A Portfolio of Study, Practice and Research

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Volume One

The construction of knowledge: A discourse analysis of psychiatrists' therapeutic repertoires for children with attention deficit hyperactivity disorder.

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Academic section

This section is comprised of five essays written over the three-year course. Four essays cover topics in relation to the core client groups: Adult mental health, people with learning disabilities, children, adolescents and families, and older adults. The final specialist essay covers the cognitive functioning in schizophrenia.
Adult Mental Health Essay

Compare and contrast the effectiveness of cognitive behaviour therapy and systemic therapy in the treatment of eating disorders

URN: 3902129

PsychD Clinical Psychology

Year I (Course 28)

December 1999
Compare and contrast the effectiveness of cognitive behaviour therapy and systemic therapy in the treatment of eating disorders

To investigate the effectiveness of cognitive behaviour therapy and systemic therapy in the treatment of eating disorders, a selection of empirical research evidence shall be reviewed. Comparing and contrasting this evidence will aim to establish effectiveness with different client sub-groups. This may be impacted upon by the principles of theory, therapy, and research methodology utilised by each model. Firstly, however it may be helpful to outline what is meant by CBT, systemic therapy, and the eating disorders.

Fundamentals

The development of cognitive behaviour therapy

The psychological therapies were not perceived as particularly 'scientific' until the movement towards more empirical methods. Through these means, behaviour therapy thrived on the “legitimacy of its foundations in academic-scientific psychology” (Rachman, 1996, pp.4). Throughout the various stages of development, behavioural approaches became increasingly influential as a result of the use of controlled trials (Paul 1966; cited in Hawton, Salkovskis, Kirk, & Clark, 1989).

Although the effectiveness of behaviour therapy grew in acceptance, by the beginning of the 1970s there was some discontent for the model. The mechanistic notions that underlie the approach began to be criticised, for although the techniques were empirically validated, the treatment was often administered in a somewhat prescriptive way. This practice failed to assess the unique qualities and experiences which may make a particular choice of treatment inappropriate for a specific individual (Hawton et al, 1989).

The early successes of behaviour therapy in treating anxiety, were not evident when dealing with depression. The cognitive element in depression began to be considered by
a number of pioneers in this field, including Beck (1967, 1976; cited in Vitousek, 1996). He expressed that a patient's negative thoughts have a central role in the maintenance of depression and that these thoughts needed to be identified and modified. With the success of Beck's work, cognitive therapy gradually merged with behaviour therapy into the model of 'cognitive behaviour therapy' (CBT).

The merging of cognitive and behaviour therapy has led to important advances in treatment. Although there remains some fundamental difficulties in combining these two approaches (e.g. empirical measurement distinguishing between cognitive and behavioural processes), CBT has been applied to a wider range of client groups and used in addressing a variety of psychological disorders.

Indeed, the origins of CBT for the eating disorders can be traced back to Beck's cognitive approach for depression. Clinical observations have often emphasised the relevance of a person's over-valued ideas and beliefs, stressing the "paralysing sense of ineffectiveness, which pervades all thinking and activities of anorexic patients" (Bruch, 1973, pp.254). These methods are frequently combined with some more behavioural stimulus control techniques to help patients conform to the prescribed eating pattern (Mahoney & Mahoney, 1976; cited in Hawton et al., 1989).

The development of systemic therapy

As cognitive and behaviour therapies were beginning to merge, Bateson's (1972) and Von Bertalanfly's General Systems Theory (1968; cited in Partridge, in press) gained support. Contrary to the aspirations of the behavioural psychologists around this time, who were aspiring to legitimise their theory on the foundations of academic-science, Bateson challenged the appropriateness of linear notions of causality which were principally derived from Newtonian physics. Instead, it was argued that there is no objective reality, and that causality is a circular process.
This notion of causality can be clarified in terms of the family systems approach, in which the complete family system is conceptualised as the main target for treatment (Burbatti and Formenti, 1988). The individual within the system who is labelled as having the ‘problem’, is perceived as having been ‘elected’ to present a symptom on behalf of the family. Hence, this ‘first order cybernetic view’ (as developed by the Palo Alto group) illustrates the way in which the system produces symptoms to solve a problem.

Towards the end of the 1970s, this approach further evolved to recognise the ‘observer’ as a part of the system, who could not be placed objectively outside of it. With this emergence of the ‘second order cybernetic approach’ professionals not only described themselves as family therapists but also as systemic therapists (Partridge, in press). To encompass this overlap, the terms ‘family’ and ‘systemic’ therapies shall be used interchangeably for the purpose of this essay.

What are the eating disorders?

There are four classifications of eating disorder in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). Those are bulimia nervosa, anorexia nervosa, binge eating disorder, and eating disorder not otherwise specified. Despite the clinical importance of all of these disorders, this essay shall focus on anorexia and bulimia nervosa. Inclusion of the other eating disorders would be beyond the scope of this essay.

The DSM-IV sets out the diagnostic criteria for these two eating disorders as follows:

<table>
<thead>
<tr>
<th>Bulimia Nervosa</th>
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<tr>
<td>• The essential feature of this disorder is the recurrent episodes of binge eating, with a lack of control over eating behaviour during the eating binges.</td>
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<td>• Together with a preoccupation of body size, other associated features often include; self-induced vomiting, use of laxatives or diuretics, strict dieting and excessive exercise.</td>
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<td>• A minimum of two binge-eating episodes a week over a period of three months are required to make this diagnosis.</td>
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<td>• Persistent self-evaluation linked to ideas about body shape and weight.</td>
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<td><strong>Anorexia Nervosa</strong></td>
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<td>• The primary feature of this disorder is a refusal to maintain a minimally “normal” body weight. This is defined as a body weight which is 15% lower than average for the individual’s age and height.</td>
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<td>• There must also be an intense fear of becoming fat, even though underweight. This is accompanied by a severe restriction in food intake, and sometimes excessive exercising.</td>
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<td>• Disturbance in the way in which one’s body shape, size, or weight is experienced, and an undue influence of body shape on self-evaluation.</td>
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<td>• Amenorrhea in postmenarcheal women.</td>
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### Bulimia Nervosa

**Empirical findings for the effectiveness of CBT in the treatment of bulimia nervosa**

Cognitive behaviour therapy has increasing support in the treatment of bulimia through controlled treatment trials. This treatment method typically reduces the frequency of bingeing and purging by up to 80%, with approximately half of the clients reporting a complete cessation of bulimic episodes (Vitousek, 1996).

One of the seminal studies into the effectiveness of CBT, was conducted by Fairburn, Jones, Peveler, Carr, Solomon, O’Connor, et al. (1991). This study investigated the effectiveness of three psychological treatments for bulimia. Using a pool of 75 participants who were diagnosed with bulimia, the participants were randomly assigned to three groups to receive 19 sessions of either behavioural therapy, cognitive behaviour therapy, or interpersonal therapy. Comparisons of effectiveness were made between all three groups.

The results indicate that there was no reported differences in the effectiveness of these three treatments in the reduction of binge episodes and the alleviation of distressing symptoms. However, the CBT approach is reported to have had a superior effect on concern about weight and shape than either of the other two approaches. The full
treatment package also produced greater reductions in the frequency of vomiting than the interpersonal approach (Fairburn, et al., 1991).

Limitations of the findings
Despite these findings by Fairburn, et al. (1991), several factors may be used to dispute the reported effectiveness of CBT in the treatment of bulimia. A closer look at the randomisation and attrition used for this study reveals that at the outset of the study the patients who were assigned to the CBT group purged more frequently than those who received IPT. The consequence of this mismatch in groups suggests that CBT can not strictly be compared to IPT in its management of vomit reduction. Indeed, the fact that those in the CBT group were self-inducing vomit more frequently at the outset of the study, may be significant. The initial frequency of this symptom may have provided the patient a more tangible measure of their 'improvement' after a number of therapy sessions, which may have contributed to increased motivation and hence further facilitated positive outcomes.

The characteristics of the selected patients may also question the conclusion by Fairburn, et al. (1991), that CBT is superior to both of the other approaches. The reported effectiveness of CBT in the treatment of bulimia nervosa appears to be less convincing after the realisation that only 88% of the participants met the DSM-III-R criteria for bulimia nervosa. Furthermore, 34% of the participants had met DSM-III-R diagnostic criteria for anorexia nervosa in the past, and 76% had previously received treatment for an eating disorder. Many others had received treatment for other psychiatric problems, had misused alcohol, or took illegal drugs. Considering all of these other variables, it becomes apparent that personal history and characteristics may have been more indicative of 'treatment outcomes' than the style of therapy used.

A follow up study one year on (Fairburn, Jones, Peveler, Hope, and O'Connor, 1993) revealed some interesting results. Participants treated with IPT continued to make improvements over the 12 months following the original study and had similar scores to
those in the CBT group on all outcome measures. This finding may have important implications for the effective treatment of bulimia, as, unlike CBT, the method of IPT enhanced treatment gains without addressing food or weight issues directly. Furthermore, the reported differences in the temporal pattern of improvement between CBT and IPT, suggests that each treatment may operate through different mediating mechanisms to achieve its goals.

**Empirical findings for the effectiveness of systemic therapy in the treatment of bulimia nervosa**

Similarities between the interpersonal therapy used by Fairburn et al. (1991) and the systemic model may have interesting implications. Jenkins and Asen (1992) state that systemic therapy is not reliant upon the amount of people being seen, but refers to the theoretical framework adopted in therapy. As in the case of IPT, the systems concept of “family therapy without the family” (Jenkins & Asen, 1992, pp.1) focuses on creating new connections between different patterns of relationships for the patient. Therefore, in IPT, although the patient is being seen individually, as with the CBT approach, the focus of treatment is more context related, rather than specifically focusing on food or weight issues. The results of the Fairburn et al. (1991) study, indicate the significance of contextual factors, as thoroughly addressed in the models of IPT and systems theory. This finding implies that these models are effective in the treatment of bulimia, albeit over a longer time-span than with CBT.
Effectiveness of the approaches within different sub-groups

Other factors which appear to be indicative of treatment effectiveness have become apparent following a study by Russell, Szmukler, Dare, and Eisler (1987). The trial compared family therapy with individual supportive therapy in bulimia and anorexia nervosa. In a controlled trial, 87 patients (57 with anorexia; 23 with bulimia) were randomly allocated to one of the aforementioned treatment groups. The results of this therapeutic trial were that there were no significant differences between the two subgroups of patients (i.e. the anorexic patients and the bulimic patients). Moreover, family therapy was found to be the superior treatment in the younger patients who have experienced a relatively short-term illness. Subsequently, individual therapy led to a more successful outcome with older patients. Unfortunately, a one-year follow up on this trial showed that “a relatively small portion of patients had recovered from their anorexia nervosa or bulimia nervosa” (Russell et al., 1987. pp.1055).

Russell, et al. attribute the effectiveness of the family therapy approach with the younger patients to the family becoming re-empowered. They purport that the family therapy approach stresses the responsibility of the parents in helping the patient regain his/her health. Clinical impressions were that communications between the parents improved, and difficult issues, such as the gradual separation of the ‘child’ from the family became more comfortable to discuss.

However, it is evident from Russell et al. (1987) that using a family systems approach is not as effective as an individual approach for the older clients. The authors explain that this may be because the patient has “relative inaccessibility” to their parents’ efforts, hence minimising the therapeutic effect.

The outcome of this study serves as a warning when attempting to compare different treatment modalities for the eating disorders. It is crucial to delineate different subgroups of bulimia nervosa and anorexia nervosa in all studies. These sentiments are reiterated by
Wilson, Fairburn and Agras (1997), in cautioning against attempting to apply the treatment programme which they developed to all bulimic patients. It is also stated that the CBT approach is clearly not "sufficient for the substantial minority who experience unresolved bulimic symptomatology" (Fairburn & Hay, 1992; cited in Salkovskis, 1996, pp.405).

Anorexia Nervosa

Empirical findings for the effectiveness of CBT in the treatment of anorexia nervosa

There is a noticeable contrast between the extent of evidence of treatment efficacy available concerning the eating disorders. CBT has a number of studies which support its clinical effectiveness in bulimia nervosa, whilst the systems theories have very few. However, this trend is reversed somewhat when applied to anorexia nervosa. Indeed, "the persistent lack of data [from a CBT perspective] is increasingly embarrassing for a modality with a stated commitment to empiricism" (Vitousek, 1996, pp.399).

One piece of research by Channon, Silva, Hemsley, and Perkins (1989) has provided some evidence for the effectiveness of the cognitive behavioural approach in anorexia nervosa. In this study, behavioural and cognitive behavioural conditions were compared to an unspecified treatment group. At the completion of treatment, all groups had significantly improved, although few differences were found between the three treatment conditions.

Limitations of the findings

Although these results are encouraging (Channon, et al., 1989), there were a number of methodological flaws which may have had a bearing on the conclusions of the study. Due to poor participant availability and the use of two alternative treatment groups, each
group only had eight members. Vitousek (1996) also questions the method of CBT used in the trials, identifying a discrepancy away from the model of CBT recommended by Garner and Bemis (1982, 1985; cited in Vitousek, 1996).

The scarcity of empirical research on the effectiveness of CBT in the treatment of anorexia.

Some reasons given for the deficiency of research evidence offered by Vitousek (1996) are for reasons of ‘practicality’. The longer recommended course of therapy for anorexics is reported to increase the likelihood of attrition, resulting in publication problems. Vitousek also expresses some concerns regarding the difficulties in formulating the therapeutic task for the later phases of the intervention.

Concern is appropriate if the model of CBT can only develop its knowledge and understanding through relying on ‘easy and compliant’ clinical groups. Indeed, these sentiments could well contribute to the fragile nature of the alliance between patients and psychologists. This observation is encapsulated by a recovered anorexic who was very familiar with current research practices: “It is difficult not to gain the impression form the literature on anorexia nervosa that individual therapy has been devalued because psychotherapists do not like anorexics and anorexics do not like psychotherapists” (MacLeod, 1982; cited in Salkovskis, 1996, pp.400).

Improving the understanding of such relational issues is of central importance to the systemic therapies. For this reason comparisons with the CBT approach can be made through an evaluation of treatment effectiveness.

Empirical findings for the effectiveness of systemic therapy for anorexia nervosa

Minuchin and his colleagues developed the first conjectures as to the usefulness of family therapy in the treatment of anorexia. Using ‘structural interventions’, Minuchin and his
co-workers aimed to alter the 'dysfunctional' state of the family. This process involved identifying the patterns of family organisations and limiting or encouraging these processes accordingly. For example, if the family accepts alliances between the child and parent which are judged to be harmful by the therapists, then directive interventions are made to reduce this tendency (Minuchin, Rosman, & Baker, 1978). The aim of this intervention is to increase in the bond between the parents as well as placing the children in a more appropriate and stronger sibling subsystem.

Minuchin et al. (1978) used family mealtimes to explore these interactions in an attempt to identify the 'dysfunction' which caused the eating problems. Initially the parents are encouraged to collaborate on what they want their child to eat. The next important step is to ensure that conflicts are not avoided at meal times, thus breaking the habitual pattern of interaction. Having taken responsibility for the symptom, the parents are then believed to be able to form a stronger coalition, and allow the child more room to develop.

This approach to anorexia has produced some very effective treatment outcomes. In a follow up study of 52 adolescents with anorexia, Minuchin et al. (1978) reported a good outcome in 80% of cases. The efficacy of a structural approach in the treatment of anorexia has been supported by a number of other controlled treatment studies (Martin. 1985; cited in Vitousek, 1996; Russell, et al. 1987).

Limitations of some of the fundamental assumptions of systemic therapy

Family therapy, as initiated by Minuchin and his colleagues, can be compared to CBT. Common to both models is the concept of 'dysfunction'. Minuchin et al. (1978) describe the family which comes into therapy as the 'dysfunctional family'. In CBT, Beck (1967, 1976) identified the concept of the formation of 'dysfunctional assumptions' within the cognitive model of depression. Since then Teasdale (1997; cited in Fairburn, Shafron and
Cooper, 1999) has stressed that treatment should aim to replace the dysfunctional mindsets (such as the anorexic identity) with more adaptive ones. Such dysfunctional assumptions are described as a rigid, extreme set of beliefs drawn from an individual's experiences, which are counterproductive (Fennell; cited in Hawton et al., 1989).

The notion that a family (or indeed, an individual) has something 'wrong' with it has been widely criticised as unconstructive. The assumption that there is 'something wrong' in a family solicits the question as to what style of family organisation is 'right' and how 'rightness' can be defined (Jones, 1990). This line of enquiry from the feminist perspective, questions the role of the therapist in the therapeutic process. Feminists have been particularly critical of the approaches which emphasise issues of hierarchy and control within families, and the practices which place the therapist in the role of the 'powerful expert'. This exercise of power in intimate relationships is described as ineffective and unethical, as it conceals the abuse of power by men over women, and by parents over children (Jones, 1990).

Other authors have also expressed strong criticisms of the structural model and the potential abuse of power. Erickson (1988, pp.229) states that "if both the family as a set of persons, and external reality, are excluded as points of departure for analysis, then what ground is there for interpretation of meaning within the system and for intervention?" Erickson's answer to this question is that the structure of relations, their meaning, and decisions about change, are produced by the therapist alone. Considering that there is no objective knowledge of the family's interactive processes, any analysis made by the therapist is an interpretation and "no interpretation is value free" (Steiner, 1986; cited in Erickson, 1988, pp.229). By this rationale, Erickson questions whether therapists "can have a sufficiently God-like perspective to perform the task (pp.229)."

Through these observations, it is apparent that the limitations of a collaborative therapeutic approach are therefore not exclusive to the cognitive behaviour therapist. In
addition to this, perceptions of ‘dysfunction’ and ‘rightness’, would inevitably have implications on how the practitioner perceives outcome effectiveness.

However, the systemic therapies have evolved, absorbing a combination of post modern and feminist ideas. This evolution has seen shifts from structural models through to developments by the Milan associates, and the Maudsley model. These developments have increased the amount of evidence for the effectiveness of a systemic approach in the treatment of anorexia.

Effectiveness of the approaches within different sub-groups

The study by Russell et al. (1987) indicates the effectiveness of family therapy in the treatment of both anorexia and bulimia in adolescent patients who had the condition for less than three years. This group of patients had achieved a mean body weight which amounted to 93% of the mean matched population level. The effectiveness of this approach was still evident during a long-term follow up (Eisler, Dare, Russell, Szmukler, Le Grange, and Dodge, 1996).

The model of family therapy used with adolescent anorexic patients closely resembles the structural model (Dare and Eisler, 1997). However, modifications to the approach have eliminated some of the controversial aspects of the model which have been discussed. Although parental control of the child’s eating is still encouraged, no assumptions are made concerning the ‘dysfunctional patterns’ of family functioning and no attempt is made to reverse such a dysfunction.

Effectiveness of a family versus an individual approach

Therapeutic approaches which have been applied to both the individual, and as the family unit, have advanced our understanding of treatment effectiveness.
Strategies such as the prevention of conflict avoidance within the family, have been criticised by some as harmful. A study (Le Grange, Eisler, Dare, and Hodes, 1992) which has compared the use of a more challenging and confrontational model of family therapy, with a family intervention where the parents and child were seen separately, found that there was no difference in effectiveness. Furthermore, the researchers reported that in families where there were already high levels of expressed emotion (Leff & Vaughn, 1985), for example criticism and hostility, the latter model was more effective. Possible reasons for this outcome are provided by Squire-Dehouk (1993; cited in Dare and Eisler, 1997), whose study identified that there is a counter-productive quality associated with increased conflict, as such conflicts are usually based around feelings of guilt or blame.

In light of these studies, it may be of use to make the comparison between a family therapy approach which utilises the technique of ‘confrontation’ and a cognitive behaviour approach which usually operates on an individual basis. If higher levels of criticism have a detrimental impact on the effectiveness of family therapy for anorexia nervosa (Szmukler, Eisler, Russell, and Dare, 1985; Le Grange et al. 1992), then why does the research evidence fail to establish an individual approach (e.g. CBT), as the favoured intervention for this disorder?

As already discussed (Channon, et al., 1989), CBT may potentially have some very useful strategies for the treatment of anorexia. However, until these are investigated through empirical means there is very little evidence to support the approach. A hypothesised advantage of CBT over the ‘confrontational’ technique used in some areas of family therapy, may be that there would be a reduction in expressed emotion. This treatment comparison has yet to be carried out.

Nonetheless, Robin, Siegel, Koepke, Moye, and Tice (1994) conducted a controlled trial which did compare the effectiveness of family therapy, with an individual therapy (‘ego oriented’). Both treatment approaches were reported to be equally effective. However, the therapist also saw the parents of those in the individual therapy group for sessions
intermittently throughout the treatment programme. Dare and Eisler (1997) report that this study contributes to the compelling evidence supporting the importance of involving the parents in the treatment of anorexia nervosa in adolescents. Whether the parents and child are seen together or on separate occasions, the empirical evidence (Robin, et al. 1994) appears to support the effectiveness of adopting a systemic approach to understand and address the experiences and interactions within the family.

Despite the contrast between the approaches of family therapy and CBT, concerning the volume of evidence for the treatment of anorexia nervosa, it appears to be a little presumptuous to make comparisons between the necessity of parental input to enable an effective intervention. The piece of research carried out by Robin et al. (1994) may have contributed to the understanding of anorexia. The problem is, however, that through using a control group of ‘individual therapy’, which also included sessions with the patients’ parents, it is impossible to make the distinction between the effectiveness of an individual approach, and one that involves the whole family.

Using outcome measure to assess effectiveness

Some concern has been expressed with regards to the methodological issues surrounding outcome measurement. Research in both CBT and systems approaches have often relied upon self-report measures. These measures are believed to be vulnerable to bias and distortion with the anorexic population for a number of reasons (Vitousek, 1996). In an attempt to preserve ego-syntonic (protected) symptomatology, information on the measures may be falsified as part of a defence stance. Conversely, a tendency towards over-compliance may also bias the outcomes. Another factor which may affect the accuracy of the anorexics’ responses is the diminished capacity of cognitive processes as a result of long term under nourishment ( Garner, Rockert, Olmsted, Johnson, and Coscina, 1985; cited in Garner and Garfinkel, 1997).
Also, measuring effectiveness solely on the alleviation of symptoms is not acceptable in respect to family therapy (Wynne, 1988; Orbach, 1985; cited in Dodge, Hodes, Eisler, and Dare, 1999). Although symptom changes in the eating disorders are often associated with psychological well being and social adjustment (Dodge, et al., 1995), it is important to investigate changes in family relationships. Scales such as the Morgan Russell Scale are often used to assess these factors. However, self-report bias may not be eliminated.

Is the evaluation of treatment effectiveness congruous with the principles of theory and practice?

One final, fundamental question needs to be considered to evaluate treatment effectiveness. That is; does the evidence do the therapy justice, and does the therapy do the evidence justice? This question can now be addressed by withdrawing from the security of these evidence-based findings and taking a more objective, macrocosmic perspective of the treatment modalities.

“The field of ‘family’ or systemic therapy has made a paradigm shift from a modernist to a post-modern perspective” (Partridge, in press, pp.179). Postmodernism rejects the modernist perspective, which is based upon the foundation assumptions of the Enlightenment perspective (Grenz, 1996). That is, aspects of reality are placed under the scrutiny of reason and assessed on the basis of that criterion. The perspective puts its faith into human rational capabilities, as scientific principles are adopted to allow the neutral observer to gain expertise in a specific field of endeavour.

Contrary to the systemic approach, the cognitive behaviour therapist places greater emphasis on the ‘scientist-practitioner approach’, a supposition which is more consistent with the Enlightenment perspective. Through CBT’s orientation in positivist epistemology, an academic-scientific approach (Rachman, 1996) is utilised in the integration of theory, research, and clinical practice.
Conversely, the systemic approach claims to have developed post-modern principles (Partridge, in press), in that ‘truths’ are not perceived as theoretical and objective (Grenz, 1996). Foucault (cited in Grenz, 1996) expresses that ‘truths’ are arbitrarily generated by the practices which make it possible. In turn, these truths which form our knowledge-base then produce our reality (Foucault, cited in Grenz, 1996). He goes on to state that science is an ‘ideology’ and when used to generate knowledge, is an act of violence. As a result of these considerations, Foucault collapses practice and theory into each other.

With this in mind, it becomes apparent that there are some anomalies in the systemic methods used to conduct therapy, and the methods used in accumulating evidence of treatment effectiveness. These can be exemplified through the work of Dare, Eisler, Colahan, Crowther, Senior, and Ansen (1995) which makes comparisons between clinical and empirical methods used with anorexia. The authors have concluded that clinical insights could not be proven to be ‘true’, and are less generalisable than the empirical equivalent. These principles appear to directly contrast with the post-modern perspective as outlined by Foucault, in that the conclusions of Dare et al. (1995) have used scientific means to generate ‘truths’ and knowledge. This is the exact process, which has been described as being an act of ‘violence’ (Foucault; cited in Grenz, 1996).

As well as the reliance on empirical means, there are several other factors, which exclude the systemic approach from post-modern principles. Although the systemic approach considers relations between different parts of the system, ‘personal’ diagnoses usually seem to be preferred to ‘relational’ diagnoses. Anderson (1992) argues that this modernist approach is harmful because the DSM-IV (and its emphasis on personal diagnosis) assumes that “psychotherapy is a relationship between an expert who has knowledge and a non-expert who needs help.....this process reduces uncertainty by telling the therapist what he or she ought to do and suggesting how the client ought to change in order to get well (pp.105).”
The incongruity of postmodernism and systemic treatment is reinforced by Erickson’s (1988) assertion that therapists replace the family’s intentions and understandings with his/her own values. This process of ‘systems analysis’ is described to be an act of “mystification and sophistry wearing a mask of science (pp.226)”.

Having considered these points, it is possible to answer the question posed at the beginning of this section. CBT clearly attempts to use scientific principles in its theory, research and practice. Although there are some hazards identified with this approach, the consistency of the model contributes to the conclusion that the evidence does the therapy justice and the therapy does the evidence justice.

However, the incongruity between the systemic approach and post-modern principles, raises some serious concerns about it’s methods of treatment and subsequent effectiveness. Contrary to Foucault’s ideas that the theory and practice are collapsed into each other, the systemic approach appears to have various divisions between philosophy, theory, practice and research methodology. Therefore, the answer to that same question, would be, that the principles of systemic therapy, and the techniques used to accumulate the evidence, are somewhat incongruous. Subsequently, any reported treatment effectiveness would need to be evaluated with these considerations in mind.

Conclusion

In comparison to other clinical populations, there is relatively little evidence for the effectiveness of cognitive behaviour therapy in the treatment of either anorexia or bulimia nervosa (Fairburn; cited in Hawton et al. 1989). Nonetheless, the shift from descriptive to experimental measures has indicated that CBT is as effective, or superior, to any other forms of therapy in the treatment of bulimia.
In spite of these developments, many fundamental issues are still not understood. For example, it is still unclear which cognitions need to be changed for treatment to be successful (Cooper, 1997). A recognition of the differences in cognitive disturbance between bulimics and anorexics, and across the different sub-groups would not only contribute to the theory, but may also provide a means of developing more effective treatment strategies.

Similarly, a number of empirical studies have begun to research the effectiveness of systemic therapy in the treatment of anorexia, and to a lesser extent bulimia nervosa. When applied to anorexia, the model has been shown to be effective with younger people, and those who have suffered for a short duration of time. Despite the conclusions drawn from the research, “the effectiveness of family therapy is no indication that family psychopathology was contributory to the development of the disorder” (Crisp, Norton, Gowers, Halek, Bowyer, Yeldham, et al., 1991, pp.326). Therefore, as with CBT, there is still a limited understanding of the core issues.

As the effectiveness of treatment strategies are increasingly being investigated, some methodological hazards have also become identified. The interpretation of data through the use of self-report measures, has sometimes been viewed as ‘contaminated’ by respondent bias. Likewise, any more qualitative interpretations made by the therapist may be subject to differing levels of distortion.

Research methodology appears to be a somewhat contentious area, especially for the systemic therapist. As the approach continues to develop around post-modern principles, the incongruous nature of the treatment paradigm, and aspirations of empiricism, may have some fundamental implications on evaluating exactly what constitutes an effective intervention.


Learning Disabilities Essay

What is the impact of others’ expectations on the communicative abilities of people with learning disabilities and how might a clinical psychologist work with these issues?

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PsychD Clinical Psychology

Year I (Course 28)

June 2000
What is the impact of others’ expectations on the communicative abilities of people with learning disabilities and how might a clinical psychologist work with these issues?

To begin to appreciate the importance of the communicative abilities of people with a learning disability, it is necessary to value the significance of their interactions with others within their social networks. The very nature of communication, especially in this population, is largely determined by the expectations and reactions of these significant others. To place these issues in context, this essay will attempt to address the theoretical understandings, in the field of communication in learning disabilities, using a number of applied examples. This process may provide the means to illustrate the diversity of the; methods and quality of communication, significant people which comprise the social networks, levels of expectation, impact of these expectations and ways in which a clinical psychologist may begin to address them.

Fundamentals

What is communication?

Standard practice implies that an author should define all of the significant terms in a question before attempting to investigate and debate the meaning of the question. However, one may argue that a standard definition to any question including the word “communication” would fail to address the very meaning of the term.

Communication cannot be simply differentiated between those who are, and those who are not judged to have a learning disability. Indeed, it has been argued that no two people, “disabled” or otherwise can ever share their insulated experiences into a single self-transcendence. “Sensations, feelings, insights, fancies – all these are private and, except through symbols and at second hand, incommunicable...communication between universes is incomplete or even non-existent...words are uttered but fail to enlighten...the things and events to which symbols refer belong to mutually exclusive islands” (Aldous Huxley, 1954, pp.3).
These "mutually exclusive islands" may take the form of the "communicator" and the "addressee". Two (or more) persons in a particular context may attempt to express, interpret and negotiate meaning through verbal or non-verbal means. Van Der Gaag and Dormandy (1994) suggest that non-verbal forms of communication can be said to be "weak communication". They argue that such methods constrain the communication to the "here and now" and are greatly inferior to their linguistic equivalent. Considering the many modes of communication used within both the learning disability and the non-learning disability populations (signs, symbols, music, art, drama, etc), including this very essay, one can challenge any suggestion of such an uni-dimensional approach to communication.

Indeed, the potential chasm between modes of communication, as well as between communicator and interpreter may be illustrated through the use of visual art. If the reader could be encouraged to study the painting below, it may be interesting to consider what the artist was trying to communicate and subsequently what the audience expects the artist was attempting to convey.
An interpretation of Hopper’s message

“Hopper portrays the couple as loving but not necessarily in love. Another interpretation might suggest that she dressed up for the man as a surprise when he came home from work. The playing of the piano gives the painting a sense of motion, but by having the looks as if she has just turned away from the man for a moment to play a note or two to break the uncomfortable silence that was the end result of the man’s focussed reading. It seems that no matter what she does, the man still refuses to acknowledge that she is even in the room. The door may represent new opportunities for the man’s business or the relationship of the couple. The darkness in the side with the man may represent the coldness of men in society, while the brightness on the side of the woman may represent the warmth and compassion of women” (Ungles, 2000, p. 1).
Above, an interpreter attempts to decipher Hopper’s message. This translation may well differ significantly from Hopper’s and even the reader’s. Hence, one can begin to appreciate the impact of an interpreter’s expectations of the communicator and the subjectivity of such an interpretation. A comparison of the emotions engendered when looking at the painting, in contrast to reading the written “interpretation”, may also encapsulate the qualitative differences between modes of communication.

**Communication and learning disability**

Having outlined the impact of different modes of communication as well as raising some issues concerning the subjectivity of interpretation, it is possible to relate the significance of such communications to people with a learning disability. Definitions of a learning disability usually refer to sub-average intellectual functioning, and limitations in adaptive skill areas, which are manifested before the age of sixteen (for details see Dodd and Webb, 1998).

Whilst valuing the need not to use de-humanising labels, there is a defensive act associated with changing a term every few years in the “irrational hope that the irrevocable handicap could go away if its name were changed” (Stokes and Sinason, 1992). With this in mind, the terms “learning disability”, “mental handicap”, and “mental retardation” shall be used inter-changeably throughout this essay.

Adults with a learning disability experience a range of communication problems (Bartlett, 1997). A survey by Law and Lester (1991) found that in a social education centre, 81% of the learning disabled population required support with their communication skills with 9.5% being non-verbal and 5.9% presenting with low comprehension and expression.

So, what is the correlation between mental handicap and communication difficulties? Leudar (1989) asserts that a mental handicap is a tangible mental phenomenon, which is distributed through the process of communication. This standpoint has been developed as some individuals with learning disabilities are said to restrict their levels of
communication or even withdraw altogether in response to difficult communicative interactions and in an attempt to assert personal autonomy in restrictive environments (Leudar, Fraser and Jeeves, 1984, 1987; cited in Leudar, 1989). Hence, the importance for "others" working and interacting with this population to be aware of the complexities of communicative ability and to adjust their expectations accordingly to facilitate maximum development.

The location of communicative disorders

There has been a major shift in the expectations of the communicative abilities of people with learning disabilities since researchers have begun to challenge the individualist perspective, that communication disorders are located within the person (Leudar, 1981; cited in Leudar, 1989). Following the work of Chomsky (1957; cited in Beveridge, 1989), for many decades the acquisition of language was seen as being genetically predetermined and accessible only to those "organically intact people". Not surprisingly, these assumptions led to poor expectations of improvement and few interventions were devised for this population.

These early beliefs, locating the deficit within the individual, led researchers to search for "what is wrong with retarded children", which is said to have blocked our understanding of their behaviour and communication in environmental and social terms (Ryan, 1975; Leudar, 1981; cited in Leudar, 1989). This process also lacked ecological validity as the performance of retarded and non-retarded people was compared on a variety of experimental tasks.

History has seen the "developmental-difference" debate, which is associated with cognitive and language development in mentally retarded children, have a profound impact on what is expected of these individuals and subsequent service provision. Initial stimulus for research in this area was provided by Lenneberg (1967; cited in Kamhi and Masterson, 1989), who stated that there was a quantitative difference between the language of retarded and non-retarded children. This "developmental perspective"
claims that handicapped and non-handicapped children pass through identical developmental stages (e.g. the stages described by Piaget, 1970; cited in Kamhi and Masterson, 1989), but at a different rate and reach a different upper level. Conversely, the "difference perspective" would argue that even when equated for level of development, there are qualitative differences in language between the retarded and non-retarded children.

Support for the qualitative view has emerged from a number of studies, including one by Semmel, Barritt and Bennet (1970; cited in Kamhi and Masterson, 1989). In a task where children were asked to suggest words deleted from a sentence context, the retarded children performed at a significantly poorer level than their mental age matched non-retarded counterparts. This finding led the authors to conclude that there are fundamental differences between the two groups, as the grammatical re-coding ability of the mentally retarded group is less efficient.

Conclusions drawn from such studies have been often been stated as over-simplifications which may detract from the quantitative, "difference" hypothesis. A seminal study by Lackner (1968; cited in Kamhi and Masterson, 1989) developed a "grammar" for each of the five retarded children, with a mental age ranging from 2.8 – 5.9 years. The single grammar which Lackner constructed for each child was compared to investigate the development of grammar from child to child as the mental age increased. Lackner observed how increases in syntactic complexity were related to increases in mental age. This led him to conclude that mentally retarded children are not qualitatively different from non-retarded children as they progress through similar developmental trends.

Limitations of these studies addressing the difference – development issues have led to questioning as to the validity of the results. Factors such as the heterogeneity of the retarded subjects, measures used, and the way in which language and cognitive level were compared, have raised serious methodological concerns. Moreover, this insistence on locating the "problem" of language and communication deficit within the individual, may
suggest that others should not expect the learning disabled person to progress “beyond their means”. This notion is contested within many disciplines, including clinical psychology, as an appreciation of the effect of social and environmental factors are continuing to develop.

From the individual to the social

There has been some recommendations for psychology to reflect upon it’s own practice to recognise and progress from the dichotomy of the universal and the individual familiar to the themes of modernity (for details see Kvale, 1992) whereby “the rootedness of human activity and language in a given social historical context is overlooked” (pp.33). This movement from the individual to the social is evident in the more contemporary developments concerning how communication in learning disability is perceived. The focus has shifted from, why those with learning disability cannot communicate, to how they can. Indeed, the expectations of their potential ability, has been renegotiated with the recognition that the route to overcoming intellectual impairment is through the quality of communicative exchanges (Beveridge, 1989).

One factor reflecting such exchanges is that regardless of a child’s linguistic ability, there is evidence that children will frequently blame themselves for any communication failures (Robinson, 1986; cited in Beveridge, 1989). Indeed, Beveridge, Spencer, and Mitler (1978; cited in Beveridge, 1989) observed how a group of learning disabled adolescents with relatively high linguistic ability would initiate few social interactions, blaming themselves for communication failures. The professional would need to detect this attribution of blame to encourage and facilitate further communicative interactions.

However, a serious concern arises when the professional does not detect how they are “disabling” that individual. This can be exemplified through the study by Newton (1981; cited in Beveridge, 1989), which shows how an interactive process in the classroom appears to devalue the communicative competence of the child with a mental handicap. Newton designed several situations which were problematic for the severely learning
disabled child. Each task relied upon the child communicating to the teacher or another pupil to solve the problem (e.g. asking for a toothbrush to clean their teeth). Newton found that in some respects the handicapped population were more reluctant to make social contact to solve the problems than were their non-handicapped counterparts.

With this evidence, alongside findings by Beveridge and Hurrell (1980; cited in Beveridge, 1989) that over 50% of initiations made by learning disabled pupils were not acknowledged by teachers, it becomes easier to understand why these pupils are reluctant to seek assistance. Furthermore, the teachers were not only fairly ineffective at predicting whether a child would be able to solve one of the problems, but were also less able to say whether a child would communicate his/her difficulty. Perhaps through the limits of communication in this environment, the teachers hold false expectations that those pupils with a learning disability who were able to solve one problem would be able to solve them all. This assumption could have an immense impact on the child accessing the relevant support to augment further development.

The impact of parental expectations on the child with a learning disability is also important in overcoming communicative obstacles. For example, parents of children with Down’s Syndrome are now advised to allow sufficient time for their child to respond to them without overwhelming them with questions, and directives (Wootton, 1989). Buckley, Emslie, Haslegrave, and Provost (1986; cited in Wootton, 1989) suggest that parents let the child lead the communication, encouraging their initiations where possible. This is deemed as important as studies have shown that children with Down’s syndrome initiate vocal communication with their parents half as much as non-handicapped children (Fisher, 1983; cited in Wootton, 1989).

**Experiencing the richness of diversity**

Previously, the point was made that it is necessary to reflect on the practice of psychology to attempt to evaluate effectiveness. A brief oscillation from the research and academic details associated with this subject may ameliorate the understanding of these issues at a
meta-level. For example, whilst considering the disabling effect of expecting children with Down’s syndrome to only be able to manage directive instruction, once again, art can be used to illustrate a point.

Art is employed as a mode of communication. Whereas rational thought has rejected the non-linear, the imprecise and the unpredictable, art in a postmodern world (for details see Kvale, 1992) rejects the idea of a unitary frame of reference. As stated previously, when interpreting a painting (e.g. Hopper’s Room in New York) the audience uses a multitude of perspectives and experiences to attribute meaning or feeling to the piece. Hence, the unitary frame of reference is replaced by a plurality of perspectives leading to a fragmentation of experiences (Kvale, 1992). One fears that substituting a diversity of experiences for the restraints of a uni-modal, directional and functional approach may well have the impact of further disabling people with Down’s syndrome and condemning them to a merely “functional” existence. An awareness of this disabling effect is essential for the clinical psychologist to recognise in order to communicate with all significant others the importance of developing appropriate expectations, which may in turn become integrated into the individual’s education programme.

The individual displaced from the social

The success of integrating a learning disabled person into an environment where communication is effectively reciprocated and the individual is given the opportunity to develop from a plurality of perspectives, can not be generalised to the whole population. The statement posited at the outset of this essay that; “Sensations, feelings, insights, fancies – all these are private and, except through symbols and at second hand, incommunicable...communication between universes is incomplete or even non-existent...words are uttered but fail to enlighten...the things and events to which symbols refer belong to mutually exclusive islands” (Aldous Huxley, 1954, pp.3), may be more literally applied to those people with an autistic spectrum disorder.
The inability to communicate at even the most basic levels are often beyond the scope of the person with autism as they have a profound deficit in their linguistic skills. Autism is believed to involve a primary deficit in pragmatics which is also linked to deficits in nonverbal communication (Fay and Schuler, 1980; cited in Schopler and Mesibov, 1985). These communication problems are described as being one of the main features at the intersection of language and social dysfunction (Schopler and Mesibov, 1985).

Indeed, from early childhood parents may expect their child to attend to them, imitate, or reproduce similar actions. The failure to even catch their child’s gaze may have massive implications on the quality of interactions and the subsequent development of communicative methods (Lord, cited in Schopler and Mesibov, 1985).

To address the issue of a non-communicative child and anxious parents the clinical psychologist needs to detect whether the child is employing any communicative strategies which can be utilised. For example, echolalia (repetitive speech) is now seen by some as a strategy to communicate (Prizant and Duchan, 1981). It has also been stated that although expressive communication may be infrequent in these individuals, as they may not initiate conversation, there is often a fairly high degree of appropriate responding (Hurtig, Ensrud, and Tomblin, 1980; cited in Schopler and Mesibov, 1985).

Furthermore, a technique called “facilitated communication” (Crossley and McDonald, 1980; cited in Bartlett, 1997) has recently been developed for physically assisting people with an autistic spectrum disorder to communicate. This technique involves a non-disabled person holding the finger of the individual with autism whilst they jointly select letters on a keyboard to spell words. Proponents of facilitated communication believe that this method has allowed individuals who were previously thought to be severely autistic, to communicate in a highly effective manner (Bicklen, 1990; cited in Warren and Yoder, 1997). Bicklen concludes that the findings from using this method help to challenge prior assumptions that autism is a social-cognitive disability and suggests that the main problem is expression.
However, there have been some concerns over who is actually doing the communicating. Indeed, there is recent evidence to show that this technique may not fully represent the client, as the facilitator may have a profound influence over the messages which are communicated (Datlow Smith, Haas, and Belcher, 1994). The debate over the use of facilitated communication has highlighted the importance of communication in reducing the impact of a “disability”. Furthermore, it has helped to clarify the danger of such high expectations, as the individual with the communication disorder is further disabled as facilitators (despite good intentions) often manipulate the communications for those who cannot speak for themselves.

From the institution to the community

There has also been an interest in the opportunities for, and quality of, communication in the community when compared to that experienced in institutions. As with the previous observations in schools, the literature does not suggest that it is the physical settings themselves that are psychological variables (Zigler, 1966; cited in Van Der Gaag, 1989), but rather the organisational characteristics. In the case of the institution, residents’ behaviour and skill attainment is largely dependant on the size of wards, the staff/resident ratios, the quality of staff training and the motivation of the residents (Van Der Gaag, 1989).

Leudar (1988) states that the “communicative environment” (Guyette, cited in Van Der Gaag, 1989) of adults with a learning disability often provide inferior opportunities for communicating than those for non-handicapped people. Staff/resident interactions have been found to be less frequent and of a poorer quality with “poor communicators” than with those who were deemed to be more able (McGarry and West; cited in Van Der Gaag, 1989).

There appears to be a direct relationship between how others’ “expectations of non-handicapped individuals can have an important influence on the communication skills
that the handicapped person actually uses" (Van Der Gaag, 1989, pp.222). Indeed, Van Der Gaag's (1989) study into the social environment and communicative competence, illustrated how increased demand in the community encouraged people with learning disabilities to further develop their communication skills. These gains were attributed to the increase in opportunity to use such skills on a day to day basis.

The impact of community discourse
In a return to the position of modernity, which accepts the concepts of a universally accepted norm and the individual as the centre of the world, (the universal and the individual) one can attempt to reassess the impact of the reintegration of those with learning disabilities back into the community. The modern polarity of the universal and the individual has become replaced by "contextual relativism where legitimation of action occurs through linguistic practice and communicative action" (Kvale, 1992). The collapse of meta-narratives in favour of local narratives ameliorates in the contribution to uphold the values of that particular community. Indeed, reality is constructed through social and linguistic means, and on interpretation and meaning of the lived world (Kvale, 1992). This premise is consistent with Vygotsky's (1978) theory of development which asserts that thought occurs primarily as a social discourse and is then internalised.

Therefore, one can only assume that all the time those with learning disabilities are excluded from the community, they can only ever operate outside of the "reality" in which those without a learning disability exist. If this assumption is accepted, the clinical psychologist must be aware when working with the individual who may have only experienced life within a long-stay hospital, that expectations of the individual to share "reality" with the their carers and their peers may be unreasonable. This said, there is a necessity for any approach adopted to facilitate the communication and development of the person with a learning disability, to be realistic about, and sensitive to this remarkable transition.
Sensitivity to alternative modes of communication

Those who work with learning disabled people need also to be aware of the impact of how others perceive "inadequacies of speech" of those with communication difficulties and the subsequent impact on self-image (Keman, Sabsay and Shin; cited in Leudar 1989). A common reaction of carers is to increase the frequency of "other initiated-other repair" (i.e. correctly rephrasing what the other has said), which is believed to negatively affect the learning disabled person's self-image (Sabsay and Keman; cited in Leudar, 1989). Despite the positive intentions of those working with this population, displaying individuals' different levels of competence only serves to reproduce the existence of the handicap (Leudar, 1989).

Processes such as this are believed (Stoke and Sinason, 1992) to contribute to the individual's "secondary mental handicap". This concept describes the learning disabled person as exaggerating their disabilities as a defence against the pain and confusion which is experienced as a result of difficult interactions in society. Sinason (1992) gives examples whereby handicapped individuals are believed to have found the difference between their voices and a "normal" voice so unbearable that they have exaggerated the level of defect. Another example of secondary mental handicap is given, where the "victim of the handicap" reduces the quality of his/her speech to render others incapable of understanding him/her and thus transferring the experience of being "handicapped" to the other party.

Communication through actions

Progressing from the complexities of understanding verbal communications, professionals including the clinical psychologist also need to be aware of the communicative intent of actions. These actions may take the form of "challenging behaviours" which have been defined as; "Behaviour of such an intensity, frequency or duration that the physical safety of the person or others is likely to be placed in serious jeopardy or behaviour which is likely to seriously limit or delay access to and the use of ordinary community facilities" (Department of Health, 1995).
Challenging behaviours have recently been interpreted by many professionals as an effective form of communication where more socially acceptable, appropriate means of communicating are outside the realms of ability for an individual (Durrand and Carr, 1991). A study by Chamberlain, Chung and Jenner (1993) claimed that the less able the client was to communicate verbally, the more likely they were to present with challenging behaviours. Furthermore, the authors state that those demonstrating the most aggressive behaviours received the highest proportion of the staff’s time.

Staff would need to have an awareness of the reinforcing effect of their reactions to these more severe challenging behaviours. Through training, one may begin to improve the staff’s recognition of the early signs of any challenging behaviour and to augment means of more effective communication. An improved quality of interaction may well give the person with communication difficulties an experience of more meaningful communicative exchanges (Bradshaw, 1998). As staff adjust their expectations of why this challenging behaviour occurs, and begin to assist the individual with more appropriate ways of communicating, the person with the “disability” may become more “able” as their own expectations of the effectiveness of alternative means of communication are realised (Bradshaw, 1998).

Likewise, those people who withdraw from communication may also be transferring a message to others. Their quietness may be misinterpreted as contentment but may also signify resentment or fury (Leudar and Fraser, 1985). Failure to identify the purpose of such withdrawal may well exacerbate the individual’s anger which if not addressed may result in more challenging behaviours.

Communication and the interview process
Communication issues are also a serious matter once an individual becomes involved in the legal system. People with learning disabilities are over-represented in the population of those people who are held by the police on suspicion of committing a crime.
Furthermore, many people with learning disabilities are at a higher risk of receiving abuse (Turk and Brown, 1992), and may find themselves being interviewed in order to prosecute the perpetrator.

Considering the seriousness of such matters, professionals involved need to be aware of the dangers associated with expecting the learning disabled person to interview with the same degree of competence that others might. Although there is very little research examining the accuracy of responses given by the learning disabled individual in this context, it has been stated that there appears to be a significant “acquiescence effect” (Sigelman, Budd, Spanhel and Sehoenrock, 1981; cited in Bull and Carson, 1995). Not only were acquiescence rates reported as being exceptionally high, but question answers were found to be especially biased by question structure and wording.

Suggestions which a clinical psychologist can work with in an attempt to avoid false confessions in this population (Bull and Carson, 1995) include; (i) a reduction in the power differential between the interviewer and interviewee, (ii) avoiding the appearance of knowing what happened, (iii) use of open-ended questions and free recall. Currently, psychology has little research to support the effectiveness of these interview techniques. Therefore, one of the major issues in clinical psychology would be to collaborate with other professionals working in the field of communication (e.g. speech and language therapists, those in legal professions) to enhance our ability to acquire accurate information through the use of interviews.

Communication of physical illness

Acquiring accurate information about physical discomforts experienced by people with restricted communication has also presented serious concerns. Indeed, Minihan (1991; cited in Dodd and Bruker, 1999) has identified communication problems as the primary reason why people with learning disabilities often fail to access effective health care. Furthermore, misinterpretation by health care workers about the person’s physical
symptoms may even result in behaviours being interpreted as challenging or self-injurious rather than due to a physical cause (Lawrie, 1995).

Therefore, reliance upon carers to interpret symptoms and communicate on behalf of people with learning disabilities may well reduce the accuracy of information which would directly impact upon diagnosis and treatment (Dodd and Brunker, 1999). This observation, alongside the shift towards community care has led to new expectations that learning disabled people take responsibility for monitoring and improving their own health.

To begin to equip this population with the skills to take this responsibility, clinical psychologists have begun to develop and implement training programmes and communication aids (Dodd and Brunker, 1999). These innovative new ideas appear to have had a positive effect on communicating health concerns, however there remains a paucity of research concerning these issues. Furthermore, expectations to improve skills can not reside with the learning disabled population alone, as GPs will also need to improve their training to be more compatible with this client group (Meehan, Moore, and Barr, 1995; cited in Dodd and Brunker, 1999).

The misinterpretation of sex abuse

Misinterpretation of a person’s experiences of sex abuse may also have serious effects upon health and intervention. With the rates of abuse in the learning disabled population so much higher than that in the non-disabled population (Tahringer, Horton and Milia; cited in Sinason, 1994) the clinical psychologist needs to be sensitive to what the individual is attempting to communicate.

Body language is often used by those with a severe communication disorder to try to relay their plight. The professional may confuse excessive masturbating or eroticised inappropriate behaviour as a part of the handicap, rather than a way of communicating disturbing experiences (Sinason, 1994). The psychologists’ failure to recognise this will
subtly maintain the pattern of abuse as the individual's message is either ignored or interpreted as a psychotic fantasy (Sinason, 1994). Instead, the psychologist always needs to consider the possible impact of abuse on individuals with a learning disability and increase the awareness of these issues to fellow professionals.

**Conclusion**

This investigation has illustrated that although people with learning disabilities are not a homogenous group, there does appear to be some common issues in the development and maintenance of their communication skills.

Possibly the most significant finding is the importance of others' responses. The way in which staff, teachers, family and peers understand and support those with a learning disability appears to be crucial to the progression of their communicative abilities.

To offer effective support the accuracy of the carers understanding of the many different means of communication is essential. Only through such an understanding can expectations of the individuals' abilities be realistic. These expectations will impact directly on the quality of interactions, thus placing an emphasis on realistic goal setting. Similarly, carers need to be sensitive to the potential disparity between expressive and receptive communication in order to achieve appropriate goals.

Despite the paucity of good clinical research in this field, there appears to be accumulating evidence for the professional to take a systemic perspective when addressing a communication difficulty. Instead of locating the "problem" in the individual, there is more of an emphasis on considering the whole of the social network within which that person habituates. The importance in adopting such a perspective has become more apparent since the move towards de-institutionalisation and caring in the community.
Alongside this transition, the emergence of community teams for people with learning disabilities also appears to have made some improvements in the appreciation of the importance of communication. Clinical psychologists and other professionals can share clinical, educational and practical skills to recognise and advise on effective procedures. Hopefully, through developing appropriate and realistic expectations, those working with learning disabled people can continue to provide a plurality of perspectives and skills which will impact positively on issues of communicative ability.
References


Child, Adolescent and Family Essay

Psychiatric classification is irrelevant to the understanding and treatment of mental health problems in childhood and adolescence. Discuss.

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Psychiatric classification is irrelevant to the understanding and treatment of mental health problems in childhood and adolescence. Discuss.

It would be very difficult to evaluate the relevance of psychiatric classification without a consideration of psychiatry’s complex historical development. Providing a brief outline of this development may clarify why psychiatric classification and the medical model is so central to the field of mental health problems.

Following this, the use of psychiatric classification in the understanding and treatment of mental health problems shall be investigated by considering its impact on the clinical population of children with Attention Deficit Hyperactivity Disorder. This exploration will consider issues of comorbidity, cross cultural diversity, and objectivity. A more systemic perspective will then offer some insight into the influence of organisations on the relevance of classification systems before looking at the impact of the social context on clinical decisions. Having examined these issues it may then be useful to consider some of the current ideologies that underlie the system of psychiatric classification before suggesting a potential improvement to this position.

The establishment of psychiatry as a branch of medicine
Psychiatry became recognised as an established branch of medicine during the time when Cartesian-Newtonian principles were at their most prominent. These principles claimed that there are two radically different kinds of substance: the human body, comprising of the human brain and entire nervous system, and the thinking substance which includes the mind, thoughts, desires and volitions (Gregory, 1987).

In the nineteenth century, with the newfound interest in organic causes for mental health problems, a number of revolutionary discoveries contributed to the conceptualisation of psychiatry as a specialised branch of medicine. An example of the apparent “success” in the field of psychiatry was the recognition that general paresis, a condition associated with delusions of grandeur and a defect in cognitive capabilities, was caused by tertiary
syphilis of the brain and was treated effectively using chemicals. Furthermore, medicine claimed triumphs in the symptomatic control of some emotional and behavioural disorders (Grof, 1985). Interventions included psychosurgery, electric-shock therapy, and a range of psycho pharmaceuticals.

The successes of this medical approach were clearly limited as an organic aetiology to a number of conditions including depression, psychoneuroses, and psychosomatic disorders were not discovered (Grof, 1985). The failure of the medical approach in understanding and treating the emotional disorders gave rise to an alternative movement – the psychological approach to psychiatry.

Although psychological research began to provide more suitable explanatory models for a variety of emotional disorders (Salkovskis, 1996), and in doing so brought psychiatry closer to the social sciences and philosophy, this had little impact on the status of psychiatry as a medical discipline (Grof, 1985). Grof goes on to describe how the hegemony of the medical model was reinforced by the “symbiotic liaison between medicine and the rich pharmaceutical industry, vitally interested in selling its products” (pp.1). The result was that many medical concepts have been applied to the “understanding” of emotional disorders, which has been widely criticised as counter-productive (Szasz, 1973). A more detailed appraisal of some of these criticisms shall be discussed later in this essay to assess whether psychiatric classification is helpful or not in the understanding and treatment of mental health problems in children and adolescence. However, an important issue which has already been raised, is that despite the apparent “misfit” of the medical model of psychiatry to a range of mental disorders, the psychologist has assumed a subordinate role to the psychiatrist regardless of which profession’s approach is better suited to the client (Grof, 1985).
Psychiatric classification

Having outlined the relationship between psychiatry and the medical model, one can begin to appreciate why there is such an emphasis on correctly diagnosing a person using an accurate diagnostic or classificatory system. This is usually done by dividing up the heterogeneous population according to the different relationships between its different members. This is often achieved using classification, in which people are grouped into a number of sub-populations, or by adopting a dimensional approach and assigning them to a position on one or more axes or dimensions (Kendell, 1975).

The diagnostic process has been described (Carr, 1999) as having three main functions: Firstly, to facilitate the growth of a body of expert knowledge about particular problems. This knowledge is said to provide a detailed clinical description of the aetiology, maintenance, course and the most effective interventions for the disorder. Secondly, the classification system is believed to contribute to the epidemiological information about the disorder which may be useful in planning services and allocating resources. Finally, through a classification system professionals are provided with a common language with which to communicate with each other.

These functions of the classification system are widely served through the use of the Diagnostic Manual of Mental Disorders (DSM-IV, American Psychiatric Association, 1994) and the International Classification of Diseases (ICD-10, World Health Organisation, 1992). There is also a multiaxial version of the ICD-10 for the classification of children and adolescents. These multiaxial systems allow for complex details about an individual to be coded without the loss of important information, which was characteristic of single-axis classification systems (Carr, 1999).

Reliability and validity

To achieve the aims of the classification systems, adequate reliability and validity are essential. Good reliability would result from clinicians interviewing the same cases and reaching similar conclusions about the most appropriate diagnosis. This remains a
problem, and Carr (1999) states that for both the DSM IV and the ICD 10 demonstrations of satisfactory reliability are unacceptably low. In an attempt to improve reliability there has been a gradual narrowing of the definitions of disorders. However, this process has resulted in poor coverage, resulting in difficulties in classifying many cases into the clearly defined categories (Carr, 1999).

Even if it was achievable, high reliability alone may not be sufficient to make an accurate diagnosis. This can be illustrated by considering the infamous study of Rosenhahn’s (1973) in which eight volunteers without a mental illness spent several weeks in a mental hospital without anybody detecting their sanity. All of the hospitals medical staff agreed that the volunteers were insane, indicating high reliability, however they were all wrong, indicating very low validity.

The current classification systems validity is compromised, as psychological difficulties are not experienced in the same way as disease-like categorical entities (Carr, 1999). Problems need to be viewed as interactional, with consideration to the child’s social networks, as dimensional psychological phenomena, or as a combination of both (Volkmar and Schwab-Stone, 1996; cited in Carr, 1999).

Even if the clinician is sensitive to these complex issues, the categorisation of a child may still be not valid as the DSM IV and the ICD 10 are, in many instances, based on insubstantial evidence (Carr, 1999). One reason for the possible invalidity of the classification systems is that they have been subject to committee biases throughout their development (Clark, Watson, and Reynolds, 1995).

The psychiatric classification of attention deficit hyperactivity disorder (ADHD)

Perhaps the most relevant way to investigate the irrelevance of psychiatric classification in understanding and treating mental health problems would be to consider how it is applied to a clinical population. Furthermore, an investigation into the psychiatric classification of ADHD may satisfy the essay question’s focus on children and
adolescents. This could be achieved as the disorder is usually considered as a condition that is particularly relevant to this client group (Report of a Working Party of The British Psychological Society, 1996).

What is ADHD?
The category of ADHD originated in the United States. This term refers to children and young persons whose "behaviour appears to be impulsive, overactive and/or inattentive to an extent that is unwarranted for their developmental age and is a significant hindrance to their social and educational success" (Report of a Working Party of The British Psychological Society, 1996, pp.8).

How is ADHD classified?
In contrast to the approach of the Americans, who mainly use the DSM IV for the purpose of diagnosis, the tradition in Europe has been to use the ICD 10. The two diagnostic systems may be consulted for a detailed examination of the differences in how ADHD (or Hyperkinetic Disorder in Europe) is conceptualised. However, for the purpose of this essay it may be useful to outline the variances between the two systems in the classification of the disorder.

Perhaps the main difference is that unlike the DSM IV, the ICD 10 adopts a strict requirement for *pervasiveness and persistence*. In effect, this means that to fulfil the ICD 10 criteria for ADHD, the individual's behaviours must be present across a range of different situations. Furthermore, the ICD 10 is more inclusive than its American equivalent as it requires that *both* significant inattention and hyperactivity are observed. With regards to these symptoms, the DSM IV utilises an *either/or* clause. As a consequence, children fulfilling the criteria of ADHD in Europe are far less common than those reaching the DSM criteria (Reason, 1999).

This difference between diagnostic systems illustrates how there are variations in psychiatric classifications and the impact that this may have on a particular population.
Consequently, the idiosyncratic nature of the classification systems will influence how a “disorder” is perceived, understood and treated.

*Why is ADHD classified?*

Those with severe, persistent, and pervasive problems may find that the conceptualisation of their experiences as a “disorder” (compliant with the disease model) may have advantages that contribute positively towards therapy (Reason, 1999). In ADHD, the child’s behaviour may be viewed by their family and surrounding networks as the symptom of a legitimate disorder which may influence the attribution of “blame” and have an impact on the way in which others react to the individual. Furthermore, a diagnostic classification is an essential pre-requisite to medical intervention, especially if it includes a prescription (Reason, 1999).

*Considerations when using the classification of ADHD*

**Cultural variability**

Comparisons of the DSM IV and the ICD 10 highlight the difficulties in the utilisation of classification systems in the understanding and treatment of mental health problems for a disorder as heterogeneous as ADHD. This point is exemplified by a study by Taylor (1987) that looked at ADHD cross-culturally and found that core symptoms were remarkably consistent across countries. However, there was considerable cross-national variability and ADHD was 20 times more likely to be diagnosed in the United States than in England. Also, cross national prevalence is believed to be effected by the variations amongst diagnostic criteria as the impact of externalising disorders may have different effects depending on cultural norms regarding acceptable behaviour (Sergeant and Steinhauser, 1992).

**Comorbidity**

In addition to cross cultural factors, the use of classification in approaching ADHD has proved to be questionable as it is not a “pure” disorder and often appears along with other mental disorders (Searight and McLaren, 1998). Indeed, these authors go on to state how
investigators have found both convergence and divergence of symptoms of ADHD, Conduct Disorder (CD) and Oppositional Defiant Disorder (ODD). These issues have been recognised through the developments of the DSM and hence specific criteria have been written into the interviews to delineate between the diagnoses of these disorders.

However, in practice, when employing teacher and parent behavioural ratings to establish a diagnosis of one of these externalising syndromes, complications have been encountered. Paternite, Loney, and Roberts (1995; cited in Searight and McLaren, 1998) could not empirically separate ODD from comorbid ODD and ADHD. This finding is particularly significant to the question of whether psychiatric classification contributes to the understanding of the disorder, as ADHD has been conceptualised as a neurophysiological deficit (McCracken, 1991) and ODD is believed to arise from family interactions (Searight and McLaren, 1998).

As no significant differences were found between the ODD and the ADHD children on cognitive or family environment factors, the validity of DSM IV appears to be less credible. Indeed, if there is not one single biological or psychological determinate that accounts for all behaviours subsumed under the heading of ADHD then the use of this cluster of symptoms as a distinct and unitary condition may suggest that a psychiatric classification exists for a “non-entity”. If so, the use of the term ADHD would be misleading with clear implications that the range of presenting symptoms are not understood. The impact of such a “bogus classification” and the subsequent prescription of treatment would raise a host of ethical, practical, ideological and financial dilemmas.

The application of classification
Having outlined some of the important features associated with the classification of ADHD, it may be useful to consider the influence of people on this diagnosis. Indeed, it could be said that psychiatric classification is a tool. How this tool is used to understand and treat childhood mental health problems is central to assessing its effectiveness.
The classification system for ADHD uses a dimension of “inattention” which is left open to interpretation. The dimension includes statements such as, “is often forgetful” and “does not seem to listen”. Although the DSM IV states that children with oppositional disorders or language difficulties may also present with these behaviours, “the proximate cause is left to the parent or teacher to interpret” (Searight and McLaren, 1998, pp.474).

A potential problem with this is that due to the extensive media attention of ADHD, the clinician may experience an attribution bias towards this diagnosis and fail to consider alternate causes. Furthermore, although psychiatric classification is not necessary to provide for children with special educational needs in Britain, it is necessary for medical intervention (Report of a Working Party of The British Psychological Society, 1996). This may explain why so many paediatricians and family physicians experience pressure to diagnose ADHD and prescribe methylphenidate (medication) treatment (Searight and McLaren, 1998).

This point illustrates how a diagnosis can be made without the clinician having a complete and unbiased understanding of the child’s mental health problem. Instead, psychiatric classification is influenced by the “media success” of the diagnosis. A process such as this could be described as completely discrediting the use of psychiatric classification in both understanding and treating mental health problems. In fact, in this case the popularity of the classification may well have contributed towards its detriment.

From these observations one can begin to appreciate that classifications do not operate in a void but the associated agents are of ultimate importance. Earlier, it was stated that psychologists who may be more appropriately qualified to understand certain mental disorders have to assume a somewhat subordinate role to the psychiatrists as a result of the socio-historical factors surrounding mental illness and the medical model. This appears to be the case in the diagnosis of ADHD, as 75% of children with this diagnosis are seen solely by primary care physicians (Zarin, Tanielian, Suarez, and Marcus, 1998). Such a diagnosis is usually made without any psychological evaluation (Wolraich, Lindgren, Stromquist, Milich, Davis, and Watson, 1990).
Organisational impact on classification

The impact of the government on how professionals should operate in order to better understand and treat ADHD also appears to have contributed to a unimodal approach. Following questions in the House of Commons from the Department of Health on December 12th, 1994, the Minister of State for Health recognised the diagnosis of ADHD (or Hyperkinetic Disorder) and advised that children with ADHD are seen in Child Mental Health Services. In addition to this the Minister of State for Education communicated that special educational needs procedures were outlined for those with ADHD in the Code of Practice (1993 Education Act) and the Further and Higher Education Act 1992 (Fogel, 1995). Nonetheless, neither minister discussed the importance of meeting the child’s needs through the co-ordinated efforts of health, education and social services. Such a multimodal approach is considered as particularly pertinent in the context of ADHD and encouraged in the recommendations from Services for the Mental Health of Children and Young People in England – A National Review (Kurtz, Thornes and Wolkind, 1995).

In an attempt to address some of these issues (November 5th, 2000) The National Institute for Clinical Excellence (NICE) issued its guidance to the National Health Service (NHS) in England and Wales on the use of methylphenidate for ADHD. In summary the guidance recommends that:

1 “Methylphenidate should be used as part of a comprehensive treatment programme for children with a diagnosis of severe ADHD.

2 Diagnosis of ADHD should be made by a child/adolescent psychiatrist or a paediatrician with expertise in ADHD and should involve children, parents & carers and the child’s school.

3 A comprehensive treatment programme should involve advice and support to parents and teachers, and could, but does not need to, include specific psychological treatment (such as behavioural therapy).
4 Children on methylphenidate should receive regular monitoring. When improvement has occurred and the child’s condition is stable, treatment can be discontinued at intervals, under careful specialist supervision, in order to assess both the child’s progress and the need for continuation of therapy.”

(NICE, 2000, pp.1)

Despite the organisation’s apparent intentions to use psychiatric classification positively in the treatment of ADHD, these recommendations may not be based on an adequate understanding of the disorder and its clinical implications. Point 1 assumes that medication is a necessary component of treatment for all of this population. This assumption could be questioned on the evidence already discussed, that comorbidity obscures the syndromes defining features. Considering the data that methylphenidate often benefits non-ADHD individuals (Searight and McLaren, 1998), the prescription of stimulants for a number of related problems in the paediatric population is likely to result in some “improvements”. With the growing emphasis on the medicalisation of nonclinical symptoms in order to streamline education and health care (Barsky and Borus, 1995), one needs to be aware of the confirmatory process of pharmacological verification in contributing to the increased use of stimulants.

Point 2 recognises the importance of a multi agency approach to ADHD, but this also increases the chances of the psychiatrist or paediatrician being subject to external forces and biases in the diagnosing of an individual. Indeed, the NICE guidelines with their emphasis clearly on the effectiveness of treating ADHD with methylphenidate may well contribute to these external pressures. The prescribing professional may be further pressurised, as the NICE document states that “this guidance does not, however, override the individual responsibility of the health professionals to make appropriate decisions…” (NICE, 2000, pp.2). This statement further questions the relevance of psychiatric classification when applied to a concept as heterogeneous as ADHD.
The next point, number 3, minimises the contribution of psychological approaches in the treatment programme for ADHD. This suggestion appears to have failed to consider the conclusion made by the Working Party of The British Psychological Society (1996, pp.62) that “it is probably not useful to think of ADHD as a mental disorder given current understandings of the psychological basis of the concept”. Such an approach is also likely to continue to see ADHD treated without adjunctive benefit of behavioural intervention despite the fact that most practitioners advocate the use of a multimodal treatment approach (Goldman, Genel, Bezman, and Slantez, 1998).

Finally, point 4 alludes to the fact that the child has a “condition”. This indicates that ADHD is conceptualised as a pathological disorder. In this light, it is advised by NICE that the diseased child is monitored until their condition stabilises, at which point treatment (medication) can begin to be discontinued. With the assurance of psychiatric classification, this guideline clearly places the apparent “disorder” within the child. This approach fails to recognise that the aetiology or any maintaining features may be the result of socio-environmental factors that are likely to remain unchanged regardless of the treatment imposed upon the child.

The medicalisation of the child assures that the political interests of the governing body, with its emphasis on “clinical and cost effectiveness”, are upheld whilst the unrepresented child is pathologised. Indeed, Ingleby (1981) states how the diagnosis of “hyperkinesis” invalidates the child’s rebellious expressions of boredom and frustration. He goes on to say that the use of diagnosis should be redirected from talking about the “maladjusted child” to think instead about the maladjustment of their schools and families.

Clinical practice and the social context
Along with the recognition that the child with ADHD does not operate within a social vacuum, but is influenced by social networks, is the acknowledgement that psychiatric classification also exists in and adapts to the social and economic climate. Neglecting the impact of these broader systemic forces may obstruct the health care professional in
recognising the ir/relevance of psychiatric classification and making informed judgements in their everyday practice.

Indeed, the way in which ADHD has captured the public imagination may reflect current cultural anxieties. This “illness” could be viewed as a projection of collective societal fears about the impact of rapid social and technological change on children (Searight and McLaren, 1998). Concerns over “family values”, the computer age, television, and the quality of education may well contribute to and become embodied in the ADHD metaphor. Problems of inattention, distractibility and poor concentration may provide comfort when attributed to “scientifically known aetiologies”. Furthermore, reassurances offered through the medicalisation of these “symptoms”, as promoted by the NICE guidelines, may serve to reattribute the causes of the problems away from the child’s social networks thus alleviating family anxieties. Having relocated the “problem” within the child, pharmacotherapeutic intervention is prescribed.

From this observation, it could be suggested that psychiatric classification and the social and economic climate can mutually verify the relevance of a particular diagnosis. Reflecting on this process is essential to the understanding of the “disorder” and issues associated with the preferred choice of treatment.

Labelling and the use of psychiatric classification
So far, this essay has explored some of the strengths and limitations concerning the soci-historical development of classification systems, the relevance of classification when applied to an ADHD clinical population, and the relationship between clinical practice and social/economic forces. The following section will aim to provide a more macroscopic perspective on the labelling process and how this may or may not contribute to the understanding and treatment of peoples’ experiences.

Szasz (1974) describes classification as a social act that entails the participation of three different agents: classifier, classified, and public called upon to accept or reject a
particular classification. Psychiatrists are said to be the agents of classification as well as objects of classification by others. However, “mental patients” are characterised by their powerlessness to classify themselves or others and are treated solely as the objects of classification by health care professionals (Szasz, 1974).

Historically, those patients who were classified as suffering from bodily diseases (which could be diagnosed and cured) received good medical attention, whereas those suffering from “mental illness” (malingers) were stigmatised and received little help from society (Szasz, 1974). Despite the historical process of labelling and relabelling of mental illness (e.g. from “lunacy” to “psychological illness”) over the past three hundred years, psychiatric classifications have done little to affect the degradation of the persons to whom these labels are attached (Szasz, 1974).

Szasz goes on to assert that psychiatrists have become the scientifically accredited experts not in the field of mental illness, but in the practice of personal conduct and social control. Szasz declared, “the covert aim of psychiatric classification is social stigmatisation and the creation of a class of justifiably persecuted scapegoats” (1974, pp. 234). This opinion could well be considered as congruent to many of the issues already outlined with regards to the possible reasons for the diagnosis of ADHD.

With such stigmatisation associated with psychiatric classification, there is a danger that the diagnosed child will be relatively powerless to resist the process of pathologisation (being solely an object of classification – Szasz, 1974). This in turn could have a negative effect on the parent/child and professional/child dynamics (Johnson, Rasbury, and Siegel, 1986). Furthermore, the way in which diagnoses focus on negative attributes and are couched in a pejorative discourse may lead the child to believe that they are “defective” and the diagnosis may become a self-fulfilling prophecy (Carr, 1999). That is, the child who is labelled as “mentally ill” is type cast in a role which gradually becomes indistinguishable from his/her “real” self (Scheff, 1966).
Ideologies of the health care profession and the impact on psychiatric classification.
So why do the categories and classifications used in psychiatry and psychology fail so often in assisting in the understanding and treatment of mental health problems? Many writers throughout the history of psychiatry have attempted to answer this question.

One approach was that of the “anti-psychiatry” movement, which emerged during the 1960s and 1970s to question the very basis of psychiatry itself. Some of the issues that were contested included the purpose of psychiatry, its conception of mental illness and the distinction between madness and sanity. Furthermore, the anti-psychiatrists questioned whether the concept of mental illness, constructed by professionals, was more harmful to human potentialities and more “false” than the “disorders” which the medical profession claimed to find within their patients (Crossley, 1998).

Although the anti–psychiatry movement is a fascinating analysis of the development and contribution of psychiatry, a detailed investigation into this movement is beyond the scope of this essay. Nonetheless, a consideration of some of the emerging ideologies of the human sciences and their impact on mental health may further clarify the ir/relevance of psychiatric classification.

For instance, in the same way as Goffman (1959) ascribes social power to those who control the “definition of the situation”, one can also consider psychiatrists as controlling the “definition of madness”. Equipped with “formalised” classification systems (DSM, ICD) those in control are thus invested with the extraordinary role of “managers of reality”.

Defenders of the classification system may argue that it is constructed on scientific principles relying on objectivity to avoid bias (Wing, Cooper, and Sartorious, 1974). However, criticism comes in terms of the biases of the scientific framework itself, which reinforces rather than undermines its own principles. Indeed, Ingleby (2000) asserts that those in the human sciences need to be aware that ideology dominates all scientific
practice and that "good" scientific practices maybe more prey to ideological influences than a "non-conformist" approach. Such considerations are rarely entertained in institutions where science is carried out because the existing culture is saturated with its own ideologies. Hence the research conducted is ritualised, as is the teaching, communications, tutorials, and conferences which all serve to become a tacit celebration of the "ethic of normality" (Ingleby, 2000).

The use of strict diagnostic criteria could be perceived as imprisoning the psychiatrist inside a cage of ideologically determined pre-conceptions. Using a quotation by Goldman (1969, pp.41) [authors words in brackets], and by replacing the notion of the "researcher" with the "psychiatrist", one can appreciate the disparity between categories and objective understanding:

"In the human sciences...it does not suffice as Durkheim believed, to apply the artesian method, to call into question acquired truths and to open ones mind entirely to the facts, because the researcher [psychiatrist] generally approaches the facts with categories and implicit and unconscious preconceptions which close off to him in advance the way to an objective understanding."

However, it is not just the psychiatrist who is blinded by the lenses of "scientifically determined" criteria in an attempt to understand mental health problems. Psychologists have also been accused as too keen to "sell out" to a paradigm of science that reduces human realities to some other, non-human reality (Ingleby, 2000). This has been described as the process of "reification", in which human realities are reduced to "the order of things" (Ingleby, 2000). This is evident in the way that classification systems deconstruct a persons behaviours and symptoms to create a pathologised label or diagnosis.
Knowing how to use psychiatric classification and “expert” knowledge

An analysis of these observations may lead the reader to wonder whether an understanding of mental illness and its subsequent treatment is accessible from within our present conceptual universe.

This question has been considered by academics approaching such issues from the perspective of “postmodernism”. In short, postmodernism adopts an anti-worldview and denies the existence of universal truths or standards (Kvale, 1992). “Postmodern society consists less of totalities to be ruled by preconceived models than by decentralisation to heterogeneous local contexts characterised by flexibility and change” (Kvale, 1992, pp.2).

With this in mind, it is essential to deconstruct the theoretical dogmas that construct our conceptual universes and form our foundational ideologies, in order to be able to begin to accommodate a conceptual multiverse. Throughout this essay, some of the ideologies behind psychiatric classification have been explored. Now, with an emphasis on the avoidance of developing polarised epistemological positions, some consideration maybe given to a preferred approach.

To do this, it may be helpful to draw parallels between the recent movement to find common ground between psychoanalysis and family therapy. Both disciplines recognise the complex relationship between knowing and not-knowing (Lamer, 2000). That is, the recognition that the therapist is knowing in terms of imparting professional advice, expertise, certainty, power and authority to their clients, while simultaneously assuming a not-knowing stance of curiosity, reflection, and collaboration (Lamer, 2000).

This approach appears to have fundamental differences to that of the therapist or psychiatrist who is positioned outside of the patient’s subjectivity. Such a posture would be reliant upon positivist ideals of neutrality and objectivity, in which the professional presumes to know the client in a scientific sense. This has been attempted using psychiatric classification. Instead, the postmodern professional would relinquish an
objectifying stance and work collaboratively with the client to investigate the psychological manifestations and interpretations that are socially constructed in the present (Lamer, 2000). Using this approach, what the psychiatrist or psychologist knows in terms of "psychological facts" (e.g., psychopathology, diagnostic categories, etc) is less relevant than how the professional knows. This method of engaging with, and exploring a client's experiences may be more effective in facilitating an understanding of any mental health problems than the use of psychiatric classification systems.

However, the not-knowing social constructionist must be aware of the power ambiguities of the therapeutic context (Lamer, 2000). Therefore, it is important that the not-knowing professional continues to recognise the power differentials between themselves and the client. In addition, the professional must be sure not to impose their knowledge on the client to preserve the collaborative therapeutic relationship.

Conclusion
In view of the evidence discussed, it has become apparent that adopting a polemic epistemological position on the relevance or irrelevance of psychiatric classification may be unhelpful. Having examined a range of issues through the use of a socio-historical perspective, the reader may well appreciate the need for the health care professional to be reflective and attempt to keep biases at a minimum in an attempt to work effectively. Furthermore, through an investigation into emerging ideologies and their effect on practice, one must be aware of how adopting one particular ideology can become a self-verifying process. The danger of this being that any forms of understanding, and the subsequent treatment of mental illness, may be reliant upon an evidence base that is not necessarily comprehensive.

In summary, it is apparent that working from within one conceptual universe may deny the professional a chance to sufficiently understand a client. Therefore, too much of a reliance on a formalised classification system, which has been developed through a particular set of ideologies may well be considered as an "abuse" of the professional's
power over an individual. However, if the psychiatric classification system is used within a collaborative, multimodal approach, with an emphasis on a multiverse of perspectives then there is more chance of its potential being utilised.

In practice, this may be more easily achieved through the use of multi-disciplinary teams, however it is the responsibility of all those members in the team not to be consumed by one over-powering ideology. This is incredibly important for the clinical psychologist to realise, as psychology was initially developed to improve the understanding and treatment of people with emotional disorders. Therefore, a reversion back to a reliance on the medical model and psychiatric classification alone would do little to progress our understanding of mental health problems in both adults and children.
References


Older Adult Essay

Depression is an inevitable part of the ageing process and requires understanding, but not treatment. Discuss.

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PsychD Clinical Psychology

Year II (Course 28)

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Depression is an inevitable part of the ageing process and requires understanding, but not treatment. Discuss.

To facilitate an understanding of depression in the context of the ageing process, it may be useful to outline some of the prominent factors that contribute to these conceptualisations. Following the introduction of these terms it will then be possible to begin to investigate how "inevitable" the association between depression and ageing are. This will be done through a review of the evidence base with special attention paid to issues of prevalence, life span, diagnosis, and biopsychosocial factors. Evidence for the effectiveness of treatment intervention will then be discussed as well as the accessibility to the health care services for the older adult population. Finally, a consideration of recent Government guidelines and recommendations will be explored in order to synthesise issues of depression, understanding, treatment and service provision in relation to older people in the mental health services.

The "understanding" of depression in older people

Depression

As a result of the high prevalence of depression it has been termed the common cold of psychiatry (Seligman, 1975). Clinical depression is a diagnostic category that has been classified in a number of ways (for details see DSM-IV, American Psychiatric Association, 1994) and is qualitatively different from the transient low mood experienced by many people as a natural reaction to loss (Fennell, 1988). People suffering from clinical depression may feel sad, guilty, tearful, irritable, and anxious. Following an exacerbation of their symptoms they may lose the ability to enjoy certain activities, may have low energy, and withdraw from the people and activities that they would normally enjoy. Furthermore, bodily functions may be disturbed as sleeping becomes difficult, appetite declines and there is a loss in libido. Over time a sense of hopelessness (Abramson, Metalsky, and Alloy, 1989) about themselves, the world and the future may develop, which can in some cases lead to suicidal ideation or completed suicide.
Relationship between depression and the ageing process

Prevalence

Depression is described by Fernandez, Levy, Lachar and Small (1995) as the most common psychiatric disturbance among the elderly population. However, such a broad conceptualisation of "depression" has been attributed to there being little consensus about its prevalence. In an attempt to clarify this, Beekman, Copeland, and Prince (1999) carried out a systematic review of studies of prevalence of depression in later life. Within this review, using "rigorous research diagnostic criteria" (pp. 3) they were able to distinguish between those people with "major" and those with "minor" (sub clinical) depression. Beekman et al. (1999) report that these previous studies suggest that major depression in older adults is a rare phenomenon (1.8%) and minor depression was more frequent at around 10%, which is lower than some reported rates of depression in the adult population (15-20%, Fennell, 1989).

Whereas the above review included a host of data including studies from other countries (i.e. Japan, Hong Kong), surveys in England have suggested that up to 15 % of over 65 year olds suffer from depression (Livingston and Hinchcliffe, 1993; Montano, 1999), a figure comparable with the reported prevalence of "minor" depression by Beekman, et al. (1999).

Age difference in the prevalence of depression

These figures suggests that depression in later life is far from "inevitable", in fact the review of literature by Beekman et al. (1999) suggests that the risk of major depression may actually decrease with age. This invokes the question of what are the developmental effects on vulnerability and stress across adulthood? This question is particularly relevant as major depression and subclinical levels of depression across adults of all ages are extremely costly to the medical services as well as to the individual sufferer (Callahan, Hui, Nienaber, Musick, and Tierney, 1994). Furthermore, for clinicians to diagnose, prevent and treat individuals across adulthood, they need to understand similarities and differences in the presentation of and risk for depression.
Comprehensive data to this effect has been produced by The National Institute of Mental Health Epidemiological Catchment Area (ECA) study (Reiger, Myers, Kramer, Robins, Blazer, et al., 1984; cited in Karel, 1997) on a study conducted in the United States. Having divided community residents of five cities into age bands (18-24, 25-44, 45-64, and 65+ years) the highest prevalence of depression was among the 25 to 44 year olds and the lowest prevalence was in the group of over 65 year olds. These age trends were predominantly consistent across the sexes and across ethnic groups, with the older adult group showing lower rates of mood disorder. In an extension of this study to adults at the older end of the adult spectrum (55-64, 65-74, 75-84, and 85+ years) there were no significant differences in mood state between the groups (George, Blazer, Winfield-Laird, Leaf, and Fishbach, 1988).

At one level these findings could offer evidence that is contradictory to the assertion that depression is an “inevitable” part of the ageing process. However, age related biases in the conceptualisation and measurement of depression has compromised the validity of such epidemiological studies. It has been suggested that this low prevalence of major depression among older adults may be an underestimation. Karel (1997) believes that these results reflect invalid measurement of depression as diagnostic criteria may be different in later life, symptoms may be misdiagnosed as having a medical cause, and older people may not be assessed as being functionally impaired by depressive symptoms. In addition, sampling biases may be present as depressed older adults are more likely to be excluded through death and being too ill to take part. There is another bias in that these results used older adults living in the community. Indeed, in a direct comparison, Ames (1991) reported that older people living in institutions had a significantly higher incidence of major depression and depressive symptoms than their community based counterparts.

One further difficulty in understanding the prevalence of depression throughout the ageing process is that epidemiological research provides a cross sectional snapshot of
people suffering from depression at one time. For these reasons the statistics of late onset and early onset of cases of depression among the older adult population is unknown (Karel, 1997).

An understanding of the onset of depression is further complicated by biochemical and neurological factors. It has been acknowledged that risk factors do change across the life span as genetic predispositions may trigger neurological disease (e.g. vascular diseases, Parkinson’s) often associated with depression (Karel, 1997). Subsequently, the onset of neurological disease and the risk of comorbid depression may be more likely in later years. These observations further question the validity of current research findings and their ability to account for the complex relationship between the onset and prevalence of depression across the lifespan.

**Diagnosing depression in the elderly**

As stated previously, the mis/diagnosis of depression in the older adult population has been recognised as seriously compromising a comprehensive understanding of the disorder and will have implications on the provision of intervention.

One frequently voiced concern given for the under diagnosis of depression is that the older person is more likely to express somatic complaints or insomnia than the more overt feelings of depression (Butler, Collins, Katona, and Orrell, 1997). Knauper and Wittchen (1994) believe that one explanation for this is that older adults who have insufficient memory capacity to cope with the complex answering processes required to complete complex diagnostic instruments, simplify the process by attributing depressive experiences to physical illness. Conversely, there are also concerns that the use of diagnostic instruments, which include somatic items, are resulting in false overestimations of the presence of depressive symptoms in older people (Karel, 1997).

Accurate diagnosis is further complicated due to the shared symptomotology of depression and dementia in some older adults. Both disorders may have features of loss
of motivation and energy, changes in sleep pattern and appetite, and poor concentration (Warrington, 1997). This relationship between biological and psychological factors has made the use of existing measures contentious as they “can identify the presence of specific symptomatology, but they cannot clarify its cause” (Terri and Wagner, 1992, pp.31). Considering as many as 30% of people with Alzheimer’s disease also meet the DSM-III criteria for major depression (Teri and Reifler, 1987), this highlights the complexities of diagnosis and the potential for misunderstanding the presenting symptoms in this client group.

In addition to this, the cohort effect is used to explain how older people grew up in an era when stigma was attached to “mental illness”. This may leave them reluctant to report symptoms of depression to their physician (Sims, 1993). To fully test the appropriateness of this hypothesis, Jorm (2000) has stated the need for longitudinal studies.

A further reason given for the under-diagnosis of depression in later life is that the physician may have to deal with a certain amount of hostility on the part of the depressed “patient” (Montano, 1994). Therefore not surprisingly, in a study by Butler, Collins, Kantona, and Orrell (1997) 50% of General Practitioners stated that they required more training to be able to recognise depression more effectively in the older adult population.

Overall, there appears to be a number of factors that limit the accuracy of diagnosis as neither the “patient” nor the physician perceives the symptoms as those of depression. Through this misidentification of symptoms, a therapeutic nihilism exists between the physicians and the “patient” as the symptoms of depression are overlooked and may be conceptualised as “inevitable” or appropriate to the person’s chronological age (Montano, 1999).

**Depression as a psycho-social factor**

Roberts, Kaplan, Shema, and Strawbridge (1997) question whether ageing alone, independent from declining health and functioning increase the risk of depression. An
answer has been provided by Lewinsohn, Rhode, Seeket, and Fischer, (1991) who reported that the negative changes in ageing are primarily psychophysiological and neuropsychological functioning, which were not associated with depression. This leads Roberts et al. (1997. pp.1384) to assert that “healthy, normally functioning older adults are not at greater risk for depression than younger adults”, however “this is not to argue that depression does not increase with age”(pp. 1389). In fact, Rovner, Broadhead, Spencer, Carson, and Folstein (1989) complete the biopsychosocial perspective through their observations that dementia patients with depression are more cognitively impaired and disabled, in terms of self-care than dementing patients without depression. The consequence of this may well be a reduction of independence, placing greater pressure on a partner, family or carers to meet the individual’s needs.

A further psychosocial factor that has been identified as contributing to the prevalence rates of depression in late life is “loss”. Osgood (1992) asserts that the process of retirement brings with it a loss of money, prestige, status, and power which were previously associated with the work role. This is then said to have the potential of manifesting into an identity crisis for some older people who were consumed in their working lives. For those older adults who were raised with a strong sense of a work ethic, leisure is no replacement for their jobs and may not be fulfilling and satisfying. For these individuals, Osgood (1992, pp.57) states that retirement represents a loss of dignity and status, and signifies that they are “old, useless, and no longer vital, contributing members of their community and society at large”. This is one hypothesis as to why suicide rates are the highest in older white males than in any other demographic group (Woods, 1999).

Alongside the loss of role and status, there is the cost of the loss of human relationships. Although bereavement is consistently associated with depression at all ages, the “older old” are exposed to it more so than other age groups (Beekman, et al., 1999).

In considering the impact of psychosocial factors it is also necessary to consider the impact of societal perceptions on the older adult population. Bodily (1994, pp.178) has
conceptualised the recurrent negative deployments of age as "the unelaborated attribution of the characteristics, limitations, or abilities of others to their chronological age", as if time itself has a negative causal force. The suggestion that depression is "inevitable" in this population and could not be treated would fit into this conceptualisation. A legitimate danger is that some adults deeply internalise this concept of "age" as an explanatory resource that obstructs them from reflecting upon their attributes. As they begin to accept and rationalise judgement from others, these older people are further disenfranchised which may actually contribute to the "inevitability" of the onset of depression.

Summary
Although there is extensive literature on depressive disorders, there is a limited understanding when applied to older adults. It is apparent that depression is the most prevalent functional psychiatric disorder in this population. Nonetheless, meta-analyses have indicated that the presence of major depression is lower in older adults than in younger groups across the lifespan. These findings are complicated through the complexities of the biopsychosocial factors in determining and maintaining the disorder. Indeed, many professionals and patients are reluctant or unable to identify the symptoms, there are further complexities regarding comorbidity, and time of onset. In addition to this the suggestion that the most ill and institutionalised are excluded from research trials seriously questions accuracy of the current evidence base.

Consequently, controversies over the under diagnosis of depression in older people would discount any conclusion as to its "inevitability", or not, as purely speculative. The question of whether it is enough to "understand" depression as a part of the ageing process is also a moot point as efforts to achieve an understanding of these issues through the "reassuring lens" of an "effective" evidence base is currently unsatisfactory.
Is there any evidence to suggest that depression in older people can benefit from treatment?

Access to treatment

If an understanding is a necessary precursor to treatment then it is not surprising that psychological interventions with older adults reflects a field that is still so early in its conceptual and research development that the evidence base is at best suggestive, but not conclusive (Smyer, Zarit, Qualls, 1990). Limitations of this resource are compounded by the fact that older people do not receive equitable access to psychological treatment. An audit by the Department of Health (1994) discovered that although 16% of the total population in Britain are older adults, less than 10% of initial contacts with clinical psychologists were from this client group. Service provision for this population is similarly unsatisfactory in the United States. As a consequence of “bias” in the detection and diagnosis as previously discussed, less than 20% of depressed older adults in the community and primary care populations are receiving adequate treatment (Cole and Yaffe, 1996).

When considering the reasons why older people are not offered the treatment that they are entitled to, and may benefit from, some psychologists have stressed the importance of reflecting on some more subtle process issues. Biggs (1993) explains that countertransference (feelings invoked in the therapist by the patient) has contributed to the professional’s lack of understanding of older adults with mental health difficulties and their subsequent exclusion from treatment programmes. Biggs (1993) points out that clinicians have their own fears about ageing and that their reactions to older clients may be influenced by unresolved conflicts with parental figures. It is suggested that effects of this countertransference will often result in the older adults being seen to be “untreatable” and thus not really deserving attention. In such cases, where the clinician has not reflected on and recognised these intrapsychic processes, then responses are said to be avoidance by the professional or the suggestion of medical rather than interpersonal forms of intervention.
Pharmacological and psychological Intervention

Although intervention can take many forms, those prognostic studies reported usually reflect medical intervention. Livingstone and Hinchcliffe (1993) reported that a third of patients remained depressed after medical treatment after a three-year follow up. Research by Heeren, Derksen, Heycop, and Van Gent (1997) claims that the ineffectiveness of pharmacological treatment is often the result of the prescription of sub-therapeutic doses. They assert that due to professional concerns over the detrimental side effects of the medication and of levels of tolerance, inadequate doses are being prescribed. Laidlaw (2001) argues that even when this is the case referral to psychotherapy is still exceptionally low.

Outcome research on the effectiveness of psychological intervention for older people with depression is extremely limited. In a review of seventeen comparative trials of psychosocial treatment, Scogin and McElreath (1994) found a good effect size in both major depressive disorder and sub-clinical varieties of depression in comparison to the no treatment or placebo groups. However, the sample size limitation precluded examination of the comparison of different treatments (cognitive, psychodynamic, and eclectic). The clinical use of these findings is further limited considering that only four (23%) of these seventeen trials included a population with a formal diagnosis of major depressive disorder, reaffirming the significance of the presence of sub-clinical depression in this population. Another study conducted by Thompson, Gallagher, and Breckenridge (1987) found similar results when comparing the effectiveness of cognitive, behavioural and eclectic/psychodynamic approaches to depression. A significant effect was evident when the therapies were compared with the waiting list group, however there were no significant differences in efficacy between treatment modalities. In a follow up study two years on, (Gallagher-Thompson, Hanley-Peterson, and Thompson, 1990; cited in Woods and Roth, 1996), as many as 70% of participants were no longer in the depressed range. As important as it is to extend clinical trials on this population, caution needs to be exercised when interpreting the above results due to the high drop out rate, mortality, measurement problems, and assisted medication effects.
Comparable results were found using group therapies for depressed older people, as psychodynamic and CBT were found to be equally effective in reducing depressive symptoms (Steuer, Mintz, Hammen, Hill, Jarvik, McCarley, Motoike, and Rosen, 1984). A further study comparing group therapy with pharmacological treatment (Beutler, Scogni, Kirkish, Schretlen, Corbishley, Hamblin, Meredith, Potter, Bamford, and Levenson, 1987; cited in Woods and Roth, 1996) found that the attrition rate over the five-month duration of therapy was lower in the cognitive therapy group. However, once again these results are only partially indicative of the effectiveness of treatment modalities, as the antidepressant used was alprazolam, which is not particularly good for making therapeutic comparisons as it is rarely used as a drug of choice for depression in this population (Beutler, Scogni, et al., 1987; cited in Woods and Roth, 1996).

Despite the limited studies on this client group, there appears to be some evidence that individual therapy may be more effective in the treatment of depression in older people (Woods and Roth, 1996). Nonetheless, the long-term support of the groups appears to provide a greater resource for longer-term support thus assisting in relapse prevention (Culhane and Dobson, 1991; cited in Woods and Roth, 1996).

**Treatment effectiveness across the lifespan**

So for those in which depression has become a part of the ageing process, what are the chances of experiencing change with respect to their difficulties when compared to their younger contemporaries? Again the evidence is somewhat conflicting. A meta analysis of cognitive therapy (Dobson, 1989) indicated that there is a significant negative correlation between patient age and the amount of change to symptoms. Conversely, having evaluated a number of outpatient therapies, Knight (1988) reported that the over 60 group improved more than younger adults. One further interesting finding was that those at the oldest end of the older adult spectrum required a longer period of therapy but were then able to achieve the same gains as their younger counterparts. Nonetheless, there are still too few studies on the treatment for adults at the older end of the spectrum,
those not in a community setting, and those with comorbid illnesses to make an informed evidence base for the efficacy of the range of therapeutic interventions (Blazer, 1999).

**Other benefits**

Another reported advantage to treating older people is that recovery from depression may have a significant influence on improvements to comorbid physical illness (Woods, 1999). Studies have indicated that those with depressive symptoms have functioning that is comparable or worse than that of adults with chronic medical conditions (Gurland, Wilkder, Berkman, 1988). The impact of this level of functioning is correlated with a risk of increased functional impairment, and even mortality (Beekman, et al., 1999). Furthermore, the experience of depression can increase the perception of poor physical health (Jaffe, Froom, Galambos, 1994) as well as health care costs (Simon, Von Korff, and Barlow, 1995).

**Summary**

There are relatively few studies that have successfully investigated the effectiveness of the range of treatments for older adults with depression. Those that have been conducted have been subject to a range of biases including; inconsistent methods of intervention, problems with appropriate measurement tools, high drop out rate, rates of mortality, and the exclusion of non-community based older adults. Considering these limitations, the evidence base is clearly insufficient to make a conclusive decision as to the effectiveness of psychological (or other) treatments for this client group with depression.

However, the research to date does allude to the fact that older people have as much potential as other client groups in benefiting from psychological intervention, especially over an extended period of time. Indeed, considering the effects of depression on older people and the serious implications that it can have when comorbid with other physical, biochemical and neurological illnesses, there is an argument that this client group should at the very least be given equitable access to psychological treatment. Furthermore, the reciprocity between evidence based practice and practice based evidence should
encourage clinicians to further create the opportunities to explore the interrelationship between “understanding” and “treating” older people for depression.

What is being done to promote both the understanding and treatment opportunities for older adults?

Directive action has recently been taken to address some of the difficulties which older people experience in the National Health Service (NHS). It has been acknowledged that more and more people are living on to old age and that this client group requires an equitable quality of care with other client groups. Those over sixty five year olds who develop depression and other mental health difficulties are to be given priority by the Government, as commissioning groups are being established to develop specific integrated investment plans (Audit Commission, 2000). Guidelines for an improved understanding and treatment options for older people have recently been published in the National Service Framework for Older People (Department of Health, 2001).

National Service Framework for Older People

Depression, as well as other mental health difficulties, has not been conceptualised in this Government document as an “inevitable part of the ageing process”. Indeed, input into the document by two prominent clinical psychologists (Twining and Rowan) has ensured that the emphasis and importance has been placed on the accessibility of psychological interventions for this population.

One of the key aims is to promote good mental health and to treat and support those older people with dementia and depression. Through integrated mental health services, the NHS and social services are setting out to ensure effective diagnosis, treatment (with an emphasis on psychological intervention) and support for the clients and their carers. The strategy also aims to recognise difficulties early, provide specialist services where necessary, and to offer community oriented services with seamless care packages.
The guidelines also state explicitly that age discrimination is to be "rooted out". NHS services are to be provided regardless of age and ethnicity but on the basis of clinical need alone. Furthermore, in a drive for person-centred care individuals will be enabled to make choices over their own treatment rather than be dictated to by professionals and policy. To address the problems of detection of client difficulties in the primary care services (as discussed previously), it has been suggested that professionals are trained in the assessment and diagnosis of depression, dementia and suicide.

These Government guidelines appear to be far more person centred than the tone of the essay title. Depression has been given priority in these guidelines and the suggestions for the preferred action by professionals appears to address some of the limitations of the service to date. Through the use of training, education and a sharing of skills amongst the professionals, the aim is to detect depression early and provide appropriate interventions swiftly.

Conclusion
Although it has been stated that depression is the most prevalent functional mental health difficulty in the older adult population it is far from "inevitable". In fact, some evidence has suggested that older adults suffer less from major depression than their younger counterparts, and that older adults actually become less prone to depression as they age. However, it is clear that caution should be exercised when reviewing the evidence base due to a host of methodological difficulties. Despite the relative wealth of information on depression across the lifespan, and the impact of biological and psychosocial factors, few studies have claimed to reach any conclusive evidence. Furthermore, Beekman et al. (1999) have stated that large-scale epidemiological studies on depression in older adults illustrate the divergence of findings reflecting either real differences in the samples studied, or methodological differences between studies.

A similar observation is made by Biggs (1993) who argues that much literature and evidence on older adults is somewhat skewed towards an unrepresentative sample of the
ageing population as it is primarily based on the most distressed, disadvantaged and unwell. A danger is that these results fail to consider the variability in the physical and mental ability of older adults as well as important differences between people in their mid-sixties and those who are in their nineties (Papouchis and Passman, 1993).

These observations appear to challenge the assumption that depression is an inevitable part of the ageing process. Instead it is apparent that people in the older adult “age band” experience less major depression then their younger counterparts. Furthermore, it appears that with the most appropriate treatments tailored to their individual needs, older people with depression are as responsive to treatment as younger people. Therefore, having concluded that this population who may experience depression, can also benefit from treatment, the question is whether the healthcare services can provide equitable access to services, accurate diagnosis, effective treatment, and support. Encouragingly, it appears that such shortcomings in practice have of late been recognised and are beginning to be addressed in alliance with recent Government initiatives.
References


Specialist Essay

Discuss the current findings on the cognitive functioning of adults with schizophrenia, and the implications for treatment.

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PsychD Clinical Psychology

Year III (Course 28)

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Discuss the current findings on the cognitive functioning of adults with schizophrenia and the implications for treatment.

The understanding of schizophrenia in adults has experienced several major changes over the last twenty years. There has been a shift from the view that it is a progressively deteriorating disorder, which has placed greater reliance on neurodevelopmental explanations of schizophrenia. Secondly, the phenomenology of the disorder has expanded from an emphasis on positive symptoms to include negative symptoms as well. And thirdly, in the 1990s the focus on these symptoms has modified as notions of phenomenology have increasingly moved beyond symptoms to an emphasis on the cognitive aspects of schizophrenia. This essay will present the current findings that attempt to elucidate the role of cognitive deficits in schizophrenia in relation to treatment and outcome. This discussion will include a consideration of the cognitive effects of antipsychotic medication, the implications of the selection of particular cognitive constructs for intervention, and the relationship between cognitive and social functioning. These issues may be best understood following a brief introduction of the concept of ‘schizophrenia’, some of the issues surrounding diagnosis and symptomatology, and the relevance of cognitive functioning.

An introduction to schizophrenia

Classification

Many epidemiological studies have used classification schemes (see Hare, 1982) to show that schizophrenia is a relatively common illness with a risk of affecting approximately 1 in 100 people (Torrey, 1987). This risk appears to be largely independent of culture and socio-economic status and is as likely to affect as many men as it is women (Hare, 1992). However, onset in men is usually in the mid–20s whereas women are more likely to be first affected in their early 30s (Frith, 1992).

Perhaps the most widely used classification scheme used is the Diagnostic and Statistical Manual (DSM-IV, American Psychiatric Association, 1994). This gives a comprehensive guide to diagnosing schizophrenia in all of its recognised forms and should be consulted
for an in depth understanding of the disorder. However, a brief précis may be beneficial at this point:

Schizophrenia is a general term encompassing a number of psychotic disorders with various cognitive, behavioural and emotional manifestations. Although schizophrenia is divided up into various subtypes, there are certain features which are believed to be common to all: (i) deterioration from previous levels of cognitive, social and vocational functioning; (ii) onset before midlife (est. 50 years of age); (iii) a duration of at least 6 months, (iv) a pattern of psychotic features including delusions, hallucinations, thought disturbances, disturbed sense of self and reality testing.

This final feature is often called ‘positive symptoms’ as they are abnormal by their presence, and are outlined by Frith (1992) as follows: Firstly, there are ‘auditory hallucinations’, in which the individual experiences hearing voices discussing them or commenting on their actions. There may also be the presence of ‘delusions’, which is when a person holds some beliefs that are maintained despite data and refutation that should be sufficient to seriously challenge them. Other positive symptoms are the experience of thoughts coming into that person’s head from someone else (‘thought insertion’), thoughts leaving their mind and entering mind’s of others (‘thought broadcast’), or the feeling that thoughts are being removed from their head (‘thought withdrawal’). Whereas the previous positive symptoms are often identified through the patient’s self reports, there may be abnormal absences in behaviour that can be observed. For example, the individual may show a reduction in spontaneous behaviour (‘affective blunting’), resulting in poverty of speech (alogia), ideas and action as well as social withdrawal (‘anhedonia’); these are termed ‘negative symptoms’ (Andreasen, 1985).
Difficulties with diagnosis

Prior to addressing the cognitive factors that may be central to the rehabilitation of a person with a particular disorder, it is important to determine that the disorder ‘exists’. Indeed this is particularly important in schizophrenia as there is some debate over the aetiology of the disorder, which has direct implications on making an accurate diagnosis.

Historically, schizophrenia was termed ‘dementia praecox’ (Kraepelin, 1896) and as no specific neuropathology had been found for the disorder it was labelled as ‘functional’, as opposed to ‘organic’ psychosis. At that time dementia praecox was considered to be a deteriorating disorder from which there was no recovery. Kraepelin (1896) hoped that a better understanding of the cause could be found so that sufferers could begin to share phases of remission that were common to the other ‘functional’ psychosis such as ‘manic depressive psychosis’. Later Bleuler (1913; cited in Frith, 1992) made changes to this classification scheme and termed the disorder ‘schizophrenia’ to capture the characteristic in which different mental faculties (i.e. emotion and understanding) appear to ‘split apart’.

Nearly one hundred years on there has not been much change in the accuracy of the classification of schizophrenia. To date no independent marker of schizophrenia has been identified in order to validate what some consider to be an ‘arbitrary definition’. Indeed, theories that have attempted to account for the disorder are as diverse as childhood trauma, early psychosocial factors, life stresses, neuropsychological, neuroanatomical and neurophysiological abnormalities, diet, genetic predisposition, and exposure to viruses (Neale and Oltmans, 1980).

This kind of diversity in the field has led some to question the label and encourage abandonment of the term ‘schizophrenia’. The deconstruction of schizophrenia is a fascinating and potentially valid ‘progression’ in understanding certain facets of human distress, but is beyond the scope of this essay (see Bentall, 1993). However, suggestions that have arisen from such an approach have contributed to the perspective that the study
of cognitive deficits is central to the identification of neuropsychological impairment in a psychiatric disorder (Bentall, 1993). Further emphasis is put on the individual’s experiences and less on generic labels with Bentall’s assertion that “neuropsychological data can best be understood in relation to symptoms rather than broad classifications” (1992, pp. 233).

Schizophrenia as a cognitive disorder

An overview of cognitive function

“The term ‘cognitive function’ is used synonymously with ‘information processing’ and ‘neurocognitive functioning’” (Sharma, 1999, pp. 44), and refers to the ability to recognise and process complex tasks adequately. These broad terms encompass working memory and visuo-motor skills, as well as sequencing and planning processes. It has been argued that these cognitive deficits in people with schizophrenia are related to impairment in temporal and frontal regions of the brain (Sharma, 1999). As tasks become increasingly complex, functional structures compete for a limited attentional capacity and optimal functioning is determined by efficient switching between parallel and sequential processing (Sharma, 1999). If the switching mechanism is operating effectively then there will be a sufficient allocation of available attention resources (Nuechterlein and Dawson, 1984).

A shift in emphasis – understanding cognitions in schizophrenia

A substantial change has already begun to occur in research, as investigations of the relationship between cognitions and schizophrenia has increased significantly. Indeed, at the International Congress for Schizophrenia Research the content of paper sessions on cognitions has shifted from a minimal representation of one single session in 1993 (7% of all paper sessions) to one quarter of all paper sessions in 1997 (Green, 1999).

This change in the trend of schizophrenia research is believed to be as much to do with the rapid development of neuroimaging techniques, as it is to do with the centrality of cognitions to the disorder (Green, 1999). The neuroimaging techniques are used to
provide demonstrations of dysfunctional neural processes in schizophrenic patients but these results cannot be fully interpreted without knowledge of the cognitive functions associated with the activation task (Buchsbaum, 1995).

The relationship between symptoms and cognitive deficits
Despite the recent belief that psychological studies are more informative when the emphasis is put on a patient's particular symptoms rather than schizophrenia in general, it is necessary to understand the relationship of these symptoms to cognitive deficits. In an overview of this relationship, Green (1999) states that until recently cognitive deficits were assumed to be derivative of the more noticeable symptoms of the disorder. However, he explains that attempts to identify cognitive deficits as a secondary response to the presence of symptoms (or as medication side effects, or institutionalisation) have not been successful. On the contrary, it has been reported that many (but not all) cognitive deficits are present before the illness becomes apparent in an individual and that they endure long after the symptoms of the disorder have remitted (Cornblatt and Erlenmeyer-Kimling, 1985, Nuechterlein, Dawson, Gitlin, Ventua, et al. 1992). The cognitive deficits have also been found in many first-degree relatives of the patients, and those relatives have never had, and may never have a schizophrenic illness (Keefe, Silverman, Mohs, Siever, et al. 1997). These findings suggest that cognitive deficits indicate a vulnerability to, rather than a presence of the illness, and could be described as intermediate phenotypic markers for schizophrenia.

Focussing in on cognitive deficits
As research has developed throughout the 1990s it has become apparent that cognitive deficits are associated with functional outcomes, such as social problem solving, social competence, community outcome, and psychosocial skill acquisition (Green, 1996). Another reason for growing interest in this area is that cognitive deficits may become targets of treatments themselves.
The aim therefore has been to identify a single cognitive dysfunction, or pattern of dysfunction, from which the various abnormalities associated with schizophrenia can be derived (Hemsley, 1994). This endeavour has been difficult to achieve as a result of methodological difficulties (Hemsley, 1988) and because there is no definitive large-scale model of normal cognitive functioning. Even if there were, there would be problems in mapping cognitive constructs onto specific task performance if there were a presence of alterations in cognitive experience that is often associated with schizophrenia (Hemsley, 1994). For these reasons, rather than adopt a reductionistic approach (attempting to match individual cognitions with functions), it may be more valuable to attend to the development of some of the current models that attempt to elucidate the role of cognitive deficits of schizophrenia in the context of treatment and outcome.

Conventional antipsychotic medications in relation to symptoms and functional outcome

Figure 1 was developed by Green and Nuechterlein (1999) and reflects three conclusions found in the literature.

Figure 1. Pathways from conventional antipsychotic treatment to functional outcome
Firstly, this model recognises that although conventional antipsychotic medications are believed to have an effect on psychotic symptoms, their effects on cognitions are considered to be minimal (Strauss, 1993). Despite this limited therapeutic effect, it is as important to note that conventional antipsychotics can have a direct deleterious effect on cognition (Keefe, Silva, Perkins, and Lieberman, 1999).

Secondly, the model reflects the literature’s identification of a weak relationship between cognitions and psychotic symptoms, especially hallucinations and delusions (Strauss, 1993). However the relationship between cognitions and particular positive symptoms is not mutually exclusive. For example, Spitzer (1997) claims to have isolated formal thought disorder to performance on a laboratory test of semantic priming. Nonetheless, Green and Nuechterlein (1999) continue to advocate keeping the psychotic symptoms and cognitive processes sufficiently separate as it is believed that some cognitive deficits remain unchanged following the improvement or full remittance of psychotic symptoms (Nuechterlein, Dawson, Gitlin, Ventua, et al. 1992).

Finally, studies have indicated that certain cognitive deficits are good predictors of functional outcome. Indeed, Green’s (1996) literature review showed that certain cognitive processes, such as verbal memory and vigilance were correlated with the outcome areas of community functioning, social problem solving and psychosocial skill acquisition in people with chronic schizophrenia. Similar results have been found by Mueser, Bellack, Douglas and Wade (1991), who identified relationships between verbal memory and social skills training, and social problem solving. Further significant relationships have also been found between measures of verbal memory and visual information processing and measures of social skill by Corrigan, Wallace, Schade, and Green (1994). However, as encouraging as these findings are, it remains tenuous to correlate cognitive measures and analogue measures of social functioning in order to prove a direct relationship between psychological deficits and functional behaviour in the community.
Nonetheless, these findings go some way to explaining the previous paradoxes of treating with conventional neuroleptics. Eliminating psychotic symptoms with this medication is unlikely to improve the schizophrenic patient’s social functioning. This factor may well contribute to understanding the high rate of hospital readmissions, as the individual may not have developed the skills to reduce the risk of intense relationships (i.e., Expressed Emotion; Brown, Carstairs, and Topping, 1958; cited in Kavanagh, 1992). Conversely, these findings have also begun to shed light on the way in which some people with schizophrenia can function in the community (and work effectively) despite experiencing positive symptoms (Green and Nuechterlein, 1999).

**Novel antipsychotic medications, cognitions and functional outcome**

The initial model (figure 1) is incomplete as it excludes new antipsychotic agents, anticholinergic agents, and negative symptoms. By comparison, the impact of conventional antipsychotic agents has been minimal, whereas the newer ‘atypical’ antipsychotic medications appear to be more effective (Keefe, Silva, Perkins, and Lieberman, 1999). Subsequently, these authors have expressed that atypical antipsychotic medications are more effective at targeting cognitions in adults with schizophrenia than the older medications. If this is the case, then it is essential to consider whether the beneficial effects of medication involve a direct action on a particular cognitive construct.

*Direct versus indirect effects of medication*

A “direct effect” is described as one in which a particular medication has an effect on a cognitive function. If an additional medication is required (e.g. to counteract the side effects of the first medication) and this too affects cognition, these effects are called “indirect effects”. This is an important point as most conventional medications require the addition of anticholinergic medication (Stalheim-Smith and Fitch, 1993). This adjunctive medication is often used alongside antipsychotics to impede or block impulses in the cholinergic nerves. Anticholinergic medication has been found to impair memory in many cases (Strauss, Reynolds, Jayaram, and Tune, 1990; Silver and Geraisy, 1995),
and in doing so makes it impossible to attribute any memory improvements to the conventional anti-psychotics, which are used in conjunction (Keefe, Silva, Perkins, and Lieberman, 1999). Green and Nuechterlein (1999, pp.312) find such results less conclusive, stating that it remains unclear whether “a differential treatment effect is the result of something good (from the new medication) or the absence of something bad (from the anticholinergic agent)”.

Effects of atypical antipsychotic medication on cognitive impairment in schizophrenia
In a review and meta-analysis of 15 studies on the effects of atypical antipsychotics on cognitions several important methodological limitations and treatment effects were identified (Keefe, Silva, Perkins and Lieberman, 1999). Perhaps one of the primary factors limiting the knowledge of cognitive functioning in adults with schizophrenia is that there is rarely the opportunity to use medication-free baseline assessments. Although some first-episode populations may be drug free, in more chronic populations conventional antipsychotics will usually already have been provided before any cognitive testing can take place (Keefe, Silva, Perkins and Lieberman, 1999). Another limitation identified by these authors is the lack of double blind study conditions (only 3 of the 15). That is, assessments often require subjective evaluations that can be contaminated by the knowledge of a patient’s medication (Rosenheck, Cramer, Xu, Thomas, et al., 1997). Furthermore, even cognitive measures are believed to be vulnerable to these biases and need to be safeguarded using a double-blind methodology.

In the 15 study meta-analysis the authors (Keefe, Silva, Perkins and Lieberman, 1999, pp. 209) recognised that there was a broad range of test measures used, which they grouped into the following categories: (1) attention subprocesses, (2) executive function, (3) working-memory, (4) learning and memory, (5) visuospatial analysis, (6) verbal fluency, (7) digit symbol substitution, and (8) fine motor function. They determined that in the double blind studies atypical antipsychotics produced a significant improvement in attention, executive functioning, and visuospatial analysis. In the open label-studies, where the researchers were aware of each treatment group on cognitive testing, the use of
atypical antipsychotic medication was found to improve executive functioning, working memory, visuospatial analysis, verbal fluency, digit symbol substitution, and fine motor functions.

The authors of the meta-analyses conclude that this study suggests that atypical antipsychotics, when compared to conventional drugs improve cognitive functions in adults with schizophrenia. The strongest effects were on verbal fluency, digit-symbol substitution, fine motor functions and executive functions. However, enthusiasm should be tempered, as cognitive functions of patients with schizophrenia did not reach ‘normal’ levels in any of the analysed studies. In addition, methodological limitations cast doubt over the validity of the findings due to the strong impact of various rater-biases inherent in the open label studies (Rosenheck, Cramer, Xu, Thomas, et al., 1997).

Cognitions, negative symptoms and functional outcome

While tracing the in/direct effects of pharmacological treatment may be strewn with methodological difficulties, nonetheless they are often easier to determine than causal relationships between cognitions and negative symptoms (Green and Nuechterlein, 1999). Recent findings on the cognitive functioning of adults with schizophrenia have led to suggestions that negative symptoms have a direct causal impact on functional outcome. Indeed, studies based on statistical models claim that cognition mediates between negative symptoms and functional outcome (Velligan, Mahurin, Diamond, Hazelton, Eckert, and Miller, 1997). Unlike medical treatment, cognitions cannot be prescribed or proscribed to determine an effect. For this reason, the relationship between cognitions and negative symptoms are described as having a shared variance to avoid making assumptions about causality (Green and Nuechterlein, 1999). This approach is adopted despite longitudinal data that has concluded that the deficits in certain cognitive functions (i.e. vigilance and perceptual span) appear to be vulnerability factors for the development of negative symptoms rather than the result of negative symptoms (Nuechterlein, Edell, Norris, and Dawson, 1986).
The cognitive/social functioning relationship

With the belief that understanding cognitions is central to the social functioning in schizophrenia, much research has recently attempted to identify the function of relevant cognitive subsystems. In a recent review of related studies, Green (1996) divided the literature into three areas of social functioning: community outcome, social problem solving, and skill acquisition.

Green's (1996) areas of community outcome included: social engagement, communication, daily living skills, recreation, level of independent living, employment and quality of life (Q.O.L; Heinrichs, Hanlon, and Carpenter, 1984). Results indicated that secondary verbal memory and card sorting were good predictors of community functioning (Buchanan, Holstein, and Breier, 1994). It is believed that secondary verbal memory is reliant upon memory for stories and lists, utilising both immediate and delayed recall, factors which may well contribute to improved social engagement. In addition, card sorting is often used as a measure of executive functioning, suggesting that ability on this task will increase the likelihood of cognitive flexibility. This is described as a valuable facet in the integration and accommodation of new information, thereby reducing perseveration and increasing the chances of independent living (Addington and Addington, 1999).

In the second group of studies, reliable predictors of social problem solving included verbal memory (Bellack, Sayers, Mueser, and Bennet, 1994); vigilance (Nuechterlein, 1991); and early visual processing (Asamow, and Nuechterlein, 1992; cited in Addington and Addington, 1999). An interesting finding was that executive functioning was not correlated with social problem solving (Corrigan, Green, and Toomey, 1994). This finding may be unexpected, as cognitive flexibility would appear to be of great use in problem solving. However, the applicability to social problem solving is questionable as questions are cast over this particular result considering only inpatients with schizophrenia were used.
Finally, the third group of studies used both inpatients and outpatients with schizophrenia to identify the relationship between cognitive functioning and the ability to acquire psychosocial skills. Skill acquisition was consistently associated with verbal memory and vigilance (Corrigan, Wallace, Schade, and Green, 1994).

Overall, Green’s (1996) review highlighted the consistency between studies on cognitive functioning and social functioning. In summary, verbal memory predicted community functioning, skill acquisition, and problem solving skills. The two areas of social problem solving and skill acquisition were reliably predicted by vigilance, and card sorting was associated with performance in community functioning but inconsistently with skill acquisition.

The social cognition/functioning relationship

Between cognition and social functioning (reviewed above) are a number of mediating variables which are labelled as social cognitions (see figure 2; based on Green and Nuechterlein, 1999. Note that the author’s modifications are in red ink.). In this model the components of social cognition include emotion perception, social schema, coping strategies, and insight into illness. Such complex cognitive processes are necessary for the accurate perception of emotion in others, which is believed to be essential in schizophrenia to avoid misinterpretation and thus compromising social interactions (Addington and Addington, 1999).
Drawing a distinction between basic cognitions and social cognitions, as this model does, may serve to clarify the specific or general nature of cognitive deficits in social cognition. That is, whether the deficits in the schizophrenic person’s ability to read emotions is...
specific to emotional stimuli or more of a general perception deficit. However, research has yet to make such distinctions in social cognitive functioning. Currently, claims are made that neurocognition is a prerequisite for social cognition, and social cognition, in turn, is a prerequisite for social functioning” (Green and Nuechterlein, 1999). Unfortunately this explanation is somewhat linear and does not account for the effect of the feedback of functional outcome back into the areas of negative symptoms, and both basic and social cognitions (red arrows added by the author), a process which one would expect to be central to the understanding of the role of cognitive processes.

Cognitive remediation for people with schizophrenia

Having discussed the role of cognitive deficits in schizophrenia and the impact of these deficits on social functioning, it may be useful to further consider implications for treatment. The evidence for the use of atypical antipsychotic medication has already been addressed and the limitations of this approach to 'correct' cognitive functioning has been recognised (Keefe, Silva, Perkins and Lieberman, 1999).

This observation may raise the question of what a successful intervention is. The answer to this question depends on both implicit and explicit goals (Wykes, Reeder, Corner, Williams, and Everitt, 1999). This can be thought about in these terms; the goal of pharmacological interventions is to improve cognition whilst it is administered ('treat'), whereas psychosocial interventions aim to improve cognitive performance after it has stopped ('retrain'). Although this is a somewhat dichotomous explanation, “the complementarity of these two related but separate goals provides a rationale for combining the approaches” (Green and Nuechterlein, 1999, pp.315).

Targeting impaired cognitive functioning with psychosocial interventions

To date, little is known about the effectiveness of using psychosocial interventions for cognitive improvement in schizophrenia. However, research over the past few years has begun to explore this relationship. A comparison between two studies on severely disabled but stabilised patients with schizophrenia assisted in the identification of the
impact of psychosocial factors in cognitive rehabilitation. In the initial study, Spaulding (1993) identified no cognitive change in 110 patients, in a State hospital long-term unit, over a 6 month period. A more recent study (Spaulding, Reed, Storzbach, Sullivan, Weiler, and Richardson, 1998) assessed cognitive change in equally disabled and stabilised patients over the same time period but in a rich psychosocial treatment environment. In this study improvements were shown on 9 of the 12 measures of cognitive functioning, with improvements on measures of memory and executive functioning, and no change on measures of reaction time and attention. The authors surmise that in a rich psychosocial environment some aspects of impaired cognition in schizophrenia are subject to improvement.

The initial result from this study raises the question, what factors of the rich psychosocial environment impacted upon cognitive impairment? The design of the Spaulding, Reed, Storzbach, Sullivan, et al, (1999) study included a randomised controlled comparison of psychosocial rehabilitation with and without a group modality designed to exercise cognitive abilities. The modality was developed using some cognitive components of Interpersonal Psychological Therapy (IPT; Brenner, Roder, Hodel, Kienzle, Reed and Liberman, 1994), combining social skills training with other psychosocial techniques. Over the 6-month duration of the study there was evidence of improvement in cognition of only those who received the cognitive component. The most significant finding was the differential improvement in the span of apprehension, a domain of cognition that is thought to be sensitive to ‘top down’ information processing (Silverstein, Knight, Schwartzkopf, West, Osborne, and Kamim, 1996). Therefore, “it is possible that the differential improvement reflects better executive level modulation of preattentitional processing routines, as opposed to improvement in the rate or efficiency of the routines themselves” (Spaulding, Fleming, Reed, Sullivan, Storzbach, Lam, 1999, pp. 279). This finding is particularly interesting as it challenges an alternative view (Posner, 1982; cited in Hemsley, 1994), that prolonged practice on a task, thus changing it from a controlled to an automatic process, serves to inhibit redundant information, reduce the load on a
limited capacity system and subsequently improve information processing. The potential benefits of over-learning will be discussed further on.

In summary, this research indicates that cognitive improvement can occur in stabilised patients and that changes are more apparent in higher-level cognitions. Improvement is evident in the integration of elemental cognitive processes, rather than improved operation of the elemental processes themselves (Spaulding, Fleming, Reed, Sullivan, et al. 1999). Next, some consideration needs to be given to whether cognitive change, improved through psychosocial interventions, has ecological benefits for the individual with schizophrenia.

The relationship between improved cognitive functioning and rehabilitation
Systematic studies of the subjective value of cognitive recovery have yet to be performed. One of the difficulties associated with demonstrating this empirically is that self-reports can be influenced by factors unrelated to cognitive change, including symptom reduction and better behavioural functioning (Spaulding, Fleming, Reed, Sullivan, et al. 1999). These authors state that is more likely that cognitive changes are links which are directly related to anything from the stabilisation of psychotic symptoms to social behaviour. The effects of the cognitive improvements on other areas of functioning can also be viewed as being direct or indirect. For example, an indirect effect may see the recovery of memory capabilities having no direct effect on behavioural functioning, but may facilitate a patient’s response to social skills training or other rehabilitation interventions (Spaulding, Fleming, Reed, Sullivan, et al. 1999). Indeed, a return to the model set out previously (figure 2) illustrates the role of social cognitions as a mediator between basic cognition and functional outcome.

To increase or reduce the load on cognitive processes?
The optimism surrounding the benefits of targeting impaired cognition to improve the social functioning of adults with schizophrenia are not shared universally. Bellack, Gold and Buchanan (1999) state that despite the inevitable limitations to cognitive studies,
there is convergent support for the argument that ameliorating cognitive deficits can be helpful. However, they assert that there is no support for the assertion that cognitive remediation is essential. They go on to make the point that the assumption that remediation is essential is consistent with the restorative model that has dominated the treatment of mental illness (including schizophrenia) for many years. This model assumes that impairments need to be corrected to achieve an effective rehabilitative outcome, an approach that has proved to be more applicable to orthopaedics (e.g. to fix broken bones) than it has to mental health (Bellack, Gold, and Buchanan, 1999).

An alternative approach to improving cognitive functions in the person with schizophrenia would be to reduce the demands on these processes. One such strategy that has been tried and has produced extensive evidence is the over learning of key skills until they become automatic, thereby reducing the load on working memory (Ericsson and Hastie, 1994). Equally, the role of attention and working memory in learning could be minimised by adapting the format and content of training (Bellack, Gold, and Buchanan, 1999).

Bellack, Mueser, Morrison, Tierney, and Podell (1990) initially used an alternative training protocol (with cognitive behavioural components) to train adults with schizophrenia to overcome cognitive deficits on the Wisconsin Card Sorting Test (WCST; a putative neuropsychological marker of prefrontal function). These cognitive improvements were maintained for at least a day. The authors concede that such an experiment has limited direct ecological validity as learning how to do the WCST has, in itself, little value. However, they claim that the participants’ ability to improve their performance questions the assumption that they are suffering from a frontal lobe impairment but places an emphasis on the necessity to clarify vague and confusing instructions. Some support for this possibility comes from Stratta, Mancini, Mattei, Casacchia and Rossi (1994) who in a similar study found that people with schizophrenia produced significant improvements in the WCST without training, but with more appropriate instructions.
Other research findings have further supported the strategy of shifting the emphasis from focusing on cognitive deficits as artefacts to practice based improvements following enhanced effort and motivation. One such study (Kern, Green and Goldstein, 1995) found that simple instructions and monetary reinforcements were effective in increasing performance on a measure of span of apprehension (a putative trait marker of schizophrenia), which is usually considered to be highly stable.

A number of accumulated similar findings have provided evidence that a range of cognitive tasks can be enhanced through practice, instruction, and provision of rewards (Bellack, Gold, and Buchanan, 1999). For these reasons, rehabilitation is believed by some to be more effective with intervention focusing on improving functional capacities and lessening the load on cognitive processes (Bellack, Gold, and Buchanan, 1999).

Conclusion
Since 1992 there has been a shift towards the subject of cognitive functioning in understanding schizophrenia, the role of these impairments in functioning, the impact of new pharmacological agents on cognition, and the role of psychosocial interventions to enhance impairment. Although much has been learned following this new direction, progress has been modest and many new avenues of necessary future investigation have been recognised. Nonetheless, there are clear developments in the current findings on the cognitive functioning of schizophrenia that have implications for intervention.

Cognitive deficits are now widely believed to be precursors to the symptoms of schizophrenia rather than derived from them. This new direction has followed on from treating positive symptoms with conventional medication, which had little effect on cognitive functioning. The development of the atypical antipsychotic medication has demonstrated how targeting areas other than the positive symptoms assist in social functioning. However, the inability to delineate specific cognitive functions and attribute them directly to areas of functioning has impeded progress. Furthermore, rarely is one
medication alone used which has served to complicate the process of attributing positive or negative effects in a simplistic linear fashion.

Alongside the difficulties inherent in researching functions as complex as cognitions, a host of methodological limitations have also restricted progress. Adopting a standardised approach with such a heterogeneous population is a significant challenge, and the range of research designs has limited the scope for comparison across studies. However, some studies have used creative statistical procedures to carry out meta-analyses in order to make comparisons across trials. One such study reached the conclusion that atypical antipsychotics had a significant impact on verbal fluency, digit-symbol substitution, fine motor functions and executive functions (Keefe, Silva, Perkins and Lieberman, 1999). Promising though this is, the authors note that cognitive functioning still failed to reach ‘normal’ levels.

The relationship between basic cognitions and functional outcome has become clearer following the introduction of the mediator, social cognition. This accounts for the social skills that the individual might employ in order to apply cognitive process to achieve a desired outcome. Unfortunately, this relationship (figure 2; Green and Nuchterlein, 1999) fails to consider the reciprocal qualities that a particular functional outcome would have on at least three of the principal sub-components; basic cognition, social cognition and negative symptoms.

The use of atypical antipsychotic medication has been used alongside psychosocial interventions in order to improve cognitive functioning. At least one study has indicated that through using IPT there was a marked improvement in the span of apprehension, a domain of cognition that is thought to be sensitive to ‘top down’ information processing. This is particularly interesting as it suggests that there is an integration of elemental cognitive processes, which may have important implications in the development of future interventions with respect to the cognitive deficits that they are designed to target.
This in itself is a somewhat contentious point as there are differences of opinion about what should be the treatment target for psychosocial interventions designed to improve cognitive processes. Whereas some believe that specifically targeting cognitive abilities are the most appropriate way to correct the cognitive functioning of adults with schizophrenia, others have reservations about this approach. It has been suggested that until more is known about relevant cognitive targets for intervention, repeated practice of cognitive tasks is unlikely to have much improvement in underlying cognitive operations. In turn this is not likely to produce much benefit for community functioning. Instead, it may be more beneficial to place greater focus upon improving functional skills through skills training programmes. Although it has not been stated explicitly, this alternative approach advocates focussing on effort and motivation, which could be conceptualised as targeting the negative symptoms. Whilst this is not contradictory to current theoretical understandings, as cognitions and negative symptoms are said to have a reciprocal relationship, this form of intervention could be conceptualised as comparatively regressive. That is, cognitive functions are perceived to be somewhat incidental as intervention is directed exclusively at the negative symptoms.

To fully realise the potential of these current findings, further research is needed on the cognitive psychopathology and neuropsychology of schizophrenia. This research needs to surmount a host of methodological limitations in order to address the longitudinal course of the disorder across its acute, post acute and chronic residual stages. In addition, these investigations need to be done in the context of the latest biopsychosocial treatment and rehabilitation.
References


Clinical Section

This section summarises the clinical experience gained in the four core placements and two specialist placements. A summary of each of the five case reports written for each core placement, and one specialist placement are also included in this section. The five clinical case reports are submitted in full in Volume Two of this portfolio, with the placement contracts, clinical evaluation forms and logbooks of clinical activity.
Summary of Clinical Experience
Adult Mental Health Placement

Placement details

Dates: October 1999 to March 2000
Supervisor: Mrs Nicky Boella, Chartered Clinical Psychologist
NHS Trust: Sussex Weald and Downs NHS Trust
Base: Horsham CMHT

Client demographics

- Individual work with 10 clients (6 male, 4 female) ranging in age from 17 to 58 years.
- Group work – critical incident stress debriefing work with 30 men from Afghanistan following an armed aeroplane hijack. Co-worked with a clinical psychologist and an interpreter.

Presenting difficulties

- Depression
- Social phobia
- OCD
- Anxiety
- Physical and verbal aggression
- Health issues (chronic fatigue)
- Alcohol dependency
- Cognitive impairment (memory)
- Sexual abuse
- PTSD
- Somatoform disorder
- Relationship difficulties
- Eating disorder
Assessment procedures

- Assessment interviews
- Assessment tools: Critical Outcome Routine evaluation, Beck Depression Inventory II, Beck Anxiety Inventory, Maudsley Obsessional Compulsive Inventory, Risk Assessment, WAIS-III, NART, AMIPB,

Interventions

- Cognitive behaviour therapy
- Systemic
- Narrative

Other experience

- Attended and presented in the systemic/narrative therapy supervision group.
- Trust away day.
- Completed and presented a service related research project.
- Regular CMHT meetings to discuss organisational issues and review clients.
- Training in assessing eating disorders, PTSD, Mental Health Act, WAIS-III.
- Critical incident stress debriefing (CISD) training.
- Visits to the surrounding services (Inpatient wards, specialist services).
People with Learning Disabilities Placement

Placement details

Dates: April 2000 to September 2000
Supervisor: Mrs Ewa Rula, Chartered Clinical Psychologist
NHS Trust: Kingston and District Community NHS Trust
Base: Richmond CTPLD

Client demographics

- Individual work with 6 clients (3 male, 3 female) ranging in age from 21 to 57 years
- Group work – A dog phobia group co-worked with 2 other trainees. The group comprised of 3 males and 2 females, aged between 25 and 50 years.

Presenting difficulties/Issues

- Eligibility for services
- Depression
- Challenging behaviour
- PTSD
- Emotional insight
- Obsessions
- Bereavement
- Family relationships
- Anxiety

Assessment procedures

- Assessment interviews with staff/clients/families.
- Functional analyses: charts, diaries, observation.
- Neuropsychological assessment using: Leiter, Vineland, Raven’s Progressive Matrices, WAIS-III.
Interventions

- Psychodynamic
- Cognitive behaviour therapy
- Systemic

Other experience

- Psychology department presentation: “The division of clinical psychology - A critical self-reflection”.
- Presented cases in a group supervision group.
- Transmission of skills to a range of staff caring for clients.
- Contributed to the development of services to offer an improved transition from child to adult.
- Training day on men with learning disabilities and sexuality.
- Conference about the development of the Institute of Psychotherapy in Learning Disabilities.
- A government/professional debate on the new proposals for people with psychopathic personality disorder.
Child, Adolescent and Family Placement

Placement details

Dates: October 2000 to March 2001
Supervisor: Dr Johanna Flack, Chartered Clinical Psychologist
NHS Trust: South west London and St. George’s NHS Trust
Base: Sutton Older Adult Community Mental Health Team

Client demographics

- Individual work with 11 clients (7 male, 4 female) ranging in age from 8 to 17 years

Presenting difficulties

- Depression
- Anxiety
- School refusal
- Relationship difficulties
- Toileting
- Psychosis
- Cognitive impairment (learning needs)
- Pervasive developmental disorder
- Challenging behaviour
- Alcohol dependence/care proceeding
- Learning disability

Assessment procedures

- Assessment through interview, play, genograms, observations, monitoring.
- Assessment using: Child Depression Scale, WICS-III, WORD, TEA-ch, Birleson Depression Scale, Connor’s, Strengths and Difficulties, British Ability Scales II.
**Interventions**
- Systemic/Narrative
- Cognitive behaviour therapy
- Psychodynamic

**Other experience**
- Contributed to a teaching session for medical students doing a BSc in Developmental Psychology.
- Presented cases in peer supervision and CAMHS meetings.
- Contributed to teaching for carers with children with autism.
- Regularly worked in the family therapy team and joined the journal clubs.
- Attended several conferences and debates on the interventions for ADHD. Also a 2 day workshop on Transforming Personality Disorder (Christine Padesky).
- Attended a narrative therapy conference, and a training day on intergenerational patterns of abuse.
Older Adult Placement

Placement details

Dates: April 2001 to September 2001
Supervisor: Mrs Lynn Beech, Chartered Clinical Psychologist
NHS Trust: Sussex Weald and Downs NHS Trust
Base: Horsham CMHT

Client demographics

- Individual work with 10 clients (4 male, 6 female) ranging in age from 65 to 91 years

Presenting difficulties

- Depression
- Anxiety
- Bereavement/loss
- Vomit phobia
- Relationship difficulties
- Guilt
- Rehabilitation
- Claustrophobia
- Learning disability
- Challenging behaviour
- OCD
- Cognitive impairment (dementia)
- Separation anxiety

Assessment procedures

- Assessment through interview, observations, monitoring.
- Assessment using: WAIS-III, AMIPB, NART, WCST, HADS, BAI.
Interventions

- Systemic/Narrative
- Psychodynamic
- Cognitive behaviour therapy

Other experience

- Presented cases in the Team meetings.
- Transmission of skills to relatives and carers.
- Worked on inpatient/outpatient dementia wards.
- Liased across 2 different Teams to meet a clients needs.
- Attended the older adult directorate meetings.
- Meet and observe a range of professionals (ECT, psychiatrist, OT, nurse)
- Attended seminars on Bowlby’s Attachment Theory, staff 'burn out'. Also attended a conference on systemic reflections on working with child abuse.
Specialist Placement I
Severe and Enduring Mental Health

Placement details

Dates: October 2001 to March 2002
Supervisor: Dr Brian Solts, Chartered Clinical Psychologist
NHS Trust: Sussex Weald and Downs NHS Trust
Base: Centurion Centre – Acute psychiatric mental health wards

Client demographics

- Individual work with 10 clients (5 male, 5 female) ranging in age from 20 to 54 years

- Group work – An ongoing, weekly, open group, offering the inpatients a forum to discuss any issues. The group work was interpreted using a psychodynamic approach. This was joint run with a clinical psychologist (supervisor). The group was run over 20 weeks and between 3 and 15 patients attended.

Presenting difficulties

- Depression
- Social phobia
- Guilt/Self-esteem
- Psychosis
- Attachment difficulties
- Sexual abuse
- “Personality Disorders”
- Self harm/suicide attempts
- Anxiety
- OCD
- Eating disorder
Assessment procedures

- Assessment interviews, observations, monitoring.

Interventions

- Psychodynamic
- Systemic/Narrative
- Cognitive behaviour therapy

Other experience

- Worked with the Home Treatment Team (HTT) in a consultative capacity.
- Carried out 2 teaching sessions for the HTT on working with relationship problems.
- Assisted my supervisor in some teaching of ward staff.
- Gave a psychological perspective at multi disciplinary meetings in relation to the needs of some challenging clients.
- Supervised some work on the locked wards.
- Contributed to a new risk assessment procedure.
- Met and observed a range of professionals.
- Attended ward handovers to give a psychological perspective on clients needs.
- Systemic/Narrative supervision group.
Specialist Placement II
Systemic and Family Therapy

Placement details

Dates: April 2002 to September 2002
Supervisor: Mrs Jayne Beal, Chartered Clinical Psychologist, and Mr Graham Lee, Family Therapist.
NHS Trust: West Sussex Health and Social Care NHS Trust
Base: Worthing CAMHS

Client demographics

- Worked with 9 families. A total of 3 of the index patients were male and 6 female. Their ages ranged from 6 to 15 years
- Family Therapy Clinic – Worked with a total of 8 families. The index patients ages ranged from 8 to 16, and 2 were male and 6 female.

Presenting difficulties

- Depression
- Social communication disorder
- Toileting
- Auditory hallucinations
- Attachment difficulties
- Sexual abuse
- Self-harm
- Panic attacks
- Anxiety
- Eating issues
- Bereavement
- Somatoform disorder
- Relationship difficulties
Assessment procedures
  - Assessment interviews, observations, monitoring.

Interventions
  - Systemic/Narrative – Family Therapy
  - Psychodynamic
  - Cognitive behaviour therapy

Other experience
  - A two hour presentation on discourse analysis and ADHD.
  - Meetings about organisational issues/change.
  - Presented and reviewed cases in meetings.
  - Met with the Drugs and Alcohol Team and the Youth Offending Service.
  - Received live supervision for a majority of the family work.
Clinical Case Report Summaries
Adult Mental Health Case Report Summary

The assessment and intervention of a 59-year-old male client with obsessive-compulsive disorder and depression: A cognitive behavioural approach.

March 2000

Year 1
The assessment and intervention of a 59-year-old male client with obsessive-compulsive disorder and depression: A cognitive behavioural approach.

N.B.: Some of the details have been changed, including all names, to preserve the anonymity of the people involved as well as the health care setting.

Name: Mr L.
DOB: 01:01:41

Reason for referral
Mr L. was identified as having obsessive-compulsive disorder (OCD) and was referred to psychology from the CMHT psychiatrist.

History of Presenting Problem
Mr L. reported that he first experienced obsessions and compulsions in 1971. These symptoms coincided with the onset of depression, which was diagnosed by the psychiatrist. These difficulties coincided with a difficult time for Mr L., when he was caring for his elderly mother shortly before she died. Since this time his mood fluctuated and his obsessions and compulsions gradually became more generalised and increased in frequency. There was a history of serious mental health difficulties throughout Mr L.'s family and his brother committed suicide in 1999. Mr L. had a heart attack in 1991. He had no previous contact with psychology.

Assessment
The assessment included interviews with Mr L. to begin to understand the nature and course of his OCD and depression. Mr L. experienced compulsions to check that his house was safe, he believed that failure to do so would result in catastrophic consequences. Mr L. reported that his depression had recently reduced in severity. The assessment also included the use of the Maudsley Obsessional Compulsive Inventory (MOCI) and the Beck Depression Inventory II (BDI-II). The MOCI indicated high scores on 'checking' followed by 'slowness'. The BDI II indicated 'moderate' levels of
depression. Other areas of the assessment included a history of his childhood, family members, employment and a risk assessment. He had a history of physical abuse from his father, had misused alcohol, and attempted suicide in 1978. At the time of assessment he reported no suicidal ideation.

Formulation
His OCD may have been the result of a genetic predisposition, as well as the result of his ‘unsafe’ childhood. He may also have believed that his mental activity was responsible for his mother’s death, which happened at a time when his siblings became mentally ill. The assessment indicated that at this traumatic time Mr L. experienced unwanted intrusive thoughts about dangers and risks. To reduce distress, he attempted to neutralise these through checking. This response to the intrusive thoughts appeared to be central to their persistence causing marked anxiety. Seeking reassurance was another behaviour that appeared to maintain his obsessional thoughts.

Intervention
CBT was selected as the most appropriate intervention. The intervention was designed to offer education about OCD and match this to the client’s experiences, to use exposure and response prevention, whilst investigating and challenging the client’s intrusive thoughts. A number of tasks and monitoring strategies were designed to facilitate this process and to encourage Mr L. to take responsibility for his progress. Some narrative therapy techniques were also deployed to assist Mr L. in developing an alternative, less pathologised story of his experiences, thoughts and feelings.

Outcome and critique
The MOCI measure indicated a reduction in Mr L.’s ‘checking’ and ‘slowness’, although his score for ‘doubting’ rose a little. His BDI II score reduced to the normal/mild range. He reported having control over the OCD symptoms for the first time in his life. The frequency of checks reduced significantly and he also reported losing the “nagging feelings”. Mr L. also managed to adjust his perception of the amount of responsibility
that he had over unwanted events. He learned to challenge and reappraise many of his negative thoughts. Mr L. developed a range of activities that he planned to pursue so that he did not have too much time at his disposal now that the compulsions had stopped. Mr L. and his wife planned to monitor his progress along with his psychiatrist. The critique included getting the timing right for exposure and response prevention. The need to use supervision promptly to work through frustrations with the client also became clear.
Learning Disabilities Case Report Summary

The Assessment and Facilitation of Emotional Insight with a 44 Year Old, Male Client with a Moderate Learning Disability: A Psychodynamic Approach.

September 2000

Year 2
The Assessment and Facilitation of Emotional Insight with a 44 Year Old, Male Client with a Moderate Learning Disability: A Psychodynamic Approach.

N.B.: Some of the details have been changed, including all names, to preserve the anonymity of the people involved as well as the health care setting.

Name: M.S.
DOB: 03.03.56

Reason for referral
M.S. was referred to psychology by the occupational therapist as he was said to “obsess” over women, be “sexually inappropriate”, “lie”, and show aggression to others.

History of presenting problem
M.S. was a 44-year-old man with Down’s syndrome and a moderate learning disability. He spoke English and had good communication skills. In the past when he moved residential homes, his behaviour became more challenging and he was described as threatening people and destroying their photographs or belongings. More recently his manageress at work was concerned that he was being inappropriate with a female member of staff. When disappointed he presented with a low mood and misused alcohol.

Assessment
The assessment involved interviews with M.S., his carers, and work colleagues. It became clear that M.S. was close to his family but his mother had died when he was young. His two older brothers and his sister were alive but did not see him regularly. When M.S. was told that his mother was dead he threw a table through the window. His carers and work colleagues gave mixed reports about M.S.’s conduct, saying that he was a “lovely” man yet there was anger and frustration directed at him. When the manageress refused his photograph M.S. deliberately made “mistakes” at work and raised his fist to her. He often bought his colleagues gifts, but destroyed things when they left. He was threatened with the “sack” should there be any further incidents. He stated that he would
never use physical aggression against a woman, as "it's wrong". M.S. was also believed to live the fantasy of being in an Australian soap family. M.S. spoke favourably about his colleagues. He appeared to be very pleased to be able to talk these issues through with the trainee clinical psychologist, who he occasionally called "perfect".

Formulation
M.S.'s experienced unstable childhood attachments. The bond between the mother and 'handicapped' child is often incomplete (Bicknell, 1983). In addition, his mother was dependant on alcohol so she may not have been so emotionally available for him. The quality of his attachment was also impaired as his dad died when M.S. was aged 2 and his mother when he was 24. M.S. had no male attachment figures, something that is considered to be crucial to the development of sexual boundaries and identification (Neven, 1997). In the female dominated health and social care settings, M.S. could be seen to idealise, flatter and seduce, in an attempt to secure stronger bonds. These bonds were often disrupted, as he was required to change residential setting so frequently. Having invested in these bonds, disruption would often result in M.S. becoming distressed, which manifested in verbal insults and the tearing up of photographs. M.S. also wanted a relationship with a "normal" (non PLD) person. His gifts and compliments were often well received and any subsequent advances resulted in embarrassment and then anger was directed at him. His "lies" and fantasies could be understood as M.S. attempting to create the 'perfect' family that he never had, but longed for. Unfortunately, these actions often left him alienated by others.

Intervention
At M.S.'s request the focus of the intervention was "losing people and cruelty". Much of the work involved focussing on the therapist/patient relationship, and issues of idealisation. This forum provided a unique arena to re-experience the vicissitudes of the parent/child relationship (Bauer and Kobos, 1987). Preparing M.S. to give up the therapeutic attachment, and acknowledging his disappointment could help him confront and modify his reaction to loss, separation an autonomy. This process was facilitated through an awareness of the counter/transference in the session. Following this
intervention his work manager and home manager were informed of the pattern of relationships that can leave M.S. feeling abandoned, resulting in inappropriate behaviour. They did some work with the staff on maintaining clear and firm boundaries in the work place.

Outcome and critique

M.S. developed a different relationship with ‘sadness’ and ‘excitement’ when he began to recognise what was triggering these feelings and how to act on them. He had developed appropriate ways to understand and express a range of powerful emotions. He no longer became “over attached” to staff and there were no further incidents of aggression or withdrawal. His managers reported that he was doing well and M.S. was pleased with this feedback. M.S. expressed his sadness at the termination of therapy and requested a photograph to maintain the memory of our work together. There was also a reduction in the ‘stories’ about his Australian soap family as he pursued his interests through a range of clubs and activities that he found rewarding. Unfortunately, it was only after the completion of therapy that the trainee discovered that M.S.’s mother committed suicide.
Assessment and intervention of an 8-year-old boy presenting with nocturnal enuresis. An integrative approach was used to understand the issues associated with living with a mother with psychosis, and the reciprocal relationship that this had on the professionals working within a multi-disciplinary setting.

March 2001

Year 2
Assessment and intervention of an 8-year-old boy presenting with nocturnal enuresis. An integrative approach was used to understand the issues associated with living with a mother with psychosis, and the reciprocal relationship that this had on the professionals working within a multi-disciplinary setting.

N.B.: Some of the details have been changed, including all names, to preserve the anonymity of the people involved as well as the health care setting.

Name: Alfonso Bala  DOB: 07.07.92 (Child)
Name: Carmeena Bala  DOB: 02.02.59 (Mother)

Reason for referral
The 8-year-old Alfonso was referred to the CAMHS to assess his toileting difficulties, especially encopresis.

History of presenting problem
Carmeena reported that Alfonso had been wetting and soiling his clothes recently. However, the details did not become clear as she became visibly agitated, swearing and shouting. It was extremely difficult to understand the content of what she was saying.

Assessment
The assessment involved interviews with Carmeena and Alfonso. It became apparent that Carmeena was experiencing her own psychotic mental health difficulties. She used sexualised talk in front of her child, spoke about people reading her mind, believed she was constantly being watched, and said that the president of the United States was after her. She spoke about these issues in an aggressive tone whilst Alfonso would keep himself busy playing with the toys. She also reported a history of depression. Initially, the assessment interviews were conducted by the trainee clinical psychologist and a specialist psychiatric registrar (SPR). However, the line of medical questions used by the SPR appeared to aggravate Carmeena as they referred to ‘schizophrenia’ and medication.
The SPR withdrew to protect the therapeutic relationship. The assessment indicated that Alfonso was anxious at home. His toileting difficulties were said to happen most nights, for as long as they could recall.

Formulation
Carmeena’s mental health difficulties were associated with Alfonso’s developmental delays. It appeared to be difficult for him to make sense of his world and learn about issues such as self-hygiene when his mother’s world was so unpredictable and non-containing. His toilet difficulties could also be seen as a method of communication as he was anxious about his mother’s behaviour but felt unable to express this verbally. This toilet problem had in effect brought his mother’s needs to the attention of the mental health services.

Intervention
Some play therapy was used to get a better insight into Alfonso’s internal world. With Carmeena’s consent the community psychiatric nurse from the adult services joined one session to assist with the assessment. As her trust developed, Carmeena agreed to a home visit from the adult mental health services. When the appropriate services were holding Carmeena’s needs, it was possible to do some work on Alfonso’s toilet difficulties. This took the form of psycho-education, monitoring of his toileting, forming an alliance between mother and son, and introducing some behavioural interventions.

Outcome and critique
The monitoring of Alfonso’s toileting showed that he went from wetting every night to only very occasionally. He took responsibility for using the toilet appropriately with his mother’s encouragement. She reported that it “is like a miracle every day”. Mother and son had an improved relationship, which reduced family conflicts as they united their efforts. Communication between them improved, as well as between Carmeena and the professionals. However, she remained cautious over receiving treatment for her own mental health needs.
Older Adult Case Report Summary

The neuropsychological assessment of a 65-year-old man presenting with "memory difficulties": Assessment profile, interpretation and recommendations.

September 2001

Year 2
The neuropsychological assessment of a 65-year-old man presenting with “memory difficulties”: Assessment profile, interpretation and recommendations.

N.B.: Some of the details have been changed, including all names, to preserve the anonymity of the people involved as well as the health care setting.

Name: Mr Reginald David Day
DOB: 04.04.36

Reason for referral
Mr Day was referred to the Older Adult Community Mental Health team to investigate his reported progressive memory impairment. The referring agent suspected that Mr Day was suffering from the early stages of a dementing illness.

History of presenting problem
Mr Day and his wife reported that his memory has been deteriorating over the past 7 years. Previously he had experienced no such problems. The difficulties began after he was believed to have had a heart attack. Following investigation it was concluded that he did not have a heart attack but a syncopal attack (unconsciousness with a slow pulse and general flaccidity). He experienced further syncopal attacks, monthly, over the following 7 years. Mr Day was otherwise in good physical and mental health. Mr Day’s father died age 84 from Parkinson’s disease and his mother died age 72 from a heart problem. She was not believed to have had a dementing illness.

Assessment
The assessment involved a series of interviews with Mr Day and his wife about the nature and course of his memory difficulties. The interviews also provided information about Mr day’s family, his interests and his employment history. Neuropsychological testing was also selected to accumulate more information on the possibility of a dementia and the potential effects of any sustained neurological damage. The following tests and measures
were used: Wechsler Adult Intelligence Scale (WAIS-III), Adult Memory and Information Processing Battery (AMIPB), Wisconsin Card Sorting Test (WCST), National Adult reading Test (NART), Beck Anxiety Inventory (BAI), and The Hospital Anxiety and Depression Scale (HADS). He also had an MRI scan.

Formulation
The hypothesis to be tested was that Mr Day had diminished cognitive functioning that manifested itself in deterioration in his ‘immediate’ and ‘recent’ memory. In addition, it was hypothesised that his deficits were not globalised, but most acute in his verbal processing skills.

Intervention
Not applicable – assessment only.

Outcome and critique
The hypothesis that Mr Day had diminished cognitive functioning, which manifested in deterioration in his “immediate” and “recent” memory, was reflected in testing. Also, the hypothesis that the deficits in cognitive functioning were not globalised but more acute in verbal processing tasks was also apparent, especially through his verbal/performance discrepancies. The neuropsychological testing information also identified the possibility of more marked deterioration in the left hemisphere, however the MRI scan did not support this. Finally, personal reports, neuropsychological testing and the MRI scan have indicated that the nature of Mr Day’s experiences and cognitive functioning are not inconsistent with those expected in the early stages of a multi-infarct dementia. The amount of clinical time taken was considerable for both client and clinician. However, with more time it might have been appropriate to use the Wechsler Memory Scale III to give a more informed analysis of Mr Day’s abilities.
Specialist Case Report Summary

Psychological engagement and extended assessment with a 37-year-old man presenting with psychosis in an adult acute inpatient mental health setting: A psychodynamic approach to formulation and work with staff to inform care planning.

September 2001

Year 3
Psychological engagement and extended assessment with a 37-year-old man presenting with psychosis in an adult acute inpatient mental health setting: A psychodynamic approach to formulation and work with staff to inform care planning.

N.B.: Some of the details have been changed, including all names, to preserve the anonymity of the people involved as well as the health care setting.

Name: Mr Peter Shaw
Age: 37 years

Reason for referral
The police detained Peter under section 136 of the Mental Health Act in the police station following a female acquaintance’s accusation that he had “stalked” her. The police described Peter as being “extremely deluded and grandiose in manner”.

History of presenting problem
In the States, Peter first experienced “alternative experiences”, he described experiencing birds joining and separating in mid air, walking on air, and people realising that he was someone other than Peter Shaw, someone very “special”. However when he returned to England and tried to re-establish relationships things became difficult as he was “misunderstood”.

Peter spoke about being able to read others’ thoughts, broadcasting his own thoughts, having the ability to control and predict what others might do, being able to control world events and the weather, and about being a “very special” person. On occasion he had referred to himself as the “messiah” to hospital staff.

Assessment
Considering Peter’s lack of trust and reluctance to be in hospital, formal assessment tools (e.g. The WAIS-III) were not used as it was thought that they might obstruct engagement. Instead clinical interviews and observations were used in an attempt to get a clearer
psychological formulation of his presentation. This was deemed as especially important as Peter had not engaged fully with the medical assessments and prior to the trainee’s involvement, there had been significant gaps in Peter’s life history and the information he was giving about his symptoms. The assessment focussed on his traumatic early life and developmental experiences.

Formulation

Peter’s reports of infancy and childhood illustrated that he had never felt loved, wanted, cared for and respected. He reported that his mother considered him to be an outsider, punished him frequently and blamed him for keeping the family apart. Klein stated that in a healthy relationship the mother acts as a receptacle for painful and complex feelings, which can later be integrated by the infant (depressive position) in order to develop a picture of one mother who can be both “good” and satisfying as well as “bad” and frustrating. As was the case with Peter, people with psychosis often had their complex feelings poorly contained contributing to excessive splitting, the lack of a secure identity and an inability to own both loving and aggressive feelings. Peter developed primitive mental defences in infancy to deal with recurring mental pain. He began to experience messianic delusions, which psychoanalytic theory has described as a process that is contrived unconsciously to avoid pain, loss, or helplessness or the feelings aroused by separation (Jackson, 2001). Using Klienian concepts, Peter could be understood as being incapable of containing the feelings aroused by his rejection and “failure”, and thus projected his anger, frustration and grief onto the outside world. This just left him with all of the “good parts”, that his father had previously represented, personified in the messiah figure (“unconditional and infinite paternal love”), which needed to be protected in a “military establishment” (hospital).

Intervention

Considering Peter’s lack of supportive relationships and his misunderstandings of where he was and for what reason, the action plan was to continue the process of an extended psychological assessment alongside his medical treatment. The aims of this plan were to
offer him support in order to minimise further misunderstandings between Peter and staff, to encourage his adherence to interventions, to contain some of his anxieties and offer him an understanding of his current situation, and to offer him a consistent therapeutic relationship throughout his hospital admission. The therapist’s continued stable presence and professional attitude are powerful therapeutic factors (Jackson, 1991). It is also necessary to use several sessions to allow the patient to begin to understand his delusional beliefs and anxieties in a direct way (Jackson, 1991). Finally, sharing psychological formulations with the other professionals in the team could also contribute to his care plan and ensure that psychological factors were considered alongside predominant medical and forensic issues.

Outcome and critique
As Peter engaged with the trainee, he was more able to invest his trust in the team. The team began to challenge their catastrophic ideas which enabled them to develop a clearer understanding of Peter’s experiences and to inform his care plan. This provided a more containing environment in which Peter could began to take a meta position and do more reality testing which resulted in him perceiving the delusions as less concrete. As he did this he moved from a position of narcissistic identification (Caper, 1998) where he could not empathise with others to a position where he was particularly empathic and considerate. This enabled Peter to re-explore the “harassment” incident and to think about more appropriate ways to handle frustrating and irritating situations, which could reduce risk.

The nurses in the rehabilitation home assessed Peter’s daily living skills as “very good”, and he responded well to a “returning to work scheme”. In the final session Peter stated that “this is the best I have felt for two years” and that he was “looking forward to starting a new life”. Objective measures of risk, in addition to the Forensic and Police reports, may have helped contain the anxiety of the team.
Research Section

This section contains four pieces of work. The service related research project was carried out in year 1, during the adult mental health placement. The qualitative research was done in year 2. The literature review was also completed in year 2 and was intended as an introduction to the major research project. The major research project was carried out across years 2 and 3.
Service Related Research Project

Nurses’ beliefs and attitudes towards challenging patients on an Acute Mental Health Ward: how this influences practice.

URN: 3902129

PsychD Clinical Psychology

Year 1 (course 28)

July 2000
Acknowledgements

I would like to express my appreciation to my placement supervisor Nicky Boella, research supervisor Mary John, and Beverly Meeson the Trust’s Research and Design coordinator, for all your time, patience, and guidance. I am also extremely grateful to all of the nurses who took time out of their busy schedules to complete the questionnaires.
Abstract

Objectives: To investigate nurses' beliefs and attitudes towards the diagnostic categories and labelling, demands, and management of the challenging patient. The nurses' perceptions of the effectiveness of their intervention as well as issues of support and possible continuing professional development were also explored.

Design: Each nurse was given the questionnaire and asked to apply the questions to their previous and current experience on the ward.

Setting: One acute mental health ward.

Participants: All nurses currently working on the ward.

Main outcome measures: Questionnaire on managing mental health patients. This was interpreted using content analysis.

Results: 54% (7 responses) of the nurses indicated that the most difficult diagnosis was that of personality disorder. The most challenging patients were described as “attention seeking” and “manipulative”, and were said to polarise staff. Several of the nurses’ (42%; 5 responses) believed that consistency and clear boundaries were important in managing the more challenging patients, however despite their efforts there was little belief in intervention effectiveness. This had a negative impact on how the nurses (67%; 8 responses) felt about their professional role. Many of the nurses felt under-trained for this role and 92% indicated that they would like to further develop their professional skills should the opportunity be made available by the service.

Conclusions: The nurses identified patients with personality disorders as the most challenging. They reported that these patients were manipulative and non-cooperative and were highly critical of nurse care. The nurses reported few effective strategies in managing these patients and experienced powerlessness and the perception of intervention ineffectiveness. However, they did value their psychological skills and communicated that they would welcome greater levels of support and the opportunity to continue their professional development in this area. This was a preliminary study that shall be repeated in the future to evaluate the implementation of nurse training workshops and support networks.
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Introduction

Nursing of the challenging patient

The label of the “unpopular”, “problem” or “difficult” mental health patient is familiar to the profession of nursing (Breeze and Repper, 1998). “Difficult” patient characteristics have been identified as; excessive demands for time, misuse of medication, hard to empathise with, dangerous to self or others, manipulative, attention seeking, or able to polarise staff (Neill, 1979; cited in Gallop and Wynn, 1987).

Early literature on this client group (Stockwell, 1972; Conrad 1979; Armitage, 1980; all cited in Breeze and Repper, 1998) has been criticised for taking a reductionist and determinist perspective on the phenomenon of the “difficult” patient. To redress this imbalance, more recent studies have switched from focussing on patient personality and traits (e.g. aggression, manipulation, demands), to investigating the social construction of the “difficult” patient (Gallop, Lancee, and Shugar, 1993; Gallop and Wynn, 1987; Johnson and Webb, 1995).

This new perspective has described “difficult” patients as those who deny the authority and the therapeutic value of the nursing staff (Breeze and Repper, 1998). The consequence of these challenges is that the “difficult” patients are labelled negatively and their care is affected. This may range from “belittling” and avoidance on the ward (Gallop, Lancee, and Garfinkle, 1989), reinforcing maladaptive behaviour, to the denial of care through rejection from the service (Repper and Perkins, 1995).

This lack of respect for challenging patients (Gallop, et al., 1989) can be described as a reaction to the nurses’ feelings of powerlessness (Carey, Jones, and O’Tool, 1990). This may be as a result of the patient not fulfilling the obligations of the sick role resulting in power struggles (Parsons, 1951; cited in Breeze and Repper, 1998). Subsequently, the nurses frequently attribute a patient’s refusal of treatment to their own therapeutic failures (May and Kelly, 1982).
Furthermore, the nurses' feelings of powerlessness may be exacerbated as they have to make difficult choices about who "deserves" help given limited time and resources (Breeze and Repper, 1998). Sharrock, Day, Qazi, and Brewin (1990) purport that greater staff time and optimism would be directed toward those patients who are more likely to make a therapeutic change, rather than those more "difficult" patients with a stable disorder.

Pringle (1998) stresses the importance of patients verbalising feelings to avoid acting out with self-destructive acts such as self-harming or overdosing. To respond to this there is a need for nurses to be trained in self-awareness, attitudes, and strategies to help them deal with any difficult emotional issues that arise (Stockbridge, 1993). Therefore, it is not surprising that inadequate training manifests itself in negative attitudes towards certain client groups (Perego, 1999), and that nurses with little experience report a greater degree of prejudice against an individual, depending on his/her diagnosis.

Another salient finding reported in the literature is that nurse/patient relationships can become more challenging around the time of patient discharge (Pringle, 1998). To respond appropriately at this time, the nurses would benefit from understanding how past experiences of relationships may be acted out between the nurse and the patient increasing levels of conflict (Pringle, 1998).

Rationale Behind the Research

Members of the Community Mental Health Team (CMHT), nursing staff and patients, on one specific acute mental health ward had expressed some concern over practice, relationships and interactions on the ward. The purpose of this study was to identify some of these issues from the nursing staff's perspective and to make appropriate recommendations.
The Current Status on the Ward

This particular acute adult mental health ward has not been subject to any similar research projects. Therefore, the ward manager, clinical psychologist and trainee clinical psychologist (researcher) collaborated to investigate this area.

The Key Objectives of the Research

A questionnaire was designed following a series of short interviews in which members of the CMHT as well as the nursing staff expressed their concerns. The questionnaire was designed to be exploratory and was constructed to investigate whether the problematic themes, which are prominent in the literature, were applicable to this specific ward. There were no specific hypotheses, but the main aims of the research were to investigate the nurses’ beliefs and attitudes towards:

| I) the diagnostic categories and subsequent labelling of the challenging patient. |
| II) the demands of the challenging patient. |
| III) how the challenging patient is managed. |
| IV) the effectiveness of intervention. |
| V) issues of support and continuing professional development. |
Method

Participants

All 24 nurses on the ward formed the target sample. They were all given the questionnaire of which 13 were returned (54%). The grades of the nurses in the intended sample and the achieved sample are shown in Table 1. Ten of the nurses who responded were female and three were male.

Table 1. Categorisation of Participants by Grade.

<table>
<thead>
<tr>
<th>Grade</th>
<th>Number in Intended Sample</th>
<th>Number in Achieved Sample</th>
<th>Percentage response rate per grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>8</td>
<td>4</td>
<td>50%</td>
</tr>
<tr>
<td>B</td>
<td>0</td>
<td>0</td>
<td>N/A</td>
</tr>
<tr>
<td>C</td>
<td>0</td>
<td>0</td>
<td>N/A</td>
</tr>
<tr>
<td>D</td>
<td>6</td>
<td>6</td>
<td>100%</td>
</tr>
<tr>
<td>E</td>
<td>7</td>
<td>2</td>
<td>29%</td>
</tr>
<tr>
<td>F</td>
<td>3</td>
<td>1</td>
<td>33%</td>
</tr>
</tbody>
</table>

The table shows that the achieved sample was made up predominantly from D-grades, followed by A-grades, E-grades and an F-grade. There were no participants from the B or C-grades.

Measures

The Questionnaire on Managing Mental Health Patients was used (appendix 1), having received approval from the Trust Research Steering Group (appendix 2). The author devised this questionnaire as no existing measure addressed the areas of interest outlined in the “key objectives” section (page 157). Following two questions determining the grade and sex of the nurse, there were a further twenty questions of which one was closed. The predominant use of open questions was selected to allow the nurses to give unrestricted responses. This was considered necessary, considering the exploratory stage of the investigation.

The questionnaire was devised through interviews with a clinical psychologist, a counselling psychologist, and two ward managers. In these interviews, the professionals were asked about patients that were most challenging to the nurses, how they are
managed, the nurses' attitudes towards these patients, and how working with these patients made the nurses feel about their own professional role. The questions were based on the information elicited from these interviews as well as on the literature.

A small pilot study was completed on a similar ward in another hospital in the Trust. Problems identified with the pilot draft of the questionnaire were amended. These included; shortening the questionnaire, simplifying complex questions and grammar, and adjusting questions to make them more relevant to those across the range of nursing experience. The amended questionnaire was administered to the target population.

Validity
Through the use of a pilot study and feedback, the measure appears to have adequate face validity. However, no further claims of the validity of the measure can be made.

Procedure
A questionnaire was given to each of the twenty-four nurses on the ward. Page one of the questionnaire was a cover sheet that explained the purpose of the research. That is, to further understand the demands placed on the nurses by the more challenging patients. The respondents were asked to apply the questions to their previous and current experience on the ward, and not just the current clients, to improve the generalisability of ward experience. The importance of client anonymity and respondent confidentiality was clearly stated. The nurses were also informed that in no way would their responses be used to judge their clinical work. All respondents were given the researchers contact number in case they required any assistance. When completed, the nurses returned their questionnaires to a "returns box", in a blank envelope to ensure confidentiality. The researcher frequently visited the ward at hand-over times in an attempt to increase the response rate.
Method of analysis
Content analysis (Breakwell, Hammond and Fife-Shaw, 1995) was used to classify the open ended, qualitative information. Going through each individual’s responses to each question and observing which themes of meaningful information were generated developed classification schemes. At the primary coding stage the researcher condensed the responses down into a few key words. The secondary coding stage involved using these key words to identify recurrent themes. Once the data had been coded in this way the rater then calculated the frequency of responses within each category.

Inter-rater reliability
Considering that this measure had not previously been used, an independent rater who was familiar with the issues raised in the questions classified the material in addition to the researcher. This process was undertaken to minimise the risk of interpreter bias.

Results
The data
The predominantly open question format of the questionnaire yielded a considerable amount of qualitative information. There was also some quantitative information generated from the closed questions.

Response Rate
Thirteen of the twenty-four questionnaires were completed and returned. The small sample does not allow for any inferential statistics. Therefore the data is best represented through descriptive statistics.

Inter-rater reliability
Content analysis (Breakwell, Hammond and Fife-Shaw, 1995) was used to interpret the data. Four of the completed questionnaires were categorised by a second rater to ensure inter-rater reliability. The second rater’s time constraints allowed for primary coding
only. At the primary coding stage there was a good agreement rate of 89% between the two raters (appendix 3).

Data Presentation
The raw data is presented in appendix 4. Due to the wealth of information gathered and the brevity of this report, only the results that generated the most recurrent themes are detailed in this section. To view the complete set of categorised data see appendix 5. Consistent with the key objectives of the research (outlined on Page 157), the data is divided into five main sections.

The following tables show the number of respondents to each question. The responses have been grouped into categories. N.B. Some participants made more than one answer to a question and may therefore appear in more than one category.
I. Diagnoses and labels

Table 2. The Categories of Responses and Number of Respondents Regarding Issues of Diagnoses and Labels.

<table>
<thead>
<tr>
<th>QUESTION</th>
<th>CATEGORIES GENERATED</th>
<th>NUMBER OF RESPONDENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients with which diagnosis do you find the most difficult to manage?</td>
<td>(N=13)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Personality Disorder</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>Aggression</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Self-harmers</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Schizophrenia</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Substance misuse</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Bi-polar affective disorder</td>
<td>1</td>
</tr>
<tr>
<td>Which labels do you and your colleagues use to describe these more challenging patients?</td>
<td>(N=11)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Attention seeking</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Manipulative</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Diagnostic term</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>“Cutters”</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>“Alchies”</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Unwell</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Don’t know</td>
<td>1</td>
</tr>
</tbody>
</table>

Table 2 shows that the nurses found it most difficult to manage patients with personality disorder” (7 responses), followed by aggression (2 responses). The most challenging patients were most frequently described as “attention seeking” (3 responses) and “manipulative” (3 responses).
II. Demands of the challenging patient.

Table 3. The Categories of Responses and Number of Respondents Regarding the Demands of the Challenging Client.

<table>
<thead>
<tr>
<th>QUESTION</th>
<th>CATEGORIES GENERATED</th>
<th>NUMBER OF RESPONDENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is it about these patients, <em>behaviours</em> that makes caring for them more demanding? (N=13)</td>
<td>Non co-operative/staff manipulation 7</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Self harm/suicidal ideation 4</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Time consuming 4</td>
<td></td>
</tr>
<tr>
<td>What is it about these patients’ <em>attitudes</em> that makes caring for them more demanding? (N=13)</td>
<td>Self-critical/destructive 5</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Critical of others 4</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Manipulative 4</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Unchangeable 2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Emotionally attractive 1</td>
<td></td>
</tr>
<tr>
<td>What other aspects are there which make caring for the more challenging patients more demanding? (N=11)</td>
<td>Nurse helplessness 4</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Inadequacies of the system/mismatch of patient to service 4</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Self-harm 2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Need for authoritarian approach 2</td>
<td></td>
</tr>
</tbody>
</table>

Table 3 shows that the most challenging behaviours experienced by the nurses were patient “non-co-operation” and “manipulation of staff” (7 responses). This was followed by self-harming (4 responses) and time-consuming behaviours (4 responses). Patient attitudes that were deemed as problematic were; critical and manipulative (total 13 responses) followed by unchangeable (2 responses). Other problems identified in managing the challenging patients were; nurse helplessness (4 responses) and service/system inadequacies (4 responses).
### III. Managing the Challenging Patient.

#### Table 4. The Categories of Responses and Number of Respondents Regarding Issues of Patient Management.

<table>
<thead>
<tr>
<th>QUESTION</th>
<th>CATEGORIES GENERATED</th>
<th>NUMBER OF RESPONDENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>What strategies do you use to manage these patients?</td>
<td>(N=12) Consistency and boundaries</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Listen and talk</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Increase psychiatric power</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Improved planning</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>“I do not manage”</td>
<td>1</td>
</tr>
<tr>
<td>What other strategies or ideas are you aware of from the literature you have read or from your colleagues which might be useful?</td>
<td>(N=9) Adopt a multi-agency approach</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Increase regulations/observation</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Listen to patient</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Play down self-injury</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Consistency of care</td>
<td>1</td>
</tr>
<tr>
<td>What makes it difficult to implement these useful strategies which you currently do not use?</td>
<td>(N=9) Poor resources</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Poor training</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Severity of patients' problems</td>
<td>2</td>
</tr>
<tr>
<td>How do you balance the care needs of challenging patients with those who are less challenging?</td>
<td>(N=11) More challenging patients allotted</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>more time</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Try to maintain a fair balance</td>
<td>6</td>
</tr>
<tr>
<td>How do you find balancing the time demands of the challenging patients with the less challenging patients?</td>
<td>(N=11) Difficult</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>Attempt to prioritise and balance it out</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Easy</td>
<td>1</td>
</tr>
</tbody>
</table>

Table 4 shows that the most favoured strategies used to manage these patients were a consistent approach with clear boundaries (5 responses). There was also a preference expressed for adopting a multi-agency approach (3 responses) and increasing regulations and observations (3 responses). A total of 8 responses indicated that it was difficult to implement these strategies due to poor resources and training. There was a split in how care needs are balanced out as 7 responses indicated the need to allow the challenging patients more time, whereas 6 responses included the need to try to maintain “fair balance”. Balancing the time demands of the patient was described as “difficult” in 8 of the 14 responses.
### IV. Effectiveness of Intervention

**Table 5. The Categories of Responses and Number of Respondents Regarding the Effectiveness of Nurse Intervention.**

<table>
<thead>
<tr>
<th>QUESTION</th>
<th>CATEGORIES GENERATED</th>
<th>NUMBER OF RESPONDENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Which patients appear to make the least/most improvements?</td>
<td>Least: (N=12)</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>Personality disorder</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Substance misuse</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Psychosis</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Most: (N=12)</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>Psychosis</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Depression</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Motivated patients</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>1</td>
</tr>
<tr>
<td>What is your understanding for why these patterns occur?</td>
<td>(N=11)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Improvements dependant on patient responsibility</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>Improvements dependant on service delivery</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>1</td>
</tr>
<tr>
<td>What effect do these more challenging patients have on how you feel about your own professional role?</td>
<td>(N=12)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Negative effect</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>Can fully utilise my skills</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>3</td>
</tr>
<tr>
<td>Please list any details of post-registration training.</td>
<td>(N=8)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>HIV</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Nursing in secure environments</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Counselling course</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Others</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>None</td>
<td>3</td>
</tr>
</tbody>
</table>

Table 5 shows that the *least* improvements were expected in patients with a diagnosis of personality disorder (8 responses), followed by substance misuse (4 responses), and then those with psychosis (3 responses). Patients reported to make the *most* improvements were those with psychosis (7 responses) followed by depression (5 responses). Of the 12 responses, 8 indicated that working with the challenging patients has a negative effect on how the nurses feel about their own professional role. The nurses had completed a total of 6 post registration courses.
V. Support and Continuing Professional Development

Table 6. The Categories of Responses and Number of Respondents Regarding Modes of Support and Continuing Professional Development.

<table>
<thead>
<tr>
<th>QUESTION</th>
<th>CATEGORIES GENERATED</th>
<th>NUMBER OF RESPONDENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Can you identify any methods of support that may help in the management of challenging patients? (N=10)</td>
<td>Therapists 6</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Improvements in policy and management 3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Peer group 1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Improved environment 1</td>
<td></td>
</tr>
<tr>
<td>Would you be interested in attending a workshop in the future to look at ways of working with the more challenging patients? (N=13)</td>
<td>Yes 12</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No 1</td>
<td></td>
</tr>
<tr>
<td>What particular topics would you find beneficial? (N=10)</td>
<td>Psychological/structured interventions 4</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Personality disorders 3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Substance misuse 2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other diagnoses 2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Public awareness 1</td>
<td></td>
</tr>
</tbody>
</table>

Table 6 shows how the nurses valued support from “therapists” (6 responses), and peers (1 response) and desired improvements in policy and management (3 responses). 92% (12 responses) of the participants were interested in attending a workshop to address issues around working with the challenging patient, but 1 person was not. Topics of interest that would be most beneficial were; psychological interventions (4 responses), personality disorders (3 responses), substance misuse (2 responses) as well as “other” diagnoses (2 responses).

Discussion

Main Findings

I. Diagnostic categories and the labelling of the challenging patient.

Seven (54%) of the nurses’ responses indicated that patients with the diagnosis of “personality disorder” were the most difficult to manage. Several other diagnostic categories were generated many of which are also associated with symptomatology of a personality disorder (e.g. aggression, self-harm, substance misuse). These most challenging patients were described as attention seeking and manipulative (50%: 6 responses). This use of these particular labels has been described in the literature as “negative”, contributing to the reductionist and deterministic perspective of the
“challenging patient” (Gallop, Lancee, and Shugar, 1993), which in turn, has a negative affect on patient care.

II. The demands of the challenging patient.

The patients' behaviours which caused the nurses the most concern were “staff manipulation” and non-co-operation (47%: 7 responses). This denial of staff authority appears to have had a profound impact on the nurses' experiences of the patients. Indeed, the nurses who reported that the patients' attitudes are highly critical and “manipulative” (81%: 13 responses) may even experience some confusion over nurse/patient roles. The critical patient has been described (Parsons, 1951; cited in Breeze, 1998) as altering the archetypal “sick role” shifting the dynamics of the therapeutic relationship, which often results in power struggles. Indeed, this point can be illustrated by one nurse’s response that the patients “only seem to think of themselves”. This observation raises the issue as to whether the nurse feels un cared for and “unsafe”, sentiments that are more commonly associated with the role of the patient.

Furthermore, coping with the demands of the challenging patient appeared to be affected by some organisational inadequacies as some of the nurses (33%: 4 responses) expressed that the “system” was not conducive to a positive therapeutic experience. The impact of some of these identified issues may have contributed to a number of the nurses (4 responses) expressing feelings of helplessness in coping with the demands of the challenging patient.

III. Managing the challenging patient.

A common theme to emerge concerned the need for an approach of consistency with an emphasis on clear boundaries (42%: 5 responses). Very few of the respondents (2 responses) communicated the importance of allowing the patient an opportunity to verbalise their feelings, which has been shown to prevent them acting out with self-destructive behaviours (Pringle, 1998). Other responses consisted of a desire to increase the “power” of the nurses to enforce treatment (2 responses). Breeze and Repper (1998)
assert that this is inevitable as the nurses attempt to secure more control over their environment. One nurse clearly indicated how difficult it was to secure control in this particular setting by stating that challenging patients are “impossible to manage on an open ward”.

Although some of the nurses were aware of the benefits of adopting a multi-agency approach (3 responses), there was overwhelming dissatisfaction (80%; 8 responses) with the level of resources provided to utilise this approach as well as relevant training opportunities. This expression is consistent with the point made by Breeze and Repper (1998) that there is currently little evidence in the literature of these services being guided to help meet the needs of the more challenging patients.

Balancing the demands of different patient needs was considered to be a very difficult procedure (73%; 8 responses). There was a split in nurse responses as to whether the more challenging patients would receive more of their time (7 responses) or whether they could maintain a fair balance between all patients (6 responses). This finding does not support the observations of Sharrock et al. (1990) who state that greater staff time is directed towards patients who are expected to make a therapeutic change. Nonetheless, the difficulty choosing who “deserves” more time and assistance is believed to further exacerbate the nurses’ feelings of helplessness as well as exemplifying the necessity of increased resources (Breeze and Repper, 1998).

IV. Effectiveness of Nurse Intervention.

Not only did a majority of the nurses find the diagnosis of “personality disorder” the most difficult to manage, but people with this diagnosis were also considered to make the least improvements on the ward (45%; 8 responses). One facet which may have contributed to the difficulties of working with this client group were the use of such labels, as it has been suggested that there is a relationship between negative labelling and diminished care and the exacerbation of mental health (Breeze and Repper, 1998).
An interesting discovery was that the nurses divided the reasons for the challenging patients’ poor improvements between patient responsibility (54%; 7 responses) and service delivery (39%; 5 responses). Furthermore, May and Kelly (1982) have suggested that nurses attribute patient refusal of treatment to their own therapeutic failures. One nurse who stated that “the ward is not suitable for people with personality disorders and the staff do not have the skills to cope” encapsulated this. Additionally, 67% (8 responses) of the nurses stated that the effect of working with these challenging patients has a negative impact on how they feel about their own professional role. Such low levels of job satisfaction and motivation may well have been a contributory factor to the low questionnaire response rate.

Furthermore, intervention effectiveness may have been restricted as a result of the nurses limited training experiences. Of the 13 responding nurses (9 of which were registered), only 6 post-registration courses were identified as having been completed. None of these courses were specifically relevant to the concerns raised throughout the questionnaire responses. Stockbridge (1994) has stated that without such training in self-awareness, attitudes and values the nurses cannot be expected to deal with difficult emotional issues.

V. Support and Continuing Professional Development.

The nurses responses indicated that they valued the opportunity to further develop their support networks and 54% (6 responses) reported that they would like to work more closely with therapists. There was also some indication that organisational issues may need reviewing as 3 responses suggested that some of the ward policies and management strategies could be improved. Also, the nurses appeared to recognise the importance of training when working with challenging patients and 92% (12 of the 13 respondents) expressed an interest in attending a workshop to address these issues. The main topics of interest identified were, developing their psychological skills (33%; 4 responses), managing personality disorder (25%; 3 responses), and dealing with substance abuse (17%; 2 responses).
Limitations

Whilst interpreting the main findings of the study it is necessary to consider some of the limitations. The lowest percentages of respondents were those with the highest "E" and "F" grades. Although there is no information as to why this may have occurred one must consider that those nurses with the most experience are clearly under-represented. This obstructs the investigation into whether those more experienced nurses may have different coping strategies.

Furthermore, although there was a response rate of 54% there was only 13 respondents. Hence, following categorisation of the responses, the number of nurses with collective opinions was low. Therefore, caution is required as such low numbers are not conducive to generalising the "findings" to the entire ward. Moreover, apart from one pilot study the questionnaire is also previously untested so the validity of the results may be undependable. However, the reliability of the questionnaire is to some extent less contentious as the use of an inter-rater provided consistent findings.

The content of the questions were somewhat complex which may have contributed to incomplete questions and the low response rate. Also, a more general term than "diagnosis" could have been used in question 1, as many of the responses were not expressed in clinical diagnostic terms.

The question which was used to determine current levels of nurse training (question 14) may have excluded those Grade A nurses as it refers specifically to post-registration training.
Recommendations

These research findings shall be presented to the ward staff and CMHT members (appendix 6). The following recommendations have been suggested in an attempt to address some of the experiences that the nurses have outlined:

1. Provision of workshops combining the skills of the clinical psychology department and the experiences of the nursing staff. From the evidence of this research the workshops could focus upon:

   - The development of an awareness of the use of value judgements and labelling in the management of patient care and how this may affect the patient.
   - Guidance in the nurses monitoring and challenging of their own beliefs to develop a non-judgemental approach.
   - An awareness of how control and authoritarian approaches may exacerbate non-compliance from the more challenging patients.
   - Achieving collaboration with the client in developing their goals and treatment plan to help them realise autonomy. Importantly, the nurse can learn to give ongoing feedback to the client to ameliorate conflict resolution and development of an identity. Furthermore, giving the patient a chance to verbalise their feelings may reduce their propensity to act them out with self-destructive acts.

2. Acknowledge the nurses' desires to have support from the therapies and to realise this in the form of regular supervision. This time can be used to interpret the nurse-patient relationship and how past conflicts may be played out on the ward.

3. In supervision, the nurses can discuss strong emotional reactions in themselves that may contribute towards a reduction in feelings of powerlessness. This space can also be used to discuss the times when patients appear to be manipulative and non-compliant, making interventions appear as non-effective.

4. Introduction of triumvirate nursing (Melia, Moran, Mason, 1999). This method utilises three nurses working together to plan and engage the individual in a therapeutic enterprise. The model is purported to offer the nurses support and to minimise the risk of boundary violations. It also claims to make time management more effective.

5. A follow up study, 6 months after the implementation of the above recommendations would be useful in monitoring service development and the nurses' beliefs and attitudes towards challenging patients.
Conclusions

Although caution must be exercised in the interpretation of this study, due to the modest response rate and the non-standardised status of the questionnaire, the results indicate several salient factors. Firstly, respondents indicated that certain patient sub-groups (i.e. personality disorder) made increased demands upon the nurses. The nurses expressed how these patients became highly critical and presented with various challenging behaviours to meet their needs. This would often result in an exacerbation of levels of tension on the ward, ultimately resulting in the nurses feeling powerless and experiencing the perception of intervention ineffectiveness. Consequently, those who responded communicated the harmful effect that these interactions have on how they perceive their own professional role. Encouragingly, these concerns may be approachable as the nurses were able to identify the need for improved support and opportunities for professional development to help to understand and care for the more challenging patients more effectively.

Hopefully, the implementation of workshops and further opportunities for supervision shall begin to reverse the negative effect that many nurses experienced about their own professional role, ultimately benefiting both the professional and the patient.

__________________________
References


Appendices
Appendix 1
Questionnaire on Managing Mental Health Patients

As a part of my training I am conducting a research study looking at the demands placed on the nurses by the more challenging patients. I am also interested in the nurses’ opinions of these more challenging patients and hope to identify some of the strategies you use to manage them.

To fully utilise your knowledge, I would like you to apply the questions to your entire experience on the ward, and not just the current patients. Also, to protect the anonymity of the patients, I would ask you not to state any names.

The information that you provide is confidential. Your responses will not be used individually but gathered as group data. Finally, I would like to emphasise that your responses will NOT be used in any way to judge your clinical work.

This questionnaire should take approximately 30 minutes to complete. Your opinions are important in helping to identify what it is like working with challenging patients and the results of the questionnaires will help to identify and prioritise any training needs.

In the nurses office there is a box with “Questionnaire Responses” written on it. When you have completed the questionnaire please seal it inside one of the unmarked envelopes in the box and leave it there. I will come to collect it in 7 days.

Thank you for your time, co-operation and information.

Clinical Psychologist in Training

Clinical Psychologist

Ward Manager
Please tick the appropriate box and write in your Grade.

Sex:  Male ☐  Female ☐  Grade: ______________________

1. Patients with which diagnosis do you find the most challenging to manage?

2. Which labels do you and your colleagues use to describe these more challenging patients?

3. What is it about these patients' behaviours that makes caring for them more demanding?

4. What is it about these patients' attitudes that makes caring for them more demanding?

5. What other aspects are there which make caring for the more challenging patients more demanding?

6. What strategies do you use to manage these patients?

7. What other strategies or ideas are you aware of from the literature you have read or from your colleagues which might be useful? Please state.
8. What makes it difficult to implement these useful strategies which you currently do not use?

9. Have you noticed any stages in a challenging patient's hospitalisation when they may become more demanding? Please state when these stages are.

10. How do you balance the care needs of challenging patients with those who are less challenging? This may include both administration as well as practical management.

11. How do you find balancing the time demands of the challenging patients with the less challenging patients?

12. Which patients appear to make the least/most improvements?

   Least                     Most

13. What is your understanding for why these patterns occur?

14. Please list details of any Post Registration training:
15. Which aspects of your training and clinical experience do you value most in working with these challenging patients?

16. What effect do these more challenging patients have on how you feel about your own professional role?

17. Above you have identified some of your responses to challenging patients. In what ways are your responses to the less challenging clients the same or different?

| Same | Different |

18. Can you identify any methods of support that may help in the management of challenging patients?

19. Would you be interested in attending a workshop in the future to look at ways of working with the more challenging patients?

Yes ☐ No ☐

20. What particular topics would you find beneficial?

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

Thank you for taking the time to fill out the questionnaire.
Title of Project: Nurse Beliefs & Attitudes about their Work with Challenging Behavior

SERVICE MANAGER

I have read the enclosed proposal and have had an opportunity to discuss it if necessary with the researcher(s) involved.

I agree that the service can manage to support this research.

Signed: ________________________________

Date: ________________________________

HEAD OF DEPARTMENT (student projects only)

I have read the enclosed proposal and have had an opportunity to discuss it if necessary with the researcher(s) involved.

I agree that the department can manage to support this research.

Signed: ________________________________

Date: ________________________________

PLACEMENT SUPERVISOR

Date: 21.1.00
**Project Title:** Nurses beliefs and attitudes about challenging clients

**The Topic (relevance to Trust annual plan/objectives)**

All 3 reviewers feel this is a relevant topic. It is felt that perhaps "clients with challenging behaviour" would be better in the title.

**Service Issues (capacity to run the project, fit with other projects going on)**

Capacity is not felt to be a problem, but the researcher should be aware that this a sensitive subject area and should take steps to ensure that there is adequate and close supervision of the project.

**The people involved in the Project (sufficient experience to carry out the project)**

As above, close supervision needed.

**Quality of the research proposal (design issues, sufficient sample size)**

No problems noted.

The project has approval, with reference to the points noted above.

R&D co-ordinator
Appendix 3
Inter-rater reliability

The second rater was given respondents 11, 12, 25 and 30's questionnaires to complete the primary coding. The inter-rater reliability was calculated as follows:

\[
\frac{\text{Number of agreement}}{\text{Number of opportunities for agreement}} \times 100
\]

\[
\frac{79}{88} \times 100 = 89\%
\]

Inter-rater reliability was 89% agreement
Appendix 4
1. PATIENTS WITH WHICH DIAGNOSIS DO YOU FIND THE MOST CHALLENGING TO MANAGE?

<table>
<thead>
<tr>
<th>Respondent</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Personality disorders + dual diagnosis</td>
</tr>
<tr>
<td>3</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Substance misuse + depression</td>
</tr>
<tr>
<td>7</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Personality disorders + substance misuse</td>
</tr>
<tr>
<td>9</td>
<td>Personality disorders + substance misuse</td>
</tr>
<tr>
<td>10</td>
<td>Bipolar affective disorder</td>
</tr>
<tr>
<td>11</td>
<td>Personality disorders 🔄</td>
</tr>
<tr>
<td>12</td>
<td>Personality disorders 🔄</td>
</tr>
<tr>
<td>13</td>
<td>Personality disorders 🔄</td>
</tr>
<tr>
<td>14</td>
<td></td>
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<td>16</td>
<td></td>
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<tr>
<td>17</td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>Aggression</td>
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<tr>
<td>19</td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>Self-harmers</td>
</tr>
<tr>
<td>21</td>
<td></td>
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<tr>
<td>22</td>
<td></td>
</tr>
<tr>
<td>23</td>
<td></td>
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<td>24</td>
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</tr>
<tr>
<td>25</td>
<td>Aggression</td>
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<tr>
<td>26</td>
<td></td>
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<td>27</td>
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<td>28</td>
<td></td>
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<tr>
<td>29</td>
<td></td>
</tr>
<tr>
<td>30</td>
<td>Personality disorders 🔄</td>
</tr>
<tr>
<td>31</td>
<td>Schizophrenia</td>
</tr>
</tbody>
</table>

nym = 31

PD = 7

Slit mouth = 1
Aggression = 2
Self harm = 1
Schiz = 1
Bipolar Affective Dis = 1
2. WHICH LABELS DO YOU AND YOUR COLLEAGUES USE TO DESCRIBE THESE MORE CHALLENGING PATIENTS?

<table>
<thead>
<tr>
<th>Respondent</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Behavioural problems, attention seeking, acting out behaviour</td>
</tr>
<tr>
<td>3</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Alchys</td>
</tr>
<tr>
<td>7</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Revolving door syndrome, manipulative, denial, social problems</td>
</tr>
<tr>
<td>9</td>
<td>Difficult, manipulative, challenging, unsuitable for acute MH services</td>
</tr>
<tr>
<td>10</td>
<td>Attention seeking</td>
</tr>
<tr>
<td>11</td>
<td>No idea? ✓</td>
</tr>
<tr>
<td>12</td>
<td>PD ✓</td>
</tr>
<tr>
<td>13</td>
<td>Difficult, attention seeking, self-centered, Manipulative</td>
</tr>
<tr>
<td>14</td>
<td></td>
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<td>15</td>
<td></td>
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<tr>
<td>20</td>
<td>Cutters</td>
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<td>29</td>
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<tr>
<td>30</td>
<td>PD ✓</td>
</tr>
<tr>
<td>31</td>
<td>He is very unwell</td>
</tr>
</tbody>
</table>

n=10
3. What is it about these patients’ *behaviours* that makes caring for them more demanding?

<table>
<thead>
<tr>
<th>Respondent</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Pushing boundaries, substances exacerbate mental state. Disruptive.</td>
</tr>
<tr>
<td>2</td>
<td>Lie about drinking/drug taking on ward. Assume staff stupid. I feel abused by their attitude.</td>
</tr>
<tr>
<td>3</td>
<td>Denial means no change. Influence others on ward. Finding best intervention is a balancing act.</td>
</tr>
<tr>
<td>4</td>
<td>Acting out and manipulation.</td>
</tr>
<tr>
<td>5</td>
<td>Overactive. Suicidal ideation.</td>
</tr>
<tr>
<td>6</td>
<td>Attention seekers.</td>
</tr>
<tr>
<td>7</td>
<td>Disrupt and make self/others unhappy. Likeable but gloomy and sad.</td>
</tr>
<tr>
<td>8</td>
<td>Attention seeking, demanding, manipulative.</td>
</tr>
<tr>
<td>9</td>
<td>As above? <em>Attention seeking</em></td>
</tr>
<tr>
<td>10</td>
<td>Not co-operating with treatment.</td>
</tr>
<tr>
<td>11</td>
<td>Time consuming.</td>
</tr>
<tr>
<td>12</td>
<td>At night inadequate support to deal with aggressive patients.</td>
</tr>
<tr>
<td>13</td>
<td>Law unto selves. Hostile, over critical, disruptive, time-consuming, cutting.</td>
</tr>
<tr>
<td>14</td>
<td>Lack of insight.</td>
</tr>
</tbody>
</table>

3. Time consuming: 13

3. Manipulative staff: 7

3. Self harm/Suicide: 4

3. Resources: 4

5. \( \text{Total} \)
4. WHAT IS IT ABOUT THESE PATIENTS' ATTITUDES THAT MAKES CARING FOR THEM MORE DEMANDING?

<table>
<thead>
<tr>
<th>Respondent</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Rude and verbal abuse, reluctance to change, lack of insight.</td>
</tr>
<tr>
<td>2</td>
<td>Drink on and expect to be bailed out each time.</td>
</tr>
<tr>
<td>3</td>
<td>Intolerant to other patients.</td>
</tr>
<tr>
<td>4</td>
<td>Fixed and unchangeable.</td>
</tr>
<tr>
<td>5</td>
<td>Self-harm</td>
</tr>
<tr>
<td>6</td>
<td>Set patients and staff against each other.</td>
</tr>
<tr>
<td>7</td>
<td>Friendly and emotional attraction to nurse. Demanding and manipulative.</td>
</tr>
<tr>
<td>8</td>
<td>Incautious nurse may find herself dropping guard of objectivity and spending more time with these patients.</td>
</tr>
<tr>
<td>9</td>
<td>Selfish</td>
</tr>
<tr>
<td>10</td>
<td>Not coping</td>
</tr>
<tr>
<td>11</td>
<td>You spend hours talking with them then they come back to show you cuts.</td>
</tr>
<tr>
<td>12</td>
<td>Demanding</td>
</tr>
<tr>
<td>13</td>
<td>Self-derogatory, hopelessness, changing at a whim. Want protection from selves, and understood. We can do that but for how long, for life?</td>
</tr>
</tbody>
</table>

N = 13
5. WHAT OTHER ASPECTS ARE THERE WHICH MAKE CARING FOR THE MORE CHALLENGING PATIENTS MORE DEMANDING?

<table>
<thead>
<tr>
<th>Respondent</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Increase in personal stress levels.</td>
</tr>
<tr>
<td>2</td>
<td>Their abuse of the service and abusive language and behaviour.</td>
</tr>
<tr>
<td>3</td>
<td>Not rewarding as they do not move and get better.</td>
</tr>
<tr>
<td>4</td>
<td>Those with PD in and out of the system. Know it better than the staff.</td>
</tr>
<tr>
<td>5</td>
<td>Close observations.</td>
</tr>
<tr>
<td>6</td>
<td>Attempt suicide often.</td>
</tr>
<tr>
<td>7</td>
<td>Self-harm, suicide, attention seeking. They appear charming and the inexperienced nurse may be persuaded that the patient is a likeable and innocent victim of a bigoted and unfair system.</td>
</tr>
<tr>
<td>8</td>
<td>Depressing.</td>
</tr>
<tr>
<td>9</td>
<td>Cannot hold them physically if they decide to leave ward.</td>
</tr>
<tr>
<td>10</td>
<td>Unit not right for this type of client. They do not benefit. Would like to see a specialised place for these maladjusted clients. I do not see them as ill, but in need of listening to, confronting, and a safe environment.</td>
</tr>
<tr>
<td>11</td>
<td>Legal aspects – force fed/force medication.</td>
</tr>
</tbody>
</table>

**Totals:**
- 4 for Self-harm
- 2 for Force fed/force medication
- 4 for Abuse of the service
- 2 for Authoritarian approach
### 6. WHAT OTHER STRATEGIES DO YOU USE TO MANAGE THESE PATIENTS?

<table>
<thead>
<tr>
<th>Respondent</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Consistent and firm. Setting of boundaries.</td>
</tr>
<tr>
<td>2</td>
<td>Drug and alcohol analysis. Impossible to manage on an open ward!</td>
</tr>
<tr>
<td>3</td>
<td>Develop clear boundaries through Care Plan. Staff consistency.</td>
</tr>
<tr>
<td>4</td>
<td>Be consistent.</td>
</tr>
<tr>
<td>5</td>
<td>If section 2 put on section 3 to enforce treatment. 1:1 observation.</td>
</tr>
<tr>
<td>6</td>
<td>Firm and fair.</td>
</tr>
<tr>
<td>7</td>
<td>Plan nursing activities.</td>
</tr>
<tr>
<td>8</td>
<td>Firm but fair. Not respond to attention seeking behaviour.</td>
</tr>
<tr>
<td>9</td>
<td>Persuade them not to leave ward or call Police to return them.</td>
</tr>
<tr>
<td>10</td>
<td>I listen to them and show respect for their feelings. When they blame staff for their ills I find where their own responsibility lies and hand it back to them.</td>
</tr>
<tr>
<td>11</td>
<td>1:1 therapy.</td>
</tr>
</tbody>
</table>

1) Consistent/ firm = 5  
2) Therapy = 2  
3) 1:1 enforced = 2  
4) Non-manage = 1
7. what other strategies or ideas are you aware of from the literature you have read or from your colleagues which might be useful?

<table>
<thead>
<tr>
<th>Respondent</th>
<th>Answer</th>
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<tbody>
<tr>
<td>1</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Work in alliance with psychiatry.</td>
</tr>
<tr>
<td>4</td>
<td>Consistency of care. Evidence based practice.</td>
</tr>
<tr>
<td>5</td>
<td>Increase staff and security. Low secure unit.</td>
</tr>
<tr>
<td>6</td>
<td>Understand behaviour and be sympathetic.</td>
</tr>
<tr>
<td>7</td>
<td>Assess in clear behavioural terms. Self identification of problems by patient. Psychology may administer psychometric testing.</td>
</tr>
<tr>
<td>8</td>
<td>Have a locked door policy at night.</td>
</tr>
<tr>
<td>9</td>
<td>Not make a big issue of cutting. I am not specialised and feel I don't understand them and feel annoyance.</td>
</tr>
<tr>
<td>10</td>
<td>C.C.T.V. on wards.</td>
</tr>
</tbody>
</table>

1) Multi agency approach  3
2) Listen to pt.  2
3) Increase reg.  2
8. WHAT MAKES IT DIFFICULT TO IMPLEMENT THESE USEFUL STRATEGIES WHICH YOU CURRENTLY DO NOT USE?

<table>
<thead>
<tr>
<th>Respondent</th>
<th>Answer</th>
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<tbody>
<tr>
<td>1</td>
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<tr>
<td>6</td>
<td>No power to control environment and admission criteria. Lack of training.</td>
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<tr>
<td>8</td>
<td>Staff not trained.</td>
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<td>9</td>
<td>Large numbers of clients. Few staff.</td>
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<tr>
<td>10</td>
<td>The Mental Health Act. Lack of adequate staff.</td>
</tr>
<tr>
<td>11</td>
<td>They demand more attention and become dependant.</td>
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<tr>
<td>12</td>
<td>Patients feel animosity and resentment to nursing staff as we are symbols of authority and social order that they despise.</td>
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<td>25</td>
<td>Open ward. Funding and planning problems.</td>
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<tr>
<td>30</td>
<td>No time or space to do group therapy.</td>
</tr>
<tr>
<td>31</td>
<td>Lack of knowledge and resources.</td>
</tr>
</tbody>
</table>

Resources - 4
Poor training - 4
IT difficulties - 2
9. Have you noticed any stages in a challenging patient's hospitalisation when they may become more demanding?

<table>
<thead>
<tr>
<th>Respondent</th>
<th>Answer</th>
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<tbody>
<tr>
<td>1</td>
<td></td>
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<tr>
<td>2</td>
<td>Discussion of possible discharge. Restriction of boundaries. Lack of nursing input.</td>
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<tr>
<td>6</td>
<td>When they’re pissed/high.</td>
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<tr>
<td>8</td>
<td>When they become institutionalised. When they repeatedly come back to ward.</td>
</tr>
<tr>
<td>9</td>
<td>Coming up to discharge.</td>
</tr>
<tr>
<td>10</td>
<td>(No)</td>
</tr>
<tr>
<td>11</td>
<td>Cutting and overdose.</td>
</tr>
<tr>
<td>12</td>
<td>Self harming to attract the attention of nurses and doctors.</td>
</tr>
<tr>
<td>13</td>
<td>When ward disturbed and they get less attention.</td>
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<td>18</td>
<td>When high.</td>
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<td>25</td>
<td>After physical restraining. Also psychiatric episodes.</td>
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<tr>
<td>30</td>
<td>Relationship break-ups. When confronted about their attitude or behaviour.</td>
</tr>
<tr>
<td>31</td>
<td>When they become hyper-manic.</td>
</tr>
</tbody>
</table>

1. Discussion - 2
2. On substances - 2
3. After new admission, limited nurse contact - 3
4. Self harm - 2
5. More information - 3
6. Running late - 1
<table>
<thead>
<tr>
<th>Respondent</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Prioritising delivery of care. Allocate time to each patient each day. Delegate others to provide for missing needs.</td>
</tr>
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<tr>
<td>6</td>
<td>Difficult but try to balance it out.</td>
</tr>
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<tr>
<td>8</td>
<td>More manageable patients receive less attention. Offer specific periods of time for challenging patients.</td>
</tr>
<tr>
<td>9</td>
<td>On large ward less challenging patients lose out—ineffective care.</td>
</tr>
<tr>
<td>10</td>
<td>No.</td>
</tr>
<tr>
<td>11</td>
<td>Spend time equally on patients—depending on their needs.</td>
</tr>
<tr>
<td>12</td>
<td>Be more fair upon treatment.</td>
</tr>
<tr>
<td>13</td>
<td>Allocate a period of time to spend with each patient.</td>
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<tr>
<td>25</td>
<td>Staff feel they lack skills with challenging patients so they give in to their demands for sake of safety.</td>
</tr>
<tr>
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<td>27</td>
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<td>29</td>
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</tr>
<tr>
<td>30</td>
<td>Periods of time allotted to each patient.</td>
</tr>
<tr>
<td>31</td>
<td>Prioritising.</td>
</tr>
</tbody>
</table>

\( \bar{N} = 11 \)
11. HOW DO YOU FIND BALANCING THE TIME DEMANDS OF THE CHALLENGING PATIENTS WITH THE LESS CHALLENGING PATIENTS?

<table>
<thead>
<tr>
<th>Respondent</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Difficult.</td>
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<td>3</td>
<td></td>
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<tr>
<td>4</td>
<td></td>
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<tr>
<td>5</td>
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</tr>
<tr>
<td>6</td>
<td>Not challenge drunk patient but try to get them to sleep it off.</td>
</tr>
<tr>
<td>7</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Difficult.</td>
</tr>
<tr>
<td>9</td>
<td>Frustrating and non-rewarding.</td>
</tr>
<tr>
<td>10</td>
<td>Easy.</td>
</tr>
<tr>
<td>11</td>
<td>Spend specific time with PD person.</td>
</tr>
<tr>
<td>12</td>
<td>More time to patients who need it.</td>
</tr>
<tr>
<td>13</td>
<td>Difficult as they demand more time.</td>
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</tr>
<tr>
<td>25</td>
<td>A challenging patient's care needs equivalent to 5 other patients needs.</td>
</tr>
<tr>
<td>26</td>
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<td>27</td>
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<td>28</td>
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<td>29</td>
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</tr>
<tr>
<td>30</td>
<td>If too much time id spent with PD patient then try to even it out with others -- delegate.</td>
</tr>
<tr>
<td>31</td>
<td>Difficult.</td>
</tr>
</tbody>
</table>

\( n = 11 \)
12. WHICH PATIENTS APPEAR TO MAKE THE LEAST/MOST IMPROVEMENTS?

<table>
<thead>
<tr>
<th>Respondent</th>
<th>LEAST</th>
<th>MOST</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
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</tr>
<tr>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Substance misuse</td>
<td>Psychosis</td>
</tr>
<tr>
<td>7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>PD – Substance misuse – self-harm</td>
<td>Psychosis-reactive depression</td>
</tr>
<tr>
<td>9</td>
<td>PD – substance misuse</td>
<td>Psychotic – depression</td>
</tr>
<tr>
<td>10</td>
<td>Don’t know</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>PD – sciz. – chronic dementia</td>
<td>Drug induced psychosis – neurotics.</td>
</tr>
<tr>
<td>12</td>
<td>PD – Schiz. – Alcohol</td>
<td>Dementia – Drug induced psychosis – reactive depn.</td>
</tr>
<tr>
<td>13</td>
<td>PD</td>
<td>Psychotic illness</td>
</tr>
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<td>18</td>
<td>PD</td>
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<td>24</td>
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</tr>
<tr>
<td>25</td>
<td>Less challenging patients</td>
<td>Aggressive patients</td>
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<td>29</td>
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<tr>
<td>31</td>
<td>Schizophrenia – Autism</td>
<td>Mood disorders – Depression</td>
</tr>
</tbody>
</table>

1) Schiz. - 3
2) Substance - 4
3) Schiz. - 3
4) Alcohol - 3
5) Motivated patients – Those compliant with medication – those with insight.
6) Psychosis - 2
13. WHAT IS YOUR UNDERSTANDING FOR WHY THESE PATTERNS OCCUR?

<table>
<thead>
<tr>
<th>Respondent</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Motivation and insight.</td>
</tr>
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<td>4</td>
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<td>5</td>
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<tr>
<td>6</td>
<td>Alcoholics need to want to address their problem. Psychotic patients can be helped with caring, understanding, management and medication.</td>
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<td>7</td>
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<tr>
<td>8</td>
<td>Deep rooted problems.</td>
</tr>
<tr>
<td>9</td>
<td>Psychiatric wards are not suitable for PD/substance misuses. Staff not have the skills.</td>
</tr>
<tr>
<td>10</td>
<td>Don't know</td>
</tr>
<tr>
<td>11</td>
<td>Fragmentation of the personality.</td>
</tr>
<tr>
<td>12</td>
<td>Deterioration, relapse, non-compliance of medication, relationship problems.</td>
</tr>
<tr>
<td>13</td>
<td>Psychotics respond well to medication.</td>
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<td>25</td>
<td>Improvements when staff give time to patients.</td>
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<tr>
<td>30</td>
<td>Medication effective with some disorders. Others are ongoing and rely on clients own motivation.</td>
</tr>
<tr>
<td>31</td>
<td>Harmful degenerative processes.</td>
</tr>
</tbody>
</table>

Patient resp - 7
2nd resp - 5
3rd resp - 1
14. PLEASE LIST DETAILS OF ANY POST REGISTRATION TRAINING:

<table>
<thead>
<tr>
<th>Respondent</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>ENB : care of HIV – + counselling certificates.</td>
</tr>
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<td>3</td>
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<td>4</td>
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</tr>
<tr>
<td>6</td>
<td>ENB-Psychiatric nursing in secure environments. Risk assessment/management. C+R</td>
</tr>
<tr>
<td>7</td>
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<tr>
<td>8</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>None.</td>
</tr>
<tr>
<td>10</td>
<td>N/A</td>
</tr>
<tr>
<td>11</td>
<td>SRN/RMH</td>
</tr>
<tr>
<td>12</td>
<td>Enrolled nurse – psychiatry. 27 years experience.</td>
</tr>
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<td>13</td>
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<td>28</td>
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<tr>
<td>29</td>
<td></td>
</tr>
<tr>
<td>30</td>
<td>Counselling course.</td>
</tr>
<tr>
<td>31</td>
<td>None</td>
</tr>
</tbody>
</table>

1) None = 3
15. WHICH ASPECTS OF YOUR TRAINING AND CLINICAL EXPERIENCE DO YOU VALUE MOST IN WORKING WITH THESE CHALLENGING PATIENTS?

<table>
<thead>
<tr>
<th>Respondent</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Support for team and training. Past experience.</td>
</tr>
<tr>
<td>2</td>
<td>De-escalation and management of aggression.</td>
</tr>
<tr>
<td>3</td>
<td>Helping skills, training, listening, empathising. Consistency and boundaries emphasised.</td>
</tr>
<tr>
<td>4</td>
<td>Patience, tolerance, team-work.</td>
</tr>
<tr>
<td>5</td>
<td>All.</td>
</tr>
<tr>
<td>6</td>
<td>Study of psychology. Observation, listening and understanding.</td>
</tr>
<tr>
<td>7</td>
<td>Working in acute adult psychiatry.</td>
</tr>
<tr>
<td>8</td>
<td>Experience.</td>
</tr>
<tr>
<td>9</td>
<td>Communication.</td>
</tr>
<tr>
<td>10</td>
<td>Management of aggression course.</td>
</tr>
<tr>
<td>11</td>
<td>Counselling course. Unable to attend PD course as yet.</td>
</tr>
<tr>
<td>12</td>
<td>Would value psychological interventions.</td>
</tr>
</tbody>
</table>

**Note:**
- The respondent also mentioned the value of team work and management of aggression courses.
<table>
<thead>
<tr>
<th>Respondent</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Demands'being made.</td>
</tr>
<tr>
<td>2</td>
<td></td>
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<tr>
<td>3</td>
<td></td>
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<td>4</td>
<td></td>
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<tr>
<td>5</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Feel abused and treated like shit putting up with all their lies and abusive behaviour.</td>
</tr>
<tr>
<td>7</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Feel frustrated as I do not have professional ability to deal with these patients.</td>
</tr>
<tr>
<td>9</td>
<td>Low self-esteem, confidence. They can also be most rewarding when discharged.</td>
</tr>
<tr>
<td>10</td>
<td>Exciting.</td>
</tr>
<tr>
<td>11</td>
<td>Dissatisfied with their care plans. Stressed.</td>
</tr>
<tr>
<td>12</td>
<td>Stressful, dissatisfied.</td>
</tr>
<tr>
<td>13</td>
<td>The more input you put in may not help. 1 step forward 2 back.</td>
</tr>
<tr>
<td>14</td>
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<td>18</td>
<td>To understand.</td>
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<tr>
<td>25</td>
<td>I feel like a policewoman. Feel inadequate.</td>
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<tr>
<td>30</td>
<td>I feel useless. I question how they are benefiting from being on the ward. Bad habits reinforced on the ward. What have they learnt?</td>
</tr>
<tr>
<td>31</td>
<td>Demand me to fully utilise my skills.</td>
</tr>
</tbody>
</table>
17. IN WHAT WAYS ARE YOUR RESPONSES TO THE LESS CHALLENGING CLIENTS THE SAME OR DIFFERENT?

<table>
<thead>
<tr>
<th>Responder</th>
<th>SAME</th>
<th>DIFFERENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Developing therapeutic relationships.</td>
<td>Able to establish better nurse/client relationship.</td>
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</tr>
<tr>
<td>6</td>
<td>De-escalation and management of aggression.</td>
<td>Tolerance understanding and patience.</td>
</tr>
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<td>7</td>
<td></td>
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</tr>
<tr>
<td>8</td>
<td>Maintain consistency. Medication. Listen and support.</td>
<td>Caring for them can be more rewarding. Feel less unprepared to deal with them.</td>
</tr>
<tr>
<td>9</td>
<td>Patience and tolerance.</td>
<td>Requires less structure and tight goals.</td>
</tr>
<tr>
<td>10</td>
<td>Same</td>
<td>Different</td>
</tr>
<tr>
<td>11</td>
<td></td>
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<tr>
<td>12</td>
<td>Different</td>
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<td>24</td>
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<tr>
<td>25</td>
<td>Demanding. Cannot stop them.</td>
<td>They are manageable in an open ward. Aggressive patients need a locked ward.</td>
</tr>
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<td></td>
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</tr>
<tr>
<td>29</td>
<td>Substance misuse.</td>
<td>Suffering is not their fault as they are unable to help selves. Those with psychosis need protection to feel safe until mind is right.</td>
</tr>
<tr>
<td>30</td>
<td></td>
<td></td>
</tr>
<tr>
<td>31</td>
<td>Time taken to respond. Level of care.</td>
<td>Observation and firmness.</td>
</tr>
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</tbody>
</table>

1. Betterифп - 2
2. recording - 1
3. more firmness - 5 2
4. Need locked ward - 4
18. CAN YOU IDENTIFY ANY METHODS OF SUPPORT THAT MAY HELP IN THE MANAGEMENT OF CHALLENGING PATIENTS?

<table>
<thead>
<tr>
<th>Respondent</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Peer group support with facilitator. Team building exercise. Clinical supervision.</td>
</tr>
<tr>
<td>2</td>
<td>Education and support from specialists. Policy and management strategies.</td>
</tr>
<tr>
<td>3</td>
<td>Support from other professional agencies.</td>
</tr>
<tr>
<td>4</td>
<td>Supervision for the team working with that client.</td>
</tr>
<tr>
<td>5</td>
<td>Improved therapeutic environment, social support. Therapies.</td>
</tr>
<tr>
<td>6</td>
<td>Counselling, group therapy, individual therapy.</td>
</tr>
<tr>
<td>7</td>
<td>Refer to psychologist, behavioural therapy, group therapy.</td>
</tr>
<tr>
<td>8</td>
<td>Helping them by the way they feel.</td>
</tr>
<tr>
<td>9</td>
<td>Group therapy. Appoint a security officer or train staff to deal with aggressive patients.</td>
</tr>
<tr>
<td>10</td>
<td>Seclusion. ECT.</td>
</tr>
</tbody>
</table>

\[ n = 10 \]
19. WOULD YOU BE INTERESTED IN ATTENDING A WORKSHOP IN THE FUTURE TO LOOK AT WAYS OF WORKING WITH THE MORE CHALLENGING PATIENTS?

<table>
<thead>
<tr>
<th>Respondent</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Yes</td>
</tr>
<tr>
<td>2</td>
<td>Yes</td>
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<tr>
<td>3</td>
<td>Yes</td>
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<td>4</td>
<td>Yes</td>
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<td>5</td>
<td>Yes</td>
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<td>6</td>
<td>Yes</td>
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<td>7</td>
<td>Yes</td>
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<td>8</td>
<td>Yes</td>
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<td>9</td>
<td>Yes</td>
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<td>10</td>
<td>Yes</td>
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<td>Yes</td>
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<td>No</td>
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<td>Yes</td>
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<td>Yes</td>
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<td>Yes</td>
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<td>Yes</td>
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<td>Yes</td>
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<td>18</td>
<td>Yes</td>
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<td>19</td>
<td>Yes</td>
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</table>

N = 15
20. What particular topics would you find beneficial?

<table>
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<tr>
<th>Respondent</th>
<th>Answer</th>
</tr>
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<tbody>
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<td>1</td>
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<td>5</td>
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<tr>
<td>7</td>
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</tr>
<tr>
<td>8</td>
<td>PD/substance and treatment interventions.</td>
</tr>
<tr>
<td>9</td>
<td>Goals, specific care-plans, structured interventions.</td>
</tr>
<tr>
<td>10</td>
<td>All.</td>
</tr>
<tr>
<td>12</td>
<td>More lectures from the psychology department.</td>
</tr>
<tr>
<td>13</td>
<td>&amp; Anything that may help.</td>
</tr>
<tr>
<td>14</td>
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<tr>
<td>25</td>
<td>Emotional abuse of aggressive outbursts from patients to nurses and doctors.</td>
</tr>
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<td>27</td>
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</tr>
<tr>
<td>29</td>
<td></td>
</tr>
<tr>
<td>31</td>
<td>Public awareness and tolerance of M.I. in the community.</td>
</tr>
</tbody>
</table>

[Other notes and responses]
Categorised data

I. Diagnoses and labels

Table 2. The Categories of Responses and Number of Respondents Regarding Issues of Diagnoses and Labels.

<table>
<thead>
<tr>
<th>QUESTION</th>
<th>CATEGORIES GENERATED AND NUMBER OF RESPONDENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients with which diagnosis do you find the most difficult to manage?</td>
<td>(N=13)</td>
</tr>
<tr>
<td></td>
<td>Personality Disorder: 7</td>
</tr>
<tr>
<td></td>
<td>Aggression: 2</td>
</tr>
<tr>
<td></td>
<td>Self-harmers: 1</td>
</tr>
<tr>
<td></td>
<td>Schizophrenia: 1</td>
</tr>
<tr>
<td></td>
<td>Substance misuse: 1</td>
</tr>
<tr>
<td></td>
<td>Bi-polar affective disorder: 1</td>
</tr>
<tr>
<td>Which labels do you and your colleagues use to describe these more</td>
<td>(N=11)</td>
</tr>
<tr>
<td>challenging patients?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Attention seeking: 3</td>
</tr>
<tr>
<td></td>
<td>Manipulative: 3</td>
</tr>
<tr>
<td></td>
<td>Diagnostic term: 2</td>
</tr>
<tr>
<td></td>
<td>“Cutters”: 1</td>
</tr>
<tr>
<td></td>
<td>“Alchies”: 1</td>
</tr>
<tr>
<td></td>
<td>Other: 2</td>
</tr>
</tbody>
</table>

II. Demands of the challenging patient.

Table 3. The Categories of Responses and Number of Respondents Regarding the Demands of the Challenging Client.

<table>
<thead>
<tr>
<th>QUESTION</th>
<th>CATEGORIES GENERATED AND NUMBER OF RESPONDENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is it about these patients, <em>behaviours</em> that makes caring for them</td>
<td>(N=13)</td>
</tr>
<tr>
<td>more demanding?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non co-operative/staff manipulation: 7</td>
</tr>
<tr>
<td></td>
<td>Self harm/suicidal ideation: 4</td>
</tr>
<tr>
<td></td>
<td>Time consuming: 4</td>
</tr>
<tr>
<td>What is it about these patients’ <em>attitudes</em> that makes caring for them</td>
<td>(N=13)</td>
</tr>
<tr>
<td>more demanding?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Self-critical/destructive: 5</td>
</tr>
<tr>
<td></td>
<td>Critical of others: 4</td>
</tr>
<tr>
<td></td>
<td>Manipulative: 4</td>
</tr>
<tr>
<td></td>
<td>Unchangeable: 2</td>
</tr>
<tr>
<td></td>
<td>Emotionally attractive: 1</td>
</tr>
<tr>
<td>Have you noticed any stages in a challenging patient’s hospitalisation</td>
<td>(N=11)</td>
</tr>
<tr>
<td>when they become more demanding?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Around discharge: 2</td>
</tr>
<tr>
<td></td>
<td>When using substances: 2</td>
</tr>
<tr>
<td></td>
<td>With limited nurse attention: 3</td>
</tr>
<tr>
<td></td>
<td>With nurse interventions: 3</td>
</tr>
<tr>
<td></td>
<td>When they are repeatedly readmitted: 1</td>
</tr>
<tr>
<td>What other aspects are there which make caring for the more challenging patients more demanding?</td>
<td>(N=11)</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Nurse helplessness: 4</td>
<td></td>
</tr>
<tr>
<td>Inadequacies of the service/mismatch of patient to service: 4</td>
<td></td>
</tr>
<tr>
<td>Self-harm: 2</td>
<td></td>
</tr>
<tr>
<td>Need for authoritarian approach: 2</td>
<td></td>
</tr>
</tbody>
</table>
### Managing the Challenging Patient

#### Table 4. The Categories of Responses and Number of Respondents Regarding Issues of Patient Management

<table>
<thead>
<tr>
<th>QUESTION</th>
<th>CATEGORIES GENERATED AND NUMBER OF RESPONDENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>What strategies do you use to manage these patients?</td>
<td>(N=12)</td>
</tr>
<tr>
<td></td>
<td>Consistency and boundaries: 5</td>
</tr>
<tr>
<td></td>
<td>Listen and talk: 2</td>
</tr>
<tr>
<td></td>
<td>Increase psychiatric power: 2</td>
</tr>
<tr>
<td></td>
<td>Improved planning: 2</td>
</tr>
<tr>
<td></td>
<td>&quot;I do not manage&quot;: 1</td>
</tr>
<tr>
<td>What other strategies or ideas are you aware of from the literature you have read or from your colleagues which might be useful?</td>
<td>(N=9)</td>
</tr>
<tr>
<td></td>
<td>Adopt a multi-agency approach: 3</td>
</tr>
<tr>
<td></td>
<td>Listen to patient: 2</td>
</tr>
<tr>
<td></td>
<td>Increase regulations/observation: 2</td>
</tr>
<tr>
<td></td>
<td>Other: 2</td>
</tr>
<tr>
<td>What makes it difficult to implement these useful strategies which you currently do not use?</td>
<td>(N=9)</td>
</tr>
<tr>
<td></td>
<td>Poor resources: 4</td>
</tr>
<tr>
<td></td>
<td>Poor training: 4</td>
</tr>
<tr>
<td></td>
<td>Severity of patients' problems: 2</td>
</tr>
<tr>
<td>How do you balance the care needs of challenging patients with those who are less challenging?</td>
<td>(N=11)</td>
</tr>
<tr>
<td></td>
<td>More challenging patients allotted more time: 7</td>
</tr>
<tr>
<td></td>
<td>Try to maintain a fair balance: 6</td>
</tr>
<tr>
<td>How do you find balancing the time demands of the challenging patients with the less challenging patients?</td>
<td>(N=11)</td>
</tr>
<tr>
<td></td>
<td>Difficult: 8</td>
</tr>
<tr>
<td></td>
<td>Attempt to prioritise and balance it out: 5</td>
</tr>
<tr>
<td></td>
<td>Easy: 1</td>
</tr>
<tr>
<td>You have identified some of your responses to challenging patients. In what ways are your responses to the less challenging patients the same or different?</td>
<td>Same: (N=8)</td>
</tr>
<tr>
<td></td>
<td>Offer patience, support and tolerance: 4</td>
</tr>
<tr>
<td></td>
<td>Others: 4</td>
</tr>
<tr>
<td></td>
<td>Different: (N=9)</td>
</tr>
<tr>
<td></td>
<td>Offer patience, support and tolerance: 2</td>
</tr>
<tr>
<td></td>
<td>Challenges more rewarding: 1</td>
</tr>
<tr>
<td></td>
<td>Boundaries and objectives: 2</td>
</tr>
<tr>
<td></td>
<td>Need a locked ward: 1</td>
</tr>
</tbody>
</table>
IV. Effectiveness of Intervention

Table 5. The Categories of Responses and Number of Respondents Regarding the Effectiveness of Nurse Intervention.

<table>
<thead>
<tr>
<th>QUESTION</th>
<th>CATEGORIES GENERATED AND NUMBER OF RESPONDENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Which patients appear to make the least/most improvements?</td>
<td>Least: (N=12)</td>
</tr>
<tr>
<td></td>
<td>Personality disorder: 8</td>
</tr>
<tr>
<td></td>
<td>Substance misuse: 4</td>
</tr>
<tr>
<td></td>
<td>Schizophrenia: 3</td>
</tr>
<tr>
<td></td>
<td>Other: 3</td>
</tr>
<tr>
<td>Most: (N=12)</td>
<td>Psychosis: 7</td>
</tr>
<tr>
<td></td>
<td>Depression: 5</td>
</tr>
<tr>
<td></td>
<td>Motivated patients: 1</td>
</tr>
<tr>
<td></td>
<td>Other: 1</td>
</tr>
<tr>
<td>What is your understanding for why these patterns occur?</td>
<td>(N=11)</td>
</tr>
<tr>
<td></td>
<td>Improvements dependant on patient responsibility: 7</td>
</tr>
<tr>
<td></td>
<td>Improvements dependant on service delivery: 5</td>
</tr>
<tr>
<td></td>
<td>Other: 1</td>
</tr>
<tr>
<td>Please list any details of Post Registration training.</td>
<td>(N=8)</td>
</tr>
<tr>
<td></td>
<td>HIV: 1</td>
</tr>
<tr>
<td></td>
<td>Nursing in secure environments: 1</td>
</tr>
<tr>
<td></td>
<td>Counselling course: 2</td>
</tr>
<tr>
<td></td>
<td>Others: 2</td>
</tr>
<tr>
<td></td>
<td>None: 3</td>
</tr>
<tr>
<td>Which aspects of your training and clinical experience do you value most</td>
<td>(N=12)</td>
</tr>
<tr>
<td>in working with these challenging patients?</td>
<td>Psychology skills: 5</td>
</tr>
<tr>
<td></td>
<td>Team work: 2</td>
</tr>
<tr>
<td></td>
<td>Management of aggression course: 2</td>
</tr>
<tr>
<td></td>
<td>General experience: 3</td>
</tr>
<tr>
<td></td>
<td>Others: 1</td>
</tr>
<tr>
<td>What effect do these more challenging patients have on how you feel about</td>
<td>(N=12)</td>
</tr>
<tr>
<td>your own professional role?</td>
<td>Negative effect: 8</td>
</tr>
<tr>
<td></td>
<td>Can fully utilise my skills: 1</td>
</tr>
<tr>
<td></td>
<td>Other: 3</td>
</tr>
</tbody>
</table>
V. Support and Continuing Professional Development

Table 6. The Categories of Responses and Number of Respondents Regarding Modes of Support and Continuing Professional Development.

<table>
<thead>
<tr>
<th>QUESTION</th>
<th>CATEGORIES GENERATED AND NUMBER OF RESPONDENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Can you identify any methods of support that may help in the management of challenging patients?</td>
<td>(N=10) Therapists: 6 Improvements in policy and management: 3 Peer group: 1 Improved environment: 1</td>
</tr>
<tr>
<td>Would you be interested in attending a workshop in the future to look at ways of working with the more challenging patients?</td>
<td>(N=13) Yes: 12 No: 1</td>
</tr>
<tr>
<td>What particular topics would you find beneficial?</td>
<td>(N=10) Psychological/Structured interventions: 4 Personality disorders: 3 Substance misuse: 2 Other diagnoses: 2 Public awareness: 1</td>
</tr>
</tbody>
</table>
Appendix 6
NB/as

1 November 2000

Course Tutors
Clinical Psychology Course
University of Surrey
Guildford
Surrey
GU2 5XH

Dear Course Tutors

Re: Mark Grixti

Service related research: Nurses' beliefs and attitudes towards challenging patients on an Acute Mental Health Ward: how this influences practice.

Subsequent to his recent placement here (October 1999 - March 2000), Mark Grixti has today presented his research findings to the and has contributed to a wide-ranging and fruitful discussion concerning his recommendations.

Steps are being taken to implement several of his suggestions, including the following:-

1. Training and workshops for nursing staff are to be discussed in the near future with ward managers, and senior ward staff. The Henderson Outreach Service Team may contribute via consultancy and teaching sessions.

2. The Head of Psychology has recently initiated a monthly support group meeting for nursing staff.

3. A "diplomatic" and systemically-conscious plan will be considered for relevant ongoing collaborative work between Psychologists and Nurses.

4. The idea of triumvirate nursing (Melia, Moran, Mason, 1999) will be further explored.

Despite this being a complex and sensitive area of research, Mark Grixti has found his way through a series of obstacles, and produced some constructive recommendations, which add fuel and focus to the Psychology services efforts to improve input for in-patients.

Yours faithfully

Nicola Boella
Consultant Clinical Psychologist

cc Margaret Henning,
Head of Psychology
Qualitative Research Project

A qualitative study on the relationship between social and professional support for first time parents: From labour to 6 weeks postpartum.

*Tis not enough to help the feeble up, but to support him after*  
Shakespeare (1623), *Timon of Athens*, (Act I, Scene I, line 110)

URN: 3902129

PsychD Clinical Psychology

Year II (course 28)

April 2001
Acknowledgements

I would like to express my appreciation to all those parents who gave up time with their families to be interviewed about some personal and sensitive issues. Thank you all.
Abstract

Research on experiences of labour, childbirth and early parenthood has identified the value of support systems in meeting the mother’s medical, social, and emotional needs. The effectiveness of these networks has been explained as central to averting considerable intrapsychic and interpersonal anxiety and distress. This research focuses on how both “new parents” experience these support networks and the value that they attach to them. Their experiences are tracked from the final stages of labour to six weeks postpartum to locate their support networks within a temporal and developmental framework. This paper reports findings from a qualitative study of six couples in Britain. Participants were interviewed about which supports they valued the most/least, who provided these supports, the most difficult aspects of this time for each individual, and how these supports may have adapted over time. The results indicated that satisfactory support in the hospital depended upon an integration of valued medical and psychosocial support. The hospital experiences were rarely reported to meet this level of satisfaction as the interviewees reported feeling out of control, a sense of unpredictability, under informed, with poor quality of attachment to the staff. Over the following six weeks, they expressed that they regained control and confidence from an improved attachment with the support networks of family and friends.

Keywords: support, professional, social, emotional, parents, qualitative, attachment theory.
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<td>Appendix 3 – Research Consent Form</td>
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</table>
Introduction

Over the past decade there has been greater focus on theories of social support as a guide to understanding the mechanisms by which support affects health and adjustment. In this field of enquiry, researchers have experienced conceptual difficulties in providing an operational definition of "social support" which has been reported as having important implications on the interpretation of research findings (Callaghan and Morrissey, 1993). For the purpose of this research it was deemed as important to operate within an epistemology which permits the idea that there can be a multitude of realities (see McFadyen, 1997), therefore emphasis was placed on understanding the meanings of individuals' accounts of support rather than the need to contain individuals' stories within the restrictions of a singular definition.

However to familiarise the reader with the term, one conceptualisation of social support is "an exchange of resources between at least two individuals perceived by the provider or recipient to be intended to enhance the well being of the recipient" (Shumaker and Brownell, 1984; cited in Callaghan and Morrissey, 1993, pp.203).

The provisions of support during labour and childbirth have been gaining more interest due to the impact of support on the results of obstetric treatment and parent satisfaction (Campero, Garcia, Diaz, Ortiz, Reynoso and Langer, 1998). Studies have reported a relationship between psychosocial support and a reduction in various types of medical interventions including, anaesthesia, analgesics, caesarean sections and forceps (Sosa and Kennell, 1980; Keirse and Enkin, 1989; Kennell and Klaus, 1991). Furthermore, psychosocial support has been found to accelerate recovery, improve parent/child bonding, and decrease anxiety and depression during the first six postpartum weeks (Klaus and Kennell, 1992; Hofmeyr and Nikodem, 1991; both cited in Campero et al., 1998).

The experience of psychosocial support during childbirth has been described as central to the quality of the mothers' experience of childbirth due to the increased medicalisation of
professional support (Campero et al., 1998). Chalmers and Wolman (1993; cited in Campero, et al. 1998) have expressed that in certain cultures the hospital professionals generally consider labour and childbirth as potentially pathological conditions in which specialised and technological care is most appropriate.

The medicalised care model has been associated with an unfavourable relationship between the medical staff and the expecting couple, which increases anxiety. In turn, higher levels of anxiety have been linked to adverse consequences in labour that have increased the probability of medical interventions (Lederman, 1978; cited in Campero et al., 1998).

Considering these research findings there appears to be some questions over the relationship between social and professional “supports” experienced by expecting and new parents. This area of investigation has been explored by many writers (e.g. Hofmeyr, and Nikodem, 1991; Klaus and Kennell, 1992; Sosa and Kennell, 1980; Chalmers and Wolman, 1993). However, one fundamental difference is that this piece of research adopts the narrative approach in which each person’s construction of experience and events is seen as reflecting their own belief system that may be in/distinguishable from their families or the professional’s who contributed to their support system. Through an interpretation of both parents’ stories this research aims to access a deeper, intricate network of stories which may reflect in some depth the parents’ narrative in relation to the context of time, place and person. The quality of these narratives can then be used to establish the supports that each of the parents in each couple found the most/least helpful from labour to six weeks postpartum.
Method

Participants
A total of 12 participants (6 hetero-sexual couples) were recruited. Selection criteria included that the two partners in each couple were co-habiting at the time of conception, childbirth, 6 weeks postpartum and at the time of the interview. It was recognised that there are different levels of stories that both influence and are influenced by current experience and the story about that experience (McFadyen, 1997). If these stories define the context of the person and the context defines the story then it was deemed as important to recruit couples that were experiencing parenthood for the first time. This measure was taken to encapsulate the powerful emotions related to the first, “unknown” experience of childbirth as well as to facilitate comparability amongst the couple’s reports.

The couples recruited all had their first child less than 5 years ago. This limit was determined at selection as the “narrative incorporates the temporal dimension” and “requires the location of events in cross-time patterns” (White and Epston, 1990, pp.3). Therefore a failure to limit the time-span between the interview and the birth of the first child could have had a retrospective effect on the stories told.

Interview Guide
Each of the 6 couples were interviewed in their homes by a different researcher. Both members of the couple were interviewed separately about their experiences of support around childbirth and up to six weeks postpartum. The use of separate interviews was deemed as important to encapsulate the stories directly from each individual’s belief system and to avoid any obstructive collusion. The interview guide (appendix 1) began with demographic questions that were followed by questions around who was present at the birth, on the return from the hospital, and during the first six weeks of the child’s life. This was followed with questions around the quality of these supports, how helpful they were, the hardest aspect of this period of time for them and the person/people supporting them.
Analytic Strategy

Interpretive phenomenological analysis (IPA) (Smith, 1996a; Smith, Flowers, and Osborn, 1997) was used to analyse the data. IPA provides a qualitative method to explore participants’ experiences, cognitions and meaning making. At the same time IPA also takes into account the understanding that research is a dynamic exercise that will be influenced by the researcher’s own conceptions and belief systems. Hence the participant’s phenomenological accounts are analysed through the researcher’s interpretive framework with the assumption that this process will result in meaningful interpretations about the individual’s thinking (Smith et al., 1997).

Smith (1996b) states that qualitative research should be transparent about its process of analysis. Therefore the details of this process as well as the two initial transcripts are included in appendix 2.

Adopting this methodology to analyse data involves a high degree of subjectivity as interpretations are influenced by the researcher’s own belief systems. Having a mixed sex group of researchers, of three males and three females, was considered as helpful to achieve a more informed awareness of the participants’ stories from a different gender perspective. Furthermore, two of the researchers had experienced childbirth themselves and several of the others had attended the birth of significant others. One important factor that also needs to be considered throughout the interpretation of the data is that all of the research group were trainee clinical/counselling psychologists and may have interpreted the priority of support differently from other groups.
Analysis

Demographic Information

There were 6 male and 6 female participants (6 couples). Mean age was 24 years (range 27-37). In terms of their highest educational qualifications, 5 had a postgraduate degree or diploma, 5 had a degree, and 2 had qualifications equivalent to an O-level/GCSE. 7 of the participants were in professional occupations, 1 was a senior manager, 1 was a charity worker and 3 were house-workers.

When the study was conducted, all of the participants lived within Great Britain and within a 30-mile radius of the London area. In terms of their ethnicity, 9 described themselves as white and British, 1 as half British and half Afro-Caribbean, and 2 were Greek.

Ten of the participants were married to their partners and two were not married. All 12 lived with their partners. 3 of the six couples’ oldest child were 4 years old, 2 were 1 year old and 1 was 2 years old. All of the couples’ first-born children were born in a hospital in England.

All participants read and signed a research consent form (appendix 3) which outlined the aims of the research. Signing of the form gave consent to audio-tape the interview and write up the results with respect to participant confidentiality.

Table of Themes

Having produced clusters of themes for the initial interview, the coding process was then applied to the other interviews until main themes were identified. Using this method of analysis meant that the researchers were already oriented or primed to certain aspects within the data when examining the latter transcripts. However, the analysis was a cyclical process and the researchers went through the data a number of times swapping more useful themes for those deemed to be less significant (Smith, Jarman, and Osborn, 1999). Table 1 shows the list of superordinate themes generated by the data.
Table 1. Superordinate themes

<table>
<thead>
<tr>
<th>Superordinate themes</th>
<th>Transcript instances</th>
<th>Identifier¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>Control</td>
<td>“you didn’t even know [] what they were doing”</td>
<td>Jackie p4</td>
</tr>
<tr>
<td>Professional support</td>
<td>“gave me no confidence”</td>
<td>Marney pg 4</td>
</tr>
<tr>
<td>Social support</td>
<td>“better [] at figuring out what I needed at a particular time”</td>
<td>Claire p4</td>
</tr>
<tr>
<td>Emotional support</td>
<td>“the knowledge and caring of our friends and family”</td>
<td>Paul p5</td>
</tr>
<tr>
<td>Isolation</td>
<td>“not being able to communicate properly made me feel isolated”</td>
<td>Olga p3</td>
</tr>
<tr>
<td>Expectations</td>
<td>“she told us one thing, and then a little later [] ruled over her decision”</td>
<td>Dave p2</td>
</tr>
<tr>
<td>Sources and application of knowledge</td>
<td>“she kind of knew all these terms and what you needed”</td>
<td>Paul p5</td>
</tr>
</tbody>
</table>

¹N.B.: Some of the details have been changed to preserve the anonymity of the participants.

Main Themes

The themes of social, emotional, and professional support were considered to be particularly relevant. Revisiting the data ensured that there was a complete corpus of data on these three areas that could be intensively examined. Although the themes of “social” and “professional” support were believed to be central at the outset of the research, the theme of “emotional” support was identified purely through the analytic process.

Experience of Professional Support

The focus of this study was an exploration into the supports that first time parents received and the effect of these experiences upon them. Ten of the twelve participants (83%) cited a number of experiences when they felt that the support of professional staff involved in the birthing process was inadequate. For example,

It was a horrendous ordeal for me. The hospital hadn’t completed anything we had asked for. We wanted a water birth but they had too many people giving birth
that night and they were short staffed. They induced me which I didn’t need but they said they wanted to hurry everybody up (Marney).

This statement is congruent with the observations made by Campero et al. (1998) that mothers who feel powerless during labour and childbirth experience great dissatisfaction with the hospital staff and are left feeling uncomfortable, passive, and dependant. This dissatisfaction may also be associated with higher levels of anxiety which can lead to adverse consequences and increased medical interventions (Lederman, 1978 ; cited in Campero et al., 1998). This was evident in the case of Jackie as she explained:

The midwife who was with me never really helped to explain what was going on [] I didn’t really feel that I had anybody on my side other than Dave [] I was quite scared by this time [] cos what they wanted to do was try a ventouse on the operating table and then straight into an emergency caesarean (Jackie).

Many other explanations of experiences of the professional support in the hospital setting were also negative. For example:

I discharged myself as I just hated it in there (Mary).

It was kind of the midwives who were actually not that good (Stephen).

The midwife who had come in with us had disappeared off the face of the earth, so we had no one kind of explaining to us (Dave).

This quotation from Dave implies that he would have valued the support from professionals more had they kept him informed of the progress of the birthing process. This interpretation is comparable to the explanations by Callaghan and Morrissey (1993) who state that an integral component of support in health comes in the form of tangible or informational support. Similarly, Campero et al. (1998) assert that women who receive
adequate information and encouragement experience a greater sense of control over their labour, which is a key component to a satisfactory birthing process.

The importance of control can be exemplified through a consideration of the temporal dimension of professional support. Having expressed how inadequate support from the professional staff was throughout her time in hospital, Marney’s perception of professional support altered over the six-week postpartum period:

Initially the hospital were in control of the situation and we felt out of control. But later with the health visitor clinic you don’t have to go but can chose to if you wish (Marney).

Only one couple reported a more positive experience at the hands of the professionals. Philip stated that:

Claire [partner] being a doctor [] wants someone who is not knowledgeable to lie to her about something. There was sort of slight of hand but Claire needed someone to tell her that everything was ok (Philip).

The difference between this story of relinquishing control to the working professionals can be compared to the other couples who felt less supported but attempted to gain some control and mastery over their situation. Unlike the other couples, Claire was a doctor and informed about the stages of the birthing process. Another factor that may have reduced anxiety was that she also worked in the hospital in which she gave birth and was familiar with the staff there. For example:

Claire was stitched up by the consultant, Heather, who she had worked under. The consultant stayed late specifically to do this, which was really sweet of her (Philip).
This interpretation implies that although this couple had a different experience of professional support, this may have been achieved through a reciprocal relationship encompassing information, collaboration, influence and control.

**Experience of Social Support**

Throughout this analysis social support is conceptualised as that which is experienced with family and friends, but not professionals. All of the female participants (100%) reported that they valued having their partner there with them throughout the birthing process. This is clearly communicated in the following examples:

Stephen was really good and organised things (Mary)

I really needed him [Paul] there because it was a horrendous ordeal for me (Marney).

Dave was very supportive both emotionally and practically (Jackie).

Research by Winter, Ferreira, and Bowers (1973) claims that the advantages which couples have over some other relationships is not that they work better together but have acquired shared understandings. This also appeared to be applicable to some of the couple’s family and friends as 75% of the couples extended their support system during the birth by allowing a friend or relative to accompany them. This was illustrated by Kyprianos who stated that:

Her mother was very supportive throughout the labour [] I think that was the most supportive fact (Kyprianos).

The remaining two couples expressed that they considered some family and friends to be of limited support during the actual birthing process. For example,
My mum wanted to be there but I banned her (Claire).

Everyone was just sort of nagging. Tony just wanted it just us two at the birth. (Liz).

In tracking the temporal dimensions of the stories it became apparent that most of the respondents became closer to their social supports over the six weeks following the birth. One fundamental element of this support took the form of practical help and advice. Marney expressed how she valued her mother’s input “by helping give him his first bath and holding him”. However, several of the participants stated that after their experiences in the hospital, any family support received had to be collaborative and non-blaming. Claire said:

She (friend) just listened [] and was very non-judgemental, which was great (Claire).

Experience of Emotional Support
Whereas professional support was conceptualised as the relationship with healthcare staff only and social support as the relationship with family and friends, emotional support encompassed the impact of the couples’ entire support network. Furthermore, there were some interesting changes in the participants’ reports of emotional support from birth to six weeks postpartum. Many of the participants’ dissatisfaction with the professional staff resulted in them feeling out of control during the birthing process. Kitzinger (1990) has identified perceived control as central to the parents’ satisfaction and self esteem. Indeed it became evident that in the weeks following childbirth, with assistance from family and friends, the new parents regained more control in the parent/professional relationship which reduced feelings of emotional vulnerability.
This shift can be exemplified by comparing how Paul experienced the supports at three different time points, during the birth, on leaving the hospital and a few weeks after returning home with his family:

They (professionals) had too many people on their books [] no friendship or closeness (Paul).

That was weird that they let us take the baby home....It was a bit scary and exciting (Paul).

Over time their (parents) advice faded into the background as we learned to cope on our own (Paul).

This transition was shared by a number of the couples and had a significant impact on their emotional states. To understand this shift it may be useful to consider the above stories in terms of attachment theory in which the professionals are the “stronger and wiser” (Holmes, 1997) “parent” figures. In his first statement, Paul could be said to have experienced a form of “avoidant parenting” (Holmes, 1997) in which the professional staff were brusque and functional in their handling of their “infants” (birthing parents). This would leave the non-attached parents in an anxious state, questioning their relationship with the “parent figure” and less likely to have confidence in their own coping mechanisms. This was reflected in Paul’s second statement, in that his feelings of being peripheral and superfluous in the hospital did not contribute to him feeling as if he was making a transition to the family home from a “secure base” (Ainsworth, 1982). In turn, Paul and his partner experienced a more secure and safe attachment with knowledgeable, informative family members. The third statement above illustrates how with the secure base in place, once the “danger had passed” the new parents managed to progress to a position where they had internalised their positive “parenting experiences”. Following this they could then move to a position of confidence where they could
function as the newborn child’s parents and consequently provide the child with it’s own secure attachments.

The quality of the emotional support received by Tony and Liz was a little different to that of the other couples who experienced an insecure attachment. Liz explained how involved their parents wanted to be:

Tony’s (parents had) been phoning up all of the time. (My) Mum was phoning like three times a day (Liz).

However Tony stated that over the duration of the birth:

Liz’s dad was a complete mess, he was really, really horrendous, tears and everything. Everyone was going nuts, and my mum was going nuts (Tony).

The reaction of this couple to their parents could be framed as an “ambivalent attachment” (Bowlby, 1988). In child terms, Bowlby has describes this interaction as, when the parent intrudes on the child when they are playing happily and ignores them when they are clearly distressed. This process could be compared to the times when this couples’ parents are intrusive, using many telephone calls when the situation was “safe”. Conversely, when the birth became a distressing event, their parents went “nuts”, offering no emotional support, and Tony found himself trying to “contain” their anxieties.
Overview

This study highlights the different support systems available to first time parents and how these supports may adjust over the first six weeks postpartum. While there is some overlap between these three identified support systems (professional, social, and emotional) this study began to identify when these different support systems were considered positive as well as their limitations.

The study indicates that first time parents value the medical knowledge of the professional staff. However, as Kitzinger (1990) has stated childbirth is a stressful process due to the complex interaction between pain, immobilization, medical interventions and the failure of interpersonal relations with healthcare professionals. The failure of the professionals to conceptualise birth as a multidimensional event left the parents feeling powerless, depersonalised, and anxious. In the one case, where the birthing process was described as satisfactory, the mother to be was a doctor in the hospital in which she gave birth and her birthing partner was also a doctor. Therefore she had some knowledge, information and control over the birthing process, and some highly valued emotional support from the staff. These factors appear to have bridged the medical/psychosocial support systems resulting in a more satisfactory experience.

Drawing on attachment theory (Bowlby, 1988), this study illustrates how over the following six weeks postpartum the new parents experienced a transition. There was a shift from “non-attachment” with the professional “parent figures” to the appreciation of a new secure base offered by the practical and social support of friends and family. This growing closeness is described by McFadyen (1997) as an attempt to restore a sense of meaning and mastery in the face of the profound challenges to their assumptive world. The final phase of this birth to six-week transition saw the parents internalise these supports, which then placed them in a position where they could offer a secure base for their own child to begin to develop an attachment.
Any conclusions drawn from this study remain tentative, as they may not be representative of the support systems that a majority of parents in Britain experience from childbirth to six weeks postpartum. Furthermore, the retrospective accounts of the parents described their support networks of up to five years after the initial birth. Although the researchers were more concerned with the stories rather than an “accurate account” of the events, it was recognised that this time span could have an impact on shaping the experience of meaning. Furthermore, the interview only encompassed one snap-shot of time in the whole process of conception, pregnancy and the transition to parenthood. These other factors would almost certainly have a bearing on parents’ reports of their experiences of support.

One other notable limitation is that six different researchers conducted an interview with each couple. Recognising the influence that interviewers have upon the content and process of the information elicited this may have resulted in a diversity of information which made comparability difficult to achieve. However, this process could also be described as reducing the effect of interviewer bias as the researchers would be operating in line with their different belief systems. Indeed, the results of the analysis may hold more credence as comparability was achieved and there was a sufficient corpus of data to support each of the major themes.

Finally, a more in depth investigation into the participants’ stories of support and what these experiences meant to them was beyond the scope of this research write up. Ideally, the richness of the data could have been reflected in further investigations of differences between the partner’s views of support, a closer analysis of which professionals/family and friends provided the greatest support, and how the values of these supports adjusted over time.


Appendices
Appendix 1
Interview guide

1. Who was present:
   a) At the birth
   b) At the “going home” time
   c) During the first six weeks of the child’s life

2. For times a), b) and c):
   a) What type of support did you need most?
   b) Who were the most important supports?
   c) For each named person:
      i. What did they do that was supportive?
      ii. What was most helpful?
      iii. What was least helpful?
      iv. Who was supporting them?
      v. How were they being supported?
      vi. What was the hardest aspect of this time for you?
      vii. What was the hardest aspect of this time for the person supporting you?

3. How did the support you received change over time?
Appendix 2
A qualitative study on the relationship between social and professional support for first time parents:
From labour to 6 weeks postpartum.

Process of Analysis

An idiographic approach was adopted (Smith, Jarman, and Osborn1999) in which one transcript was looked at in detail before analysing the others. Emerging themes were listed and connections between them identified. As some of the themes clustered together they formed superordinate concepts. After several readings of the first transcript new superordinate themes arose which assisted in grouping some of the other identified themes. There was great concern to ensure that each of these themes could be well illustrated with examples from the data. Having developed these superordinate themes for the first interview, the coding process was then repeated for each of the other interviews to see if the main themes were still applicable.

On completion of this process it was evident that some themes initially identified were not particularly relevant to the other transcripts, or needed to be re-categorised to encompass the new information. Once the main themes of professional, social and emotional support had been selected for more intensive analysis, the data was then re-examined to ensure that there was sufficient data for a detailed examination.

The extracts from each transcript were then grouped according to the new numerical coding categories to produce collections of data relating to each concept. Below is a description of these categories and sub-categories:

Table 2. List of coding categories for the main themes of professional, social, and emotional support

<table>
<thead>
<tr>
<th></th>
<th>Types of professional support</th>
<th>Professionals only</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Types of professional support</td>
<td></td>
</tr>
<tr>
<td>1.1</td>
<td>Directive</td>
<td></td>
</tr>
<tr>
<td>1.1.1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.1.2</td>
<td>Collaborative</td>
<td></td>
</tr>
<tr>
<td>1.1.3</td>
<td>Not valued/incompetence</td>
<td></td>
</tr>
<tr>
<td>1.1.4</td>
<td>Valued/competent</td>
<td></td>
</tr>
<tr>
<td>1.1.5</td>
<td>Conflicting/confusing information</td>
<td></td>
</tr>
<tr>
<td>1.2</td>
<td>Types of social support</td>
<td>Family and friends only</td>
</tr>
<tr>
<td>1.2.1</td>
<td>Directive</td>
<td></td>
</tr>
<tr>
<td>1.2.2</td>
<td>Collaborative</td>
<td></td>
</tr>
<tr>
<td>1.2.3</td>
<td>Not valued/absent</td>
<td></td>
</tr>
<tr>
<td>1.2.4</td>
<td>Valued</td>
<td></td>
</tr>
<tr>
<td>1.2.5</td>
<td>Power/powerlessness</td>
<td></td>
</tr>
<tr>
<td>1.3</td>
<td>Types of emotional support</td>
<td>Professionals and/or family and friends</td>
</tr>
<tr>
<td>1.3.1</td>
<td>Trust and containment (or not)</td>
<td></td>
</tr>
<tr>
<td>1.3.2</td>
<td>Care/reassurance (or not)</td>
<td></td>
</tr>
<tr>
<td>1.3.3</td>
<td>Competence/incompetence</td>
<td></td>
</tr>
<tr>
<td>1.3.4</td>
<td>Collaboration/non-collaboration</td>
<td></td>
</tr>
<tr>
<td>1.3.5</td>
<td>Absent (valued or not)</td>
<td></td>
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</tbody>
</table>
Finally, the analytic themes were translated into a narrative account in the write up. Although an emphasis was on the shared experiences of the participants, it was also useful to look at unique individual accounts of support networks. Having identified a number of main themes through an analysis of the data, these themes were then interpreted through an existing theoretical framework. For the purpose of this study, attachment theory was especially useful to provide an interpretation of the participants’ stories as it could be used to understand the meanings and development of support over a time continuum of six weeks.
Interview Transcript

Six weeks as a parent—support, coping and response.

Interviewer: (I)
Respondent: Marney (M)

I. Did you say that you had your first child in hospital?
M. Yes.

I. And was your partner in the hospital with you?
M. Yes, Paul was there.

I. Was anyone else there around the time of birth?
M. My mother, Yvonne, and my brother in law, Mick.

I. Was anyone else there at all?
M. A few hours later, after birth there was the grandparents and some of my extended family.

I. So these people were all in the hospital around the same day of the birth?
M. Yes.

I. And you had a?
M. Boy, called Dylan.

I. SO you and your partner were there and Mick and Yvonne were there too at the time of the birth. Was that pre-planned to have those people there?
M. Not really, it was a later decision. They decided to come to the hospital when they did.

I. Well, what did you think about this plan?
M. It was good. I was a bit disappointed that the grandparents were not there straight away as well.

I. Would that be Dylan’s grandparents?
M. Yes, Paul’s mum and dad. They came as quick as they could.
I. Ok. Just for the record their names are...?

M. Jenny and Tito.

I. I was wondering what it was like having those people around at the hospital. Did you manage to talk to them when you were in hospital?

M. Yes, for the first six hours when I was in labour I was just sitting around in a chair not doing very much and that helped while the time away. And then after that it started to get painful so I kicked everybody out. Then they had to sit and wait outside the room until the baby was born and then they came in.

I. How soon after the birth did they come back in?

M. Ah, several hours later.

I. And where was Paul throughout all of this?

M. Most of the time he was with me. Now and then he would pop out to see Mick and Yvonne to make sure they were alright and given them an update.

I. I see. So what was that like to have Paul disappearing off for periods of time whilst this was all going on?

M. Wasn't too bad I didn't really mind because I knew he wouldn't be long.

I. So it was quite reassuring to know that he was only going for a short period of time.

M. Yes.

I. How supportive was Paul through the whole time?

M. I totally needed him there because it was a horrendous ordeal for me. The hospital hadn't completed anything that we had asked for. We wanted a water birth but they had too many people giving birth that night and they were short staffed. They induced me which I didn't need but they said they wanted to hurry everybody up. So it went against all our wishes. Also, when they induce you you need to have an epidural and that didn't work either, so through all the pain and the agony Paul was around to be able to assert my rights and I was confident that he was able to do that.

I. I see, and was there one particular person that he had to negotiate with?
M.: The midwife. And then the anaesthetist then didn’t turn up for about an hour and I was in agony.

I.: So although Paul was very supportive, it sounds like you didn’t have that much confidence in the professional staff.

M.: None at all.

I.: Did things improve once the antitheticalists got there?

M.: No, got worse. The midwife was trying to get the kid to come out as quick as it was gonna come because they wanted to go off duty. You felt rushed, unrelaxed, and unsupported. Then they said that this baby would not come out if they didn’t cut, I didn’t want that and they enforced their rights and did it.

I.: Really? You already mentioned an epidural, did you have any other drugs at all?

M.: Yes, everything.

I.: So with all that, how easy or hard was it to know what was going on with these professionals.

M.: I was aware what was going on but it was — that’s why I needed Paul at my side. I got my point across, but I don’t think that they would have listened if he wasn’t there.

I.: You have said how supportive it was for Paul to be there. How do you think Paul experienced the other professionals...

M.: I think that he was alarmed as well. And he was disturbed because they hadn’t done what they said they would do and everything was done according to their plan and not our plan.

I.: Sounds really frustrating after all the thought that you had put into it...

M.: And also there are some criteria that you have to meet to have a water birth and we met all of those criteria and they still wouldn’t let us have it.

I.: How about from the point of birth onwards, did things change then?

M.: No. People contradict each other, they all give you advice because they all know best in their own way or in their own field or because they are older than you. So everything conflicts and nothing makes sense and in the end you have to make your own mind up.
I. The professionals were contradicting each other were they?

M. Yes, in different methods of child care. One would say one thing then the other would change it then another would say something completely different and you would be totally confused. This was over things like breast feeding and when you should or shouldn’t clean there eyes.

I. At what stage did this happen?

M. The day after he was born. And that continued all the way through.

I. Just so I get the timing right; around the time of birth there was some differences between the professions about what they thought they would do and what you had previously agreed to do.

M. Yes.

I. Which sounds very unsupporting. And then the next day they were telling you how to care for the baby.

M. Yes, I wanted to breast feed but the baby wasn’t having it and he needed coaxing. But they were not able to coax it. So each person would try different things like holding your breast, putting the baby’s mouth to the breast, and really awful stuff, not nice at all, totally undignified. And they were asserting their authority rather than act in a relaxed nature. Because he was so big they took him off to have a blood test and said that he had to have a bottle because he is too big and he needs food.

I. Right, a stressful time for you then.

M. Totally, and because it’s your first born you try to do what is best by their information but it conflicts with each other so your left confused and struggling.

I. For mum, for you it must be difficult enough not to be able to bond with the child the way you had planned, what was it like for dad as well?

M. Same thing I think. The agony that I was feeling was passed on. He was concerned for me the baby, himself and how we were going to cope with it.

I. So lots of problems with the professionals, were there any professionals that were quite useful over the birth to six months period?

M. No. The community midwife was no good either, very bolshy and unreassuring. She gave me no confidence. She also took my stitches out which really hurt.
I. So she doesn’t seem to have nurtured your confidence in caring for Dylan.

M. No, the people who gave me confidence were my mum and mother in law.

I. So in what ways were Yvonne and Jenny more supportive?

M. They said it doesn’t matter and were more relaxed in their approach and I suppose we had more confidence in them because they were our parents. They were able to support us and our baby.

I. They have some experience of child birth themselves I imagine, how many children did Yvonne have?

M. Three. Me, Jason and Darren who was older than Jason

I. You said was older?

M. He died.

I. Were there any particular things that your mum said which were helpful?

M. No not really, I think it was just the moral support. She said not to worry about the breast feeding but to use the bottle and as long as he is comfortable and secure and happy on bottled milk then that is what is important really. And Jenny gave me some advice too.

I. Ah, so Yvonne and Jenny both helped reduce that anxiety around the actual feeding of the child.

M. Yes. And also by helping give him the first bath and holding him and stuff.

I. Right, is it very difficult when you have never had a child before and there was you and your partner then suddenly there is three of you in your house? Is it difficult to know how to do all of those basic caring duties?

M. Yes it is because everything is new and you don’t know if you will burn the baby or drop the baby. Your initial anxiety is that the baby is so fragile. You wonder how you can keep up the daily tasks with the added pressures of having a new baby.

I. So you’ve got the baby to look after which is all a new experience which your not sure is right or not and then the rest of life goes on like all the washing and stuff. How did you manage all of that?

M. Well with support from parents, Paul and Mick.
I. Did you and your partner Paul have different tasks?

M. Mine was just to rest to get over the birth. For the first week everything was new and about 150 people came round and visited, I think. There was family, friends and friends of friends.

I. Was that a little draining having all of those visitors while you were trying to rest up?

M. No, Paul controlled it. And Mick as well.

I. How did they do that?

M. They got people to come at a particular time.

I. Was that OK for you or did it feel like they were taking too much control?

M. No, it was good cause they needed a task too.

I. So, while you were resting up who did most of the looking after Dylan?

M. We all did. The grandparents, Mick and Paul and I. The first few weeks were tough cause he had colic.

I. Right, where did you get any help or advice for colic from?

M. The health visitor.

I. Oh right, when did the H.V. begin to visit?

M. She visited before the baby was born and 10 days after.

I. How useful was the H.V.?

M. She had her opinions. She was OK compared to the midwives. Just having one person to talk to rather than many midwives made it easier.

I. So just having one voice was helpful.

M. Definitely, it made me more confident to try things.

I. I see, so when there were many professional opinions it sounds like it was difficult to know who to listen to but when you only had to hear just one H.V. it made it easier.
M. Yes.

I. You’ve told me how many family and friends became involved, especially after you all got home from the hospital, were there too many voices then that were conflicting with each other?

M. No. It worked well as the family know each other, know boundaries, are more laid back and supportive. Everybody had a vested interest in their grandson or nephew whereas with the midwives it’s different it’s “another” baby.

I. So for you were the best supports from the non-experts and the best supports from family.

M. Yes.

I. And where would Paul stand on that do you think, what would he say?

M. He would agree with me. The family was supportive and the professionals confusing.

I. Over the whole span of time, from giving birth to six weeks later, what was the most difficult time for you?

M. The third day after giving birth.

I. Quite definite, what was it?

M. My breasts engorged as I couldn’t breast feed and I was in a lot of pain. My breasts were like the size of footballs.

I. You have very clear memories of that, no doubts about the worst part. And again, would Paul say that that was the worst part?

M. No! He liked that, he was OK with the breasts like footballs thing! {laughs}

I. What would you say his worst experience over this period was?

M. The time in the hospital I should think.

I. So it sounds, like family were supportive, some taking care of crowd control, some with the colic…

M. ….Some washing up, bottles, washing, they all had different tasks. Mum took 2 weeks off work to help out, and all the other took turns coming in to help.
I. Did Paul have to return to work?

M. After 2 weeks

I. Was that strange for you to have all of Paul’s support and then he was gone back to work?

M. No. It was quite nice really. I could then be a bit more relaxed with the baby. Roles changed a bit and I began to care for the baby in the night and took more responsibility for Dylan.

I. So it sounds like when Paul withdrew a bit you could get more involved.

M. Yes.

I. You appear to have got a lot of support which was useful, but what was the hardest aspect of your partner supporting you over the initial 6 weeks. What was most difficult about his support for you.

M. Don’t think it was. We had some arguments out of tiredness.

I. Ok, was anything particularly hard for him?

M. Perhaps commitment. After you have the baby you think, wow I’ve got this baby for the rest of my life. Your concerns change to make sure it has the best on offer.

I. So did having your family around you help make that transition from being a young couple to having this massive responsibility?

M. Totally. We would have felt very isolated if we were on our own, especially after all the professional support that we didn’t get. Without the support around us we would have had too much to learn and do. Lots of my friends cried after they had a child but I didn’t do that because I felt so heavily supported.

I. Did some people get involved not just enough to lift the pressure but also made you think that they’re interfering too much?

M. I though it might have done with our mothers but it didn’t because they knew when to step back and go home.

I. After the 10 day visit when did the H.V. call next?
M. After a while you go to the clinic for weighing and stuff. This happens most weeks.

I. Did they ask you to come this often?

M. No, I just wanted to know the baby is fine.

I. was using this service quite reassuring?

M. Yes.

I. I see, so there appears to be a slight change in the way that initially your involvement with the professionals was difficult but as time went on and you grew in confidence then the professional support became quite useful.

M. Yes. I think that initially in the hospital they were in control of the situation and we felt out of control. But later with the H.V. clinic you don’t have to go but can chose to if you wish.

I. So would you say that you prefer to know what you need and then go and get it rather than be told what you have to have?

M. Yes. A bit more control.

I. What do you think Paul’s impressions are of the changeover in your experiences of professional support?

M. He didn’t know much about it as he was at work and looking after the baby was then my main job. He was less aware of the changes with the professionals.
Interview Transcript

Six months as a parent — support, coping and response.

Interviewer: (I)
Respondent: Paul (P)

I. You and your partner Marney had your first child in hospital?

P. Yes. That was Dylan.

I. Who was there at the birth?

P. Myself, Marney, her mother (Yvonne) and my brother (Mick).

I. Which professionals were there for you in the hospital?

P. A midwife, and anaesthetist, half a dozen midwifes. It was annoying.

I. So many?

P. Yes that is why we had our next child at home. We had never met the midwife before Marney was in labour, over the 12 hour labour they changed shift many times and we had to tolerate their agenda and there was little consideration for our wishes.

I. Have you got any examples of that?

P. It was our first child and we knew no better. And every so often a new midwife would come in and introduce herself as the new one. There was no chance to form a relationship with any of them. The one who actually delivered Dylan might have half smiled but there was nothing there, no meeting of personalities.

I. Was that the most difficult part of this process for you, not being able to bond with the midwives or was it something else?

P. Oh, it was certainly more than that. For instance they could not locate the anaesthetists, the did not answer his pager for over an hour...

I. How did this timing affect things?

P. Very much, we wanted to have a birth without major drugs but it was thought best that we did. Then the guy could not be got hold of which was worrying at the time.

I. Sounds very worrying for you, how aware was Marney of all this?
P. Totally aware, probably more worried than me. I got very involved in ushering people along and co-ordinating them more than I usually would.

I. And was Marney aware of what you were doing?

P. Yes and she trusted me to get things done. And I would have stopped at nothing to get them done.

I. Sounds very difficult. Was there anything about the professionals involvement that was more useful?

P. Their knowledge of the “operation” if you like. They were proficient in child birth. They appeared to be adequately skilled and in that field there was nothing for me to be worried about.

I. Does that include their knowledge and practice around the administration of medication?

P. Yes, I had to usher them along by stating how urgently Marney needed painkillers but they seemed to know what they were doing.

I. Did Marney have any reservations about their actual practice?

P. No, I don’t think so. Apart from the turnover of staff and not being able to locate the anaesthetists. They also ignored her wishes of a water birth, that was unfair. But if she was concerned about these things she would talk through me. The midwife would talk to Marney a lot through the process but the feedback would come through me.

I. You sound very supportive throughout the birth, but were there any times over the process when Marney would have found you less supportive or a bit of a nuisance?

P. Oh certainly. There was times when she would be rude and brash to people. She ordered Mick and Yvonne out of the ward when birth was imminent.

I. Was that something that surprised you at the time?

P. Yes, in a funny way. I saw the humorous side but when things got serious there was great truth in her words. She knew I knew when things were serious and would get her point across.

I. Sounds like she got her point across to you clearly at these times.
Yes.

How useful was it to have family members there at the hospital? Was it difficult at times to have the relatives there?

No, for me it was fine. We were in a strange situation and I was happy for some family support.

Did you ever feel caught in the middle of tending to Marney’s needs and looking out for your family in the hospital?

No, I knew Marney trusted me to see to her wishes and the family there also respected that. I was just a mouthpiece for her when she needed it.

Over the duration of the labour did you stay with Marney or were you also popping out to give the relatives and update?

Once things hotted up and the relatives were told to get out then I stayed with Marney till the birth. But afterwards then I did see more of them.

Right, at what point did Yvonne and Mick come back into the room to see Marney and Dylan?

Uhm, as soon as birth was done and things tidied up. Some minutes after birth.

So there are five of the family now at the hospital, including baby Dylan. Did anybody else come to the hospital?

The next day more family and friends visited. My mother and father, friends, and Marney’s cousin.

Did they all come at once?

They did. It was great though, I wish more people were there.

Did it at any point seem too much after your long night?

Nothing was too much, it was like a different world.

Would Marney agree with that?

She certainly was pleased for everyone to be there.

How long was it before mum and Dylan returned home?
They asked us if Mamey and Dylan wanted to stay in the first night to try and get the breast feeding right. She thought it best to stay in to get the help of the professionals, cause now we had friendly staff showing her how to feed. Again not one mentor, just several but the post birth nurses were much more friendly and helpful.

I see, and do you think that Mamey had the same experience around that?

Yes, I would say so.

What was it that was most helpful about these post birth nurses?

They were using all their experience to get the baby to feed which was really helpful.

How did the feeding go?

50% success. He did breast feed a bit which we though was very important. We got some of the breast milk down him with their help. But we gave up with the breast feeding a couple of weeks on.

Whose decision was it to give up?

Ah, all three of us. Including Dylan in that.

How about your family. Did they help at all with ideas around feeding?

Yes. My mother gave us her opinions, she had worked in a maternity unit in the past and had some advice.

Once you did return home was it just the 3 of you there or did others come around?

We went home on our own. That was weird that they let us take a baby home. It was a bit scary and exciting but nothing would have stopped us taking on that adventure. We owned the right to do that.

Were there any nerves over what to do with a new baby once you got home?

I wouldn’t have known but I knew Mamey would know what to do and I knew that I would learn. I had to, he was my new son.

And who in the family was most helpful at this time?
Both grandmothers were often round and were very hands on. Also my father was there. They all held the baby every evening in our house as Dylan had colic and cried a lot. So the 3 grandparents certainly.

How did you know what colic was?

I'd say Mamey already had a great interest in babies anyway so she kind of knew all these terms and what you needed to sort them out.

So one of the best supports that you had once you got home was Mamey's own self-learning.

Oh yes, certainly. Also Marney had a network of friends who has recently had babies too so she knew what they had gone through and how they had coped.

And were yours and Marney’s friends around at all once you returned home?

It was largely the 3 grandparents, Mick and the rest of the people came to pay their respects frequently.

Was that manageable, considering that you may have been tired and had just go home, to have these people coming around?

I only appreciated their visits.

How were there visits organised?

People turned up and some were more arranged.

So, sounds like initially the professionals at the hospital were not as useful as they could have been.

Yes, poor bedside manner. They did become more useful later but still more functional than friendly. A bit more caring though than the midwives.

So what is different about the support of the professionals compared to the support of your family and friends?

The professionals in the hospital see several hundred babies and our family far less. So it was the sheer difference in numbers. The nurses see hundreds of babies and it showed.

So, if you were to rate which supports were the most useful what would you say?

Certainly the knowledge and caring of our friends and family.
I. And how long did you stay at home with mum and Dylan?

P. I only had a weeks paternity leave. Then I had a one line letter saying "your paternity leave is over you are due back at work on Monday".

I. Very sensitive.

P. Yes, no support from work.

I. What was that like for Marney. You were so supportive and then you went to work.

P. I think that she was empowered and she also knew she could get me by phone. It was fine, we expected this to happen and she was the main one now.

I. How did you feel leaving the house and going back to work?

P. I would have liked a longer paternity leave just to enjoy it but she could cope well on her own now.

I. Did she still have any professional help at this point?

P. The health visitor visited but not very regularly. The H.V. resigned after a month and after our experience with many midwives this was not surprising to us. But we didn't think this service was all that great.

I. So even now, when Marney saw the H.V., after you had returned to work, you still had reservations about how useful this was?

P. Totally, it all seemed part of the same unimpressive system. They seemed like they had too many people on their books and we were just another number. No friendships or closeness.

I. So from birth to 6 weeks there was no difference in the quality of support from the professionals?

P. That's right.

I. What was the hardest time over the first 6 weeks for you?

P. Just prior to birth and giving birth. Our wishes were not respected, communication was poor, and there were many flaws in the system. It was out of our hands.
And for Mamey.

The same.

And once you got Dylan home, do you remember any feelings around the transition of moving from being a young couple to parents?

I didn’t see it as daunting at all, it was a planned pregnancy and it was something I wanted to take on.

as much as you were looking forward to it, when you had questions where did the answers come from?

If Mamey didn’t know then grandparents.

Did grandparents ever give conflicting or unhelpful advice?

No, I don’t think so. Over time their advice faded more into the background as we learned to cope on our own.
Appendix 3
A qualitative study on the relationship between social and professional support for first time parents: From labour to 6 weeks postpartum.

Research Consent Form

As part of a research project, I would like to invite you to share with me some of your experiences and feelings around having a new born baby. Some of the issues that are of particular interest are those of how parents respond to the birth of their first child and the supports that they receive. It would also be interesting to begin to understand each partner’s thoughts and feelings about this time in their lives. To do this, I would like to complete a short interview (approx. 30 minutes) with each partner separately. Afterwards, if you wish, we can all meet up together to talk about the interview.

Care will be taken to ensure that you (or any person of organisation that you mention) can not be identified through the report. In making a transcription of the audio-tape, any names will be deleted or replaced by pseudonyms. After the transcription has been made, the audio-tape will be destroyed.

If there are any questions which you do not wish to answer feel free to say so. If there are any questions you would like to ask during the interview, please feel free to do so. You are free to withdraw from the study at any point without needing to justify your decision.

Please read the following. If you are in agreement, sign where indicated.

I confirm that I have read and understood the above information and agree that the purposes of this research and what my participation in it would entail, have been clearly explained to me in a manner that I understand. I therefore consent to be interviewed about my experiences and feelings about the birth of my firstborn child and the issues of support and coping in this context. I also consent to an audio-tape of this interview being made and to all parts of the recording being transcribed for the purposes of this research.

Signed: ................................................................. Date: ..................................

Please Print Name: ..........................................................................................

Signed: ................................................................. Date: ..................................

Please Print Name: ..........................................................................................

On behalf of all those involved in this research, I undertake that confidentiality will be ensured in respect of the audio-tape and transcription of the same. I also undertake that any use of the audio-tape or transcribed material will be for the purposes of research only. The confidentiality of the above participant will be protected and they (or any person or organisation they mention) will not be identifiable to others (who are not already familiar with the circumstances described) in the research report.

Signed: ................................................................. Date: ..................................

Please Print Name: ..........................................................................................
Literature Review

Discourse analysis is a research methodology incorporated within the theoretical framework of social constructionism: Critically review the significance of discourse analysis and its application in the field of clinical research.

URN: 3902129

PsychD Clinical Psychology

Year II (Course 28)

October 2001
Discourse analysis is a research methodology incorporated within the theoretical framework of social constructionism: Critically review the significance of discourse analysis and its application in the field of clinical research.

Smith (1996, pp. 265) asserts boldly that the “neglect of qualitative approaches within mainstream psychology has produced a distorted agenda as to what counts as legitimate inquiry and an impoverished map of psychological knowledge.” In order to redress this “imbalance”, the first section of this literature review will critically evaluate the underlying theoretical framework surrounding qualitative research methodology, before focussing in particular on discourse analysis. The underlying framework of discourse analysis is explored because epistemological and theoretical clarity are deemed to be vital to the understanding and interpretation of all research (Abraham and Hampson, 1996). With an understanding of this alternative epistemological paradigm, the usefulness, critiques, and application of discourse analysis to the areas of psychiatric medication, the construction of “mental illness”, “mental retardation”, and care in the community will be discussed through a review of the literature.

A shift in the theoretical frameworks of research: From traditional scientific research to social constructionism

Philosophies central to traditional psychological research

Modernism and psychological research

Modernism in Western culture is closely associated with advances in science and technology, which led human beings to begin to envision a mastery of the fundamental order of the universe (Kvale, 1992). It became apparent that all scientific endeavours could be unified under a single logic and that such rules of procedure could be adopted by any discipline in order to generate knowledge (Burr, 1995).

Gergen (1992) states that psychology became an enthusiastic and able participant in the “modernist romance”, and that there are four main presumptions that helped psychology
associate itself with the modernist movement: A basic subject matter; Universal properties; Empirical method, and; Research as progressive. These are defined below.

1) A basic subject matter: This is the belief that there is a knowledgeable world that is constituted of subject matter. Some psychologists believe that this matter is in the mind (e.g. cognition, motivation, emotion) whereas others embrace the idea that the answers lie in observable behaviour (e.g. behaviourism).

2) Universal properties: In addition to the belief that there is a knowledgeable subject, modernist psychology also accepts that there are universal properties. These are universal principles and laws that may be discovered about the properties of the subject matter. Through the use of these universal principles the discipline attempts to develop empirically grounded theoretical networks to enable generalisations from the study of single instances to other instances across time, situation and persons.

3) Empirical method: Through a rational justification of logical empiricist philosophy, modernist psychology has attempted to determine truth through method. By way of empirical methods, modernist psychology seeks to establish obdurate truths about the nature of a subject. Furthermore, it is assumed that when properly deployed, modernist scientific methodology is not subject to the entry of ideological influence, or values into the research findings.

4) Research as progressive: Derivative of the preceding assumptions is the belief that empirical methods contribute to the progressive nature of research. This methodology pertains to move towards reliable, value-neutral truths in its discovery of the various elements of the objective world.

A critique of traditional psychological research
A vast majority of psychological research is still conducted within a modernist framework (Gergen, 1992), as experimenters within this traditional scientific method attempt to screen out interpretation and to produce a clear and unmediated representation of the
object of interest (Burr, 1995). However, by over valuing this single type of "objective" knowledge common to traditional scientific inquiry, some researchers have stated that psychological research has limited itself (Cronbach, 1975; Stanovich, 1989; Wachtel, 1980). Indeed, psychological research has been described as being in "crisis" from the end of the 1960s and the beginning of the 1970s (Parker, 1989) as an awareness developed of the impossibility of the assumption of the presence of universal truths. Indeed, Kuhn’s "The structure of scientific revolutions" (1970) provided one of the most critical attacks on modernist thought. This criticism asserted that those facts, which appeared to be increments in knowledge, were no more than alterations in viewpoints. In other words, truth was beginning to be seen as matter of perspective. Therefore, what passes as knowledge within the sciences may be considered to be the result of social constructions within the culture of science (Latour and Woolgar, 1979).

Not until the early 1980s did the implications of such a critique of psychological methodology become broadly apparent. The writings of Habermas (1981) argued that scientists systematically transform questions of ideology into technical questions. Following this transformation, questions of ideology are suppressed. Consequently, technical solutions are received without question and these newfound "solutions" obscure the ideological positions of the scientists themselves. These ideas are significant as they illustrate that rational justification of science and a reliance on empirical methodology do not position the scientist above moral, ethical and ideological considerations (Gergen, 1992).

Social constructionism: an alternative approach

Such critical perspectives of traditional psychology contributed to the emergence of social constructionism in psychology, which is usually dated from Gergen’s (1973) paper "Social psychology as history". The term "social constructionism" is the theoretical orientation which subsumes alternative approaches, such as "discourse analysis", "critical psychology", "deconstruction" and "postmodernism" (Burr, 1995). Defining social constructionism is difficult considering that there is no single feature to identify a social
constructionist position. However, Gergen (1985) has expressed that a social constructionist approach has one or more of the following key features:

1) It adopts a critical stance towards taken for granted knowledge and invites the individual to challenge knowledge based on positivism and empiricism familiar to traditional science. This perspective invites a critical approach to assumptions of how the world appears to be in terms of constructed categories that do not necessarily refer to “real” divisions.

2) The ways in which the world is interpreted, the categories and concepts adopted, are historically and culturally specific. Categories used to identify oneself and others is dependant on where and when in the world one lives. For example, up until 1987, people in Western civilisation who were homosexual were categorised by the DSM-IV (American Psychiatric Association, 1994) as having a “mental illness”. This illustrates that all ways of understanding people are historically and culturally relative.

3) If knowledge of the world is not “real” and objective then where does it come from? The social constructionists believe that it is constructed between people. Hence, social interaction of all kinds, and particularly language, fabricates knowledge. Therefore, what is regarded as truth is not derived from objective observation but by social processes and interactions.

4) Each different construction of knowledge invites different action from human beings. For example, “drunks” were previously seen as responsible for their behaviour and a typical response was imprisonment. However, when the concept shifted from seeing alcoholism as a “crime” to seeing it as an “illness”, the social action became offering medical and psychological treatment. Hence, constructions of the world and its inhabitants sustain some patterns of social action and exclude others.
The significance of the researcher in social constructionist research

As stated, the challenge of social constructionism to traditional understandings of science has emphasised that all knowledge is constructed within human relationships, social discourses, and cultural contexts (Kvale, 1992). This position disputes the presence of neutrality or objectivity in research, in favour of utilising an "interpretative study of a specified issue or problem in which the researcher is central to the sense that is made" (Banister, Burman, Parker, Taylor and Tindall, 1994, pp.2). This "interpretation" which provides a bridge between the researcher, the objects of study, and the researcher's representations of the object of study is considered to be a process (Banister, et al., 1994). This process is ongoing as our relation to the world keeps changing. The qualitative researcher would follow the process and accept that there will always be a gap between the issues that they are attempting to understand and the researcher's perception of the object of study (Burr, 1995).

Acknowledging the influence of the researcher through reflexivity

To appreciate the influence of the researcher in social constructionist research, the process of reflection is used. Reflexivity has been described as "the capacity of any system of signification to turn back upon itself, to make its own object by referring to itself" (Ruby, 1982, pp. 2). The process involves the person making themselves the object of their own observation. Gergen (1992, pp.24) has stated, "critical self-reflection is essential for the postmodern scholar."

The reflexive spiral is not a position adopted within quantitative research, where there is the assumption that the elimination of subjectivity leads to the production of a fully objective account (Banister, et al., 1994). However, in qualitative methods, reflexivity is used to conceptualise subjectivity as a resource, not a problem, which is acknowledged and used theoretically and pragmatically (Coyle, 1995). Hence, considering the "position of the researcher" through a reflexive analysis contributes to the understanding of the area of investigation, whereas ignoring that the activity of studying something will affect it, further compromises the positivist ideal of "objectivity" (Gergen, 1992).
**Deconstructionism in qualitative research**

 Whilst reflecting on texts (verbal or written accounts), the researcher will take them apart or deconstruct them. Deconstruction is a method often used in qualitative research that further resists definitions and prescriptions, for it is looking for how a "problem" is constructed rather than attempting to claim what it really is (Derrida, 1983). When conducting research the researcher invariably relies upon the conventions of language that govern what can be communicated. Therefore, if language guides the formation of our accounts, it subsequently constructs an array of putative (considered to have existed) objects. One must accept that it is not possible to exit the language that constructs "reality", so truth and accuracy are not a product of the real world, but a product of textual history (Gergen, 1992). With this in mind, one can begin to appreciate that language conventions are dependant on social processes, which will be influenced by various ideological biases. Following on from this it is apparent that all attempts of objective scientific writings and reports are essentially value-saturated phenomenon, which are products of social agreement (Ingleby, 2000).

Foucault (1979, 1980) extends this point by asserting that descriptive writing cannot be separated from issues of power. This observation is of huge consequence to those working in the field of psychology, as academic writing is perceived as a form of rhetoric, its effects are potentially persuasive and thus potentially powerful. The ways in which evidence is accumulated and used in the field must be reflected on and deconstructed, so as to identify the misuse of power and a transgression in the code of ethics in relation to client care.
Discourse analysis

The inter-relationship between social constructionism, reflexivity, deconstructionism, and discourse analysis

Social constructionism is considered to be a loose collection of theoretical perspectives and discourse analysis is just one research methodology that falls within its rubric (Burr, 1995). Nonetheless, some theorists have described discourse analysis as the research methodology that is most congruent with the principles of social constructionism (Parker, 1992).

Discourse analysis is a research methodology that has developed from various domains including speech act theory, ethnomethodology, conversation analysis, and semiology (see Potter, 1996). It is a field of enquiry that is particularly reliant upon the postmodern movement and operates under the assumption that “meaning is not static and fixed but is fluid and provisional” (Coyle, 1995, pp. 244). Furthermore, language is not conceptualised as reflective of “reality” but rather as constitutive (having the power to enact) of experience (Potter and Wetherell, 1995). In other words, the linguistic categories that we use to describe “reality” bring into being the objects they describe, or put simply, language constructs reality (Parker, 1992). There is always a number of ways to describe something and our choice of words can be seen to form perceptions and experiences which create different versions of events and reality (Willig, 1999). Therefore, discourse analysis is used to understand the ways in which “language constructs objects, subjects and experiences, including subjectivity and sense of self” (Willig, 1999, pp.2). For an in-depth description of rhetorical strategies and devices used within a text, Edwards and Potter’s (1992) *Discursive Psychology* is particularly useful as it provides a number of working examples.

An increasing number of psychologists are using discourse analysis (e.g. Potter and Wetherell, 1987; Edwards and Potter, 1992; Burman and Parker, 1993) as it allows the researcher to question concepts that are taken for granted in psychology. Such studies analyse the way in which particular categories are constructed and used and the
consequence of this action. In addition, discourse analysis allows the researcher to reflect on the different subject positions that may facilitate or impede particular actions or experiences (Potter and Wetherell, 1995). For example, differences between the discourses of a psychiatrist and a patient could identify positions of power and how those are used, as the psychiatrist can prescribe or proscribe certain practices whilst the patient may passively grant the psychiatrist access to their body and mind. Deconstruction of these dominant psychological concepts and subject positions can demonstrate that things could be different and are not simply reflections of "reality" (Willig, 1999). Such deconstructions allow the opportunity for the researcher to reflect on the process of reification, in which human realities are reduced to the order of things (Ingleby, 2000), and to create a space for alternative approaches which may question the usefulness of existing doctrines of psychological "common sense". The ultimate aim being to take a "critical, progressive and political stance to truth claims made by discourses which help maintain oppressive power relations, and to increase the 'voice' of marginalized discourses" (Burr, 1995, pp. 172).

Diversity of styles of discourse analysis

At this point it may be useful to briefly outline the four main styles of discourse analysis currently in use. As could be expected the different techniques do not fit neatly into categories, however there are some significant differences in style. The discursive psychology approach (see Edwards and Potter, 1992) has been likened to conversational analysis (see Wooffitt, 2001). That is, its central focus is on the discovery and explication of patterns of utterances, or it is used to make a microscopic, close-grained analysis of text. This is unlike the Foucauldian approach (see Parker, 1992; Willig, 1999) which is more sociological and moves from a microscopic to a macroscopic position. This approach treats language as a screen on to which more traditional sociological issues can be inscribed, such as power, gender and status. A third technique is critical discourse analysis (see Fairclough, 2001). This method analyses text, interactions and other semiotic material, but begins with sociological opinions and works back to the text. It is critical in that it is committed to progressive social change. Finally,
rhetorical analysis (see Billig, Condor, Edwards, Gane, Middleton, and Radley, 1988) is a form of analysis that incorporates and integrates several of the techniques from the other three models.

Critique of the analysis of discourse
Discourse analysts have long struggled with the criticism that discourse analysis is based on deconstructionist theoretical foundations, which challenges notions of “truth” and “reality” (see Burman and Parker, 1993). Therefore, if there was no “truth”, only competing discourses, then it would be contradictory to make truth judgements that, for example, a particular group are oppressed. The “discourse-reality” problem has caused much debate within the field of discourse analysis, as different people’s versions of this problem itself cannot be separated from political implications. For this reason, discourse analysts have been criticised for making the same mistakes as traditional psychologists, in representing their accounts as “truth” (Potter, Wetherell, Gill, and Edwards, 1990). Indeed, to remain true to the theoretical framework, it is essential that discourse analysis, which is itself just another body of theory and practice, continues to recognise that it is, after all, a social construction. A humility to the approach thus appears to be paramount to developing and maintaining its credibility considering the inevitable questions of how is this research evaluated and if it is not, then how is it judged as useful. These issues will be considered later in the literature review, when discourse analysis is applied to the field of clinical research.

An additional criticism made by Abrams and Hogg (1990) on the compatibility of discourse theory and research, is whether the political intentions of discourse analysts impede their qualifications to represent marginalized groups. They state that discourse analysis appears to appeal to those who hold left wing or liberal views and that there is no particular reason why right wing groups, such as the National Front, should not be given “voice”, just as much as black people, women and homosexuals.
Discourse analysis and its application in the field of clinical research.

The second section of this evaluation moves from a review of the literature on the theoretical framework of discourse analysis to a review of the literature of its application. Although discourse analysis has become more popular as a psychological research method (Harper, 1999), there are still relatively few studies using this methodology in clinical research. However, considering limitations of space, a selection of studies has been chosen to illustrate the application and usefulness of discourse analysis across a range of clinical settings. These will be critically appraised. The literature review will focus on the following areas: Discourse analysis and psychiatric medication; discourse analysis and the construction of “mental illness”; discourse analysis and “mental retardation”; discourse analysis and care in the community.

Discourse analysis and psychiatric medication

To assist the reader in the credibility of the analysis, a shortened account of how Harper (1999, pp.133) used discourse analysis to deconstruct a professional’s views on a “mental health patient” is provided.

Transcript analysis – Medication and schizophrenia

Harper: Right, why don’t you feel, why do you feel the medication hasn’t affected the beliefs?

Dr Lloyd: This is the interesting thing. I think because they’re <pause> they’re deeply ingrained thought patterns <Harper: Right>. I don’t think you can any more just say they’re illness-based. Their origin is illness-based but they have had <pause> their existence and their entertainment and their reinforcement by repeated thinking has had positive effects for Alan for the reasons I gave earlier and therefore, even if the reason for the existence of the <pause> delusional beliefs is no longer there, assuming <Harper: Uh-huh> <pause> that the neuroleptic medication that affected the other things affects what lies at the bio-chemical core of those delusions <Harper: Uh-huh> They’re too important to leave. <Harper: Right, right>
I mean that’s that’s one possible explanation <Harper: Uh-huh> I don’t think Alan doesn’t have schizophrenia apart from the delusions because he’s on neuroleptic medication. Erm it’s difficult to know now what’s long-standing ingrained personality patterns and what’s long-standing, ingrained, chronic, psychotic deficits and what is institutionalisation from being 25 years inside <Harper: Right> erm <we will never really know. 

*(Interview with Dr Lloyd, consultant psychiatrist)*

Dr Lloyd is described by Harper as using a number of rhetorical strategies to suggest that medication has not affected Alan’s beliefs. This is partly achieved through a five part list as he details the presence of; a) “deeply ingrained thought patterns”, b) positive effects through the reinforcement of repeated thinking, c) “long-standing ingrained personality patterns”, d) “long-standing ingrained chronic psychotic deficits”, and e) “institutionalisation”. Listings of this kind have a number of uses in persuasive discourse (Edwards and Potter, 1992). The descriptions used are said to imply deficit and pathology in the patient which is a rhetoric often chosen by the “psy professions” (Gergen, 1990) which subsequently constructs the individual as pathological and deficient.

Furthermore, Harper interprets the use of eclectic listing (multifactorial talk) as a device to give the psychiatrist sufficient flexibility to fend off a variety of possible challenges. Dr Lloyd incorporates a range of theoretical frameworks including; biological, sociological, behavioural, cognitive, and personality psychiatry. One effect of this multifactorial approach is that if the biological model was challenged as ineffective, as medication was not successful with this individual, then other explanations could be incorporated to explain the presence of delusions. Harper also attends to ways in which multifactorial talk can be used to represent the various theories as relevant, but a fixed hierarchy is constructed in which biology and biological mechanisms are situated as the “core” constituents of schizophrenia. Although the shift from the failure of medication may appear as a progressive step, Harper notes that the oppositions of
pathology/normality and individual/social remain unchallenged, so the pathological thought patterns are still located within the individual. Even when the social is recognised through the term “institutionalisation”, the concept remains individualistic contributing to the construction of the pathological individual.

Through a set of qualifications such as “I think”, “I don’t think”, “assuming”, “it’s difficult to know”, “we will never really know”, the psychiatrist introduces ambiguity and apprehension. This is a useful defence (Harper, 1999), for if counter-evidence or a challenge go against his judgement, Dr Lloyd has already attended to the fallibility of his tentative hypothesis allowing for the flexibility to change if required.

Finally, Harper refers to the use of a four-part list at the end of the extract, where Dr Lloyd mentions “long-standing, ingrained, chronic psychotic deficits”. This list is explained as serving the function of giving the symptoms agency. Furthermore, the use of the word “ingrained” is reiterated to repeat its effect implying that the symptoms are to be seen as permanent, and impervious to medication.

Reflecting on this study, Harper (1999) himself identified a number of potential criticisms. Indeed, a major controversial point is whether he needed to carry out this research at all or whether the implications he identified were just as accessible through an analysis of his own political position. In other words, he knew what the outcome would be before embarking on the interviews. This criticism is levelled at much discourse analysis as the process of questioning and the researcher’s political interests openly drive interpretation. Therefore, through these means the researcher (e.g. Harper) needs to be aware that analysts not only read but also produce the discourse (Burman and Parker, 1993). Unfortunately, limitations of space in publications rarely allows for researchers to communicate how they managed to incorporate and interpret their own influence, leaving the author open to a host of criticisms (Harper, 1999).
A further criticism that could be directed at Harper’s (1999) application of discourse analysis to the field of mental health is that unlike traditional psychological approaches it does not claim to discover anything. Burman and Parker (1993) consider this point and state that discourse analysis has sometimes been construed as “banal” in its efforts to avoid claiming to have found answers in mental health. They assert that the approach attempts to “elucidate interesting webs of meaning”, but it should not classify or categorise the seemingly obvious (Burman and Parker, 1993, pp.163).

Finally, the Harper (1999) study is also open to accusations of “ontological gerrymandering”, as it asymmetrically focuses on the talk of professionals rather than balancing this out with the discourse of users. This use of a “singularising narrative” (Burr, 1995) however is not necessarily deemed as a study weakness within the social constructionist model. Indeed, following Derrida’s (1978) recommendations of rejecting binary oppositions, the unit of study is said to be both what is taken as well as what it appears to exclude (Burr, 1995). Therein, rather than approach different “systems” (i.e. psychiatrists or clients) as opposite sides of a dichotomy, they can be considered to be inseparable components, neither of which can make sense without the other (Burr, 1995).

**Discourse analysis and the construction of “mental illness”**

In an earlier study (*The professional construction of ‘paranoia’ and the discursive use of diagnostic criteria*), Harper (1994) used discourse analysis to investigate how mental health professionals used rhetorical strategies to meet challenges that paranoid beliefs might be true. The limitation of space does not allow for a detailed explanation of this study, however a brief summary of one aspect of the study will permit some critical reflections. Harper (1994) critically explored the relationship between an empiricist account (focussing on recognised psychiatric symptoms) and a contingent account (the personal processes in making a clinical judgement), when a professional was making a diagnosis. In discussion, Harper states that the diagnosis of paranoia is constructed through a number of discursive practices. That is, the presence of contingent factors in the process of diagnosis suggests that this form of categorisation is not “factual”, but a
construction. As the “paranoia” can no longer be perceived as “naively objective” (pp. 140), Harper extends that it would be more useful to deconstruct this categorisation, creating a non-pathological understanding of the experiences and invoking a more systemic formulation.

Although Walkup (1994, pp. 148) “applauds” Harper’s research, a number of criticisms are expressed. Firstly, Walkup (1994) asserts that unlike Szasz (1973), Harper fails to clarify exactly where he stands on the position of anti-psychiatry. This is a valid point considering that discourse analysis requires the researcher to identify the reciprocal relationship the researcher and the interviewees have on each other. Walkup’s desire for Harper to openly state a polemic position on psychiatry raises another complex issue, for alongside the need for the researcher to be open about the influence of their position on the discourse, it is also important not to exclude other positions (Burr, 1995). If Harper categorised himself into one particular school of thought (i.e. anti-psychiatry), he would find himself in a position which would surely be untenable for a “deconstructionist researcher”. For, attempting to keep an “open mind” whilst producing and manipulating discourse “allows us the possibility of personal and social change through our capacity to identify, understand and resist the discourses that we are also subject to” (Burr, 1995, pp.153).

As outlined in the criticisms for the Harper (1999) study exploring the discourse of professionals, again there is some question over whether the author (Harper, 1994) could fail to find what he assumed was present (Walkup, 1994). This is an interesting criticism considering Harper (1994) makes a similar observation about the medical professional assessing for a mental disorder. Furthermore, if ideological and political interests guide the research without these being explicitly identified and interpreted, then this critical method of analysis could be accused of operating under similar constraints to those assigned to traditional psychological methods (Burman and Parker, 1993).
Finally, Walkup's (1994, pp.149) apparent frustration with the study results in the statement that the "article finds itself in a 'tight spot' for if we assume that any world of activity is socially constructed in much the same sense as the diagnostician's, then nothing distinctive has been learned about diagnosis". This opinion certainly seems to fit with Burman and Parker's (1993) caution over interpreting discourse analytic studies findings as "banal". A contentious point, and within the pluralistic model of social constructionism, the validity of this statement would have to be up to each individual researcher/clinician to determine. This pluralistic perspective could be accused of positioning researcher, professionals and clients in an unfamiliar and dangerous position. However, a mere awareness of the power of de/construction of "mental illness" appears to provoke a reflexive position on diagnosis that may otherwise have been ignored.

In another study, Lewis (1995) used a qualitative methodology incorporating grounded theory (see Glaser and Strauss, 1967; Henwood and Pidgeon, 1992) and discourse analysis techniques to look at different subjective experiences of "patients" (medically-diagnosed) and "non-patients" (self-diagnosed) who had depression. The author claims that the integration of discourse analysis and grounded theory was useful in identifying that depression has a "highly variable and subjective" (p.379) meaning to each individual. Lewis (1995) states that these techniques identified that diagnosis can serve to be both reassuring and pathologising.

At the expense of "ignoring" the outcome of the study, a closer look at the methodology provokes some interesting methodological questions, such as how was the analysis done? Lewis (1995) claims to have used an "integrative" approach of grounded theory and discourse analysis. The form of discourse analysis is described as an "interpretative discourse analysis technique[s]"and referenced to Henwood (1993). Although the theoretical framework of discourse analysis resists "how to do it " rules (Burman and Parker, 1993), the examples of how this method was used appears to have little in common with dominant forms of discourse analysis outlined in the Diversity of styles of discourse analysis section of this literature review, and more with alternative qualitative
methods such as grounded theory. Furthermore, the author did not differentiate between when the two approaches were being used, leaving the reader on an uneven epistemological footing with which to interpret the participant’s discursive repertoires. On the occasion where it appeared that discourse analysis was being used, the author then interpreted the speech in terms of attitudes and beliefs. This procedure could be conceptualised as incongruent with the theoretical framework, as unlike other qualitative positions, discourses are not a route to descriptions of “essentialist concepts” such as “opinions” and “beliefs” and cannot be taken as being manifestations of some inner condition such as temperament or personality (Burr, 1995).

In addition, no consideration was given to the reflexive subjective position of the interviewer in creating and interpreting the discursive repertoires. Failure to do so may have been a choice, as some have expressed concerns about the framework in that nothing can be interpreted if meanings only relate to each other and not to anything outside (Burman and Parker, 1993). In other words, the process of self-referentiality breeds solipsism (i.e. the view that the external world exists only as a product of one’s consciousness). However, Burman and Parker (1993) state that a measured amount of reflexivity is required for a more informative analysis. In the context of this literature review, the main point of interest to draw from the Lewis (1995) study is the necessity to remain within the methodological framework and epistemological paradigm in order to produce clear and interpretable analysis.

The concept of self-efficacy has been used in clinical research to investigate its link with addictive behaviour (Stuart, Borland and McMurray 1994). An interesting paper by Hawkins (1995; Self efficacy: A cause of debate) used discourse analysis to argue that “self-efficacy” is a useful concept when used as a descriptive metaphor, rather than as a “real” mental entity. In disputing Bandura’s (1995) claims that self-efficacy is a cause of behaviour, Hawkins (1995) concluded that by using discourse analysis the debate about the reality or non-reality of mental entities can be circumvented. This observation is echoed by Potter and Wetherell (1987, pp. 179) who state that, “much of our vocabulary
of mentalistic terms has no "inner" referent at all; instead of being merely descriptions of mental states these words are themselves an autonomous part of particular social practices."

Discourse analysis and "mental retardation"

Peter (2000) applied discourse analysis to the case file of an individual labelled as having mental retardation in order to explore the power dynamics behind services and to understand mental retardation. The study incorporated Foucault's (1979) work on the mechanism of discourse in the process of social control. Firkins (1999) described this mechanism as the role of language in constructing an ideology that maintains power imbalances, ensuring that people with disabilities remain under the control of professionals.

The case study was of one male who lived in a group home with several other people who were also blind and labelled as having mental retardation (for details see Peter, 2000). Much of the data that was analysed came from the client's case notes.

In line with Foucault's (1979) assertion that a person's identity is constructed out of culturally available discourses, Peter (2000) recognised that the client's identity was constructed through discourse, as one of incompetent and dependant. For example, one entry into the case notes read: "This child's mutism, his general reaction pattern today as well as that which has been noted at the Central School suggest gross mental retardation." Constructions such as this when the boy was only 6 years old are believed by Peter (2000) to have been powerful enough to deny him any schooling for the first 15 years of his life. Although this discourse constructed him as "retarded", in time this individual managed to make his abilities noticed, illustrating that his case file depicted a defective identity. Using scientific discourse and talk of objectivity, the professionals were in a powerful position in which they defined the client's identity negatively (Peter, 200). Alternatively, Peter (2000) believes that a discourse from the client, in his own words about his very
positive relationships and developmental milestones would challenge the deficit model ideology and be more helpful in casting his abilities in a more enabling light.

**Discourse analysis and care in the community**

Cowan (1999) used a discourse analytic approach (Edwards and Potter, 1992) to explore public opinion relating to the establishment of community mental health facilities. This was carried out, as Cowen (1999) believed that previous studies had failed to take account of the rhetorical richness and complexity of public expressions about the move towards community care. This is explained to have led to a marked discrepancy between empirical findings (Department of Health, 1993), which have reported optimism about the public accepting members of this client group into the community, and those at the forefront of service implementation.

The data comprised of written text, group discussions and individual interviews with community residents. The data was then analysed in two parts, the case against the community care project and then the case for the community project. An example of some text from the first part of the analysis may illustrate how the discourse analysis process was used.

A letter to the council opposing the new community facility, signed by 17 residents stated: “Several hundred children, mostly unaccompanied, pass this house at least twice a day. It is an unfortunate fact that the chronically mentally ill look different and behave both differently and unpredictably...”. This passage is said by Cowan (1999) to infer that the school children are potentially vulnerable to the risks posed by the “chronically and mentally ill” and by implication, the prospective members (residents) of the community care project. The use of the term “an unfortunate fact” is said to portray the factual acceptance of mentally ill people as having pre-existing features, a discursive strategy that is employed to avert any counter-criticisms of the resident’s prejudice.
Cowan (1999) used discourse analysis to inform an understanding of a community problem. She pre-empts that critics within psychology may argue that the data may not represent the views of a wider population and can therefore not be generalised to the entire community. However, as argued by Widdicombe and Woffitt (1990), these objections are only relevant to studies concerned with quantification. The aim of Cowan’s (1999) analysis was to provide an in-depth understanding of the deployments by local residents when arguing for or against a particular community care project. Cowan (1999), nevertheless expects that the issues discussed in her paper would be transferable to other contexts. This particular assertion may be over optimistic and could be accused of attempting to make methodological leaps that are not grounded within the theoretical framework.

Tuffin and Danks (1999) carried out a similar study by investigating the discursive resources used by New Zealanders when talking about community care. As with the above study, the authors chose discourse analysis (Potter and Wetherell, 1987) to move “beyond attitudes”. Tuffin and Danks (1999) concluded that the main strength of this form of investigation was that through attending to the participant’s discursive repertoires, essential details were identified as to the positioning of the “mentally disordered”, as well as possibilities for change.

The application of discourse analysis to the field of psychology

Discourse analytic studies such as those outlined above have occasionally been accused of having little benefit to the field of mental health. Maingueneau (1999, pp. 176) paraphrases these critiques that perceive discourse analysis as “a trifling activity, which fluctuates between useless sophistication and confusion, mixing in an uncontrolled way linguistic analysis with second hand psychological or sociological views.”
So is it useless or useful?

Willig (1999) recognises the “risks” in getting involved in formulating concrete proposals for psychological interventions. She states that this is why many discourse analysts avoid such “application”. A majority of those using discourse analysis employ it as a social critique, rather than to develop new, “better” interventions (Willig, 1999). In line with Foucault’s (1979, 1980) argument, Wetherell and Potter (1992) assert that the exercise is not to undermine a “truth” and then replace it with a new “truth” but to examine the discursive processes which falsify or legitimise certain statements. Therefore, the relationship between discursive critique and social action is not addressed and claims are rarely made as to how an improved understanding can lead to change. Those who are highly sceptical of imparting explicit advice (Burman, Aitken, Alldred, Allwood, Billington, Goldberg, Gordo Lopez, Heenan, Marks and Warner, 1996) believe that a history of specific recommendations have contributed to the failings of the field of psychology and that just by challenging assumptions renders issues open to new possibilities. Harper (1999, pp. 140) has suggested that this is a position exclusive to academics, as “practitioners are not in a position to chose whether or not to intervene, they are already intervening; for them the choice is how to intervene”.

Harper (1999) appears to avoid counter-criticism by making a subtle shift in discourse to move from this concept of “application” to one of “usefulness”. This concept is considered in the context of postmodern notions of theory and practice (Hoshmand and Polkinghorne, 1992), in which new “treatment technologies” are not developed, but a particular intervention results in a richer understanding and preferable outcomes. Following the deconstruction of a “mental health patient” detailed earlier, Harper (1999) states that he is not attempting to apply his findings but make suggestions consistent with the analysis. To do this he shifts from a micro-analysis of rhetorical strategies to a macro-analysis of political interests and the subsequent effects of these. Examples of the type of suggestions made are a shift in the balance of power so that professionals develop consultation and partnership with service users (Williams and Lindley, 1996), professionals become more informative about all the effects of medication, the
development of more organizations to support the client, and a challenge to the binary concept of the client as “other” in the user/professional relationship (Thomas, 1997).

The first part of this literature review used selected literature to focus on the differences between traditional scientific approaches to research and the theoretical framework of social constructionism, which incorporates discourse analysis. Following this it has reviewed salient literature that has applied discourse analysis to psychiatric medication, the construction of “mental illness”, “mental retardation” and care in the community, and considered its potential to inform psychological and political practice. A number of epistemological, political and practical concerns have been identified and the complexities associated with the notion of application have been acknowledged. However, this review has indicated the role of discourse analysis in evaluating existing interventions. For example Harper (1994; 1999) was able to demonstrate that through applying discourse analysis to the field of mental health he was able to identify pertinent questions around the “creation” of mental illness and the subsequent treatment regimes. The study by Peter (2000) also served to identify how individuals could become victims of oppressive regimes that serve to label and further disable socially disempowered people.

The preceding discussions may well leave the reader in “two minds” as to the usefulness of employing discourse analysis as a research methodology. To deconstruct current practice without replacing it with an alternative tangible system may appear not to contribute to and progress the field of clinical psychology. Alternatively, if it is acknowledged that there are controversies, conflicts and questions within current practice, then to develop solutions without deconstructing them to their foundations, may itself be an “ineffective intervention”. Perhaps resistance to using discourse analysis is maintained not just as a result of its controversial theoretical framework but also because discourse analysts have perhaps applied their technique too vehemently to other research approaches in order to give their own marginalised group “voice”. It would be unfortunate if discourse analysis was deemed to be superfluous to research in clinical
psychology just as it would be unhelpful for discourse analysts to discount the necessity of other research techniques.
References


The construction of knowledge: A discourse analysis of psychiatrists' therapeutic repertoires for children with attention deficit hyperactivity disorder.

Most people, most of the time, know only what comes through the reducing valve and is consecrated as genuinely real by the local language.

Aldous Huxley, 1954, p. 12

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Abstract

This study is concerned with psychiatrists' talk about interventions for attention deficit hyperactivity disorder (ADHD). It examined how discourses of knowledge function in the construction and negotiation of approaches for intervention.

Ten child psychiatrists, seven males and three females, were recruited from one NHS Trust in England. Having obtained their informed consent each was interviewed using a semi-structured interview schedule focusing on aspects of diagnosis and intervention identified within the mainstream literature. The interviews were transcribed and analysed using Foucauldian discourse analysis.

Participants drew upon a range of discursive resources in constructing accounts of knowledge and negotiating subject positions. The empiricist (scientific) account was constructed as central in evaluating the effectiveness of interventions and addressing potential risks. However, the contingent (personal/professional) accounts of knowledge were also identified and highlighted a contrast with the empiricist account. A shift between these accounts of knowledge, and various subject positions, appeared to serve a number of functions including the maintenance of the professional legitimacy of psychiatric practice and the minimisation of risk. These findings were extended to consider the relationship between knowledge and power, and the implications for practice. It is proposed that over time, the dominance of the empiricist account of knowledge can be seen to marginalise the contingent account. The result is, stimulant medication is used more widely, which can leave other forms of intervention somewhat marginalised. The suggestion is, giving voice to subjugated forms of knowledge that challenge the prevailing inequalities of power could enable clinicians to re-evaluate interventions for children with ADHD.

250 words
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Chapter one - Introduction

Research introduction

This study will explore the psychiatric constructions of knowledge in relation to therapeutic interventions for children diagnosed with attention deficit hyperactivity disorder (ADHD). It will then attend to the relationship between these constructions of knowledge and power. Finally, it will consider the implications for clinical practice. Discourse analysis is the method that will be used for this investigation, a research method that is part of the social constructionist epistemology. Firstly, this introduction will review the current research evidence and thinking in relation to attention deficit hyperactivity disorder in children.

Attention deficit hyperactivity: the main issues

**Box 1 Reflexive boxes**

Reflexive boxes shall be used to set aside text from the rest of the research so that side issues or reflexive elaborations can be considered (as recommended by Edwards and Potter, 1992).

**Diagnosis and prevalence**

ADHD is the most widely diagnosed and researched childhood disorder in the United States and Europe (Barkley, 1990). In the United States (U.S.), using the DSM-IV classification system (American Psychiatric Association, 1994) up to 50% of referrals to child psychiatry clinics are for ADHD, where the prevalence is estimated between 3%-5% of school-aged children (Cantwell, 1996), with boys outnumbering girls by 3:1 (Tannock, 1998). From 1990 to 1993, the number of yearly outpatient appointments escalated from 1.6 million to 4.2 million in the U.S. (Swanson, Lerner, Williams, 1995). In Europe, using the ICD-10 (World Health Organisation, 1990) classification system in which diagnostic criteria are more stringent, and the term hyperkinetic disorder is applied, prevalence rates of 1% are reported in school aged children (Taylor and Hemsley, 1995).
To diagnose ADHD, the core symptoms must be across two dimensions, hyperactivity/impulsivity and inattention. Using the DSM-IV classification (appendix 1) the presence of six of the listed symptoms in either of, or in both of these dimensions is considered to be consistent with a diagnosis of ADHD, whereas the ICD-10 classification (appendix 1) requires both significant inattention and hyperactivity to be observed. To diagnose ADHD the symptoms must be pervasive and persistent with time, develop before the age of six/seven, cause marked impairment and not be part of a developmental disorder (American Psychiatric Association, 1994; World Health Organisation, 1990).

The complex nature of ADHD has led to difficulties in diagnosis. Steifel's (1997) article reviews the difficulties of diagnosing a heterogeneous disorder that is often comorbid with oppositional defiant disorder or conduct disorder (DSM-IV, American Psychiatric Association, 1994). In addition, Searight and McLaren (1998) discussed how social, cultural and economic factors have contributed to the increase in the diagnosis of ADHD.

ADHD is believed to be a life-long condition that places sufferers at risk of a range of problems including social isolation, school failure and psychological problems (Tannock, 1998). Those with ADHD have been described as anti-social, aggressive and disorganised (Tannock, 1998). Research has also indicated that children with ADHD are more likely to fail academically, although they generally score in the average to above average range on standardised ability tests (Hinshaw, 1994; Barkley, 1990). These children are also more liable to school exclusion for behavioural reasons (Hayden, 1997).

Causes of ADHD
Authorities on ADHD report that the precise causes of the disorder are unknown at this time (Cooper, 1999). Nonetheless, a significant amount of research has been directed at determining the causes of ADHD and the results have been delineated by Tannock (1998) into the following areas:
Cognitive research

Cognitive research has focused primarily on impulsivity, or a dysfunctional response inhibition system. Research has indicated an extreme slowness of the inhibitory control system, in which the individual acts impulsively before the inhibitory system is fully activated (Tannock, 1998). An alternative model (Barkley, 1997) proposes that neurologically based difficulties of response inhibition cause executive functioning problems that are essential for effective self-regulation. The executive functions that are affected are working memory, internalised speech, motivational appraisal and behavioural synthesis.

Sonuga-Barke, Taylor, and Heptinstall (1992) also developed a cognitive theory that suggests that children with ADHD have difficulty in inhibiting responses. An interesting difference to other cognitive theories is that it considers difficulties that are situation specific, implying the important role of socialisation in the development of the difficulties.

Neurobiological research

Research on cognitive theories of ADHD is usually based on the assumption of neurological problems (Tannock, 1998). These assumptions are founded on a long research history, comparing similarities between symptoms of ADHD and those produced by frontal lobe damage (Hinshaw, 1994). In one neurological study, Rapport (1995) found that children with deficits in attention and learning in supportive environments may have lower levels of dopamine. Rapport describes this as a neurochemical difference from those children who have attention deficits and struggle to learn in less supportive environments, who are believed to have poorly regulated norepinephrine.

Alternatively, some studies have suggested that toxic damage to the brain causes ADHD-type symptoms (Barkley, 1997). These hypotheses typify the inconsistencies between studies about the biological nature of ADHD. The use of modern neuroimaging techniques, albeit limited, has also failed to clarify the debates in this area (Tannock,
1998). Although such techniques claim to identify common abnormalities that co-occur with ADHD, neuroimaging research has failed to show a direct link between neurological abnormalities and ADHD. With no evidence of brain damage, the characteristics of ADHD are believed to be the result of abnormal neurological development of unknown cause (Barkley, 1997). This has led researchers to look towards genetic factors.

**Genetic research**

There is some evidence of a genetic link in ADHD (Tannock, 1998). A number of studies have accumulated evidence through twin studies, however the long-standing arguments around the influences of environmental factors on child development still persist (Cooper, 1999). However, a little more credence has been given to genetic theories by molecular genetic research indicating an association between certain genes and ADHD symptoms (Thompson, 1993).

**Biopsychosocial perspective**

Most of the previous accounts of the causes of ADHD have been criticised for locating the disorder within the individual and failing to recognise the impact of social factors (Cooper, 1999). Slee (1995, pp. 74) states “locating the nature of disruption in the neurological infrastructure of the child is myopic and convenient”, and individualising a problem can lead to a serious misdiagnosis. A misdiagnosis could pathologise the individual whose behaviour was an appropriate reaction to unsympathetic or harmful environmental conditions.

A polemic stance has seen ADHD conceptualised as a purely biological or purely environmental set of problems. This has contributed little to the understanding of ADHD but is indicative of the “tribalism of competing disciplines and professions” (Cooper, 1999, pp. 9). Furthermore, the way in which researchers have attempted to isolate single factors that determine ADHD has exacerbated the limitations of adopting polarised perspectives (Tannock, 1998).
Interventions

Psychopharmacological interventions

Psychostimulant medications (stimulants) are used most commonly to treat ADHD. The three most frequently prescribed stimulants are methylphenidate (Ritalin), dextroamphetamine (Dexidrine) and pemoline (Volital) (Santosh and Taylor, 2000). Occasionally tricyclic antidepressants are given as an alternative, if the stimulants have no effect or if the child experiences an adverse reaction such as tics and anxiety symptoms (DuPaul and Stoner, 1994).

Effects of medications

Stimulants are used to stimulate areas of the brain that are believed to regulate alertness and arousal (British Psychological Society [BPS] 1996). Although poorly understood, it is believed that the effects involve the stimulation of pre-synaptic inhibitory autoreceptors, causing reduced activity in dopaminergic and noradrenergic pathways (Solanto, 1998). The concurrent increase in intrasynaptic dopamine is believed to improve executive control processes, inhibitory control and working memory (Douglas, Barr, Amin, O’Neil, and Britton, 1988).

Much of the hypothesising about the neurological basis of stimulant action is based on “a string of elegantly designed experiments” on mice (Santosh and Taylor, 2000, pp. 29). These authors emphasise that the findings may not be replicable in children and state that in some trials the “mice in question seem to have had a different neurochemical milieu from that occurring naturally in children with ADHD”. Instead, they believe that “other animal models, such as the spontaneously hypertensive rat, may well be closer” (Santosh and Taylor, 2000, pp. 29).

Effectiveness of stimulants in ADHD

ADHD has been treated with stimulant medications for over 50 years and the research is so well established that the short-term effect of methylphenidate is clearly understood (Santosh and Taylor, 2000). Scores of published studies have evaluated the efficacy of
stimulant drugs, involving thousands of subjects (Wilens and Biederman, 1992). Also, for more than a decade several formal meta-analyses have been available (Kavale and Forness, 1983) as well as a published "review of reviews" (Swanson, McBurnett, Wigal, Pfiffner, Lemer, Williams, et al., 1993). These have contributed to a consensus about stimulant medication. The current consensus within the medical profession is that stimulant medication reduces the symptoms of ADHD in 75% of patients whilst maintaining a good safety record (Santosh and Taylor, 2000).

Stimulants have been found to improve the child’s classroom performance and on-task behaviour (Santosh and Taylor, 2000). Furthermore, parent-child interaction is said to improve when the child is on stimulants as compliance is increased. In social settings children taking stimulants are reported to experience fewer problems during game play, improved peer status, and increased attention (Whalen, Henker, Buhrmester, Hinshaw, Huber, and Laski, 1989).

Many professionals in the field of child mental health have recently celebrated the results of the Multimodal Treatment Study (MTA) of Children with ADHD trial, by the MTA Cooperative group (1999). The trials incorporated a detailed and intensive treatment regimen that was delivered consistently across different sites for many children (Taylor, 1999). The treatment regimes included medication only, psychological (behavioural modification) intervention only, combined medication and psychological intervention, and a community team approach. From these trials, Taylor (1999) concluded that the carefully executed regimen of medication is superior to alternative treatments and nearly as effective as the combined treatment, which came out as the most effective. He adds that the superiority of medication management to behavioural treatment is robust and states that although combined treatments were the most effective, the extra benefits over medication alone were very small.

The MTA (1999) trials were conducted in the U.S. where practice is different from that in the U.K. (Taylor, 1999). Commercial information has indicated that in the U.S. the
quantities of medication used annually and the numbers of prescriptions are 10 to 30 times greater than in the U.K. (Taylor, 1999). However, the use of stimulant medication has received more formal recognition now in England and Wales in the form of the recent guidelines published by the National Institute of Clinical Excellence (NICE, 2000). Two of the recommendations are:

1. *Methylphenidate should be used as part of a comprehensive treatment programme for children with a diagnosis of severe ADHD.*

2. *A comprehensive treatment programme should involve advice and support to parents and teachers, and could, but does not need to, include specific psychological treatment (such as behavioural therapy).*

(NICE, 2000, pp.1)

For those in the medical profession, these guidelines, alongside research findings, may be seen to promote the use of medical interventions for ADHD. However, to balance this review of treatment approaches, consideration should also be paid to the suggested limitations of the psychopharmacological approach.

**Criticisms of medical treatment regimes**

The current use of stimulants sweeping the U.S. and Europe serves to ease parents’ anxieties, conflicts and exasperations around the difficulties associated with ADHD (Pozzi, 2000). Many clinicians are using a combination of pharmacological and psychological therapies in severe cases of childhood ADHD to ease family conflicts (Jackson and Williams, 1994). However, the real concern is the speed at which diagnoses are made and the extensive use of stimulants, whilst there is still a lack of knowledge about the diagnosis of ADHD (Taylor, 1994). Furthermore, although there are claims that the short term effects of medication are understood (Santosh and Taylor, 2000), the longer term effects are still undetermined (Breggin, 1998).
Santosh and Taylor (2000, pp. 29) asserted that although stimulants (e.g. methylphenidate) appear to “work”, the “mechanism by which stimulants act to reduce hyperactivity is not yet known in detail”. This statement about the ‘knowledge’ of the effects of stimulants appears to challenge Taylor’s (1999) statement that children’s mental health practice has evolved into an evidence based discipline. Indeed, not knowing how the stimulant medication works, but prescribing it nonetheless, could be interpreted as reversing the evidence/practice relationship, in which sound evidence is converted into ‘good’ practice.

Searight and McLaren (1998, pp. 467) conceptualise ADHD as a “metaphoric expression of social anxieties” and believe that to “medicalise misbehaviour” and subsequently control it using drugs is not helpful to the child. Breggin (2000) shares this viewpoint and states that stimulant drugs are useful only to suppress behaviours that are unwanted in the classroom or in highly controlled family situations. Furthermore, as observed in animal studies (Breggin, 2000), the administration of stimulant drugs encourages perseveration or obsessive-compulsive behaviour and over-focussing. These behaviours may be less disruptive than typical ADHD behaviours, however they may still be adverse to the child’s mental health.

There are also concerns regarding the emotional and behavioural effects of stimulants. Methylphenidate is believed to be responsible for causing ‘cognitive toxicity’ in some children as they become compliant, withdrawn, isolated, and over-focussed (Swanson, Cantwell, Lerner, McBurnett, Pfiffner, and Kotkin, 1992). Cramond (1994) found a correlation between descriptors for creativity and descriptors for ADHD, however when the children with ADHD were medicated their self-esteem lowered and their creative
potential was suppressed. Further studies have indicated that children taking stimulants on a long-term treatment programme experienced reduced levels of self-esteem (McGuiness, 1989).

Although there are a huge number of empiricist accounts of the ‘effectiveness’ of stimulants on children with ADHD, ethical and sociological questions also need to be addressed before prescription (BPS, 1996). One ethical concern is that stimulant medications are listed in Schedule II of the Convention on Psychotropic Substances (Drug Enforcement Agency, 1995) alongside the banned drugs amphetamine and metamphetamine. This could be understood as a legitimate concern considering that in the U.S. 90% of those diagnosed with ADHD receive stimulant medication (amphetamine) to address their difficulties (BPS, 1996). Breggin (2000, pp. 17) has clearly expressed his concerns with the practice of “bathing a young child’s growing brain in toxic chemicals”. He speculates that there could be long term serious consequences for the individual considering that there is a 25-30% reduction in blood flow in the brain whilst taking regular doses of stimulants. However, long-term effects are simply not known as long-term trials do not exist (Santosh and Taylor, 2000).

The number of children given stimulants may be increasing as studies have indicated that any child, whether they have difficulties or not are likely to report improved concentration as a result of taking stimulants (Rapport, Buchsbaum, Zahn, Weingarten, Ludlow and Mikkelsen, 1978). Hence it is imperative not to assume that a ‘positive response’ to medication signifies the presence of ADHD (Santosh and Taylor, 2000). In fact it has been argued that since the effects of stimulants are not unique to children diagnosed with ADHD, then the ‘disorder’ can not be attributed to any specific brain abnormality, which for most prescribing clinicians is fundamental to their choice of intervention (DeGrandpre, 2000). If there were significant differences in the neurochemistry of a child with ADHD to a non-ADHD child, then it would be expected that the effects of medication would be different as the normal inhibitory functioning of their brains would then be overstimulated (DeGrandpre, 2000).
Behavioural interventions

The BPS (1996, pp. 46) states "medication, although important, plays a facilitative rather than a primary role in long-term intervention". However, the BPS (1996, pp. 50) also concedes "there does not seem to be a defined area of non-medical intervention specific to ADHD". Goldman, Genel, Bezman, and Slantez (1998) perceive this as a problem, asserting that the effects of methylphenidate may obscure some of the clinical difficulties and will prevent the use and development of behavioural therapies.

Central to the development of behavioural therapy in ADHD is the functional assessment. This includes multiple assessment strategies in order to identify specific events that induce or sustain a particular behaviour (DuPaul and Ervin, 1996). Instead of pathologising the child, this process aims to investigate the function of the individual's behaviour in relation to their environment (school, home, etc) and to develop strategies to minimise these difficulties (DuPaul, Eckert and McGoey, 1997).

The most effective behavioural strategies used with ADHD to date are believed to be positive reinforcement, response cost and behaviour reduction training (BPS, 1996). Social skills training is also reported to assist in reducing impulsivity and aggression (Kazdin, Sveldt-Dawson, French and Unis, 1987), in which the children are encouraged to focus on peer behaviour, problem solving, communication and self-assessment. These behavioural strategies are believed to be most beneficial when used in collaboration with the parents, as family factors can be associated with peer relationship difficulties, aggressive behaviour, and social withdrawal (Cantwell, 1997).

Cognitive Behavioural Interventions

There has been relatively little research on cognitive behavioural (CBT) interventions for ADHD (BPS, 1996). Useful strategies are believed to be self-monitoring, cognitive modelling, self-instructional training, self-control skills and interpersonal problem solving (Overmeyer and Taylor, 1999). Through such means children are helped to develop a
"coping template" to interpret the world and thus develop more appropriate strategies (Cooper, 1999).

The success of the approach is dependent on many factors including the motivation and language capabilities of the child, age-appropriate materials, and the parents’ suitability to act as co-therapists (Overmeyer and Taylor, 1999). Although this intervention is often attractive to families the results of group studies have so far been disappointing with small effects (Gilltleman-Klein and Abikoff, 1989). However, large group community based parenting programmes effectively used CBT techniques to improve child management skills and disruptive behaviour (Cunningham, Bremner, and Byle, 1999). In the U.K., programmes such as these need to be targeted at families and children with ADHD (rather than oppositional disorder) in order to determine the potential effectiveness of CBT with this client group (Overmeyer and Taylor, 1999).

Although these interventions used a CBT approach it is interesting to see ADHD conceptualised as a systemic phenomenon and not located solely within the child. Indeed, the importance of a multi-dimensional approach in combining family therapy, individual therapy and medication management is believed by some to be the most supportive style of intervention (Cordell and Allen, 1997).

Multimodal Intervention

Current thinking around the use of Multimodal treatment is primarily based on the MTA (1999) trials discussed earlier. In addition to these results, clinicians have warned that medication should be used as a first line therapy only when the case of ADHD is particularly severe, and in mild cases the "most powerful treatment available" (stimulants) should only be used if behavioural interventions are not sufficient (Taylor, 1999, pp.1097).
Summary
This review has highlighted beliefs and controversies around the understanding of ADHD and interventions. Indeed, the different versions of knowledge around the cause include approaches that are cognitive, social, neurobiological, genetic and biopsychosocial.

Although many studies report the effectiveness of stimulant medication over other approaches, knowledge around the medical approach appears to be far from complete. Some studies have reported that stimulant medication is well established and understood. However this can be directly contrasted to the claims that there is still limited knowledge around what the medication does.

Some research trials have identified that medical interventions have often been found to be more effective than other approaches, including behavioural, cognitive behavioural, and systemic interventions. However, concerns around difficult diagnoses being made under time pressure, the lack of knowledge around the cause of ADHD, and ignorance about what the drugs actually do may temper the enthusiasm to medicate. In addition, there are ethical concerns over the use of medication and the possible risks to the child’s physical and mental health.

Although ADHD has been the subject of a huge amount of research it is apparent that there are conflicting views on whether it is a discrete disorder, what causes it, how it is diagnosed, and how it should be treated. This review of the literature has identified how a number of different of versions of knowledge operate in relation to ADHD. However, how some of these versions attain priority over others in the clinical forum is currently difficult to determine.

Chapter two - Aims of this study
This introduction has put forward a version of events largely based on published research evidence and counter claims. This body of knowledge is central to an understanding of the developments and concerns in the field of ADHD. These resources were available to me throughout clinical training and I became particularly familiar with them over the
course of the child and family core placement as well as a specialist child and family placement. Working alongside a number of experienced professionals in specialist ADHD clinics, it became apparent that there was some incongruity between the literature, how professionals spoke about interventions for ADHD, and actual clinical practice. For example, on a number of occasions professionals spoke about the use of psychological interventions and parents' reluctance to give their children medication but then the child was still put on medication only.

**Box 3 The objective/subjective position of researchers**

Researchers within the traditional scientific paradigm construct themselves as having an objective relationship with their data in order to prevent bias from personal factors. However, within the social constructionist framework, 'objectivity talk' is seen as just another discourse through which a particular version of events is constructed in accordance with the assumptions that are embedded in the researcher's perspective (Burr, 1995). The task of the social constructionist researcher is then to acknowledge their own intrinsic involvement in the research process and to view research as a co-production between themselves and the participants. Following discussions with my research supervisors, I decided it was important to remain consistent within the epistemological framework and to, when necessary, write in the first person. Woods (1998, pp. 28) is sensitive to this kind of dilemma stating, “qualitative methods may be perceived as less 'scientific'”. He believes such methods “have tended to exercise the critical faculties of examiners most greatly” leading to the “most discussion and dissension among them”. It was thus hoped that transparency around the thinking throughout this piece of research would negate some of these potential difficulties.

This sense of confusion invoked in me gradually led to the formulation that there were a variety of constructions or representations around the interventions for ADHD. The outcome of these could have serious implications for the child's mental and physical health. Within the medical culture it was evident that the scientific version of events was often considered to have greatest credence; however, at times, other accounts were
noticeable. Those knowledges that are located lower down the hierarchy, those that have been disqualified as inaccurate, as beneath the required level of scientificity, are known as ‘subjugated knowledges’ (Foucault, 1980).

The construction of knowledge/power

For Foucault, such knowledges that prevail within a culture at a particular time are intimately bound up with power (Burr, 1995). That is, a particular version of events (discourse) promotes some social practices whilst marginalizing alternative ways of acting. Indeed, ‘knowledge’ is the construction of a particular version of events that determines what one person is allowed to do to another (McHoul and Grace, 1993). When ‘knowledge’ is conceptualised in this way, it becomes evident that “meaning is not static and fixed but is fluid and provisional” (Coyle, 1995, pp. 244). Therefore the power to act in particular ways, to categorise something as a disorder, to control or be controlled is reliant upon the ‘knowledges’ that prevail within that culture or society (McHoul and Grace, 1993).

Scientific discourse can be interpreted as one form of ‘knowledge’ that exercises power through securing others within its bounds (McHoul and Grace, 1993). Foucault (1978) chose to analyse scientific discourse and the way that it is used in psychiatry, the field that he believed was one of the most complex as it attempted to apply science to humans. Foucault (1978, pp. 25) indicated that these discourses are “practices linked to certain conditions, obedient to certain rules and susceptible to certain transformations”. He was interested in how the disciplines of the human sciences act as forms of social practice and have a wide-ranging effect on society. A detailed and current analysis of the relationship between discourse, knowledge, and social practices can be read in the literature review (Grixti, 2001). This review looked at discourse analysis and the construction of knowledge in relation to a range of clinical issues, including psychiatric medication (Harper, 1999), the construction of ‘mental illness’ (Harper, 1994), ‘mental retardation’ (Peter, 2000), and care in the community (Cowan, 1999).
McHoul and Grace (1993) ask whether individuals and populations should simply comply with these constructions of medicalised knowledge. They assert that dominating discourses, such as those that serve to promote medical knowledge, carry out the function of 'normalisation,' attempting to manoeuvre people into 'correct' ways of thinking and behaving. The process can become so 'normalised' that 'knowledges' become 'truths' until they "no longer have to pass through the consciousness of speaking subjects nor through the efficacity of thought" (Foucault, 1978, pp. 22).

**Discourse analysis and the construction of knowledge**

This process has begun to be reversed as an increasing number of psychologists are using the qualitative, social constructionist methodology of discourse analysis to allow the researcher to question concepts that are taken for granted in society (for details of this approach see the literature review, Grixti, 2001). In using discourse analysis, language is not conceptualised as reflective of "reality" but rather as constitutive of (having the power to enact) experience (Potter and Wetherell, 1995). In other words, the linguistic categories that we use to describe 'reality' bring into being the objects they describe, or put simply, language constructs reality (Parker, 1992). There is always a number of ways to describe something and our choice of words can be seen to form perceptions and experiences which create different versions of events and reality (Willig, 1999). Therefore, discourse analysis is used to understand the ways in which "language constructs objects, subjects (subject positions) and experiences, including subjectivity and sense of self" (Willig, 1999, pp. 2).

This study applies discourse analysis to examine transcripts of interviews with psychiatrists working in specialist ADHD services talking about interventions. Psychiatrists were selected as the most appropriate participants for this analysis as they are central to the production of knowledge, especially in relation to 'mental illness' and intervention. Furthermore, the power that psychiatrists hold to construe the world in terms of those who are 'mad' and those who are 'sane' creates a power inequality between those who define and those who are defined (Burr, 1995). All the psychiatrists...
were selected from an NHS Trust in line with Foucault’s (1980, pp. 99) beliefs that the power struggles that should be unmasked are not the ‘totalising discourses’ (i.e. national/governmental discourses), but the ‘local’ power struggles that exist in institutions or at the micro level of society. He stated that the issues of interest are how the mechanisms of power have been invested, colonised and utilised resulting in the types of social domination that are readily identifiable.

There has not previously been a discursive analysis that has specifically aimed to identify the constructions of knowledge in relation to interventions for ADHD in children, and the rhetorical functions performed by knowledge talk. This study intends to fill this gap as well as to consider the relationship between constructions of knowledge and subject positions. The final aim is to examine the relationship between knowledge, subject positions and power.

**Summary**

There are a number of versions of knowledge concerning the interventions for children diagnosed with ADHD. As a result of the range of knowledges, at times there is some conflict between these versions. Some versions of knowledge gain dominance over others which shapes power relations and has implications for clinical practice. An investigation of the discourse, knowledge and power triad can be conducted using Foucauldian discourse analysis to examine how language constructs prevailing knowledges around interventions for ADHD.

In summary the aim was to address the following questions:

1) how do psychiatrists use discourse to construct accounts of knowledge in relation to interventions for ADHD?

2) what is the function of these constructions of knowledge?
3) which positions are made available within their discourses?

Once these aims have been addressed, the following aims can also be taken up:

4) what is the relationship between discourse, the construction of knowledge and power?

5) how do the discursive constructions and subject positions open up or close down opportunities for practice?

6) what are the consequences of taking up particular subject positions for the psychiatrists' subjective experience?

Chapter three - Method

Design

As discussed, the qualitative methodology of discourse analysis was used in this study. Data were gathered using a semi-structured interview format as recommended by Willig (2001).

Box 4 Reliability and validity in qualitative research

Reliability and validity can be a problematic concept for qualitative (including discourse analytic) research (Willig, 2001). However, the qualitative researcher can engage with concerns about reliability and validity in a number of ways:

1) Situating the sample (Elliot, Fisher and Rennie, 1999)

Information on each of the participants is presented to the reader. This allows the reader to make judgements on the interpretations made within the analysis.
2) Disclosure of orientation (Stiles, 1993; Elliot, Fisher and Rennie, 1999)
This includes a disclosure of the researcher's expectations of the study and personal speaking position. My speaking position was that of trainee clinical psychologist. Also, for some time I have been interested in the relationship between medication and the talking therapies for mental illness. My expectations for the outcome of the study were not clear, as I had not used discourse analysis previously. However, I expected the participants to invoke different accounts of knowledge to negotiate the complex issues associated with ADHD.

3) Description of internal processes of investigation (Stiles, 1993; Smith, 1996)
This consists of transparency in relation to the coding process and developing themes. A coded transcript (appendix 2) and an early analysis (appendix 3) are provided.

4) Providing credibility checks (Smith, 1996; Elliot, Fisher and Rennie, 1999)
All participants are offered the opportunity to check the credibility of the analysis. The research report (anonymised) was checked and commented on by all three research supervisors and the field supervisor. The focus was especially on the analysis section to work towards reliability regarding interpretations. For further credibility checks the analysis was also presented in a discourse analysis study group to get a set of interpretations from a range of discourse analysts. Finally, the analysis was presented to a Child and Adolescent Mental Health Team. Following this they formed a 'reflecting team' (Andersen, 1995) to check out the credibility of the work and to exercise criticism. This process was video taped for reference.

5) Presentation of evidence (Smith, 1996)
Sufficient raw data (verbatim quotes) are placed in the text to enable the reader to understand the interpretations as they develop. One complete unmarked transcript is also submitted (appendix 4) as well as the coded transcript.
Box 4 Reliability and validity in qualitative research (cont)

6) Internal coherence (Smith, 1996)
This ensures that the study presents a consistent argument in the form of a clear and
comprehensible narrative. This was achieved through consultation with the research
supervisors, the field supervisor and a proof reader.

Participants
As indicated by Turpin, Barley, Beail, Scaife, Slade, Smith and Walsh (1997), ten
participants were considered to be a sufficient number. Each of the psychiatrists selected
had at least three years and a maximum of twelve years experience of working in a
specialist child ADHD clinic. Eight of the participants had consultant status and two
were specialist psychiatric registrars (SPR). They worked across a total of seven different
clinics. The sample comprised seven males and three females. Five participants were
British and five were other nationalities.

Characteristics of participants
Including all the details known about them facilitates understanding participant responses.

Dr DePaul
Age: 34 years
Sex: Male
Nationality: British
Spoken English: Good
Title: Specialist Psychiatric Registrar (SPR)
Experience of specialist ADHD clinic: 3.5 years

1 N.B.: Some of the details have been changed, including all names, to preserve the anonymity of
the people involved as well as the health care setting.
Other notes/observations:
Dr DePaul drew my attention to his extensive library in his office. He commented how ironic it was that his copy of the DSM-IV and ICD-10 were sandwiched between works by ('anti-psychiatry') writers such as Foucault, Sasz, and Goffman. Prior to the study this SPR and I had met briefly on one occasion. Dr DePaul is at the end of training and about to become a consultant psychiatrist.

**Dr Edmund**

Age: 40 years  
Sex: Male  
Nationality: Chinese  
Spoken English: Good  
Title: Consultant Psychiatrist/Clinical Lecturer  
Experience of specialist ADHD clinic: 5 years  

Other notes/observations:  
Dr Edmund and I were previously unacquainted.

**Dr Godfrey**

Age: 40 years  
Sex: Female  
Nationality: Iranian  
Spoken English: Good  
Title: Consultant Psychiatrist  
Experience of specialist ADHD clinic: 3.5 years  

Other notes/observations:  
Dr Godfrey presented as particularly enthusiastic to share her knowledge on ADHD. We had not met prior to this study.
### Dr Gola

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<tr>
<td>Experience of specialist ADHD clinic:</td>
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**Other notes/observations:**
Dr Gola and I were previously unacquainted.

### Dr Julalab

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<tr>
<td>Experience of specialist ADHD clinic:</td>
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</tr>
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</table>

**Other notes/observations:**
Dr Julalab and I had met prior to the study to discuss the current thinking on treating ADHD, when she was very positive about both medical and psychosocial interventions for ADHD.

### Dr Kelley

<table>
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<tbody>
<tr>
<td>Sex:</td>
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<tr>
<td>Nationality:</td>
<td>British</td>
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<tr>
<td>Spoken English:</td>
<td>Good</td>
</tr>
<tr>
<td>Title:</td>
<td>Consultant Psychiatrist</td>
</tr>
</tbody>
</table>
Experience of specialist ADHD clinic: 5 years

Other notes/observations:
Prior to the study I had met Dr Kelley on several occasions. He appeared enthusiastic about participating in this study.

Dr Pava
Age: 40 years
Sex: Male
Nationality: Indian
Spoken English: Good
Title: Consultant Psychiatrist
Experience of specialist ADHD clinic: 7 years

Other notes/observations:
Dr Pava and I met prior to the study to discuss the current developments and concerns around interventions for ADHD. He was noticeably respectful of psychology as an intervention but believed it to be sub-standard to medical approaches. Dr Pava described psychiatry as being at the “top of the field”, so other disciplines “downstream” would be affected by any changes in psychiatric practice.

Dr Rubin
Age: 56 years
Sex: Male
Nationality: British
Spoken English: Good
Title: Consultant Psychiatrist
Experience of specialist ADHD clinic: 12 years

Other notes/observations:
Dr Rubin was enthusiastic to share his knowledge with me concerning all aspects of ADHD. We had not met prior to the interview.

**Dr Wayne**

Age: 32 years  
Sex: Male  
Nationality: British  
Spoken English: Good  
Title: Specialist Psychiatric Registrar (SPR)  
Experience of specialist ADHD clinic: 5 years

Other notes/observations:  
Dr Wayne has specialised in neurodevelopmental psychiatry. He is near to the end of his SPR status. We had not met prior to interview.

**Dr Wolf**

Age: 55 years  
Sex: Female  
Nationality: British  
Spoken English: Good  
Title: Consultant Psychiatrist  
Experience of specialist ADHD clinic: 9 years

Other notes/observations:  
Dr Wolf and I had not met prior to the interview. This was my first of the interviews and Dr Wolf was noticeably patient as I was still developing my interview style.
**Procedure**

**Ethical Considerations**

Ethical approval was obtained from two separate research committees, both within the same Trust, as well as the University committee (see appendix 5).

<table>
<thead>
<tr>
<th>Box 5 Ethical reflections</th>
</tr>
</thead>
<tbody>
<tr>
<td>My reflections on developing ethical issues and their influence on analysis can be found in appendix 6.</td>
</tr>
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</table>

**Piloting the interview schedule**

The interview schedule was piloted on a paediatrician and a clinical psychologist who were not part of the study. The pilot could not include a psychiatrist as there was a problem with recruiting numbers. However, this was not considered to be a problem as the pilot fulfilled its goals in identifying the need for more clarity of expression, and a need to reduce the number of questions. The revised interview schedule was then piloted on the same clinical psychologist which enabled a comparison to the original interview schedule. Further minimal adjustments were made to the language used as well as the supplementary questions.

Piloting the interview was essential not just for developing clearly worded questions but also for developing an appropriate interviewing style. Thought was given to the impact that different interview styles could have on the participants’ responses.

**Recruiting participants**

A meeting was held with a consultant psychiatrist who was also a manager in the large NHS Trust. The inclusion criteria outlined to him were, psychiatrists with a minimum of three years experience of working in a specialist ADHD clinic, they had to be currently working in this setting, and to have a good command of the English language. He identified a number of potential participants in the Trust, their location and contact numbers.
A letter was sent to a total of twenty-two psychiatrists, explaining the research and inviting them to be participants (appendix 7 - information letter). Of the twenty-two who were invited, ten opted into the study.

Box 6 Recruiting participants
Initially twelve psychiatrists were invited to participate in the study but only five responded affirmatively. Another meeting with the Trust manager generated a further ten names of which five more accepted. The eventual agreement of these ten participants to take part followed numerous contacts by telephone to arrange interview appointments that fitted in with their busy work schedules. Seven declined as they were excluded by pressures of time. The other five gave no reason.

Interviewing participants
In addition to the information letter, prior to interview a consent form (appendix 8) was presented to each participant summarising the purpose of the research outlined in the information letter. The consent form also addressed issues of confidentiality and anonymity. Participants were asked to give consent for the interview to be audio-taped with the understanding that the data would be held in accordance with the Data Protection Act (1998).

Each of the interviews was approximately forty-five minutes long and was conducted in an office in the participant’s work place.

The semi-structured interview schedule
The interview (appendix 9) was designed to address the research questions that had emerged from my clinical experiences as well as the review of the literature. The semi-structured format was constructed to ensure comparability across interviews but also to allow topics of interest to be explored more fully as the respondents talked more freely about their beliefs and experiences. The interview schedule initially attended to the concepts of description, diagnosis and aetiology of ADHD, before moving onto
intervention, risk and guidelines. This structure was chosen so that responses on intervention could be placed in the context of the preceding themes. The structure and rationale of the interview is presented below:

Interview schedule structure

Section one: Context Section (Approximately one third of the total interview).
To begin with, general questions and prompts were employed so that the participants could use their own choice of terms in order to describe ADHD. The aim was to create a common understanding of what was being discussed and to gently orient the participant to the area of interest. This was followed with an enquiry that was designed to establish how ADHD was diagnosed and conceptualised, and to begin to explore any differences between personal and professional opinion. This information could then be referred to throughout the interview. The final part of section one referred to causes of ADHD. This was an important area as it could be a necessary precursor to the selection of interventions.

Section two: Intervention (Approximately two thirds of the total interview).
The aim of this section was to elicit the knowledges surrounding interventions. This included the criteria they used to judge a particular intervention, their satisfaction or concerns with particular approaches, and their views about the effect that interventions have on the child, family, and professionals. This section also aimed to get the participant’s views on what the interventions actually targeted and their impact. Views of risk were also explored in this section as well as the impact of guidelines.

Analysis of data

Transcription
The interviews were audio-taped and transcribed by the author, following Potter and Wetherell’s (1987) guidelines. The transcription symbols as detailed by Atkinson and Heritage (1984) are in appendix 10. The time ratio of transcription to recorded interview was approximately 7:1, a total of 68 hours. The interviewees all declined the offer of
checking the transcription for accuracy. The interviewer/researcher is referred to as ‘Mark’, and to improve clarity there is a one-line gap to signify a change in speaker (i.e. between the interviewer and respondent).

Coding
Each transcript was read several times to facilitate familiarisation with the data. This immersion in the data served to identify recurring themes and limit the data to be included in the final analysis. A computer program (Kukartz, 1998; ‘WinMax’) for qualitative research was used throughout coding as the themes were generated, and to insert memos (appendix 2). The same extract was often included in more than one coded category so a cyclical process was adopted to code and recode different excerpts. The coding process was a necessary preliminary to the analysis itself and served to identify analytically interesting points of text that were relevant to the research aims (Henwood and Pidgeon, 1992).

Foucauldian discourse analysis
The data were analysed using the Foucauldian version of discourse analysis as outlined by Willig (2001). Foucauldian discourse analysis is concerned with the interconnected triad of discourse, power and knowledge (Carabine, 2001). That is, certain dominant discourses privilege certain versions of knowledge which legitimate existing power relations and social structures. Foucauldian discourse analysis looks at how discourses are bound up with institutional practices that organise, regulate and administer social life.

The Foucauldian version of discourse analysis is concerned with the functions that are being fulfilled by the language used by the speaking subjects. However, it also asks questions about the relationship between the discourse and how subjects think, what they do, and the conditions within which such experiences take place (Willig, 2001).
As Potter and Wetherell (1987) state there is no 'right' or mechanical process to follow in conducting discourse analysis. Nonetheless, the Foucauldian version as outlined by Willig (2001) is set out in six stages. These are as follows:

**Stage 1: Discursive constructions**

This stage is concerned with the discursive object, which in the case of this study is 'knowledge' in relation to interventions for ADHD in children. This first stage involves identifying the discursive object (knowledge) within the texts.

**Stage 2: Discourses**

The second stage aims to locate the various discursive constructions of the object within wider discourses. In other words, the analysis then attends to the different ways that knowledge is constructed. Stages 1 and 2 are not presented explicitly in the analysis section as they are primarily concerned with the coding of themes that arise from the raw data (appendix 2).

**Stage 3: Action orientation**

This third stage of the analysis involves a close (micro-level) examination of the excerpts in which the different constructions of 'knowledge' are deployed. Attention will be given to the way rhetorical devices achieve this. There will also be an examination of what is gained from constructing the object in this particular way, the function of this action, and how it relates to other constructions produced in the surrounding text. Focussing on the action orientation aims to give a clearer understanding of what the various constructions of 'knowledge' are capable of achieving within the text.

**Stage 4: Positionings**

The next stage is to take a look at the 'subject positions' that the discourses offer. Discourses do not just construct objects but also subjects, which makes positions available within the networks of meaning that speakers can take up as well as position others (see Davies and Harré, 1999).
Stage 5: Practice

This stage looks at the relationship between discourse and practice. It makes use of a systematic exploration of the ways that discursive constructions and subject positions open up or close down opportunities for action, or the way that they limit what can be said and done. This process considers how certain practices become legitimate forms of behaviour within certain discourses. Through reciprocity, these practices reproduce the discourses that legitimate them.

Stage 6: Subjectivity

The final stage traces the consequences of taking up a particular subject position for the participant's subjective experience. Having looked at what can be said and done from within different discourses in Stage 5, this final stage is "concerned with what can be felt, thought and experienced from within various subject positions" (Willig, 2001, pp. 111). Both stages 5 (practice) and 6 (subjectivity) are not explicitly developed until the discussion section as these areas of interest operate at a more macro-level (global) with the texts and therefore can be understood as more "speculative" (Willig, 2001).

Chapter four - Analysis

This section takes each selected excerpt that was identified from stage one and two of the analysis process and examines the 'action orientation'. That is, the rhetorical devices which are deployed to construct different accounts of knowledge and the function of these discursive strategies. Next, where appropriate, subject positions will be analysed. The analysis addresses the research aims 1-3 identified earlier:

1) how do psychiatrists use discourse to construct accounts of knowledge in relation to interventions for ADHD?

2) what is the function of these constructions of knowledge?
3) which positions are made available within their discourses?

The accounts of knowledge that became central to this analysis were: empiricist, contingent, moves between empiricist and contingent, and a temporal dimension.

**The empiricist account**

Empiricism depends upon the collection and analysis of data in order to acquire knowledge (Willig, 2001). It is a scientific account in which the research results are often referred to as immutable facts and scientific givens (Harper, 1994). In this empiricist form of discourse, “data are depicted as ‘doing confirming’ and ‘concluding’ independently of the actions of the scientists” (Edwards and Potter, 1992, pp. 135).

The following excerpt followed on from an inquiry about which form of treatment Dr Wolf considered as the most effective for ADHD.

**Excerpt 1 (Transcript 10 – Dr Wolf)**

319: But if we have made a clear diagnosis of ADHD and we’ve done something about all of those other features then erm I would be looking to erm (.) a treatment particularly in ADHD erm my first line would be erm medic-
320: medication.
321: 
322: 
323: 
324: 
325: Mark: Would that be any particular medication?
326: 
327: Dr Wolf: Stimulants (.) yes (.) the evidence is overwhelming that's it's erm useful.
328: 
329: 
330: Mark: Can you say a bit more about that?
331: 
332: Dr Wolf: Erm well (.) erm there are there are hundreds of
The construction of knowledge: A discourse analysis of psychiatrists’ therapeutic repertoires for children with attention deficit hyperactivity disorder

333: reports that indicate that it’s an effective treatment ()
334: that stimulant medication is an effective treatment for ADHD
335: it’s (inaudible)
336:
337: Mark: Sorry I missed that.
338:
339: Dr Wolf: It improves inhibition time (.) and erm erm more
340: most recently there’s been a study in the United States
341: which has randomised children to various treatment groups
342: and again the evidence is very clear that erm stimulant erm
343: medication is erm erm very effective in the short term
344: (.) the long term is more difficult the long term evidence
345: is not so (.) is just not there to be compared with.

In excerpt 1, Dr Wolf uses an empiricist discourse to describe her preferred intervention for ADHD, as research outcomes are used to confirm the effectiveness of stimulant medication in the treatment of ADHD. The discursive ‘work’ of reinforcing the factuality of the empiricist version of events can be interpreted as being achieved through ‘explicit consensus and corroboration’ (Edwards and Potter, 1992). This rhetorical strategy ‘brings forth’ other witnesses to strengthen a point and make it appear more factual. In this excerpt, Dr Wolf works to validate the treatment approach in stating, “there are hundreds of reports that indicate that it’s an effective treatment” (lines 332-333). This use of “hundreds” (line 332) is an example of how ‘quantification’ (Potter, 1996) can be used to maximise a particular point. The sheer number of “reports” (line 333) can be seen to do the work of confirming the use of medication without any consideration of the actions of the researchers.

Her assertion that “the evidence is overwhelming that it’s erm useful” (lines 327-328) is as an ‘extreme case formulation’ (Pomerantz, 1986). An extreme case formulation is a descriptive practice that uses extreme points on relevant descriptive dimensions in order
to justify a point. Dr Wolf makes her empiricist account more effective by drawing on the term “overwhelming” to warrant a stronger case for the use of stimulant medication. The plausibility of her constructions of effective intervention are then qualified by embedding it in a particular narrative sequence as she references a specific “study in the United States” (line 340). Dr Wolf could also be seen to demonstrate that she is familiar with the intricacies of this study as she uses a scientific discourse in stating that it “randomised children to various treatment groups”. The empiricist account is further strengthened as Dr Wolf continues to deploy extreme case formulations in asserting that the “evidence is very clear” (line 342) that stimulant medication is “very effective” (line 343). Finally, lines 344-345 further assert the importance of an empiricist discourse, but constructs Dr Wolf as impartial enough to be able to express a critique. This can serve to support her position as any criticisms about ‘bias’ can be countered with this explicit acknowledgement of limitations of the “long term evidence” for the treatment of ADHD.

Positioning

‘Reflexive positioning’ is a term given to the discursive process by which one positions oneself (Davies and Harré, 1990). In this excerpt Dr Wolf adopts an empiricist position that serves to remove any personal or clinical views on the pharmaceutical intervention for ADHD. Her discourse positions her as an objective onlooker who has relied upon a wealth of empirical work (lines 341-345) to make an informed judgement about this medical intervention. Although Dr Wolf actively constructs her own position as an objective onlooker, the ‘impartiality’ of her account could be questioned. For example, in excerpt 1, she appears to attend to the reported advantages of using medication at the exclusion of reporting any of the disadvantages that may be associated with this form of intervention. Hence, medical interventions are constructed as favourable in the absence of any forms of knowledge to the contrary.
To illustrate comparability between the psychiatrists, the following three examples have been selected.

**Excerpt 2 (Transcript 9 – Dr Wayne)**

297: if you read the MTA trial, the MTA trial is so powerful as
298: it will never be surpassed in its size, quality erm
299: thoroughness really but it addressed problems in a sort of
300: gold standard way

In this excerpt, Dr Wayne explicitly names the research trial that he is referring to. In line 297, he references his source of empirical information which serves to construct an objective and factual foundation from which he can frame his own accounts of treatment. The trial is described as “so powerful” (line 297), an extreme case formulation that could be described as making this version of events more effective by placing it favourably on the constructed continuum of relevant dimensions of judgement (Pomerantz, 1986). Next, a further extreme case formulation is then deployed in relation to time, stating, “it will never be surpassed” (line 298). This provides the professionals with the assurance that they have achieved the ultimate access to knowledge in this area, thus affording them the rights to practise accordingly. Dr Wayne goes on to say that it will never be surpassed “in its size, quality erm thoroughness” (line 298-299). This is a ‘three part list’, a rhetorical strategy that is often deployed to create a complete and convincing account by constructing a ‘stronger’ argument through listing examples (Jefferson, 1990). Finally, the validity of his empiricist account is further qualified by the assertion that “problems” (line 299) were addressed in a “gold standard way” (line 300). This figurative device (Hepburn, 2000) has much rhetorical force as the use of the word “gold” often has connotations with absolute excellence, as in ‘gold medal’ for example.
Dr Kelley also uses the same study and the identical figure of speech to Dr Wayne when describing the interventions used in research trials, with the same rhetorical effect.

Excerpt 3 (Transcript 6 – Dr Kelley)

268: Dr Kelley: Erm (.) well in terms of the erm the MTA
269: trials (.) the trials in the States (.) I think that's
270: currently the gold standard in terms of treatment
271: intervention. I think they've rigorously adapted a (.)
272: double blind crossover type erm methodology

The legitimacy of his empiricist account is qualified in stating, “they’ve rigorously adapted a (.) double blind crossover type erm methodology” (lines 271-272). This use of a scientific account may serve to give Dr Kelley access to the category membership of science/research and thus strengthen the narrative of empiricist knowledge and epistemological rigour. The ‘facts’ appear to present themselves to the professionals who appear to have a passive role in interpreting them (Gilbert and Mulkay, 1984). The psychiatrists can then be seen to present the ‘facts’ in the same objective manner and construct them as a preferred form of knowledge. Excerpt 4 is another example of this process.

Excerpt 4 (Transcript 7 – Dr Pava)

294: Dr Pava: I mean if one looks at research it is
295: probably the largest research area in child psychiatry is
296: whether stimulants work in ADHD (.) in this point in time
297: even the most rigorous critics of whether medication works
298: have had to accept that stimulants do work in ADHD (.) the
299: response rates are roughly between sixty-five to seventy-five so it would be
300: around seventy that respond to stimulants, it's not that
301: everyone responds to it but if you don't respond to one
302: stimulant in an ideal dosage then another stimulant might
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303: still respond (.) so it's not just that if you try one
304: stimulant and they haven't responded that means that they
305: won't respond to another (.) so if you use all, two or three of
306: the stimulants at different times you actually get a
307: response rate at about ninety to ninety-five percent that respond to medication
308: (.) so the findings are robust

Explicit consensus and corroboration are used to warrant the merits of this treatment approach as it is described as “probably the largest research area in child psychiatry” (line 295). For a further example (Dr Edmund, Transcript 2) see appendix 11. Dr Pava then supports this statement with, “even the most rigorous critics of whether medication works have had to accept that stimulants do work” (lines 297-298). The way in which Dr Pava explicitly recognises that there are “critics”, shows an awareness and consideration of competing discourses. This does the work of consolidating his position, for if the “most rigorous critics” have agreed, this implies that there is simply no case to answer. This account appears to silence any competing discourses under the weight of an empiricist account of knowledge.

Another rhetorical strategy used in this excerpt is one identified by Antaki and Wetherell (1999) and is named a ‘show concession’. This identifies a concession before reinforcing the initial belief to fortify the speaker’s position. Dr Pava makes a show of conceding by using a three part structure of proposition, concession and assertion. He proposes that “stimulants do work in ADHD” (line 298) and uses an empiricist account to warrant his statement in the form of ‘objective’ numerical data (lines 299-300). He then makes the concession, “it’s not that everyone responds to it” (lines 300-301), which allows him to reassert his proposition, “but if you don’t respond to one stimulant in an ideal dosage then another stimulant might still respond” (301-303). The power of this conversational structure is in its ability to use sequential development to dismiss any rival claims (Antaki and Wetherell, 1999). In the following lines Dr Pava then further consolidates the final part of the show concession, the ‘assertion’, by using an empiricist account to construct a
continuum of effectiveness at which medication is described to have a “response rate at about ninety to ninety-five percent” (line 307), concluding, “so the findings are robust” (line 308).

Positioning

In addition to positioning oneself (‘reflexive positioning’), it is also necessary to consider how what one person says can position another. This process is named ‘interactive positioning’ (Davies and Harré, 1990). Both of these types of positioning can be applied to excerpt 4, but to do this, the question that preceded the excerpt is presented:

Excerpt 5 (Transcript 7 – Dr Pava)

289: Mark: so (3) you sound pretty sure of the effects of
290: medication, especially with those at the more severe end of
291: ADHD, I wonder how that knowledge came about, how we know
292: this?

The interactional dynamic of questioner/respondent may well position the psychiatrist as the bearer of knowledge, or ‘expert’, whose role it is to give the ‘correct’ answers to the research questions. However, the term “you sound pretty sure” (line 289) could be seen as questioning the psychiatrist’s preceding response, as it is a colloquialism that can be perceived as challenging, as in “you sound pretty sure of yourself!”.

To ‘correct’ this connotation, and avoid closing down the discourse, I then ‘own’ the question by shifting to the first person (line 291), before a final orientation of a shared perception of knowledge by using the term “we” (line 291). This final shift increases the generality of the ‘knowledge narrative’ in order to pose a less confrontational question. Indeed, by explicitly invoking the discourse of “knowledge” (line 291), it becomes ‘externalised’ (White and Epston, 1990) which serves to objectify it. This makes it more likely that the psychiatrist can talk about knowledge as separate to his own belief system as it has moved from the ‘personal’ to a ‘body of knowledge’. This appears to be the case
as Dr Pava relies upon an empiricist account of the effects of medication. It is also noteworthy that he maintains the constructed position of a shared perception of knowledge when he states, “even the most rigorous critics of whether medication works have had to accept that stimulants do work in ADHD” (excerpt 4, line 297-298). This statement could be described as reconciling the differences between my questions about the treatment approach and Dr Pava’s defence of it. Or put simply, the challenging part of my question could have placed me in the membership category of “rigorous critics” (line 297), and that I, among others, should “accept” the evidence. This reconciliation could be seen to subjugate any competing discourses, attributing to the unification of knowledge and reinforcing the empiricist account.

It was noticeable that in this excerpt he did not speak of ‘children’ or ‘kids’, which he did on other occasions. These ‘absences and silences’ (Carabine, 2001) can be seen as a device to construct membership categories. Rather than saying that the child is expected to “use all, 2 or 3 of the stimulants” (lines 305-306), he substitutes this with a generalised second/third person narrative (“you”, “they”). This creates a membership category that constructs a more symmetrical power relation (Hepburn, 2000) between the psychiatrist and the child. This is achieved by excluding the ‘vulnerable’ child from the empiricist account of treatment approaches for ADHD, thus reducing the likelihood of the professional being positioned as ‘abuser’ from those critics who refer to the use of stimulants as the ‘medicalisation of misbehaviour’ (see McGuiness, 1999).

The contingent account - I

Making clinical decisions - Personal and professional accounts of knowledge

The contingent account is different from the empiricist account in that it does not depend upon scientific ‘facts’ but on the individual’s personal and professional inclinations (Gilbert and Mulkay, 1984). Personal accounts of knowledge comprise individual beliefs that may or may not be fully compatible with the other systems of knowledge that they hold. Professional accounts of knowledge are beliefs that the clinician holds alongside their professional body concerning issues of practice.
The contingent account is rhetorically organised and is embedded in discursive practices (Edwards and Potter, 1992). It incorporates the influences of institutional, economic, legal, and societal beliefs into the production of knowledge and the process of decision-making.

In order to compare the empiricist and contingent accounts, excerpts from the same psychiatrists will be used in the following analysis.

**Excerpt 6 (Transcript 7 – Dr Pava)**
The following excerpt was embedded in a discussion about the possible toxicity of stimulant medication.

767: Mark: And is there the scientific research on those who
768: have been on it [stimulants] for longer course, fifteen, eighteen years?
769:
770: Dr Pava: No I mean there's all all all that we have
771: is clinical experience and nothing nothing negative being
772: reported in that erm so apart from that we can't state
773: clearly (.) so that's why I'm saying that 5 years is what we
774: do have for scientific, clear evidence which is more than we
775: can say about the non pharmacological treatments (6).

The question (lines 767-768) invokes an empiricist account of knowledge by referring to “scientific research”. Dr Pava then explicitly presents an alternative account of knowledge in stating, “all all all that we have is clinical experience” (lines 770-771). This statement appears to question the validity of the professional contingent account of knowledge by minimising it by using the word “all”. However, doubts around the use of the contingent account are then immediately negated through the deployment of an extreme case formulation in that “nothing nothing negative being reported” (lines 771-772). The function of this pattern of discourse could be understood in terms of a show
concession (Antaki and Wetherell, 1999). He initially states that clinical experience has not highlighted any risks of longer term use of medication, he then introduces a concession to challenge this initial belief in stating, “apart from that we can’t state clearly” (lines 772-773). Finally, he qualifies the concession and reasserts the superiority of psychiatric knowledge by re-invoking an empiricist account of the scientific evidence over the shorter time span of five years (lines 773-775). This shift from a professional contingent account is a defensive function deployed to ward off criticism of the longer-term use of medication with children with ADHD. Rather than invoking a discourse about possible limitations (‘absences and silences’, Carabine 2000), Dr Pava makes a claim for contingent knowledge before reverting the discussion back to an area that is less disputable, as it is supported with empirical evidence.

Positioning
Although Dr Pava had previously invoked the empiricist discourse in evaluating the risks associated with medication, the interviewer’s question also specifically attended to “scientific research” (line 767). In using this question, I positioned myself as prioritising the empiricist account of knowledge in the evaluation of risk which may have pre-empted an equally empiricist response. However, Dr Pava then invokes a discourse of contingent knowledge, clinical experience, but uses the collective term “we” (line 770) which may serve to construct a wider membership category thus conforming to the more empiricist ideal of ‘generalisability’ to support his claims. This discursive feature can be seen to maintain his position as a knowledgeable clinician, which is shared by his contemporaries. Dr Pava can then be seen to do some work to locate himself back onto ‘safer’ ground by reverting back to an empiricist account and by comparing this knowledge against “non pharmacological treatments” (line 775). This comparison is another example of interactive positioning, in which Dr Pava constructs a continuum of professional accounts of knowledge, he then uses it to place psychiatry as superior to other non pharmacological treatment approaches. Considering Dr Pava was aware that I occupied the role of trainee clinical psychologist, his direct comparison between
knowledges could be seen as a discursive strategy in which the professional category of psychiatry, is positioned as more knowledgeable than psychology.

The following excerpt was selected as it invokes both personal and professional contingent factors in relation to the diagnosis and treatment of ADHD.

Excerpt 7 (Transcript 6 – Dr Kelley)
80: Mark: Right Ok (.) I'll cover a little bit more of the
treatment in a second. You have made a differentiation
82: between behavioural disorders and ADHD and the use of having
83: it as a distinct disorder (.) ADHD. In your view does that
84: make it (.) would you classify it as a mental illness?
(lines 85-95 of Dr Kelley's response are omitted here to facilitate the focus)
96: Dr Kelley: I
97: think most of the hhh most of the energy around the
98: recognition and treatment of ADHD has come from erm has come
99: from the mental health erm sciences and profession (.) it
100: hasn't come from paediatrics (.) it hasn't come from other
101: other branches and professionals (.) so it's a disorder (.)
102: it's erm and I think that it has to be called a disorder
103: because it's erm it's on a continuum and therefore erm (.)
104: it's difficult to say what is and what isn't a disorder as
105: behaviour is on a continuum and clearly erm there's no sharp
106: cut-offs between having a disorder and not having a disorder
107: it's at best a clinical guess.

My question has invoked a dimension of classification that may have been too general for the psychiatrist to respond to in empiricist terms. However, Dr Kelley appears to bring forth an empiricist account in stating the “mental health erm sciences and profession” (line 99) are responsible for the development of an understanding of ADHD. Perhaps to
consolidate an empiricist account, Dr Kelley then appears to allocate responsibility of these findings through eliminating “paediatrics” (line 100) and “other branches and professionals” (lines 100-101). Having determined that the knowledge is based within the membership category of “mental health sciences and profession” he then uses syllogistic reasoning to deduce, “so it’s a disorder” (line 102). However, the reliance on the deployment of a more logico-deductive discourse is soon abandoned as his discourse shifts to a more personal contingent account and he speaks in the first person saying “I think that it has to be called a disorder” (line 102). Finally, in line 107, Dr Kelley attends to a professional account of knowledge by concluding, “it’s at best a clinical guess” (line 107). When comparing the use of the term “clinical guess” to the possible alternative of clinical certainty, it is apparent that Dr Kelley constructs the accuracy of the diagnosis as dependant on the judgement of the individual clinician. Adopting a more macroscopic view of this passage illustrates how Dr Kelley initially attempts to use a more empiricist account to categorise ADHD as a mental illness/disorder. However, as he then moves towards using a more contingent account he challenges this as he progressively moves from a position of certainty to conceptualising ADHD as professional guesswork (for another example of competing personal and professional accounts see appendix 11 – Dr Gola).

Positioning

A comparison between how Dr Kelley positions himself in excerpt 3, transcript 6 (empiricist account) and excerpt 7, transcript 6 (contingent account) illustrates how psychiatrists can orient themselves with different accounts of knowledge. Davies and Harré (1990) point out that this is not an unusual process as all people frequently experience multiple and contradictory positions. However, an awareness of the different ways that psychiatrists ‘do’ knowledge may be important when investigating treatment approaches for ADHD. For example, Dr Kelley’s contingent account of the disorder is described as, “at best a clinical guess” (line 107). However, he refers to the empirical treatment approaches as “gold standard” (excerpt, 3, line 270), having used a rigorous research methodology (lines 271-272). This highlights a possible incongruence in his
accounts of knowledge as Dr Kelley’s ‘convincing’ empiricist account of treatment may appear to be less conclusive when it is positioned alongside the professional account of clinical guesswork in determining a diagnosis. 

A third example of the use of a contingent account of clinical knowledge can be seen in the following excerpt:

Excerpt 8 (Transcript 10 – Dr Wolf)
149: (.) if you’re doing research I
150: think that you probably need to do to find erm a further
151: instrument other than the ICD ten and DSM four because they
152: don't erm provide a quantitative rating (.) they give you
153: the areas and leave the judgement. So if you wish to do
154: research you wish to use some other instrument otherwise
155: what you do is to use the general guidance to come to a
156: clinical decision. I'm interested in the clinical
157: judgements for a particular division.

This response followed my questions around the sources of knowledge that were used to determine if a child had ADHD. Dr Wolf acknowledges how research requires explicit procedures to provide a “quantitative rating” (line 152) to determine classification. This is a form of knowledge that maximises the use of numerical data associated with an empiricist account, which in turn minimises the value of the more subjective personal “judgement” (line 153). Next, in line 154, she uses the word “otherwise” to distinguish between the necessity to use instruments for research and to use “general guidance to come to a clinical decision” (lines 1550-156). This shift in perspective moves from an empiricist account, where ADHD is marked out as a special phenomenon that is best quantified, to a contingent account where a clinician’s judgement is guided by “general” factors. Dr Wolf then identifies the difference in classifying ADHD for research and clinical purposes in stating, “I'm interested in the clinical judgements for a particular
division” (line 156-157). This shift aligns her more closely with a contingent account as she states that her own personal interests lie in clinical judgements. This serves to minimise the amount of emphasis that she places on the construction of knowledge using more standardised, empirical methods.

Positioning
In her discourse, Dr Wolf constructs and occupies different subject positions. Referring to the use of stimulant medication in the empiricist account (excerpt 1; transcript 10) she states, “the evidence is overwhelming that's it's erm useful” (lines 327-328). This use of convincing empiricist knowledge then appears to be somewhat undermined when she occupies a more contingent position asserting, “I'm interested in the clinical judgements for a particular division” (lines 156-157). This can be understood as Dr Wolf shifting from a reliance on research and empiricist knowledge for the treatment of ADHD, although as a clinician she appears to construct a contingent account as most useful in determining the disorder.

The contingent account - II
Social contingent account (familial)
The analysis has looked at personal and professional contingent accounts of knowledge and how they compare with empiricist accounts. The next section will extend this to social contingent factors, specifically the influence that the child’s family has on the psychiatrists’ decision making.

Excerpt 9 (Transcript 9 – Dr Wayne)
398: There are
399: parents who will say "I'm not going to give my kids the
400: medication" same way as that as the asthmatic child's
401: parents may choose not to give that child drugs (.) that
402: happens all the time (.) so you have to be resourceful and
403: you have to work around the people that you are working with
404: (.) so there's no point just knowing about one treatment
405: modality (.) if the gold standard doesn't work then you go
406: for the silver standard. So yes you have to be mindful.

Dr Wayne makes a comparison with asthma (lines 400-401), in which an alliance appears to be formed between the treatment of ADHD and physical illness, to warrant a stronger case for medicating. Dr Wayne then uses “all the time” (line 402) to convey the frequency with which parents refuse medication on behalf of their child, which he claims to meet through being “resourceful” (line 402). He then talks of the need to move from the “gold standard” (line 405), a figure of speech associated with excellence that he uses interchangeably with medication (transcript 9, line 315, “medication is the gold standard”). With the parents preventing the child from having access to the gold standard intervention then Dr Wayne talks of going for the “silver standard” (line 406). Here it is apparent that he has constructed a continuum of excellence in which medication is placed ahead of the non-pharmacological interventions.

Positioning

The way in which a professional moves to a social contingent (familial) repertoire where the families’ values are acknowledged can be seen as positioning the professional as a person, “who recognises the importance of social context whilst still asserting the empiricist repertoire” (Harper, 1994, pp. 137). This use of two positions can be seen as serving both personal and interpersonal interests as the professionals can maintain a position of competence, which is paradoxically strengthened through acknowledging the social context (Harper, 1994). Dr Wayne recognises that some parents may have an alternative (contingent) account of preferable interventions, but he maintains that the empiricist account of knowledge is “gold standard”. This appears to construct the empiricist account as the ‘correct’ account of knowledge although he is prepared to “work around the people that you are working with” (line 403).
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**Moving between empiricist and contingent accounts**

**Discourses of risk in intervention: a cost/benefit approach**

The excerpts already analysed indicate that empiricist and contingent accounts of knowledge are not mutually exclusive, but are deployed interchangeably to perform particular rhetorical functions. A further reading of the texts highlighted the way in which the shift between these accounts of knowledge was evident when the interviewees were speaking about the costs/benefits of using medication to treat ADHD, especially in relation to “risk”.

To put this excerpt in context, it followed from a discussion about where ‘blame’ for a child’s behaviour is located. Dr Wolf had previously asserted that using stimulant medication as an intervention for ADHD may create a more blame free environment (transcript 10, lines 464-471) and parents can be made to feel less guilty (lines 475-476).

**Excerpt 10 (Transcript 10 – Dr Wolf)**

479: Mark: I see. So do parents have a favourable reaction to-

480:

481: Dr Wolf: No no I don't think they do, I think that many
482: parents are obviously horrified at the idea of erm putting a
483: child on drugs (.) as indeed I'm- everybody must be (.)
484: it's it's not something to be done lightly it's something
485: you erm you think about very seriously but erm you then
486: consider- that's where one's clinical judgement about
487: functional impairment comes in (.) you ask yourself how
488: significant is the problem erm how is difficult it is for
489: this child to manage this family to manage, what's likely to
490: happen, erm if you do nothing at all .hhh and and you share
491: that judgement making with the parents erm I I don't think
492: any of us would lightly say that we are just there to dish
493: out pills (.) it's very much a question of talking about
494: what are the precise aims (. ) what we really want out of 
495: this and and and very often parents are erm persuaded erm no 
496: that's not quite right I hope I don't go round persuading 
497: parents (. ) hhhh parents are often happy to do something on 
498: a trial basis (. ) so you try and set up a reasonable 
499: experiment of what we are going to measure, erm what would be 
500: our outcome, what are we hoping to change, how are we going 
501: to make a judgement about that (. ) etc. 

In this excerpt Dr Wolf invokes both a familial and a personal account of the reaction to stimulant medication. Her statement in lines 481-483 uses the extreme term “obviously” which can be seen to move her view beyond question from any competing discourses about how parents are “horrified at the idea of erm putting a child on drugs”. Dr Wolf then just stops short of directly aligning her own personal beliefs alongside that of the parents (“as indeed I I'm-”) and constructs a more generalised membership category of “everybody”. This progressive shift is an example of how different contingent accounts of the risks of medication are brought forth to move from a parental, to a personal, to a very general set of beliefs. A further contingent account is then invoked, a professional account, in which Dr Wolf refers to “one’s clinical judgement” (line 486). This professional account of knowledge appears to do the work of negating her initial personal/emotional reaction that she shared with parents. This account does the work of disconfirming the other accounts that constructed the use of medication as horrifying, and with the use of “clinical judgement” a cost/benefit approach is deployed to begin to redress the balance. Dr Wolf then uses a three part list (line 488-490) to build a more persuasive case in attending to the difficulties experienced by the child and family. This list is contrasted with one possible response of doing “nothing at all” (line 490), an extreme case formulation that serves to maximise the value of using this intervention, the alternative being to leave the family to suffer. Dr Wolf then reintroduces the parents’ role in decision making by stating, “you share that judgement making with the parents” (lines 490-491), before saying how parents are “persuaded” (line 495) by the professional.
Although Dr Wolf retracts this statement as it may have served to judge this process as manipulative, she then asserts that “.hhhh parents are often happy to do something on a trial basis” (lines 497-498). This is an interesting statement. In this excerpt she initially constructs parents as being horrified about putting their child on drugs. She then said that she shared this horror, as indeed “everybody” (line 483) must. However, a shift to a professional account then appeared to do the persuasive work of moving parents from “horrified” to “happy”. The move from a personal/parental account to a professional account is then completed as Dr Wolf finally invokes an empiricist account in lines 499-501. The reference to “a reasonable experiment” (line 498) can be seen to warrant the use of medication as the process is now constructed as scientific, which in turn may suggest that it is safe and objective. However, the adjective “reasonable” may serve to ‘soften’ any ‘horrifying’ connotations associated with experimenting on children. Following this, the “reasonable” nature of the experiment is further attended to by way of a four part list, in which “measure”, “outcome”, “change” and “judgement” (lines 499-500) are used to construct the process as almost mechanical in its objectivity and thoroughness.

**Positioning**

Dr Wolf speaks in the first person about her perceptions of parents’ horrified reactions and in doing so orients herself alongside their position. Furthermore, her choice of the words, “putting a child on drugs” is a discursive strategy that clearly constructs an asymmetry of power between the psychiatrist and the child. It places stimulant medication within a membership category of “drugs” which can have a number of negative and abusive connotations. Half way through explicitly aligning herself with parents’ beliefs Dr Wolf (line 483) moves from a first person position to a more generalised second person narrative (line 485). This shift in orientation moves her from a critical position shared by parents to a position of ‘insider’ as she then speaks in terms of “one’s clinical judgement” (line 486). Having reoriented herself as a clinician, she indirectly assumes a position of an advocate of medication. Dr Wolf then works to construct parents as “happy” (line 497) to be party to this approach. Next, she speaks of the decision-making process as reliant on empiricist means, although she maintains the
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alliance between herself and the parents by using “we” (line 499-501) numerous times. As this excerpt develops, Dr Wolf constructs a larger membership category in which she positions herself alongside the parents and their concerns over medication. This helps to position her as an empathic practitioner who would not use medication unless it was absolutely necessary. Hence, Dr Wolf has done the work that allows her to talk about the necessity of medication without the danger of being seen as ‘uncaring’ or ‘insensitive’ to the needs of the child and family.

A closer look at the texts indicated that there were numerous examples of a move between empiricist and contingent accounts from each psychiatrist. The following three excerpts have been selected as they draw on the discourses of three psychiatrists as yet unmentioned. These analyses will inform the reader of some of the different ways that such a shift is achieved, however the analyses will be more limited due to the restrictions of space.

To place excerpt 11 in context, it followed from an enquiry about the longer-term treatment effects of stimulant medication, to which Dr Julalab stated that such effects were unknown.

Excerpt 11 (Transcript 5 – Dr Julalab)
353: Mark: I wonder if that causes concern for parents and clinicians?
355
356: Dr Julalab: Well I guess that's something that applies to lots of different medicines one gives (.) erm and that's why lots of different medications that were thought to be safe at some stage were prescribed and were discontinued a little bit later and some of them were medicines that were used routinely in psychiatry or in medicine (3) erm so (5) science is not perfect and that's something that we have to
363: live with and I don't think that it just applies to
364: methylphenidate (.) erm there are others (.) very serious
365: medications that were taken (.) you know that ones that were
366: taken during pregnancy and the children ended up having limb
367: abnormalities and erm erm so yes medicine is full of risks
368: but but but there are also lots of benefits so one has to
369: look at the bright side (Smiles/Laughs).

Dr Julalab constructs a normalising account of the risks that are associated with prescribing medication. This is achieved by using the extreme case formulation “lots” (lines 357 and 358), which serves to place knowledge of the longer-term effects of stimulant medication in the company of other medical interventions. She states, “science is not perfect and that's something that we have to live with” (lines 362-363), which closes down the debate on its risks and it normalises the inadequacies of science. Dr Julalab then constructs a relational norm or continuum in which an extreme case formulation is given in terms of “very serious medications” (lines 364-365) which resulted in “limb abnormalities” (lines 366-367). Bringing attention to the incontestable severity of this practice and the clarity of evidence as to the costs of using such drugs in pregnancy may assist in the construction of Dr Julalab as a reflexive and critical practitioner. However, it is noticeable that she attends to the risks of ‘other’ disorders at the expense of talking about the risks associated with treating ADHD. In addition, at the end of the excerpt Dr Julalab disclaims her concession that “medicine is full of risks” (line 367) by stating, “but but but there are also lots of benefits so one has to look at the bright side (Smiles/Laughs)” (lines 368-369). This illustrates a more personal account of knowledge in which the costs are unknown so they cannot be assessed, whereas the benefits are known and are therefore attended to. The phrase, “look at the bright side” in line 369, provides a vivid image of the aspects of knowledge that are attended to, the benefits, whilst there is a noticeable silence or absence about the contrasting ‘dark side’, or the risks of treating ADHD with stimulant medication. The presence of ‘humour’ at the end of this passage may serve a particular function. Gilbert and Mulkay (1984) have
indicated that humour can be understood as signalling the juxtaposition of two opposing discourses. Here, for example, there may be a contradiction between a reliance on science and an empiricist account and personal and professional concerns over attending to the benefits at the expense of recognising the potential costs/risks.

**Positioning**

In this excerpt the style of the question uses ‘ignorance’, which positions me as a naive interviewer. This approach is believed to be beneficial in giving voice to otherwise implicit assumptions (Willig, 2001). Dr Julalab then takes on a similar position in her response. It begins with “Well I guess” (line 356), a term that also expresses uncertainty, or a decision that is based on insufficient information. In this position, Dr Julalab is able to delegate responsibility to an unnamed, generalised third party that use ‘risky’ medication in stating “medications that were thought to be safe at some stage” (lines 358-359). This positioning serves to construct her as a person who is an interested onlooker who has no part in the application of risky medications.

The next excerpt followed on from an enquiry about how much is known about the effects of using stimulant medication over the longer term.

**Excerpt 12 (Transcript 8 – Dr Rubin)**

436: Dr Rubin: (3) We know (.). we know securely, in over two year periods of time, longer than two year periods of time it's not experimental (.). it's naturalistic. But there has been a lot of been a lot of follow up of kids erm (.). here we have done follow up of kids who were undertaking treatment, showed the disorder really is a risk (.). without therapy.

Dr Rubin can be seen to create a contrast between two systems of knowledge, “experimental” and “naturalistic” (line 438). Having experimental knowledge appears to warrant it as correct and beyond reproach as Dr Rubin states, “we know securely” (line
The use of the term “naturalistic” implies that the other, more contingent system of knowledge is less controlled. However its use begins to be qualified in the lines 438-441. Dr Rubin relies upon the term “lot”, which is a form of quantification often deployed in empiricist accounts of knowledge, to warrant the validity of the knowledge from “follow up of kids”. The cost/benefit relationship is then deployed in line 441 as the ‘cost’ is aligned with those who are “without therapy” and the “disorder” is spoken about as the “risk”. This reconstruction of the disorder as the risk, rather than the use of stimulant medication can be seen as attending to the benefits of medication whereas there is a noticeable silence or absence about the potential costs.

Positioning

Dr Rubin positions himself in a different way to Dr Julalab (excerpt 11). His statement, “we know securely” (line 436) positions him as an insider when it comes to the acquisition of knowledge about the risks of medication. Furthermore, the certainty of his response can be contrasted with Dr Julalab’s as he adopts a position holding ‘definite’ knowledge. Dr Rubin’s certainty about the knowledge of the risks of medication and his position as ‘insider’ constructs him as a person who is in a position of power. This position becomes even more apparent as he constructs an asymmetrical category membership between his status and that of the clients in calling them “kids” (lines 439-440). Hence, Dr Rubin is positioned as a person who holds the knowledge which influences what forms of treatment can be prescribed to the less empowered children.

Excerpt 13 was selected for analysis as it proved to be an exception to the other transcripts as Dr DePaul attends to the gaps in the empiricist account.

Excerpt 13 (Transcript 1 – Dr DePaul)

310: Mark: Right, so there isn't data on the long term effects?
312: 
313: Dr DePaul: No but it is proposed that you just keep
314: going for years and years. The MTA is you know an elegant
315: trial it's 560 whatever, 570 kids over 6 centres, over
316: randomised 4 different erm treatments (.) erm up to 14 months
317: with follow up at 20 months. That's way way the biggest,
318: way the longest (.) up till then either medication or
319: behaviour treatments have only ever been tried for up to 3
320: months you know (.) and no-one ever goes on Ritalin for just
321: 3 months. So you know there's huge gaps in our
322: understanding. We are giving you know stimulants, Class A,
323: Amphetamines are Class A drugs you know (.) these are not
324: (.) we are not playing around with Smarties.

Dr DePaul could be seen to move between empiricist and contingent accounts as he
took to the 'lack' of knowledge of long term effects of stimulant medication. In lines
313-314, he begins with a more contingent account of institutional expectations of
practice but he quickly contrasts this with an empiricist account. Dr DePaul qualifies the
use of the MTA trial in referring to it as "elegant" (line 314), thus constructing it as a
desirable and well designed. The quantifiable qualities of the empirical trials are then
reflected in his narrative as he refers to them as "way the biggest, way the longest" (lines
317-318) which serve to maximise the knowledge derived from the trials. However,
having attended to the benefits of this trial in terms of the longer term effects of
treatment, Dr DePaul then uses the extreme case formulation, "huge gaps in our
understanding" (lines 321-322). This descriptive work serves to minimise the presence of
a comprehensive and persuasive empiricist account, even with such "elegant" research
trials, and attends to the absences in empirical knowledge. The way Dr DePaul attends to
the benefits of empirical knowledge, before explicitly identifying the risks, can be seen as
an exception when compared to excerpts 11 and 12. Lines 323 and 324 maximise the
attention to risk as he positions stimulant medication alongside "Class A drugs", putting
them in a category of other drugs which can be associated with high risk. His last
statement (line 324) accentuates the potential costs of using stimulants as he makes an ironic comparison between Class A drugs and a ‘harmless’ children’s sweet.

Positioning

In this excerpt Dr DePaul is positioned somewhere between the two previous psychiatrists (excerpt 11 and 12). That is, he shares Dr Julalab’s construction of the practitioner as ‘uncertain’ in stating, “there’s huge gaps in our understanding” (lines 321-322). However, rather than positioning himself outside the scope of responsibility, similar to the case with Dr Rubin, he positions himself as an ‘insider’ who is aware of the limits of knowledge. This positioning appears to put Dr DePaul in the potentially less comfortable position of a practitioner with limited knowledge about the risks of medication but one that is still prescribing.

Temporal constructs of knowledge

Knowledge cannot simply be considered as a stable condition, but is subject to transformations and reorganisations (Foucault, 1970). Foucault looked at the historicity of the concepts developed at a particular period of cultural history. The final section of the analysis is also concerned with the way in which psychiatric discourses use the concept of ‘time’. It will analyse the interaction between these temporal influences and the psychiatrists’ constructions of knowledge.

The following excerpts were taken from questions about the effects of the recent NICE guidelines on interventions in ADHD.

Excerpt 14 (Transcript 1 – Dr DePaul)

447: (...) but now you've got a very
448: (...) NICE guideline (...) in fact a big wave within psychiatry
449: saying you know "we should be giving it more". So you know,
450: in terms of prescribing it's freeing you up, but in terms of
451: whether you should, you know try psychosocial interventions
452: first, that gets harder and harder to justify

Dr DePaul identifies that there has been a change in practice in stating, “but now” (line 447). He refers to the NICE guidelines as a “big wave” (line 448) within psychiatry. This use of imagery creates the rhetorical effect of a widespread movement that may have such momentum that it is unstoppable, and it is thus unlikely to be guided by other more subtle movements. The use of reported speech (line 449) is a rhetorical function that can serve to distance the speaker from the reported speech act, as it serves to acknowledge that there are competing versions of a ‘preferred’ treatment approach. Dr DePaul is not constructed as an objector to pharmacological intervention, but as an impartial professional who has the capacity to step outside of the guidelines to make an independent and informed judgement. However, the use of “we” in this example places him in the same category as those others in the field of psychiatry. In line 447, the word “now” indicates that there is evidence of a change in this way of practising that suggests that current constructions of knowledge are undergoing change. A consideration of the cost/benefit approach to this change is invoked as he states that the NICE construction of ‘best practice’ acts as an ‘agent’ to free up the psychiatrist to prescribe (line 450), although he explicitly states that the cost might be a reduction in using alternative, “psychosocial interventions” (line 451). His statement that this is “harder and harder to justify” brings in a continuum of difficulty, which runs alongside a parallel continuum of time.

Positioning
In this excerpt, Dr DePaul reports how he has been positioned by the guidelines and the current climate in psychiatry. These two factors are said to free up the psychiatrist to prescribe, but the reverse argument that he puts forward is that psychosocial interventions are harder to justify. The way in which Dr DePaul is positioned as somewhat powerless over the interventions that can be used for ADHD, could be understood to remove responsibility for the way he currently ‘has’ to practice, whilst attending to other treatment approaches on offer.
The impact of the temporal dimension on knowledge can also be found in the following excerpt.

Excerpt 15 (Transcript 3 – Dr Godfrey)

572: (.) a few years on
573: we have referrals from the school and the teachers have
574: learned to recognise ADHD (.) erm obviously because they
575: have been educated over the years they are much better at
576: picking it up (.)

As with excerpt 14, Dr Godfrey uses the word “now” (line 572) to indicate that the temporal dimension has affected the way in which practice is understood. She then uses an estimate to quantify the amount of time in years (line 572) to draw a favourable comparison to how “teachers have learned to recognise ADHD” (lines 573-574). This also gives ADHD a past, or the implication that it has always been there, just not recognised. This statement attends to the temporal dimension in constructing ADHD not just as a medical condition, but one that can now also be applied in the educational setting too. This could be conceptualised as normalising the ‘disorder’, in the way that people, as well as medical professionals, are manoeuvred into ‘correct’ ways of thinking and behaving. The process of normalisation, that appears to have become more apparent with time, can be seen to create a knowledge that gradually becomes accepted as a ‘truth’, which subsequently makes it more difficult to challenge. Dr Godfrey talks of the teachers being “educated over the years” (line 575) which is a statement that illustrates how over time the boundaries of the knowledge of the ‘disorder’ have blurred significantly. That is, there is a role reversal in that teachers are said to have learned to “recognise ADHD”, the role that was formerly associated with the psychiatrist, and the teachers are said to have been “educated”, which is the role that they used to occupy.
Positioning

Dr Godfrey refers to teachers being “educated over the years” (line 575) to recognise ADHD. She does not explicitly say who has been positioned as educator, however ADHD was previously classified as a ‘mental illness’ and it is therefore possible to assume that psychiatrists as well as other mental health professionals would play a substantial part in this role. With more professionals recognising ADHD (including teachers) they could be said to occupy positions of greater power over those that they are observing. As Mendez (1988, pp. 144) states, only those people who are in the appropriate position of power in a particular social domain can “bring forth psychological problems” so that they are accepted.

Chapter five - Discussion and overview

This section will progress from making links between discourses, the constructions of knowledge and subject positions, to a consideration of how these influence practice and subjectivity (stages 5 and 6 of Foucauldian discourse analysis). This section addresses the research aims 4, 5 and 6 identified earlier:

4) what is the relationship between discourse, the construction of knowledge and power?

5) how do the discursive constructions and subject positions open up or close down opportunities for practice?

6) what are the consequences of taking up particular subject positions for the psychiatrists’ subjective experience?

Power/resistance and the relationship with practice

The empiricist account

The empiricist account of knowledge is regarded by Foucault (1977) to be one possible account of events, but one that has become accepted as the ‘truth’. He asserts that
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Empiricism has an ideological function to produce knowledge that has direct power implications, as when one claims an alliance with the 'truth' then that is a power play. However, it was not his intention to explain why power takes place, as this would begin to attribute the devices of power to a singular 'author'. Instead he was interested in the effects power exercises. It is therefore the task of the discourse analyst to "discover how these discourses or regimes of truth operated in relation to the dominant power structures of a given society" (McNay, 1994, pp.54).

This analysis of the psychiatrists' empiricist accounts of knowledge indicated that a particular version of events was put forward which would have a direct impact on clinical practice. This account knowledge is used most often to pronounce the 'truths' about the human condition (McHoul and Grace, 1993). Using the empiricist account, stimulant medication was constructed as the most 'effective' intervention for ADHD. This account of knowledge will have the opposing effect on the other, alternative forms of knowledge identified. Foucault (1980) called these alternative knowledges 'subjugated voices', those that have been disqualified as inadequate or naïve, and are often ranked beneath science. These 'other' forms of knowledge will be discussed later, but it is worth noting how the more dominant, 'official' knowledges work as instruments of 'normalisation'. They attempt to manoeuvre populations into ways of thinking and acting (McHoul and Grace, 1993). Foucault called this process a 'power relation', in that methods of power in their 'modern' form have assumed responsibility for the categorisation of children with ADHD and determined the ways in which clinicians 'should' intervene.

The effects of power are not to be thought of as negative, but as producing 'reality' and rituals of 'truth'. However, as the empiricist form of knowledge appears to be the most dominant in terms of interventions for ADHD, the other subjugated forms of knowledge therefore hold less power. It is through the reappearance of this occluded set of disqualified knowledges, beneath the required level of scientificty, that criticism performs its work (Foucault, 1990). This is where the discussion will now turn its attention.
The contingent account

A comparison between these two ways that the psychiatrists ‘do’ knowledge highlighted incongruence between diagnosis and interventions for ADHD. An empiricist account was often used to construct a convincing and indisputable case for the use of medication to intervene with ADHD. However a more contingent account of the diagnosis of ADHD was often deployed. Indeed, it became evident that the difficulties around making a ‘formal’ diagnosis often resulted in the psychiatrists using their clinical experience and judgement. The value of this form of knowledge was clearly questioned by Dr Kelley’s assertion (excerpt 7, transcript 10,) that diagnosis was “at best a clinical guess”. This conveyed a reluctance to rely upon clinical judgement. In addition, others expressed more of a dichotomy between the uses of empiricist knowledge. This took the form of reliance upon contingent forms of knowledge to make a clinical diagnosis, whereas a more empiricist approach to diagnosis was valued to conduct research trials. This observation assisted in the deconstruction of accounts of knowledge as it attends to other versions that may have been subjugated. At times the empiricist discourse was constructed as ‘less valued’ in ‘real’ clinical work and of more relevance to research, thus reconstructing the dominant discourse of empiricism as secondary to contingent accounts in clinical settings. Furthermore, the way that some of the psychiatrists constructed diagnosis as more of a clinical judgement, but then relied upon an empiricist account of knowledge concerning intervention may question the ‘validity’ of both research and practice. This could be explained at two levels. Firstly if research trials were conducted on clients whose diagnosis is not determined ‘empirically’ then the generalisability of the outcome of the results would be in question as the participants may not be a ‘representative sample’. With the difficulties around diagnosis (Taylor, 1994) it could be argued that the positive therapeutic effects of medication from research trials must be interpreted with caution as the participants may have inaccurate diagnoses. Also, therapeutic effects of stimulant medication are not unique to children diagnosed with ADHD (Santosh and Taylor, 2000) so the results would appear to be positive whoever was a participant.
Secondly, if research participants are diagnosed in a different way to clients in the clinical population, then results of the former group may not represent the latter. This ‘misfit’ would mean that the ‘knowledge base’ derived from the research trials would be of limited clinical value.

The social contingent account (familial) of knowledge was also identified in the analysis. In the example given (excerpt 9), the parents’ contribution to the selection of intervention is constructed as an account of knowledge that is less valuable than the empiricist account. The psychiatrist does not construct the parental account as a valuable form of knowledge, but as a difficult response that has to be worked around. In doing this, the social contingent account of knowledge (familial) is nothing more than one discourse that is secured within the bounds of a more dominant, scientific discourse. This subjugation of a familial discourse could be described as a ‘relation of power’ (Foucault, 1979). It serves to make a division between types of knowledges which positions one form of knowledge over another. Again, this is central to issues of practice as the parental account of knowledge is constructed as ‘inferior’, which could have serious implications considering the extent of knowledge that parents may have of their child. In addition, in the identifiable struggle for power of doctors over patients (Foucault, 1981), a more subjugated familial discourse may remain unheard. This is an issue that has been identified in the social constructionist thinking around both family therapy and psychoanalytic approaches (Lamer, 2000). In contrast with dominant professional hierarchies of knowledge, these therapists aim to suspend their own ‘expertise’ to empower the families and work with the families’ own belief systems.

The effects of moving between empiricist and contingent accounts
The two accounts of knowledge appear to be positioned on a hierarchy of ‘truth’, which is dominated by the empiricist account. However, power and resistance always operate in tandem (Foucault, 1977). In this case, the resistance that comes in the form of the contingent account could dislodge the empiricist account from the position of ‘truth’. Foucault describes this implicit threat as creating the need for the ‘truthfulness’ of certain
discourses to be re-affirmed constantly. This was evident in the section of the analysis that identified the movement between empiricist and contingent accounts of knowledge in relation to risks. This will have an impact on what can be said and done in practice.

The analysis of excerpt 10 (transcript 10) is an illustration of how competing accounts of 'knowledge' are deployed in the power/resistance relationship. In reference to the risks of stimulant medication Dr Wolf deploys both a social contingent (familial) and a personal account of knowledge to talk about the 'horror' of putting a child on drugs. As indicated in the analysis, Dr Wolf then moves to a professional account to disconfirm the initial account of medication as horrifying. Finally, there is one final shift away from the initial account as she deploys an empiricist account to construct medical interventions as a reasonable scientific experiment. This shows how a movement between accounts of knowledge are important in suppressing other resistant accounts, which in turn re-affirm the dominance of medical intervention.

This movement between the two accounts of knowledge would have implications in relation to practice. Both personal and social contingent accounts of knowledge, in terms of the risks of giving children medication for ADHD, become subjugated discourses as they are marginalised by the dominant empiricist account. This serves to legitimate this mode of intervention despite the acknowledgement of considerable concerns to the contrary. This is an important point in relation to practice when one considers the potential/hypothesised risks of medication outlined in the introduction (Swanson, Cantwell, Lemer, McBurnett, Pfiffner, and Kotkin, 1992; Breggin, 2000).

Alternative movements between the two accounts of knowledge are also apparent in psychiatrists' discourses about risk. In excerpt 13 (transcript 1) Dr DePaul talks explicitly about how in the absence of empirical evidence, institutional influence, which is another form of contingent account, continues to actively support the use of medical interventions for ADHD. This is another example of the way that competing discourses, or those that are resistant to treating ADHD with medication are 'silenced' to reaffirm this approach as
the 'best'. This is an interesting 'power play' as without the empiricist account of knowledge to promote the medical approach an alternative account is brought forth to achieve the same effect.

The empiricist account was often constructed as paramount to 'accurate knowledge' in the treatment of ADHD, but empirical information was not always available. What replaced these absences? Risk could have been attended to more directly, however this would have given voice to 'resistant', previously subjugated discourses. Instead, the absences were often used to reaffirm the medical approach to intervention. When absences in the empiricist account of the longer-term risks of medication were identified, personal and professional contingent factors were often deployed to attend to the benefits only. This could be seen as a process that maintains the dominant discourse around the use of medication, which will occlude other interventions, including clinical psychology. Hence, the discursive constructions of knowledge around intervention will limit the possibilities for action within clinical practice whilst securing psychiatric power over the 'disorder'.

In accordance with Foucault's thinking, this discussion of the relationship between discourse, knowledge, and power, does not intend to identify the psychiatrists as professionals that are in a position to 'create' power. Power is not something that is wielded by a particular person or group but a 'discursive relation'. Power is located outside of conscious or intentional decision, and is believed to install itself. Subjects act as a channel for the flow of power as it circulates, or functions in the form of a chain.

This explanation of power can be used to help interpret the psychiatrists' movement between the empiricist and contingent accounts of knowledge. That is, rather than the psychiatrists being seen to create a discourse that promotes the use of medical interventions for ADHD, they can be understood as being vessels of power. This explanation may go some way in explaining why personal contingent factors, such as concerns over the risks of medication, became discourses that were subjugated by other
accounts. As dominant accounts of knowledge are constructed regarding the most ‘effective’ interventions for ADHD, psychiatric power is installed and maintained by way of a self-verifying process. Positions that are ‘resistant’ to the dominant discourse are then subjugated through power plays of ‘truth’. Through this process alternative accounts of intervention are constructed as ‘inferior’, resulting in approaches such as clinical psychology being marginalised. Professions outside of the chain of power would then experience difficulty in being heard in relation to intervention approaches.

Temporal dimension
Constructions of knowledge are neither absolutely fixed nor open to the fleeting changes of the moment (McHoul and Grace, 1993). In fact, Foucault (1980) showed how ‘truths’ are subject to change and reorganisations through turning the focus onto the historical development of concepts of knowledge. Unfortunately, there is insufficient space to uncover the archaeology of ‘knowledge’ in this discussion. However, the ‘temporal constructs of knowledge’, identified in the analysis section begin to contribute to the understanding of the fragility of such concepts over a snapshot of time.

This analysis of the temporal constructs of knowledge indicated that intervention approaches in ADHD appear to be in a state of transformation as medication is being recommended as the treatment of choice. The psychiatrists constructed a graphic image of the way that the momentum is gathering behind this approach. Research, governmental guidelines (NICE), and psychiatric practice and opinion are vessels of power that are strengthening the dominant empiricist account and in turn, medical intervention. As indicated by Dr DePaul (excerpt 14, transcript 1), the impetus behind using medical interventions has reorganised the psychiatrist into a position where employing psychosocial interventions is “harder and harder to justify”. This clearly marginalises psychological intervention as well as alternative approaches. Considering the absences around the empiricist account of risks for this choice of intervention and the ‘personal’ concerns of the psychiatrists that were identified, this movement in the field of ADHD appears to be surprising if not alarming. However, as discussed, the psychiatrists
should not be viewed as being in a position of omnipotence, but as vessels through which power flows, often silencing resistant, contingent constructions of knowledge.

**Discourse positioning and subjectivity**

This section explores the relationship between discourse, positioning and subjectivity. Such 'speculation' is an important part of Foucauldian discourse analysis and is perhaps more acceptable than in other social constructionist approaches such as the discursive psychology approach (see Edwards and Potter, 1992). Having considered how discourse affects practice, subjectivity is concerned with what can be thought, felt and experienced from within various subject positions.

For example, many of the psychiatrists were positioned as clinicians who operated within the ‘rules’ outlined by the empiricist account. Being positioned within a discourse of empiricism allowed the psychiatrists to attribute responsibility to science for their clinical reasoning. In addition, such positioning can be seen to reduce any dissonance concerning the choice of interventions as the empiricist account of knowledge is positioned as superior to a contingent account. Therefore, the psychiatrists may not only disclaim responsibility for medicating children diagnosed with ADHD, but may actually feel less guilt about it too.

This was certainly evident with Dr DePaul (excerpt 13). Initially, Dr DePaul adopted a ‘neutral’ position of ‘interested onlooker’ that may have felt comfortable as he was ‘removed’ from a position of responsibility. He then repositioned himself as ‘insider’, a practitioner who is aware of the limits to knowledge around the medical approach to ADHD. This could be seen to evoke feelings of discomfort as he acknowledged absences in the empiricist account of knowledge. However, in excerpt 14, Dr DePaul goes on to take up a position of powerlessness because, as time progresses, he ‘has’ to practice in the way that is ‘dictated’ to him. These positional moves may invoke feelings of helplessness in the psychiatrist as he feels that he must practise in a way that he is not comfortable.
with. In addition, despite his acknowledgements of discomfort, the removal of responsibility may leave him feeling less guilty about prescribing medical interventions.

By way of scientific data and ‘facts’, the empiricist account may also make available the position of ‘expert’ for the psychiatrist. This ‘expert’ position might serve to meet personal and professional needs, which will impact on perceptions of self-esteem. In reciprocal fashion, this positive self-evaluation will continue to contribute to the dominance of some versions of knowledge over others.

**Analytic reflections**

Adopting a relativist approach makes it very difficult to justify one particular reading of a text as ‘better’ than others when using discourse analysis (Burr, 1995). It is important not to ‘close off’ the text to alternative readings, but to acknowledge that these research findings are open to other interpretations that are potentially, equally valid (Burman and Parker, 1993). To facilitate the evaluation of validity and reliability, specific measures were taken in this study (see method, reflexive box 4).

Part of the reflexive process central to discourse analysis is the researcher’s contribution to the study. This has been addressed throughout by considering my clinical experiences, positioning, and ethical reflections. Hopefully, offering explicit accounts of the text and clear interpretations has complemented this. However restrictions of space have limited the extent to which my own role in the research could be reflected upon. Otherwise, it would have been interesting to bring into the analysis pertinent ideological issues. For example, the method of discourse analysis is a social constructionist approach that moves away from traditional empiricist values. This shift in epistemology is mirrored in this study as empiricist accounts of knowledge were deconstructed in what could be perceived as a ‘critical’ act. It could be argued that the epistemological framework could have predicted some of the results before the study was undertaken. However, it is unlikely that the different versions of knowledge, their function and their implications for practice could have been predicted at the outset of the study.
To be able to use discourse analysis depends on the understanding of a difficult theoretical framework (Parker and Burman, 1993). However, unlike analyses in traditional psychology, it cannot pretend to ‘discover’ things in the same ‘exciting’ way. This is partly because of the need to remain epistemologically consistent, which means accepting that there are no ‘truths’ only different versions. Researchers from other disciplines may criticise this approach in limiting the scope for new ‘discoveries’.

Furthermore, discourse analysis resists explicit ‘how to do it’ rules, leaving the approach open to the interpretation, but also to criticism. The absence of rules certainly had an impact on me throughout the research process. Managing the movement between more traditional mainstream ideas about what research is whilst attempting to remain within a social constructionist framework was an immensely consuming process. Also the move from a micro (analysis) to a macro (discussion) level examination of the discourses was a difficult transition to make, but a necessary one to understand implications for practice. Nonetheless, the further the interpretations are from the data at a micro level, the more open they are to criticisms around validity and reliability.

Finally, to ensure that this piece of research is more than an academic exercise, and so that it can begin to influential, it needs to be disseminated. The unmasking of subjugated and marginalised discourses needs to be extended beyond this analysis and actually applied to this completed study. There is often some resistance to publish qualitative research in mainstream psychology journals (Turpin, et al., 1997), however these are the forums where it will have the most impact upon clinical thinking and practice.

A further recommendation would be to apply the same research methodology to psychologists’ accounts of interventions for ADHD. This could explore whether there are alternative constructions of knowledge and whether this group of professionals are organised in the same way in relation to power.
Chapter six - Conclusion

Using discourse analysis two accounts of knowledge were identified in relation to interventions for ADHD. The empiricist account was used to construct stimulant medication as the most ‘effective’ form of intervention. This appeared to be the most dominant, ‘official’ form of knowledge. The second account of knowledge, one that had previously been occluded was the contingent account.

Despite a reliance on an empiricist account for intervention, discourses of diagnosis were more reliant on contingent accounts. This highlighted an interesting ‘conflict’ between the two discourses. This raised questions about the ‘construction’ of the disorder, and in turn the ‘validity’ of the empirical accounts of interventions, and whether the research findings are applicable to clinical practice. By identifying this more marginalised account of knowledge, the power of the dominant empiricist account began to be resisted.

Discourses of risk moved between the empiricist and contingent accounts of knowledge. The psychiatrists invoked an empiricist account to counter the risk effects of medication. In the absence of empirical information a contingent account was then brought forth to achieve the same effect. This was another way that a dominant discourse, that of the positive effects of medical intervention, was attended to as the negative effects were minimised. This maintains the power of psychiatric intervention and further marginalises alternative approaches.

Psychiatrists’ movement between the two accounts of knowledge was discussed in terms of them being the ‘vehicles’ rather than the ‘creators’ of power. This can go some way towards explaining the way that empiricist and even professional accounts of knowledge, subjugated personal contingent concerns. Furthermore, psychiatrists can be seen as a link in the ‘chain of power’ as the dominant discourses of intervention for ADHD are maintained through research and governmental guidelines, as well as through psychiatric practice and opinion.
Finally, the effects of these two accounts of knowledge were considered in a temporal dimension. This indicated that the momentum behind medical interventions is increasing with time. The consequence of the strengthening of this dominant discourse is that alternative approaches to intervention are becoming harder and harder to justify. The way that the medical approach is dominating the field positioned some of the psychiatrists as powerless over how they practise. Nonetheless, as the responsibility over practise is assumed by higher professional bodies, the individual practitioner’s concerns are somewhat alleviated. This further subjugates personal contingent accounts thus feeding back into the self-verifying cycle of power.

It should be pointed out that discourse, knowledge and power do not create an impenetrable web that cannot be challenged and ‘developed’. Indeed, from this study it is evident that by giving voice to marginalised discourses, other versions of events begin to challenge the existing ones. However, it is worth noting at this point that Foucault cautioned against looking into the future and postulating which versions of events would be ‘better’ for society. He resisted making any universal political or moral judgements, as he was aware that what appeared to be change for the better often turned out to have undesirable consequences. Foucault’s main focus was to understand the ways that we understand ourselves so that we can begin to question their legitimacy and challenge them. In doing so, previously marginalised knowledges will be given voice and empowered. In keeping with Foucault’s ideas I would also resist the temptation to project these research findings into the future and make explicit recommendations about what ‘should’ be the ‘correct’ version of events.

This study has ‘unmasked’ some of the knowledges that influence the choice of intervention for ADHD and the knowledges that create ‘reality’. More importantly, this study has endeavoured to give voice to those marginalised forms of knowledge whose resistance challenges prevailing inequalities of power.
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References


The construction of knowledge: 
A discourse analysis of psychiatrists’ therapeutic repertoires for children with attention deficit hyperactivity disorder


Grixti, M. (2001). Discourse analysis is a research methodology incorporated within the theoretical framework of social constructionism: Critically review the significance of discourse analysis and its application in the field of clinical research. In M. Grixti, *Portfolio I*. Submitted as part fulfilment of PsychD Clinical Psychology requirements.


MATERIAL REDACTED AT REQUEST OF UNIVERSITY
Consultant Psychiatrist: Dr. Pava (Male)

Mark: So if I start with some quite general questions around ADHD/hyperkinetic disorder just so we can establish a common understanding before going into some more detail about treatment. So could you tell me how you would describe ADHD or hyperkinetic disorder?

Dr Pava: Hyperkinetic disorder would be a child of less than 7 having symptoms of hyperactivity, impulsivity, inattention with or without oppositionality happening at both at home and at school but having an impairment as a result. That would probably be what was the official definition. And the ADHD definition is a more loose definition of that, it can be happening only at home or at school a milder form of the character of the disorder.

Mark: In your practice do you use one or the other or both definitions?

Dr Pava: I tend to use the diagnosis of the ICD-10 which is the hyperkinetic disorder but have used the term of ADHD in children who don't fulfil the criteria for the clinic where I work, I think do meet the criteria for the hyperkinetic disorder, by the time they've reached me so,
probably, in another setting I might have used the context of ADHD because kids don't meet the criteria of hyperkinetic but not in this clinic so much.

Mark warrants the constructed continuum of problems.

Mark: And this is the more severe end?

Dr Pava: Yes that's right.

Mark: And so you mentioned the 3 main symptoms (.) I'm just wondering how you judge thresholds when you are making a diagnosis.

Dr Pava: The basic idea is to have a look at whether the inattention in keeping with whatever the age of the child is (.) not only his chronological but his mental functioning. And whether it is in keeping with the context, so it is not just to be taken as erm being overactive compared to his peers, compared to what you'd expect of his age range you know in the family, put together, so that would be the same in all of the domains of the symptoms (.) erm and so, by necessity, most erm diagnostic processes for ADHD would include at least some understanding of what the cognitive level of functioning for the child is because you need to have that on board because the child could be 20 and functioning as a 5 year old and obviously the activity levels of a 5 and 10 year old are different so you need to take that on board.

Mark: Right, so you'd measure cognitive functioning as well would you?
that would be done.

Mark: And how do you measure that?

Dr Pava: Well yes I mean I the clinic we have the

Psychology positioned as assisting the psychiatrists in making a differential diagnosis. "Luxury" may also suggest that the psychologist is an appendage rather than a necessity in this arena colonised by medical practice. The collective term of "we" is used when talking about diagnosis which positions the 2 disciplines shoulder to shoulder - is this maintained in treatment bit?

luxury of having psychologists in the team so we do use the

71: WISC and so on (.) most kids do get tested intellectually

Psychology as rescuer

and if we do find that there is no specific problem with

intellectual functioning then we do go ahead and do further

testing to make sure that they don't have any specific

reading disability, or spelling or whatever (.) so it would

be making sure that the construct of dyslexia doesn't exist

A constructed quantity of sufficient intellectual functioning.

Luxury of having psychologists in the team so we do use the

most kids do get tested intellectually

and if we do find that there is no specific problem with

intellectual functioning then we do go ahead and do further

testing to make sure that they don't have any specific

reading disability, or spelling or whatever (.) so it would

be making sure that the construct of dyslexia doesn't exist

Part and parcel means an essential ingredient. His choice of words position his clinic as an "expert" and conclusive in it's judgements. Unlike others, he does an expert diagnosis in every case (EXTREME CASE FORMULATION - clear cut and non-negotiable).

include but it depends (.) I'm sure that not every clinic

would have the luxury of being able to do it, but that would

be what I would want to do in every case.

Mark: Even with the luxury of being able to do a wider

assessment is it difficult to isolate ADHD from other

comorbid factors?

---MEMO: memo15
DISCLAIMER - concedes difficulty then uses empirical criteria to validate diagnostic accuracy.

->BEGIN: Diagnosis. Contingent
90: Dr Pava: Yes to some extent but usually if you've got
->END: Diagnosis. Contingent

->BEGIN: Diagnosis. Empirical
91: a child who has symptoms present before the age of 7, so
92: we are talking about quite an early onset, and you are sure
93: that a disorder like anxiety or depression isn't actually
94: being able to explain the symptoms better than a label of
95: ADHD then yes, you would go for the other label but
96: otherwise I think that if you have someone got symptoms of
97: all the domains to not have another disorder that could
98: explain it better, whether it's depression, anxiety, or

->MEMO: memo17
Introduces other psychiatric constructs and uses an elimination process to accept or reject the ADHD diagnosis. Being "sure" something else isn't present makes him sure that another "label" is appropriate. RHETORIC OF ARGUMENTATION (Edwards and Potter) - By an impersonal operation of logic - process of elimination. If A = B then C.

99: whatever or intellectual disability (inaudible) but apart
->END: Diagnosis. Empirical
100: from that if you are fairly sure that everything is fine and
101: the child still exhibits these symptoms in the context of
102: both home and at school (.) erm then sometimes they show it
103: only in the clinic.
104:
105: Mark: Okay, with someone who is showing fairly pure
106: symptoms of ADHD across different setting, quite pervasive,
107: I wonder if that is considered as a mental illness or not?
108:
109:

->BEGIN: Diagnosis. Mixture
110: Dr Pava: Yes I think it is, I personally think that it
111: is a mental disorder just like anything else. It would be
112: wrong to assume that it is wrong to assume that it's just a
113: thing that doesn't have a basis for it (.) it could be ()
114: part of the problem is that many people refuse to give the
115: label or don't want to label the child because they think

->MEMO: memo18
This whole passage is full of interesting rhetorical strategies. He goes from a personal opinion that it "is" a mental illness to an objective account of it being "wrong" to not recognise it, to extreme lay terms around "lumping symptoms" together to fend off criticisms of a non empirical procedure, to forming an alliance with the non-psychiatric and medically accepted diabetes (with envy at the simplicity of their diagnosis) E.C.F - The absence of a "very specific" test could be interpreted as a weakness in diagnosis in
empirical terms but he defends the absence of this by saying that the failure to test other psychiatric problems is a marker of comparability justifying this procedure. Brings an open question into the more secure arena of medical model.

116: it's just a badly behaved child or a child who has got some symptoms and we are wanting to lump them into a diagnosis
118: but I think it's more than that, I think that these kids really do have a problem and need to be treated for it just because you've got a test that shows you that blood sugars are high that's why it suddenly came to be seen as a disorder, whereas in ADHD because we do not have any specific test for it (.) erm very unlikely to develop a test that is very specific for ADHD erm but that's the same for most psychiatric problems, there is no diagnostic test for almost any psychiatric disorder.

-->END: Diagnosis. Mixture

128:
129: Mark: I suppose I'm thinking that with something like diabetes that is very much located within the individual,

-->BEGIN: Diagnosis. Empirical
130: diabetes is located within the individual, where with ADHD there seems to be (.).

-->END: Diagnosis. Empirical

132: Dr Pava: (. ) well I think that that's the problem, people presume that diabetes is located within the individual actually even with a disorder that is an infection (.) forget diabetes but even tuberculosis which is clearly an infection (.) even there you have all 3 components you have a biological component, a psychological component, and a social component. For example if you've got tuberculosis you can end up having (. ) the biological thing would be the bacteria, and the psychological would be the coping mechanism and how he copes with stress and that, and if the immune system (. ) if you are stressed the

-->MEMO: memo16

Mark has introduced his own beliefs which may be contrary to those held by the interviewee.

-->BEGIN: Diagnosis. Empirical
136: infection (. ) forget diabetes but even tuberculosis which is clearly an infection (. ) even there you have all 3 components you have a biological component, a psychological component, and a social component. For example if you've got tuberculosis you can end up having (. ) the biological thing would be the bacteria, and the psychological would be the coping mechanism and how he copes with stress and that,

-->END: Diagnosis. Empirical

143: and if the immune system (. ) if you are stressed the

-->MEMO: memo21
Shifts in knowledge - The psychiatrist chooses not to discuss his reasons why ADHD is a mental illness but actually attempts to argue his point by moving out of the field of mental illness and into the field of medical illness. He then applies his medical understanding (empirical) to mental illness which bases his arguments on a very different diagnosis.

144: immunity will be worse and you have a higher chance of
145: developing illness with tuberculosis, and then of course
146: there's the social thing in that if you are in an
147: overcrowded situation where someone else had tuberculosis
148: it's because of the overcrowding that you are being exposed

-->BEGIN: Diagnosis. Mixture
149: in the first place (,) so you've got, even in a very very
150: medical model of illness you have all 3 components so I

-->MEMO: memo20
He sets up a continuum of a "very very" medical model and asserts that he recognises the extreme (ECF). He then wards off criticism of a medical model by placing his ideas at a milder end of it. Moves from empirical to personal opinion which strengthens empirical opinion as balanced (Harper 1994 - p137).

151: don't see why you can't use the same understanding for a
152: disorder like ADHD (,) but it has all 3 components I think.

-->END: Diagnosis. Mixture

153:
154: Mark: And which of those is the major factor in the
155: cause of ADHD?
156:
157: Dr Pava: I mean I think that's going to be a very erm
158: difficult one to erm answer (,) because I don't think that

-->BEGIN: Diagnosis. Empirical
159: ADHD is a unitary or a homogenous group, I think it has
160: subsets in that (,) erm having different roots into the

-->MEMO: memo22
He acknowledges how he cannot answer the question, speaks of the higher potential for a biological cause, then acknowledges the importance of social interactions, almost "rules out" the uniform statement, and finally despite having poor evidence of one cause states that on top of little evidence he thinks it is biological. SHOW CONCESSION - i) potential to be biological (ii) challenges own statement (iii) qualifies and reasserts initial belief. This process strengthens own position.

161: common syndrome (,) presentation. I think that the

-->END: Diagnosis. Empirical

162: hyperkinetic disorder, the more severe one that we see, the
163: ones we make diagnosis of, I think that has a higher
164: potential to have a biological (,) route erm and even then
165: would have psychological, social erm you know interactions
166: with that (,) so I think that would be more in that group

-->BEGIN: Diagnosis. Empirical
167: where it was to (,) someone there who's having erm a less
168: severe form of ADHD and if it is only in the context of home
169: and not elsewhere then that situation may be due to the fact
-->END: Diagnosis. Empirical
170: of parenting or interactions (.) might play more of a role
-->BEGIN: Diagnosis. Contingent
171: in that particular subset of kids so I don't think that we
172: can rule out and say (.) give a uniform statement saying
173: that it is more biological than (.) but I do think that it
174: has biological underpinnings erm.
-->END: Diagnosis. Contingent
175:
176: Mark: And those biological or neurological factors would
177: environment actually shape the neurological functioning?
179:
-->BEGIN: Diagnosis. Empirical
180: Dr Pava: It you can have both erm I mean it's a
181: fallacy to believe that genetics doesn't play a role in the
182: environment because we know that it does and parents of
183: children with ADHD at least 1 in 4 to 1 in six who have
184: diagnosed ADHD themselves, if you've got a parent with
-->END: Diagnosis. Contingent
185: undiagnosed ADHD then they're going to be inconsistent in
186: parenting (.) they're going to find it more difficult to
187: control their temper and erm so on and so forth. So you're
188: going to have an environment that is not ideal for the child
189: anyway but why that environment came about is probably the
-->BEGIN: Diagnosis. Contingent
190: biology of the parent so as to whether it is environment or
-->MEMO: memo23
This suggest that it is down to personal view. He moved from being definite about
biology to accepting that it is personal view
191: biology I think is a moot question, I think that there is a
192: contribution of both erm it just depends on how one views it
193: and what particular child is in front (.) and it is almost
-->END: Diagnosis. Contingent
194: impossible, I think, to look at a child and say that there is
195: this much biology in this child and this much hyperactivity
196: in this child I think that there would be an interplay
197: between multiple factors.
198:
199: Mark: That's interesting that you were saying about it
200: depends how one views what determines cause and erm
201: thinking about the genetic lineage, through erm families, I
202: suppose that someone from a more psychodynamic background
203: may say that it is to do with more intergenerational
204: patterns erm and psychosocial factors rather than it
205: necessarily being biological.
206:
207: Dr Pava:  Well I think that erm I'm not of the opinion
208: that you can explain habitability of the (.) because ADHD,
--->BEGIN: Diagnosis. Empirical
209: the genetics of ADHD is one of the most highly heritable erm
210: that we have got in psychiatric disorders, apart from autism
211: ADHD is the next highest heritable condition that we have
--->END: Diagnosis. Empirical
212: (.) and in terms of the intergenerational hypothesis from a
213: psychodynamic view I don't think that that would stand the
214: test in terms of the 80% that we are talking about (.) and I
215: suppose that the other thing is that in terms of the
216: psychodynamic view of ADHD, we really do not have much to
217: suggest that that's a causal link (.) it modifies I think in
218: terms of what the outcome would be but I don't think that
219: it's the causal link to producing the disorder.
220:
221: Mark:  Right, I see yes. Okay now if we could move on to
222: treatment from there, it seems like a good place to do that,
223: I wonder which forms of treatment you would advocate for
224: this disorder?
225: --->BEGIN: Intervention. Empirical
226: Dr Pava: Well I think that the whole support from (3)
227: erm research is for medication (.) that's stimulants in
228: treating ADHD erm especially if it is hyperkinetic disorder
--->END: Intervention. Empirical
229: then I think we should go with medication as treatment for a
--->BEGIN: Positioning psychology.Psychology as abuser
230: child with hyperkinetic disorder diagnosed and not waste
--->MEMO: memo24
Following difficulties of diagnosis, he states that treatment is certain once diagnosed.
This suggests the partly contingent process of diagnosis is then formalised and the
treatment response automatic.
231: time using non-pharmacological treatment with that
232: particular sub-group of kids (. not if you are talking
--->END: Positioning psychology.Psychology as abuser
--->BEGIN: Intervention. Empirical
233: about a less severe erm group or a child who is pre-school
--->MEMO: memo25
These criteria fit in with the administration of the culture of professionals. Logical steps
proposed (RHETORIC OF ARGUMENTATION?)
and having symptoms (.) then in that particular group I would probably go for behavioural intervention first and add medication if it doesn't erm if it is insufficient. I think social skills training will have to be used as part and parcel with most kids erm irrespective of whether you use medication or not (.) so and if you've got symptoms of only at school and not at home then I would still think that medication has a role but in terms of education and looking at if they have specific spelling or reading or learning difficulty that is actually hampering their attentional process that would have to be tackled specifically (.) and —BEGIN: Intervention. Mixture similarly, if it is home specific and not happening at school —MEMO: memo26 Is this more about the child fitting with the way professionals have carved up treatment approaches - but he acknowledges the child as central. then in that context again looking at parenting and working around that as well so it would have to be viewed in the context of what's the particular profile of the child. —END: Intervention. Mixture

Mark: That's interesting, so if it was either one or the other, home specific or school specific, there is still a case for using medication even though the child shows that in other environments they don't show these symptoms?

Dr Pava: Yes because the thing is that erm from research and everything, if you look at them in great detail it is to do with differing different thresholds for reporting(.) a to whether the child has symptoms what —END: Intervention. Empirical

Dr Pava: setting or not, for example, if you look at the Asian sub-population in boys parents would report less hyperactive behaviour (3) even though it's the same amount of social/cultural contingent factors hyperactivity because the threshold is higher in certain situations but if you got a class where most of them are disruptive then a child with ADHD could still be considered in the context of an EBD school, to be okay. So a teacher's rating of the hyperactivity of that child would
Considering the talk on Asian cultures the psychiatrist may be saying that the professional culture has superiority in identifying symptoms/what is socially acceptable. Ties in with Harper 1994 - flexibility of criteria - moving between emp/cont accounts.

Mark: so (3) you sound pretty sure of the effects of medication, especially with those at the more severe end of ADHD, I wonder how that knowledge came about, how we know this?

Dr Pava: I mean if one looks at research it is probably the largest research area in child psychiatry is whether stimulants work in ADHD (.) in this point in time
299: response rates are roughly between 65-75 so it would be 
300: around 70% that respond to stimulants, it's not that 
-->END: Intervention. Empirical
301: everyone responds to it but if you don't respond to one 
302: stimulant in an ideal dosage then another stimulant might 
303: still respond (.) so it's not just that if you try one 
304: stimulant and they haven't responded that means that they 
-->BEGIN: Intervention. Empirical
305: won't respond to another (.) so if you use all, 2 or 3 of 
306: the stimulants at different times you actually get a 
307: response rate at about 90 to 95 % that respond to medication 
308: (.) so the findings are robust and we are we are talking 
-->END: Intervention. Empirical
309: about short term response and that is the other thing with 
310: stimulants, they are usually methylphenidate, you see a 
311: response within 30 minutes so you don't need to wait for 
-->MEMO: memo30
Moved from the strong evidence argument to a clinical one to bring in parents and teachers as witnesses.
-->BEGIN: Intervention.Contingent
312: days to see change (.) you just give the medication in doses 
313: and usually you give the parents or teachers a ring to find 
-->BEGIN: Positioning psychiatry.Psychiatry as rescuer
314: out what happened and the child is so different (.) so it's 
315: that dramatic. 
-->END: Intervention.Contingent 
-->END: Positioning psychiatry.Psychiatry as rescuer
316:
317: Mark: Right. With such a high response rate of 90-95 % 
318: (.)
319:
320: Dr Pava: When you use different types of stimulant. 
321: The average would be around 70 so you've got around 30% who 
322: don't respond and then you use a different stimulant and of 
323: that 30% you would improve it of another about 20%. 
324:
325: Mark: So it has a high impact on these children with 
326: ADHD. Does it also have a significant impact, this drug, on 
327: children who haven't got ADHD? 
328:
329: Dr Pava: Yes medication in terms of stimulants would 
330: have an improved attention span for those who would have 
331: inattention due to other reasons too. For example if you 
332: have a child who has got erm head injury having inattention, 
333: medication would help you with that condition so it's not
A criticism of the practice-theory link!

Mark: I was wondering how if ADHD is so effective with sorry if medication is so effective children with ADHD and it is also effective on children without ADHD, what does the drug actually do to the child?

Dr Pava: I mean in terms of what medication does there are lots neurochemical things that it does but erm one of the things that recently has been erm reported about is what happens to children with ADHD, their brains is that normal development if you look at normal brain development in children between the ages of 4 and 22, erm normal development and then look at what happens in ADHD there are significant differences in how the brain develops and erm for a start children with ADHD have a smaller brain there are parts of the brain where there are differences of up to 14 to 16% in size for example the cerebellum is smaller by 14 to 15% compared to a normal child, in ADHD. So what's been done is they've looked at erm erm brain size of children who have been treated with medication and those who haven't and what's been shown clearly that instead of medication having a negative impact on the brain development. In fact those who have been treated with medication actually the brain develops more like a normal brain compared with the ones who haven't been given medication so that's part of the reason why I think that medication really does have a robust erm and a role to play in treating the disorder.

Mark: Right I see.

Dr Pava: So I'm not saying that erm medication is...
368: entirely (.) the answer to everything but I think that it
369: does have a significant role to play and also ADHD is one of
-->END: Intervention.Mixture
370: the few conditions which has erm low response rate to
371: placebo so compared to a lot of other disorders, for example
372: depression where you have quite high rates of placebo
373: response, you give them a non-active drug and they respond,
-->BEGIN: Intervention.Mixture
374: 25 to 20 % respond but with ADHD you have a very low placebo
-->MEMO: memo33
Introducing other disorders to justify treatment. Also to fill the gaps of non-knowledge to maintain superiority.
375: response (.) so it can't be because of it is a pill it has
376: to be something that the pill does.
-->END: Intervention.Mixture
377:
378: Mark: Was the pill designed specifically to target ADHD?
379:
-->BEGIN: Intervention.Mixture
380: Dr Pava: In terms of erm...no. Stimulants were not
381: designed for ADHD it was actually produced in the past for
382: medical purposes (.) it was being used for narcolepsy (.) so
383: that was what it's original use of stimulants were erm but
384: that doesn't mean much because there are lots of medication
-->MEMO: memo34
This knowledge is identified to be non-specific but then it is fiercely guarded by bringing in other treatment approaches as a point of reference. So this maintains the legitimacy but only against other psychiatric practices - are such discourses that "work" beyond question?
385: and I think the most recent one is Ibuprofen, which is just a
386: painkiller, which has been proven to have an immediate effect
387: on Alzheimer's but that doesn't mean anything in terms of
388: whether the drug was first discovered or used for one
389: disorder and whether it has any implications in terms of
390: whether it produces effects you know on another.
-->END: Intervention.Mixture
391:
392: Mark: Right, there seems to be a difference there to me
393: in that although a lot of the evidence around how effective
-->BEGIN: Intervention.Mixture
394: it is, is in, and is looked at in a very scientific
395: framework whereas the actual development of the drug was not
396: as scientific as the current trials=
-->END: Intervention.Mixture
397:
Dr Pava: I mean the development of the drug anyway anyway has got nothing to do with the disorder because it was not the disorder didn't exist at that time when the drug was there. The diagnosis of ADHD came much later it is only a diagnosis that has come in the late (inaudible) and it is in the 80s that the diagnosis came into being. Stimulants have been there since the 50s.

Mark: So the diagnosis almost fits onto the drug, rather than the other way round?

Dr Pava: No no no I don't think that's right at all that it's wrong to believe that drugs are made with a purpose for a particular disorder all the time you have drugs that are made for something else which they then find also works for a typical thing like now there's Viagra which was designed for impotence and and is an aphrodisiac for some but now you realise that it actually works for diabetic neuropathy but nothing to do with how it was produced so I don't think that drug development and whether the diagnosis already exists or not erm I don't think that it needs to follow from one to the other at all. They are independent completely.

Mark: And if they are independent processes does that question the typical theory to practice link, is practice creating the theory?

Dr Pava: No I don't think that either basically because erm in terms of the availability of the drug this is a drug that is already available in the market for treating a particular condition ok and this

Bringing in another disorder/treatment to validate this one. He states that drugs and diagnosis are independent completely. This discourse attempts to maintain an empirical knowledge base and the power of psychiatry even though it appears to undermine the theory-practice link.
Mendez - bringing forth a pathology. Pava chooses not to say "when we created it" to objectify the disorder.

-->BEGIN: Diagnosis. Empirical

430: condition of ADHD when it came into being it was purely

-->END: Diagnosis. Empirical

-->BEGIN: Intervention. Empirical

431: about how and why and what the neurochemical basis was and
432: what is the dopamine hypothesis for ADHD and what the
433: hypothesis was that there is no dopamine in the brain in
434: certain parts of the brain and that was how they looked
435: for a drug that would create dopamine and what was available

-->BEGIN: Intervention.Contingent

436: was stimulants and that's how methylphenidate was used so I
437: don't really think that using a drug that was there before,
438: after a disorder necessarily has any links at all. We need

-->END: Intervention.Contingent

439: to have a theory to first try why you want to use the drug,

-->BEGIN: Intervention.Mixture

440: it's just the same with Viagra or erm whatever, it's the
441: reason why you end up using it in a very different condition

-->MEMO: memo37

Pseudo-empirical.

442: like that you know it's got nothing to do with thing, it
443: is because they knew that this particular drug increased
444: blood flow where there were restrictions and low blood flow.

-->END: Intervention.Mixture

445: So the neuropathy would mean that there was restricted blood
446: flow and that's how the hypothesis of using that in another

-->BEGIN: Intervention.Mixture

447: condition is the same thing in ADHD. So I don't think that
448: necessarily makes it less scientific, or less biological, or
449: less of a disorder as such it's interesting that it

-->MEMO: memo38

Not a matter that is worthy of thought. Close down debate. Not attend to this as it criticises theory practise doctrine. Silences and absences.

450: happens at different times erm but apart from that I don't
451: give it much thought.

-->END: Intervention.Mixture

452:

453: Mark: When we were talking earlier you mentioned how
454: there may be some psychodynamic explanations for some of
455: this but you were saying that there was not much convincing
456: research in about them. I wonder if with the amount of
457: convincing research that you have mentioned around the use
458: of methylphenidate, whether that has suppressed other
459: medical and non-medical areas which may produce less
460: controversial ways of treating ADHD=
461:

-->BEGIN: Intervention. Empirical
462: Dr Pava: No I don't think. I think it's because
463: the the if you look at the evidence base for non-
464: pharmacological treatment we have very little to suggest
465: that anything works to the extent of medication. Now
466: even in the larger a study of the MTA trials which is new it
467: shows that psychological interventions work but much less

-->BEGIN: Intervention. Contingent
468: than medication. Erm so if you're looking at it from a cost

-->END: Intervention. Empirical
469: effective perspective the cost effective view of
470: psychological intervention erm in a child with ADHD then

-->MEMO: memo39
Psychology not cost effective - this is contingent discourse that used in addition to avert
this treatment approach.
471: if you are talking about the core symptoms of ADHD,
472: inattention, hyperactivity and impulsivity, then the answer
473: is no, it is not cost effective to use psychological
474: interventions with this particular group when you can use
475: medication and get much better responses, ok. And in terms

-->END: Intervention. Contingent
476: of research, which is not a question of suppressing or
477: anything, people are working on non-pharmacological
478: interventions that were lower and have done for a long time

-->BEGIN: Intervention. Empirical
479: and erm it's only the fact that nothing seems to

-->MEMO: memo40
Psychology as hopeless for ADHD. But it is not as simple as what works but also within
the economic constraints that dictate successful interventions.
480: work that prevented it from becoming mainstream practice
481: rather than it being the other way round. Because even now,

-->END: Intervention. Empirical

482: lately people have gone back to looking at Pavlovian methods

-->MEMO: memo41
Psychology has been mislead for 100 years and is put back in it's place.
483: of trying to work with kids with ADHD because nothing else
484: seems to be really having the same kind of effect so now

-->END: Intervention. Empirical
485: they are having erm all these meters and so on to detect
486: movement and so on and the hand gets a set of vibrations
when they are moving too much (.) so they get a feedback 
that should decrease their movement and so on. And that 
sort of treatment are now being tried (.) so it is not that 
--BEGIN: Intervention.Mixture 
it is not (.) and when you look at the expense (.) how 
expensive the trials are for non pharmacological and 
--MEMO: memo42 
Knowledge is only determined within economic terms - so drugs superior. Wouldn't use psychology even if it did work due to expense - this is excellent example of subjugating a discourse. 
pharmacological trials the non pharmacological ones are much 
much more expensive (.) and in fact the MTA trials did use 
millions to do psychological interventions. The reality is 
--END: Intervention.Mixture 
that by assuming that psychological interventions from the 
MTA trial work, erm it doesn't mean that what we do as a 
psychological intervention in day to day practice is going to 
have any kind of effect to the same size to that which is 
shown in the trial because we would not be able to do that 
--BEGIN: Intervention.Mixture 
kind of thing (.) in that trial they had school 
interventions, social skills groups, holiday camps, training 
for 27 weeks, groups being run for everyone, and everything 
and that kind of a package will not be done by anyone in 
our setting with here or in America (.) and it is when you 
--MEMO: memo43 
EXF and FIGURATION and 5 part lists used here to show that the best that psychology can offer is clearly no comparison 
use that kind of a Rolls Royce kind of treatment that you've 
got a response which is roughly maybe 60% of what the drug 
medication. medication did when done properly, when the 
medication is used properly (.) so if that is what it takes 
for a response of 60% then I would argue that we shouldn't 
be wasting those kind of resources for a (.) at least with 
the core features of ADHD. I still think that behavioural 
--END: Intervention.Mixture 
interventions, and I make it very clear that I'm not talking 
about psychodynamic interventions, as I don't think that 
psychodynamic interventions have much of a role in ADHD, but 
--BEGIN: Intervention.Contingent 
I think that behavioural interventions, cognitive 
--MEMO: memo44 
Psychology positioned outside of ADHD. 
behavioural interventions or pure behavioural strategies I 
think has a significant role (.) parenting and so on (.)
518: has a role especially in dealing with non ADHD symptoms that
519: co-exist with ADHD. For example, peer interactions,
<!--END: Intervention.Contingent
520: oppositional behaviour, aggression, social skills, constant
521: quarrels between mother and child, those kind of things (.)
522: I think those areas so respond to some extent to medication
523: as well but if you're focussing your treatment on those non
524: ADHD, core ADHD symptoms then I think these kind of
525: behavioural strategies, social skills and so on have a
-->MEMO: memo45
Subject is decided and somewhat closed
-->BEGIN: Intervention.Contingent
526: significant role to play in those symptoms. I'm making it
527: very clear as to where one would like to target.
-->END: Intervention.Contingent
528:
529: Mark: I see. So do you think that there might come a
530: time where some psychological, be it behavioural or CBT,
531: interventions do target the actual core symptoms of ADHD?
532:
-->BEGIN: Intervention.Empirical
533: Dr Pava: I think that with the current knowledge at
534: the moment I don't think that we have evidence to suggest
535: that we would be able to target the core features but I
-->END: Intervention.Empirical
536: think that it has a significant role in the peripheral
537: features which I think the peripheral features are the ones
538: which actually (.) to a large extent determine the negative
539: outcome (.) as well (.) in the long term (.) so if a if a
540: child has got ADHD living in a family where the parents are
541: very hostile to the child and doesn't really praise him or
542: anything positive happening (.) and that child also has
543: oppositional behaviour that child is probably going to end
544: up having conduct disorder (.) as he grows up so I think
545: you know that if we had an intervention to decrease their
546: expressed emotions between the mother and the child to
547: increase positive interactions we might be able to change
548: the negative outcome (.) and I'm not sure that just giving
549: medication would suffice in that particular group of
-->BEGIN: Intervention.Contingent
550: children (.) so I wouldn't say that psychological
551: interventions have no role at all but if you're talking
-->END: Intervention.Contingent
552: about core features of ADHD (.) inattention, hyperactivity
553: and impulsivity for those features I think that it is going
Contrary to the psychiatric practice-theory model of treatment?

Contrary to the psychiatric practice-theory model of treatment?

Recognition and evidence for disbelieving in psychology

Recognition and evidence for disbelieving in psychology

Using empirical methods but recognising the culture differences. Which culture makes the final decision of whether the treatment is effective?

Using empirical methods but recognising the culture differences. Which culture makes the final decision of whether the treatment is effective?
587: settings.
-- END: Intervention.Mixture

588:

589: Mark: And the child (.) I wonder what the child's
590: experiences of treatment are.

591:
--BEGIN: Intervention.Contingent

592: Dr Pava: The child erm (3) amazingly a lot of children

593: who have taken medication and have shown response want to
594: continue with it (.) it becomes a difficulty when they are

--END: Intervention.Contingent

595: actually having to (.) start getting bullied in secondary
596: school and so on when they have to go out of the class and
597: get their medication from the headmaster or teacher (.) so
598: they are open to ridicule and stuff (.) so that's when
599: things start getting (.) difficult (.) and of course during
600: adolescence when you are trying to establish independence
601: and so you don't want any thing (.) you don't want to take
602: anything (.) you naturally want to become an independent
603: person (.) so that's when you start having problems with
604: medication. The few kids who do develop side effects (.)
605: they would find it difficult to (.) they would want to not
606: have medication but might be in a position to reason that if
607: they didn't take medication then they might end up getting
608: excluded from school or would lag behind and they would end
609: up taking the decision to take it (4) but parents and
610: societal values also play a big role because in this country
611: medication is not the first option (.) most parents need
612: convincing that their child needs medication (.) unlike in
613: America where, I think, you need more convincing of parents
614: that psychological interventions need to be used rather than
615: medication (.) so different societies have different values.

616:

617: Mark: Do you think that the English culture will become
618: more like America where drugs are more acceptable?

619:

620: Dr Pava: I think I think erm (3) in terms of
621: medication and so on there has been a dramatic change in
622: practice over the last three to four years where we have
623: started to prescribe much more than we ever did before (.)
624: but I still don't think that it would reach the proportion

--BEGIN: Intervention.Contingent

--BEGIN: Positioning psychiatry.Psychiatry as rescuer
A continuum is constructed in which drugs can then be looked at as needing to be increased to get a balance. Psychology is imbalanced and needs reducing. Subtle shift from psychology as useful to useless. In that he wants "middle ground" (reasonable) to "little less psychology" (more direct) to "less" to "wasting time".

because of the fact that currently more clinics, not here, more clinics do use psychological interventions as their first line and when they fail with psychological interventions only then do they consider medication and I don't think that that's correct because of the fact that not only are you wasting that much time but very often it is not audited, so you continue to go on with psychological treatment, maybe family therapy, or whatever for 2 years before you consider the diagnosis of ADHD and you treat that with stimulants and I think that 2 years is a long time for a child who's developing to have missed out on all the opportunities that might have been available if he had been diagnosed and treated with medication.
are better (.) maybe at that point in time if you've got the
Psychology as a "luxury" - this implies that it is not of use to child and family
luxury of being able to offer something more, go ahead (.)
but it doesn't seem to add much erm but in the less severe
Child's needs first? Or other economic/professional factors?
ones erm you have to make a decision based on (.) what the
needs of the child are.
Mark: You erm (.) earlier you touched on the issues that
as children turn to adolescents the medication may not agree
with their system and I wondered what your thoughts are
around the risks of using medication/methylphenidate with
children with ADHD.
Dr Pava: What sorts of risks are you taking about?
Ark: Any risks to health.
Dr Pava: Oh yeah, in terms of side effects (.) there
are side effects with medication including methylphenidate
there are side effects and erm in terms of side effects you
have children who might find it difficult to fall asleep if
you give them medication after 4pm you might have kids who
lose their appetite and lose weight or erm in terms of
growth curves slight differences are occurring as a result
of that (.) a few kids will develop things like dysphoria,
feeling low, initially when you start medication (.) until
Risks identified and the DISCLAIMER
available to deal with all these side effects but sometimes
these side effects are significantly and severely reduced on
the medication (.) and can consider other alternatives.
Mark: Other alternative interventions?
Dr Pava: Interventions in terms of medication and non
pharmacological depending on what is most appropriate for
that particular child.
Mark: So you mentioned sleeping, appetite, and mood can sometimes be detected quite early on, perhaps not trajectory, growth curve that might take a little while. What we do is as a result of that we end up monitoring the growth during the follow up so when they come every 3 months at least you take their height, weight, it's charted and if they go off the chart what they expected to do, cause you have to draw a curve for each person that you predict, and if they go off the curve then you know that you need to be worried about it and you take appropriate action and probably stop the medication and change the medication or change at what's happening in terms of the erm do they need drug holidays you know take them off the medication during weekends or there are lots of different types of interventions you can do but it's not the same strategy for everyone.

Mark: You mentioned that methylphenidate is often quite a long course of treatment and I wondered what the longer term effects or risks are?

Dr Pava: Yes I in terms of long term effects of methylphenidate we don't have very many studies we have 5 year follow ups done which say that there isn't much side effects I mean negative consequences in the long term if anything it shows positive consequences especially drug abuse when clearly those who have been treated with methylphenidate end up abusing drugs and alcohol much less than kids with ADHD who have not been given methylphenidate. So that's a clear positive effect rather than being a negative one and of course there's a study I mentioned little while ago about brain development using neuroimaging now we know that when you actually give medication the brain seems to be developing more like a normal brain as opposed to those kids who have not received medication I think that's the most
important erm to date to suggest that maybe it's not always negative effects that we are looking for.

Mark: So there's some evidence of the positive effects of the drug on the brain. I also read something quite recently about saying that it could have a toxic effect as well on the brain.

Dr Pava: I hadn't read that literature. The ones that I mentioned about toxic effects is is to do with erm in terms of long term effects in terms of brain.

Put all beliefs aside and prioritise the empirical discourse. Function - strengthens it and subjugates others.

you have different people that have different theories about it and erm in the non peer review journals or the lay press you will have people hyping the issues of effect but if you look at it from a scientific perspective irrespective of your views on whether you like medication or not and look at it just from the scientific content of it then I don't think that we have very much to suggest that there's a toxic effect. I'm not saying that they may not find some negative effects in the future but it is definitely not something that we have found. And the other thing to remember that people have been using stimulants for ADHD for the last 18 20 years anyway and lots of them have been on medication for a long time and I said 5 years because shows that there have been people who have been on medication for years, 15 years and have had no problems. 
Mark: And is there the scientific research on those who have been on it for longer course, 15 18 years?

Dr Pava: No I mean there's all all all that we have is clinical experience and nothing nothing negative being reported in that erm so apart from that we can't state clearly so that's why I'm saying that 5 years is what we do have for scientific, clear evidence which is less than we can say about the non pharmacological treatments.

Mark: Okay. Just a moment ago you were saying you compared practice between the U.S. with practice in the U.K. and perhaps the changes that need to happen and that brings me to the recent NICE guidelines that have come out around treating ADHD, I wonder what your thoughts on these NICE guidelines are. Whether you find that they are helpful or restricting?

Dr Pava: I think that they are helpful but with the new knowledge of what the research shows I think it should be because the NICE guidelines talk about treatment for hyperkinetic disorder they don't talk about sub-syndrome hyperkinetic disorder for those who don't meet the criteria for hyperkinetic disorder that seems to have been just left out of the NICE guidelines. I think now evidence shows that even those kids respond to medication and I think that is a necessary thing that needs to be changed in the NICE guidelines so it would be rather than it being erm I think that it's too strict what's being prescribed I think we should be a little more open to prescribing medication to kids who do not fulfil all of the criteria as well because evidence shows that they respond.
Mark: So the NICE guidelines should advocate using medication more with all children with hyperkinetic disorder?

Dr Pava: I mean hyperkinetic disorder yes, erm and erm I think what it needs to advocate is that erm even if they don't fill all of the criteria for hyperkinetic disorder, if they have impairment and they have a syndrome as such erm medication is not too bad. I think it needs to be included in this country I think it's too restricted and--

Shifting the constraints of criteria to give psychiatry access to all children with ADHD. From empirical evidence to personal opinion based in fact.

it's to talk about the non hyperkinetic kids which has been shown in the MTA study only 145 of them had hyperkinetic disorder compared to 579 who had ADHD then you've got only one fourth of the population that we have got some guidelines for the rest, three quarters don't so that's the reason why I think we need to have it.

Mark: And as a clinician do you find that as guidelines become tighter do you find that your practice becomes a bit restricted and you lose some of your own autonomy and clinical judgement or not?

Dr Pava: Erm no not really I think I welcome the NICE guidelines because at least because what the NICE guidelines suggest what we have been doing for a long time just beyond that all the NICE guidelines give you is the minimum good practice it doesn't give you the maximum good practice interpreted as giving drugs more, not less.

Mark: So I have no problems with erm with erm following it anyway.
Appendix 3
An early analysis

Developing key themes

The following excerpt followed on from an enquiry about the role of research in interpreting and developing treatment approaches.

Transcript 7 – Dr Pava

The reality is
that by assuming that psychological interventions from the
MTA trial work, erm it doesn't mean that what we do as a
psychological intervention in day to day practice is going to
have any kind of effect to the same size to that which is
shown in the trial because we would not be able to do that
kind of thing (.) in that trial they had school
interventions, social skills groups, holiday camps, training
for twenty seven weeks, groups being run for everyone, and everything
and that kind of a package will not be done by anyone in
our setting whether here or in America (.) and it is when you
use that kind of a Rolls Royce kind of treatment that you've
got a response which is roughly maybe sixty percent of what the drug
medication (. ) medication did when done properly, when the
medication is used properly (.) so if that is what it takes
for a response of sixty percent then I would argue that we shouldn't
be wasting those kind of resources for a (.) at least with
the core features of ADHD.

Throughout this excerpt, Dr Pava uses both empiricist and contingent accounts of knowledge. Empiricism depends upon the collection and analysis of data in order to acquire knowledge (Willig, 2001), this is a scientific account in which the research results are often referred to as immutable facts and scientific givens (Harper, 1994). In this empiricist form of discourse, “data are depicted as ‘doing confirming’ and ‘concluding’ independently of the actions of the scientists” (Edwards and Potter, 1992, pp. 135).

Dr Pava makes use of an empiricist account in stating, “assuming that psychological interventions from the MTA (Multimodal Treatment Study) trial work” (lines 495-496), thus constructing ‘truth’ as dependent on scientific methods (McHoul and Grace, 1993). Dr Pava’s statement “assumes” that psychological interventions may be judged by science to “work”, however, he then makes a shift from an empiricist to a contingent account to disclaim the possible benefits of this intervention.

The contingent account acknowledges personal and professional inclinations of the individual as well as the influence of social, political and economic factors (Gilbert and Mulkay, 1984). Dr Pava uses a 5 part list (Edwards and Potter, 1992), a rhetorical strategy which is often used to construct a persuasive account by using a number of
examples to support a claim. The use of this list (lines 500-502) serves to construct the psychological interventions used in the trials as exceptionally comprehensive. Having created a convincing account of the thoroughness of this approach, the psychological approach can then be brought into question as he invokes an economic discourse (line 510) to imply that this intervention is a misallocation of resources. He further qualifies his viewpoint by using a figurative device (Hepburn, 2000), one that is commonly used in language to make a point more persuasive by adding rhetorical force. Dr Pava achieves this by referring to “a Rolls Royce kind of treatment” (line 505) to hold it up as the best thing on offer, and perhaps one that could not be reasonably expected from an NHS service.

Other contingent factors are introduced as he makes a cultural comparison, which he believes is consistent, in stating, “that kind of a package will not be done by anyone in our setting whether here or in America” (lines 503-504). This comparison with America, where the research trials that he is referring to were held, can be interpreted as conveying an ‘explicit consensus’ (Edwards and Potter, 1992), in that other witnesses are ‘brought forth’ to strengthen a point and warrant factuality.

Subsequently, Dr Pava reverts back to an empiricist account, asserting that with the psychological treatment package “you’ve got a response which is roughly maybe sixty percent of what the drug medication (. ) medication did when done properly ” (lines 505-508). This contribution combines personal guesswork, “roughly maybe” (line 506), with the more empirical research statistics comparing the two approaches, which can be seen as creating the existence of a ‘correct’ way to intervene. His representation of ‘correct knowledge’ is then consolidated by asserting, “we shouldn’t be wasting those kind of resources for a (.) at least with the core features of ADHD” (lines 509-511), a declaration that would be difficult to challenge in the context of his cumulative argument.

The analysis of this excerpt identifies various discursive constructions. The functions of these discourses could be seen as ‘normalising’, in attempting to categorise different treatment approaches as ‘correct’ or ‘incorrect’, calling upon science, culture, clinical practice and resources to promote a version of the ‘truth’. This process will be explored further throughout the analysis. Note how this excerpt is an example of how a variety of discursive constructions constitute knowledge.
Appendix 4
Mark: If I start off with some quite general questions just to get a common understanding could you tell me how you would describe ADHD?

Dr Kelley: Ok well I (cough) see it as a disorder of hyperactivity (.) impulsivity and inattention (.) I see it as a clinical disorder and all of these behaviours are on a continuum of a wider population (.) I think there is a small group of children that happen to have a disorder in these three areas to a clinically significant degree which has an impact on their lives as individuals and an impact on their family's lives and on their attainment at school and on their later lives as well (.) so it is a (. ) ADHD or hyperkinetic disorder is is (.) a valid well a valid diagnostic concept or construct. It has proven its validity over time.

Mark: So with those (.) the three core areas that you were saying (.) hyperactivity (.) impulsivity and inattention (.) and you explained them being on a continuum (.) I just wondered where the thresholds would be on a continuum (.) what makes ADHD and what is sub-threshold?

Dr Kelley: Hmm I think (.) I think the threshold question is very interesting and it's quite easy to recognise the hardcore ADHD cases of hyperkinetic disorder and cases within ADHD but the harder clinical task is actually to separate out (.) perhaps those cases which are less prominent symptomatology but still have the disorder and to separate them out with background generalised conduct disorder and family disruption and other school factors and community factors which are, if you like, providing some background noise which is quite difficult to separate out ADHD (.)
44: factors so it's erm I think clinically one, one tries to
45: ultimately there's no absolute scientific way of doing
46: this one tries to separate out the ADHD factors from
47: all of the other factors and tries to try to decide
48: we would try to decide whether there is a treatability
49: factor is there something that we can, by treating can
50: improve the general situation for a young person erm
51: and that's one of the one of the tasks for the
52: clinician.
53:
54: Mark: So with erm you have set out that there is
55: ADHD and there is lots of other perhaps comorbidities in
56: other areas that might influence that so with treatability
57: are you looking to treat ADHD or is it more of a general
58: behavioural disorder?
59:
60: Dr Kelley: Well I think it's more of a
61: behavioural disorder but what has been
62: impressive I think, over time, I think our ideas of ADHD are
63: gradually evolving and certainly see that in
64: practice of child and adolescent psychiatrists which is
65: the group I belong to erm there is increasing
66: recognition of the value of the identification of ADHD as
67: opposed to and to separate out that particular
68: constellation of symptoms which constitute the disorder,
69: separate them out from other similar often and often
70: co-existing things like conduct disorder or specific
71: learning difficulties or other issues of comorbidity
72: cause there is proven treatability I think if you
73: take the larger American studies the MTA study etc is
74: very impressive data, that there is treatability when you
75: identify these young people with ADHD and when you treat
76: them you do actually produce positive treatment effects
77: which have, certainly have, a medium term impact and hopefully
78: over time a long term impact.
79:
80: Mark: Right Ok I'll cover a little bit more of the
81: treatment in a second. You have made a differentiation
82: between behavioural disorders and ADHD and the use of having
83: it as a distinct disorder ADHD. In your view does that
84: make it would you classify it as a mental illness?
85:
86: Dr Kelley: I don't see it as a mental illness erm I I
87: think it's hhhhh is it a mental disorder I mean it's a
88: disorder, whether you could I mean it's classified, as
89: suppose, as a mental disorder but erm I think even having the
90: word erm "mental" erm is probably unfortunate (.) I think
91: that it erm sends the wrong erm perhaps the wrong message
92: (.) ADHD (.) ADHD is a behavioural disorder (.) I think it
93: has erm it has an organic basis and erm it can it can
94: certainly send the wrong message to the child(.) family and
95: educators as classifying it as a mental disorder. That is
96: where it's that is where it's classified at the moment and I
97: think most of the hhh most of the energy around the
98: recognition and treatment of ADHD has come from erm has come
99: from the mental health erm sciences and profession (. ) it
100: hasn't come from paediatrics (. ) it hasn't come from other
101: other branches and professionals( . ) so it's a disorder (. )
102: it's erm and I think that it has to be called a disorder
103: because it's erm it's on a continuum and therefore erm (. )
104: it's difficult to say what is and what isn't a disorder, as
105: behaviour is on a continuum and clearly erm there's no sharp
106: cut-offs between having a disorder and not having a disorder
107: it's at best a clinical guess.
108:
109: Mark: So with that continuum (.) and saying that "at
110: it's best it's a clinical guess"(. ) I wonder what other
111: factors influence that clinical decision now (. ) erm it
112: seems that prevalence of ADHD has gone up and if it is
113: biologically based you imagine that it has perhaps been
114: around for some time and what has changed to make that
115: "clinical guess" more prevalent( . ) that ADHD is more
116: prevalent in children?
117:
118: Dr Kelley: Erm (4) I mean, that's a very good question
119: because erm (7) I think there are (. ) if we look at the wide
120: (. ) if we look at the social situation( . ) I think that
121: there are erm (. ) there are reasons why erm particularly for
122: young boys (. ) there are reasons why it is more difficult
123: for them perhaps in this generation than in any previous
124: generation( . ) those boys would (. ) erm have a disorder of
125: this kind erm (. ) I think this is to do with the nature of
126: of of a schools ( . ) the nature of ( . ) erm the nature of
127: housing (. ) the nature of city life etc (. ) and it's much
128: more pressure on young (. ) younger children to be( . ) to
129: conform physically( . ) to do with structure( . ) because of the
130: concerns about their safety in the streets for instance
131: they're much more likely to be contained at home erm (. )
132: Because many more children (. ) I think are given the
133: opportunity of education (. ) and for longer perhaps than
ever before I think that a lot of children who would
previously have dropped out earlier erm in education have
gone on as they are expected to stay in school until a noble
age and are expected to conform to a structure (inaudible).
And then there are factors (.) there are social factors that
in the community (.) everyone is in agreement that
communities are less cohesive than they used to be.

Mark: So with those factors of school and family (.)
psychosocial and environmental factors (. ) what I still
don't see is how that fits with ADHD still having a
biological determinant.

Dr Kelley: Well (. ) I think the ( .) well again that's an
interesting question because erm I think that it has been
demonstrated that between cultures erm erm for instance an a
culture like Chinese or Japanese culture which is actually
much more conformist than our own ( .) I think ( .) if you
look at ( .) they will come up with similar rates of ADHD to
to the Western culture ( .) but it's interesting that if
you compare the two you will find that the children who are
rated as ADHD in Japan are actually ( .) probably show less
symptoms or signs of the disorder than children who are
rated to be in the United States ( .) so ( .) that would
suggest that there are cultural factors that contribute to
the expression of the behaviour ( .) to go
back to ( .) to go back to your ( .) if you remind me again of
your question ( laughs ).

Mark: Yeah ( .) cause ( .) cause you were talking about
the erm social and environmental precipitators for ADHD and
previously you were talking about having a biological
determinant ( .) I was wondering how the two fitted together.

Dr Kelley: Well ( .) I I think that it's it's about the
expression but one may have a biological erm ( .) erm maybe a
genetic coding or whatever erm a phenotype which lends
itself to the expression of a particular behaviour ( .) but
one still needs a set of circumstances to allow that
behaviour to be erm to be expressed ( .) for instance a child
who has erm a phenotype which erm would have a tendency
towards ADHD ( .) if that child is given is given ( .) very
every positive teaching experience ( .) a very good
environment( .) given lots of one to one( .) support( .) etc( .)
it is possible that it will not result in an expression of
the behaviour (.) erm because the environment is protecting
or if the child is given lots of opportunities for erm
compensatory behaviours then again it is possible that the
behaviour will never express itself. But if you create an
unfavourable environment (.) you erm you expect children
to perform in a way that there constitution is maladapted to
look at the impact of stimulation of erm stimulation
(inaudible) (.) and the attention span is something that is
dropping in general in children over time. So could (.)
could it be the case that children are hyper-stimulated and
derm does that have an impact on them?
It seems like again (.) there are a lot of
environmental effects on people's concentration and
attention (.) and you have explained how that effects
people(.) but what leads us to believe that there is a
biological determinant(.) where does that come from?

I think that the (.) I mean this is not an
area of expertise but I think that the genetic (.)
evidence of a genetic basis of ADHD is very robust (.) it's
not absolutely robust but it's fairly robust and I think
that's been that's been establishes in many different
studies that there is loading within families (.) that
the usual (.) usual ways of establishing genetic (.)
linkage is through adoption studies etc (.) looking at (.)
mono-zygotic (.) dyzygotic twins etc (.) and I think all of
those have established that there is a genetic loading
involved in the (.) genesis of ADHD. Erm (4) and then
the the different (.) again whether (.) I don't think
that there (.) although there are references to the
chromosomal (.) factors which may be important (.) I
don't think that the there is a single gene that is (.)
basically linked to ADHD but there are (.) in particular
families and particular small groups there are sometimes
clearly identifiable factors that would carry on on (.)
chromosomes.

And how would these be recognised (.) by what
means?
Dr Kelley: Erm (.) well again (.) I'd say my (.) it's not my area of expertise but I think it's it's about erm (4) it's about looking at particular groups (.) whether there is strong clustering I think and if there are genetic similarities between the erm individual with ADHD and mapping out a particular loci which may be erm (.) you know(.) contribute to the ADHD gene. Like all complex behaviours erm there are multiple genes supposed to be involved erm and this interaction is (inaudible).

Mark: So initially perhaps it's an interaction of a number of different (.) a number of different genes (.) perhaps more so than an interaction of different environmental influences. One predisposes the other? Is that right?

Dr Kelley: I would think that you need a genetic predisposition. I think to develop ADHD erm you need a genetic predisposition. Then you need an(,) not necessarily an unfavourable environment but certainly it helps to have an unfavourable environment (3) So that if erm (.) It very much depends I think on the extent of the (.) the extent of the disorder I think that there are some young people who have a core genetic difficulty which erm produces the expression of behaviour (.) but that is despite having a favourable environment, without having siblings with any evidence of the disorder, despite having parents who appear to be very competent, despite having positive schooling experiences (.) etc (.) these young people go on to express ADHD type behaviour. It all has (.) it's erm persuaded me that that that there is a genetic loading there (.) that's producing the behaviour. But in other cases erm it's not so (.) it's not so clear that there are (.) with all the background noise it's very hard to segregate out all the different factors (.) all the effects of families, social factors, deprivation, failing schools, erm it's much less clear in those cases (.) to be able to say "this is ADHD".

Mark: Right (.) with such a complex picture around diagnosis (.) I will move on to treatment now (.) but following what you said (.) with such a complex picture (.) how are the best treatment strategies determined?

Dr Kelley: Erm (.) well in terms of the erm the MTA
the trials in the States. I think that's currently the gold standard in terms of treatment. I think they've rigorously adapted a double blind crossover type erm methodology and erm they have used erm to the best of my knowledge they used erm psychopharmacology erm they've used a behavioural a behavioural social skills module erm and and maybe the social skills module was separate from the erm from the behavioural approach but certainly they have looked at all the possible combinations of those three three treatment types and what's persuasive is that is the importance of a of medication again but it was seen as an either or thing, historically, that one would either use one might use medication or might use a behavioural intervention. I think there's less evidence now that a behavioural intervention is likely to be successful in the absence of psychopharmacological support particularly in those cases which are more severe erm I think there's less enthusiasm amongst child and adolescent psychiatrists for waiting a length of time before actually erm before actually administering using medication.

Mark: So, in that trial well, in those trials, the medication came out as the most effective?

Dr Kelley: Yes, but it was but it but if one had to choose if one only had resource for one single treatment I think that medication would be the treatment of choice but it anyway it's never that simple because to give medication effectively you do need to introduce behavioural concepts you do need to it's very difficult to give pure medication without actually giving some behavioural support for instance But if I I I think that it's a syllogistic situation I think that if you've got medication plus behavioural support then you you maximise the opportunity for the family and for that person you push the likelihood of successful intervention upwards statistically.

Mark: So you have said that if you had one option it would be medication and then to be backed up with behavioural support you said was important. I'm wondering about I'm thinking about how much really. With the medication I imagine that there is a certain dosage.
Dr Kelley: Well the in terms of dosage within the UK for instance there's a recommendation in the BNF of 60mgs as the upper the upper limit of upper dosage limit I think that maybe in cases it's exceeded, depending on the individual situation but most people have 60mg methylphenidate. But in practice I think what happens is I think people think about the dosage in terms of mg per Kg and it varies quite significantly I think between countries certainly I know that in the US sometimes they give up to 2mg per Kg particularly in the centres where they treat large numbers of young people. Most clinicians here would be more conservative I myself am not terribly happy to give more than 1 to 1.5 mg per Kg.

Mark: And when comparisons are made between the doses the correct dose to use of methylphenidate I wonder how that's compared with the correct dose to use of psychological interventions that you mentioned.

Dr Kelley: Well I think one of the one of the difficulties that people in an ordinary CAMHS service is facing that is very real is that in terms of cost there's absolutely no comparison between the cost of psychopharmacology which is just tiny in comparison to the cost of a proper behavioural intervention. I think that the MTA trials the the the behavioural interventions that were employed I haven't I haven't read the trials recently so I can't be specific but these were not they were not skimpy behavioural interventions they were very significant behavioural interventions, for a significant amount of time and trained therapists, that had specific training I think in dealing with ADHD these were not they had a significant amount of time to deal with the problem in practice in real life CAMHS it's unusual to find therapists that are actually very familiar with modification in ADHD and it's unusual that they would have the amount of time to devote to a single case. So what tends to happen is that
families are offered some kind of modified behavioural
approach (.) not a(.) probably not erm the sort of
behavioural support that they would (.) be offered if they
went into the research kind of programme.

Mark: With such an agreement about the most effective
treatment being methylphenidate (.) and sub-standard
behavioural interventions being offered (.) I suppose my
concern is that all this kind of agreement (.) this
universal perception of what works serves to reinforce
what's already in practice erm rather than develop other
areas of intervention?

Dr Kelley: Probably (Laughs) (10).

Mark: It seems that the momentum (.) through trials and
erm also with cost implications, more and more momentum is
building up behind this particular intervention(.) at the
risk of excluding other ways of treatment which might be
less controversial than using methylphenidate with young
children.

Dr Kelley: Erm (8) I'm sure (.) I'm sure that's right
erm I had the first couple of years to a progress to the idea of
methyl (.) of using methylphenidate and it's interesting
it's interesting that people have (.) that people have
moved quite a distance in such a short period of time.
Certainly the older consultant (.) child psychiatrists that
trained with (.) some of whom retired
recently (.) it was only in their last five years of
practice that we actually (.) actually used methylphenidate
historically although it's been around quite a
long period of time erm (5) So practice (.) practice is
changing and I think it's erm absolutely erm you know I
think that if a child and adolescent psychiatrist takes a
position that mental failure is not indicated at all(.) ever
for ADHD (.) hyperkinetic disorder(.) it's now out on a
limb erm they can they can defend their position
philosophically but I think they can't defend it erm in (.)
scientifically I think (.) erm there is such a weight of
evidence they would find it very difficult (.) that's
that's in general(.) I think in specific cases (.) of course
one should always look at the specific case (.) erm it is a
fact that (.) erm in research in general psychological
treatments (.) in research into psychopharmacological
treatments (.) there is much more money behind research into
psychopharmacological treatments(.) there's much more
research dollars available for that sort of thing. That's
unquestionably the case (.) but what's erm what's erm
interesting about methylphenidate is that it's not
particularly (.) I don’t understand it to be a huge erm cash
cow for for the companies that produce it. It's been around
for such a very long time erm I don't understand it as such
a money-spinner as say SSRIs are. And that I think reduces
the ethical blurring (.) the ethical blurring I think
around methylphenidate.

Mark: But it has cost implications for the actual
service?

Dr Kelley: Oh absolutely. Huge cost implications when
compared to behavioural interventions. Massive cost
implications. Erm and it has cost implications around
training as well because as I experienced myself doing the
CBT course (.) people think they know what CBT is but
actually don’t know what it is very often, so a large number
of people are doing behavioural modification that actually
don’t have the training and skills to do it properly in the
dosage that may be required to produce an effect. And that
absolutely has cost implications.

Mark: I suppose that through people not being well
enough trained to work psychologically (.) as you were
saying there with ADHD (.) the implications are that it
probably adds more momentum to the need to use
methylphenidate rather than other interventions.

Dr Kelley: I think that there are other factors as well
including (4) as well as there being intra-clinic
limitations I think there are also limitations (.) and
methylphenidate is often used, I think, because there doesn't
seem to be any other changeable factor that one can work
with. The young person may be in a sink school (.) with erm
maybe a dysfunctional situation at home erm and there
doesn't seem to be other workable factors (.) if one uses
methylphenidate perhaps in those cases when erm (5) the
alternatives are not pursuable. I think that's the
unfortunate (.) that's that's the unfortunate reality with
the use of psychopharmacology it's not just ADHD that is getting exposure to the psychopharmacological culture it's a depressive disorders and erm it's to do with treatability and dealing with social adversity and (fade out).

Mark: If the child was in a socially adverse environment such as a sink school or an dysfunctional family some people who have voiced opinions against using methylphenidate rather than be used to help the child's inattention impulsivity and hyperactivity it is used to pacify the adults in these settings.

Dr Kelley: Erm I think that's a possibility. Erm It's unquestionably that's reality. It's a reality because if you look at certain communities in the United States for instance you see that in the more in some communities particularly in the more socially disadvantaged communities in the States up to 10% of the children are taking methylphenidate so there has to be some element of social prescribing, I think, going on. I think in a situation here, when a clinician sees a child with ADHD behaviour who is experiencing some very negative feedback from parents and the school with no opportunity, I think, to affect any other change, then the clinician may prescribe something to try to set up a more positive cycle a more positive chain of events So I think that I think that it's absolutely okay to prescribe in a social context and very often that social context is improved.

Mark: And you've got the individual and you've got the social context and I suppose when your looking at effectiveness you use your clinical judgements as well as looking at the system. I wonder if the children themselves are included in the measures of effectiveness what they perceive as effective?

Dr Kelley: Hhhh Yup I think you you always seek the child's opinion about or about the use of medication or the experience of taking the medication their views about taking medication. I think it is true than only in older childhood that you're beginning to get sophisticated responses about that whereas from ages six to eight or six to nine you get (you certainly get
opinions about whether the child wants to be on medication but you're not likely to get clear feedback as to the actual effect of the stimulants on them. It's always salutary to erm and a lot of kids are surprised by giving positive feedback because most children don't like taking medication erm and most children given the choice between taking medication and not taking it(,) they would choose not to take it. Erm it's also quite salutary when you get quality feedback (,) when the child says "I want to take this". Because they are aware of the positive knock on effects in school (,) you know when they get good feedback from teachers or when they get less negative feedback from parents. And erm (4) so, certainly, we use feed (,) we do use feedback erm I think, practically speaking, as well when children (,) in our culture when children get to a certain age(,) around about twelve(,) practically it becomes impossible to get them to comply erm with with a medication that they don't want to take(,) actively do not want to take medication they won't and they will find ways covertly and overtly not to. So it's interesting.

Mark: You say that when they get older they can make a bit more of a erm perhaps informed choice (,) perhaps not which they can't do when they're younger. And I wondered (,) a part of the information around that choice might be not just the effect that the drug is having there and then but perhaps the longer term effects. Stimulants are often said to be a longer term treatment (,) what are the longer term effects of taking methylphenidate?

Dr Kelley: Erm hhh (10) I think what (,) well there aren't to my knowledge long term studies on the efficacy of treatment of ADHD erm (5) certainly (4) large scale studies of of of significant value (,) I can't think of any off hand a follow up of childhood into adulthood erm of treated versus non-treated ADHD (,) I don't think such studies exist (,) if they do I would be very (Laughs) very glad to read them. Erm I think medium term studies exist (,) these would be two to five years sort of time scale (,) those sort of studies compare the erm treatment intervention. But again most (,) the problem with psychopharmacological studies is that (6) with a preponderance of studies actually is that they are quite short term (,) in terms of weeks and small numbers in months rather than very long term studies in terms of erm treatment. Erm although it's the case that
ADHD: you start off treatment and you have a starting point and you do not have a clear end point in sight and there is a general belief amongst psychiatrists that every year there should be a new evaluation about a decision. At least every year there should be a drug free period where one can monitor the impact in the school environment where the effects of the behaviour are most important. And I think that it's most important clinicians do that. Erm in my experience children and young people do not comply for very large numbers of years anyway and I think it's very difficult to get anyone to comply to long standing medication over the years. I think I'm right in saying that in Massachusetts one of the great American researchers who wrote the manuals on ADHD treatment I think even his people with all the enthusiasm they have for ADHD treatment I think that most people stay the distance for three to three and a half years. These are highly motivated selected people etc and the medication was not maintained over a number of years. So I think when people ask me you know "does this mean he has to be on it for life" or whatever, I usually say well I'm not thinking as far ahead as that. I want to see what the impact is going to be over the next six months or a year and I want you to tell me whether this has made a qualitative change or not.

Mark: You were saying that there doesn't seem to be any evidence in about the impact of medication over an extended period of time are parents also picking up on this are they asking you what effects of the medication will be on their child?

Dr Kelley: I think they're more concerned about if the young person would be on medication for life. You're consigning this young person to take a pill for life. That's what the concerns are they don't actually ask too many questions about "will there be long term side effects as a result of this medication".

Mark: Do you have personal concerns about that there maybe?

Dr Kelley: Erm well I'm not overly concerned about methylphenidate as a medication I have to say it's it's a relatively clean medication which is probably
the most researched paediatric medication (3) erm very large
studies with methylphenidate (.) it's been around for thirty
or forty years but I think it's a very clean erm (4)
medication and we can be (.) I think that we can assure
parents that it's not likely to have erm very serious health
implications for (.) for their child. There are concerns in
adolescence of erm (.) this is after all an amphetamine
derivative (.) there are concerns about generalising to
substance abuse from the use of methylphenidate. I think
those concerns are more historical than present (.) I don't
think that there's erm (5) I don't think that erm there is
real active concern there (.) there are always concerns
about the use of other medications or substances in
conjunction with methylphenidate which is potentially
hazardous. Erm but but (6) but the one issue that comes up
for me erm time and time again is about growth and
development. And methylphenidate needs to be monitored
quite closely (.) that's usually the reason for stopping
methylphenidate (.) around the danger of growth trajectory
particularly weight. That's the one that effects me (.)
effects me most. I know other clinicians who have had
experience with methylphenidate have had children with
psychotic episodes but it's not something that I have
experienced.

Mark: You were saying that It's an amphetamine
derivative (.) I'm wondering how using stimulants with
perhaps overstimulated(, or hyperactive children could
work(,) as it seems to have the opposite effect in adults.

Dr Kelley: Yeah (.) I mean yeah it's paradoxical you
have one wouldn't expect erm an amphetamine derivative
to have a different effect in erm anyone (,) but it
does seem to have a paradoxical effect with children. One
would expect an amphetamine derivative to have a (,) well
you would expect it to increase levels of activity, but this
doesn't happen, it is a paradoxical effect. And I haven't
read anything which appears to be a conclusive as to why
that is.

Mark: I suppose with the current way of thinking (,) at
some point from childhood to adulthood there is quite a
drastic change for the effects to be reversed (.) to go from
being a sedatory effect to a stimulant effect. Do you know
what might explain that?
Dr Kelley: I think at all ages (.) erm (.) I think if you or I took erm methylphenidate it would erm (.) although I haven't tested this (Smiles) I think that it would improve (.) it would improve erm (3) concentration. Some people erm some people erm use methylphenidate when they are coming up to major examinations whatever (.) But I have never read a satisfactory explanation for (.) why. And it certainly (.) it certainly has much less of an impact on erm (.) ADHD itself changes in younger children and adolescent ADHD does not present in the same way as a child with ADHD so there is much more (.) their restlessness is much more subjective. They they may display some restlessness but certainly not anything to the degree of a child with ADHD and their impulsivity will be more contained but they can still have quite a degree of distractibility. Erm and erm again (.)

Mark: It seems that although methylphenidate has been used specifically with ADHD (.) from what you have described it also has a more generic effect on both adolescents and adults if taken in small doses. So is (.) is it a kind of drug that has been used as a catchall drug (.) is it being used very generically or is it being used specifically for symptoms which are exclusive to ADHD?

Dr Kelley: Hhh (12) I think it's been used very generically but it's it's erm (.) ADHD is not erm (.) is not a disorder that you can identify with erm precision. Erm we're reliant (.) there's no test you can do to identify it (.) we're reliant on information from schools and from parents very often and also from observation erm which (.) and that information can be flawed (.) parents can give their perception and the children can be scapegoated etc. Erm and we're talking about a range of behaviours which erm are very general (.) one overlaps with another (.) these erm symptoms in the complex disorder (.) so erm I don't think it's been used (Laughs) as a social control agent I think that we are trying to use a specific (.) for you know people who have clearly identified problems in the area of overactivity (.) inattention (.) impulsivity. And (4) anyway it is true that erm they (.) may (.) not (.) have (.) ADHD (.) it is true that simply giving methylphenidate may ADHD (.) erm as I think test results have demonstrated with people with Conduct Disorder erm (13). Erm I still think
that the balance of evidence is still in favour of using methylphenidate in selected people (.) using it as opposed to not using it(,) but trying to use it as selectively as possible(.) and when one has exhausted all the other possible areas of opportunity.
02 August 2001

Mr Mark Grixti  
Flat 4  
23 Lower Rock Gardens  
BRIGHTON  
East Sussex  BN2 1PG

Dear Mr Grixti

**The construction of effective interventions for children with attention deficit hyperactivity disorder: A reflection on psychiatrists’ discursive explications of therapeutic repertoires (ACE/2001/52/Psych)**

I am writing to inform you that the Advisory Committee on Ethics has considered the above protocol (and the subsequent information supplied) and has approved it on the understanding that the Ethical Guidelines for Teaching and Research are observed and the following condition is met:-

- That the Information Sheet for Volunteers and the Consent Form are presented in a more ‘professional’ manner with regards to their layout on the University’s headed paper.

For your information, and future reference, the Guidelines can be downloaded from the Committee’s website at [http://www.surrey.ac.uk/Surrey/ACE/](http://www.surrey.ac.uk/Surrey/ACE/).

This letter of approval relates only to the study specified in your research protocol (ACE/2001/52/Psych). The Committee should be notified of any changes to the proposal, any adverse reactions, and if the study is terminated earlier than expected, with reasons.

Contd ....
I should be grateful if you would confirm in writing your acceptance of the condition above, forwarding the amended documents for the Committee's records.

Date of approval by the Advisory Committee on Ethics: 02 August 2001
Date of expiry of approval by the Advisory Committee on Ethics: 01 August 2006

Please inform me when the research has been completed.

Yours sincerely

Catherine Ashbee (Mrs)
Secretary, University Advisory Committee on Ethics

cc: Anonymised for confidentiality
Re: A reflexive investigation into the effectiveness of treatment for attention deficit hyperactivity disorder

The Ethical Committee (Research) considered and approved the above study at its meeting on 19 October 2001. The committee stressed the need to be particularly vigilant about confidentiality in this staff-subject project.

Initial approval is given for one year. This will be extended automatically only on completion of annual progress reports on the study when requested by the EC(R). Please note that as Principal Investigator you are responsible for ensuring these reports are sent to us.

Please note that projects which have not commenced within two years of original approval must be re-submitted to the EC(R).

Any serious adverse events which occur in connection with this study should be reported to the Committee using the attached form.

Please quote Study No. in all future correspondence.

Yours sincerely,
25 June 2001

Mark Grixti
Trainee Clinical Psychologist
Dept of Clinical Psychology
Surrey University
Guildford
GU2 5XH

Dear Mr Grixti

Re A reflexive investigation into the effectiveness of treatment of attention deficit hyperactivity disorder

Thank you for your letter dated 10.5.01 regarding the above research proposal. If there is no patient involvement, this does not require approval by a Research Ethics Committee.

Yours sincerely
Appendix 6
Ethical reflections

Ethical concerns
I have outlined my ‘ethical reflections’ here as they progressively became more important to the analysis of the texts. Having not used discourse analysis before, I had awareness but not experience of the impact of doing it on my own ethical position.

Discourse analysis is sometimes described as a ‘critical’ methodology (Parker, 1992) and my understanding of this became clearer as the coding process developed. I began to feel some discomfort at making interpretations based on the psychiatrists’ discourse, as it often felt over critical. I had respect for the psychiatrists and was grateful for them taking time out of their busy schedules to help me complete my research interviews. To make critical interpretations certainly raised some ethical concerns for me.

Reflections guide interpretations
Having identified this discomfort, I wondered how I could use these ‘ethical reflections’ to help inform my interpretations and improve the analysis. This is a process Potter and Wetherell (1995) have also identified.

Central to social constructionism is the emphasis on knowledge being a version of events (Burr, 1995). The version of events put forward by the psychiatrists was developed from their training, clinical practice, and belief system. Thinking about this from their perspective, rather than a psychological position, helped me to get a better insight into their role in the discourse, knowledge, power triad. To do this study properly, it felt important to stay within a Foucauldian approach, without taking too much of an ‘anti psychiatry’ position. This was easier to do by applying the idea that some forms of practice are not better or worse than others, only different versions. Furthermore, Foucault was reluctant to denigrate one clinical approach in favour of others as this process has been taken before, often with regrettable results.

These reflections reduced my ethical concerns and helped me to focus on the analysis. It also contributed to my understanding of Foucault’s idea that power is not owned by people, but people act as vessels for the power. Having ‘externalised’ power in this way, I could begin to develop a different relationship with the psychiatrists’ moves between the empiricist and contingent accounts of knowledge. I moved from seeing these shifts as a conscious, controlled process, to a function that maintained power by silencing resistant discourses. This helped me to empathise with the way that the psychiatrists were organised by power. This was evident when the empiricist account silenced their personal or even professional accounts of the risks of stimulant medication.

Working with power
Having externalised ‘power’ and analysing the way it functions I was also interested in its relationship with my subject position. There was clearly a power differential between me and the psychiatrists. I only have ‘trainee’ status, I am younger than the participants, and have less clinical experience. The psychiatrists often had consultant status and all were
well respected in specialist ADHD clinics. So what does this mean for this piece of research?

I could have chosen to use a less critical research method and left the psychiatrists in the position of experts and used another form of analysis on their texts. This other form, such as IPA, could have looked at interesting themes that developed from their responses. But would this have achieved the aims set out? It is unlikely, as a more deconstructionist approach is required to ‘unmask’ the power that flows through discourse and versions of knowledge.

I came to the realisation that investigating power is a powerful process and it organised me into a position where I questioned the ethics of my research. It would have been easier not to use such a critical approach and work with these difficult dynamics. However, if I had not asked the questions I did and analysed them using discourse analysis, I would have felt that I was ‘colluding’ with the power plays that I set out to ‘unmask’. Being a trainee I may not have had the ‘right’ to deconstruct the ‘experts’ discourses on ADHD. Perhaps I am one of the ‘resistant’ discourses that would remain subjugated employing more traditional research methods. What are the wider implications of this?

Considering my subject position and ‘trainee’ status left me feeling low on the ‘hierarchy of power’ what implications would this have in clinical practice? Clients and families may experience an even bigger power differential between themselves and the psychiatrists. If this is the case it is unlikely that they will get the opportunity to have their concerns heard. This will further exacerbate the marginalising of alternative discourses. This realisation was encouraging when addressing my ethical concerns. In fact, as I reflected more and more on these concerns I began to question whether it would be ‘unethical’ not to explore the relationship between discourse, knowledge and power in relation to ADHD.

As I developed a better understanding of my ethical concerns, I felt more confident in doing this research. Furthermore, looking at how I was organised by my ethical concerns assisted in the analysis and discussion. Guiding these reflections and maintaining my motivation for this study was further developed through support and enthusiasm from my supervisors as well as other professionals working with children and families.

Using a ‘critical’ research method
As discourse analysis is sometimes described as a ‘critical’ approach, it could be argued that the participants should be informed of the research method that will be used. In this study, although the participants were told that I was using a more social constructionist qualitative research methodology, I did not explicitly state that it was discourse analysis. Parker and Burman (1993, p. 35) state that “it is simply not possible to tell the subjects everything which they could be told about the study” as it might “alter those critical aspects of their behaviour which are of interest to the researcher”. Nonetheless, no intention was made to deceive any of the participants and my aim to examine the
knowledges around the interventions for ADHD was made explicit on the Information Letter distributed prior to the study. Also, the Research Consent form invited the participants to refuse to answer any questions, or withdraw from the interview at any time if they wished. They were also invited to read an analysis of their transcript to begin to make a comparison between our interpretations of the text. All of these measures were carried out with respect to the confidentiality of each of the participants. However, although these measures were taken to address some potentially difficult ethical issues, now that I have a better understanding of the social constructionist epistemological position, if I was to repeat the study I would identify the selected research method at the outset. This disclosure would serve to minimise any imbalances of power between the researcher and participants.
Appendix 7
Information sheet for volunteers
Effective interventions for children with ADHD: A psychiatric perspective

Dear Dr ********

I am writing to you to introduce myself in the hope that I can meet with you to pursue my research interests for my thesis. I am currently in the final year of my PsychD in clinical psychology at Surrey University. I have also recently completed my child and family placement at the NHS Trust. Whilst working in the NHS Trust, I became aware of the impact of Attention Deficit Hyperactivity Disorder (ADHD) on such a large number of children, their families, and their schooling. My understanding of these difficulties was further informed through attending lectures, debates, and discussions provided within the locality.

Psychiatrists are well informed about ADHD and there is a sound evidence base. However, research has identified some gaps in the knowledge of the effects of stimulants on children. Furthermore, although recommendations have suggested that an improvement in psychological therapies may be beneficial to help meet these children’s needs, it is not clear what drives decisions to provide this type of intervention.

The potential developments in the field of ADHD could well be modelled on the improvement of interventions and knowledge bases for the depressive disorders. Indeed, the effectiveness of treatment for depression was progressed through an improved medical understanding, alongside the development of psychological approaches for the emotional disorders.

With this in mind, the aim of my research is to investigate psychiatrists’ perspectives on the advantages/limitations of medical interventions for children with ADHD. I would also be interested to hear your thoughts on the advantages/limitations of forms of psychological intervention for this client group, as well as how a cross-disciplinary approach could be of maximum benefit.

Please could you let me know if you are willing to share your thoughts and knowledge on ADHD. If you are, this would involve a 50-minute interview (please complete and return the attached form overleaf). The interview will be conducted at a venue that is convenient for you. I hope to complete the interviews between **** and ****. Your confidentiality will be protected and you (or any person or organisation mentioned) will not be identifiable to others. The interview will be audio-taped which following transcription will be destroyed. All data will be respected in accordance with the Data Protection Act (1998).

This research is conducted in collaboration with Dr Nan Holmes (Chartered Clinical Psychologist, University of Surrey) and Ms ..., Consultant Clinical Psychologist (NHS Trust). In the interest of dissemination of information, I intend to present the findings back to the Trust as well as to write a paper. I would also be pleased to feedback the findings to the participants individually if so desired.

Thank you in anticipation.

Mark Grixfi
Trainee Clinical Psychologist
University of Surrey
I would/would not be willing to be interviewed for this piece of research on ADHD.

-If the answer to the above is affirmative then please state a preferred date(s) that you would like to be interviewed.

-Preferred venue for the interview.

Contact telephone number:

E-mail:

Signed:

Print:

If for any reason you prefer not to be contacted again by me, please indicate this on the form before returning it.
Appendix 8
Research Consent Form

A reflexive investigation into the effectiveness of treatment for attention deficit hyperactivity disorder

I am conducting a piece of research as a part of my PsychD course in clinical psychology. I would like to invite you to share with me some of your thoughts, experiences and feelings around the effectiveness of treatment for attention deficit hyperactivity disorder in children. Some of the issues that are of particular interest are; what are the most effective interventions, with whom are they most effective, the areas which need to be further understood to improve effectiveness and the role of psychological therapies in treatment. To do this, I would like to complete a short interview with you for approximately 50 minutes. The interview would be audio-taped.

Care will be taken to ensure that you (or any person or organisation that you mention) cannot be identified through the report. In making a transcription of the audio-tape, any names will be deleted or replaced by pseudonyms. After the transcription has been made a copy will be sent to you for verification purposes (unless you specify otherwise) and then the audio-tape will be destroyed.

If there are any questions that you do not wish to answer feel free to say so. If there are any questions you would like to ask during the interview, please feel free to do so. Your participation is entirely voluntary. You are free to withdraw from the study at any point without needing to justify your decision.

Please read the following. If you are in agreement, sign where indicated.

I confirm that I have read and understood the above information and agree that the purposes of this research and what my participation in it would entail, have been clearly explained to me in a manner that I understand. I therefore consent to be interviewed about my thoughts, feelings and experiences concerning the treatment of attention deficit hyperactivity disorder. I also consent to an audio-tape of this interview being made and to all parts of the recording being transcribed for the purposes of this research. I understand that all personal data will be held and processed in accordance with the Data Protection Act (1998). I agree that I will not seek to restrict the use of the results of the study on the understanding that my confidentiality is preserved.

Participant's Signature
Signed: ........................................  Date: ......................................

Please Print Name: ..................................................................................

The confidentiality of the above participant will be protected and they (or any person or organisation they mention) will not be identifiable to others. Use of the audio-tape or transcribed material will be for the purposes of research only. Confidentiality will be ensured in respect of the audio-tape and transcription in accordance with the Data Protection Act (1998).

Researcher's Signature
Signed: ........................................  Date: ......................................

Please Print Name: ..................................................................................

Witness' Signature
Signed: ........................................  Date: ......................................

Please Print Name: ..................................................................................
Interview Schedule

1. Context Section

Descriptions
Just so we can get a common understanding, could you tell me how you would describe "ADHD"?

- Core symptoms
- Thresholds for "abnormal"
- Is it a mental illness?

Diagnosis
How do you make your diagnosis of ADHD?

- Which classification system (differences in these)
- Comorbidities
- Pressures from profession/parents to diagnose which go against own beliefs?
- Any personal reservations/concerns around diagnosis?

Causes
What would you say the cause(s) of ADHD are?

- Biological or Psychological or genetic? (How do we know this?)
- Where is ADHD located? |In child or elsewhere?
- Explore neurological/environmental relationship.
- If biological why are numbers rising? (what has changed – professionals or children?)
2. Intervention section

**Intervention**

Which forms of intervention would you advocate for ADHD?

- What for whom?
- How is this known?
- Explore theory/practice links and clinical experience.
- Specificity of interventions?
- Personal/professional opinions?
- If one intervention is so effective is it necessary to develop other approaches?
- Who measures effectiveness? (child?)
- In a typical case, what would the child’s perception of effectiveness be?
- *If answer is to concentrate and comply – Is drug used to “pacify adults”?*

What does the drug actually do to treat ADHD?

- Did theory come before the practice? (post hoc)
- Explore temporal dimension of treatment development – “a pill for every ill or an ill for every pill”.

How do you decide which children would benefit from which treatment when you are considering which intervention to recommend?

- Referral decisions

Does the preferred intervention work with all children with ADHD?

- The effects of it with non-ADHD children?

Explore the risks associated with medical interventions.

- Long/short-term effects? Risks?
- How is this known?
- Personal/professional opinions?

What is the effect of current guidelines on determining treatment approaches?

- Restrict or empower the psychiatrist? (NICE)
Appendix 10
Transcription Symbols

(.) pause in talk less than 2 seconds
(5) 5 second gap
.hh speaker’s in breath
.hh speaker’s out breath
= no gap between speakers/overlapping talk
- break off a sentence abruptly
but emphasis
(but) inaudible or doubt about its accuracy
(laughing) classificatory information
practice extension of preceding vowel sound
(()) a description of a non-verbal activity
**** Detail anonymised

Use commas and full-stops as required to improve clarity of read.
Appendix 11
An empiricist account

This response was to a question about the confidence of using stimulant medication.

Transcript 2 - Dr Edmund
344: because it has been around for about 50, 60 years erm and it
345: is probably one of the best research drugs around in
346: psychiatry erm (7) erm you know, it is much better researched
347: than any other intervention in psychiatry (.) there are most
348: things published with methylphenidate than most of these
349: psychological treatments (.) psychiatric treatments in
-->MEMO: memo65
350: general (.) psychiatric or psychological treatments. I am

In Dr Edmund’s (transcript 2) empiricist account he uses a similar rhetorical device to Dr Pava (Excerpt 3, transcript 7) of explicit consensus. Dr Edmund invokes the factor of time in supporting the use of stimulants in stating, “because it has been around for about fifty, sixty years erm and it is probably one of the best research drugs around in psychiatry” (lines 344-346).

Dr Edmund could be seen to further qualify this statement by introducing psychological interventions as a comparative measure of empirical inferiority by asserting, “there are most things published with methylphenidate than most of these psychological treatments” (lines 347-349). A more micro level consideration of this statement could be used to consider how Dr Edmund uses the word “most” (lines 347-348) to construct a continuum of empirical evidence in which he places methylphenidate at what appears to be the favourable end. This use of “most” is another example of an extreme case formulation, which can be be understood as warranting a stronger case for medicating over psychological treatments. This statement exemplifies the way in which “data are depicted as ‘doing confirming’ and ‘concluding’ independently of the actions of the scientists” (Edwards and Potter, 1992, pp. 135). Moreover, the outcome data of treatment trials could be perceived as secondary, as they are not even referred to. Instead, the quantity of “things published” (line 348) alone are used here to warrant a particular treatment approach.

Positioning
Dr Edmund’s response followed the question:
340: Mark: I wonder how confident people are about using
341: methylphenidate with ADHD?

In this case the question is constructed in a simpler way than in the Dr Pava example (transcript 7; lines 289-292). The question is softened using “I wonder” (line 340) in which the subject position of an unknowing agent is occupied. In turn, the respondent is positioned as the informant who would be expected to supply answers to the questions. However, it should be acknowledged that the creation of such positions is not linear but the result of a cumulation of fragments from an ongoing narrative (Davies and Harré,
1990). Indeed, the positions may be influenced by known roles, as Dr Edmund was aware that I was also a trainee clinical psychologist. This knowledge may contribute to the specific speech conventions such as, researcher-participant, student-teacher, psychologist-psychiatrist.
A personal/professional contingent account

This was the response to the Dr Gola being asked which treatment approaches he preferred.

Transcript 4 - Dr Gola
289: Dr Gola: I think I would probably if it's not too severe to try to try the psychological and behavioural methods first. Erm but I must say and I don't know why I have got to this point although I do that I have found out that even when I do that I end up having to prescribe medication eventually. And sometimes I question whether that is an appropriate way of doing it.

This question appears to have invoked some level of uncertainty for Dr Gola. He begins with two comments that indicate this in line 289, with “I think” and “I would probably”. He then constructs a continuum of severity and classifies psychological and behavioural methods of intervention as worth trying with the milder end of the disorder (line 289-290). So far he appears to be using a personal contingent account as he conveys a more personal preference for intervention with less severe children. However, from line 291, this personal contingent account appears to be resisted by another discourse. Dr Gola seems to recognise this subtle shift in stating “I don’t know why I have got to this point” (lines 291-292). He then disclaims the approach that he initially supported by saying that “I end up having to prescribe medication eventually” (lines 293-294). It could be the dominance of a professional contingent account that moved him to this position. The words “having to” indicate that he is a clinician who is ‘forced’ to prescribe medication. However, the personal contingent account reappears as he expresses with the comment “And sometimes I question whether this is an appropriate way of doing it” (lines 294-295).

Positioning
The shift between personal and professional accounts serves the function of constructing Dr Gola as a thoughtful practitioner with reservations around the use of medication. He is then positioned as ‘helpless’ as he is ‘forced’ to prescribe mediation despite his reservations. Having removed responsibility for this action, he then objectifies prescribing by questioning it appropriateness. This puts him in a position where it would be difficult to challenge his choice of intervention.