A Grounded Theory Approach Exploring Men's Access to IAPT Services and Accounts of Psychological Help Seeking

by

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Introduction to the Portfolio

This portfolio contains a selection of work completed during the PsychD in Clinical Psychology. It is comprised of three sections.

The academic section contains a literature review, a professional issues essay, two problem-based learning reflective accounts and two summaries of the personal and professional leaning and discussion group process.

The clinical section comprises an overview of clinical experience gained over the five placements.

The research section contains a service related research project, abstract of a qualitative research project, the major research project and a research log.

All work has been anonymised to maintain confidentiality.

Copyright Statement

No part of this portfolio may be reproduced without permission of the author except for legitimate academic purposes.

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1. ACADEMIC SECTION

Literature Review

"The Clinical Applicability of Acceptance and Commitment Therapy to Psychosis"

February 2011

Year 1
Abstract

There is growing interest regarding whether Acceptance and Commitment Therapy (ACT) is a clinically beneficial psychological intervention for psychosis. This review aimed to provide a critical appraisal of the available research on ACT for psychosis in an attempt to establish whether ACT is an empirically-supported intervention for psychosis, alongside whether any adaptations to ACT would need to be made to use it with psychosis. The literature published on ACT for psychosis since the theoretical emergence of ACT in 1999 was reviewed. A total of eight papers were critically reviewed: four using data from randomised controlled trials, three clinical case studies, and one discussion paper. The reviewed evidence suggested that ACT can be delivered in brief individual sessions with inpatient and outpatient samples with minimal adaptation from its original format needed for psychosis. ACT appeared to facilitate change in psychological flexibility for individuals experiencing psychosis, as evidenced through a reduction in the believability of and distress associated with psychotic symptoms at short-term follow-up. Whilst the evidence is promising, due to the current scarcity of research, ACT does not currently fulfil the criteria for an empirically-supported intervention for psychosis. Implications for clinical practice and future research are discussed.
Psychological therapies were previously considered ineffective for schizophrenia, with best practice for this disorder considered to be in the form of antipsychotic medication alongside case management (Tarrier & Wykes, 2004). However, with the growing body of evidence suggesting that psychotic symptoms can be resistant to medication the view that a clear adjunctive role exists for psychosocial interventions in the treatment of psychosis has evolved (Breier, Schreiber, Dyer & Pickar, 1991). Current guidelines defining best practice within the field of psychosis have gone some way to challenging the view that schizophrenia is impenetrable to psychological therapy, with at least 16 individual sessions of manualised Cognitive Behavioural Therapy (CBT) alongside family work currently considered the best practice psychological interventions for schizophrenia (NICE, 2009). Proposed outcomes for clients using CBT encompass the client being able to self-monitor psychotic symptoms and apply alternative ways of coping with their symptoms, alongside a decrease in distress and an improvement in functioning (NICE, 2009).

Although CBT is not aimed directly at eradicating positive symptoms but at easing distress by working with the meaning of symptoms (Perez-Alvarez, Garcia-Montes, Perona-Garcelan & Vallina-Fernandez, 2008), the efficacy of CBT for psychosis is largely measured using outcome measures focused on positive symptomatology (Tarrier & Wykes, 2004). Concerns have been raised regarding whether the focus in traditional CBT on decreasing the frequency and severity of symptoms may intensify the internal focus inherent within psychosis, thus exacerbating the struggle with positive symptoms (Nelson, Sass & Skodlar, 2009). Furthermore, questions remain as to which diagnostic sub-group CBT works for and during which particular phase of illness it is most effective (Tai & Turkington, 2009). Coping and adjustment to psychosis appear to influence service engagement (Tait, Birchwood & Trower, 2003) and psychological interventions more focused on altering the \textit{function} rather than the content of positive symptoms may help individuals better adjust to their symptoms thus increasing the potential for service engagement and decreasing risk of relapse (Teasdale et al., 2002).
The Emergence of Acceptance and Commitment Therapy (ACT)

Acceptance and Commitment Therapy (ACT; Hayes, Strosahl & Wilson, 1999) has been proposed as part of the new or ‘third wave’ of cognitive and behavioural therapies (Hayes, 2004). The emergence of a new wave of cognitive-behavioural therapies has stemmed from questions as to whether, as proposed by traditional CBT, cognitive change and reduction in symptomology are necessary indicators of clinical improvement. The common underlying thread of these third wave therapies is the emphasis placed on contextual and experiential change strategies which endeavour to alter the function of problematic psychological events even if the form or frequency of such events shows minimal shift over time.

ACT is theoretically rooted in Relational Frame Theory (RFT; Hayes, Barnes-Holmes & Roche, 2001) and RFT is the most differential characteristic between ACT and CBT (Ruiz, 2010). The underpinning assertion of RFT is that verbally mediated private events such as cognitions, emotions and memories, do not influence behaviour directly through their content or frequency but through the context in which they occur. ACT views human struggle with and attempts to avoid problematic psychological events, including psychotic symptoms, as problematic, rather than the presence of the symptoms themselves (Hayes, 2004). The treatment goals within an ACT framework are to foster acceptance of unwanted thoughts and feelings thus discouraging experiential avoidance, whilst simultaneously encouraging clients to identify the life values that are important to them and commit to acting in ways that further their values (Hayes, 2004). ACT uses a series of metaphorical and experiential exercises to increase psychological flexibility through six specific processes: (1) acceptance, (2) cognitive defusion, (3) contact with the present moment, (4) self as context, (5) values, and (6) committed action. Through these processes ACT aims to cease the client’s struggle with unwanted internal events without changing or eliminating them and uses mindfulness exercises to help the client develop a non-judgmental stance to inner experiences as they occur. The principles of values-based living and committed action seek to help clients identify that psychological pain does not necessarily need to be eradicated before life can be lived fully and encourages clients to make psychological space for inner experiences whilst remaining in contact with their values (Hayes, 2005).
The Integration of ACT with the Recovery Model

As a psychological intervention, ACT appears to fit within the Recovery Model framework advocated for adult mental health service delivery (Department of Health [DoH], 2001). The Recovery Model advocates that meaning and purpose in life are important to recovery from mental health problems and that recovery can occur in the presence of active symptomatology (Jacobson & Curtis, 2000). Concern has been raised within the Recovery Movement that measuring recovery in terms of a reduction in symptomatology is not necessarily what service users consider important in defining the recovery journey (Langdon, Swift & Budd, 2006). ACT seems to recognise the concerns raised about determining recovery in terms of a reduction or cease in symptoms and its philosophical underpinning that individuals can pursue a valued life despite continuing symptoms is in line with the definition of recovery advocated by the Recovery Model. As such, ACT seeks to move away from outcome measurement focused on symptom reduction towards outcomes defined by: (1) a reduction in the distress caused by psychological experiences, (2) a reduction in the believability of cognitions experienced as part of psychological events, (3) a shift in the individual’s relationship with their psychological experiences, and (4) committed action towards life values even if symptoms remain.

Distinctions Between ACT and CBT

Within the literature, the theoretical and clinical distinction of ACT to existing approaches has been examined. At present there is conflicting opinion as to whether ACT represents a revolutionary new treatment approach as proposed by its founders, or whether it is an extension of existing CBT (Hoffman & Asmundson, 2008). For psychosis, it has been argued that within traditional CBT positive symptoms must be eliminated before a new understanding of the self can be established (Temple, 2004). However, within the ACT framework psychotic symptoms do not necessarily need to be eradicated for the therapy to be effective, as long as the symptoms do not impede functioning or the individual's ability to live life in accordance with their values. Despite the conflicting views within the field, a growing body of research evidence suggests that ACT is a clinically useful psychological intervention for a range of physical and mental health conditions, with results demonstrating reductions in the distress associated with such conditions alongside self-reported improvements in
quality of life (Hayes, Masuda, Bissett, Luoma & Guerrero, 2004). Whether ACT has a clinically superior benefit for psychiatric problems, including psychosis, above the benefits of CBT is yet to be evaluated (Guadiano, 2005).

Position of Interest
As a trainee clinical psychologist professional guidelines outline the requirement to keep informed of current developments in evidence-based practices and interventions in order to deliver the best care to service users within our competence (British Psychological Society [BPS], 1995; 2009). For me, attendance at a number of conferences on third wave therapies facilitated an interest in the principles of ACT alongside raising questions about the current evidence-base for ACT as a psychological intervention. Having not previously worked in psychosis I am keen to explore the current evidence base for ACT in order to evaluate whether I should be developing skills in ACT in order to use this as an approach in my clinical work within a recovery-oriented psychosis service and support other mental health professionals in evolving their clinical practice through providing training on ACT interventions for psychosis.

Objectives of Review
There is a growing interest regarding whether ACT is a beneficial intervention for psychosis. In an attempt to answer this question, the scope of this review is to examine the existing literature on ACT for psychosis, with the aim of answering two specific questions: firstly, whether the evidence to-date supports ACT as being an empirically supported psychological intervention for psychosis, and secondly whether specific adaptations would need to be made to ACT in order to use it as a psychological intervention for psychosis. A review of the available evidence will be presented alongside a critical appraisal of the research evidence in line with the criteria established for determining empirically-supported psychological treatments (Chambless et al., 1998) in order to draw conclusions regarding the current status of ACT as an empirically-supported intervention for psychosis.
Method

Definition of terms and boundaries

Based on the two explicit questions of the review, explicit inclusion and exclusion criteria were set. Studies that had as their sample adults aged 19 to 64 years were included. Studies where the participants were diagnosed with suffering or had a history of suffering from psychotic symptoms (including diagnoses of psychotic depression, bipolar disorder, schizophrenia and schizoaffective disorder) were included. Journal articles which referred to using ACT with psychosis within their abstract and which were published within the timescales of 1999 to 2010 were included, given that ACT emerged in 1999. For the purposes of this review, diagnoses of organic or brief reactive psychosis were excluded as their aetiology is thought to differ from functional psychosis, book chapters and dissertations were excluded, and journal articles not written in English language were excluded.

The search strategies for the databases MEDLINE, PSYCHOINFO, PSYCHARCITLES, EMBASE, PUBMED, Psychology and Behavioural Sciences Collection, Comprehensive Clinical Psychology and The Cochrane Central Register of Controlled Trials (CENTRAL) were devised using relevant subject headings for each database. The terms “schizophrenia”, “bipolar disorder”, “schizoaffective disorder”, and “psychosis” were used in combination with the terms “Acceptance and Commitment Therapy” or “ACT”. Abstracts produced from the database search were reviewed to determine if they presented ACT applied to psychosis. Additional articles were retrieved from reference lists of relevant articles.

Papers Identified

According to the above search criteria a total of eight papers were identified. Of the eight papers applying ACT to psychosis, two papers were Randomised Controlled Trials (RCTs), three were case studies, two were papers reviewing data from the RCTs, and one was a discussion paper on ACT applied to the management of hallucinations.
Critical Review of the Literature

Evidence from Controlled Trials

To date there have been two clinical trials both conducted in the USA investigating the use of ACT with psychosis. The first RCT (Bach & Hayes, 2002) investigated the use of a brief form of ACT (four 45-50 minute individual sessions conducted by a psychology student) with individuals experiencing auditory hallucinations or delusions in an acute inpatient setting. The ACT intervention (n=40) was compared with Treatment as Usual (TAU, n=40) which consisted of medication, attendance at three or more ward-based psychoeducational groups and a minimum of once weekly individual psychotherapy sessions with a psychologist. Treatment outcomes were assessed in relation to believability of positive symptoms and the negative behavioural impact of symptoms as measured by rehospitalisation rates at four-month follow-up. Frequency, believability and distress associated with positive symptoms were measured retrospectively using self-report rating scales devised by the researchers. The second RCT (Gaudiano & Herbert, 2006) compared Enhanced TAU (ETAU) with ETAU plus individual sessions of ACT in an inpatient sample (n=40) experiencing hallucinations and/or delusions. The ACT intervention (n=20) varied as a function of the individual’s length of current inpatient stay, with an average of three sessions per individual, and consisted of one-hourly individual sessions delivered by a psychologist. The ETAU intervention (n=20) consisted of psychopharmacology, case management and ward-based psychotherapy alongside the ACT therapist meeting with participants individually for 15 minutes daily to provide additional support and answer questions but not to discuss coping strategies related to ACT. The outcome measures consisted of rehospitalisation rates at four-month follow-up, self-report measures of psychotic symptoms, and standardised measures of positive symptoms and functioning which have demonstrated good psychometric properties, including the Brief Psychiatric Rating Scale (BPRS; Lukoff, Nuechterlein & Ventura, 1986); the Clinical Global Impressions Scale (CGI; Guy, 1976) and the Sheehan Disability Scale (SDS; Leon, Olfson, Portera, Farber & Sheehan, 1997).
What Do RCTs Suggest ACT is Effective for When Applied to Psychosis?

The results of these RCTs suggested that individuals treated with ACT had a lower rehospitalisation rate at four-month follow-up than those experiencing TAU. In the first trial 20% of individuals in the ACT condition were rehospitalised compared with 40% of individuals in the TAU condition, and in the second trial individuals in the ETAU condition had a 1.62 greater likelihood of rehospitalisation than individuals in the ACT condition. The results of the second trial indicated that at four-month follow-up individuals in the ACT condition showed medium effect size gains compared to individuals in the ETAU only condition (d=0.60), with ACT increasing the probability of achieving clinically significant change by 43% relative to the ETAU condition. In both trials individuals continued to self-report the presence of positive symptoms post-treatment and no significant differences across treatment conditions were noted post-treatment in terms of frequency or severity of positive symptoms. However, across both trials a statistically significant decrease in the believability of symptoms was noted between treatment conditions at four-month follow-up. Both trials suggested that ACT was effective in decreasing self-reported distress associated with hallucinations, however statistically significant differences across treatment condition were only noted in the more recent trial. Furthermore, the results suggested that ACT was more clinically effective for hallucinations than delusions.

The outcome data from Gaudiano and Herbert's 2006 RCT has been further investigated to explore potential mediators of change in ACT for psychosis as well as whether ACT is an effective adjunctive to medication for psychotic major depression (Gaudiano, Herbert & Hayes, 2010; Gaudiano, Miller & Herbert, 2007). Using secondary mediation analyses of the outcome data, Gaudiano et al. (2010) revealed that hallucination believability was a significant mediator of self-reported distress associated with hallucinations, with a total of 68% of treatment effect variance on distress accounted for by hallucination believability at post-treatment. However, the results are limited by the cross-sectional measurement of outcome and mediator variables, which makes it difficult to determine the extent to which a casual relationship exists between believability and self-reported distress associated with hallucinations. Using the outcome data from the 2006 RCT to examine psychotic
depression as a diagnostic sub-type, Gaudiano et al. (2007) found that for the subsample of individuals diagnosed with psychotic depression at admission (n=18) there was a clinically significant improvement by discharge for 44% of individuals diagnosed with psychotic depression in the ACT condition as measured by BPRS total scores. Furthermore, a significantly greater post-treatment improvement in self-reported distress associated with hallucinations was noted in the ACT than ETAU condition. The results did not indicate any significant differences across treatment conditions with regards to rehospitalisation rates over the four-month follow-up. However the very small sample size limits the power of the study to determine small but clinically significant differences between conditions.

Evidence from Case Studies

There were a number of case studies available (n=3) which have examined the application of ACT to psychosis. In contrast to the controlled trials which have focused on inpatient samples, the case studies have examined the use of ACT in outpatient services. Within these case studies there is disparity regarding the length of time over which these ACT interventions have been delivered and the range of outcome measures used to evaluate therapeutic progress.

The longest ACT intervention consisted of 37 weekly and biweekly individual sessions delivered over the course of one year. The results of this case study examining clinical progress in a 21-year old Caucasian male, provided preliminary support that ACT may be beneficial in producing a reduction in self-reported distress associated with visual hallucinations and paranoid delusions, and may help individuals experiencing psychotic symptoms to respond more mindfully and in a values-consistent way to their symptoms (Baruch, Kanter, Busch, & Juskiewicz, 2009). A further case study, reporting on clinical progress in a 30-year old Caucasian male, evidenced that ACT delivered across 15 50-minute weekly or bimonthly individual sessions over the course of six months can be beneficial at post-treatment and six-month follow-up in reducing self-reported distress associated with hallucinations alongside the severity of less distressing symptoms, including delusions, anxiety, depression and suicide risk (Veiga-Martinez, Perez-Alvarez & Garcia-Montes, 2008). In an attempt to explore whether ACT can help individuals
with cognitive difficulties experiencing psychosis, the shortest ACT intervention was used with a 22-year old Caucasian female experiencing auditory hallucinations and delusions (Pankey & Hayes, 2003). The ACT intervention consisted of four sessions and used clinician-derived self-report rating scales to assess the effectiveness of ACT in relation to client-determined outcomes, namely medication compliance, dysregulated eating, cessation of appliance dismantling within the home, and improvement in amount and quality of sleep. Improvements on all outcome measures provided preliminary evidence that ACT can be used with individuals with mild cognitive difficulties to facilitate cognitive defusion from delusions alongside willingness to experience aversive emotions. The results of all the case studies echo the findings of the controlled trials, in that the frequency of delusions and hallucinations can remain stable over time, but believability and distress associated with these symptoms diminishes over treatment.

**Collective Summary of Evidence from Reviewed Studies**

Evidence from the reviewed controlled trials and case studies provides promising support for ACT as a psychological intervention which can be delivered in brief-format and used in conjunction with medication to reduce distress associated with hallucinations in particular and decrease experiential avoidance of psychotic symptoms. The evidence reviewed does to some extent support the notion that ACT may be effective in reducing the distress associated with and believability of psychotic symptoms even if such symptoms remain present. Furthermore, the evidence from the reviewed case studies preliminarily supports the notion that ACT can help clients pursue worthwhile values in the presence of active symptomatology (Pankey & Hayes, 2003; Veiga-Martinez et al. 2008). Viewed collectively, the evidence supports ACT’s proposition that functional impairment is influenced by the individual’s response to and interaction with their symptoms, and not simply by the presence of the symptoms themselves.

The evidence from the RCTs reviewed suggests a trend towards ACT reducing the likelihood of rehospitalisation for individuals suffering with psychosis. However, the results only reached significance in the 2002 trial and survival curves for the treatment groups in the 2002 trial assumed similar slopes over time, indicating that
the effects of the ACT treatment were initially significant but diminished over time. Furthermore, small sample sizes due to attrition at follow-up in both trials limit the power to detect small between-group differences. Whilst it is recognised that cultural factors play an important part in the course of illness for psychotic disorders (Rosenfarb, Bellack, Aziz, Kratz & Sayers, 2004) it is interesting to note that although the ethnic groups most represented by the samples differed across the RCTs (80% Caucasian in the 2002 trial and 90% African-American in the 2006 trial) the results suggested similar change processes and outcomes in relation to psychotic symptoms and functional impairment across these racial groups. This suggests that ACT may be clinically applicable with a range of ethnically diverse clients experiencing psychosis.

Methodological Considerations

There are a number of issues which must be considered when interpreting the clinical applicability of the evidence. Whilst RCTs are considered the gold standard of research evidence which all treatments are judged by (Banerjee, 2006), in the 2002 trial individuals were asked to retrospectively identify the frequency of their most distressing symptom over the past month. This, alongside the lack of collateral information used to validate self-reported accounts of symptom frequency raises questions regarding the validity of the frequency data provided by participants in light of the cognitive difficulties evidenced in psychosis (Heinrichs & Zakzanis, 1998). Across the studies reviewed there are notable issues of treatment fidelity as only the 2006 trial paid attention to establishing some measure of adherence to ACT principles and within-session experiential exercises appeared to differ across studies. Questions about the sole effect ACT has on producing clinically significant change remain, as across the studies participants were receiving adjunctive forms of treatment alongside the ACT interventions, including medication (Bach & Hayes, 2002; Gaudiano & Herbert, 2006; Pankey & Hayes, 2003; Veiga-Martinez et al. 2008) participation in a psychosocial rehabilitation programme (Veiga-Martinez et al. 2008) and Functional Analytic Psychotherapy (FAP; Baruch et al. 2009). The mechanisms of therapy and the role acceptance plays in determining treatment outcome remains unclear as level of acceptance of positive symptoms was not directly measured, perhaps explained by the lack of ACT-oriented outcome measures.
specifically developed for psychosis. Furthermore, the relatively small follow-up period within the literature (minimum of four months and maximum of six months) raises questions as to whether post-treatment gains evidenced by ACT are maintained in the long-term, given the chronic nature of psychosis.

Treatment Modality
The evidence reviewed suggests that ACT can be delivered in brief format through individual sessions and demonstrate clinically significant change post-treatment. However, the considerable disparity in the length of treatment sessions delivered across studies, ranging from one session (Gaudiano & Herbert, 2006) to 37 sessions (Baruch et al., 2009), and the lack of clarity regarding treatment components included makes it difficult to establish the core components which need to be incorporated in ACT interventions and the optimal length of treatment needed to observe clinically significant change. Across the studies reviewed the ACT interventions were delivered solely by psychologists, raising questions as to the level of professional training needed to deliver ACT for psychosis and whether other mental health professionals can deliver ACT with similar clinical effects. Furthermore, the sole delivery of ACT in individual format across the studies raises ongoing questions as to whether ACT delivered in group format for psychosis evidences equal or greater clinical change to that observed when delivered individually.

Adaptations of ACT for Psychosis
A number of reasons for modifying ACT materials and strategies when working with psychosis have been outlined. These include engagement variability, reduced information processing capacity in psychosis, perception of internal events as external, compelling salience and strong emotional investment in symptoms and the potential for positive symptoms to be experienced as valued by the individual (Farhall, Thomas & Shawyer, 2010). The four core elements of ACT (dropping the control agenda, acceptance, defusion and values) are recognised as forming the framework of an ACT approach to psychosis, however a more psychoeducational and experiential approach using concrete, simple metaphors is advocated (Pankey & Hayes, 2003). Exercises aimed at increasing the client’s ability to experience
positive symptoms whilst simultaneously committing to values-based actions are acknowledged as being accessible for individuals experiencing psychosis, with little adaptation needed from their original format (Pankey & Hayes, 2003; Perez-Alvarez et al. 2008). Examination of the literature on mindfulness for psychosis is beyond the scope of this review. However, mindfulness practice is a core component of ACT and whilst only two of the case studies appeared to explicitly incorporate mindfulness exercises into their ACT intervention, the results preliminarily support the notion that mindfulness-practice can be incorporated within ACT interventions for psychosis with minimal adaptations (Baruch et al. 2009; Pankey & Hayes, 2003).

Conclusions

Review of the current evidence examining ACT for psychosis suggests there is growing evidence for ACT as a promising psychological intervention which can reduce the distress and believability of psychotic symptoms. The evidence reviewed suggests that ACT can be delivered in brief individual sessions with inpatient and outpatient samples and can evidence clinical change in psychological flexibility following treatment and at four month follow-up. Furthermore, the research evidence suggests that ACT can be applied to psychosis with minimal adaptations from its original format. However, whilst the evidence is promising, ACT does not appear to fulfil the criteria for an empirically supported intervention as defined by the American Psychological Association (Ost, 2008). Although the clinical usefulness of treatment dissection due to the complicated and comorbid nature of psychosis has been questioned (Kuipers, 2005), review of the evidence identified a lack of clarity regarding core components included in the ACT interventions, alongside considerable disparity in the length of ACT interventions delivered. As such, the current state of the evidence for ACT applied to psychosis makes it difficult to establish the core components which need to be included in ACT interventions in order to make the treatment effective, and the optimal length of treatment needed to observe clinically significant change when applying ACT to psychosis. Furthermore, the mechanisms of therapy and the role of acceptance remains unclear as these were not explicitly assessed within the studies reviewed.
Reflection on Implications for Clinical Practice

Whilst the current evidence for ACT applied to psychosis is promising, further research needs to be conducted before ACT can be considered an evidence-based intervention for psychosis. However, there is growing recognition within clinical practice that practice-based evidence, such as that within the reviewed case studies, may be a useful contributor to evidence-based practice (Marginson et al., 2000). As trainee clinical psychologists working in the NHS, where resources and budgets are considerably stretched, we have a responsibility to contribute to evidence-based practice and to encourage other mental health professionals to evaluate the clinical effectiveness of ACT by routinely evaluating ACT interventions used in clinical practice. ACT has the possibility to provide clients with a set of useful psychological tools through which to live a more meaningful life, however effective evaluation of ACT for psychosis is limited by the current scarcity of acceptance and values-based outcome measures for psychotic symptoms. Preliminary evidence suggests that the self-report Voices Acceptance and Action Scale (VAAS; Shawyer & Ratcliff, 2007) may be a psychometrically sound and clinically useful tool for assessing the psychological impact of voices. In order to move away from treatment efficacy measured by rehospitalisation rates, clinical psychologists must contribute to further clinical and research development of ACT-oriented outcome measures, which in turn may make outcome measurement more in line with the underlying philosophy of the Recovery Model.

ACT may pose a challenge for clinicians with regards to potentially requiring a shift in professional mindset. Such a mindset involves promoting acceptance amongst professionals and family members that the client can live in accordance with their values even in the presence of psychotic symptoms. Holding skills in supervision, training and consultancy, clinical psychologists seem well placed to support other mental health professionals in evolving their clinical practice, and where necessary, in helping multi-disciplinary teams to reassess their mindsets in accordance with what service users consider important for their recovery journey.
Directions for Future Research

Review of the evidence has identified that more research evidence is needed to determine whether ACT is superior to established treatments such as CBT for psychosis. Whilst ACT appears to show residual therapeutic benefits post treatment, the follow-up period has been limited to four-months within the existing controlled trials, thus the long-term therapeutic benefits of ACT for psychosis remain unclear. Initial evidence suggests that believability of symptoms may be a mediating factor in distress associated with positive symptoms (Gaudiano et al. 2010), however there is limited literature examining the change process in ACT. Further research is needed to examine through what processes ACT works in terms of clinical change (Nelson et al., 2009). The current state of the evidence makes it difficult to establish the level of clinical expertise needed to deliver ACT as an intervention for psychosis. Whilst the existing evidence has utilised psychologists to deliver ACT interventions, it remains unclear whether other mental health professionals could deliver ACT and how much training for professionals would be needed in order to effectively deliver ACT as an intervention for psychosis. Limiting the clinical application of ACT to solely individual format raises ongoing clinical and research questions as to whether ACT delivered as a group intervention for psychosis evidences equal or greater clinical change compared with the individual-format interventions delivered across the existing studies. A number of RCTs currently examining the effectiveness of ACT applied to psychosis (Farhall et al., in progress; White & Rattrie, in progress) may move ACT towards being an empirically-supported intervention for psychosis and address some of the outstanding questions raised by this review.

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"What Distinctive Contribution Can the Profession of Clinical Psychology Make in Today’s NHS? In What Ways Should the Profession be Concentrating Its Efforts in the Future?"

January 2012

Year Two
It would be difficult for anyone to deny that the National Health Service (NHS) is currently going through a significant amount of change. As clinicians working in the NHS we are moving into an organisational system focused on increased accountability and efficiency and access to more information and choice for service users, as outlined in the government White Paper entitled ‘Equity and Excellence: Liberating the NHS’ (Department of Health [DoH], 2010). At a time when the government proposes that restructuring of services and reduction in staffing costs are needed in order to achieve greater efficiency within the NHS, it is essential that clinical psychologists are able to evidence the value that they bring not only to mental health services but to society more generally. The government White Paper outlines their plan to enable service users to have access to more information and more choice in relation to their care, which appears to echo the principles of the Recovery Model within mental health services. As the economy dictates the rationalisation of public funds for mental health service provision, it becomes increasingly important for clinical psychologists to promote the value of their profession to services and organisations. In this essay I will present my thoughts on the contributions that clinical psychologists can bring to the twenty first century NHS. I will argue that the profession should be concentrating its efforts on more explicitly utilising our skills as scientist-practitioners, on developing and promoting ourselves as leaders within teams, services and organisations through engaging in consultancy, training and supervision, on thinking about how to make psychological services more accessible and sensitive to the needs of men and individuals from black and minority ethnic backgrounds, and on positively promoting clinical psychology and mental health issues within the public domain.

The Value of a Scientist-Practitioner

Amongst the profession it is well recognised that clinical psychologists bring a range of skills to mental health services, including core competencies in research, evaluation and audit, training and development, clinical supervision, service innovation and improvement, and clinical leadership (British Psychological Society [BPS], 2007). Whilst a large part of the work that clinical psychologists do involves

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1 The first person will be used throughout as the author considers that writing in this way helps to clarify the author's thoughts, experiences and opinions for the reader.
delivering both direct and indirect interventions with clients experiencing a range of presenting problems, we clearly have more skills to offer than just being a therapist. One of the significant strengths that clinical psychologists bring to teams is the scientist-practitioner framework within which we work. Over the last eighteen months of clinical training, my interactions and experiences of working jointly with other health professionals within clinical placements have enabled me to see that the scientific approach clinical psychologists take to appraising the quality and relevance of research evidence for the clinical contexts in which they work in order to integrate research into clinical decision-making, alongside the professions' routine use of outcome measures to evaluate interventions used within clinical work are significant contributions that clinical psychologists make to multidisciplinary working. In speaking with other colleagues on placement in both adult and child mental health services it has become apparent that for other mental health professions using outcome measures appears to be an exception rather than routine part of clinical practice.

The value that clinical psychologists place on outcome measurement within clinical work and the training they have in being able to scrutinise and critically evaluate a range of standardised assessment tools is an important contribution that clinical psychologists make to the NHS. These are critically useful skills that clinical psychologists bring to teams, particularly in light of the current government reforms to health and social care systems which are embedded within an outcomes approach focused on better routine outcome measurement across all mental health services (DoH, 2011). Furthermore, with the government introduction of ‘Payment by Results’ for adult mental health services where payments for care packages will progressively reflect the quality of services provided as demonstrated in outcome and other quality indicators, there is a strong incentive for services to ensure that they are adequately and effectively measuring client outcomes (DoH, 2011). Research skills form a critical part of clinical psychology training and provide us with a valuable set of skills that can be of great benefit to teams and services at a time when it is critically important that services are able to evidence effectiveness. Therefore, one of the ways in which clinical psychologists can embrace the role of scientist-practitioner in the developing outcomes-focused NHS is through providing training and
consultancy to services and other mental health professionals on how to select and utilise psychologically-informed outcome measures in order to monitor and evidence the effectiveness of the interventions and services provided.

An important part of the work that clinical psychologists will do in helping teams to implement and evaluate outcome measures will involve thinking with teams, services and service commissioners about how meaningful and valid outcome measures are for service users. User-led research has identified that for service users the eradication of symptoms is less important than the provision of services which incorporate qualities such as acceptance, shared experience, emotional support, control and choice, and which aid the search for meaning and purpose in life (Faulkner & Layzell, 2000). The principal focus for mental health services is to move away from focusing exclusively on traditional outcomes such as compliance with treatment and relapse or rehospitalisation prevention towards helping service users to attain outcomes which they report to be a reflection of the recovery process including independence, employment, satisfying relationships and good quality of life (Drake et al., 2001).

Despite the recognition of these markers of recovery, evaluation of outcomes which are encompassed within the Recovery Model must take into account that recovery is a process, not an end point and researchers and clinicians cannot neglect the fact that there is not one predictable outcome or set of outcomes for individuals with mental illness (Kelly & Gamble, 2005; Thornton, 2000).

As clinical psychologists routinely utilise outcome measures in clinical practice, and because being able to design and test psychometric properties of measures such as questionnaires, which are often the principal method of outcome measurement, form a core part of the research skills taught within clinical psychology training, clinical psychologists have an important role to play in working alongside service users to develop and disseminate outcome measures which evaluate meaningful markers of recovery for service users, clinicians and mental health service commissioners. Evidence based practice is a critical component of our work as clinical psychologists. Perhaps now more than ever evidence based practice is crucially important in light of strained financial budgets within the NHS and the government focus on improving the quality and accountability of health care services. The comprehensive research
skills that clinical psychologists hold, place us in a good professional position to be leading work on evaluating psychological interventions in order to contribute to evidence based practice within the NHS. However, due to clinical and service demands there is often limited time available for clinical psychologists to engage in randomised controlled trials, which are currently considered the gold standard research evidence on which evidence based practice is determined (Banerjee, 2006). Furthermore, the financial, practical and resource implications of research trials used to evaluate psychological interventions present a dilemma in relation to how clinical psychologists can realistically contribute to evidence based practice under heavy clinical and service demands.

Whilst the importance of contributing to evidence based practice cannot be denied, for a profession which is based upon a philosophy of respect for individual differences and which values our clients as individuals (Division of Clinical Psychology [DCP], 2010), it feels difficult to accept the ‘one size fits all’ approach asserted by the evidence based practice guidelines developed by the National Institute of Health and Clinical Excellence (NICE). Over the course of my clinical placements I have been involved in setting up, delivering and evaluating a number of group and individual interventions using interventions such as Acceptance and Commitment Therapy (ACT; Hayes, Strosahl & Wilson, 1999) and mindfulness, which are not currently considered evidence based interventions as indicated by NICE but which had a notable effectiveness with regards to improving quality of life and reducing psychological distress as indicated by outcome measures and qualitative data from service users. It strikes me that whilst we recognise as a profession that we can contribute directly to creating evidence based practice by designing, conducting, analysing and reporting research we can also contribute to evidence based practice through engaging in practice-based evidence (Shapiro, 2002).

The Value of a Reflective Practitioner
Reflective practice is one of the key indicators of a capable practitioner (Sainsbury Centre for Mental Health, 2001) however my experience of working in several multi-disciplinary teams within the NHS over the last year has been that reflective practice
is largely a core competency distinct to the profession of clinical psychology. Within my clinical placements I have worked within teams faced with a significant amount of uncertainty and distress as a result of service redesign and reorganisation. With so much change and uncertainty imminent for teams as a result of reforms to the NHS, I find it striking that outside of clinical supervision there appears to be no shared ‘reflective space’ in which team members from other professions can reflect on the challenges and distress they may be experiencing both individually and as a team. There is evidence that healthcare staff who feel contained and supported show greater confidence, collegiality and understanding of their own and others’ emotional reactions in their care for clients, which can in turn lead to better provision of care and improved client outcomes (Franco, Bennet & Kanfer, 2002; Frost et al., 1991).

At a time of considerable service reorganisation and change in the NHS, where frustration, distress and burn-out may be high within staff teams, the need for a safe ‘reflective space’ for practitioners appears paramount.

As clinical psychologists I believe that the skills we hold as reflective practitioners along with our understanding about group processes and models of psychological distress have an important part to play in helping promote healthy, effective ways of working within the organisations in which we work. Clinical psychologists have a key role to play in helping organisations develop less distress-provoking ways of working and in helping organisations to think about how to use psychological principles to support their staff (BPS, 2007). In my opinion the emphasis that is placed on reflective practice within our clinical training and the professional responsibility that clinical psychologists have for providing training, supervision and the transmission of skills to other professions, suggests that clinical psychologists are particularly well placed to facilitate and support reflective practice within multi-disciplinary teams. This could be through facilitating such reflective environments themselves or by enabling services and teams to feel empowered to establish and evaluate reflective resources for themselves (BPS, 1995).

Whilst the government White Paper will have significant implications for the way clinical psychologists will be encouraged to work in the evolving NHS, looking inwardly at the composition of the profession and the composition of people who
access mental health services also raises questions as to whether the current way in which psychological interventions and services are organised and delivered makes the profession and the skills clinical psychologists can offer as accessible as they could be. There is concern amongst the profession that the healthcare needs of minority ethnic groups are underserved and inadequately addressed in the United Kingdom (Williams, Turpin & Hardy, 2006). Furthermore, there are also concerns that consultation rates and help-seeking patterns in men are consistently lower than in women, especially for emotional problems, despite there being little difference in overall prevalence rates of emotional disorders between men and women (Galdas, Cheater & Marshall, 2005; Judd, Komiti & Jackson, 2008). Concerns about diversity within mental health services also extend to the composition of the profession of clinical psychology itself. Clinical psychology is regarded by many as being a relatively exclusive profession in as much that the majority of clinical psychologists are White, middle-class and predominantly female (McInnis, 2002). In addition to concerns about the composition of the profession itself, the professions' conceptualisation of multicultural competence which is focused on how, within the context of therapeutic interventions, psychologists can work effectively with diverse clients, has been challenged (Vera & Speight, 2003).

As a profession the services and teams in which we work, alongside the current evidence based interventions we integrate into our clinical practice, are based on individualist ways of working which emphasise working therapeutically with an individual rather than the individual and their system. As a result, our current ways of delivering psychological interventions may not fit with collectivist values which emphasise relationships and view the self as part of a larger system (Morris, 2012). This in itself raises questions as to whether the current way in which psychological interventions are delivered, along with current focus on engaging solely the individual in the therapy process prevents black and minority ethnic groups from accessing and utilising mental health services.

In order to embrace our skills as leaders, wherein there is the expectation that clinical psychologists will play a major role in leading, developing and evaluating psychological therapies services (BPS, 2007) it would be of great value for clinical
psychology to be thinking about how to make both the profession and the services in which we work more accessible to individuals from both genders as well as individuals from a diverse range of backgrounds. In my opinion, this involves working with service users and other clinicians from black and minority ethnic groups in order to scrutinise how culturally sensitive, acceptable and accessible the current interventions, psychological models, formulations and services we work within are to service users from non-western society. To date, there is limited understanding amongst the profession about the attractiveness or cultural acceptability of clinical psychology as a professional career amongst men and different ethnic minority communities (Williams et al., 2006). The research skills that we hold as clinical psychologists put us in a good position to be able to explore some of these questions. It is through exploring these questions that we can hope to better understand how to successfully attract, recruit and retain both male staff and those from minority ethnic groups, alongside how to make the interventions, services and ways in which we work more accessible and culturally sensitive to service users.

Looking inwardly at ourselves as a profession and the services we deliver may result in changes to our ways of working, however national policy will also have an impact on the role of clinical psychologists in the developing NHS. As clinical psychologists working in the current NHS, the government White Paper and the Recovery Model are encouraging us to reflect on the ways in which we currently work with service users. For mental health professionals, the Recovery Model requires the development of a different relationship between service users and professionals; a relationship in which clients are empowered to have more choice over their care and professionals take up the role of a personal coach or trainer rather than an expert (BPS, 2008). Clearly, this has implications for our ways of working as clinical psychologists, particularly with regards to the way in which psychological interventions are delivered within mental health services as well as the way in which we conceptualise our tasks as a therapist. Whilst research on recovery-oriented practice is still in its infancy, as a profession we need to work alongside service users to establish how to define and deliver recovery-oriented practice and how to measure the recovery-orientation of our services and the psychological interventions that we offer. The profession clearly advocates the view that service users should be acknowledged as
experts of their own experiences (BPS, 2000). If we are to truly hear the views of our service users and respect them as experts of their own experiences then we need to broaden our conceptualization of evidence based practice to include interventions which may not currently be considered ‘evidence based’ but which may be more meaningful for the service user and their family, and shift our current focus on risk avoidance towards creative risk-taking (Social Care Institute for Excellence [SCIE], 2007).

Whilst evidence based practice will continue to remain a critical part of our work as clinical psychologists, concern has been raised that evidence based practice and the Recovery Model reflect different judgments of the value of various treatment outcomes by service providers and service users (Frese, Stanley, Kress & Vogel-Scibilia, 2001). As a developing clinician, the ‘one size fits all’ treatment approach advocated by practice guidelines such as NICE feels uncomfortable, particularly as I consider that one of our strengths as a profession is that we formulate presenting problems rather than try to fit clients into diagnostic categories. Surely if we are to truly be recovery-oriented in our clinical practice we need to be mindful that whilst evidence based practice should guide our clinical practice, in order to be in a position to give our clients choice over their treatment, as advocated by the Recovery Model, we need to offer a range of psychological interventions including interventions which are not currently considered evidence based interventions but which may be more fitting with non-western beliefs about well-being and recovery.

The Value of Psychological Formulation

For some mental health practitioners, the principles encompassed within the Recovery Model could feel disempowering and deskilling, particularly as the Recovery Model will require a shift in professional roles and ways of working. Whilst the Recovery Model may bring a change in ways of working for clinical psychologists, I think that the skills we hold in psychological formulation and in being an integrative practitioner will continue to remain core skills that clinical psychologists will bring to teams and client care. As a profession, our ability to draw on a number of different models within clinical practice is a significant strength (DCP, 2010) and our training in a number of different interventions and therapeutic
modalities puts us in a good position to be able to offer our clients choice at a time when enabling service users to have choice over their care is considered to be an important component of recovery-oriented practice. Furthermore, the unique skills that clinical psychologists hold in formulation are valuable to teams and services, particularly when current mental health care appears to be uniformly driven by an understanding of mental illness as represented by patterned clusters of symptoms. This is notably reflected in the government’s ‘Payment by Results’ strategy for mental health services, where mental health clinicians are required to classify each mental health service user into a care cluster based on their characteristics and presenting problems.

Clinical psychologists have a key part to play in using psychological formulation in teamwork and organisations in order to promote a psychosocial perspective of clients’ presenting problems which is not solely about diagnoses and psychiatric labels (DCP, 2011). Helping teams to hold in mind that a psychiatric label is a part of the individual not all of the individual will be a particularly important component of recovery-oriented practice. Furthermore, the consideration that clinical psychologists give to a client’s protective factors within psychological formulation sets us apart from other mental health professionals. At a time when ‘Payment by Results’ may encourage teams to focus on presenting problems and deficits of service users, clinical psychologists have an important part to play in helping teams to develop an understanding of an individual which encompasses their strengths and protective factors as well as their presenting problems. In reflecting on my experiences of conducting joint assessments with other mental health professionals over the course of the last eighteen months of my training, it appears that teams and services still largely work within a deficit-focused approach, despite the emergence of the Recovery Model. Whilst conceptualisation of the client’s deficits is important, it is clearly not the whole picture, and the deficit focused approach unhelpfully emphasises negative aspects of individuals and situations (Tedeschi & Kilmer, 2005). As a profession, we can play a pivotal role in using our competencies in psychological formulation to help mental health services move towards a strengths-based approach to assessment and intervention. Strengths-based approaches send a clear message to the client and to society that as clinicians we recognise a client’s
identity and competencies beyond his or her presenting concerns and diagnostic profile, and such an approach appears to integrate well within the Recovery Model.

**The Value of Clinical Psychology to Society**

From a personal perspective, I find it interesting that compared with other mental health professions such as psychiatry, clinical psychology does not appear to be a particularly public-facing profession. As part of our research module on clinical training, I undertook a qualitative research project with some colleagues looking at the general public's understanding of the role of clinical psychologists in the NHS. The results of this research identified a lack of clarity around the professional role of a clinical psychologist and revealed that the media provide the public with a basis for knowledge about the profession. A clear need to promote the role of clinical psychologists in order to increase understanding of the profession was identified within this research, which fits with the 2010-2011 strategic objectives of the profession outlining the intent to create a high-profile UK-wide professional body which promotes psychology and the work of psychologists (DCP, 2011). Psychology does appear to be growing in interest within the press, however there is concern that rather than acknowledging the scientific status of the profession and the helpful contributions clinical psychology could make on public issues, the media values clinical psychology for the contribution it can make to feeding public need for frivolity, gossip and an excessive desire for psychological insight into the lives of celebrities (Howard & Bauer, 2001). In this way, the media can be just as damaging to the integrity of the profession as it can be to perpetuating stigma associated with mental illness through the narrowly focused and stereotyped stories of mental illness that it presents to the public.

As clinicians, paying more attention to experiences of stigma and discrimination within our psychological formulations and ensuring that these issues are incorporated into the intervention plan is an important part of ensuring that we acknowledge, are sensitive to and working towards challenging the very real issues of stigma and discrimination that may be around for our clients (Byrne, 2000). However, as previously discussed in relation to multicultural competence, as a profession we need to go beyond interventions focused on the individual and work at a societal level to
combat stigma associated with mental illness. Whilst it will be important for us to consider experiences of discrimination, prejudice and stigma within our psychological formulations with clients, in order to achieve multicultural competence as a profession, we need to function as a change agent at organisational, institutional and societal levels. Purely focusing on the individual in a therapeutic context cannot end the societal conditions that maintain societal inequality, including discrimination and prejudice. Thus in order to be able to identify ourselves as profession that practices within a framework of multicultural competence we need to focus our involvement in interventions aimed at both an individual and community-based level (Vera & Speight, 2003).

There appears to be a need for greater transparency from the profession to the public in terms of our skills and the work that we do. Concern has been raised that the profession is anxious and awkward about being overtly public facing in comparison with other professions such as psychiatry and that as a profession we need to take ownership of our skills in a robust and public manner using the media, rather than allowing those without our training and codes of ethics and conduct to set the agenda instead (T. Byron, December 8, 2010). As a profession we need to work with the media in order to actively promote the value that clinical psychology can bring in helping the public to understand important societal issues and to see that as a profession we can make a scientific contribution as a central academic and professional force in society through promoting health and quality of life, fostering learning and raising achievement, enhancing work satisfaction and motivation and fostering harmonious communities (Mackay, 2001). As clinical psychologists we can all play a part in sharing our science with the general public in a positive and helpful way which maintains the integrity of the profession. It will be important for us to do this in order to stimulate an interest and awareness in the many skills that clinical psychologists bring to the NHS and the ways in which clinical psychology can contribute to society.
Conclusions

At this current time of NHS reform, it is important that as a profession we are able to promote to teams, services, and service users the range of unique skills that we bring to multidisciplinary working. As reflective practitioners we have an important role to play in helping teams and organisations develop healthy and effective ways of working which are informed by psychological models and principles and which support recovery-oriented practice. In an NHS which is becoming increasingly more focused on client outcomes and ensuring quality and effectiveness of service provision, the scientist-practitioner framework that clinical psychologists work within will prove a valuable resource in helping teams and organisations to monitor the effectiveness of the services and interventions provided as well as in contributing to evidence based practice. Furthermore, at a time when mental health commissioning is organised around care clusters and diagnostic profiles, clinical psychologists have an important role to play in leading teams on developing culturally competent psychosocial formulations which incorporate strengths and which are recovery-oriented. Perhaps the biggest challenge we face as a profession is thinking about how we make ourselves, the models we work within and the psychological interventions we deliver more culturally sensitive and accessible.

With funding cuts all around us and an increasing government emphasis on impact, it is vital to the health and development of our profession that the public recognise the important contribution that clinical psychology can make to the wellbeing of our society. As a profession we have a shared responsibility to engage with the public and the media in order to promote the value that the profession brings to the NHS and to society more generally.

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March 2011

Year 1
In the induction block we were told that our first Personal and Professional Development (PPD) group task would be a Problem-Based Learning (PBL) task focused on 'The Relationship to Change'. At this point we were given little guidance about this task. Being aware of my own need for some certainty at a time when I felt overwhelmed by a sense of uncertainty, the lack of clarity surrounding this task felt a difficult position to be in having just started clinical psychology training.

**Approaching the PBL Task**

Within our first PPD group session we found ourselves exploring the notion of relationship to change and were particularly focused on defining change and trying to make sense of what was required of us. We were encouraged by our group facilitator to think about whether our personal relationship to change affects the outcome of change. Each group member spent time reflecting on their own relationship to change and we identified that as trainee clinical psychologists we can be facilitators of change for our clients. The group agreed that it would be helpful to spend further time thinking about a positive and negative personal experience of change in order to determine whether this was the angle we wanted to approach the PBL task from. Reflecting on our experiences of change identified that every group member approached change in a different way. However, a common thread of our experience was identified wherein change was easier to manage if the change was personally instigated rather than forced upon the individual by their system. We all researched different models of change in an endeavour to provide an explanatory framework for understanding our own relationships to change.

As a group we identified several themes that emerged from reflecting on our experiences of change. These were motivation and preparedness for change, managing simultaneous changes, systemic influences on change, barriers to change, and self-efficacy. There were also discussions focusing on how, as clinicians, we can facilitate positive experiences of change by implementing certain interventions. The importance of the therapeutic alliance for treatment outcome and how through thinking about our own difficult experiences of change we become better positioned to be genuine and empathic when clients present as resistant or ambivalent about change was discussed. Furthermore, for some group members it felt important to
extend thinking beyond our clients, to more widely think about the role that we as applied psychologists may have in facilitating change within multi-disciplinary teams. This seemed particularly important in light of the service reorganisation and associated changes which some group members were experiencing within their clinical placements.

**Personal Reflection on Change**

In reflecting on my own experiences with change, wherein I have, at times, found change overwhelming and difficult to manage, the process of finding an explanatory framework to help me understand why I found change a difficult process was particularly useful. In reflecting on recent periods of change in my life, I identified that I find change particularly difficult to manage if I am experiencing multiple changes in my life. Specifically, my ability to cope with the change and approach the change with a positive outlook is reduced when I am experiencing multiple changes in a number of areas of my life. The Focal Theory of Change (Coleman, 1989) provided a framework through which I was able to understand my own relationship to change. Within this theory gradual adjustment to one change before confrontation with another is thought to beneficial as it helps to reduce the stresses inherent within the transitional process. Furthermore, the theory suggests that if change occurs in too many areas of life at once, then individuals may experience considerable discomfort both with self and with the world. As a developing clinician, this model enabled me to reflect on the importance of thinking about therapeutic change in the context of the client’s system in order to fully understand where therapy is positioned in relation to other changes that the client may be experiencing at the point of entering therapy.

**Group Process**

My experience of the group process was that there was some difficulty in agreeing on the way in which we wanted to approach the PBL task. This process was at times difficult to manage. It meant that we spent a considerable amount of time within our group sessions discussing individual group members’ ideas as to how we could address the PBL task and we found it difficult to move forward with agreeing on the content and structure of our presentation. Within this process I was aware of my own feelings around how each individual had an interesting and informative perspective.
but some of the perspectives seemed so different that I found it difficult to identify how they could be integrated coherently to form a presentation.

I found it difficult to raise my anxieties and concerns within the group. I think this was a reflection of my desire not to be seen by other group members as raising conflict, but also of the fact that we were still getting to know each other on a personal level and trying to understand and navigate our own and each others’ functioning within the group. Whilst this may have been a natural part of the ‘storming’ stage of our group development (Whelan, 1994), speaking personally, this developmental process made the group feel like an unsafe reflective space which in turn made it difficult to explicitly address the conflict and frustration that arose as part of negotiating the task. My experience of this process was that rather than explicitly discussing and addressing frustration that came up in negotiating the PBL task, myself and other group members tended to use support systems outside of the group to reflect on their frustrations and concerns about the group dynamics. The difficulty that we had in addressing conflict and within-session issues that arose seemed to present a barrier to effective management of the PBL task (Schneider-Corey & Corey, 2006).

The frustration and difficulty that the group appeared to have in asserting a specific position on how to approach the task appeared to effect group cohesion. Emotional contagion has been evidenced as playing an important part in group dynamics (Kelly & Barsade, 2001). My understanding of our group process was that the frustration and hostility that arose though trying to negotiate the task was transferred amongst the group. From my perspective, the contagion of negative emotions amongst the group appeared to decrease cooperation and reduced my perception of effective task management. In an endeavour to manage my own anxiety and frustration around the task, I found myself challenging my own need to present myself in a favourable light and putting aside the anxieties that I had about my opinion not being as valuable as other group members, in order to suggest the use of a clinical case study to integrate the different personal experiences of change that we had identified. This idea appeared to facilitate a sense of cohesion wherein it was collectively decided that we would use the case study to draw together our personal experiences of change, change as a process for clients and other clinicians, and how our own experiences
and knowledge of specific interventions could help us to ease the process of change for those with whom we work.

**Reflection on Group Process**

Following the PBL presentation we reflected on our group dynamics and some of the difficulties we had experienced in the PBL process. In the debrief session after the presentation we focused on the negatives of the group dynamics. It was recognised by group members that there was considerable difficulty in drawing ideas together and that the group did not feel a safe space in which group members could discuss their feelings in relation to the emerging group dynamics. Whilst these feelings strongly resonated with me, I also felt that it was important to highlight to the group that despite the difficulties in the process and the different ideas that had arisen in our group discussions, we had, to some extent, been able to integrate the diverse perspectives in a coherent way to produce a presentation that encapsulated a wide range of concepts, and from which I felt I had learnt a lot both personally and professionally about change. It felt important for this to be recognised in light of the fact that the perceived negativity within the group could lead to self-reinforcing cycles of negativity which in turn could make group dynamics difficult to be addressed in future (Kelly & Abrade, 2001).

The feedback that we received on our PBL presentation was that although the ideas hung together, the task seemed to have been approached individually rather than as a group. My experience of the group process was that our group decision-making tended to suppress ideas which appeared to be disparate with the emerging themes in the interest of preserving group harmony. This process has been recognised to be common within groups (Myers, 2002). However, this tendency to strive for group harmony did appear to result in a failure to adequately discuss any ideas which seemed disparate with the common emerging themes, which in turn made group members more determined to have their ideas integrated within the presentation. This was reflected in the feedback we received on our presentation which commented that we seemed to have approached the task individually rather than collectively.
The concept of cognitive centrality appeared to provide a useful explanatory framework for some of the group dynamics (Kameda, Ohtsubo & Takezawa, 1997). In an endeavour to more widely explore the notion of 'relationship to change' a couple of the group members raised concepts that appeared to be novel for the majority of group members. These concepts opened up our thinking about relationship to change, however, whilst negotiating the PBL task it felt that there was little existing overlap in the group knowledge of these concepts. As a result, these ideas appeared to be given less weighting compared with the ideas and concepts which were shared amongst the majority of group members; a process supported by the concept of Social Judgement Scheme (SJS; Davis, 1996).

**Reflections for Clinical Practice**

Being part of the PBL task has helped me to better understand the position that I adopt within groups. Whilst avoiding conflicting may be helpful in some areas of my life, within the PBL task, trying to avoid rather than explicitly address conflict and negative emotions experienced as part of the group process actually had a detrimental impact on our ability to make decisions and effectively manage the task. It is recognised that healthcare professionals need to be assertive in order to be effective clinicians and put forward the interests of their clients and of their discipline within multi-disciplinary teams (Taylor, 2006). Through reflecting on my experience of the group process, I have felt more empowered within my current placement to address difficult feelings and potential areas of conflict that have arisen. This has been particularly salient when confronted with having to change the way I work in order to adjust to working with a supervisor who has a different working style to my own. Furthermore, although a difficult process to experience, the critical interaction within our group did appear to help us produce a presentation which extracted and synthesised the diverse perspectives from each group member. Working within multi-disciplinary teams, wherein there is a variety of skills, knowledge and perspectives, as applied psychologists we have a responsibility to help individuals and teams recognise that conflict can be functional, and that decision quality is enhanced when multiple perspectives emerge on a particular issue (Amason, 1996)
Exploring some of the models of change and our differing relationships to change within the PBL task has been helpful for me as a trainee clinical psychologist working within a multi-disciplinary team currently experiencing a considerable amount of change due to service reorganisation. Through the PPD group discussions and sharing of psychological models around barriers to change, I feel that I have more of an explanatory framework with which to understand some of the difficult team and interpersonal dynamics that I encountered when first starting my placement.

My understanding of my own relationship to change has also helped me to spend more time thinking about the process of change with clients. Being more aware of some of the difficulties I experience with change has helped to reduce my own frustration and anxiety about my abilities as a clinician when confronted with clients who are experiencing considerable ambivalence around change and are finding it hard to engage in treatment. The models of change reviewed in our PBL task have provided a useful set of explanatory frameworks which I have been able to use psycho-educationally with clients to think about and validate their relationship to change. Furthermore, my experience of our PPD group process has raised the importance of being mindful of within-session dynamics that emerge with clients and has highlighted the importance of using supervision to reflect on and devise a formulation to better understand these interpersonal dynamics.

Conclusion

As a trainee clinical psychologist working in contexts where the need for organisational and clinical change is evident, it feels important that I am able to learn from my own experiences of change in order that I can highlight, and where possible, ease the process of change for others. My experience of the group process has highlighted the diverse range of skills and knowledge that can be held within one profession alone. As an applied psychologist, I consider it important to be able to integrate both my own experience of group processes and group decision-making with the empirical literature on effective decision-making, in order to be able to work towards facilitating effective leadership within teams.
References


Problem Based Learning Reflective Account

February 2012

Year 2
The Problem-Based Learning (PBL) Task

The PBL task involved a case vignette which described a family consisting of Mr and Mrs Stride, their three year old twin daughters and Mr Stride’s parents. Mrs Stride had a mild learning disability and was raised in the Looked after Children system. Mr Stride had attended a school for children with special educational needs. Mr and Mrs Stride were reported to live in conditions of deep poverty and there was a history of domestic violence between Mr and Mrs Stride, which the children had witnessed. The children were placed on the child protection register under the categories of emotional abuse and neglect and were accommodated in short-term foster care. The Local Authority wanted to place the Stride children for adoption in the belief that Mr and Mrs Stride would never be able to adequately care for their children. Mr Stride’s parents were reported to be supportive but unable to look after the children due to physical ill-health, however they had not been assessed for kinship care. A large number of professionals were involved with the family and as a clinical psychologist the children’s guardian had approached us to conduct a full risk assessment and, if appropriate, help the court develop a rehabilitation plan for the Stride children. Each Personal and Professional Learning Discussion Group (PPDLG) was instructed to think about whose ‘problem’ this situation was and why.

Approaching the PBL Task

As a group, the way in which we approached this PBL task was very different to the first PBL task. My experience of the group process during the first PBL task was that there was difficulty in agreeing on the way in which we wanted to approach the task. Consequently we spent a considerable amount of time discussing individual group member’s ideas as to how we could address the PBL task and we found it difficult to move forward with agreeing on the content and structure of our presentation. The frustration and difficulty that the group had in asserting a specific position on how to approach the task appeared to effect group cohesion as the frustration and hostility that arose though trying to negotiate the task was transferred amongst the group. From my

2 The first person has been used throughout to encourage a reflective stance on the PBL task and group process.
perspective, the contagion of negative emotions within the group appeared to decrease cooperation and reduced my perception of effective task management. My experience of this process was that rather than explicitly discussing and addressing frustration that came up in negotiating the PBL task, myself and other group members tended to use support systems outside of the group to reflect on our frustrations and concerns about the group dynamics. During the first PBL task, I found it difficult to raise my anxieties and concerns within the group. I think this was a reflection of my desire not be seen by other group members as raising conflict, but also of the fact that we were still getting to know each other on a personal level and trying to understand and navigate our own and each others' functioning within the group, which is identified to be a natural part of the 'storming' stage of group development (Wheelan, 1994).

Approaching the second PBL task felt a very different process for us as a group. At both an individual and group level we had grown to be able to tolerate uncertainty and acknowledge our strengths and weaknesses as individuals and as a group, which enabled us to approach the second PBL task with minimal conflict. The most notable developmental group process was reflected in our ability to agree much more quickly and easily as a group on how we wanted to approach the PBL task. After one group discussion we agreed that we wanted to utilise a series of role plays in order to represent the views of different people presented within the case vignette. We agreed that each group member would represent one person from the case vignette and the role play would involve the audience metaphorically going through a keyhole to hear conversations between different people from the case vignette.

During the first PBL task we were highly anxious about the idea of using role-play and decided to utilise resources and mediums we felt comfortable with in order to minimise some of the anxiety felt within the group about the PBL task. Personally I think that for the second PBL task we were more willing to take risks in relation to both the mediums we wanted to use for the PBL task and the roles we put ourselves forward for, which I think was a reflection of two important developmental processes. Firstly, as a group we experienced less of a sense of needing to 'prove ourselves' and our capabilities both to
each other and to the course team, and secondly, as a group we were more aware and mindful of each others' strengths and weaknesses when thinking about how to approach the PBL task which made it much easier to assign roles for the task.

The biggest challenge we were presented with as a group in this PBL task was in deciding on whose voices from the case vignette we wanted to represent within our role play. In trying to decide on whose voices to portray within our role plays we found ourselves faced with a difficulty in that we only had six members of our group and a large number of people presented to us within the case vignette. Consequently, in our group discussions we had some difficulty in agreeing on whose voices from the case vignette should be portrayed through our presentation. After two sessions we decided that our presentation would involve role-playing three separate conversations: a conversation between the social worker and the children's guardian, a conversation between Mrs Stride and her community psychiatric nurse, and a conversation between the clinical psychologist and the supervisor. I think that the difficulty we had as a group in deciding on whose voices from the case vignette to represent within our role plays mirrored the conflict that can exist within large professional networks, such as those around Mr and Mrs Stride, with regards to whose viewpoints are most acknowledged and are most pivotal in decision-making processes.

**Implications for Clinical Practice**

The PBL task highlighted the importance of a multi-disciplinary child-centred approach to assessment and formulation when working with children and families in need (Department of Health [DoH], 2000), however as a group we reflected on how difficult it can be to keep the child's perspective in mind when there are a number of different services and agencies involved with a family. I think that this difficulty was mirrored in our role plays where we chose to represent the voices of adults and the voices of the Stride children were not particularly considered or represented in our presentation. As a group we used psychological knowledge and research evidence to inform our thinking about the possible psychological effects on the Stride children of witnessing domestic violence and living with parents with identified learning disabilities and how this may
inform decision-making in relation to their future. However at no point did we step back to think about hearing the voices of the Stride children and what they might want for their future. I think the difficulty we experienced as a group in holding in mind the children’s voices reflects the real-life difficulty in clinical practice of reaching a multi-disciplinary and multi-agency consensus on the weight to be given to the child’s voice in decision-making (Head, 1998). Whilst it is acknowledged that the child’s voice should be central to any process which affects their future, regardless of age or cognitive ability, thinking about how to capture and ensure that the child’s voice remains heard and captured throughout decision-making processes can be difficult (Head, 1998).

Whilst the child’s voice is important, the PBL task also highlighted how many different perspectives there are to consider when working across child and adult mental health services and the complexity of ensuring that every persons’ view gets heard in any decision-making process. For us as a group the PBL task made this difficulty very real when we were trying to decide on whose viewpoints we would role-play for the presentation. As a group we decided that due to practical restraints we could not include the perspective of every individual so we made a decision to role-play the voices of the people that we thought would be most influential and who would hold differing views in terms of the decision-making process. Reflecting now on our approach to the task, we ended up prioritising the views of some individuals over others rather than ensuring that our presentation captured the views of everyone.

In reflecting on our presentation after the PBL task our group facilitator highlighted that alongside the voices of the Stride children, the voice of Mr Stride was also absent in our group discussions and final presentation. As a group we reflected on how easy it was to lose Mr Stride’s voice and how perhaps our knowledge that he was a perpetrator of domestic violence had confined us to solely focusing on the risks he may pose to the children. As a group we reflected on how professional networks can often become stuck in adopting polarised views of individuals which take into account either their deficits or their strengths rather than marrying the two and that some of this process had been re-enacted within our group process (Scourfield, 2006). On a personal level, the PBL task
has highlighted the important role that clinical psychologists can play in using psychological formulation to help professional networks to develop a psychosocial understanding of an individual's presenting problems which is not solely focused on deficits but which incorporates their strengths and protective factors as well as their difficulties. Whilst understanding the client's deficits is important, it is not the whole picture, and a deficit focused approach unhelpfully emphasises negative aspects of individuals and situations which can result in dichotomous categorisation of individuals as either possessing strengths or weaknesses (Tedeschi & Kilmer, 2005).

It was interesting to note that across all the presentations, none of the groups stated their position on whether or not they thought the Stride children could be returned to the care of their birth parents. Within our group we found it difficult to agree on whether we thought Mr and Mrs Stride could adequately care for their children. This decision was made difficult by the lack of definitive guidelines around what demarcates 'good enough' parenting, which in clinical practice often results in clinicians being susceptible to employing vague and subjective criteria based on their personal experience (Budd, 2001). My experiences on placement have enabled me to see that within professional networks there can often be pressure put on clinical psychologists to come up with definitive answers, particularly when there is a considerable amount of anxiety amongst the professional network to achieve a position of 'safe certainty' and thus make the 'right' decision (Mason, 1993).

The PBL task highlighted the important role that clinical psychologists can play in helping professional networks, such as those around Mr and Mrs Stride to see that there may not necessarily be definitive answers about parenting capacity but that as scientist-practitioners we can use research evidence to inform clinical decision-making, such as providing information on risk and protective factors rather than offering a definitive opinion. As a trainee clinical psychologist I am often aware on placement of my own need to seek a position of 'safe certainty' however the PBL task has highlighted that striving for a position of 'safe certainty' can be unhelpful and that aiming to hold a
belief of authoritative doubt which encompasses both expertise and uncertainty is a more helpful position to adopt (Mason, 1993).

After the PBL presentation we had space and time within one of our group sessions to reflect on the dilemmas and difficulties involved in working with complex cases and professional networks. Having this reflective space felt important in the case of the Stride family where there were differing professional opinions and the potential for anxiety to be evoked within the professional network as they strived to make the 'right' decision. The importance of reflection, supervision and professional support is important when working with families and within professional networks where there may be a considerable amount of tension (Kellett & Apps, 2009). Personally I think that the skills clinical psychologists hold in being reflective practitioners places us in a good position to help professional networks reflect on some of the professional dilemmas and difficult feelings that can surface for clinicians when working with cases that have the potential to evoke high levels of anxiety and differing professional viewpoints.

Conclusion

As a group, this second PBL task was pivotal in enabling us to acknowledge our growth both as individuals and as a group over the last year of clinical psychology training. We reflected on how we had moved from a position of almost being paralysed by uncertainty and anxiety when given the first PBL task towards a position of 'safe uncertainty' wherein we were better able, both as individuals and as a group, to manage anxiety and uncertainty (Mason, 1993). Being able to manage and reflect on our own anxieties and feel comfortable in a position of uncertainty are skills which seem particularly important when working in professional networks where there may be high levels of anxiety and often an unhelpful desire amongst professionals to establish a position of 'safe certainty' (Mason, 1993). On a personal level completing this PBL task has facilitated a greater understanding of the multifaceted approach to assessing parenting capacity and has highlighted important professional and ethical dilemmas that can arise in child protection work.
References


The account reflects on my experience of our PPLD group development over the course of the first year of clinical psychology training and the shift in functioning within our group from a problem-focused orientation towards an emotion-focused orientation by the end of the first year of clinical psychology training. The genogram task that we completed as a group is recognised as having played a pivotal role in facilitating emotional connectivity amongst group members, which in turn enabled more open group discussions about our individual needs and expectations from the group. On a personal level the account reflects on the initial anxiety and concern felt at the start of the group process and the impact that having a group facilitator who was a member of the course team had on my initial perception of the group as being an unsafe space for being open, honest and vulnerable within the group setting. The account reflects on the importance that embracing feelings of vulnerability had on my personal development within the group and how being willing to be vulnerable and share some of my personal self within the group facilitated a more rewarding experience of the PPLD group. The PPLD group facilitated a number of insights into my personal self and the account discusses the implications that these insights have had on my clinical practice and on my ongoing personal and professional development as a trainee clinical psychologist.
A narrative of our PPLD group process over the course of the second year of clinical psychology training is presented. The account reflects on how the change in group facilitator alongside having a group member absent for six months of the group sessions appeared to have a significant impact on group dynamics. The account discusses how, as a group, we found it difficult to navigate the uncertainties and sense of disconnection which arose from having an absent member of the group alongside our ongoing endeavour to establish how psychologically safe the group is, and can ever be, when the facilitator is a member of the course team. The incorporation of structured reading tasks into the PPLD group sessions this academic year is discussed and acknowledgement is given as to how the group used experiences on placement and the structured reading tasks to raise some important dilemmas for clinical practice and reflect both individually and as a group on our professional development. Speaking personally, the PPLD group provided a valuable space for thinking about both my personal and professional development and how the PPLD group discussions have contributed to my clinical practice and ongoing personal and professional development as a trainee clinical psychologist is presented.
2) CLINICAL SECTION

Overview of Clinical Experience Gained Over the Five Placements

July 2013

Year 3
Overview of Clinical Experience Gained Over the Five Placements

Adult Placement

This placement was split between an Adult Community Mental Health Recovery Service (CMHRS) and a Continuing Needs Service (CNS) for psychosis and gave me the opportunity to work with working age adults. I carried out assessments, formulations and interventions with regard to presentations including depression, anxiety, eating disorders, obsessive-compulsive disorder, bipolar disorder, schizophrenia, and personality disorder. Within the CMHRS I worked in an outpatient setting with couples as well as individuals, at times dealing with high risk cases. I also was involved in setting up and co-facilitating a group treatment programme using Acceptance and Commitment Therapy (ACT). The main theoretical models used were Cognitive-Behavioural Therapy (CBT), mindfulness, ACT and integrative. My work also included neuropsychological assessment and recommendations to inform care plans for individuals presenting with behavioural difficulties. In the CNS I delivered individual, group and family interventions using a range of approaches including CBT, mindfulness and family work for psychosis. I gave presentations to local carer support groups on the use of ACT as a treatment approach for psychosis. I was also involved in setting up, co-facilitating and evaluating a group treatment programme using mindfulness for psychosis. This group treatment programme was subsequently rolled-out across the other Community Mental Health Recovery Services within the NHS Trust. Both these placements gave me a considerable breadth and depth of experience and enabled me to develop my confidence and competencies in using a range of therapeutic models.

Child and Family Placement

This placement was also split across two services: a tier three Child and Adolescent Mental Health Service (CAMHS); and a tier two specialist service working with adolescents and their families to prevent family breakdown and entry into the local authority care system. Working within the tier three CAMHS service gave me the opportunity to work with children aged between three and eighteen years along with their families and educational providers. Work took place in schools and outpatient
settings and involved assessment, formulation and intervention with regard to anxiety, phobias, obsessive-compulsive disorder, depression, feeding difficulties and anger management. The main theoretical models used were CBT, narrative and mindfulness, with all therapeutic work underpinned by systemic and developmental concepts. I presented to the team on men’s access to mental health services with a particular focus on understanding the barriers to accessing mental health services for young men and fathers. The work within the tier two specialist service involved engaging young people and their families in a range of interventions that were provided within the home, school and community. Interventions involved working with the young person and/or their parents and were planned and delivered with the aim of reducing conflict and preventing young people coming into the care of the local authority. The main theoretical models used were narrative, CBT, family therapy and behavioural, with all therapeutic work underpinned by systemic and developmental concepts. Neuropsychological assessments and recommendations for intervention formed a core part of the clinical work across both placements and were completed with regard to memory, concentration, attention and behavioural difficulties. Critical to the work across both teams was a multi-disciplinary approach and liaison with external professionals and agencies.

**Learning Disability Placement**

This post involved working within a Community Team for People with Learning Disabilities Team (CTPLD). My role involved working with adults in residential homes, day centres and outpatient settings. I conducted assessments, formulations and interventions with staff, carers and service users. The service users I worked with were experiencing moderate to acute difficulties often in combination with communication difficulties and physical health problems. The types of presenting problems that I worked within included challenging behaviour, depression, anxiety, grief and loss. Direct work with clients involved developing skills in working with individuals with a diagnosis of an autistic spectrum disorder, Asperger’s syndrome and Down’s syndrome. The models of assessment, formulation and intervention were mainly integrative, combining behavioural, cognitive and systemic techniques whilst integrating psychodynamic ideas where appropriate. Staff consultation and training formed a large
part of the clinical work. Neuropsychological assessments and recommendations were mainly conducted in the context of screening eligibility of clients for the service but were also conducted with regard to better understanding client’s cognitive strengths and areas of need in order to inform therapeutic interventions. Critical to the work was a multi-disciplinary approach and there were many opportunities for joint-working with speech and language therapists and social workers. The work on this placement involved working with cases where there were identified safeguarding issues which raised my awareness of the ethical difficulties associated with providing care in this context. This placement built my confidence in working therapeutically at both a direct and indirect level with individuals with an identified learning disability and emphasised the valuable role that clinical psychologists can play in supporting staff through training and consultation.

Older People Placement
This post was within a Community Mental Health Team for Older People (CMHT-OP). My role involved conducting assessments, formulations and interventions with clients between the ages of sixty and late nineties. The clients I worked with were presenting with a range of presenting problems including health anxiety, depression, grief, chronic pain, difficulties adjusting to physical disability and personality disorder. A considerable amount of the clinical work involved conducting neuropsychological assessments to explore whether reported behavioural concerns and concerns about memory, attention and concentration could be explained by a dementia profile. The main theoretical models for intervention were CBT, mindfulness and ACT alongside opportunities to get involved in carrying out some family work in conjunction with the Admiral Nurse. Consultation and training to carers was an integral part of the work and alongside the Admiral Nurse I was involved in co-facilitated several carer workshops focused on dementia psychoeducation and carer wellbeing and self-care. Service development opportunities included working with a service user to develop a leaflet about the psychology service for service users. On this placement I was responsible for supervising the clinical and research activities of the two honorary assistant psychologists who had been appointed to the team. This involved supervising their
facilitation of a cognitive stimulation therapy group for dementia alongside the service-evaluation project they had been asked to undertake by the team manager. This placement really built up my confidence and competency in neuropsychological assessment and enabled me to see the value of integrating attachment theory and a lifespan perspective into formulation. Furthermore, this placement enabled me to develop confidence in sharing psychological knowledge with others and in encouraging others to integrate time for reflective practice into their work.

Specialist Placement – Children and Young Peoples’ Development Service
My specialist placement was based in a Children and Young Peoples’ Development Service working with children and young people from birth until the age of seventeen years old. The service consisted of a range of teams and professionals from health, social care and the voluntary sector. The service provided support to children and young people with a disability or developmental health needs, as well as their families. Working with challenging behaviour and anxiety formed the core of the therapeutic work. Most of the therapeutic work was carried out indirectly through meeting with the parents/carers rather than seeing the child for direct therapeutic work. The main theoretical models for intervention were behavioural, cognitive and neurodevelopmental, with systemic and attachment concepts informing all of the clinical work. In addition to therapeutic work, I was a part of the social and communication assessment team which involved carrying out school observations to inform assessments of children where there were suspected social and communication difficulties, alongside joining multi-disciplinary colleagues to observe DISCO and ADOS assessments being undertaken. Liaison with multi-disciplinary professionals within the team alongside professionals from external agencies was essential to clinical practice within this role and there were multiple opportunities for joint-working with occupational therapists, speech and language therapists, physiotherapists, nurses and social workers. Neuropsychological assessment was integral to the clinical work. Models of consultation and training were actively encouraged within the psychology team and I played an active part in providing consultation to multi-disciplinary colleagues, alongside providing input into the support group for parents/carers of children and young people with a diagnosis of Autism. On
this placement I was responsible for supervising the clinical and research activities of the honorary assistant psychologist which enabled me to build upon my supervision and consultation skills that I had developed in my placement with older adults. This placement taught me a lot about the importance of dynamic assessment when working with children with learning disabilities and developmental delay. Through this placement my confidence in working indirectly with parents and carers to manage behavioural concerns has developed and I feel more confident and competent in assessing and working therapeutically with developmental disorders.
3. RESEARCH SECTION

Service Related Research Project

"An Evaluation of the Effectiveness of Within-Service Dialectical Behaviour Therapy (DBT) Training and Consultation for New Therapists"

July 2011

Year 1
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Abstract

**Background:** Training and supervision is important to effective implementation of Dialectical Behavioural Therapy (DBT), however the financial implications of using national DBT training packages at a time of strained National Health Service (NHS) budgets has resulted in interest regarding whether DBT training can be provided locally.

**Rationale:** Within a local NHS Trust a four day within-service DBT training provided by senior psychologists was established for potential therapists from a range of disciplines. The DBT service had yet to evaluate whether this training and the consultation groups were effective in equipping therapists with the skills needed to implement DBT.

**Objectives:** To explore new therapists' experiences of the within-service DBT training, consultation groups and therapist journey.

**Method:** DBT therapists who had received the within-service training in the last three years were approached to participate in a focus group or individual interview. Using a semi-structured interview schedule, two clinicians participated via focus group and six clinicians were interviewed individually. The data was transcribed and analysed using thematic analysis.

**Results:** Six themes were identified: (1) uncertainty about DBT skills and care pathways, (2) the DBT training is theoretically heavy, (3) learning and developing by doing DBT, (4) the consultation groups are a valuable clinical resource but neglect CPD, (5) DBT as a skills toolkit for enhancing clinical practice, and (6) prior experience of being a therapist viewed as a help and hindrance.

**Implications:** The findings are discussed in relation to future service planning and delivery.
Introduction

Working with individuals with Borderline Personality Disorder (BPD) can present complex treatment challenges and arouse difficult feelings for clinicians (Bodner, Cohen-Fridel & Iancu, 2011). Dialectical Behaviour Therapy (DBT; Linehan, 1993) was developed as a response to the recognised complexity of working with BPD and is recommended as a potential psychological intervention for this clinical population (National Institute for Health and Clinical Excellence [NICE], 2009). Delivering DBT is a complex method that takes time to learn and clinicians are presented with a number of barriers to becoming effective DBT therapists (Perseius, Kaver, Ekdahl, Asberg & Samuelsson, 2007; Swenson, Torrey & Koerner, 2002).

Whilst, participation in specialised DBT training increases fidelity to the treatment model (Ben-Porath, Peterson & Smee, 2004), DBT is an intensive training commitment (Palmer, 2002) which requires ongoing training in order for it to be sustained within community mental health services (Herschell, Kogan, Celedonia, Gavin & Stein, 2009). Ongoing training and supervision are essential for effective implementation of DBT (Swales, 2010) however debate exists regarding the minimum training needed for clinicians to be able to deliver DBT effectively. Four-day DBT training programmes appear to be clinically effective in reducing the frequency of self-injurious behaviour, however participation in more intensive DBT training (14 days) may have significantly greater effects on client outcomes (Pasieczny & Connor, 2011). Whilst there is some evidence that DBT may be a cost-effective intervention in terms of client outcomes (Brazier et al., 2006), at a time of difficult economic circumstances within the NHS, DBT training can be an expensive service commitment both clinically and financially. Due to the potential financial implications of training clinicians in DBT using the national training package, at a local service level it may be more cost-effective for DBT training to be provided within-service by clinicians already using DBT within clinical practice.
Rationale
Currently across a local NHS Trust, DBT training and consultation is provided by senior psychologists. The training consists of a four-day programme for potential therapists from a range of disciplines, including psychology, nursing, social work and occupational therapy, and who work in a variety of services. There is currently no structured follow-up of newly trained therapists assessing whether the training and consultation is effective in equipping therapists with the skills and confidence needed to use DBT once they have entered into clinical practice. This research was considered important by the lead professionals of the DBT service in order to establish whether modifications needed to be made to the within-service DBT training and consultation groups.

Objectives
This research aimed to explore new DBT therapists' experiences of: (1) the within-service DBT training, (2) the consultation groups, and (3) their therapist journey.

Method
A qualitative research design was chosen as it was thought that this approach would allow deeper exploration of therapist experiences than quantitative analysis would allow.

Materials
A semi-structured interview schedule was constructed (see Appendix A) which aimed to address new DBT therapists' thoughts on: (1) the within-service training, (2) the consultation group, (3) the DBT care pathway, and (4) their therapist journey.

Procedure
The interview schedule was circulated to the four DBT leads across the Trust in order to establish whether any revisions needed to be made to the interview schedule. The four DBT leads across the Trust were then approached by the researcher via e-mail and asked to provide a list of DBT therapists who had received the within-service training in the
last three years. Fifteen DBT therapists were identified. These 15 therapists were approached over e-mail to participate in a focus group. Due to a considerable amount of service redesign within the Trust it was difficult for some clinicians to attend the focus group and those that were unable to attend were approached to participate in an individual face-to-face interview. The focus group and interviews were arranged at a location convenient to the clinician and were audio-taped for the purposes of data transcription.

Participants
Two clinicians participated in the focus group and six clinicians participated in a face-to-face interview. The remaining seven participants were unable to participate for a number of reasons. Of the eight clinicians who participated, one was an occupational therapist, two were social workers and five were psychologists. Six of the participants were female and two were male.

Ethics
University and NHS ethics were not required, but the Research and Development (R&D) Team within the NHS Trust were informed of the project and authorised the research (see Appendix B). Participants were informed that their data would remain anonymous and informed that they could withdraw from the research at any time in line with the British Psychological Society's (BPS) Code of Conduct (BPS, 2009).

Analysis
Thematic analysis was considered to be the most appropriate method of data analysis due to this approach not being bound to any pre-existing theoretical framework (Braun & Clarke, 2006). The data was analysed in accordance with the framework provided by Braun and Clarke (2006). The research interviews and focus group were analysed inductively and any themes were identified on a semantic level. The data from the focus group and individual interviews were analysed separately due to the different research designs. The data was transcribed (see Appendix C for sample) and coded to produce a series of initial codes: 89 codes amongst the six research interviews and 29 codes from
the focus group. These initial codes were then reviewed comparatively in order to identify themes, including divergent themes, emerging within and across the data. The final stage involved refining and validating the themes using an independent researcher.

**Reflections**

In conducting data analysis the researcher was aware of her own position as a developing clinician and was mindful that her own experience of the therapist journey may have generated some preconceived ideas about the experiences of new DBT therapists.

**Results**

Semantic thematic analysis identified six themes across the focus group and individual interviews.

**Uncertainty about DBT skills and care pathways**

This theme reflected uncertainty in relation to the exact nature of the DBT skills and the DBT care pathway. Analysis of the five individual interviews identified a lack of certainty and clarity about what the DBT care pathway is and what processes this pathway encompasses. Furthermore, across both the focus group and individual interviews all participants identified feeling that the DBT skills covered within the training felt abstract and vague and there was a lack of clarity about the exact nature of the DBT skills and how to use these in clinical practice.

'I think the sense that certainly I had was, well you keep talking about all these DBT skills but what are they, I have no idea..... (Participant 1, line 139)'.

**The DBT training is theoretically heavy**

Across the focus group and individual interviews, all eight participants reported that the within-service training was at a detrimentally fast pace. In relation to specific aspects of the training, all participants mentioned that the behavioural principles module was
difficult to comprehend and there was a lack of understanding about how the behavioural principles could be applied in clinical practice.

‘...the behavioural principles lecture we had really relied on a kind of undergrad psychology degree and there were people in training that didn’t have that and even though I had that I struggled, and I felt it was too intellectual, and they didn’t kind of relate it to how we could use that in therapy’ (Focus Group Participant 2, line 27).

It was recognised by three participants from the individual interviews and one participant from the focus group that more focus was needed within the training on discussing and demonstrating how to problem-solve difficulties that may arise within sessions.

‘If we’d had more time, I think then to have talked about what obstacles you might come across, given us a couple of case studies to work through, that sort of thing, cos I think that means you consolidate those skills, what you’ve been learning, because it was so quick, it just went in one ear and out the other, to be honest’ (Focus Group, Participant 2, line 128).

Learning and developing by doing DBT

All eight participants spoke about needing to utilise DBT clinically to really understand and be able to apply the skills introduced within the training package. Furthermore, all of the participants mentioned that skills, confidence and an appreciation of the emotional impact of the work only develops once DBT is put in action in clinical practice.

‘You never really know what it feels like unless you’re doing it, so in a sense they probably did say you know it’s going to be tough, it’s going to be difficult and you always expect that but you know it’s like anything...in a sense you only really appreciate once you’re doing it’ (Participant 2, line 70).
Consequently, the importance of a period of follow-up training to enhance and consolidate skills and problem-solve clinical difficulties once implementing DBT in clinical practice was highlighted.

'I think it would probably be helpful to have a bit more...um...maybe you know a refresher or you know another part. Because I think actually if you haven't been doing DBT at all you tend to learn once you got into the consultation groups and you start attending the supervision and you start just doing it really....' (Participant 4, line 15).

The consultation groups are a valuable clinical resource but neglect CPD

The DBT consultation groups appeared to be valued by all eight participants for the experiences of shared learning, decision-making and accountability that this forum facilitates.

'It's very supportive in a sense and it's actually very nice to get everyone's' head together to present a situation and everyone can actually say how they view it or what they think of it, especially with the client group, you do need that extra thinking space to do that' (Participant 2, line 31).

However, both participants from the focus group and three participants interviewed individually mentioned that protected time for ongoing skills practice and development was currently neglected within the consultation groups and was an important part of feeling skilled-up as a clinician in light of DBT being an ongoing learning process.

'...so we've done the four days training but it's about taking the different areas of DBT and building on it. So maybe in the consultation groups just identifying a time that we could actually look at a specific area and as practitioners what we bring, what has been our experience of it, and just work it out together really' (Participant 3, line 36).
DBT as a skills toolkit for enhancing clinical practice

There was recognition by all the participants that DBT provides a toolkit of skills which ‘filters through into wider clinical work’ (Participant 1, line 101) and can be applied across a range of settings and with clients with a range of presenting problems. For two of the participants interviewed individually there was recognition that DBT has equipped them with a different way of thinking about and managing risk and both participants from the focus group identified using their knowledge of DBT to shift perceptions of clients within the multi-disciplinary team.

‘I think it helps you to develop your tolerance of risk as well so that you know, then you can help other team members...it’s actually been quite helpful because I feel like I’ve got more skills to deal with those situations’ (Participant, 4, line 76).

Prior therapist experience viewed as a help and a hindrance

An existing conflict emerged for four of the participants between prior therapist experiences as advantageous but simultaneously impeding clinical practice. Specifically, previous experience of conducting therapy was considered advantageous in helping them understand some of the more complex aspects of the within service training, particularly behavioural principles.

‘I think maybe for psychology it was ok because my background was that I knew a bit about functional analysis and things that were covered...but I think the impression I got was that for some people that didn’t have some of those backgrounds or maybe weren’t even therapists it possibly was quite brief and it’s quite a complex model and quite a lot to get through....’ (Participant 4, line 4).

However, for these four participants previous experience of alternative therapeutic models impeded their ability to maintain fidelity to the DBT model.

‘...I noticed that I was kind of stuck in my cognitive way of working and it was quite easy to slip back into almost more familiar ways of working’ (Participant 1, line 186).
Discussion

Whilst DBT is recommended as a potential psychological intervention for BPD (NICE, 2009) and staff training identified as essential for effective implementation of the therapeutic model, the financial burden of national DBT training packages may force local services to establish within-service DBT training for clinicians. At a local level it is important that within-service DBT training and support structures for clinicians are evaluated in order to establish whether such practices are both cost-effective in producing significant outcomes and in enabling clinicians to effectively deliver DBT. This research identified that the local DBT service may benefit from making modifications to the within-service DBT training and consultation groups in order for these resources to be more clinically useful and supportive for new DBT therapists. Specifically, in line with professional practice guidelines the findings illustrated that when designing and implementing within-service training packages greater consideration needs to be given to participants' levels of psychological knowledge and skill when designing and implementing within-service training (BPS, 1995).

Implications and Recommendations

The research findings suggest a number of ways in which the within-service DBT training and consultation groups could be improved. The findings suggest that the training needs to be less theoretically heavy, with less psychological jargon and more explanation of psychological concepts, in order for clinicians, particularly those from non-psychology backgrounds, not to feel deskilled and disparate as a result of the training package. The findings suggest that more focus on teaching therapists the exact nature of the DBT skills and allowing time for demonstration and practice of these skills within the training may improve perceived therapist confidence in implementing these skills in clinical practice. With regards to more routine evaluation of the within-service training, the service may benefit from implementing a routine quantitative evaluation of therapist knowledge and confidence in applying the principles of DBT pre- and post-participation in the within-service DBT training. This may more routinely help to
identify whether the DBT training is effective in increasing staff knowledge, understanding and confidence of the DBT skills and principles.

Importantly, this research has highlighted DBT as an ongoing learning process and that a follow-up package of within-service training may be beneficial in helping newly trained therapists to feel as skilled up as they possibly can during the initial stages of their therapist journey. Furthermore, due to the ongoing nature of the therapist journey, continuing professional development (CPD) was also recognised within this research as being important for consolidating skills learnt within the training and in clinical practice. CPD is central to remaining competent amongst allied health professionals (Department of Health [DoH], 2003) and psychologists working within the DBT service have a clear role to play in the participation, facilitation and supervision of CPD amongst multi-disciplinary mental health professionals (BPS, 2004). Whilst the findings highlight the valuable input of the DBT consultation groups in facilitating shared accountability for clinical decision-making alongside ongoing learning, there is an ongoing need for protected CPD time to practice and develop the DBT skills. Further work needs to be done locally to think about how the consultation groups can ensure protected time for CPD in the future.

Clear pathways to psychotherapeutic help within mental health services are recommended (BPS, 2007). This research has highlighted uncertainty regarding the DBT care pathway at a local level. If specific personality disorder pathways have been developed within the DBT service, such care pathways need to be more explicitly disseminated to clinicians.

**Dissemination to Service**

In line with the importance of disseminating research findings to inform service delivery (BPS, 1995), the research findings will be disseminated to the lead clinicians of the DBT teams across the Trust via a face-to-face consultation. Furthermore, an executive summary report will be produced for the DBT service and copies of this report will be
disseminated to the DBT therapists, including those clinicians who participated in the research (see Appendix D for evidence of dissemination to service).

Limitations

It is important to note that although 15 new DBT therapists were identified by the leads of the DBT service, for a number of reasons not all of these therapists were interviewed. Whilst this highlights the challenges faced when conducting research in clinical settings, evidently the perspectives of the clinicians interviewed may not be transferable to the remaining new therapists within the DBT service. It is also important to note that the majority of the participants were psychologists. Interviewing clinicians from a wider range of mental health disciplines may have given a different picture in relation to their experiences of the within-service DBT training, consultation groups and therapist journey. However, it is important to note that within this research sample, individuals from occupational therapy, social work and psychology were interviewed and similar themes emerged across these disciplines. The use of both a focus group and a series of individual interviews may somewhat limit the research findings. However, it is encouraging to note that within both the focus group and individual interviews, participants felt able to express negative opinions and there is some evidence suggesting little difference in participant disclosure across individual and group response formats (Wutich, Lant, White, Larson & Gartin, 2010).

Conclusion

This research has highlighted that DBT training can be implemented at a local level and that local level support structures such as supervision and CPD are particularly important for the development and consolidation of the skills needed to implement DBT. It will be important that the research findings are translated into clinical practice in order to improve local support structures for clinicians delivering DBT.
References


Appendix A

Interview Schedule
Interview Schedule

1. Was the within-service DBT training set at an appropriate level?

2. Are there any ways in which the within-service DBT training could be improved?

3. What are your thoughts on the DBT consultation groups?

4. Are there any ways in which the DBT consultation groups could be improved?

5. Do you feel that practicing DBT has enabled you to develop transferable skills which aid you as a clinician?

6. Did the within-service DBT training acknowledge the emotional impact of the work on you as a new DBT therapist?

7. Was there anything that could have been put in place at the start of your DBT therapist journey to support you in your clinical practice?

8. Were there any difficulties or challenges you encountered in the initial stages of practicing as a DBT therapist?

9. Do you feel that the within-service DBT training has equipped you with enough competencies to be an effective DBT therapist?

10. Which aspects from the DBT training do you feel most confident in applying?

11. Which aspects from the DBT training do you feel least confident in applying?

12. Do you feel you have an understanding of the DBT care pathway?
13. Do you feel supported in implementing the DBT care pathway?

14. What do you see are your commitments as a DBT therapist?
Appendix B
NHS Research and Development Letter of Approval
Dear [Name],

Re: An Evaluation of the Effectiveness of Dialectical Behaviour Therapy (DBT) Training and Consultation for New Therapists in [Insert Institution Name]

Ref: SE2011/10

Thank you for submitting the relevant documentation for the above service evaluation project. We will keep a copy of your project proposal on file. The Trust grants permission for you to undertake this service evaluation as proposed.

It is your responsibility to comply with the Trust monitoring arrangements and as such you are required to submit a copy of the final report for this study in due course.

All parties to familiarise themselves and comply with Trust R&D policies and procedures, available on the Trust website:

http://www [Link] aboutus/policies-and-procedures?searchterm=POLICIES Failure to comply with any of the above may result in withdrawal of Trust approval.

I wish you well with your project.

Kind regards

[Name] R&D Facilitator
On behalf of the R&D Team

cc: Senior Clinical Psychologist
Individual Interview: Participant 3

I: So the first question is was the within-service DBT training set at an appropriate level?

P: I think it was yeah. Uuuum... I didn’t necessarily have any knowledge about DBT before but I think having had four days then that allowed an understanding about it.

I: Ok. Are there any ways in which the within-service DBT training could be improved?

P: Uuum.... I think when we actually had the training I think some of the trainers went through things very fast so I think maybe just the time that we have to actually absorb the information and put it into practice.... I think maybe a longer period of training would enable that to happen.

I: So how many days was your training?

P: It was four days.

I: And how long did you feel would have been enough to......

P: I think two weeks, two weeks yeah.

I: Was there anything that particularly stuck out where you thought ‘oh that was rushed through, I could have done with a bit more time for that’?

P: I can’t even remember now, but I guess some of the theoretical concepts, it’s just understanding them in real terms. I think maybe if we had the theoretical side of it and then see it in practice then that will enable you to grasp it a bit better.

I: Ok, and what are your thoughts on the DBT consultation group?

P: I find that really useful, um.... I guess in my situation because I haven’t.... unfortunately my individual client stopped, so even though I’ve been running the group I’ve not been able to do the individual work and for me I realised that I’m not so up on the skills because I’m not doing that on a weekly basis. So whilst I’m building up on my group skills I think definitely having individual clients would definitely have helped me to build up a bit more.

I: And has the consultation group helped you to realise that those individual skills have been lacking?

P: Yes I think learning from the other practitioners who may have their individual clients...um just seeing the dilemmas that they go through, the difficulties, together working out how they deal with them definitely is a useful resource.
I: Are there any ways in which the DBT consultation group could be improved?

P: I think one area we’ve identified here for us as a team here is about training, so we’ve done the four days training but it’s about taking the different areas of DBT and building on it. So maybe in the consultation groups just identifying a time that we could actually look at a specific area and as practitioners what do we bring, what has been our experience of it, and just work it out together really.

I: Do you feel that you don’t get enough time for that at the moment then?

P: I don’t necessarily know if it’s enough time or it’s just that the way we’ve structured our sessions hasn’t actually facilitated that happening. That was a suggestion that was made last week so obviously we’ll look at how we’re utilising and structuring the time.

I: Do you feel that practicing DBT has enabled you to develop transferable skills which aid you as a clinician?

P: Definitely. There’s a few of my clients that I work with that don’t necessarily meet the criteria for DBT or for whatever reason they can’t do DBT um... and just having that knowledge of DBT and the skills and you know the theoretical concepts behind it I’m able to actually use that with those clients. Maybe not so much the practice of the chain analysis and all of that but the chain of thought in helping to break things down for them and helping them to understand and see the links, so definitely that’s been useful for me. And I think that was one of the main reasons why I wanted to do DBT as well... um... because I just feel that it will give me very good skills outside of DBT in itself, just to deal with the clients that I have to deal with on a daily basis [laughs].

I: Yup. Did the within-service DBT training acknowledge the emotional impact of the work on you as a new DBT therapist?

P: I think maybe the consultation group would recognise that. I definitely think that they’re quite supportive um... yeah. So I think maybe we get that kind of support from the consultation group. Because the training was such a short period of time and because we haven’t had exposure to it, you almost don’t really know what you are dealing with until when you’ve actually seen the clients or when you actually start to do the work then you yourself start to recognise the impact that it’s having on you and obviously you take it to that forum and then you’re able to get the support. So I think the training it would have been difficult um.... to actually.... um actually now thinking about it they did say a few things or maybe some of the leads maybe shared about their experience but I guess that doesn’t become real to you until when you actually start to practice yourself. So it’s like yeah that’s what they’ve gone through but it doesn’t really come real to you.

I: Ok. Was there anything that could have been put in place at the start of your DBT therapist journey to support you in your clinical practice?
P: Um.... I don't necessarily think so. I guess the only thing that I'm thinking about really is the commitment that you make as a practitioner to take on DBT, it almost feels like that's your individual decision.... you've got to fit that in and manage that in your caseload and everything else that you've got to get on with. So that commitment comes from you and how you manage it is up to you. I guess maybe if there is... something should be acknowledged within the wider team, that this is something that is going to be beneficial for the team um and you act as a resource so there should be some protection in saying that's your DBT time in that way.

I: Was that problematic then?

P: It wasn't problematic in the sense that my manager obviously didn't object to me doing it but it was just left to me to get on and manage that, it wasn't something that was managed for me and you know protected in any way. There was no restrictions so you just got on and did it but it meant that I had to do that and manage my caseload so it almost felt like oh I made the sacrifice so whatever the consequences is you've just got to get on with it [laughs]; you've still got the caseload, you've got to get on with the DBT. So, it almost felt like I... because I made that choice then I had to.... as opposed to it's something that's going to be beneficial to the team and it's something that the team is actually benefitting from by me being a therapist, by me offering this service.

I: That's really interesting. I guess you have kind of touched upon this a bit already but were there any difficulties or challenges you encountered in the initial stages of practicing as a DBT therapist?

P: I think that was one of them um.... but also I think as an individual therapist, even though I only did it for a very short period of time, um.... again it's the whole thing about.... I think I underestimated how much time I needed to put into DBT for it to be effective. So, um DBT is very prescriptive so you've got to know the stuff and if you don't know the stuff then you don't really have anything to give [laughs] so I think as I said I underestimated how much time that I would need to actually read and you know to build up..... and obviously because I didn't have that protected time or whatever it's like juggling all of it which was just a lot.

I: Mmm. How did you manage that?

P: Well I guess it eased up because my individual client.... it initially was quite difficult because I was very mindful that I was like I've got to do this preparation before I see the client but also mindful that when I go to consultation group it's not just preparation before you see the client, it's the general preparation for DBT. And because my caseload was quite heavy at the time it just seemed very difficult to juggle all of it um.... I don't know whether to say unfortunately or fortunately [laughs] but then fortunately my client dropped out so the pressure eased then. It was just more about contributing to the group work process. But yeah obviously now we're in the second cycle of taking on clients and I've now been allocated an individual client so the process will start again.
I: Do you have any sense of what could help that process?

P: I think it's going to come down to... as I said we are left to manage our own time, so I think I need to actually allocate that time. Now having some insight into what is actually required and what I need to do to get up to speed and be effective in what I'm doing then I need to protect that time myself, put that time aside.... but also you know bring it to the attention of the team manager when they're allocating cases. You know, having a voice to say well actually I'm doing this as well so you need to consider that and the impact of the two; how they work together.

I: Do you feel that the within-service DBT training has equipped you with enough competencies to be an effective DBT therapist?

P: I think with DBT the more practice that you have, the better you become um... the more competent you become. Yeah, I think the training gives you the basic foundation to start with but it is really then down to you to constantly do the reading to build up the skills. The training wasn't sufficient but I don't there is any training that you actually do that would actually make you quite competent and that's it. You are aware of the skills but you know actually practicing them so that they actually relate to what you learnt am I think only through practice. The more practice you get the more confident you become, the more competent.

I: So which aspects from the DBT training do you feel most confident in applying?

P: Um.....oh that's a hard one, I don't know. I don't know, I think the group, the skills part of it um...once I grasp it I feel that I'm able to relate it to um the group. Um.... I don't think there's one thing, I think it's just getting that understanding and being able to convey that so that your client understands what it is that you're talking about and how it relates to their personal situation.... um......... mmm no, again it goes back to the practice.... I'm just thinking about one client that I'm actually care coordinator for but she's in DBT and obviously because I'm doing DBT it's quite blurry so even in our care co-ordination sessions when she's sharing her difficulties with me I find myself always going back to the skills so there is something about understanding the skills and understanding what that person is going through and being able to locate what skills they could use to be effective in their situation.

I: Ok, so which aspects from the DBT training do you feel least confident in applying?

P: So if we are in the group setting um and they're feeding back.... when the client undermines what they do or might not be able to readily identify the skill, I think I need more practice on that to be able to pull it out of them and rather than telling them let them think for themselves what that skill is or what they could do differently. Yeah I think I definitely need more practice on that. I'm confident that I'll get there but again I think that just comes from recognising that from not doing the individual sessions, that's where I identified that I was missing out because just watching other facilitators... how they are able to pull out those skills, how they are able to really get the client to identify
what they are doing, I think that actually comes with the practice of doing the individual sessions.

I: Ok. Do you feel you have an understanding of the DBT care pathway?

P: No [laughs]. What is the DBT care pathway? Actually no I'm not very clear about what the pathway is.

I: Ok, that's fine. Do you feel supported in implementing the DBT care pathway?

P: I'm just trying to think, what is the DBT care pathway? I guess it's about them meeting the criteria to be eligible for the service in the first place [pause].

I: What would help it to feel a bit clearer?

P: I think that's something that we have actually identified within our group... like the referral pathway just being really clear about what the criteria is, what the referral process is um.... so I think we've identified within our group that this needs to be a lot clearer.

I: The last question is, what do you see are your commitments as a DBT therapist?

P: Um... my commitments as a DBT therapist.... um... I guess one of my commitments is about doing the best for the client um... but also my commitment that in order to give the best to the client is one looking after myself but also um ensuring that I'm prepared and equipped to actually do the work that I need to do with them. I don't know, basic things like consistency, being boundaried, being quite fair. Talking about the relationship, you know, giving the clients the respect and something about believing in the clients and their willingness and their ability to change um....... and I guess for the service as a whole.....I guess just ensuring that it's an effective resource um... and just ensuring that I guess recognising that it's a valuable resource. I need to ensure that I'm equipped to deliver the service um.... and ensuring that they're actually getting - not value for money- but they're getting value out of offering that service... you know so there is something measurable at the end of it that they can say is a positive outcome, it's not just offering the service for the sake of offering the service but the quality of service that we offer you know is at a good standard. And yeah we can have some positive outcomes at the end of it.

I: Ok, that's it in terms of the questions for today. Thank you.
Appendix D

Evidence of Dissemination to Service
Service Related Research Project Evidence of Feedback to Service

From: Service Lead
Sent: 15 August 2011 12:13
To: Gemma Webster
Cc: 
Subject: RE: Evaluation of within-service DBT training and consultation groups

Dear Gemma,

Thank you for sharing this report, it is very helpful. I will share it with the rest of the training team and we will keep its recommendations in mind when refining the in-house course. Of course, the DBT leads also need to know about the points re ongoing CPD, and I will ensure that these are highlighted to them for their consultation team meetings.

Kind regards,
Service Lead

From: Gemma Webster
Sent: 12 August 2011 14:46
To: 
Cc: 
Subject: RE: Evaluation of within-service DBT training and consultation groups
Importance: High

Dear Service Lead,

Following the completion of the SRRP, please find attached the executive summary report for the project, which I hope will be of interest to the DBT service.

Please let me know if you have any questions or require a copy of the report submitted to the University.

Best wishes,
Gemma

From: Service Lead
Sent: 13 July 2011 14:43
To: Gemma Webster
Cc: 
Subject: RE: Evaluation of within-service DBT training and consultation groups

Dear Gemma,

Thank you so much for your offer. As we will be discussing a range of matters at the meeting of 19th September we unfortunately would not be able to devote time to being taken through and account of your SRP and your findings. However, if you could please email me an executive summary of your findings beforehand for me to circulate so that we can take these findings into account when revising training plans, that would be helpful.

Regarding feeding back the SRP findings in person – if the University requires that, it’s your call to decide whether to do the person-to-person feedback to the clinical psychologist (and his team) who technically commissioned/designated the focus of your SRP - he is not a member of our DBT leads/training team) or to me.
Notwithstanding whatever the university may say, as part of the Trust R&D governance procedures we absolutely require a copy of your report to be lodged with the R&D Office.

Kind regards,
Service Lead

From: Gemma Webster
Sent: 13 July 2011 14:22
To: Service Lead
Subject: RE: Evaluation of within-service DBT training and consultation groups

Hi Service Lead,

I was talking with the P and P Lead today at the regional psychology meeting and she mentioned about a potential meeting you had set up on the 19th September for yourself and the DBT leads to talk about the DBT training. I would be happy to come along to this meeting if you think it would be helpful otherwise I can just e-mail you an electronic copy of the executive summary report. However I need to double-check with the University whether I am required to feedback the results to the service in person. I will get back to you regarding this.

Many thanks
Gemma

From: Service Lead
Sent: 08 July 2011 19:32
To: Gemma Webster
Subject: RE: Evaluation of within-service DBT training and consultation groups

Hello Gemma,

If you could email the report to me I will lodge a copy in our R&D Office as well as ensure that I send it on to the other DBT service leads. I will also share it with our psychology consultants advisory committee as that will be timely to our discussion of future training and enabling of aspirant DBT therapists in the service.

This will meet both the requirement for a report on a service evaluation study to be lodged in our R&D Office as well the requirement for dissemination of findings of projects we have hosted.

I really look forward to seeing your report. I am happy to meet with you if you feel that it will be helpful for us to reflect together as to what your findings mean for the service and how best we take forward the findings.

Kind regards,
Service Lead
Major Research Project

“A Grounded Theory Approach Exploring Men’s Access to IAPT Services and Accounts of Psychological Help-Seeking”

July 2013

Year 3
A Grounded Theory Approach Exploring Men’s Access to IAPT Services and Accounts of Psychological Help Seeking

by

Gemma Webster

Submitted for the degree of Doctor of Psychology (Clinical Psychology)

School of Psychology
Faculty of Art and Human Sciences
University of Surrey

July 2013

Word Count: 19,852

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Background: Men are considered to be reluctant to seek help for their psychological distress, with men within the age ranges of 35 to 49 years old considered to be particularly vulnerable in terms of their mental health (Her Majesty’s Government, 2011; Moller-Leimkuhler, 2002). To date research has largely focused on trying to understand men’s reluctance to utilise mental health services, resulting in a paucity of research exploring what men do to cope with psychological distress instead of accessing mental health services alongside how men overcome barriers to psychological help-seeking. This research aimed to explore the accounts of psychological distress and the pathways into IAPT services for men between the ages of 35 to 49 years old.

Method: Men within the age ranges of 35 years to 49 years who had been referred to an IAPT service were the target population. In-depth semi-structured interviews conducted with 11 men, obtained detailed narratives of episodes of mental distress and accounts of psychological help-seeking. An abbreviated version of Grounded Theory was adopted using the framework provided by Charmaz (2006).

Results: Stigma and endorsement of masculinity scripts informed the men’s decisions at various stages of the pathway into psychological help-seeking and engaging with help-receipt. Disparaging or encouraging commentary from within social support networks played an important part in psychological help-seeking. The men’s perception of the severity of their mental health symptoms alongside their perception of the risks of not seeking psychological help impacted on whether psychological help-seeking was initiated. GP communication style was highlighted as important in determining whether the men’s mental health problems were recognised.

Contribution to the Field: This research bridges an important gap in understanding how masculinity scripts, stigma and social support networks inform men’s decision-making around psychological help-seeking. This research provides a tentative conceptual framework which outlines how men between the ages of 35 and 49 years old come to engage in psychological help-seeking. Clinical and research implications raised by this research are discussed.
Acknowledgements

The author would like to thank both of her university supervisors for their support and guidance at both a personal and professional level over the course of the preparation of this research. The author would also like to thank her field supervisor for his help and support in enabling recruitment from the IAPT service and for making the recruitment process as seamless as humanly possible. Great appreciation goes out to the men who came forward to participate in this research; without them this research would not have been possible. Finally, thank you to my loving and supportive partner who has provided endless amounts of emotional and practical support to enable me to successfully bring this project into fruition.
Introduction

This introduction explores men’s mental health, masculinity and help-seeking, and the impact of social support networks on psychological wellbeing and help-seeking. An outline of the development of a government-driven programme for widening access to primary care psychological therapies is presented given that this research was interested in exploring men’s engagement with primary care mental health services. An overview of models and theories of help-seeking for physical health problems will be provided alongside a critical review of how helpful these frameworks are for explaining men’s psychological help-seeking. These different aspects of the introduction aim to provide the reader with some background understanding of men’s mental health and the various factors which inform men’s attitudes towards help-seeking, in order to contextualise the rationale, aims and objectives of the study.

Men and Mental Health

Examination of the research literature identifies that consultation rates and help-seeking patterns in men are consistently lower than in women, especially for emotional problems (Galdas, Cheater & Marshall, 2005). Epidemiological studies have indicated that while men and women differ in the types of emotional disorders that they experience, there is little difference in overall prevalence of emotional disorders between men and women (Weismann & Klerman, 1977). This suggests that the low treatment rates cannot be explained by better psychological health amongst men (Judd, Komiti & Jackson, 2008). Research that has investigated men’s help-seeking behaviour suggests that although minor emotional symptoms increase the probability of consulting a General Practitioner (GP), the determining factors are physical symptoms, with some arguing that men may exhibit their emotional symptoms as a physical complaint (Moller-Leimkuhler, 2002; Royal College of Psychiatrists, 2006; Smith, Braunack-Mayer & Wittert, 2006). Furthermore, men’s mental health conditions upon entering treatment are typically more serious than women (Lincoln & McGorry, 1995). Alarmingly, suicide rates for men in the United Kingdom (UK) are three times higher than those of women, with men between the ages of 35 and 49 years having the highest suicide rate (HM Government, 2011). This startling figure combined with the wealth of research literature that suggests
men find it difficult to seek help for psychological problems has been put forward as an ethical dilemma in which “women seek help – men die” (Angst & Ernst as cited in Moller-Leimkhuhler, 2002, p. 3). This has led to a strong narrative within that men are reluctant to engage in help-seeking for psychological problems.

In an attempt to try to understand why men largely continue to be absent from mental health services, the question has been raised regarding how valid the current diagnostic criteria for anxiety and depression are when they are grounded in female presentations of signs and symptoms (White, 2006). Research suggests that depression may present more covertly in men, with men overcompensating for the perceived loss of control of their mental state by overworking, increased alcohol or drug usage, increased potential for violence, or maladjusted behaviour either towards themselves or others (Brownhill, Wilhelm, Barclay & Schmied, 2005). Men report managing their distress differently to women through escapist and avoidant behaviours so that access to help does not occur until the distress accumulates and the externalisation of the psychological distress reaches a threshold in which aggression towards self and others and suicide attempts manifest (Ridge, Emslie & White, 2011). This suggests a potentially delayed presentation of psychological distress in men compared to women (Brownhill et al., 2005). Such a delayed presentation of psychological distress in men may be linked to a higher threshold men may have for tolerating psychological distress before they seek help (Riska & Ettorre, 1999).

**Attitudes Towards Help-Seeking**

Within the physical health literature, attitudes towards help-seeking appear to be a key determinant in whether an individual intends to initiate help-seeking. The Theory of Planned Behaviour (Ajzen, 1991) conceptualises attitudes as whether an individual appraises the intended behaviour favourably or unfavourably. The theory proposes that attitudes are formed through an evaluation and weighing of the anticipated benefits and risks of performing the behaviour alongside social norms associated with seeking professional help. According to this theory, benefits of help-seeking can include distress reduction, increased positive affect and the attainment of support, whilst the risks include fear of violating gender role expectations,
embarrassment over disclosing problems to strangers and vulnerabilities to self-concept and self-esteem resulting from self-disclosure. Attitudes towards psychological help-seeking, particularly in young adult men, are important in explaining the relationship between traditional masculinity ideology and intentions to seek psychological help (Smith, Tran & Thompson, 2008). Furthermore, for some individuals the perception that help-seeking will make psychological distress long-term, thus exacerbating the distress rather than offering the prospect of recovery appears to influence the decision to delay help-seeking (Biddle, Donovan, Sharp & Gunnell, 2007). In this context, help-seeking is conceptualised as initiating an irreversible status passage from which undesirable outcomes such as frightening or disruptive treatments, a public and personal change of identity and stigma of mental illness would follow (Biddle et al., 2007). In addition to the important role that attitudes play in help-seeking (Ajzen, 1991), perceived barriers and benefits of health action alongside the perceived susceptibility and perceived severity of the disease are proposed by the Health Belief Model to be cognitive components that influence help-seeking (Glanz, Rimer & Lewis, 2002).

Attitudes towards help-seeking are informed by a number of social and cultural factors and masculine gender role socialisation has been put forward as a framework for understanding men’s attitudes towards help-seeking. The gender role socialisation paradigm assumes that men learn gendered attitudes and behaviours from cultural values, norms and ideologies about what it means to be a man (Addis & Mahalik, 2003). Masculinity ideology and masculinity scripts have been put forward as two pivotal concepts which seek to explain the process of why men find it difficult to think about and engage in services focused on their health (Courtenay, 2006). Conforming to these traditional masculinity scripts offers clear guidance about how men are supposed to act in society and an individual’s degree of endorsement and internalisation of cultural norms and values regarding masculinity are thought to influence attitudes towards help-seeking (Mahalik, Good & Englar-Carlson, 2003; Pleck, Sonestein & Ku, 1993). Many of the tasks associated with seeking help from a health professional which include relying on others, admitting a need for help, or recognising and labelling an emotional problem, conflict with the messages men receive from the media and from their peer groups about the
importance of self-reliance, physical toughness, and emotional control (Addis & Mahalik, 2003). Internalising the ideological position that men should be tough, competitive, and emotionally inexpressive can have detrimental effects on a man’s physical and emotional health (Courtenay, 2000). It has been argued that the social construction of traditional masculinity wherein weakness and need for help are not considered to be masculine qualities disempowers men from seeking help from mental health services (Galdas et al., 2005). Indeed, conforming to such traditional masculine ideologies has been associated with negative attitudes towards psychological help-seeking (Berger, Levant, McMillan, Kelleher & Sellers, 2005).

Despite providing a tentative framework for understanding men’s reluctance to engage in help-seeking, the gender role socialisation paradigm has been criticised for the narrow construction of gender that it articulates. Firstly, it fosters the notion of a singular male personality, which has been disputed as ignorant of the various forms of masculinity that women and men demonstrate (Connell, 1995). Secondly, within this paradigm, gender is implied to represent a static and innate property, which has received extensive criticism within the social constructionist literature in which gender is considered to be something that men and women ‘do’ rather than an attribute that they possess (West & Zimmerman, 1987). Gender can be considered as dynamic and enacted by men in various arenas of social life resulting in different kinds of masculinities that men construct through practices and relationships they encounter within their social world (Connell, 1995). From a social constructionist perspective, men are not considered to be passive victims of a socially prescribed role but are considered to be active agents in constructing and reconstructing dominant norms of masculinity (Courtenay, 2000). Similarly, men’s health beliefs and behaviours can be understood as a means of constructing or demonstrating gender. In this way men are considered to use health beliefs and behaviours to demonstrate dominant masculine ideals that clearly establish them as men (Courtenay, 2000; Ridge et al., 2011).

Psychological distress appears to present men with a real threat to their masculinity and can result in feelings of isolation and ‘otherness’ (O’Brien, Hunt & Hart, 2005). Related to men’s image concerns is a perceived gender specific stigma that men may
associate with violating the dictates of the masculine gender role. Specifically, the stigma of not living up to a masculine image likely interferes with asking for psychological help, particularly when asking for help is related to masculinity scripts that endorse strength and independence (Mahalik et al., 2003). Where mental health problems are concerned, several key practices of masculinity have been highlighted within the research literature. These include delaying or avoiding treatment for ‘minor symptoms’, trivialising or overlooking serious symptoms, enduring symptoms to an acceptable often serious threshold, and remaining “strong and silent” about mental health problems (O’Brien et al., 2005). For those men that do engage in a process of disclosing mental illness, the very process of disclosure can have a negative and damaging impact on their self-image. A fear that disclosing mental health problems to male peers would result in being marginalised and excluded from peer groups has been articulated by men (Strike et al., 2006). Psychological help-seeking could therefore be hypothesised to present men with very real challenges to both their social and self-image.

Self-esteem also appears to be an important psychological barrier to seeking help from non-professional sources of support such as family and friends (Nadler, 2002). Perceptions of the normative nature of a problem appear to influence help-seeking behaviour and self-esteem appears to be negatively affected when a problem is perceived to be non-normative (Nadler, 2002). A man is least likely to seek help for problems that he sees as unusual, particularly when such problems are also perceived as central to his identity (Addis & Mahalik, 2003). It has been argued that seeking help from another entails an implicit internal evaluation of the risks and benefits to one’s self-esteem alongside an evaluation of the meaning of help-seeking for the individual concerned (Fisher, Nadler & Whitcher-Alagna, 1982). Where seeking help from another is conceptualised as admitting that one cannot deal with the problem alone, an individual’s self-concept can be threatened with issues of weakness and inadequacy (Fisher et al., 1982). Here self-stigma whereby the individual perceives the act of seeking professional help for distress as a threat to their self-worth and as a weakness of character, can prevent help-seeking (Vogel, Wade & Haake, 2006). For some individuals the need to maintain a positive self and social image outweighs the
benefits of help-seeking, thus resulting in avoidance of informal help-seeking behaviours (Miller, 1985).

Whilst examination of the research literature presents a picture of men being reluctant to think about and engage in services around their mental health as a result of gender socialisation and masculinity scripts, there are some men who do successfully access mental health services (Strike, Rhodes, Bergmans & Links, 2006). For some men, consultation with health services is seen to preserve rather than threaten masculinity, with preservation of future health through engaging in help-seeking assuming a higher priority than preservation of their masculinity (O'Brien et al., 2005). Furthermore, it has been suggested that both the effects of gender socialisation and the process of constructing masculinity in particular help-seeking contexts are moderated by social psychological processes (Addis & Mahalik, 2003). Social norms have been conceptualised as an avoidance factor in the help-seeking process and attitudes transmitted by the social support network, including family members, friends and work colleagues can determine how an individual defines and acts upon distressing symptoms (Angermeyer, Matschinger & Riedel-Heller, 2001; Vogel et al., 2007). This suggests that social support networks can have a significant impact on psychological wellbeing and help-seeking.

The Impact of Social Networks on Psychological Wellbeing

Smaller social networks, fewer close relationships and lower perceived adequacy of social support have all been linked to mental health symptoms (Barnett & Gotlib, 1988). Both the Stress-Buffering Model and the Main Effects Model posit that social ties are related to psychological wellbeing, however the mechanisms through which social ties operate differs according to each model (Cohen & Wills, 1985). The Stress Buffering Model asserts that social support prevents or modulates responses to stressful events that are damaging to health, whilst the Main Effects Model asserts that social relationships have a beneficial effect regardless of whether the individual is under stress (Cohen & Wills, 1985). Whilst social support networks can have a positive impact on psychological wellbeing, research suggests that support networks can also be disabling (Kawachi & Berkman, 2001). Both presence of a mental health problem for an individual and seeking professional help to address one's mental
health can be stigmatised within social support networks surrounding the individual (Vogel, Wade, Wester, Larson & Hackler, 2007). Social stigma attached to seeking professional help has been conceptualised as one of the most significant barriers to psychological help-seeking, with social stigma being defined as the fear that others will judge a person negatively for seeking help for a problem (Deane & Chamberlain, 1994).

Horwitz (1977) established that people generally talk to at least four members of their social network about their personal concerns before seeking psychiatric help. Men may experience barriers to seeking help from health professionals when they perceive other men in their social networks disparage the process of help-seeking, particularly if the man identifies himself as similar to the members of the reference groups, perceives the other men as unanimous in their attitudes, experiences a large number of men expressing similar attitudes, and the members of the reference group are important to that man (Addis & Mahalik, 2003). In particular, a man is unlikely to seek help if those men in his social support network who are important to him endorse norms of self-reliance or norms that suggest his problem is non-normative (Addis & Mahalik, 2003). On the contrary, having a social support network that accepts and encourages help seeking for a problem is thought to be a necessary condition for help-seeking to be initiated (Rickwood & Braithwaite, 1994). Research suggests that those close to an individual may influence the decision to seek mental health services through specifically prompting the individual to seek help and normalising help-seeking by sharing their own experiences of accessing mental health services (Vogel et al., 2007). The extent to which initiating help-seeking is either supported or dismissed by the social support network of the individual thus plays an important part in the individual navigating their relationship to help-seeking.

**Improving Access to Psychological Therapies (IAPT) Initiative**

In 2007, the former Labour Secretary of State for Health announced substantial new funding to fully implement a large-scale initiative for Improving Access to Psychological Therapies (IAPT) within the National Health Service (NHS) for individuals suffering with depression and anxiety disorders. The rationale for this initiative was underpinned by two factors: (1) the recognition that depression and
anxiety disorders are serious mental health conditions which affect approximately six million people in the UK and have a major impact on an individual’s functioning, and (2) that accessibility of treatments for these mental health conditions was problematic (Department of Health [DoH], 2008; Layard, 2005). The IAPT programme aims to improve access to evidence based psychological therapies by funding the implementation of National Institute of Clinical Evidence (NICE) guidelines for people suffering from anxiety and depression. The IAPT programme is underpinned by the NICE guidelines which strongly support the use of Cognitive Behavioural Therapy (CBT) for depression and anxiety disorders (NICE, 2007; NICE, 2009). Furthermore in light of the evidence that some individuals respond well to ‘low-intensity’ interventions such as guided self-help and computerised CBT, NICE also advocated a stepped-care approach to the delivery of psychological therapies in mild to moderate depression and some anxiety disorders, with individuals suffering with severe depression and anxiety disorders being stepped up to ‘high intensity’ face-to-face psychological therapy (NICE, 2007).

The IAPT programme sought to address the problem of accessibility to psychological therapies by training larger numbers of psychological therapists to provide interventions (DoH, 2008). One of the main objectives of the IAPT programme was identified as improving recovery rates so half of those engaging in treatments would ‘recover’ and therefore fewer individuals would receive sick pay and benefits (DoH, 2008). Alongside the benefits at an individual level, it has been argued that the IAPT programme has the potential to facilitate substantial economic benefits to society by reducing public costs including welfare benefits and medical costs, alongside increasing revenues, and increasing productivity as individuals are able to return to work (Layard et al., 2006).

The Department of Health funded two pilot projects that aimed to collect information to inform the national roll-out of the IAPT programme. These pilot projects received £1.3-1.5 million extra funding to develop expanded psychological treatment services for depression and anxiety disorders that primarily focused on delivering the CBT-related interventions recommended in NICE guidance, using a stepped-care approach (Clark et al., 2009). These demonstration sites opened in summer 2006 and initial
evaluation suggested that over a 13 month period 5500 people were referred to the two sites, of whom 4800 were considered suitable for the service. Both demonstration sites achieved recovery rates of between 55% and 56% for people who received treatment and at post-treatment the observed increase in employment rates without claiming sick pay was 5% across the two sites (Clark et al., 2009). Furthermore, comparison between self-referrals and GP referrals across these two sites supported the idea that self-referral may be particularly helpful for promoting access to treatment for some community groups. This in turn led to the UK Government approving the use of self-referral in the national roll-out of IAPT services.

Critique of the Literature
Existing models of help-seeking for physical health problems imply that rational thought processes are involved in decision-making around behavioural choices. Engaging in rational thought processes may be particularly difficult for individuals suffering with mental distress, which raises questions as to the validity of this assumption for explaining the decision to engage in psychological help-seeking. Whilst the existing models of help-seeking behaviour highlight the cognitive processes that influence help-seeking for physical health problems, these models do not appear to adequately consider the range of social and cultural factors that may inform decision-making around help-seeking. Additionally, consideration of the subtle but important role that cognitive and affective judgements may play in help-seeking appears to have been neglected within existing models of help-seeking. It is possible that affective judgements may be as important if not more important in informing help-seeking for men, however this has not been adequately explored within the existing explanatory models.

Research Aims
Whilst exploration of the barriers to psychological help-seeking for men is important, little attention has been given to how men define psychological distress and overcome the barriers to help-seeking in order to access mental health services. To date research has largely focused on trying to understand the reluctance of men to utilise mental health services. This has resulted in a paucity of research exploring
what men do to cope with psychological distress instead of accessing mental health services, alongside how men overcome the barriers to psychological help-seeking spoken about within the research literature in order to access mental health services. This research aimed to contribute to the understanding of: (1) the pathways into mental health services for male service users, (2) the resources that men employ prior to accessing mental health services, and (3) how men overcome barriers to help-seeking in order to access mental health services. The research was considered important in order to develop a conceptualisation of the journey into primary care mental health services for men between the ages of 35 and 49 years old and thus develop targeted interventions to promote psychological wellbeing for men along different aspects of the care pathway. The decision to focus on men within the age range of 35 to 49 years old was based on the recognition that these men are at an increased suicide risk and are therefore particularly vulnerable in terms of their mental health (HM Government, 2012).

Research Questions
This research aimed to answer the following questions: (1) what are the pathways into primary care mental health services for male service users between the ages of 35 and 49 years old, and (2) how do men between the ages of 35 and 49 years old account for their psychological help-seeking?

Method
Design
A qualitative method of enquiry was chosen to investigate the research question as a qualitative approach to data collection and analysis was thought to be more appropriate for answering the research questions. As this research aimed to explore an inductive and permissive process, the deductive and reductionist nature of a quantitative approach was not considered suitable given the research aims. An abbreviated form of Charmaz’s (2006) Grounded Theory was adopted given the time constraints imposed on the research. The abbreviated version of Grounded Theory ensures that interview transcripts are analysed using the principles of Grounded
Theory however theoretical sensitivity, theoretical saturation and negative case analysis can only be implemented within the texts being analysed (Willig, 2001).

Grounded Theory results in the generation of a theory that explicates a phenomenon from the perspective and in the context of those who experience it (Birks & Mills, 2011). Grounded Theory was thought the most appropriate methodological approach to use given that little is known within the existing research about how men come to successfully engage in psychological help-seeking and access primary care mental health-services. Furthermore, due to the open-ended nature of the research questions and the focus on understanding the process and meaning of male service users’ accounts of mental illness and help-seeking, Grounded Theory was considered the most appropriate qualitative method of enquiry. The research hoped to generate a theory explaining how men engage in psychological help-seeking and enter into primary care mental health services and the focus on social processes inherent within Grounded Theory was thought appropriate for enabling investigation of how men’s construction of mental health and psychological help-seeking may be influenced by social structures, situations and relationships (Tweed & Charmaz, 2012).

Throughout the research process, an evaluative framework outlining a number of characteristics of good qualitative research was considered in order to guide data collection and analysis (Yardley, 2007). These characteristics were specified to be: (1) sensitivity to context which encapsulates sensitivity to relevant literature, empirical data, socio-cultural setting, participants’ perspectives and ethical issues, (2) commitment and rigour which encapsulates in-depth engagement with the topic, methodological competence, thorough data collection and in depth/breadth analysis, (3) transparency and coherence which encapsulates clarity and power of argument, transparent methods and data presentation, fit between theory and method and reflexivity, and (4) the impact and importance of the research findings at both a theoretical, socio-cultural and practical level (Yardley, 2007).

**Epistemological Position**

A critical realist position was adopted owing to the type of knowledge sought and the positioning of the researcher in the research process. It was assumed that although
the data can tell the researcher about what was going on in the real world for the men interviewed, the data did not directly reflect reality but needed to be interpreted by the researcher. In this way, the active role played by the researcher in interpreting the data to provide access to the underlying processes that constitute the data was acknowledged (Willig, 2012). The framework for conducting Grounded Theory provided by Charmaz (2006) was therefore used in light of the researcher’s belief that she played an active part in the co-creation of knowledge with research participants. From a critical realist standpoint it therefore was assumed that the men had engaged in a process of help-seeking, however it was not necessary for participants to be aware of the underlying mechanisms or conditions that informed their psychological help-seeking and experiences of accessing the IAPT service as the researcher considered it to be her task to uncover these mechanisms.

**Procedure**

As the study applied an abbreviated version of the Grounded Theory approach, a sample size of between 15 and 20 participants was assessed as being adequate to maximise representativeness and theoretical sensitivity within the study timeframe based on previous research (Thomson, 2011). The concept of theoretical sufficiency was considered more appropriate than achieving theoretical saturation, given that categories can be closed too early when theoretical saturation is strived for and an ongoing process of familiarisation and analysing data can always result in new categories emerging. Theoretical sufficiency was considered to have occurred when new data did not necessarily add anything to the developing model (Dey, 1999).

The IAPT service was provided with the inclusion criteria for the research, which were men:

- between the ages of 35 and 49 years;
- from a range of socioeconomic, occupational, educational and religious backgrounds;
- who had accessed primary care within the last 12 months and who were currently being seen within the service or who had been discharged from the service in the last six months;
who had been referred to primary care mental health services for the first time;
- who could communicate in English.

Men who were currently experiencing a psychotic episode were excluded. The research protocol agreed that in order to maintain confidentiality of participants’ personal identifiable information, a nominated individual from the IAPT service would search the electronic database in order to identify eligible participants in line with the research inclusion and exclusion criteria. Recruitment packs were prepared for the IAPT service which included a recruitment letter (Appendix A), participant information sheet (Appendix B), consent form (Appendix C) and copy of the indicative interview guide (Appendix D). The recruitment packs were provided to the IAPT service for them to send out to the identified eligible participants, with a request that eligible participants telephone the researcher within two weeks of receipt of the recruitment pack if they were interested in taking part in the research.

Participants
Men within the age ranges of 35 years to 49 years who had been referred to a primary care IAPT service were the target population for the study. The sample was self-selecting as purposive sampling techniques were unable to be applied given the time-frames imposed on the research. The decision to focus on men within the age range of 35 to 49 years old was based on the recognition that this age range of men are at an increased risk of committing suicide and are therefore particularly vulnerable in terms of their mental health (DoH, 2012).

Scrutinising the database in line with the inclusion criteria identified a total of 95 participants from the IAPT service who were eligible to take part in the research. These participants included men who had dropped out during treatment, men who had completed treatment and men who were awaiting treatment or currently engaged in treatment. Out of the 95 eligible participants identified and written to, a total of 12 participants telephoned the researcher to express an interest in participating in the research. One of the men had to be excluded from the research due to not meeting the research inclusion criteria, therefore a total of 11 interviews were conducted. The
mean age of participants was 42.7 years old, with the youngest participant being 38 years old and the oldest participant being 48 years old. Table 1 outlines the demographic information for each of the 12 participants.

Table 1

<table>
<thead>
<tr>
<th>Participant</th>
<th>Age</th>
<th>Ethnicity</th>
<th>Nationality</th>
<th>Level of Qualifications</th>
<th>Working Status</th>
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<tr>
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<td>A-Level</td>
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<td>English</td>
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<td>White</td>
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<td>GCSEs</td>
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</table>

Data Collection

The venue and dates for conducting the research interviews were agreed with the IAPT service prior to speaking with research participants. Participants who

3 Participant G was excluded from the research due to not being able to communicate in English without a translator.
telephoned to express an interest in taking part in the research were informed that the research interviews would be conducted at a centralised GP surgery within the borough served by the IAPT service. Participants were given a choice of available dates to meet for the research interview. Participants were informed that any travel expenses incurred from the research interview would be reimbursed. In-depth semi-structured individual interviews were used to obtain detailed narratives of episodes of mental distress and accounts of psychological help-seeking. The interviews lasted between 39 minutes and 91 minutes with the mean interview time being 58 minutes. The interviews were audio-taped using a Dictaphone in order that the data could be transcribed into written text for the purposes of data analysis. A topic guide was used but issues were allowed to emerge naturally. In line with the methodology of Grounded Theory the interview schedule evolved to incorporate emerging hypotheses and questions arising from data analysis (see Appendix E). The development of the interview schedule enabled the continual exploration and escalation of the data to conceptual and theoretical levels. The main topics explored were: the problems that men sought help for from the IAPT service, their experience of living with a mental health problem and experience of psychological help-seeking. Prompting throughout the interview ensured that all areas were explored in sufficient depth.

Ethical Considerations
The study adhered to the code of conduct and ethical principles of the British Psychological Society (2009). The research protocol was scrutinised by London Queen’s Square Research Ethics Committee, the University of Surrey Faculty of Human Sciences Ethics Committee and the Research and Development Department for the NHS Trust from whom the participants were recruited, who gave the research a favourable opinion (see Appendix F). Service user consultation was sought from a male member of the University of Surrey Service User and Carer Consultation Panel regarding the recruitment resources in order to gain feedback on the readability and appropriateness of the resources for the research purpose.
Data Analysis

Given the epistemological position of the researcher, the framework for constructing Grounded Theory provided by Charmaz (2006) was adopted to guide data analysis. In line with Grounded Theory methodology, interviews were transcribed and open (line-by-line) coding was carried out as soon as possible after each interview was conducted. A break was scheduled between the initial line-by-line coding of the first three interviews and setting up the next interviews. This was to allow time to look for emerging patterns and discrepancies across the data and to adapt the interview schedule in order to explore areas of interest and uncertainty from the initial three interviews, within the next set of interviews. Open (line-by-line) coding was applied to all the interviews. Due to the wealth of codes produced through the line-by-line coding of the data, a one to two page ‘mind map’ summary of the main issues emerging for each participant was constructed for each participant. Constructing these ‘mind maps’ for each participant helped to summarise the main codes emerging in the data and enabled differences and similarities in the data across the interviews to be noted.

Following line-by-line coding, utilising Grounded Theory methodology necessitated focused coding of each interview (see Appendix G for coded extract). Focused codes were active and remained close to the data with the aim of focused coding being to move across interviews and observations and compare participants’ experiences, actions and interpretations (Charmaz, 2006). A position of openness and curiosity was adopted throughout focused coding in order to remain open to potential new categories and for negative cases to challenge the existing focused codes. In order to keep sensitivity to context in mind, any unexpected findings or observations which conflicted with the researcher’s understanding of the topic were actively sought, examined and accounted for at this stage of data analysis. Once focused coding for all the interviews was complete, the focused codes for each of the interviews were put into a table with supporting quotations from the transcript, in order to compare, contrast and refine focused codes across the interviews.

Integrating theory at diverse levels of abstraction is a principal goal of Grounded Theory (Charmaz, 2006). Following the development of the focused codes,
theoretical coding was applied to all the interviews in order to move analysis to a more abstract and interpretive level and develop categories which integrated the focused codes into a conceptual model. In line with Grounded Theory methodology, the theoretical codes were integrated visually into a conceptual model which illustrated the relationship between the theoretical codes. Drawing out the model visually facilitated a process of needing to go back into the data in order to clarify and specify the relationships between the theoretical codes and re-code both some of the focused and theoretical codes in order to integrate coding into a coherent conceptual framework (see Appendix H). The emerging model was shared with participants in diagrammatic format via e-mail. The men were given the opportunity to comment on the model in a telephone conversation with the researcher. Sharing the model with participants in this way highlighted the salience of the model to the men and the men commented on the model as meaningfully capturing their process of psychological help-seeking and journey into the IAPT service. This was considered an important part of the analysis process as it enabled the researcher to ensure that the model presented was coherent and meaningful (Yardley, 2007).

Reflexivity
Using a Grounded Theory approach meant that memo-writing was an integral part of data collection and analysis. This process enabled the researcher to keep sensitivity to context in mind by facilitating a reflective stance on the socio-cultural setting of the study and consideration of the general and specific effects of the researcher's actions and characteristics on the research process. Memos were written prior to and following each research interview in order to summarise reflections on the interview process and highlight patterns that appeared to be emerging within participants' accounts. Memo-writing was also used during the process of open, focused and theoretical coding. Given the recognition that the theory arising from the data involved a process of social construction, memo-writing was particularly important in helping to avoid forcing the data into extant concepts and theories (Charmaz, 2006). During the initial stages of line-by-line coding of the research interviews, memo-writing facilitated a critical process of identifying gaps in data collection and served as a prompt for re-examining the data in an attempt to answer questions about the data and add new questions to the interview schedule. Memo-writing was
important in drawing out similarities and differences across interviews and was used to specify, clarify and question the codes and categories constructed (see Appendix I). In the final stages of data analysis, memos were used to assess and summarise which codes best represented what was occurring in the data and were used to raise focused codes to theoretical categories.

In order to encourage a reflective stance on the researcher's positioning and the impact of this on the collection and interpretation of data, a move to writing in the first person will be used in this section. My interest in men's mental health sprang from my clinical work particularly with adolescent males who had clinically significant levels of anxiety and depression and spoke about how they would not have chosen to access a mental health service if they had not been detained in a secure unit. Additionally my own personal experiences of living with a partner who had experienced some mental health concerns but had chosen not to engage in psychological help-seeking led me to form some assumptions about men being reluctant to engage in help-seeking in relation to mental health concerns. At all stages of the research process the key was to be open to recognising how my own position both privileged and limited me as a researcher (Hall & Callery, 2001). Throughout the interview process with participants I made the assumption that the participants and I were co-creating knowledge. I tried to ensure that my coding process was grounded in the data and that any hypotheses that came up during and after research interviews were checked out in further interviews with participants through integrating hypotheses in the interview guide. I deliberately ensured that a review of the literature was held off until after all the data had been analysed so that existing literature and concepts would not influence coding of the data. Emerging theoretical explanations arising from the data were incorporated into the interview guide so that potential hypotheses and assumptions that did not fit the reality of the men's accounts of psychological help-seeking were revised.

I was aware at the start of the research process of my assumptions that there may be both internal and service barriers to men accessing mental health services. These assumptions had been formed from my own experience of living with a partner who was reluctant to engage in psychological help-seeking alongside my observations.
from my clinical practice that for the most part fathers were largely absent from therapeutic sessions. In order to be transparent about this assumption I ensured that the wording of my interview guide did not talk about barriers to help-seeking or engagement with the IAPT service in order that this assumption was not forced upon the men interviewed. I was also aware of my assumption that the gender of the professionals that the men came in to contact with would have an impact on men’s willingness to engage in psychological help-seeking and psychological therapy. For example, my assumption that men encountering a male or female GP or IAPT practitioner might impact on both the men’s decision to disclose their mental health symptoms and their willingness to engage in psychological therapy. I was not sure in which direction gender would affect this process but suspected that it might be harder for men to talk to a male than female practitioner about their mental health symptoms. Within the interviews, the men began to talk about their experiences of encountering different gender GPs and IAPT clinicians and it became apparent that my interview schedule needed to be adapted to ask the men specifically about this as a process.

Throughout the research process, I was very aware of approaching the research from a female perspective and of the considerable age difference between myself and the men interviewed. In the course of interviewing the men I wondered about the impact that my age and gender had on the men’s ability to be fully open with me about their mental health experiences and their accounts of psychological help-seeking. I began to question this assumption more as prescription to masculinity scripts became increasingly apparent within the accounts of the men. In two of the interviews in particular I was aware of the men finding it difficult to answer some of the questions posed in the interview schedule. These men would quite often respond to the open-ended questions with monosyllabic answers and I found myself engaging in a process of having to ask a lot of follow-up questions to try and elucidate more rich information from the men. At times I felt compelled to step out of my role as a researcher and draw on my therapeutic engagement skills in order to build up enough of a relationship with the men in a short space of time that would enable them to feel comfortable talking with me about what were quite personal experiences. When I spoke with these men about their experience of the interview process they reported
that they had initially found it difficult to open up to a stranger but spoke about wanting other men to learn from their experiences as a factor that encouraged them to eventually speak openly about their experiences.

Unless a relationship of trust is developed with participants, confidence is undermined about whether the research findings accurately represent what is significant to them in their everyday lives (Acker, Barry, & Esseveld, 1983). The influence of the nature of the relationship between researcher and participant on the quality of the data was considered throughout interactions with participants (Popay, Rogers, & Williams, 1998). I used empathy, affirmation and some self-disclosure when specifically prompted by participants. For example when asked by participants about my own motives for training to be a clinical psychologist and for choosing this research topic. My willingness to be open and candid with participants appeared to prompt deeper reflection by participants and enable participants to speak about both positive and negative experiences of accessing the IAPT service. In an attempt to share relational power with participants I talked with participants about the analysis process, what would be presented, and how the findings would be used. I shared the conceptual model in diagrammatic format with the participants and the model was altered based on comments made by participants following the research interviews.

**Results**

This research aimed to answer the following questions: (1) what are the pathways into primary care mental health services for male service users between the ages of 35 and 49 years old, and (2) how do men between the ages of 35 and 49 years old account for their psychological help-seeking? A number of theoretical categories arose from the data which drew together the focused codes and explained at a conceptual level the process of how the men came to engage in psychological help-seeking and into contact with the IAPT service. Each of the theoretical categories will be described in turn, with quotes from the men used to illustrate the theoretical categories. The theoretical categories were integrated into an explanatory framework that outlines the journey into psychological help-seeking and pathways into the IAPT service for the 11 men interviewed. A description of how the theoretical categories inter-link to form the conceptual model will be provided.
Figure 1 presents the conceptual model that arose from the integration of the theoretical categories. The model conceptualises the process of psychological help-seeking and the pathways into the IAPT service for the 11 men interviewed. The arrows present in the model map the sequential nature of the psychological help-seeking process and indicate how each step in the process leads on to the next step. For each of the 11 men interviewed, stigma and endorsement of masculinity scripts were apparent as factors which informed the men's decisions at various stages of the pathway into psychological help-seeking and engaging with help-receipt. Endorsement of masculinity scripts and stigma were therefore considered a core category. The purple boxes in Figure 1 illustrate the stages at which endorsement of masculinity scripts and stigma informed the men's decision making-process.
Figure 1. Conceptual model outlining the men’s process of psychological help-seeking and pathways into the IAPT service.
Stigma and Endorsement of Masculinity Scripts

For most of the men interviewed, the constructs of stigma and masculinity were apparent as processes which informed the men's decisions at various stages of the pathway into psychological help-seeking and engaging with help-receipt. Endorsement of culturally and socially-bound notions of masculinity appeared to influence how acceptable psychological help-seeking was considered to be. Interestingly, the sexual orientation of the men emerged as a characteristic that exerted an influence on how masculinity was conceptualised. This became particularly apparent in the case of Lawrence who identified himself as being a gay man. Lawrence conceptualised that masculinity scripts were less influential in determining his pathway into psychological help-seeking reflecting: “I think probably if I was straight, if I was a father of two, I would have to get on with things and soldier on more. I think perhaps, and this is sound sexual orientation-ist...that I'm a lot more aware of myself, not just mentally but physically and all those sorts of things”.

Chronic Suffering with Mental Health

Analysis of the data identified chronic suffering with mental health amongst the 11 men interviewed, with the men suffering for several months and in some cases several years with their mental health before help-seeking was initiated. This chronic suffering with mental health appeared to be underpinned by two factors: (1) experiences of having their mental health dismissed by others, or (2) not conceptualising their symptoms as a mental health problem.

Having mental health dismissed by others

For several of the men interviewed their social support networks were the first arena in which they discussed their concerns around their mental health. As Paulo illustrates, the responsiveness from individuals within the social support network following disclosure about mental health concerns, played an important part in enabling the mental health symptoms to remain ongoing. This occurred through his social support network discouraging further disclosure: “I did not describe my symptoms at all or my feelings....I think I did it once....and when I did my friends told me if you tell anybody else that they'll think you're mad”. Geoff experienced a
similar process within his social support network in which his concerns about his mental health were dismissed by others: "so when I was like talking to my mates I could see that they were embarrassed and they didn't really you know....oh no you're alright, you're alright, yeah yeah, don't be silly. So you kind of think, alright I'll stop now because I don't want to worry them either". For those participants who chose to disclose their concerns about their mental health within their social support network, prescription to masculinity scripts within their support network had a significant influence on the way in which their disclosure was responded to. For Bob, notions of masculinity appeared to determine the responses of his social support network to his disclosure around his mental health: “well it's the old saying big boys don't cry and err a lot of people would say oh just grow a set”, and Paulo described how his concerns were perceived as “.....nothing....it's the usual macho way you know....there's nothing happening with you”. Having their mental health concerns dismissed by others played an important part in these men avoiding further disclosure of their mental health concerns. This in turn led these men to look inwardly to manage their symptoms through a number of coping strategies.

Not conceptualising symptoms as related to mental health

For several of the men the responsiveness of their social support network to their disclosure about mental health concerns was pivotal in ensuring that the associated distress remained chronic. However several of the other men interviewed spoke about not identifying their symptoms as indicative of a mental health problem. This resulted in them engaging in a process of minimising and dismissing their mental health, as illustrated by Richard: “I didn’t know I had anxiety....didn’t know what depression was...just thought it was life....just thought it was normal”. Similarly Howard spoke about not conceptualising his symptoms as related to mental health: “I didn’t even realise it was depression at the time....I just thought it was me being a nasty piece of work” and John “hadn’t really recognised the underlying stress and anxiety that was going on so it hadn’t really occurred that there was something there that needed to be fixed”. For Paulo, a mental health conceptualisation of his symptoms had not been considered as he “was looking for an explanation to physical symptoms and had never ever considered any....that these were...could have been
anything to do with a mental problem”. Turning inwardly to manage their symptoms was the approach also adopted by these men.

Self-Management of Mental Health

Expressing emotion seen as weakness

Across the 11 men interviewed endorsement of masculinity scripts emerged as playing an important part in how the men managed their mental health. As Bob illustrates: “...big men don’t cry and all that, so you’re supposed to....it’s the British stiff upper lip and all that like...men don’t cry and all that like...men don’t cry and all that sort of thing so err I used to just keep it bottled up inside”. In line with these masculinity scripts, several of the men spoke about feeling obligated to manage their mental health through avoiding disclosure. Barry spoke about “...a pressure amongst men, especially maybe the more conventional men -whatever that means- to be tough....to tough it out” and James conceptualised his avoidance of disclosure as being “....a man thing.... if you’ve got a problem you just lock it away, you don’t go asking for help or you’re a sissy or something like that, you know?”. For Geoff, avoiding help-seeking was equated with strength and masculinity: “....a man should be strong, strong minded and everything, he should be able to...he’s the rock you know...so when you’re like...that rock crumbles and you know what I mean....the man isn’t the man he’s supposed to be!” and Lawrence described an implicit masculinity script he felt within society that men “...would think that it’s a sign of weakness to have mental health problems....they would just soldier on more.... it’s something women get”.

John recognised commonalities in his own notions of what it meant to be a man and how this informed his approach to managing his mental health with other men within his social support network: “now that I’ve been through it I see other people doing the same stuff I did and I think some of those things seem to be particularly bloke-ish. Things like well I’m gonna deal with it on my own, I don’t need help, I’m not stupid, I’m not an idiot, I can deal with this”. For most of the 11 men interviewed, degree of prescription to masculinity scripts informed whether or not disclosure either within
their social support network or to a professional, was perceived as a viable option for managing their mental health.

**Turning inwardly to manage mental health**

For the men interviewed there was a need to look inwardly to develop coping strategies to self-manage their symptoms. This self-reliance resulted from having disclosure discouraged within their social support network, or because help-seeking presented a significant internal threat to their self-concept as a man. Geoff spoke poignantly about his view of help-seeking at the time of experiencing his symptoms: "well to get to the point where I think I had to, I had to get help, to me that was an embarrassment and....a bit of a letdown for myself to think I had to get help in the end. I thought I was strong enough to actually be able to do it on my own". Oliver spoke about the relationship between him turning inwardly to manage his mental symptoms and how this fitted with his notions of masculinity: "I don't wanna emasculate myself in front of anybody.... I don't wanna admit to anybody, including myself that I have a weakness". As a result of these notions of masculinity, several of the men spoke about managing their mental health through keeping their emotions and feelings "bottled inside" and turned to a number of coping strategies to manage their symptoms.

For the men interviewed, there were individual differences in the coping strategies chosen to manage their mental health symptoms, however some commonalities were present. Several of the men interviewed spoke about managing their mental health through withdrawing from their social support network. Howard "became a recluse" and "stayed away from people for fifteen months", and avoiding contact with others was a coping strategy employed by Richard who "just couldn't be bothered to answer the phone", Geoff who "really didn't want to go out... didn't want to leave the house...didn't want to see anybody" and Bob similarly spoke about isolating himself as a way to cope with his symptoms: "I was isolating myself...only coming down into the areas of the hostel when I knew everyone else was in bed".
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Self-soothing through substances

Both Bob and Oliver spoke about using drinking and drugs to manage their symptoms. Bob spoke about managing his mental health through “basically drinking....I was blocking it out of my mind so I didn’t have to think about it during the day and then I’d have a couple more beers in the evening and I’d basically...I’d pass out so I wouldn’t have to think about anything”. Similarly Oliver spoke about “drinking beyond any measure of comprehension but still function because of the drugs and....take counteracting drugs like speed or cocaine to counteract the alcohol”. He went on to describe “wanting to deal with any problems by having a drink...and as they say, there’s no answer at the bottom of a glass but that’s where I always seem to look for them...and if it’s not drink then it’d be cannabis, if it wasn’t cannabis then it’d be cocaine...it was a way of life”. Turning to drugs to manage his mental health was a coping strategy also used by Richard: “I might have a bit of sniff now and then but other than that it’s always cannabis” and Geoff spoke about “going off the rails a bit...turned to drugs and that sort of thing”.

Using physical exercise

Physical exercise emerged as a coping strategy used by some of the men interviewed. Tim spoke about his experience of using physical exercise to manage his symptoms and the impact that this had on delaying psychological help-seeking: “I used to go to the gym five days and a week and I think that actually prolonged me actually asking for help because I had....I think the exercise kept me....gave me some stimulus....it just kept me going”. Similarly to Tim, Bob spoke about using physical exercise to manage his symptoms: “I’d just go for a long long long walk, three or four hours long. It didn’t matter where I was going, I’d just walk. I’d get so far and say okay well now I can turn back” and Howard “would listen to music....or go for long walks” to manage his symptoms.

Changing one’s relationship with work

For the men that were working at the time of experiencing mental health difficulties either withdrawing from work or focusing on work were important coping strategies. Tim spoke about focusing on work alongside physical exercise as coping strategies he employed: “I was just going to the gym and work, that was my life so my balance
was totally wrong" whilst for Paulo, giving up work became essential to managing his symptoms: "I think one of the most important things for me was to actually....for somebody to actually tell me you have to stop work".

Acknowledgement of Difference

Self-acknowledgement

Acknowledging a difference in their mental state emerged as a critical process in moving the men towards questioning the effectiveness of self-managing their symptoms. All of the men interviewed spoke about knowing that something was not right internally regardless of whether or not they conceptualised this difference in themselves as being symptomatic of a mental health problem. Richard spoke about acknowledging a difference in himself: "I knew I wasn't right because I weren't getting out of bed and stuff like that" and Howard also described his experience of coming to acknowledge a difference in himself: "some things I would normally laugh at a couple of weeks beforehand and the same kind of thing...I would just snap...and I would be so grumpy with my wife at the time". Tim recollected his experience of coming to acknowledge a difference in himself: "I was just constantly down...couldn't get myself out of this hole" and Geoff spoke about it being "hard to kind of actually open your eyes and think that you do need help, I have got mental issues. So that's, I suppose that's admitting it to yourself in a way, to take the next step". For these men acknowledging a difference in themselves was not enough of a cognitive process alone for help-seeking to be initiated. A threshold of concern about their symptoms also needed to be reached, as will be discussed under the theoretical code 'reaching a threshold of concern about symptoms'.

Acknowledgement by others

Whilst all of the men acknowledged feeling that they "weren't right", for some of the men, their symptoms became visible to people within their social support network. This visibility to others facilitated an outsider acknowledgement of difference as illustrated by Geoff: "people could see that there was a problem...someone that knew me...she said you're not your normal you, you haven't been for a long time....and even though I'd thought that, you kind of think that no one else can see that, but
obviously they can”. Similarly, Barry was “very noticeably quiet at work and they were concerned” and Tim spoke about having his distress recognised by individuals within his social support network: “I had already started talking to a friend...she’d made it quite clear...she’d see how bad I was”. For these men, some of whom had not acknowledged the difference in themselves as concerning their mental state or reached an internal level of concern about their symptoms, outsider witnessing of their mental state was critical. Outsider acknowledgement of difference in the men resulted in a threshold of concern about the man’s symptoms being reached for the outsider witness. Acknowledgement of difference in the man by an outsider witness in conjunction with a level of concern being reached by the outside witness appeared to facilitate the witness conceptualising the difference in the man as concerning the man’s mental state. This conceptualisation by the outside witness then informed how the outsider responded to the difference observed in the man.

This responsiveness of outsider witnesses to the difference in the men contrasted starkly with some of the men’s experiences of having their mental health symptoms dismissed or minimised by others within their social support network. In listening to the men’s accounts it was apparent that for several of the men, navigating their journey into help-seeking involved having to navigate discordant discourses within their social support network about the acceptability and normative nature of help-seeking. As the men’s symptoms become more severe and impeded their functional ability, the men became able to move away from feeling tied to act in line with masculinity scripts, to be able to hear the concerns and advice from others regarding the need for help-seeking to be initiated. This in turn enabled help-seeking to be initiated by significant others within their social support network on their behalf. It was interesting to note that the outsider witnesses to the men’s psychological distress were mostly women or men with lived experience of mental health problems. For those men that did not rely on others to initiate help-seeking on their behalf, the progression of their mental health symptoms to a life-threatening level facilitated an important cognitive process. Here, discouragement from their social support network around disclosure and endorsement of masculinity scripts and potential stigma that may result from disclosure within their social support network became disregarded.
For these men, preserving life took greater precedence over prescribing to socially defined notions of masculinity within their social support networks.

Threshold of Concern about Symptoms

**Level of concern to self**

For those men who acknowledged a difference in themselves, a threshold of concern about the symptoms needed to be reached in order for psychological help-seeking to be considered. This threshold was determined by two factors: (1) feeling that the symptoms were beyond their internal control, and (2) the degree of impact that the symptoms had on their ability to function both occupationally and interpersonally. Barry illustrates his experience of his symptoms: “I felt like it was a little bit out of control, rather worrying.... the whole idea that I was actually doing it pretty much constantly or sort of throughout the day, feeling awful, that I found obviously it’s not healthy and it is quite a worrying thing that is going on”. Similarly, James spoke about the point at which he perceived his symptoms as being beyond his internal control: “I knew...even when I was getting angry...I knew it was silly and I shouldn’t be doing it....but I couldn’t kind of wind it back and stop it”. Tim spoke about the impact his symptoms had on his functioning: “over a period of time I just started to get really down and then one day I found myself at home and didn’t want to go to work, I found I didn’t want to get out of bed”. Richard also spoke about a similar process of symptoms impeding on his functioning: “I want to be doing what I want to be doing....I’m used to doing everything and I’m like this now, and it’s no good”. Feeling that their symptoms were beyond their internal control and the symptoms impeding on their functional ability appeared to result in the men reaching a threshold of concern about their symptoms. However, the level of concern that the mental health symptoms raised for each of the men appeared to determine whether or not psychological help-seeking was considered.

**Level of concern to others**

Similarly, for those men whose difference in themselves was noted by outsider witnesses, the visibility of their mental state to others within their social support network resulted in a threshold of concern being reached. For those people
surrounding the man, the threshold of concern was reached through noticing the impact that the symptoms were having on the man’s ability to function, alongside noticing that the man was not his “normal self”. Deviation from “normal self” was conceptualised by the men as becoming socially withdrawn, neglecting personal care as illustrated by Howard: “I let myself go...I let my beard grow...it was rare that I’d wash to be honest...that was how much it got to me”, or being unable to function at work as illustrated by Paulo: “I was getting worse and worse...I mean I was feeling worse and worse to the point where I stopped work for a month”.

Other people in the men’s support network reaching this threshold of concern led to help-seeking being initiated by individuals within the social support network on behalf of the man. Lawrence spoke about help-seeking being initiated by a significant individual in his life: “my flatmate took me because I didn’t want to go and didn’t feel comfortable going by myself”, whereas for several of the other men partners played an important part in initiating help-seeking on behalf of the men. For Geoff, his partner played an important part in initiating help-seeking: “she said look you need to go and see someone. She come with me the first time actually to the doctors. She come with and said, look he needs help! And then she said I’m going to leave you to it Doctor”, as was the case for John: “my girlfriend was really scared because she thought I’d had some kind of stroke....I mean fortunately she was there and then afterwards I couldn’t string a sentence together so she rang the Doctor who rang back”.

What was apparent within the accounts of help-seeking of these men was that whilst the men cognitively knew that there was something internally not right, “it needed that initial someone” to seek help from the GP to address their psychological wellbeing on their behalf.

Acknowledgment That Difference Concerns Mental State

Following an internal process of acknowledging a difference in themselves, some of the men spoke about acknowledging that the difference concerned their mental state. For the men who had not conceptualised the difference in themselves as being a result of a mental health problem, outsider witnessing of their symptoms resulted in
others acknowledging the difference as concerning their mental state. For this group of men, having the difference acknowledged as a mental health problem by others informed the responsiveness of the outsider witnesses to the men’s symptoms through individuals taking action to seek help on behalf of the men.

**Cognitive Evaluation of Risks of Not Addressing Mental State**

For the men who had reached a threshold of concern about their symptoms and acknowledged the difference in themselves as concerning their mental state there was also a need to engage in a process of cognitively weighing up the risks of not addressing their symptoms in order for psychological help-seeking to be self-initiated. Importantly here, acknowledging that the difference in themselves concerned their mental state was not enough for help-seeking to be self-initiated. The men had to acknowledge the difference in themselves as concerning their mental state and engage in cognitively evaluating the risks of not addressing their mental state for help-seeking to be self-initiated. In particular, cognitive evaluation of the risks of not addressing their mental health was most pivotal for the men that were faced with their own mortality. For these men, not addressing their mental health presented them with the greatest costs to their physical health resulting in the initiation of help-seeking. Bob described his experience of weighing up the costs of not addressing his mental health: “I think I finally grew up. I realised I’m not getting any younger and if I don’t do something now I’ll be dead in two...I’d have been dead in two years probably” which was a cognitive process also apparent for Oliver: “I knew it needed to be done because if I pick up another drink that’s basically me dead...so I knew it was either...if there was a danger...there was a danger of me picking up a drink...well there still is a danger of me picking up a drink without all these little back up things in place”. Help-seeking for these men was therefore dependent on where the identification of the distress lay. Those men who self identified their distress and cognitively evaluated the risks of not addressing their mental state were able to self initiate help-seeking but those men who were reliant on others to acknowledge their distress were also reliant on others to facilitate help-seeking.
Service Prioritisation of Health Need

The men who chose to self-refer to IAPT spoke about encountering a service prioritisation of health need as illustrated by Richard: “when I rang them up they said they couldn’t help because I smoked drugs”, which was an experience shared by Bob: “I approached them and they told me that I had to get sober first because I was drinking”. Similarly Tim poignantly described his initial telephone conversation with the IAPT service in which he encountered a prioritisation of health need: “the lady said something to me and it sounded like I wasn’t gonna get any help and then I said look ...you know there are people that are worse but I have a need”. Where prioritisation of health need was encountered by the men who were currently using substances to manage their mental health, these men then sought help from alternative services, namely detoxification and rehabilitation services. The men spoke about how on completion of detoxification treatment they encountered ongoing issues with their mental health and subsequently either re-initiated self-referral to IAPT or sought help via the GP.

GP Communication Style and Responsiveness

For those men that initiated help-seeking through consulting with their GP, it emerged that two disparate approaches to addressing their symptoms were adopted by the men: (1) initiating help-seeking via the GP and openly discussing and focusing on concerns about their mental health, or (2) initiating help-seeking via the GP and focusing on physical health issues. For those men that initiated help-seeking via the GP and focused on physical health issues, the communication style of the GP was critical in facilitating a more holistic disclosure by the men about the extent and nature of their symptoms. This disclosure then resulted in the GP conceptualising the difference noted by the men as a mental health problem. Specifically several of the men spoke about explicitly needing prompting from the GP in the form of the GP asking specific questions about their mental health in order to facilitate them disclosing the exact nature of their symptoms.

Oliver reflected: “the only reason I said anything to me GP was because he asked me how I was, because he asked me how I was feeling....if he didn’t then I wouldn’t be sitting here...I’d still be sitting at home saying I wanna drink, I wanna drink” and
Tim described a similar experience in which the open communication style of the GP facilitated disclosure about his mental health concerns: "my fear was well where do I start? How do I tell this guy? And I sat down and he said explain to me and I started and about two minutes into it I broke down and he just listened and listened and listened". James spoke about a conversation about his mental health being opened up within a routine appointment with his GP: "it was a normal one but it kind of opened it out because I normally keep everything in....and it kind of caught me off guard because I weren't ready for it! As it started going on, I kind of....it kind of really got uncomfortable and sort of...I started to...she broke the wall down basically.....or opened the door, whatever it is.....if I would have known, there's no way she could have got in there" and Barry described framing his mental health concerns within the context of his physical health concerns: "I joined because I had a couple of other little minor things which had been annoying me, nothing to do with what we're discussing today. And I went along, in a typical male sort of way, and said right my toe's hurting, this needs sorting and I'm starting to attack myself, and he sort of went, hey hang on a minute and picked it up".

What was apparent within the accounts of help-seeking for these men was that both an open and responsive communication style of the GP enabled the men to disclose the true nature and extent of their symptoms, thus facilitating their symptoms being conceptualised as a mental health problem by the GP. As Tim very eloquently illustrated: "life's about relationships and if there's no trust between me and my GP then how the hell am I gonna get to come and see you".

**Solutions Offered**

For those men who sought help via the GP there was a considerable disparity in the first-line solutions offered to the men to address their mental health symptoms. Several of the men spoke about prior knowledge of available solutions informing their conversations with the GP about their preferred solution. Across the 11 men interviewed the solutions offered by the GP were medication alone, psychological therapy alone or a combination of medication and psychological therapy.
Medication as a solution

Several of the men spoke about their GP being “so keen on giving medication” as the first line treatment for their symptoms. Issues of stigma and weakness were raised for the men through medication being prescribed as a solution to their mental health problems. Tim spoke about being “very anti-medication because again that’s failing in my mind” and Lawrence similarly spoke about perceiving medication as a weakness: “the first time was here’s some drugs and even though I’ve had low mood before I’ve never really wanted to try any sort of anti-depressants because they have....I thought I was pretty much in control of my mental health, I suppose I thought they were for weak people, there’s sort of a stigma attached to them”. Geoff spoke about issues of stigma that were brought up for him through being prescribed medication by his GP: “and then they put me on anti-depressants, which, you see again the taboo of being on anti-depressants” and John described his experience of being prescribed medication to manage his symptoms: “I went to the Doctor and she said right yeah I’d had a breakdown and gave me some Diazepam which was almost indistinguishable from having a breakdown as far as I could tell, so I took it for a couple of days and then knocked it on the head and then she put me on Citalopram for a while”. Paulo found it difficult to make sense of being offered medication as a solution to his symptoms: “I couldn’t understand what was happening...the words you know anti-depressants....I was given the medication as the most normal thing...the only explanation a GP may give is oh a third of people take this...so it’s a green ticket... they are immediate.....you can go to the pharmacy and ‘pap’ you get your fix”.

Richard’s experience of using medication to address his mental health problems was positive, however similarly to the other men he also spoke about initial concerns and preconceptions about medication as a solution: “I was more worried about...taking something like that because I’d never...obviously I’d smoke anything and put anything up my nose and that, but obviously when it came to them tablets I’m more worried. I dunno...because I’ve had an ex-girlfriend and her mum was like stuck on pills and she wouldn’t leave the house and all that, so....I used to see her and think well I don’t wanna be like that”. Whilst a conversation with his GP about medication as a solution occurred for Barry, rather than being offered medication as the first line
solution to address his mental health, Barry “raised them as a potential but said at that point I was reluctant in the first instance to do that”. For Barry, psychological therapy was a more acceptable and less threatening solution to address his mental health, as was also the case for several of the other men as illustrated below.

What emerged within the accounts of several of the men when talking about medication being prescribed as a solution was the view that medication was a “quick fix” but short-term solution. Lawrence spoke about his experience being that anti-depressants “seem to be prescribed as a stop gap between people getting the help that they should do...should get. And sometimes they’re prescribed to people and that’s all people do, so they’re not actually getting to the bottom of their problems or sorting themselves out, they’re just on a drug which is hiding the symptoms of how they’re actually feeling”.

**Psychological therapy as a solution**

Both Tim and Howard spoke about requesting psychological therapy as a solution from their GP. Tim spoke about perceiving psychological therapy as a more acceptable solution than medication due to being “the type of person not to take tablets for anything because it’s chemical, it’s not gonna....it’s just patching it up”. Howard similarly spoke about requesting psychological therapy from his GP to address his mental health problems: “I said to her I’m not being funny but I’m taking it out on my partner and I’m getting more and more irritable, I need something done...I need therapy or something... she said what we’ll try and do is get you on to anger management if we can....I said that’d be superb if you can do that”. Barry spoke about his awareness of different treatment options informing his thinking with the GP around the solution to address his symptoms: “I know that there are other kind of SSRI type of tablet treatments and there’s also CBT and things like that, which I said I was more in favour of”. Following psychological therapy being directly requested by the men or offered by the GP as a solution to address mental health symptoms, the pathway into the IAPT service differed depending on whether the men were referred directly by the GP or encouraged by the GP to self-refer to IAPT.
Cognitive Evaluation of Solution Acceptability

The men engaged in a process of cognitive evaluation of the acceptability of the solutions offered by the GP to address their mental health. The acceptability of the solutions offered was informed by issues of stigma and how well the solution integrated with or threatened notions of masculinity. Talking about his experience of being prescribed medication as a solution to his symptoms, Paulo described: "the medication it put me....it did scare me a lot...I didn't take it for a very long time....I did not use it...or if I did I suffered feeling so bad that I thought no" and when offered psychological therapy as a solution by his GP, John described how he was "absolutely I am not doing that....and it's not that I'm a particularly macho tattooed bloke who sets great store by what you have to do to be a real bloke, but I just really didn't want to do that. That just wasn't how I sort of saw myself I guess.....not necessarily myself as a man but it just wasn't how I saw myself. I think that's probably reasonably common in blokes". This cognitive evaluation of the acceptability of the solution(s) offered generally resulted in the men engaging with the solution which was both the least stigmatising and least threatening to their self-concept.

Ongoing Monitoring of Solution Effectiveness

For the men that were prescribed medication as the first line solution for their symptoms, a process of ongoing monitoring of the effectiveness of this as a solution for addressing their mental health by themselves and externally by others was undertaken. As illustrated by Lawrence, these men spoke about their symptoms not adequately being addressed by the initial solution of medication: "I didn't do anything for two weeks, hoping that the drugs would actually do something, make me feel better. I wasn't feeling any better, if anything I was feeling worse because I wasn't having any good days at all, so my flat-mate again took me back and came in with me....and explained what was happening. And that's when my normal GP put me onto the health and wellbeing". Geoff also spoke about his experience of questioning the effectiveness of medication to address his symptoms: "when you hear of people being on anti-depressants you just think they're like a happy pill, and you take them and you're like wahay...you know....everything's great! But it wasn't, and I was sitting there thinking right are they really working? So after that my
Doctor referred me to the mental health services". For John, having outsider monitoring of the effectiveness of the initial solution played an important part in recognising that his symptoms were not being adequately addressed by medication: "my girlfriend started to say to me you know when you do that thing, you've done it again and it's just not getting any better and I started to realise yeah I am doing that and I don't really know why I'm doing that and I can't really stop it....lots of weird little things that really aren't important but were very important and really starting to impinge on getting through the day and I think my girlfriend pointed that out and after having been on the Citalopram for a while I had enough perspective on it to go yeah that isn't right, I do need a bit of help here so I went to the GP". For all of these men, acknowledging that their mental health was not being adequately addressed by the initial solution resulted in the men re-appraising psychological therapy as a solution to address their mental health symptoms.

Cognitive Shift
For the men for whom medication was perceived as the least threatening solution to address their mental health, an internal cognitive shift had to occur in order for psychological therapy to be considered as an acceptable alternative solution to address their mental health. This cognitive reappraisal of psychological therapy occurred in the context of medication not adequately addressing mental health symptoms. Paulo spoke about initially feeling that "counselling was something that you do not need" and then went on to talk about a cognitive shift in how he perceived psychological therapy as a solution to address ongoing symptoms: "it can't hurt [laughs]....you know you start to think that it can't be that bad....I guess it's um...it's um.....I was quite....just very curious....and um...maybe I....yeah I did start to believe that maybe talking to someone would be a good idea". Similarly John spoke about experiencing a cognitive shift in how he came to think of psychological therapy as an acceptable solution to address his mental health: "I was grappling with it for ages. I just got to the point where I was like it's okay to ask for a bit of help...I was like fine...I don't feel weak but I do feel unable to change whatever is going wrong here...I don't have enough understanding of what it is, but I can't get past that so I need...I don't know, by that point I just thought yeah help is fine. It doesn't have to reflect badly on me, it doesn't have to be the source of judgment, whereas I think
early on I was judging myself”. Geoff spoke about it being “hard to kind of actually open your eyes and think that you know I do need help. I have got mental issues. So that’s...I suppose that’s admitting it to yourself in a way, to take the next step”. Realising that their symptoms were not being adequately addressed by medication resulted in the men shifting cognitively to perceive and seek out psychological therapy as an alternative solution to address their mental health symptoms.

Perceptions of Receiving Help
Reflecting back on their experiences of help-seeking and of accessing mental health services, several of the men spoke about getting help for their mental health problems being “a slow process to get the help that you need”. Lawrence and Paulo’s experience of help-receipt from the primary care mental health services are captured as a “lack of support” or “very little help in between”. Several of the men also spoke about having learnt through their experiences with the IAPT service that exaggerating symptom severity would enable more prompt help-giving from professionals in the future. Bob disclosed that “a friend was always saying.... say you’re hearing voices in your head so they’ve gotta put you on a mental health programme” and exaggerating symptom severity in order to get mental health needs addressed more promptly was also spoken about by Lawrence: “If I spoke to somebody and they said I’m feeling down, I’m feeling depressed, I would say go to your GP, tell them that you’re going to kill yourself and then you might get help quicker.... I now know the answers to tick to get seen quicker if I want help. So you know, if you say you’re going to harm yourself then you’ll get help quicker, which isn’t the way to think but I also didn’t want to wait you know seven months”.

Across the accounts of the 11 men interviewed most of the men spoke about having a positive experience of receiving help from the IAPT service once they had been seen for psychological treatment, with several of the men saying that they would recommend men utilise mental health services as illustrated by Geoff: “I think I could benefit other people now because I did feel, I could see that they needed help. I would actually you know say look you need to ring these people, they’re really good....they will help you....and there isn’t a taboo, you know, they won’t think you’re mad. They’re not going to lock you up”. Similarly, Tim spoke about his
experiences of help-seeking informing advice given to others within both his social and professional network: "I have told not only my friends but some of my clients to use mental health practitioners because it's important because some people don't wanna go and see the GP". All the men that had completed treatment with the IAPT service spoke about not having reservations about using mental health services again in the future.

**Discussion**

This research aimed to contribute to the understanding of: (1) men's accounts of psychological distress, (2) the pathways into mental health services for men between the ages of 35 and 49 years old, and (3) the resources that men employ prior to accessing mental health services. The research was considered important in order to develop a conceptualisation of the journey into mental health services for men between the ages of 35 and 49 years old; an age group that are considered to be particularly at risk with regards to their mental health (DoH, 2012). The research findings will be discussed against the backdrop of the existing models of help-seeking for physical health problems. Particular attention will be given as to how the tentative conceptual model of men’s psychological help-seeking that has arisen from this research converges and differs from the explanatory frameworks for understanding help-seeking for physical health problems. The importance of social support networks, endorsement of masculinity scripts and stigma in psychological help-seeking will be discussed within the context of the model and the findings of previous research. The clinical and research implications arising from this current research will be discussed and a critique of the research will be provided.

From a physical health perspective, explanatory models of help-seeking propose that attitudes towards help-seeking inform an individual's decision to address their physical health needs and thus engage in help-seeking (Glanz et al., 2002; Azjen, 1999). The findings of this current research support the research examining men’s access to help for physical health reasons. Similarly to the explanatory framework provided by the Health Belief Model (Glanz et al., 2002) this research found that men’s perception of the severity of their mental health symptoms alongside their perception of the perceived benefits of engaging in psychological help-seeking impacted on whether they made the decision to self-initiate psychological help-
seeking. For the men, severity of their mental health symptoms was conceptualised in terms of how much control they felt they had over their symptoms and the degree of impact that the symptoms exerted on their functional ability. The men that perceived their symptoms were beyond their internal control and had a detrimental impact on their functioning were more likely to self-initiate psychological help-seeking, particularly in the context of being faced with serious and potentially life-threatening negative consequences as a result of not addressing their mental health. For these men, the perceived benefits of psychological help-seeking played an important part in enabling psychological help-seeking to be self-initiated. The perceived benefits of psychological help-seeking also outweighed modifying variables such as perceived stigma and threats to masculinity that the men thought may occur through engaging in psychological help-seeking. Perhaps the biggest difference when comparing the findings of this current research with the explanatory models for help-seeking for physical health problems is that men appear to be more open to important others facilitating access to primary care mental health services.

**Pathways into Help-Seeking**

This research has highlighted the important role that social support networks do play along the pathway into psychological help-seeking for men experiencing mental health problems. Several of the men interviewed spoke about their experiences of individuals within their social support network dismissing their concerns and encouraging them not to disclose the concerns to others because of the stigma and threat to masculinity that they perceived would occur as a consequence. This process resulted in the men becoming self-reliant and managing their own emotions as well as symptomatic expressions of distress. This in itself prolonged their mental distress and delaying psychological help-seeking. Previous research suggests that men may experience barriers to help-seeking when they perceive other men in their social networks to be disparaging of help-seeking (Addis & Mahalik, 2003; Angermeyer et al., 2001). Clearly for the men interviewed within this current research attitudes transmitted by the social support network played an important part in determining how the men defined and acted upon their symptoms. For the men interviewed, the endorsement of masculinity scripts involving strength and self-reliance both by the men themselves and by men within their social support networks played an important
part in delaying the men from seeking help for their mental health symptoms. However, several of the men also spoke about individuals within their social support network normalising both mental health problems and psychological help-seeking. Some of the men spoke about this process of normalisation and validation occurring through individuals disclosing their own mental health experiences and psychological help-seeking. Several of the other men spoke about help-seeking being normalised through individuals within their social support network encouraging or initiating help-seeking on their behalf which ties in with existing research (Vogel et al., 2007).

Within the extant health literature, delaying or avoiding treatment for minor symptoms and trivialisation of serious symptoms in order to avoid challenges to masculinity have been evidenced as processes undertaken by men in relation to physical illness (O’Brien et al., 2005). This research has highlighted that a threshold of concern needed to be reached either internally by the self or by others within the man’s social support network in order for psychological help-seeking to be initiated. The men who self-initiated psychological help-seeking spoke about two factors that led to a threshold of concern about their symptoms: (1) feeling that the symptoms were beyond their internal control, and (2) the symptoms having a detrimental impact on their ability to function. Surpassing this threshold owing to perceiving that the symptoms were beyond their internal control and the consequent feeling of not being able to function as a result of the symptoms resulted in the men cognitively weighing up the risks of not addressing their mental state. Being faced with one’s own mortality if mental health symptoms were not addressed or being faced with the negative interpersonal, social and occupational consequences that resulted from symptoms being beyond internal control were the risks identified by the men that prompted initiation of psychological help-seeking. For the other men, individuals within their social support network needed to reach a level of concern about the men’s symptoms in order for psychological help-seeking to be initiated on the man’s behalf. For those people surrounding the man, the threshold of concern was reached through noticing the impact that the symptoms were having on the man’s ability to function, alongside noticing that the man was not his “normal self”. Deviation from
"normal self" was conceptualised by the men as becoming socially withdrawn, neglecting personal care or being unable to function at work.

What this current research suggests is that men can suffer chronically with their mental health before psychological help-seeking is initiated. This research suggests that for men to initiate psychological help-seeking both an internal threshold of concern alongside a cognitive evaluation of the risks of not addressing their mental state needs to occur in order for psychological help-seeking to be considered as an acceptable approach to managing mental health symptoms. The findings of this research suggest that compared with help-seeking for physical health problems, the impact of the mental health symptoms are more pervasive before the man accesses help in so far as the symptoms appear to be impacting on the individual’s entire world rather than on one specific domain.

Pathways into IAPT Service

Whilst the accounts of psychological help-seeking of the 11 men interviewed identified commonalities in the processes through which these men came to seek help, what also was apparent was that the pathway into mental health services for the 11 men interviewed was very individual. The accounts of the 11 men interviewed identified that there were three separate pathways into the IAPT service as illustrated visually in the model in Figure 1. The first pathway into the IAPT service involved men making a self-referral to IAPT without consulting with their GP, thus the IAPT service was the first point of contact for these men. The second pathway involved men seeking help via the GP and either being offered medication alongside psychological therapy or requesting psychological therapy from the GP as a solution to address their mental health symptoms. The third pathway involved men accessing IAPT after medication did not adequately address their mental health symptoms. For these men, realising that their mental health symptoms were not being adequately addressed by medication resulted in a cognitive reappraisal of the acceptability of psychological therapy as a solution to address their ongoing mental health symptoms. This cognitive reappraisal then resulted in a cognitive shift in which psychological therapy was considered as an alternative or additional solution to address their mental health, with the men making an active choice to seek psychological therapy.
The disparity in the pathways into the IAPT service for the men interviewed appeared to occur as a result of several factors. Strong endorsement of masculinity scripts by the men delayed seeking psychological therapy due to the threat psychological therapy posed to their self-concept and internal notions of maleness. Prescription to masculinity scripts ties in with existing research which suggests that masculine gender role conflict is consistently inversely related to men's willingness to seek psychological help (Mahalik et al., 2003). Looking specifically at types of masculinity scripts, men who endorse restrictive emotionality and endorse scripts of power, success and competition appear to be more reluctant to seek psychological help, with endorsement of such scripts being correlated with negative attitudes toward psychological help-seeking (Good, Dell & Mintz, 1989; Robertson & Fitzgerald, 1992). Several of the men interviewed for this research spoke about internalised masculinity scripts creating barriers to psychological help-seeking as a result of psychological help-seeking being seen to violate masculine gender roles. The process of seeking help "implies dependence, vulnerability or submission to someone with more power" (Mahalik et al., 2003, p. 127) and admitting to suffering with mental health problems may leave men feeling threatened by feelings of helplessness and loss of power; feelings which directly contradict masculinity scripts that endorse independence and invulnerability (Addis & Mahalik, 2003). With the increasing 'feminisation' of psychology in which 72% of psychologists are women, the experience of considering and taking part in ongoing therapeutic work with typically a woman could be thought of as challenging to men's notions of masculinity (Cynkar, 2007).

Co-morbid substance misuse also emerged as a factor determining the pathway into the IAPT service for several men. For those men who used substances to manage their mental health symptoms, having to navigate other services to address their substance misuse prior to gaining access to IAPT emerged as a critical process to navigate. This in itself led to a protracted period of time between initiating help-seeking and receiving help from the IAPT service, with the men speaking about an exacerbation of their mental health symptoms occurring between accessing an alternative service and gaining access to the IAPT service. It has been advocated that treatment for substance abuse should be integrated into existing mental health
services (DoH, 2002). Whilst service users report the need for a single provider who can be trusted to understand and address both mental health and substance abuse problems when they coexist, the findings of this research suggest that the existing separate treatment for mental health and substance abuse provided within primary care mental health services delivers fragmented care (Drake & Wallach, 2000). Furthermore, the fragmented nature of care provided for co-morbid mental health and substance abuse disorders may result in men’s mental health needs being missed if they are required to address their mental health needs separately to their substance abuse.

Finally, the solutions offered by the GP also had a clinical impact on the pathways into the IAPT service for the men interviewed. For those men who requested psychological therapy from their GP or were offered psychological therapy alongside medication, entry into the IAPT service occurred over a less protracted period of time. However, for those men for whom medication was offered as the first line treatment and for whom medication was viewed as the least threatening solution to their self-concept and masculinity, entry into the IAPT service occurred over a longer period of time. Research suggests that GPs can fail to recognise depression and anxiety within routine consultations and that failure by the GP to consider mental health problems as an underlying cause for symptoms can routinely occur within GP consultations with patients (Kendrick, King, Albertella & Smith, 2005; Ormel et al., 1990). Factors that appear to be related to poor detection of mental health problems within routine GP consultations include the presence of physical illness or somatic presentation, inadequate training in the diagnosis and management of mental disorders, short consulting times and poor communication skills (Howie, Porter, Heaney & Hopton, 1991; Millar & Goldberg, 1991; Pearse & Neary, 1994; Wright & Perini, 1987). What this current research has illustrated is that the communication style of the GP and the extent of the GP’s knowledge of the man’s background and personal history were positively associated with the ability of the GP to recognise the presence of mental health problems within the men. This was particularly the case for the men who spoke about approaching the GP and focusing on their physical health symptoms. These men spoke about needing explicit prompting from the GP in the form of the GP asking them specific questions about their mental health in order
for them to disclose the nature and extent of their mental health symptoms. The men spoke about the GP playing an important role in determining the extent to which their mental health needs were met and this research has highlighted that GPs act as a critical gate-keeper into primary care mental health services.

**Overcoming Barriers to Receiving Help**

Despite the chronic nature of suffering with their mental health, the strength and resilience of the men interviewed was striking. What was apparent was the men's resourcefulness in finding ways to self-manage the mental health symptoms they experienced. Furthermore, as the men spoke about their accounts of psychological help-seeking and experiences of accessing IAPT services, their resilience and determination to gain help for their mental health once they had accepted the need to access psychological help was apparent. This was particularly notable when the men spoke about encountering prioritisation of health need by the IAPT service. The men were often faced with long waiting lists for psychological assessment and intervention which can be barriers to successful engagement with receiving help (Redko, Rapp & Carlson, 2006). Despite encountering a delay in receiving help from the IAPT service and experiencing it as a long and slow pathway with “little help and support in-between” the men interviewed all remained engaged with pursuing help from the IAPT service for their mental health symptoms. This suggests that once psychological help-seeking had been initiated, either by the self or others, the men made a psychological investment and commitment to themselves to address their mental health needs.

**Clinical Implications**

This research supports the important role of the GP in screening for and identifying mental health problems such as anxiety and depression in men presenting to primary care services. GPs continue to be criticised within the literature over inadequate recognition and management of mental health problems within primary care services (Kerwick, Jones, Mann & Goldberg, 1997). A range of GP and practice factors contribute to the under-recognition and less than optimal management of depression in general practice. GP factors include inadequate GP knowledge and skills in working with mental illness, whilst practice factors include inadequate consultation
time and insufficient access to specialised mental health resources (Richards, Ryan, McCabe, Groom & Hickie, 2004). This research evidences how easily mental health problems can be missed within primary care services if the communication style of the GP does not involve asking direct and specific questions about men’s mental health status within routine appointments. Choosing to focus on physical health symptoms rather than concerns about their mental state was a strategy adopted by several of the men in their contact with the GP. This finding indicates that there is a need for GPs to consider the possibility of the presence of mental health symptoms when men present with physical health symptoms, particularly where there may be repeated presentations within primary care.

GPs with a declared interest in mental health and who have obtained mental health training appear more likely to provide appropriate mental health assessment and treatments (Davenport, Hickie, Naismith, Hadzi-Pavlovic & Scott, 2001). Additionally, those GPs who have a better conceptual understanding of mental illness and an interest in psychological medicine seem to produce a more accurate diagnosis of the patient’s condition (Marks, Goldberg & Hillier, 1979). Given their training in mental health assessment, the findings of this research lay out an important role for clinical psychologists in supporting and where indicated, providing training to GPs on the integration of standardised mental health screening tools within their clinical practice. Furthermore, this research suggests that providing training to GPs on the subtleties of how men may present with mental health problems (i.e. through somatic complaints) would be beneficial, particularly given that some GPs lack confidence in assessing and treating mental health disorders (Ross & Hardy, 1999).

This research found that men’s perception of the severity of their mental health symptoms alongside their perception of the perceived benefits of engaging in psychological help-seeking impacted on whether they made the decision to self-initiate psychological help-seeking. For the men, severity of their mental health symptoms was conceptualised in terms of how much control they felt they had over their symptoms and the degree of impact that the symptoms exerted on their functional ability. The men that perceived their symptoms were beyond their internal
control and had a detrimental impact on their functioning were more likely to self-initiate psychological help-seeking, particularly in the context of being faced with serious and potentially life-threatening negative consequences as a result of not addressing their mental health. At a clinical level this research supports a need to address the threshold level that both men and those who have close relationships with the men need to reach in order for psychological help-seeking to be initiated. Reducing this threshold level will be important in helping to reduce the level of self-harm that men will endure prior to seeking psychological help.

Across all of the men interviewed, their social support network played an important part at different points of their pathway into psychological help-seeking and into accessing the IAPT service. The men spoke about social support networks either being disparaging or encouraging of psychological help-seeking. Those individuals within the men's social support network who had personal experience of mental health problems were more encouraging and normalising of psychological help-seeking. The pivotal role that the social support network played in these men's pathways into help-seeking and into the IAPT service raises interesting implications at a community psychology level. Social support has been conceptualised as guidance and feedback provided by others which enable a person to emotionally master a stressful life episode (Leavy, 1983). Four types of support behaviours have been identified: (1) emotional support which involves caring, trust and empathy, (2) instrumental support which includes helping others to do things, (3) informational support which includes giving information or teaching a skill which can provide a solution to a problem, and (4) appraisal support which involves information that helps an individual to evaluate their own behaviour (House, 1981).

Several of the men spoke about the need for psychoeducation about mental health problems at a community level, with the view that psychoeducation would facilitate greater awareness and understanding of mental health problems, in particular anxiety and depression, thus impacting on social support behaviours. Integrating psychoeducation on emotional distress and its variable presentation with regard to gender and mental health disorders into the school curriculum on a national level would, through familiarisation, normalise mental health experiences at both an
individual and systemic level. Psychoeducation about mental health problems through school curricula and the media was conceptualised by several of the men as an important intervention that may enable earlier identification and treatment of mental health disorders in men. Given the pivotal role that the social support network played for these men in their pathway into psychological help-seeking, this research has illustrated the importance for clinicians of thinking systemically about how to harness the power and influence of social support networks in helping to promote and intervene where there may be concerns about men’s psychological wellbeing.

Within the accounts of psychological help-seeking, this research found that for most of the men interviewed, the idea of psychological therapy as a solution to address their mental health symptoms presented a significant threat to their notions of masculinity and self-concept. At the start of the help-seeking process, the idea of needing psychological therapy was perceived by the men as “a crutch” that represented “weakness”. Over time, symptoms not being adequately addressed by medication resulted in several of the men engaging in a cognitive reappraisal of psychological therapy as a solution to address ongoing mental health symptoms. This cognitive reappraisal facilitated a cognitive shift in which psychological therapy was considered an acceptable solution to address ongoing mental health symptoms. This research has highlighted that if psychological help-seeking is to be seen as a viable option for men experiencing mental health problems, the meaning of psychological help-seeking and engaging with mental health services needs to be re-framed at a societal level.

Men addressing their psychological wellbeing, needs to be conceptualised at both an individual and societal level as an expansion of positive masculine qualities and a means to potentially preserve masculinity rather than as a feminisation process (Kilmartin, 2005). This research has suggested that intervening with men at important stages of identity development, such as in adolescence or in mid-life may be fruitful in enabling men to think about and perhaps challenge some of the culturally-bound notions of masculinity. This will be particularly important given that previous research suggests prescription to masculinity scripts can have a detrimental effect on men’s psychological wellbeing, and the findings of this
research that prescription to masculinity scripts both by the men and individuals within their social support network delayed men's psychological help-seeking. Alternatively, at a service level mental health service providers may need to think about how they can increase the congruence between traditional notions of masculinity and the services they provide.

Several of the men spoke about encountering a prioritisation of health need by the IAPT service in which they were either signposted to alternative services due to not meeting the referral criteria or were placed on a waiting list, which several of the men described as being a wait of several months for assessment and treatment. The clinical implications raised here are that potentially men may disengage from the psychological help-seeking process after a protracted and what the men described as "frustrating" period of time of trying to engage with the IAPT service. Several of the men spoke about their experience of receiving help from both the GP and the IAPT service as being a "slow process with little help and support in-between". The men spoke about a lack of signposting to self-help resources by both the GP and IAPT services in between initiating help-seeking and receiving help from the IAPT service, which left the men feeling "in limbo". Importantly, the men interviewed were committed to seeking help and did successfully engage with help. For those men who may be more ambivalent and have less social support, service prioritisation of need and a lack of signposting to self-help resources in between initiating help-seeking and help-receipt are potentially significant barriers to access. As a result, the men spoke about having to continue to find their own ways to manage their mental health symptoms in the time-period between seeking and receiving help from the IAPT service. For some of the men, particularly those men who used substances to manage their mental health, the time period between seeking and receiving psychological help involved an exacerbation of their mental health symptoms. The findings from this research raise clinical implications as to how the mental health needs of men are managed both by GPs and by IAPT services in the period between initiating psychological help-seeking and receiving help from services.

Whilst all of the men spoke positively about the intervention that they received from the IAPT service, it was interesting to note that after their experiences of help-receipt
from the IAPT service several of the men spoke about their belief that exaggerating or falsifying the extent and nature of mental health symptoms would facilitate more prompt help-giving from professionals in the future. Discussions with the IAPT service identified that this perception is erroneous and that prioritisation for help-receipt is not based on symptom severity. Conversely to the men's perception, exaggeration of symptoms is more likely to result in individuals being put on the waiting list for more intensive treatments which can have longer waiting list times. This may suggest that clinicians and service structures are used to considering symptomatology from a feminised perspective in which the severity of men's psychological distress may not adequately be assessed and picked up by services (White, 2006). Consequently, greater consideration to the presentation of male distress may be needed in order to ensure that men's mental health needs are adequately assessed and addressed by primary care mental health services. Clearly there is a need for IAPT services to make the pathway into treatment more explicit to individuals at the point of help-seeking.

**Research Implications**

This research has raised ongoing questions as to what factors inform the self-management strategies used by men to manage their mental health symptoms prior to help-seeking being initiated. Stigma, prescription to masculinity scripts and the social support network were identified to play a significant role in informing men's decision-making around psychological help-seeking. This is in line with men's access to help for physical health conditions. Additionally, one could speculate from the findings of this research that access to self-soothing substances and self-concept regarding masculinities may also play an important part in how men select strategies to manage their mental health symptoms. However, it would be helpful for future research to explore how men come to engage in their chosen self-management strategies, particularly given the findings from this research that the men chose self-management strategies that were harmful to both their physical and psychological wellbeing in the long-term. This avenue for future research would enable a better understanding of men's decision-making processes around self-management strategies used to manage mental health symptoms and may elucidate specific physical and mental health promotion strategies.
This research identified that a number of different solutions were offered to the men by the GP to address their mental health symptoms. There was considerable disparity noted amongst the men’s accounts in terms of the first-line solution(s) offered by the GP to address their mental health symptoms. This research has identified that the solutions offered by the GP played an important part in determining how the men came to access the IAPT service, with the pathway into the IAPT service occurring over a more protracted period of time for the men offered medication as a first-line solution. Examining what informs the decision-making process of GPs around the solutions offered to men to address their mental health will be an important avenue for future research. GP referral decisions appear to be influenced by waiting times and perceived quality of mental health services, with rationing of referrals evident to avoid long waiting times for the client (Knight, 2003). One could hypothesise that the decision making for the GPs that the men came into contact with could have been informed by patient identified need rather than accessibility of talking therapy resources. The perceived adequacy and satisfaction of GPs with regards to their partnerships with mental health services appear to be critical in informing GPs’ attitudes around referrals to mental health services (Schafer, Amoateng & Wrycraft, 2009). It is possible that where psychological therapy was not recommended as a first-line solution, the GPs were protecting the men from a service that they did not value. Having a greater understanding of the referral decisions of GPs may highlight important service issues that need to be addressed in order to influence GP referral decisions and therefore better bridge the gap between GPs and primary care mental health services.

Psychological intervention as a solution to address mental health symptoms presented most of the men with a threat to their notions of masculinity and self-concept. Over a protracted period of time, the men came to conceptualise psychological therapy as a less threatening and more acceptable solution to address ongoing mental health symptoms. This research has highlighted that mental health services offering talking therapies need to think carefully about the materials used to promote talking therapies. In particular this research suggests that promotional materials will need to take into account some of the notions of masculinity that are clearly around for men in current Western society. Understanding what would make
mental health services and in particular psychological therapy more acceptable to men is an important area for future research. Furthermore, better understanding of what informs men’s decision to stay engaged with help-seeking following initiation of psychological help-seeking is needed. Given that for most of the men interviewed, the pathway into the IAPT service was experienced as a “*slow process with little help and support in-between*”, further research needs to explore what enables men to remain engaged with IAPT services once help-seeking has been initiated and also what would be helpful for men in the period of time between psychological help-seeking being initiated and psychological help being provided by IAPT services. Several of the men spoke about feeling “*left in limbo*” following psychological help-seeking being initiated. This will be a particularly important psychological process to understand given the barriers to help-giving, such as IAPT prioritisation of health need and waiting lists for psychological assessment and treatment that were apparent in the accounts of help-seeking for these 11 men. Clearly if we are to prevent men from disengaging from psychological help-seeking and enable men to successfully engage with primary care mental health services further research is needed in order to better understand how to support the mental health needs of men whilst they are waiting to be assessed and treated by IAPT services.

Evidently this research explored the accounts of help-seeking and pathway into IAPT services for men within a specific age range (35-49 years) and for men who could communicate in English. Whilst the research endeavoured to capture the accounts of men across a broad range of demographic factors including ethnicity, socioeconomic status, religion and sexuality, the final sample was mainly limited to men of White British origin who identified themselves as being heterosexual. Given that accessing mental health services appears to be particularly problematic for men from Black and Minority Ethnic (BME) groups (Williams, Turpin & Hardy, 2006) it will be important that future research explores the process of help-seeking and pathway(s) into IAPT services for men across more culturally diverse backgrounds and a wider age range. Additionally, the sexual orientation of the men emerged as a characteristic that exerted an influence on how masculinity was conceptualised by the men. Given that the research sample was relatively narrow in terms of the sexual orientation of participants, it would be interesting for future research to explore whether the
accounts of psychological help-seeking and pathways into IAPT service are strikingly different for gay men when compared with the largely heterosexual sample of men that came forward to participate in this research.

This research identified the important role that the social support network played in the pathways into psychological help-seeking for the men interviewed. This current research indicates that a threshold of concern has to be reached by individuals within the social support network in order for help-seeking to be initiated on the man’s behalf. Further research needs to explore the accounts of psychological help-seeking for those individuals who have been involved in initiating psychological help-seeking on behalf of men. Exploring accounts of psychological help-seeking from within the social network may help us to build up a multi-faceted understanding of the psychological processes that influence psychological help-seeking for men that are particularly vulnerable in terms of their mental health.

**Critical Evaluation of the Research**

This research aimed to explore the accounts of psychological help-seeking and pathway into IAPT services for men across a number of demographic variables. However, the majority of the 11 men that came forward to take part in the research identified themselves as being of White British origin. The findings of the research therefore are transferable to men within the same age range and from the same ethnic background as the men interviewed for the research purposes, but tell us little about the process of psychological help-seeking for men outside the ages of 35 to 49 and from different ethnic backgrounds. Broadening the recruitment strategy to include recruiting through community locations rather than directly through the IAPT service would have strengthened the research.

Sampling men from only one IAPT service raises methodological issues with regards to how applicable the pathway(s) into IAPT services would be for men from other geographical areas. The pathway(s) into IAPT services for men living in rural areas may be very different to the pathways for the men interviewed within this current research, all of whom accessed an IAPT-service based in an inner city. Given the national guidelines for the regional delivery of IAPT services (DoH, 2008), clinically
one would anticipate that the conceptual model of the pathways into IAPT services for the 11 men interviewed would be transferable to other men's pathways into IAPT services. However this remains a hypothesis which recruiting from more than one IAPT service may have helped to answer. It will therefore be important for future research to identify whether the pathway(s) into psychological help-seeking and IAPT services do differ between men living in rural and urban locations.

Given the current focus on service user involvement within adult mental health services (DoH, 1999) this study could have been strengthened by drawing on men's views and expertise across several stages of the research design. Whilst service user consultation was sought on the interview guide and the 11 men interviewed were directly asked for feedback on the emerging model, including men in establishing the research questions and consulting with men at the various stages of data analysis and data presentation may have enhanced the research process and robustness of the model in several ways.

Conclusions

It has been noted that no research has explored in detail whether men's perceptions of masculinity influence their decision-making processes with regards to seeking help when they experience ill health (Galdas, Cheater & Marshall, 2005). This research bridges an important gap in current understanding of how masculinity scripts, stigma and social support networks inform men's decision-making around psychological help-seeking. In terms of understanding how men do come to successfully access mental health services, this research provides a tentative conceptual framework which outlines the journey into psychological help-seeking and IAPT services for men between the ages of 35 and 49 years old. The accounts of psychological help-seeking for the 11 men interviewed raised important clinical implications with regards to training for GPs in how to assess for mental health problems in men presenting routinely to primary care services. Furthermore, important clinical implications at a community psychology level have been raised by this research with regards to: (1) how mental health practitioners can harness the power and influence of social support networks in helping to promote and intervene
where there may be concerns about men’s psychological wellbeing, and (2) how mental health practitioners can work with communities to re-conceptualise men addressing their psychological wellbeing as an expansion of positive masculine qualities rather than as a threat to masculinity.
References


Popay, J., Rogers, A., & Williams, G. (1998). Rationale and standards for the systematic review of qualitative literature in health sciences research. *Qualitative Health Research, 8,* 341-351. doi: 10.1177/104973239800800305


Dear Potential Participant,

I am writing to ask if you would take part in some psychological research. My name is Gemma Webster and I am a second-year Trainee Clinical Psychologist in the Clinical Psychology Department at the University of Surrey, based in Guildford where I am undertaking a three-year postgraduate training programme in clinical psychology to become a Doctor in Clinical Psychology.

I would like to invite you to participate in my research which will be researching how and why men (aged 35 to 49 years old) access services for psychological problems. I’m also interested in finding out what kinds of things men, such as yourself, were doing to manage their problems before they came to the service. We are interested in men of this age because research suggests that men within this age range may find it particularly difficult to access help for psychological difficulties.

The purpose of this letter is to give you the information you will need to help you decide whether or not you would like to participate in the research. Participation in the research is completely voluntary.

The proposed research has been reviewed by London Queen Square Research Ethics Committee who think that the research has paid attention to participant wellbeing and your privacy. NHS Research Ethics Committees in the UK operate in accordance with the Department of Health’s ‘Research Governance Framework for Health and Social Care’ and aim to protect the rights, safety, dignity and well-being of research participants, and facilitate and promote ethical research that is of potential benefit to participants, science and society.

What will I have to do?
I will ask you to come and meet me at either a GP surgery or another site used by the mental health service, for a maximum of 1.5 hours. I will reimburse you on the day for any travel expenses. I will ask you some questions about yourself, the problem that you came to the service to seek help for and your experiences of using the service.

How do I agree to take part?
If you would like to participate in this research or find out any more information about the research then please contact me, Gemma Webster, on within two weeks of receiving this letter.

Along with this letter I have enclosed an information sheet which outlines in more detail what taking part in the research will involve as well as a copy of the consent form which you will need to bring with you to the interview and the list of questions that I will be asking on the day. I hope that there is sufficient information to help you make up your mind regarding participating in the research project but if you have any questions please contact me on the telephone number outlined above.

Thank you very much for taking the time to read this letter.

Yours sincerely

Gemma Webster
Trainee Clinical Psychologist
PARTICIPANT INFORMATION SHEET

Men’s Access to Mental Health Services and Accounts of Help Seeking

Introduction
My name is Gemma Webster and I am a second-year Trainee Clinical Psychologist working in the Clinical Psychology Department at the University of Surrey, based in Guildford. Here I am doing a three-year postgraduate training programme in clinical psychology for a PhD. Before I started my Doctorate in Clinical Psychology I did a Masters in Clinical Forensic Psychology and worked in Child and Adolescent Mental Health for two years. As part of my doctorate in clinical psychology I conduct research with members of the public.

What is the study about?
I am researching how and why men aged 35 to 49 years old come to access services for psychological problems. I'm also interested in finding out what kinds of things they were doing to manage their problems before they came to the service. I hope that the findings from the research will help health professionals to understand how men seek help from mental health services and so help mental health service provision in the future.

Do I have to take part?
No, taking part in this study is entirely up to you. You can contact me on [insert contact details] for further information and I would be happy to answer any queries. Even if you agree to take part, you can choose not to answer any of the questions and should you want to, you can stop the interview at any time. Whether or not you decide to take part in this research, your decision will have no effect on your treatment.

What will I have to do?
You will be asked to meet me in a private room at a local community site for an interview which will last up to a maximum of 1.5 hours. I will reimburse you on the day for any travel expenses. During the interview you will be asked to talk about yourself, why you came to the service to seek help and your experiences of using the service. I will be recording your answers on a recording device (Dictaphone), this will be to remind me what we have discussed and will be used so that I can transcribe your responses into written text.

Once the research interview is complete I would also like to contact you to get your feedback on the findings of the research. This telephone call will not be recorded. In order to contact you to get your
feedback on the research findings I will need written consent from you when you meet with me for the interview that you agree for me to keep a record of a telephone number for you. Your contact telephone number will be stored in a lockable filing cabinet at the IAPT service and only myself and members of the administration team from the service will have access to the contact details. The contact details collected from you for the research purposes will be destroyed once I have contacted each participant to get their feedback on the research findings.

**How do I agree to take part?**

Once you telephone me to express an interest in participating in the research, I will ask you whether you would agree for me to have a contact telephone number to contact you on in order to set up a date and time to meet with you for the research interview, once I have spoken to the service to establish room availability. I will keep a written record of the contact telephone number you provide me and will take the written record of your contact details to Wandsworth Psychological Therapies and Wellbeing Service as soon as possible after our telephone conversation where your contact details will be kept in a secure, lockable filing cabinet at the service.

When you meet me for the interview you will be asked to sign a Consent Form, to say that you have understood what the research is about and that you have had the chance to ask me any questions first. The Consent Form also says that all information about you is kept confidential in accordance with the Data Protection Act 1998.

**Does what I say get shared with anyone else?**

What you say will remain confidential and will be seen by myself. Your name and all personal details about you will be kept anonymous in the study. The research is always supervised by someone senior to me, so my research supervisors will have access to the information about you during the research study. As supervision is to help me ensure I am conducting the research properly and according to ethical guidelines, your real name would not be used during these sessions and I would use a fictitious name to identify you. No other clinical professionals involved in your care will have access to the information you give me during the research.

If during the research interview you tell me that staff within the service have acted in a way which indicates gross professional misconduct, I will have to feed this back to the Service Lead and/or Locality Manager for the service. I will tell you that I am going to do this and will provide you with information on how you can go about making a complaint about the service should you wish to do so.
As part of the research, I may use a professional transcription service to convert the audiotaped recordings into written text. The professional transcription service will be asked to sign a confidentiality statement. The transcriber will not have access to any of your personal identifiable information and will be asked to store the transcriptions on a password protected document before passing them on to me.

The audio-recording of the interview and the transcribed data from the interview will be encrypted, password protected and uploaded to a secure server as soon as possible after the data has been collected and transcribed. All information gathered during this research study will be stored securely in a locked filing cabinet at the University of Surrey, in accordance with the Data Protection Act 1998 and the guidelines set out by the British Psychological Society. All data will be encrypted, password protected and uploaded to a secure server as soon as possible. The consent forms and anonymised transcripts will be kept for 10 years so that any participant, or others, can challenge the data should they wish to do so. Additionally, as the research is being conducted for the award of a doctorate of psychology, the data will be kept to ensure that any challenges to this award can be made. The audiorecordings of the research interviews will be kept for 5 years post publication of the data.

**What happens when the research study is completed?**
Research takes time, often years, to complete. By then you may have forgotten about it! But my supervisors and I will be seeking to publish the findings of the research. Sometimes we present our research findings at meetings (for instance, at service users' and carers' support groups or conferences). Again, all personal details about you will be kept confidential and no-one will be able to identify who you are.

Reports of research are often published in academic journals, which the general public don't tend to see. This piece of research will be completed in May 2013. I can send you a written summary of the research findings if you would like, plus copies of any articles in which the research is published.

**What are the benefits of taking part?**
The research provides an opportunity for you to talk about and reflect on your experience of your problem(s) and of accessing psychological therapies. Changes to health services are based on the findings of research studies. Your input to this research into men's accounts of seeking help for common psychological problems is therefore vital. While you may not see any immediate change or benefit you will be contributing to an important piece of research that
we hope will improve the health treatment and services of others in the future.

**Are there any downsides of taking part?**
You may find some of the questions quite personal. If you find a question too personal or upsetting in any way, you don’t have to answer it. We can also take a break at any time during the interview or decide not to carry on with it. Many people find talking about their experiences can be helpful, but others can find it brings up upsetting feelings or memories. If this happens and you would like some support afterwards, then I can spend some time afterwards with you or you can contact [local collaborator], your Psychological Wellbeing Practitioner or GP within working hours. If you need to speak to someone outside of working hours then you can contact the Samaritans on 08457 909090. However, should you disclose that you or someone else is at risk of harm then I will need to report this to [local collaborator] who is Cluster Lead, or your Psychological Wellbeing Practitioner. This would usually be discussed with you first.

**What if there is a problem?**
If you want to make a complaint or have any concerns about any aspect of the way you have been treated during the course of the research, then you can contact [local collaborator] or one of my university supervisors. Their names are Mary John and Linda Morison and their contact details are provided at the end of this form. Alternatively, to make a complaint you can contact the NHS Trust Patient Advice and Liaison Service (PALS).

**Who is organising and funding the research?**
The University of Surrey.

**Has the research been approved by any committee?**
The study has been approved by the London Queen Square Research Ethics Committee and the University of Surrey Faculty of Arts and Human Sciences Ethics Committee.

Please contact me on the details provided below to ask me any questions.

*Thank you for taking the time to consider participating in this study.
I look forward to hearing from you.*

**Research being conducted by:**
GEMMA WEBSTER
Title: Trainee Clinical Psychologist
Work address: Department of Clinical Psychology, University of Surrey, Guildford, Surrey, GU2 7XH.
Email: g.webster@surrey.ac.uk
Mobile:

**Supervised by:**
**Supervisor's name:** MARY JOHN  
**Title:** Programme Director University of Surrey Doctorate in Clinical Psychology  
**Work address:** Department of Clinical Psychology, University of Surrey, Guildford, Surrey, GU2 7XH.  
**Work telephone number:** 01483 689441  
**Email:** m.john@surrey.ac.uk

**Supervisor's name:** LINDA MORISON  
**Title:** Senior Research Tutor, University of Surrey  
**Work address:** Department of Clinical Psychology, University of Surrey, Guildford, Surrey, GU2 7XH.  
**Work telephone number:** 01483 689439  
**Email:** l.morison@surrey.ac.uk

**Local Collaborator:**  
**Title:** Cluster Lead & Clinical Psychologist  
**Work address:**  
**Work telephone number:**  
**Email:**
Men's Access to Mental Health Services and Accounts of Help Seeking

- I understand that my participation in this research study is voluntary and that I am free to withdraw from it at any time without having to give a reason. Should I withdraw from the study, this will not affect any treatment that I or my family are receiving.

*Please initial in the box to indicate that you have read and understood this statement*

- I have read and understood the Patient Information Sheet supplied and have had the opportunity to consider the information, ask any questions and have had these answered satisfactorily. I have been given a full explanation by Gemma Webster, the chief investigator, about the nature and purpose of the study and of what I will be expected to do. I have been advised about any potential effects on my well-being, and how these can be supported. I agree to let Gemma Webster, the chief investigator, know immediately if I feel distress, discomfort or feel unwell in any way during the research interview.

*Please initial in the box to indicate that you have read and understood this statement*

- I understand that all personal information about me is held and processed in the strictest confidence, and in accordance with the Data Protection Act 1998. I understand that Gemma Webster, the chief investigator, and her supervisors will be seeking to publish the findings of the research and may present the research findings at meetings. I understand that all personal details about me will be kept confidential and no-one will be able to identify who I am.

*Please initial in the box to indicate that you have read and understood this statement*

- I understand that if during the interview I disclose information that indicates that there has been gross professional misconduct by the service then Gemma Webster, chief investigator will have to feed this back to the Clinical Lead and/or Locality Manager for the service. I understand that Gemma Webster, chief investigator, will provide me with information about how to make a complaint about the service, should I wish to do so.

*Please initial in the box to indicate that you have read and understood this statement*

- I consent for Gemma Webster, the chief investigator, to hold a written copy of my telephone number in order that she can contact me via telephone to get my feedback on the research findings. I understand that this identifiable information (name and telephone number) will be stored in a lockable filing cabinet and will be destroyed once all research participants have been contacted for their feedback on the research findings.

*Please initial in the box to indicate that you have read and understood this statement*
I consent for Gemma Webster, the chief investigator, to hold a written copy of my telephone number in order that she can contact me via telephone to set up a date and time for me to meet her for the research interview. I understand that this identifiable information (name and telephone number) will be stored in a lockable filing cabinet and will be destroyed once the research interview is complete.

Name of participant:
Signature:
Date:
Name of researcher: GEMMA WEBSTER
Signature:
Date:
Thank you for coming to meet with me today. As you will be aware from reading the information sheet about the research, we are meeting today to discuss your experiences of accessing mental health services. For some people talking about their mental health difficulties and their experiences of accessing mental health services can be difficult and may bring up strong feelings. If this happens for you at any point during the interview, you can ask me to stop and we can take a break or end the interview if you do not feel able to carry on after a break. If you feel that you need to talk to someone after the interview is finished then the best person to speak to would be [insert name of local collaborator], your Psychological Wellbeing Practitioner (if you have one) or your GP during working hours. You can also contact the Samaritans if you need someone to talk to outside service working hours. The interview will last for a maximum of 1.5 hours and will be audio-taped so that the data can be transcribed into written text. When the data is analysed your responses will be anonymous and it will not be possible to identify you. The research I am doing is part of a larger study looking at how men of all ages think about and come to access services. I will start the interview by asking you a few questions about yourself and then ask you some questions about why and how you came to access mental health services. Before we start with the interview questions, do you have any questions?

Warm Up Questions
1) Can you tell me about the problem(s) that you sought help for from [insert name of service]?

2) How long was this problem going on for before you sought help from [insert name of service]?

Main Questions
3) How did you come to access [insert specific name of service]?

4) What prompted you to access [insert specific name of service]?

5) What kinds of things were you doing to manage the problem(s) before you accessed [insert specific name of service]?

6) Was there anything that you thought about doing to manage your problem(s) but decided against?

7) What was your experience of accessing [insert specific name of service]?
Initial Interview Guide

Thank you for coming to meet with me today. As you will be aware from reading the information sheet about the research, we are meeting today to discuss your experiences of accessing mental health services. For some people talking about their mental health difficulties and their experiences of accessing mental health services can be difficult and may bring up strong feelings. If this happens for you at any point during the interview, you can ask me to stop and we can take a break or end the interview if you do not feel able to carry on after a break. If you feel that you need to talk to someone after the interview is finished then the best person to speak to would be [insert name of local collaborator], your Psychological Wellbeing Practitioner (if you have one) or your GP during working hours. You can also contact the Samaritans if you need someone to talk to outside service working hours. The interview will last for a maximum of 1.5 hours and will be audio-taped so that the data can be transcribed into written text. When the data is analysed your responses will be anonymous and it will not be possible to identify you. The research I am doing is part of a larger study looking at how men of all ages think about and come to access services. I will start the interview by asking you a few questions about yourself and then ask you some questions about why and how you came to access mental health services. Before we start with the interview questions, do you have any questions?

Warm Up Questions

- Can you tell me about the problem(s) that you sought help for from [insert name of service]?

- How long was this problem going on for before you sought help from [insert name of service]?

Main Questions

- How did you come to access [insert specific name of service]?

- What prompted you to access [insert specific name of service]?

- What kinds of things were you doing to manage the problem(s) before you accessed [insert specific name of service]?

- Was there anything that you thought about doing to manage your problem(s) but decided against?

- What was your experience of accessing [insert specific name of service]?
Thank you for coming to meet with me today. As you will be aware from reading the information sheet about the research, we are meeting today to discuss your experiences of accessing mental health services. For some people talking about their mental health difficulties and their experiences of accessing mental health services can be difficult and may bring up strong feelings. If this happens for you at any point during the interview, you can ask me to stop and we can take a break or end the interview if you do not feel able to carry on after a break. If you feel that you need to talk to someone after the interview is finished then the best person to speak to would be [insert name of local collaborator], your Psychological Wellbeing Practitioner (if you have one) or your GP during working hours. You can also contact the Samaritans if you need someone to talk to outside service working hours. The interview will last for a maximum of 1.5 hours and will be audio-taped so that the data can be transcribed into written text. When the data is analysed your responses will be anonymous and it will not be possible to identify you. The research I am doing is part of a larger study looking at how men of all ages think about and come to access services. I will start the interview by asking you a few questions about yourself and then ask you some questions about why and how you came to access mental health services. Before we start with the interview questions, do you have any questions?

Warm Up Questions

- Can you tell me about the problem(s) that you sought help for from [insert name of service]?
- How long was this problem going on for before you sought help from [insert name of service]?

Main Questions

- How did you come to access [insert specific name of service]?
- What prompted you to access [insert specific name of service]?
- What did you want/hope to gain from [insert specific name of service]?
- What was your understanding of mental health services/psychological therapy before you came to access [insert name of service]?
- What kinds of things were you doing to manage the problem(s) before you accessed [insert specific name of service]?
- What did you think of doing to manage your problem(s)? What did you do? What didn’t you do?
- What was your experience of accessing [insert specific name of service]?
- Do you think being a man has made any differences to your experiences?
Thank you for coming to meet with me today. As you will be aware from reading the information sheet about the research, we are meeting today to discuss your experiences of accessing mental health services. For some people talking about their mental health difficulties and their experiences of accessing mental health services can be difficult and may bring up strong feelings. If this happens for you at any point during the interview, you can ask me to stop and we can take a break or end the interview if you do not feel able to carry on after a break. If you feel that you need to talk to someone after the interview is finished then the best person to speak to would be [insert name of local collaborator], your Psychological Wellbeing Practitioner (if you have one) or your GP during working hours. You can also contact the Samaritans if you need someone to talk to outside service working hours. The interview will last for a maximum of 1.5 hours and will be audio-taped so that the data can be transcribed into written text. When the data is analysed your responses will be anonymous and it will not be possible to identify you. The research I am doing is part of a larger study looking at how men of all ages think about and come to access services. I will start the interview by asking you a few questions about yourself and then ask you some questions about why and how you came to access mental health services. Before we start with the interview questions, do you have any questions?

Warm Up Questions
• Can you tell me about the problem(s) that you sought help for from [insert name of service]?

• How long was this problem going on for before you sought help from [insert name of service]?

Main Questions
• How did you come to access [insert specific name of service]?

• Were you aware of what the different treatment options were? i.e. Did GP give alternatives/choices?

• If long waiting list for psychological therapy, did your GP talk with you about what the alternatives were? i.e. were they offered services privately?

• What prompted you to access [insert specific name of service]?

• What did you want/hope to gain from [insert specific name of service]?

• What was your understanding of mental health services/psychological therapy before you came to access [insert name of service]?

• What kinds of things were you doing to manage the problem(s) before you accessed [insert specific name of service]?
- What did you think of doing to manage your problem(s)? What did you do? What didn’t you do?

- What was your experience of accessing [insert specific name of service]?

- What was your experience of speaking with a male/female professional about your problems?

- Do you think being a man has made any differences to your experiences?
Health Research Authority
NRES Committee London - Queen Square
Room 4W/12, 4th Floor West
Charing Cross Hospital
Fulham Palace Road
London
W6 8RF
Telephone: 020 3311 7287
Facsimile: 020 331 7280

26 June 2012

Miss Gemma Webster
Clinical Psychology Department of Psychology,
Faculty of Arts and Human Sciences,
University of Surrey,
Guildford, Surrey
GU2 7XH

Dear Miss Webster

Study title: A Study of the Pathways into Mental Health Services and Accounts of Help-Seeking for Male Service Users.
REC reference: 12/LO/0596

Thank you for your letter of 11 May 2012, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information was considered in correspondence by a sub-committee of the REC. A list of the sub-committee members is attached.

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, subject to the conditions specified below.

Ethical review of research sites

NHS sites

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

Non-NHS sites

Conditions of the favourable opinion

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

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

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.ctfonm.nhs.uk.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

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

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

Approved documents

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

<table>
<thead>
<tr>
<th>Document</th>
<th>Version</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advertisement</td>
<td>2</td>
<td>11 May 2012</td>
</tr>
<tr>
<td>Covering Letter</td>
<td></td>
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</tr>
<tr>
<td>Evidence of insurance or indemnity</td>
<td></td>
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</tr>
<tr>
<td>Interview Schedules/Topic Guides</td>
<td>01/07/11</td>
<td>19 March 2012</td>
</tr>
<tr>
<td></td>
<td>Indicative interview guide (Appendix E)</td>
<td>19 March 2012</td>
</tr>
<tr>
<td>Interview Schedules/Topic Guides</td>
<td>1</td>
<td>11 May 2012</td>
</tr>
<tr>
<td>Investigator CV</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Letter of invitation to participant</td>
<td>1</td>
<td>11 May 2012</td>
</tr>
<tr>
<td>Other: CV of Supervisor Linda Morrison</td>
<td></td>
<td></td>
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<tr>
<td>Other: Participant Recruitment Flyer</td>
<td></td>
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</tr>
<tr>
<td>Other: Indicative Interview Guide</td>
<td>1</td>
<td>11 May 2012</td>
</tr>
<tr>
<td>Participant Consent Form</td>
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<td>19 March 2012</td>
</tr>
<tr>
<td></td>
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<tr>
<td>Participant Consent Form: Participant Consent Form</td>
<td>2</td>
<td>11 May 2012</td>
</tr>
<tr>
<td>Participant Information Sheet</td>
<td></td>
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<tr>
<td>Participant Information Sheet: Participant Information Sheet</td>
<td>2</td>
<td>11 May 2012</td>
</tr>
<tr>
<td>Protocol</td>
<td>1</td>
<td>19 March 2012</td>
</tr>
<tr>
<td>REC application</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Response to Request for Further information</td>
<td></td>
<td>11 May 2012</td>
</tr>
</tbody>
</table>

Statement of compliance

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

After ethical review

Reporting requirements

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

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

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

Feedback

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

Further information is available at National Research Ethics Service website > After Review

List of names and professions of members who were present at the meeting.

"After ethical review - guidance for researchers" (SL: AR2)

Copy to:
Dear Gemma

Reference: 783-PSY-12 (FEO/NRES)
Title of Project: Mens' Access to mental Health Services and Accounts of Help Seeking

Thank you for your submission of the above proposal.

The Faculty of Arts and Human Sciences Ethics Committee has now given a favourable ethical opinion.

If there are any significant changes to your proposal which require further scrutiny, please contact the Faculty Ethics Committee before proceeding with your Project.

Yours sincerely

Dr Adrian Coyle
Chair
Chair’s Action

Ref: 783-PSY-12 FEO/NRES
Name of Student: GEMMA WEBSTER
Title of Project: Mens’ Access to Mental Health Services and Accounts of Help Seeking
Supervisor: MARY JOHN, LINDA MORISON
Date of submission: 03 JULY 2012

The above Project has received a favourable ethical opinion from the NHS and expeditious favourable ethical opinion has now been granted by the Faculty of Arts and Human Sciences Ethics Committee.

Signed: __________________
Dr Adrian Coyle
Chair

Dated: 
Miss Gemma Webster

University of Surrey
Department of Psychology
Faculty of Arts and Human Sciences
University of Surrey
Guildford
GU2 7XH

Dear Miss Webster:

Our ID: 1513/NOCI/2012
TITLE: A Study of the Pathways into Mental Health Services and Accounts of Help-Seeking for Male Service Users.

Thank you for your application to the NHS for research governance approval of the above named study.

I am pleased to inform you that the study has been approved, and so may proceed. This approval is valid in the following Organisations:

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

- NRES Committee London – Queen Square Favourable Opinion Letter (signed and dated 28/06/2012)
- NRES Committee London – Queen Square Provisional Opinion Letter (signed and dated 03/05/2012)
- NHS R&D Form (submission code 96536/352171/14/346, signed and dated 28/06/2012)
- NHS SSI Form (submission code 96536/349720/6/631/180887/250323 signed and dated 02/08/2012)
- Protocol (version 1, dated 19/03/2012)
- Participant Recruitment Flyer (version 2, dated 11/05/2012)
- Participant Recruitment Letter (version 1, dated 11/05/2012)
- Indicative Interview Guide (version 2, dated 11/05/2012)
- Participant Information Sheet (version 2, dated 11/05/2012)
- Participant Consent Form (version 2, dated 11/05/2012)
- Participant Demographic Information Form (version 1, dated 11/05/2012)
- CV for Gemma Webster (unsigned and undated, received on 15/08/2012)
- Email from Gemma Webster with clarifications (dated 03/09/2012)

Your research governance 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.
2. You notify the Consortium Office should you deviate or make changes to the approved documents.
3. You alert the Consortium Office by contacting me, if significant developments occur as the study progresses.

02/10/2012
progresses, whether in relation to the safety of individuals or to scientific research.
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 research governance 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.
6. You ensure that all information regarding patients or staff remains secure and strictly confidential at all times. You ensure that you understand and comply with the requirements of the NHS Confidentiality Code of Practice, Data Protection Act and Human Rights Act. Unauthorised disclosure of information is an offence and such disclosures may lead to prosecution.

Good luck with your work.

Yours sincerely

Research Governance Officer
you need to tell your staff if I say there's a problem and I can sort it out, tell them there is a problem and I'll come and sort it!

I. [laughs]

P11. I said why leave it till you know. It's ridiculous. He said no I'll have a word from her. Made everything? So I mean I was always nice, I wasn't laying off and shouting but yeah ... So I got that sorted.

I. That's good

P11. But yeah, so really all in all it's been a godsend doing that. It's a bit awkward at first, as I say, because you do feel like you've let yourself down, going to see a counsellor, or what other people say, a shrink, or whatever, do you know what I mean, whatever you want to call it. But I would definitely, definitely, if someone else was feeling that down and desperate, I would advise them to go to their doctor to get onto that course because ...

I. Would you?

P11. Yeah I would, 100%. Maybe not the CBT bit ...

I. [laughs]

P11. As I say there's different ones for everyone, so yeah

I. So how long did you ... Because you mentioned about going to your GP this time round.

P11. Yeah

I. How long was the problems with the depression going on before you went to see your GP?

P11. GP? It really got bad. I mean as I say after my daughter died and that, I was up and down but I was masking it with drugs and God knows what else really. But when I knew I was at rock bottom, it

Feel that you have let yourself down going to see a counsellor

Would advise others that were feeling down and desperate to go to Doctor and seek treatment

Problems really got bad
Experienced period of being up and down after daughter died; was masking feelings with drugs
Felt at rock bottom
Was eight to twelve months before

Letting self down by engaging in psychological therapy

Advising others to engage in psychological help-seeking

Symptoms got really bad
Feeling up and down
Masking symptoms with substances
<table>
<thead>
<tr>
<th>Line by Line Coding</th>
<th>Focused Coding</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Actually deciding to go and get help</td>
<td>Chronic suffering with mental health before initiating help-seeking</td>
</tr>
<tr>
<td>• Took a long time before seeking help</td>
<td>Putting expectations on self to be self-reliant and cope without help</td>
</tr>
<tr>
<td>• Engaged in process of soul searching</td>
<td>Got to point of wanting to disclose mental health symptoms</td>
</tr>
<tr>
<td>• Tried to cope on his own</td>
<td>Avoiding disclosure to protect social support network from mental health symptoms</td>
</tr>
<tr>
<td>• Got to a point where he wanted to talk to someone</td>
<td>Engaging in disclosure with friends</td>
</tr>
<tr>
<td>• Did not want to worry family and friends</td>
<td>Having mental health symptoms dismissed by peers</td>
</tr>
<tr>
<td>• Got to the point where he was really closing problems in</td>
<td>Learning to avoid further disclosure to protect others</td>
</tr>
<tr>
<td>• Went to start saying certain things to friends</td>
<td>Being tipped over the edge into help-seeking</td>
</tr>
<tr>
<td>• Chose not to speak to family because they had been through a lot; did not want to put family through anything else</td>
<td></td>
</tr>
<tr>
<td>• Started talking to friends; could see that friends were embarrassed</td>
<td></td>
</tr>
<tr>
<td>• Friends told him that he was alright; friends told him not to be silly</td>
<td></td>
</tr>
<tr>
<td>• Subsequently decided that he would stop talking to friends; did not want to worry friends</td>
<td></td>
</tr>
<tr>
<td>• Felt that he had no-one that he could talk to about all his problems</td>
<td></td>
</tr>
</tbody>
</table>

| Event that tipped him over the edge | |
| Went and saw ex-partner; ex-partner was mother of children | |
| Ex-partner had been through a lot as well | |
| Split up with ex-partner | |
| Friendly now with ex-partner | |

must have been eight months to a year before I actually decided that I needed to go and get help.

I: Okay.
P11: Do you know what I mean? So it's a bit like, okay, I've got no one really I can talk to about this.

I: Mm.
P11: But...

I: So how did you get to that point then, to actually sort of getting through the door in the GP's surgery to...

P11: I actually the thing that kind of tipped me over the edge is I went and saw my ex. like my kid's mother and that and, well she's been through a lot as well, do you know?

I: Mm.
P11: Well I mean we've split up now but yeah. But yeah we're quite friendly now believe it or not.
<table>
<thead>
<tr>
<th>Line by Line Coding</th>
<th>Focused Coding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Would go round to ex-partner's house and drink; feelings would all come out after drinking. Ex-partner said that he needed to go and see someone, ex-partner accompanied him to first appointment with GP.</td>
<td>Acknowledgment by ex-partner of mental health symptoms Told by ex-partner to seek help for symptoms</td>
</tr>
<tr>
<td>Ex-partner told GP that he needed help. Ex-partner left him with GP Facilitate process of telling GP everything.</td>
<td>Ex-partner initiating help-seeking via GP</td>
</tr>
<tr>
<td>Needed that initial someone that knew him. Ex-partner recognised and told him that he was not his normal self and had not been normal self for a long time.</td>
<td>Needing that initial someone to initiate help-seeking on his behalf</td>
</tr>
<tr>
<td>Had though to himself that he was not his normal self; thought that no-one else could see what was going on; recognition that obviously people could recognise changes in him.</td>
<td>Acknowledgement of difference by others</td>
</tr>
<tr>
<td>Engaged in process of blanking a lot out.</td>
<td>Self-acknowledgement of difference internally</td>
</tr>
<tr>
<td>Normal self was someone that was happy go lucky and chatty: normal self defined by always having a smile on face; always tried to sort out other people's problems. Always make sure that everybody else was alright; did not care about himself to same extent as caring about others. Thought that if others were alright then he was alright.</td>
<td>Visibility of symptoms to others</td>
</tr>
<tr>
<td>Happy go lucky nature just disappeared. Was always going out: got to the point.</td>
<td>Blanking symptoms out</td>
</tr>
<tr>
<td>But she's actually turned round and said look ... Because I used to go round there do you know what I mean. I'd have a drink and it would all come out, and she said look you need to go see someone. She come with me the first time actually, to the doctors.</td>
<td></td>
</tr>
<tr>
<td>I: Right. P11: So she come with me and said, look you need help [laughs]. And then she said I'm going to leave you to it doctor, do you know, and then I just told the doctor everything really. So it need that initial someone [sighs] someone that knew me that knew... But she said you're not your normal self, you haven't been for a long time.</td>
<td></td>
</tr>
<tr>
<td>I: Mm. P11: And even though I'd thought that you kind of think that no one else can see that, but obviously they can.</td>
<td></td>
</tr>
<tr>
<td>I: Okay. P11: Because you blank a lot out but....</td>
<td></td>
</tr>
<tr>
<td>I: And what was the normal you like, before all this happened?</td>
<td></td>
</tr>
<tr>
<td>P11: Happy go lucky, chatty, a bit like now really [both laugh]. But I always had a smile on my face. And I was always the one that tried to sort out other people's problems, do you know what I mean? I always made sure everybody else was alright. I didn't really care about myself to that extent; do you know, I was just like well they're alright, that's alright. I'm alright if they're alright.</td>
<td></td>
</tr>
<tr>
<td>I: Okay. P11: Do you know just happy go lucky really. And then it just went. You know I was always going out and then it got to the point where I didn't want to leave the house, do you know what I mean?</td>
<td></td>
</tr>
<tr>
<td>Self-acknowledgement of difference in mental state</td>
<td>Used to putting others needs before own needs</td>
</tr>
<tr>
<td></td>
<td>Self-acknowledgement of difference in mental state</td>
</tr>
<tr>
<td></td>
<td>Becoming withdrawn through mental state</td>
</tr>
<tr>
<td>Line by Line Coding</td>
<td>Focused Coding</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>of not wanting to leave the house.</td>
<td>Noticing deterioration in physical appearance</td>
</tr>
<tr>
<td>Did not want to jump in the bath. Defines self as someone who cares about personal hygiene</td>
<td>Self-acknowledgement of difference in mental state</td>
</tr>
<tr>
<td>Got to the point of not going out, not wanting to have a bath or a shave.</td>
<td>Acknowledging difference in mental state</td>
</tr>
<tr>
<td>Would just sit in the bedroom or lay down.</td>
<td>Acknowledging difference in functional ability</td>
</tr>
<tr>
<td>Asked about concentration problems during assessment with IAPT service.</td>
<td>Questioning mental state</td>
</tr>
<tr>
<td>Started to think about questions being asked of him, recognised that he did have concentration problems Would be watching a film but recognising that the content was not sinking in</td>
<td>Mind being absent from daily life</td>
</tr>
<tr>
<td>Would be unaware at end of film what had happened, would have a total mind blank</td>
<td>Conceptualising behaviour as not hurting anyone</td>
</tr>
<tr>
<td>Was not thinking about anything in particular, just aware of not being there</td>
<td>Shutting self away</td>
</tr>
<tr>
<td>Thought that his behaviour was not hurting anyone</td>
<td></td>
</tr>
<tr>
<td>Shut self away</td>
<td></td>
</tr>
<tr>
<td>Line by Line Coding</td>
<td>Focused Coding</td>
</tr>
<tr>
<td>---------------------</td>
<td>----------------</td>
</tr>
<tr>
<td>Started drinking</td>
<td>Using substances to manage symptoms</td>
</tr>
<tr>
<td>Got to the point with partner’s help of there being a cognitive shift</td>
<td>Reaching a cognitive threshold for engaging in help-seeking</td>
</tr>
<tr>
<td>Ball rolled</td>
<td>Committed to help-seeking once help-seeking initiated</td>
</tr>
<tr>
<td>Never missed an appointment. Recognition that there are people out there that do need the help, defines self as being lucky to get help. Would not abuse help offered. Taking time out</td>
<td></td>
</tr>
<tr>
<td>Felt great telling someone that did not know him about everything</td>
<td>Re-evaluating meaning of symptoms through psychological help-seeking</td>
</tr>
<tr>
<td>Not wanting people to think anything bad about him. Defines self as a good person. Recognises that he has been through a lot of shit</td>
<td></td>
</tr>
<tr>
<td>Everybody makes mistakes. Felt better to offload to someone that was not a family friend or family</td>
<td>Needing to offload outside of social support network</td>
</tr>
<tr>
<td>GP spoke about needing to see someone. Given leaflet by GP. Self-referred to IAPT service. Telephoned IAPT service. Had an assessment on the telephone. Spoke to male adviser. Had a 30 minute interview on the</td>
<td>Signposted to IAPT service by GP</td>
</tr>
<tr>
<td>1. Okay</td>
<td></td>
</tr>
<tr>
<td>P11: And just started drinking, which was silly but yeah, it got to the point where I thought no... Well with my partner’s help, yeah, taking me to the doctor</td>
<td></td>
</tr>
<tr>
<td>1: Okay</td>
<td></td>
</tr>
<tr>
<td>P11: And then the ball rolled and I never missed an appointment or nothing because you know. I mean there is people out there that do need the help and everything and I was quite lucky to get on it. So I wouldn’t abuse anything like that that I was on, that’s why I wanted to come and help now because I know you do a great job. So you know it’s taking time out and ... It was very good, telling somebody that didn’t really know me about everything, do you know, from day one basically to, so up to date. Yeah, and then they don’t, you know what I mean, they can see what you’re saying and ... I don’t like people to think anything bad of me; anything like that, but I know that I’m a good person, it’s just that I have been through a lot of shit and you know ...</td>
<td></td>
</tr>
<tr>
<td>1. Yeah.</td>
<td></td>
</tr>
<tr>
<td>P11: ... everybody makes mistakes. But yeah I just felt better to offload to someone that wasn’t a family friend or family do you know?</td>
<td></td>
</tr>
<tr>
<td>1. Okay</td>
<td></td>
</tr>
<tr>
<td>P11: So that was good</td>
<td></td>
</tr>
<tr>
<td>1. Yeah, so when you went to your GP were you told what the different treatment options would be?</td>
<td>Needing to self-refer to IAPT after consultation with GP</td>
</tr>
<tr>
<td>P11: Mm, well she said about seeing someone, and she gave me a leaflet and everything but that’s how I actually I’d run up, they give you a leaflet and phone number and then you kind of have an assessment on line and the gentleman that I talked to, I can’t</td>
<td></td>
</tr>
</tbody>
</table>
Appendix H
Evolution of Theoretical Categories
<table>
<thead>
<tr>
<th>Early Theoretical Category</th>
<th>Focused Codes</th>
<th>Final Theoretical Concepts</th>
<th>Focused Codes</th>
</tr>
</thead>
</table>
| Chronic suffering with mental health | - Not recognising mental ill-health/distress  
- Minimisation of mental distress | Chronic suffering with mental health | - Having mental health dismissed by others  
- Not conceptualising symptoms as related to mental health |
| Finding own way to manage mental health | - Using substances  
- Gambling  
- Social isolation  
- Work orientation  
- Stopping work  
- Physical exercise  
- Avoiding disclosure  
- Bottling feelings inside | Self-Management of mental health symptoms | - Expressing emotion seen as weakness  
- Turning inwardly to manage symptoms  
- Self-soothing through substances  
- Using physical exercise  
- Changing one's relationship with work |
| Coping strategies cease to be effective | - Exacerbation of mental health symptoms through coping strategies  
- Being unable to function  
- Worsening of physical health  
- Feeling trapped by symptoms | Acknowledgement of Difference | - Self-acknowledgement  
- Acknowledgement by others |
| Recognising extent of mental ill-health | - Realising risk to self  
- Feeling out of control  
- Feeling unable to function  
- Having mental ill-health legitimised by others | Threshold of Cognitive Concern about Symptoms | - Level of Concern to Self  
- Feeling out of control  
- Feeling unable to function  
- Level of Concern to Others  
- Visibility of symptoms to others |
<p>| Life events as | - Facing own | Cognitive | - Facing own |</p>
<table>
<thead>
<tr>
<th>Early Theoretical Category</th>
<th>Focused Codes</th>
<th>Final Theoretical Concepts</th>
<th>Focused Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>trigger</td>
<td>mortality</td>
<td>Evaluation of Risks of Not Addressing Mental State</td>
<td>mortality</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Facing serious occupational, functional and interpersonal consequences</td>
</tr>
<tr>
<td>Cognitive Shift</td>
<td>• Noticing change in self</td>
<td>Cognitive Evaluation of Risks of Not Addressing Mental State</td>
<td>• Facing own mortality</td>
</tr>
<tr>
<td></td>
<td>• Wanting life to be different</td>
<td></td>
<td>• Facing serious occupational, functional and interpersonal consequences</td>
</tr>
<tr>
<td></td>
<td>• Degree of endorsement of masculinity scripts</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Perceived stigma attached to help-seeking</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sense of Responsibility For Own Wellbeing</td>
<td>• Located Internally</td>
<td>Acknowledgement That Difference Concerns Mental State</td>
<td>• Self-Acknowledgement</td>
</tr>
<tr>
<td></td>
<td>• Located in Others</td>
<td></td>
<td>• Acknowledgement by others</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Action by Others</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Self-Action</td>
</tr>
<tr>
<td>Responsiveness from Others</td>
<td>• Responsiveness of social support network</td>
<td>Conceptualisation of Difference as Mental Health Problem</td>
<td>• Conceptualisation by self</td>
</tr>
<tr>
<td></td>
<td>• Responsiveness of GP</td>
<td></td>
<td>• Conceptualisation by social support network</td>
</tr>
<tr>
<td></td>
<td>• Responsiveness of IAPT service</td>
<td></td>
<td>• Conceptualisation by GP</td>
</tr>
<tr>
<td>Solutions Offered</td>
<td>• GP background and theoretical orientation</td>
<td>Solutions Offered</td>
<td>• Solutions determined by GP</td>
</tr>
<tr>
<td></td>
<td>• GP communication style</td>
<td></td>
<td>• Medication as first-line solution</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Medication as quick-fix solution</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>• Prior knowledge of available solutions informing requests</td>
</tr>
<tr>
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</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Early Theoretical Category</th>
<th>Focused Codes</th>
<th>Final Theoretical Concepts</th>
<th>Focused Codes</th>
</tr>
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• Searching for meaning of ongoing symptoms |
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• Re-evaluating notions of masculinity | Cognitive Shift | • Positive reappraisal of acceptability of psychological therapy  
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Appendix I
Examples of Memo-Writing
Understanding How Men Come to Access Help

GPs are an important link in the chain. There appears to be a process whereby men recognise that if their GP does not ask them about how they are feeling or ask questions specifically related to mental health within the consultation, several of the men interviewed said that they would not disclose how they were feeling. It was interesting to note that several of the men went to the GP to discuss issues related to their physical health even though they were currently experiencing symptoms associated with anxiety or depression. Several of the men identified that a conversation about mental health needed to be initiated by the GP in order for them to disclose about the nature and extent of their mental health symptoms. Furthermore those men who initiated help-seeking via the GP have spoke about the important role that the GP plays in the pathway into the IAPT service once help-seeking has been initiated. Specifically, how psychological therapy and medication is introduced and framed, particularly at the first point of contact, makes a difference with regards to the willingness to be open to different therapeutic approaches, namely psychological therapy.

There appeared to be a need for a cognitive shift to happen internally in order for help-seeking to be initiated. In several cases this cognitive shift was brought about through being faced with serious or life-threatening implications to their physical health if they did not address their mental health problems. Two participants described how they coped with their mental health symptoms through heavy alcohol use which in turn resulted in serious implications to their physical health. Faced with the reality that death would become them if they did not address the difficulties underlying their alcohol use, these men described undergoing a cognitive shift in which seeking help for their mental health difficulties outweighed the stigma that they perceived to be attached to help-seeking behaviours as a man. Other men went to speak to their GP and were subsequently prescribed anti-depressants for their symptoms but found that the medication did not adequately address their symptoms. For these men this then appeared to facilitate a cognitive shift from being initially
reluctant to engage in psychological treatment to a position of curiosity towards psychological treatment.

Several of the participants spoke about their help-seeking being initiated by another person, in three of the cases their partner and in one case his flat-mate. I am left wondering what makes the difference between men needing their help-seeking to be initiated by others and what enables men to ask for help of their own accord? Further exploration of the data is needed to see if it is possible to answer this question from the interviews already gathered.

**Barriers to Help-Seeking?**

Several of the men spoke about stigma attached to mental health problems and stigma attached to help-seeking in the context of being a man. Narratives around needing to keep emotions and feelings inside/bottled up and just get on with things emerged within several of the interviews. Narratives around help-seeking being a sign of weakness as a man emerged. For several of the men, the prospect of needing to seek help and engage in therapy presented them with a dilemma in which they were forced to re-evaluate their perception of themselves as an individual and as a man.

Several of the men spoke about needing to change the language they used to talk about their symptoms and mental health experiences particularly when talking with male peers, for example not feeling able to describe the exact extent and nature of how they were feeling and the symptoms they were experiencing. Despite having to change the language used to talk about their mental health experiences, several of the men described how through talking about their experiences with other people they discovered that other people had either been through the same thing or knew someone who had suffered with mental health problems. A process of normalisation of their own mental health experiences occurred through these conversations and interactions with others which led several of the men to the realisation that mental health problems are more common and ‘normal’ than they initially thought. However this appeared to happen after the men had engaged in psychological help-seeking.
rather than before help-seeking was initiated and did not appear to be a contributory process to help-seeking being initiated.

Several of the men spoke about how they would use their own experiences of trying to navigate mental health difficulties to encourage other men to seek help for similar problems and engage in treatment for psychological problems. Several of the men spoke about wanting to participate in the research so that other men would hear their story and not leave psychological help-seeking as late as they did. Two of the men in particular spoke about feeling that their lives had been wasted as a result of not seeking help earlier. I got a sense that for these men it was very much an experiential process whereby they had to go through the process of treatment in order to be able to really grasp and appreciate what it involved. Once they had been through the treatment process the majority of the men would recommend it to other men suffering with similar mental health symptoms that they had experienced.

The Wait for Help

It is interesting to note that several of the men spoke about having to wait for treatment i.e. encountering waiting lists (and in several cases long waiting lists of six to twelve months) for psychological treatment from the IAPT service. I am left wondering why these men were not deterred from accessing help from services in spite of waiting lists? I wonder whether for these men the hardest step is seeking help for their symptoms in the first place? The men have spoken about accepting and not challenging the length of the wait for help-receipt and it has emerged that once help-seeking is initiated for mental health symptoms, whether by the self or by others, there is a commitment made on the men’s behalf to addressing their mental health symptoms in order to move forward with their life.
Memo – Exploring the Role of Disclosure in Help-Seeking

Disclosure has emerged within the men’s accounts as an important process influencing help-seeking. However after initial analysis of five interviews I am left feeling unclear as to how disclosure works as a process to influence help-seeking. There appear to be two separate processes emerging: (1) avoiding disclosure, and (2) choosing to disclose to certain people within the social support network, referred to by one participant as the “circle of trust”. I am unclear from the participants’ accounts at present how the men decide upon who can be defined as this ‘circle of trust’. What are the qualities of individuals within the social support network that men base this decision on?

Questions have started to emerge for me about how the men come to decide to disclose their mental health concerns within their social support network. Looking back at the existing five interviews, disclosure appears to occur as a result of the men:

- Being “freaked out” by their symptoms
- Searching for the meaning of their symptoms
- Framing their symptoms in terms of physical health symptoms i.e. changing the language they use to talk about their symptoms within their support network.

For those men that did speak about making a decision to disclose their symptoms within their social support network, a painful process of having their feelings/mental health symptoms dismissed or minimised by individuals within their social support network occurred. Several of the men spoke about how endorsement of masculinity scripts and preconceptions of the meaning of mental health symptoms by individuals within the social support network informed their response to the men’s disclosure. Narratives such as “big boys don’t cry” and being perceived as “crazy” were transmitted to several of the men. This led several of the men to avoid making further disclosures about the ongoing nature of their symptoms within their social support network, thus prolonging the psychological distress these men were experiencing.
Whilst actively disclosing their mental health symptoms occurred for some of the men, other men spoke about avoiding disclosure of their mental health symptoms within their social support network. For these men avoiding disclosure appeared to result from a number of multi-faceted processes. Firstly, endorsement of masculinity scripts and notions of what it means to be a man in modern Western society appeared to influence some of the men’s decision not to disclose their mental health symptoms within their support network. The men also spoke about the implicit stigma that they perceived was attached to mental health problems within society and fear of the social stigma that was perceived to be attached to having a mental health problem appeared to discourage men from disclosing their symptoms within their social support networks. Additionally, several of the men spoke about preconceptions they had about the associated consequences they perceived could occur from disclosure of their symptoms. In particular, some of the men spoke about a fear of being “locked up” or “sectioned” as a result of disclosing their mental health symptoms to others.

Whilst some of the men made an active decision not to disclose their mental health symptoms within their social support network, the accounts they gave of trying to manage their symptoms left me wondering about the visibility of their mental health state to individuals within their social support network without the men actually having to make a disclosure. In particular, some of the men spoke about withdrawing socially to manage their mental health and letting their personal hygiene deteriorate and I wonder whether these observable changes in the men would have served as a behavioural manifestation of disclosure to others, without the men actually having to make a verbal disclosure. I do not know enough about the visibility of their mental health state to others from the accounts of the men interviewed so far and will need to explore this further.
Memo Example of Questioning Accuracy of Theoretical Categories

Looking at the early theoretical category of 'life events as trigger', having re-examined and re-submersed myself again in the data I wonder whether this category adequately and accurately captures the cognitive process that is going on for them men at this stage of navigating their relationship to help-seeking. For example, one of the participants spoke about "not getting any younger and if [he] don't do something now [he'll] be dead in two...[he'd] have been dead in two years probably" whilst another "knew it needed to be done because if [he] pick up another drink that's basically [him] dead...so [he] knew it was either...if there was a danger...there was a danger of picking up a drink...well there still is a danger of picking up a drink without all these little back up things in place". Rather than life events being a trigger the accounts of the men seem to depict a process of cognitively weighing up the risks of not addressing their mental state. Reflecting on the data I think that 'cognitive evaluation of the risks of not addressing mental state' as a theoretical category more accurately captures the cognitive processes that inform the men's attitudes around help-seeking. The accuracy of this theoretical concept needs to be explored in more detail in further interviews.

Similarly further examination of the data collected to date suggests that the theoretical category 'recognising extent of mental ill-health' does not adequately capture the cognitive processes happening for the men on their journey into help-seeking. The men interviewed to date have spoken about realising the risks posed to themselves by their mental health symptoms (i.e. facing their own mortality as a result of chronic substance use to manage their symptoms or constant suicidal ideation), but the men also spoke about their symptoms leaving them feeling unable to function and feeling that their symptoms were beyond their internal control. Some of these men did not appear to have conceptualised these symptoms as a mental health problem and thus 'recognising the extent of mental ill-health' is misleading. Nevertheless the men speak about either themselves or others being concerned by their symptoms and an internalised threshold of concern needing to be reached either by the self or other people close to the man in order for action to be taken to address the symptoms. The theoretical category 'threshold of cognitive concern about
symptoms' fits the processes being described more adequately. Again the accuracy of this theoretical concept needs to be explored in more detail in further interviews.
Qualitative Research Project Abstract

“What is the Publics’ Perception of the Role of Clinical Psychologists in the NHS?”

May 2011

Year 1
Abstract

This study aimed to gain a broad understanding of the perceptions of the general public regarding the role of clinical psychologists in the National Health Service. Four female participants were interviewed using a semi-structured interview schedule. The data were transcribed and subsequently analysed using thematic analysis. Important themes that emerged from the data were that there was a lack of clarity around the professional role of a clinical psychologist. Despite this there was awareness that 'clinical psychologist' is an expert and specialist role, and that clinical psychologists work in a broad range of settings. The participants cited the media and personal experience as the basis of their knowledge. The findings of research of this nature could have important implications on how clinical psychology is promoted to the general public. Limitations of the study are discussed.
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