during the experience of being detained under the MHA, as if some essence of who they were had been removed. Claire describes feeling that “something inherently has been taken away from you”, and that she was “stripped of everything”. Ann reports a feeling of being “reduced to nothing” because of the way she was treated. These accounts seem to describe someone else acting upon them, resulting in something almost tangible being taken from them without their permission.

Kate appears to identify her psychiatrist having control of her, which appears closely linked to her being left her without an identity:
Researcher: “I suppose I am specifically looking at the experience of being sectioned and how that affected your identity.”

Kate: “You haven’t got one basically, you know it’s the psychiatrist who has got control of you, everything, your freedom, your life, your medication, visitors…”

4.5.2 Something lacking

Some of the participants also described a sense that the experience of being detained under the MHA left them lacking, without any description of causality but merely that there was a sense of incompleteness about themselves: “your assumption about yourself is that you are not quite the ticket […] you feel less of somebody” (Claire).

Ann describes herself as being “empty”, whilst George’s understanding of being “one of them” involved descriptions of something lacking in him as a person:

George: “Because being ‘one of them’ I didn’t know what that involved. You know only the words that are branded around like ‘nutter’, ‘six pence short of a shilling’, you know ‘a sandwich short of a picnic’ etcetera etcetera.”

Peter also describes himself as having a “little lack of identity”, though he appears to reject others’ view that as a patient you have no identity at all.

Peter: “Other people presume that the patients have no identity at all, that they have no emotions, no personality, no rights, no nothing. In a way it’s surprising for them when they do show such characteristics. That’s the opinion of some.”
As mentioned previously it could be especially salient for Peter to reject others’ views of patients as he is still in a position living in residential care of being identified as a “patient”.

Gemma also reports a sense of part of her identity being “lost” because of being detained under the MHA:

Gemma: “I think I lost a bit of my identity really. I lost the person who I was before I had been sectioned”

The main theme, of identity not being complete, appears to describe a general feeling about the effect of being detained under the MHA on an individual’s identity, although there are links to previous subthemes, particularly participants’ experience of dehumanisation, this theme appears to describe something less precise or definable. It is as if, from the descriptions above, that the wholeness of their identity has been challenged and that there is a sense of nothingness (Ann: “You are just reduced to a nothing the way you are treated”) or lacking about their identity that remains.

4.6 Coping

The sixth theme to emerge from the data relates to how participants coped with being detained under the MHA. Though the interview schedule attempted to focus the participant on how they coped or managed with the changes in their identity, it appeared in many ways that the experiences of being detained were too intertwined with changes in identity for this to be done. This will be discussed further in the Discussion.

4.6.1 Distraction and avoidance

Several participants described using distraction and avoidance after discharge to prevent themselves remembering their experiences of being detained. Ann describes using distraction, where she “quickly turns to something else” when she has
"flashbacks to a time that wasn’t very nice in your life". George also reports trying to "forget" and "ignore":

George: “I have been maltreated some times by people in the past [when detained]. I wish that had never happened, but I just ignore that, turn a blind eye to it. I prefer to forget it [...] I have some unpleasant experiences in my time that I would rather not remember.

Gemma and Ann describe avoiding discussing the experience of being detained with others: “It’s [being detained] something I don’t discuss with anybody” (Gemma) and “... if any of the family or anybody mention it [being detained] I’m not keen” (Ann). Gemma’s wish not to discuss her experiences with anybody is similar to Laura’s, who reports:

Laura: “So I’ve been rather reticent about coming forward and putting my hands up, putting my head above the parapet and saying, ‘well actually you know I suffer from bipolar and I’ve been sectioned twice’ [...]Because if nobody knows about that then it doesn’t make any difference...”

Laura and Gemma’s accounts of trying to keep their experiences of being detained to themselves could be conceptualised as a form of covert ‘passing’, which is identified by Breakwell (1986) as an interpersonal coping strategy. Breakwell describes ‘covert passing’ occurring when the “characteristics which identify the threatening position are easily hidden” (p. 117).

4.6.2 Acceptance

Many of the participants reported having to accept the situation of being detained: “[You] just get on with it” (Ann), “You just have to accept it” (Claire), “I just had to put up with it; there was nothing I could do about it” (Peter). Mary’s account seems to highlight acceptance of the situation being the only choice:
Mary: "I sort of thought... I don't have a hope in hell, and you know fighting my corner sort of thing, it was just to accept what was decided"

Claire seems to describe acceptance as being the end stage of a process you go through when you are detained:

Claire: "It's not like a grieving process but you have certain stages you go through when you've first been sectioned [...] then you realise what has happened and get really angry, then you're upset and then you are kind of resigned".

Although Claire describes this process as not being like a grieving process there does appear to have similarities with Engel’s (1962) (cited in Gross, 1987) three phases of mourning; disbelief and shock, developing awareness (where apathy, exhaustion, and anger are common), and resolution (which includes acceptance and the establishment of a new identity). It could also be argued that acceptance is similar to Breakwell’s concept of ‘compliance’, an interpersonal coping strategy, which she describes as involving acceptance of the threatening position and living up to expectations of how to behave in this position (Breakwell, 1986).

4.6.3. Agency

The majority of the participants described psychological or physical resistance to the experience of being detained, where it seems they tried to regain control. Resistance in the form of “trying to escape” (Pamela) was in the majority of participants accounts, “I can remember trying to escape” (Francesca); “I was desperate to get out, I threw chairs against the windows” (Claire); “I kept trying to get out of the ward” (Ann).
Also Claire’s form of resistance as described in her account below appeared more pervasive:

Claire: “I lost the ability to, or didn’t particularly want the ability maybe to listen and comply, and that’s what it puts you into when you are sectioned […] you deliberately do everything against what other people want you to do”.

Claire’s description above could be seen as a form of ‘negativism’. Breakwell describes negativism as an interpersonal coping strategy where one feels a desire or compulsion to refuse to do what others want them to do or even to act in the opposite to what is required (Breakwell, 1986). George also appears to describe this: “I just refused everything, I just refused to co-operate”.

Furthermore, Peter’s account appears to describe a psychological resistance to some of the potential changes to his identity, such as issues of control and individuality:

Peter: “No matter how much I was restrained I sill wanted to work things out for myself […] they just made me more individual still. More persistent in pursuing my own course […] because I never quite let myself go in a way, I never became institutionalised [the experience of being detained] even intensify[ed] my individuality”.

5 DISCUSSION

5.1 Summary of Findings with Theoretical Links and Implications.

The results from this study provide an initial understanding of the effects of being detained under the MHA on an individual’s identity. It appears there is the potential for detention to cause multiple effects on an individual’s identity: a sudden rupture in identity, feelings of powerlessness and distinctiveness, changes in self-worth, and a sense of not having a complete identity. These reported changes in how participants
view themselves suggest that being detained could be experienced as a threat to identity as defined by Breakwell (1986), as the identity principles of continuity, positive distinctiveness, self-esteem, and self-efficacy are challenged. These findings also indicate that participants used several coping strategies to manage the impact of their experience of being detained.

It is therefore felt that this study points to the relevance of Breakwell’s Identity Process Theory (IPT) to the field of clinical psychology and mental health, therefore expanding its already recognised area of relevance in the fields of social and health psychology (e.g. Johnson & Robson, 1999; Turner & Coyle, 2000; Vignoles, et al., 2002). Indeed IPT seems to have been helpful in providing a framework to understanding the experiences of being detained under the MHA. Furthermore, these research findings also appear to build on other qualitative studies that have investigated the effects of being detained under the MHA, in particular those that report the potential negative effects on self, and highlight the complexity and diversity of individuals’ experiences (Barnes et al, 2000; Hughes et al., 2007; Olofsson & Jacobsson 2001; Thornhill et al., 2004).

5.1.1 Life Changes

This theme highlighted that for some participants being detained under the MHA was perceived as resulting in a sudden change in their life circumstance and identity. Some of the participants described this as a permanent change, which they felt had an impact on their future identity path following discharge and on their stability of their future life and identity.

This main theme can be understood in terms of IPT’s (Breakwell, 1986) (see Introduction) continuity principle. Participants’ descriptions of their experiences of being detained could be conceptualised as a discontinuity of identity before and after being detained, with detention triggering a different identity trajectory. It seems from participants’ reports that such a rupture and new trajectory does not allow a return to the old identity path, which has become irrecoverable. There also appears an awareness that future continuity is open to threat and rupture, causing a sense of
vulnerability. This loss of future stability appears related to IPT's principle of self-efficacy, with participants appearing to feel a loss of control over their lives, and highlights the interdependence of IPT's identity principles.

These findings have implications for IPT, as they suggest a possible expansion of the continuity principle, when applied to the experiences of being detained under the MHA. Participants identified that not only was there a discontinuity between past and present identities (as focused on in the current continuity principle), but that there was also the risk of discontinuity between participants' present and perceived future identity. This challenge to future continuity could also be conceptualised as a threat to identity and an important aspect of the continuity principle. In this study's findings, there are also descriptions of a previous (to being detained) identity being irrecoverable. This indicates that it may be important to consider the perceived permanence of the discontinuity to identity as this could be a particularly salient aspect of the threat to identity continuity for individuals detained under the MHA.

5.1.2 Distinctiveness

Participants seemed to describe a sense of individual and group distinctiveness in their accounts. This could be understood as providing them with a sense of differentiation from others, which has been described as a core Western value (Synder & Fromkin, 1980). However, participants report that what makes them distinct (being detained under the MHA) is often negatively valued, resulting in negative consequences in terms of their treatment by others. Therefore, it could be argued that positive distinctiveness has not been obtained and that a desirable distinctive identity is not achieved. Brewer's (1991) optimal distinctiveness theory suggests the motive for distinctiveness needs to be balanced with the motive towards inclusion and closeness to others. It appears that the participants are describing being placed in a negatively distinct position with resulting negative affect (e.g. feelings of isolation). Vignoles et al. (2002) describe there being three sources of distinctiveness: position, difference and separateness, with each playing a unique part in relation to identity construction and subjective well-being. It could be seen that the experience of being detained under the MHA may provide more feelings of separateness (defined as distinctiveness in
terms of psychological distance or separation from other) and negatively evaluated difference for participants, rather than distinctiveness in terms of position (distinctiveness in one’s place within social relationships). Such experiences of separateness and difference could be conceptualised as leading to a stigmatised identity. This may explain why participants experienced distinctiveness with negative affect and well-being, and why there is an overlap between the sub-themes of ‘seeing self as different’ and ‘negative evaluation of self’. This overlap suggests an interrelationship between IPT’s distinctiveness and self-esteem principles, and again highlights the crossover of the identity principles.

This study emphasises that the need for distinctiveness due to positive characteristics outweighs the need to feel unique. This seems in agreement with optimal distinctiveness theory (Brewer, 1991). It is possible that the balance between uniqueness and inclusion could be particularly difficult for an individual detained under the MHA as there is the potential risk of not being treated as a unique individual by mental health services. Ann highlights this potential in her account:

“They go through all the process of individual care plans... but really they are just paying lip service to it. It isn’t individual. I mean everybody really is treated the same”.

This risk of lack of distinctiveness then is potentially combined with the risk of being too (negatively) distinct to others outside of the hospital environment, and thus might be seen as a possible double threat to identity.

5.1.3 Powerlessness

The third main theme of powerlessness describes participants’ perceptions that they experienced loss of control over their lives, and that this affected their perceptions about their present and future ability to control their lives. Participants’ descriptions of reduced self-efficacy during the process and duration of being detained, and for future events, appears to challenge their identity as an individual with the ability to influence action and who has feelings of competence and control. This could be conceptualised
as a challenge to IPT’s self-efficacy principle, indicating that the experience of being detained places individuals in a threatened position, where their self-efficacy is challenged. The experience of control being taken away resulted in some participants comparing themselves to criminals and perceiving they had regressed back to a childlike identity. It also appears such comparisons had consequential repercussions on participants’ self-esteem, thus suggesting that the experience of loss of control not only challenges IPT’s principle of self-efficacy but also has ‘knock on’ implications for the self-esteem principle.

Being detained thus appears to have potentially multiple effects on an individual’s identity, with challenges to the content of identity - with a threat to self-definition (with challenges to whether you are competent), and challenges to the value dimension - with a threat to self-esteem (with challenges to your feelings of worth if you are not competent).

This theme also highlights the importance of perceived future loss of self-efficacy for participants as there seemed to be an awareness that they could re-experience being detained with consequential loss of self-efficacy. For some participants this perceived reduction in future self-efficacy seemed to have an impact on their present abilities to make plans and conduct their relationships with others. Again, this link to future perceptions is thought to have important implications for the development of IPT.

5.1.4 Self-worth

A number of participants described the experience of being detained under the MHA as a dehumanising and devaluing one, which resulted in negative evaluations of self.

The experience of being dehumanised and devalued and its potential to affect an individual’s self-worth could be conceptualised using the literature on the effects of stigma. Crocker & Quinn’s (2000) examination of the relationship between social stigma and low self-esteem or feelings of social worth, emphasises the importance of the situational context on an individual’s level of self-esteem. This may be important when considering why some participants reported that the increased negative self-
evaluations whilst under detention changed to more positive evaluations after being discharged (see 3.43). This phenomena could be understood in terms of changes in the situational context, as the visible ‘stigma’ of being in hospital detained, which may be overt to family, friends, and work colleagues, is no longer there after discharge, causing a corresponding increase in self-esteem.

It is also important to consider how the experience of being devalued, as reported by a number of participants, might affect self-esteem. It is felt this might depend on whether participants construe others as prejudiced against them (described by Major & Crocker, 1994, as ‘attributional ambiguity’) or whether a participant attributes blame to themselves for their stigmatising conditions, which can then lead to feelings of low self-worth. How participants subjectively understand the stigmatisation (Camp et al., 2002) and construe others’ actions may explain why different participants experience different degrees of effect on their self-esteem. Therefore, for some participants receiving ‘dehumanising’ treatment resulted in them feeling they were less than human, whilst others perceived their dehumanising treatment as reflecting on the qualities of professionals. Whether they see others as prejudiced and consequently are able to externalise blame or whether they see themselves as responsible for their situation and deserving of their treatment, would then seem a very important distinction. Furthermore, it is recognised that being in a hospital under a section might also place participants in a situation where evaluation by others is particularly salient, as how others perceive them determines their detention status. Therefore they are in a context where they are more likely to be vigilant to potential negative evaluation by others and therefore at increased risk of lower self-esteem.

Some participants described positive changes in self following discharge from a section of the MHA, reporting feelings of pride that they had ‘survived’ their experience which gave them a greater understanding of themselves and others. It appears then that these participants might have re-evaluated their experiences post discharge, resulting in enhanced self-esteem. Breakwell (1986) reports that the power of situational change (e.g. being detained) to threaten identity is dependent on its social and personal meaning. For these participants it appears that they have re-evaluated the personal meaning of their experience, thus seeming to defend from the
challenge to the self-esteem principle. These findings support Breakwell's (1986) reports that although an individual may reside in a 'threatened' position for an extensive period, actual threats to identity are short-lived because of the coping strategies initiated.

5.1.5 Identity not complete

Some participants described a sense that there was something missing in their identity and that it was no longer complete. Although what was 'taken away' could be considered as being some of the constructs mentioned in previous themes such as power and self-worth it appeared in the accounts that it was something less tangible, as if participants were left with a feeling of incompleteness. This could be similar to Goffman's report of 'mental patients' being constructed by society as not having a 'viable self' (Goffman, 1991, p.152), and the effect on the patient of this construction may be to leave them feeling that their identity is insufficient and lacking in meaning.

This study indicates that another potential motivational identity principle relevant to the context of being detained under the MHA is one of identity completeness. Breakwell (1987) notes that the identity principles she first identified in IPT are unlikely to be the only ones that motivate identity processes. In the context of this study then, it appears that identity completeness has the potential to be another identity principle in that when it is threatened there are resulting negative effects. However, whether such a construct of identity completeness is distinct enough from the other principles of continuity, self-esteem, distinctiveness, and self-efficacy to form another motivational principle is unclear, and thus may warrant further investigation in other contexts.

5.1.6 Coping

The sixth theme describes some of the coping strategies that participants used to manage the impact of their experiences. It has been difficult to differentiate in participants' accounts whether they are describing coping with the situation of being detained or coping with the impact on their identity as a result of detention. It is felt
that such lack of subjective clarity has potential implications for IPT, as it may indicate that the theoretical differentiation of the threatening situation and the threat to identity, in relation to coping, may not always be that easy to access. It might be wise then to further explicitly explore whether individuals (who are detained under the MHA) are able to differentiate between coping with the threatening situation or the threat to identity.

With this said, IPT does appear to provide a general framework for understanding the coping strategies that were highlighted in this theme. As discussed in the Results section, participants coping strategies could be conceptualised in terms of 'negativism', 'passing' and 'compliance' (Breakwell, 1986). These are all examples of interpersonal coping strategies, which rely on changing relationships with others in order to cope with threat. Though what appeared to be intra-psychic strategies (such as distraction and acceptance) were referred to in participants’ accounts, it seemed that interpersonal coping strategies were more easily identifiable in relation to threat to identity. This may be because they focus on an action, whereas intra-psychic strategies that focus on cognitions and emotions may have been harder to recognise and describe.

5.2 Clinical and Service Delivery Implications

Whilst some of the implications outlined below may already be recommended in policy and documentation, what is indicated by this study is that either they are not always perceived by individuals who have been detained as having been implemented or that there is a need for their further highlighting. These implications may be particularly relevant in the current climate of potential amendments to the MHA (1983), as there may be an increase in the use of compulsory powers (Dillon-Hooper, 2006).

5.2.1 Enhancing self-efficacy

Some participants in this study reported that the more times they were detained under the MHA the greater their understanding about the process became, and that the first
time they were detained they were more likely to feel a lack of knowledge. As discussed in the Results section participants’ experiences of lacking knowledge and understanding was interpreted as having the potential to cause feelings of powerlessness, with this powerlessness leading to negative affect (Bandura, 1997). Rose (2001), who reported that mental health users’ satisfaction was positively correlated with the amount of information provided, highlighted the importance of providing information to services users. It has also been argued that individuals are likely to infer their abilities and self-worth from their circumstances (Bern, 1972, cited in Markowitz, 2001), and the findings of this study suggest that the circumstance of being detained has an impact on individuals’ evaluations of themselves. It may help reduce the impact on identity, especially feelings of low self-worth and self-efficacy, if the inferences individuals make about themselves when first detained are explored and challenged by a more informed understanding of the process and reasons for detention (i.e. not because you are ‘bad’ and need punishment, but to provide care and treatment). Therefore, it is felt particular attention should be paid by mental health professionals to conveying to an individual, who is detained under the MHA for the first time, a thorough explanation of the process. It is noted that this may need to be done repeatedly, especially as some of the participants in this study reported that during the process of being detained they were unaware of their circumstances, which was frequently put down to medication and their mental health state.

Participants’ descriptions of the impact of the long-term effects on feeling out of control as a result of detention, suggest the need to help individuals regain a sense of empowerment and hope about the future. Reduced self-efficacy has been found in other studies (Hughes et al., 2007) to have an impact on individuals’ feelings of hopelessness about their ability to recover from mental illness. Jacobson and Greenley (2001) have also reported that feelings of empowerment aid recovery from mental illness and that a component of empowerment is responsibility. Thus, it is suggested that practices such as advance directives, where an individual documents what they would like to be done if they become unwell again in the future, may increase an individual’s sense of responsibility, and control over their future. This in turn may aid recovery.
5.2.2 Reduction of negative distinctiveness

This study suggests that participants experience feelings of stigmatisation because of their experiences of being detained under the MHA and that this causes feelings of isolation. Experiences of stigma have also been identified as impacting on the degree of severity of symptoms, self-esteem and life satisfaction (Markowitz, 2001). Therefore, it is recommended that attempts be made by services and mental health professionals to support any reduction in the negative evaluations by others of people who have been detained under the MHA. This could include; increased education to organisations (such as police departments (as supported by other studies such as Rose (2001)), schools, and business) about the role of the MHA as a treatment method and specifically the negative impact of ‘stigma’ on individuals. Though these measures may already be undertaken to a degree, the findings from this study do indicate that there is a need for further challenges to the public’s image of individuals who have been detained under the MHA, and for an increased understanding of the detrimental effects of stigma. It has also been argued that reducing social stigma is likely to help reduce internalised stigma, which will aid recovery from mental illness (Jacobson & Greenley, 2001).

Some participants compared their experiences to those of criminals and highlighted the role of the police in increasing negative distinctiveness and self-evaluations. Therefore, it is recommended that every possible attempt to reduce police involvement (whilst still being aware of issues of risk), would be beneficial in reducing some of the negative distinctiveness that participants have reported. If police are needed it may be helpful for them and other professionals later on in the process to stress to the detained individual why they are being detained and to challenge some of their potential perceptions that have been detained because they have done something ‘criminal’ or because they are ‘bad’. It is noted that Hughes et al., (2007) also suggest that police involvement should be minimised during the detention process where possible.

Helping individuals to find areas of positive distinctiveness in their identity could also be beneficial in reducing the impact of the experience of negative distinctiveness. For
example; group or individual support where the positive consequences of having been through the experience of being detained are explored (i.e. increased self-awareness and empathy to others); or involvement in service-user groups where experiences are valued and utilised to help improve service provision. Faulkner and Thomas (2001) have also recommended that more attention be paid to the role of self-help and peer support in overcoming stigma and discrimination because meeting with others with similar problems were found to promote feelings of belonging and acceptance, and thus potentially challenge feelings of negative distinctiveness.

5.2.3 Promoting positive coping strategies

Participants reported various coping strategies (distraction, avoidance, acceptance and agency) to manage the impact of being detained. Some ways of coping with a threatened identity could be construed as less beneficial and more damaging than others. For example, Breakwell (1986) describes ‘negativism’ (as described in the Results) as a strategy for coping that has the potential to turn the emotion provoked from the threat (e.g. anger) inwards (potentially resulting in behaviours such as self-harm). If mental health professionals and indeed individuals who are detained under the MHA were made more explicitly aware that some reactions to detention are a likely form of coping with the situation, then this might help both professionals and those detained gain a better insight into why certain behaviours are utilised. Individuals who are or were detained could be supported in implementing less damaging coping strategies such as group support (participation in service-user groups has been reported to contribute to a more robust sense of identity and to build confidence (Barnes & Shadlow, 1996)). Other more potentially positive strategies could include the reflection on and maintenance of more ‘positive’ role identities (e.g. being a mother, employee, friend) whilst being detained, which could help to combat threats to continuity, self-esteem, and self-efficacy. This could be done via promoting the engagement in activities that provide an identity outside of being a ‘patient’, which might include support in maintaining involvement in parental decision-making when detained or assisting an individual to find employment after discharge.
5.2.4 Implications for psychological therapies.

Many of the points mentioned above seem be relevant in the implementation of psychological therapies for individuals who are or were detained under the MHA. For example, these findings suggest that individuals may experience threats to their self-esteem and self-efficacy, and therefore interventions based on improving self-esteem and assertiveness may be beneficial. Exploration of the costs and benefits of strategies used to cope with the impact of being detained may also be constructive in helping an individual to reduce the threat to their identity in a positive manner.

These findings also indicate that individuals who have been detained feel particularly vulnerable to feeling that their self-efficacy is threatened. This could have specific implications for the therapeutic relationship, where overly directive interventions could be perceived as threatening and coercive. This would have important implications as a positive therapeutic alliance is reported to lead to more positive therapeutic outcomes (Martin, et al., 2000). This point could be particularly salient for Clinical Psychologists working on inpatient wards where they may be perceived as aligned with the mental health professionals involved in the detention process.

5.3 Limitations

The participants were diverse in age, and the duration and number of times detained, though they represented a non-diverse ethnic range, with them all describing themselves as ‘white British’ (possibly the result of recruitment location). There were more women represented in the sample than men (8:2), and the majority (7:3) reported being diagnosed with Bipolar Disorder. These issues need to be taken into account when reflecting on the application of the findings and when considering future research populations. The lack of ethnic diversity in the sample could be argued as especially relevant, as Breakwell (1986) reports that the principles of identity are specific to western cultures and because African-Caribbean people are more likely to be detained under the MHA (Audini & Elliot, 2002). The participants of this study may also represent a biased sample of individuals who have been detained under the
MHA, as they represent individuals; who are willing to discuss their experiences, who are presently receiving mental health services, and whose care team evaluated them as not having any risk concerns and not currently experiencing an acute episode of mental illness. This recruitment and selection procedure could have resulted in a sample of individuals with selective experiences. For example, it may have resulted in the self-exclusion of individuals who have particularly distressing experiences, as they do not feel able to discuss them.

The time since discharge from participants’ last detention ranged from approximately four years to one year ago. It has been reported that individuals show a changing attitude towards their experience of being detained with time, towards a more positive one (Rooney et al., 1996). While this could be relevant to these participants, which may have resulted in them being at different stages of coping or reflecting on their experiences, it is noted that commonalities between participants were also found.

The interview process and context may also have had an impact on participants’ accounts, with my role as a mental health professional and the audio-taping of the interview potentially resulting in a limitation to the openness of participants’ descriptions. I was aware that these factors may be present when interviewing and therefore used my clinical skills to try and provide a non-judgemental, empathic, and curious stance.

5.4 Further research

In terms of future qualitative research, it would be useful to build on this study’s findings with a different sample of participants including a more diverse range of people (e.g. specifically with more male participants or participants from ethnic backgrounds other than ‘white British’). This could help provide some insight into the relevance of these findings to other individuals, especially as aspects of identity have been reported to be culturally sensitive (Breakwell, 1986).

This research has also emphasised the potential to feel stigmatised for having been detained under the MHA. A qualitative study exploring the experience of such
stigmatisation and the ways that individuals who have been detained under the MHA have coped or adapted to this, may provide some interesting insights that could inform psychological theory and practice. Specifically a qualitative study using Discourse Analysis to investigate the construction, by members of the public and individuals who have been detained, of the concept of stigma as related to being detained under the MHA, may provide interesting insights into the role of social and self stigma for these individuals.

While the implications of the current research in relation to IPT have been highlighted, it is important to note that future research is needed to further evaluate the theoretical implications to IPT and to allow for a more robust extension of the theory. This could include the investigation of the importance and relevance of future continuity and future self-efficacy to identity principles and their salience in threatened identity positions. A more thorough exploration of the possible use of intra-psychic and inter-group coping strategies that may be used by individuals who have been detained but are potentially more difficult to identify than inter-personal strategies, would also be beneficial in the understanding of the experiences of individuals who have been detained under the MHA.
6. REFERENCES


Appendices

Appendix 1: Participation Information Sheet

Participant information sheet

Study title

A study exploring people’s experiences of being detained under a section of the Mental Health Act.

Invitation paragraph

I would like to invite you to take part in a research study about the effects of being detained under the Mental Health Act. This research study is being carried out as part of a Doctorate in Clinical Psychology qualification and is being sponsored by the University of Surrey.

Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with friends, relatives, care team and your GP if you wish. Please ask if there is anything that is not clear or if you would like more information. Please take time to decide whether or not you wish to take part.

Thank you for reading this.

What is the purpose of the study?

This study is trying to find out more about people’s experience of being detained in hospital under a section of the Mental Health Act. In particular, the study is interested in the possible effect of being sectioned on how people see themselves. It is hoping to explore what these possible effects are and how people cope with these effects.

This study will run from August 2006 until September 2007.

Why have I been chosen?

We are interested in speaking with you because: 1) We understand you have been detained under the Mental Health Act in the last 2 years; and 2) a member of the team who is involved in your care thought that you might be a suitable participant.

In total, approximately 12 people will participate in the study.

Do I have to take part?

It is up to you to decide whether or not to take part. If you decide to take part you will be given this information sheet and asked to sign a consent form. If you decide to take part you are free to withhold any personal information or to
withdraw at any time, without giving a reason. This will not affect the care you receive. Neither will a decision not to participate.

What would taking part entail?

Meeting up
You will be invited to meet up with one researcher, Katherine Boucher, to talk about your experiences of being detained under the Mental Health Act. This would be done over one meeting and will last about an hour and a half. This meeting can be done at a mutually convenient location. You will not be asked to do anything else after this meeting.

Audio-taping
You will be asked if you would mind the meeting being audio-taped. If you agree, the tape of your interview will be stored in a locked cabinet and will only be listened to by the researcher and one of her supervisors. No one else will listen to your tape. Your name and address will not be attached to the tape so you will not be identifiable. If you decided to allow your interview to be audio-taped you would be free to stop the taping at any time.

What are the advantages and disadvantages of taking part?

There are no anticipated disadvantages of taking part in the study. However, if you wanted to stop the interview for any reason, you would be free to do so immediately.

It is hoped that the study will contribute to a greater understanding of the experiences of being detained under the Mental Health Act and the effect this might have on people’s identity. If you would be interested in the results of the study we will be happy to share them with you at a later date.

What if I become distressed?

It is possible that some people may experience distress when discussing their experiences. Before the research procedure begins the researcher will discuss this possibility with you and the two of you will develop a plan for how to cope with any distress that may arise. The support mechanisms in place if you do become distressed include:

- Providing you with an opportunity to discuss it with the researcher in the meeting or afterwards.
- Considering who else would be able to offer you support e.g. other health care professionals, family, and friends.
- Discussing with your clinical care team (your CPN, Consultant Psychiatrist, Care Co-ordinator) how they may best support you.
- Alternatively, below are a list of organisations where you can talk to someone confidentially about your feelings or experiences
  - Samaritans: 08457 909090  www.samaritans.org.uk
  - NHS direct: 08454647  www.nhsdirect.nhs.uk
Confidentiality

With regard to your GP and care team
Your care team will know that you are taking part in the study. We will also ask you for permission to inform your GP. The researcher will have no other contact with your care team or GP, with one exception: if you say something that leads the researcher to believe that the safety of yourself or someone else is at risk, this information will need to be passed on, which could possibly lead to a Mental Health Assessment. Before doing so, the researcher will speak with you about how she will do this.

With regard to writing about the research project
All the information collected during the study will be kept strictly confidential. When the study is written up you will not be identifiable. Your responses will be coded and your name and address removed so that you will not be recognised from it. The study has been checked to ensure it complies with data protection laws.

What will happen to the results of the study?

The results of this study will be written-up by September 2007, and submitted to the course being undertaken by the researcher at the University of Surrey. You could receive feedback on the results of the study if you would like it. An article about the study will be written collaboratively by the researcher and her supervisors with the intention of getting it published in a national psychology journal. No participant will be identified in any part of the write-up or article.

Who has reviewed the study?

This study has been reviewed by West Sussex Local Research Ethics Committee, which raised no objection to it, and by the Research and Development department within your local NHS Trust.

Contact for further information

If you have any questions or concerns about this study, you should discuss them with the researcher leading the study:

Katherine Boucher
Trainee Clinical Psychologist
C/o Department of Psychology
University of Surrey
Guildford GU2 7XH
Tel: 01483 689441

If you have any complaints about your participation in this research, in the first instance please contact the Chief Investigator, Katherine Boucher. The normal National Health Service complaints mechanisms will also be available to you. You may wish to seek advice from the Patient Advice and Liaison Service: 01323 446042.
In the unlikely event of you suffering significant and enduring harm as a result of your participation in this research, the University of Surrey (as sponsor of the research) holds no-fault insurance cover which is intended to provide compensation to participants, regardless of liability. The University of Surrey also has public liability insurance, which covers public liability claims.

If you decide to participate in the study you will be given a copy of this information sheet and a signed consent form to keep.
CONSENT FORM

Title of Project: A qualitative study investigating the effect of being detained under the Mental Health Act (1983) on an individual's identity.

Name of Researcher: Katherine Boucher

1. I confirm that I have read and understand the information sheet dated 17th July 2006 (version 4) for the above study and have had the opportunity to ask questions.

2. I understand that my participation is voluntary and that I am free to withhold personal information or to withdraw at any time, without giving any reason, and without my medical care or legal rights being affected.

3. I give permission for my responses to be directly quoted in any write up of the study with the understanding that all quotes will be anonymous and that I will not be identifiable by them.

4. I give permission for my GP Dr ( ) to receive details of my participation in this study.

5. I give permission for my interview to be audio-taped.

6. I give permission to be contacted again after my interview to discuss the results of the study.

7. I would like to receive a copy of a summary of the main findings of the study. My e-mail address is ________________________________

Name of participant __________ Date __________ Signature __________

Name of person taking consent (if different from researcher) __________ Date __________ Signature __________

Researcher __________ Date __________ Signature __________

1 for participant; 1 for researcher; 1 to be kept with care team note
Appendix 3: Personal Data Form

PERSONAL DATA

A1. **Are you?**
   - Male
   - Female

A2. **How old are you?** [ ] years

A3. **How would you describe your ethnic origins?**
   Choose one section from (a) to (e) and then circle the appropriate category to indicate your ethnic background.

   (a) *White*
      - British
      - Irish
      - Any other white background, please write in below

   (b) *Mixed*
      - White and Black Caribbean
      - White and Black African
      - White and Asian
      - Any other mixed background, please write in below

   (c) *Asian or Asian British*
      - Indian
      - Pakistani
      - Bangladeshi
      - Any other Asian background, please write in below

   (d) *Black or Black British*
      - Caribbean
      - African
      - Any other Black background, please write in below

   (e) *Chinese of Other ethnic group*
      - Chinese
      - Any other, please write in below

A4. **How many times have you been detained under a section of the Mental Health Act?**
A5. Which sections of the Mental Health Act have you been detained under?

__________________________________________________________

A6. Could you give the dates and duration of each detention episode.

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A7. Have you ever received any formal mental health diagnoses? If so, what were they?

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

A8. Are you presently employed? YES / NO

If yes: What is your employment?

___________________________________________________________________________

A9. Please could you indicate your present personal situation by circling the appropriate term below:

Married       Single       Divorced       Widowed

Living with a partner   Other (please specify) ___________________________
I am interested in your experiences of being detained under the Mental Health Act, and in particular how that might have affected how you see yourself. I will ask a number of questions relating to this area and please feel free to express your thoughts openly in this confidential setting. (Possible prompts bulleted – if answers given in the negative then explore i.e. If not why not?).

**Before being sectioned:**

1. Could you tell me how you saw yourself before you were (first) detained under the Mental Health Act?
   - How would you describe your personality?
   - How was your level of self-esteem - how did you feel about yourself?

**Process of being detained – involuntary admission:**

2. Could you please describe to me what happened the day you were admitted to hospital under a section of the Mental Health Act and the process that was involved?
   - Who was involved? Police? Social workers?
   - Where were you?
   - Did you resist the process?

3. Did that experience of being admitted to a hospital under a section effect how you saw yourself at the time?
   - Did it affect your level of self-esteem? How you felt about yourself?
   - Did it make you feel that you were different from others?
   - Was there a sudden change in how you saw yourself?
   - Did it change how you viewed your abilities to control situations?

4. How did you cope with the changes in how you saw yourself at the time?
   - Did you recognise the changes in how you saw yourself or did you try and ignore them?
   - Did you become more or less withdrawn?
   - Did you join any support or patient groups?

5. Thinking about the changes in how you saw yourself at the time, as you have just discussed, would you have wanted that experience to have been different?
• Would you have wanted people who were involved (police, SW, Drs, family) in the process to have treated you differently?
• Would you have wanted your rights to have been different?

Whilst in hospital under a section of the MHA:

6. Could you please describe your experience of being in hospital detained under a section of the Mental Health Act?

• How were you treated?
• Was it helpful/unhelpful?
• Did you understand why you were being detained?
• What was your relationships like with professionals and/or other clients

7. Did your experience of being in hospital detained under the Mental Health Act effect how you saw yourself at the time?

• Did it affect your level of self-esteem? How you felt about yourself?
• Did it make you feel you were different from others?
• Was there a sudden change in how you saw yourself?
• Did it change how you viewed your abilities to control situations?

8. How did you cope with the changes in how you saw yourself at the time?

• Did you recognise the changes in how you saw yourself or did you try and ignore them?
• Did you become more or less withdrawn?
• Did you join any support or patient groups?

9. Thinking about the changes in how you saw yourself at the time, as you have just discussed, would you have wanted your experience to have been different?

• Would you have wanted others to have treated you differently?
• Would you have wanted patient rights to have been different?

After discharge:

10. How do you feel about the experience of being detained under the Mental Health Act now?

• Was it a positive or a negative experience?
11. How do you see yourself now?
   - How would you describe your personality?
   - How is your level of self-esteem - how do you feel about yourself?

12. Does your experience of the process of being detained under the Mental Health Act (i.e. the day of admission) effect how you see yourself now?
   - Does it affect your level of self-esteem? How do you feel about yourself?
   - Does it make you feel you are different from others?
   - Do you feel that part of who you are is the same as before being detained? Or are you a completely different person?
   - Does it change how you view your abilities to control situations?

13. Does your experience of being in hospital detained under a section of the Mental Health Act effect how you see yourself now?
   - Does it affect your level of self-esteem? How do you feel about yourself?
   - Does it make you feel you are different from others?
   - Do you feel that part of who you are is the same as before being detained? Or are you a completely different person?
   - Does it change how you view your abilities to control situations?

14. How do you cope with these changes in how you see yourself now?
   - Do you try and ignore the changes or do you accept them?
   - Have you become more or less withdrawn?
   - Have you joined any support or patient groups?

15. Now, looking back on your experiences, and the changes in how you see yourself now, would you have wanted your experience to have been different?
   - Would you want how others treated you to have been different?
   - Do you want there to be changes in patient rights?

16. Is there any additional information that you want to add?

17. How do you feel about being interviewed on this subject?

Thank you for your time, your answers have been most helpful to the project.
Appendix 5: Analysed Interview Transcript

P5: I left home at 15, I got married at 17, to a brilliant bloke who I’ve been married to now for 34 years, and I think my sense of self has come from him and from my kids than from me, so, um. But you know, I’ve gone my best, I’ve been a good mum, I’ve got myself into university in the end, which having left school at 15 with nothing obviously wasn’t easy, but so, we do okay really.

R6: Okay, thank you. And you started talking a bit about it before, but could you describe to me some more what happened the day you were admitted to hospital under a section of the MHA, and the process that was involved.

P6: The process is awful, because you shouldn’t be in a prison cell I don’t think, I think that is disgraceful.

(phone rings - break)

R7: So I was asking you about the actual day you were sectioned and the process.

P7: Well as I say being taken to a police cell I think is wrong, I don’t think that should happen. It makes you feel, you know, completely like low life, and you know it was very hot in there and they wouldn’t give me a drink, I kept asking for a drink of water. I mean I’m a smoker and there was no way to have a cigarette, and they just kept you hanging around for what seemed like hours. And you are just locked in this cell, and at the time, I was having these, something was going wrong with me obviously mentally because er, I was in this cell and it was, this is going to sound absolutely like I am a nutcase but it was around the Saddam Hussein time, and for whatever was going on in my brain, he was in another cell, to my mind, and basically what happened, is that, I thought, was it Ricin or something gas, wasn’t it Ricin, was coming up through a toilet in this room and I took all my clothes off to stuff them down the toilet to stop this gas, and um, that actually was on CCTV and I actually ended up leaving that cell with a black eye, which nobody knows how I got, but unfortunately, I left it longer than the period that they keep the CCTV, otherwise my husband was going to get it looked in to. And umm it was just the worst experience of my life...
R8: Right

P8: ... Was that time, without a doubt.

R9: And did you resist the process?

P9: Um no I don’t think so.

R10: So the police were involved and then did um a mental health worker, come and see you a psychiatrist or...

P10: Um a duty doctor actually that I did know, ended up coming along and I think there was another doctor there, I think there were maybe two doctors, um and basically from when that happened I was sent to

R11: Okay. Did that experience, the actual day of being, sectioned, affect how you saw yourself at that time?

P11: Oh yeah definitely. It was completely demeaning and just takes away any self-esteem that you’ve got. Because you are just reduced to nothing, you know the way you are treated and... You know you wouldn’t do it to somebody who was physically sick, I mean I’m a nurse and I know that actually means nurture, so what’s the difference if somebody is mentally unwell, they should be shown the same compassion and kindness surely, but they’re not.

R12: Did it make you feel that you were different from other people?

P12: Definitely yeah. Yeah. It is a very isolating experience, very.

And there is such a stigma attached to it as well, so.

R13: How did you cope with the changes in how yourself at that time?

P13: I don’t, well I think in a way being, I was kept on a locked ward, it was still a locked ward at that period, and I was so busy trying to cope with that, because that is horrendous being locked in, for 6 months, and well I don’t know I don’t know how I coped with it.

R14: And what did you do that day to cope, you know the day you were admitted, and taken to the police cell and can you think how you coped then with your feelings about it?

P14: Well I don’t know, with all those funny things that happened, you know these, what I know were completely irrational beliefs, that you know that I was being, I don’t know whether that was, it is difficult to um to define it but whether that was some sort of
breakdown. Some sort of mental breakdown because I couldn’t deal
with it.

P15: Right

P15: I really don’t know but it seems feasible that I just completely
snapped because I am quite a logical rational person so to even sit and
tell you that I thought Saddam Hussein was in the next cell, you
know, it’s like send for the men in the white coats for me, you know.

R16: So something in your mind you felt sort of broke down.

P16: Broke down yeah, yeah.

R17: Because it was too hard to cope with.

P17: Yeah, yeah. And my thoughts were far from normal, definitely.

R18: Thinking about the changes in how you saw yourself at that time
of being admitted would you have wanted that experience to have
been different - the process of being detained?

P18: Definitely yeah. I don’t think it should be, definitely don’t think
it should be something that’s dealt with in a prison cell. Because what
do you equate a prison cell with? Because I equate it with punishment
for having done wrong and going to back to what I said, I don’t think
that people with mental health problems should feel you know that
they are being punished. I don’t know why they take people to prison
cells. Um. And not straight to a hospital. If you broke your leg you
wouldn’t go via a prison cell. You know, on the way to the hospital
and I think it is wrong.

R19: And what happened in the process of actually going to hospital
from the prison cell, what was that like?

P19: Um I can’t really remember now. I think by the time I got to the
hospital I think they gave me something called Aquaphase. Do you
know that?

R20: Yeah

P20: And I think that just makes you sleep, so that’s why it’s all a bit
misty. I think you have something like two or three of those injections.

R21: So the actual day of admission and entering the hospital...

P21: It’s all a bit blurry. Yeah I can remember the prison cell more
distinctly. Umm. And that has to be the worst of it I think.
R22: Okay thank you. Now moving on to actually being in hospital
under a section, could you describe your experience of that, of staying
in hospital detained under a section?

P22: Um. Yeah it's vile, absolutely vile, you know you haven't got
your liberty and it's um, it just, I think it dehumanises you. Um. In
fact looking back I don't know how I stood it for 5 or 6 months. I
don't think I can remember just sort of, 'cos I think I had, I don't know if
they are called reviews, but they are like um you get a chance to get
let out before the time is up based on a panel of people that come in
and listen and you know to try and get through each day, and trying to
get out of the ward when the door was left or if someone came in
trying to get out, I kept trying to get out the door... and it was just
awful. The only, you know, good time was sleeping.

R23: Did you understand why you were being detained?

P22: No I don't think I did, certainly not initially. I don't think I
understood the time or why. It just felt like I had done
something wrong and I was being locked up for it. So no, I'd say not.

P22: Um. (interrupted by door bell. Brief break)

R24: So we were talking about actually being in hospital under a
section and whether you understood why you were being detained.

P22: No I don't think I did, certainly not initially, I don't think I
had the grasping of that time of why. It just felt like I had done
something wrong and I was being locked up for it. So no, I'd say not.

R23: And what was your relationship like with professionals and other
clients?

P25: Um. Well the other clients, most of them seemed to me, 'cos by
that time I'd got rid of all, I don't know the weird thoughts I'd been
having. And I felt like I was amongst mainly a bunch of lunatics. They
seemed really needing to be there and some of them I was quite scared
of. You know if you've got people that are like hearing voices and
then shouting out in response to them and that, it can be quite
unnerving. And my experience of psychiatric staff isn't a very good
one. To be perfectly honest, not, I can't tar them all with the same
brush. But there was an awful, um, lack of any empathy, you know
um, it was very clearly obvious that we were the abnormal and they

Major Research Project
were the normal. And their job was to look after us because we weren't up to, up to scratch. But um, you know, like anything, there were some good staff, but I would have to say in the main, to them it was probably like a lot of things you deal with every day of your life, so you become a bit blasé, and come across as probably a bit uncaring and a bit unfeltthing. You know they get to two o'clock or nine o'clock and go off duty and go back to their normality, but if you are there for six months you don't have that luxury and it is hard because it is not life, it is not a true life being locked on a ward all day.

R26: So feeling very different from other people?

P26: Yeah...

R27: Did your experience of being in hospital under a section effect how you saw yourself at that time, whilst you were there?

P27: Yeah definitely. Yup I mean it would wouldn't it, if you are with a load of people that are obviously very mentally ill and you are in with them, your assumption about yourself is that if you need to be there your not quite the ticket, and you know you just, like over there there's a tiny little smoking room on each ward. All the wards over there are the same, and you get as many people that can get in there in there, and that's what's you do all day, just sit and drink tea and smoke. And well it's just terrible.

R28: What did you feel about yourself at that time?

P28: Actually I used to think about suicide a lot. Umm. You know I didn't, as I started to feel a better and more normal, I didn't know how I was going to cope with being in that environment for that period of time and um, it's just like a prison sentence really. I can't, well I can only imagine, I've never had a prison sentence, but it can only be what I would think it must feel like to be in prison, because all your rights are gone. Your rights as a human being or as an individual are no longer yours. You know, it's just awful, dreadful.

R29: And how did you cope with the changes in how yourself at the time, how did you cope whilst in hospital?
Um I think I only coped because I didn’t have a choice, you know as I say, I did think about an overdose but there was no way of getting one. A few times I can remember keeping a tablet under my tongue and not actually swallowing it so I could stockpile them, but I never got to get enough for that. And I don’t know I suppose in the end it settled down some sort of routine as it were. And I’m lucky I’ve got a very good husband, and three daughters, and I just basically got by, by living for their visits. My husband came everyday, my mum came a lot, my daughters came, um so I was an awful lot luckier than a lot of the inmate, who didn’t get any visitors, and you know I just got by. You do don’t you. Somehow you sort of, you find the wherewithal to cope with it. But I think if I was faced with that again I would make sure I had a stock of something to take, I wouldn’t, I could never go through that again. Never.

I joined a group called the mental health project, like charity thing. And I was quite active with them even after I’d left the hospital. In fact I got a phone call from them last week asking me to go to their locality meeting. But apart from that no.

Okay, thank you. And thinking about these changes and how you saw yourself at that time in hospital, as you’ve just discussed, would you have wanted your experience to have been different?

Yeah definitely. You know, I think now I understand it, I think they could still achieve the same, I mean basically the MHA is about safety from yourself and others safe around you and I think that could be achieved in a whole different way. In a much more sort of humanistic fashion. If you like. You know, alright you lose your liberty because somebody decides that you are a danger to yourself or others but it doesn’t mean you should lose sight of you and who you are. And I think you need that extra bit of help and kindness to get you back to your normal, rather than I say feeling like it is just one big punishment for everything. In fact in this day and age it all seems a bit sort of barbaric almost to me.
R32: Would you have wanted others to have treated you differently?
P32: Yeah I would have liked them to have treated me like an individual. And that doesn't happen, it doesn't happen. And I think I am more acutely aware of it than a lot of people because I come from what I like to think of as a caring profession. You know, it doesn't matter in my nursing career over twenty odd years it doesn't matter whether I've been dealing with somebody whose I don't know, we've discovered in the end is a pentidine addict in with renal colic pretending, so that they can get, or somebody who is terminally ill or a small child dying, we are not there to make those judgments about people, we there to treat everybody as a person in their own right, you know, they are not just an illness. And I wasn't just a mental case, I'm me, I'm you know, and I don't think people seem to look beyond the mental illness and see the person that they are meant to be dealing with and helping. Personally, I mean I suppose years ago it was worse because you got packed off to the lunatic asylum if you had any mental illness. But I still think, as I say, in this day and age, an age of enlightenment, the, it should all be changed. I don't quite know what the answer is and what to change it to, but I am sure there is a better way of it functioning than as is. And I feel quite passionate about that. And I actually think that due those sections and that period in life that culminated in me actually, a year ago come January, I nearly died from an overdose, I was a life support machine for a month, and you know it got to a stage where they called everybody in and said I was going into organ failure and that I probably wouldn't make it, and in my mind that is a result of the treatment that I got.
R33: Gosh.
P33: So
R34: So it was that powerful for you..... Thinking now about after you were discharged, would you like to take a few minutes first...
P34: Sorry.
R35: That's alright... would you like to have a break?
P35: No I'm okay thanks.
P36: We have only got a few more bits left.
P36: yeah sure.

R37: Um. Yeah now I am thinking of after you were discharged, you mentioned quite a lot about this already, but your feelings about the experience of being detained under the MHA, and whether you think it was a positive or negative experience, has been answered somewhat in your previous...

P37: Yeah I think it has.

R38: ...but is there anything...

P38: totally negative, totally. And it is hard to bounce back from when you do come out because you know it is such a big thing. It is not something you can just sort of turn the other cheek to. It impacts so much on you, and I think it is such a drastic event that it will never leave you. Never. Even in my sort of happier, well adjusted moments I still get quite a lot of flashbacks to that and what it was like. And you know it probably compares, as I say on par with the flashbacks I get back to last January when as I say I did, you know. And if it equates to nearly losing my life then I think it says something of what a, you know, a dramatic event in my life it has been really. And I often think of other people that are in there, you know, if we drive by there I think those poor people, I wonder what they are feeling, and what they are doing. And that's just, you know, I've got some positive experiences with some of the mental health team, you know like I said and certainly my psychiatrist and but the staff there I think it has all become too commonplace for them. And they just go through it like some ultimatum and it's wrong. It impacts my, my dramatic event in my life it has been really. And I often think of other people that are in there, you know, if we drive by there I think those poor people, I wonder what they are feeling, and what they are doing. And that's just, you know, I've got some positive experiences with some of the mental health team, you know like I said and certainly my psychiatrist and but the staff there I think it has all become too commonplace for them. And they just go through it like some ultimatum and it's wrong. It impacts my...

R39: Okay thank you. How do you see yourself now, how would you describe how you see yourself now?

P39: Urn, well fairly normal I like to think. You know I've been working, I still don't like it if anybody refers back to that time, if any of the family or anybody mention it I'm not keen. I don't know really.

R40: Does your experience of the process of being detained under the MHA, so the day of admission, affect how you see yourself now?

P40: Yeah I think it must do. I don't think, I think your life is like a piece of plain paper and that everything that happens to you adds...
P41: So it affected your level of self-esteem?
R41: So it affected your level of self-esteem?
P41: yeah, yeah,
R42: So you feel that part of who you are is the same as before being detained or do you feel like a completely different person?
P42: Um no I don’t know about completely differently but I’ve got those difference because I’ve been through that horrible period and it sort of stains you if you know what I mean? It’s difficult to explain, it makes you feel less of somebody for having been through it. Yeah I can’t think of any better words to describe it. Not saying that there isn’t one but yeah. It’s just sort of less of a human being really.
R43: Does it change how you view your abilities to control that particular situation or now?
P43: Control that particular situation or now?
R44: Thinking now, does that experience of that actual day of being sectioned the admission day, does that do you think affect your view on how much in control you are of things?
P44: I think it does because I don’t think, I think the whole experience makes you feel like you can’t really control your life, because that is such a controlling factor in your life when it happens and you don’t know just how much of a grip you’ve got on that control because look at me it was taken from me and that was that, you know for quite some time. So yes I do think it makes you feel less in control.
R45: Okay. It’s a bit of a, really a similar question, I’m sure it’s blurred quite a bit, but the actual time of being in hospital detained under a section, do you think that period also has any effects on how you see yourself now.
P45: um. Yeah I suppose so because I’ve still been a mental health patient. You know. And it’s not a nice feeling, that’s a horrible
now? So now how do you manage those changes?

P46: I think probably fear of anything like that ever happening again, I mean I’m not really on any particular medication, I only take an antidepressant but I am quite mindful not to forget that and to take care of myself. As I said to you a long with the bipolar I had an alcohol problem that they said was to do with the bipolar but whether it was or not, so I am careful with that. I don’t drink anymore only when we go out. I think I am probably quite aware that I like to keep my life on the straight narrow as much as I can so that nothing like that come along and kick me in the teeth again.

R46: How do you cope with these changes in how you see yourself now?

P47: Well as I said earlier I’ve grown up with a lot of those feelings because of the way things were when I was a child, so feeling different is something I’ve got used to living with from quite an early age. So I think it’s another negative experience that I’ve dealt with and I think when you’ve already dealt with other things that you feel different with it probably makes it easier. You get used to the different knocks that you can get and you just have to get on with it really. I’ve heard different people say the experience can make you stronger but I don’t think I would say that, it might make you a bit more sort of silent, but I think that is just a front, a front that you put on to deal with it.

R48: Okay. And now looking back on your experiences in total, the changes in how, in particular the changes it’s had on how you see yourself, would you have wanted your experiences to have been different?

P48: yeah, definitely. Definitely. I mean I don’t understand why you have to go via a police station I don’t know why you can’t go as a direct admission to the hospital. You know, like I said before if you
were in car accident, you'd be expected to go to A and E. That to me is weird, the complete wrong place to deal with it.

R49: And how about the actual time in hospital, how would you want that to be different?

P49: Well it's different already because they don't lock it anymore. It's not a locked ward, so that psychologically I think is of great benefit that you are not actually feeling that you've been locked up. But as I say they go through all the processes of individual care plans and things like that but really you know they are just paying lip service to it, it isn't individual. I mean everybody really is treated the same. And I think you just feel, at times, the closest I can think of it is it's like they are dealing with animals, which might be a bit harsh but I'm afraid that's how I see it. And I wouldn't wish it on my worst enemy.

RSO: Okay thank you. Is there any additional information that you'd like to add before we finish?

PSO: Um. There probably is but I can't... you know I was thinking back then, you said about how can you get through it, and I tell you what most people do to get through it is they get hold of cannabis and alcohol within the unit and that's how they deal with it, a lot of them. Which may be probably quite a good idea, but the whole thing, the whole system is definitely wrong. And you know, I've probably spent a year, a year and a half in that environment and you know 10 minutes is too long. So.

R51: Okay. Thank you. And just to end with how you feel about being interviewed about this, on this subject?

P51: Um actually more upset than I'd thought I'd be. I didn't think I felt upset about it but I do. You know, not slash my wrists about it but it is, I suppose, like I said to you before, sometimes you go off in your ordinary events of your day and you may get a flashback or two to a time that wasn't very nice in your life, but that I think you can quickly turn to something else, where as when somebody asking you directly about something you haven't got that mechanism where you can flip from one thing to another. So I think you sort of, the process of having
an interview about something makes you stay focused on the whole
event rather than when it comes unbidden into your mind you can
choose to...

R52: distract yourself
P52: Yeah and that's probably why I found it more difficult because
I've probably only flitted on it from time to time. Yeah quite
upsetting.

R53: Okay. Well thank you very much for your time and your answers
have been really helpful.

P53: I hope so.
R54: And that is very kind of you to give your time.

P54: That's alright.
18 July 2006

Mrs Katherine A.A Boucher
Trainee Clinical Psychologist
University of Surrey
Psychology Department
University of Surrey
Guildford, GU2 7HX

Dear Mrs Boucher

Full title of study: A qualitative study investigating the effects of being detained under the Mental Health Act (1983) on an individual's identity.

REC reference number: 06/Q1911/39

Thank you for your letter of 07 July 2006, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.

Ethical review of research sites

The Committee has designated this study as exempt from site-specific assessment (SSA). There is no requirement for [other] Local Research Ethics Committees to be informed or for site-specific assessment to be carried out at each site.

Conditions of approval

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

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<tr>
<th>Document</th>
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<td>Letter from Sponsor</td>
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Research governance approval

You should arrange for the R&D department at all relevant NHS care organisations to be notified that the research will be taking place, and provide a copy of the REC application, the protocol and this letter.

All researchers and research collaborators who will be participating in the research must obtain final research governance approval before commencing any research procedures. Where a substantive contract is not held with the care organisation, it may be necessary for an honorary contract to be issued before approval for the research can be given.

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.

Please quote this number on all correspondence

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

Yours sincerely
Ms Katherine Boucher  
Department of Psychology  
School of Human Sciences

Dear Ms Boucher

A qualitative study investigating the effects of being detained under the Mental Health Act (1983) on an Individual’s identity (EC/2006/82/Psych) – FAST TRACK

On behalf of the Ethics Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the submitted protocol and supporting documentation.

Date of confirmation of ethical opinion: 24 August 2006

The list of documents reviewed and approved by the Committee under its Fast Track procedure is as follows:-

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<tr>
<th>Document</th>
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<td>Main Interview</td>
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<tr>
<td>Summary of Risk Assessment</td>
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<td>Letter to GPs</td>
<td>21/04/2006</td>
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</tbody>
</table>

This opinion is given on the understanding that you will comply with the University’s Ethical Guidelines for Teaching and Research, and with the condition set out below.

- The Consent Form should include a space for signature of a witness as shown in the attached sample.

The Committee should be notified of any amendments to the protocol, any adverse reactions suffered by research participants, and if the study is terminated earlier than expected, with reasons.

...
I would be grateful if you would confirm, in writing, your acceptance of the condition above enclosing the amended Consent Form for the Committee's records.

You are asked to note that a further submission to the Ethics Committee will be required in the event that the study is not completed within five years of the above date.

Please inform me when the research has been completed.

Yours sincerely

[Signature]

Catherine Ashbee (Mrs)
Secretary, University Ethics Committee
Registry

cc: Professor T Desombre, Chairman, Ethics Committee
    Dr M Hayward, Supervisor, Department of Psychology
Dear Mrs Boucher

ID: 0762/NOCI/2006 A qualitative study investigating the effects of being detained under the mental health act (1983) on an individual’s identity.

Thank you for your application to the Research Approval and Monitoring Committee for approval for this study.

A sub-committee of the RAMC have considered this study. The documents considered were as follows:
- NHS REC form parts A and B (signed and dated 03/07/06)
- NHS R&D form (signed and dated 02/06/06)
- Protocol version 6 dated 28/06/06
- Interview schedule (version 3 dated 23/05/06)
- Personal data questionnaire (version 2 dated 16/05/06)
- West Sussex LREC approval letter (signed and dated 18/07/06)
- Letter confirming University of Surrey as RG Sponsor (signed and dated 08/05/06)
- CV for Katherine Boucher (signed and dated 14/07/06)

I am pleased to tell you that the study was approved, and so may proceed. This approval is valid in the following Organisations:
- Sussex Partnership NHS Trust

Your RAMC approval is valid providing you comply with the conditions set out below:
1. You commence your research within one year of the date of this letter. If you do not begin your work within this time, you will be required to resubmit your application to the committee.
2. You notify the RAMC by contacting me, should you deviate or make changes to the RAMC approved documents.
3. You alert the RAMC by contacting me, if significant developments occur as the study progresses, whether in relation to the safety of individuals or to scientific direction.
4. You complete and return the standard annual self-report study monitoring form when requested to do so at the end of each financial year. Failure to do this will result in the suspension of RAMC approval.
5. You comply fully with the Department of Health Research Governance Framework, and in particular that you ensure that you are aware of and fully discharge your responsibilities in respect to Data Protection, Health and Safety, financial probity, ethics and scientific quality. You should refer in particular to Sections 3.5 and 3.6 of the Research Governance Framework.

Please contact the Consortium Office if you wish this approval to be extended to cover other Consortium Organisations; such an extension will usually be agreed on the same day. We also have reciprocal arrangements for recognition of Research Governance approval with some other NHS Organisations; such an extension can usually be arranged within five working days.

Good luck with your work.

Yours sincerely!
Dear

Re: A qualitative study investigating the effects of being detained under a section of the Mental Health Act on an individual's identity.

Thank you for meeting with me recently and agreeing to be interviewed on your experiences of being detained under the Mental Health Act. Your time was very much appreciated and provided helpful information for the research study.

The study aimed to explore the effects of being detained under the Mental Health Act on an individual's identity. I have now completed all the interviews, analysed the data and am currently writing up the findings. I have enclosed a written summary of the research. The findings described overall themes that were captured in the interviews and does not represent all individual experiences.

I have enclosed a summary of the findings with space for feedback and a stamped addressed envelope to return any comments. If you wish to provide feedback that would be most appreciated, though you are under no obligation to do so. If it is easier please feel free to e-mail me with any comments at k.boucher@surrey.ac.uk.

Once again, I would like to thank you for taking part in this research study.

I wish you all the best for the future,

With kind regards,

Katherine Boucher
Trainee Clinical Psychologist.
Summary of findings from the research study: A qualitative study investigating the effects of being detained under a section of the Mental Health Act on an individual's identity.

1. Life Changes

A main theme that emerged was a general perception that there had been sudden changes in participants' life situation. Some participants appeared to find this change in their lives not only as sudden but also sometimes permanent, with their lives not being able to go back to how they were before. This seemed to result in some participants' views of themselves changing (feeling that they were not the same person as before they were detained) either at the time of detention or since discharge when reflecting back on their experience. This sudden change in life circumstance as a result of being detained, also seemed to cause changes in thoughts about the future and in particular its stability. There was an awareness by some participants that things could change again in the future.

- Was there anything in the findings that you particularly agreed with or that you felt fitted well with your experiences?

- Was there anything in the findings that surprised you or you disagreed with in relation to your experiences?

- Do you have any overall comments about these findings?
2. Distinctiveness

A second main theme that emerged was one of distinctiveness, where participants described feeling that they were seen and treated as different by others because of their experience of being detained under the Mental Health Act. This was described as sometimes feeling other people saw them as abnormal or were frightened of them. This appeared to result in some participants seeing themselves as different from others, and feeling alone and isolated because of this. Participants also described feeling that as patients who were under a section of the Mental Health Act they were part of a distinct group of individuals who were different from staff or voluntary patients in a fundamental way.

- Was there anything in the findings that you particularly agreed with or that you felt fitted well with your experiences?

- Was there anything in the findings that surprised you or you disagreed with in relation to your experiences?

- Do you have any overall comments about these findings?
3. **Powerlessness**

All of the participants described feelings of powerlessness related to their experiences of being detained under the Mental Health Act. This seemed to include feeling powerless in the process of being detained as a result of not understanding what was happening. There were also descriptions of feeling control and power were taken away from them when detained in hospital. Some participants reported long-term effects on their feelings about their ability to have control over their lives, also describing that they felt they had less control over their future.

- Was there anything in the findings that you particularly agreed with or that you felt fitted well with your experiences?

- Was there anything in the findings that surprised you or you disagreed with in relation to your experiences?

- Do you have any overall comments about these findings?
4. **Self-worth**

A fourth main theme that emerged from the data was one of self-worth, where a majority of the participants reported feelings of low worth and value because of their experiences of being detained under the Mental Health Act. There were also reports of feeling devalued and dehumanised. These feelings of low self-worth were for some participants' temporary, as they reported more positive views about themselves at the time of the interview. Some participants described having learnt from their experiences, it having helped them develop as a person, and that they felt pride at having got through it.

- Was there anything in the findings that you particularly agreed with or that you felt fitted well with your experiences?

- Was there anything in the findings that surprised you or you disagreed with in relation to your experiences?

- Do you have any overall comments about these findings?
5. **Identity not complete**

The fifth theme that emerged from the data describes a feeling reported by participants of a lack of wholeness to their identity. Some participants reported that it felt like something had been taken away from them when they were detained under the Mental Health Act and that they felt lacking in some way. It seemed that it was difficult to describe exactly what was missing from their identity, but rather a generalised sense that their identity, as something complete, had been changed.

- Was there anything in the findings that you particularly agreed with or that you felt fitted well with your experiences?


- Was there anything in the findings that surprised you or you disagreed with in relation to your experiences?


- Do you have any overall comments about these findings?


THANK YOU FOR YOUR TIME COMPLETING THIS FORM. PLEASE COULD YOU RETURN IT IN THE STAMPED ENVELOPE PROVIDED. THANK YOU.
Summary of findings from the research study: A qualitative study investigating the effects of being detained under a section of the Mental Health Act on an individual’s identity.

1. Life Changes

A main theme that emerged was a general perception that there had been sudden changes in participants’ life situation. Some participants appeared to find this change in their lives not only as sudden but also sometimes permanent, with their lives not being able to go back to how they were before. This seemed to result in some participants’ views of themselves changing (feeling that they were not the same person as before they were detained) either at the time of detention or since discharge when reflecting back on their experience. This sudden change in life circumstance as a result of being detained, also seemed to cause changes in thoughts about the future and in particular its stability. There was an awareness by some participants that things could change again in the future.

- Was there anything in the findings that you particularly agreed with or that you felt fitted well with your experiences?

Yes, the first experience changed my outlook after I was discharged and I feel I am a completely different person now (for the better, in most ways), sometimes in negative ways as well.

- Was there anything in the findings that surprised you or you disagreed with in relation to your experiences?

No

- Do you have any overall comments about these findings?


2. **Distinctiveness**

A second main theme that emerged was one of distinctiveness, where participants described feeling that they were seen and treated as different by others because of their experience of being detained under the Mental Health Act. This was described as sometimes feeling other people saw them as abnormal or were frightened of them. This appeared to result in some participants seeing themselves as different from others, and feeling alone and isolated because of this. Participants also described feeling that as patients who were under a section of the Mental Health Act they were part of a distinct group of individuals who were different from staff or voluntary patients in a fundamental way.

- Was there anything in the findings that you particularly agreed with or that you felt fitted well with your experiences?

- Was there anything in the findings that surprised you or you disagreed with in relation to your experiences?

  I did not feel that distinctly different from other patients or staff. I think the whole experience is alienating in general, but not in a definitive way.

- Do you have any overall comments about these findings?
3. **Powerlessness**

All of the participants described feelings of powerlessness related to their experiences of being detained under the Mental Health Act. This seemed to include feeling powerless in the process of being detained as a result of not understanding what was happening. There were also descriptions of feeling control and power were taken away from them when detained in hospital. Some participants reported long-term effects on their feelings about their ability to have control over their lives, also describing that they felt they had less control over their future.

- Was there anything in the findings that you particularly agreed with or that you felt fitted well with your experiences?

  Yes, there is a very distinct imbalance of power when one is sectioned. It was found very isolating and intimidating.

- Was there anything in the findings that surprised you or you disagreed with in relation to your experiences?

  No

- Do you have any overall comments about these findings?

  I think that many psychiatric professionals, nurses, doctors, and other workers are not aware of the impact of putting someone on a section. The effects are profound and long-lasting.
4. **Self-worth**

A fourth main theme that emerged from the data was one of self-worth, where a majority of the participants reported feelings of low worth and value because of their experiences of being detained under the Mental Health Act. There were also reports of feeling devalued and dehumanised. These feelings of low self-worth were for some participants' temporary, as they reported more positive views about themselves at the time of the interview. Some participants described having learnt from their experiences, it having helped them develop as a person, and that they felt pride at having got through it.

- Was there anything in the findings that you particularly agreed with or that you felt fitted well with your experiences?

  Yes I felt a certain amount of pride
  with what I coped during the time and
  that it made me a stronger more
  determined person.

- Was there anything in the findings that surprised you or you disagreed with in relation to your experiences?

  It didn't affect my self-esteem or
  self-worth although I did feel slightly
  dehumanised. It made me more angry
  and willful, rather than down-trodden
  and rejected.

- Do you have any overall comments about these findings?
5. **Identity not complete**

The fifth theme that emerged from the data describes a feeling reported by participants of a lack of wholeness to their identity. Some participants reported that it felt like something had been taken away from them when they were detained under the Mental Health Act and that they felt lacking in some way. It seemed that it was difficult to describe exactly what was missing from their identity, but rather a generalised sense that their identity, as something complete, had been changed.

- Was there anything in the findings that you particularly agreed with or that you felt fitted well with your experiences?

  Yes, there is definitely something profound that was removed once I had been sectioned for the first time and this was an integral part of my identity. It felt like the transition from child to adult and the nostalgic feelings and feelings of sadness afterwards.

- Was there anything in the findings that surprised you or you disagreed with in relation to your experiences?

  No

- Do you have any overall comments about these findings?

  

THANK YOU FOR YOUR TIME COMPLETING THIS FORM. PLEASE COULD YOU RETURN IT IN THE STAMPED ENVELOPE PROVIDED. THANK YOU.
Summary of findings from the research study: A qualitative study investigating the effects of being detained under a section of the Mental Health Act on an individual's identity.

1. Life Changes

A main theme that emerged was a general perception that there had been sudden changes in participants' life situation. Some participants appeared to find this change in their lives not only as sudden but also sometimes permanent, with their lives not being able to go back to how they were before. This seemed to result in some participants' views of themselves changing (feeling that they were not the same person as before they were detained) either at the time of detention or since discharge when reflecting back on their experience. This sudden change in life circumstance as a result of being detained, also seemed to cause changes in thoughts about the future and in particular its stability. There was an awareness by some participants that things could change again in the future.

- Was there anything in the findings that you particularly agreed with or that you felt fitted well with your experiences?
  *I feel that I can relate to all of the statements above, especially the future.*

- Was there anything in the findings that surprised you or you disagreed with in relation to your experiences?
  *My experiences are based mainly on what I have been told. With that in mind my feelings and thoughts are based solely on reflection as you describe.*

- Do you have any overall comments about these findings?
  *What appears to be a good summary.*

2. Distinctiveness

A second main theme that emerged was one of distinctiveness, where participants described feeling that they were seen and treated as different by others because of their experience of being detained under the Mental Health Act. This was described as sometimes feeling other people saw them as abnormal or were frightened of them. This appeared to result in some participants seeing themselves as different from others, and feeling alone and isolated because of this. Participants also described feeling that as patients who were under a section of the Mental Health Act they were part of a distinct group of individuals who were different from staff or voluntary patients in a fundamental way.

- Was there anything in the findings that you particularly agreed with or that you felt fitted well with your experiences?
  *One of the first things I have been asked by fellow patients is whether I am a voluntary or sectioned patient.*
• Was there anything in the findings that surprised you or you disagreed with in relation to your experiences?

No

• Do you have any overall comments about these findings?

Succinct; what is written is very much a description of how it was for me.

3. Powerlessness

All of the participants described feelings of powerlessness related to their experiences of being detained under the Mental Health Act. This seemed to include feeling powerless in the process of being detained as a result of not understanding what was happening. There were also descriptions of feeling control and powers were taken away from them when detained in hospital. Some participants reported long-term effects on their feelings about their ability to have control over their lives, also describing that they felt they had less control over their future.

• Was there anything in the findings that you particularly agreed with or that you felt fitted well with your experiences?

Again I can only reflect on what I have been told. I do not remember being powerless. There was an inevitable effect on my life which continues.

• Was there anything in the findings that surprised you or you disagreed with in relation to your experiences?

No

• Do you have any overall comments about these findings?

None

4. Self-worth

A fourth main theme that emerged from the data was one of self-worth, where a majority of the participants reported feelings of low worth and value because of their experiences of being detained under the Mental Health Act. There were also reports of feeling devalued and dehumanised. These feelings of low self-worth were for some participants' temporary, as they reported more positive views about themselves at the time of the interview. Some participants described having learnt from their experiences, it having helped them develop as a person, and that they felt pride at having got through it.

• Was there anything in the findings that you particularly agreed with or that you felt fitted well with your experiences?

Yes I did not have much in the way of self worth. I have learnt a lot from my experiences which I have passed on to my ex-work colleagues.
• Was there anything in the findings that surprised you or you disagreed with in relation to your experiences?

No

• Do you have any overall comments about these findings?

None

5. **Identity not complete**

The fifth theme that emerged from the data describes a feeling reported by participants of a lack of wholeness to their identity. Some participants reported that it felt like something had been taken away from them when they were detained under the Mental Health Act and that they felt lacking in some way. It seemed that it was difficult to describe exactly what was missing from their identity, but rather a generalised sense that their identity, as something complete, had been changed.

• Was there anything in the findings that you particularly agreed with or that you felt fitted well with your experiences?

*This is not something I have thought of before. It is I think inevitable that I felt my identity would have been affected in some way*

• Was there anything in the findings that surprised you or you disagreed with in relation to your experiences?

*No. See below*

• Do you have any overall comments about these findings?

*Out of all the findings I am not sure that this is a cogent finding. May be it is not possible to distil a theme from the empirical methodology used for the study. I think that the highlighted area seems OK. May be some sort of examples would help.*
Table 3: Number of Participants who Contributed to Subthemes.

<table>
<thead>
<tr>
<th>Main Theme</th>
<th>Subthemes</th>
<th>Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Life changes</td>
<td>i) Rupture: permanent and sudden change to life situation.</td>
<td>Ann, Claire, Pamela, George, Kate, Laura (6)</td>
</tr>
<tr>
<td></td>
<td>ii) A new identity trajectory</td>
<td>Ann, Claire, Pamela, George, Kate, Laura, Gemma, Francesca (8)</td>
</tr>
<tr>
<td></td>
<td>iii) Loss of stability</td>
<td>Ann, Claire, Margaret, Pamela, Kate, Gemma (6)</td>
</tr>
<tr>
<td>2) Distinctiveness</td>
<td>i) Being perceived and treated as different.</td>
<td>Claire, Margaret, Pamela, George, Peter, Kate, Laura, Gemma, Francesca (9)</td>
</tr>
<tr>
<td></td>
<td>ii) Seeing self as different</td>
<td>Ann, Claire, Margaret, Pamela, Gemma. (5)</td>
</tr>
<tr>
<td></td>
<td>iii) Group distinctiveness</td>
<td>Ann, Claire, Pamela, Peter, Kate, Laura. (5)</td>
</tr>
<tr>
<td>3) Powerlessness</td>
<td>i) Lack of understanding in the process</td>
<td>Ann, Claire, Margaret, Pamela, George, Peter, Kate, Laura, Gemma. (9)</td>
</tr>
<tr>
<td></td>
<td>ii) Control and power being taken away.</td>
<td>Ann, Claire, Margaret, Pamela, George, Peter, Kate, Laura, Gemma. (9)</td>
</tr>
<tr>
<td></td>
<td>iii) Long-term effects on self-efficacy</td>
<td>Ann, Claire, Margaret, Pamela, Kate, Gemma (6)</td>
</tr>
<tr>
<td>4) Self-worth</td>
<td>i) Devaluing and dehumanising experience</td>
<td>Ann, Claire, Pamela, Peter, Kate, Laura, Gemma. (7)</td>
</tr>
<tr>
<td></td>
<td>ii) Negative evaluation of self</td>
<td>Pamela, George, Peter, Kate, Laura, Gemma, Francesca. (7)</td>
</tr>
<tr>
<td></td>
<td>iii) Positive changes in self</td>
<td>Ann, Claire, Peter, Kate, Francesca (5)</td>
</tr>
<tr>
<td>5) Identity not complete</td>
<td>i) Something being taken away</td>
<td>Ann, Claire, Kate (3)</td>
</tr>
<tr>
<td></td>
<td>ii) Feeling lacking</td>
<td>Ann, Claire, George, Peter, Kate, Gemma (6)</td>
</tr>
<tr>
<td>6) Coping</td>
<td>i) Distraction and avoidance</td>
<td>Ann, Claire, Margaret, Pamela, Peter, Gemma. (6)</td>
</tr>
<tr>
<td></td>
<td>ii) Acceptance</td>
<td>Ann, Claire, Margaret, Pamela, Peter, Gemma. (6)</td>
</tr>
<tr>
<td></td>
<td>iii) Agency</td>
<td>Ann, Claire, Pamela, George, Peter, Kate, Laura, Francesca. (8)</td>
</tr>
</tbody>
</table>