A Narrative Analysis Investigating the Impact of First Episode
Psychosis on Siblings' Identity

by

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Volume I

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Introduction to the Portfolio

The work presented in this portfolio was carried out across a three year period as part of the PsychD Clinical Psychology programme at the University of Surrey.

The portfolio is divided into two volumes. This is volume one of two. The volumes contain the following:

Volume One

Volume 1 contains academic, clinical and research dossiers. The academic dossier comprises two essays, three Problem Based Learning reflective accounts and a summary of two Professional and Personal Learning Development Group accounts. The clinical dossier contains summaries of Clinical Placements undertaken throughout training, summaries of four clinical case reports and a summary of an oral presentation of clinical activity. The research dossier contains a Major Research Project, Service Related Research Project, the abstract of a Qualitative Research Project and a research log.

Volume Two

Volume 2 contains an academic and a clinical dossier. The academic dossier contains two Professional and Personal Learning Development Group Process accounts. The clinical dossier includes the four case reports that are summarised in Volume 1, and the documentation that was submitted in support of the oral presentation of clinical activity, also summarised in Volume 1. The clinical dossier also includes documentation from all clinical placements undertaken as part of the training course.

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Critically evaluate the contribution of attachment theory to the formulation and treatment of borderline personality disorder

December 2007

Year I

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Introduction

My interest in attachment theory attracted me to this essay title, having first been intrigued by this subject as an undergraduate. At this time, I found myself reflecting upon my own early years and how they and the relationships that I had formed may have affected my development and the person I had become. I found the subject fascinating and was somewhat unnerved that early experiences, most of which are beyond our control, might influence us so dramatically.

I found myself thinking in similar ways throughout my first job in mental health. Working as a health care assistant with adolescent and young adult inpatients diagnosed with anorexia nervosa, I spent much of my time in an observing role. It struck me how few patients received visitors, and furthermore, the levels of distress I observed in many of the patients on the rare occasions when members of their family did visit. I distinctly remember the occasion when a fifteen year old patient broke through a window with her arm in an attempt to escape a family therapy session she had been forced to attend. Difficult and complex family relationships seemed to be a theme across this patient group and, regardless of the cause, appeared to be one of the maintaining factors of their serious debilitating illness.

My first job as an assistant psychologist was in a Child and Adolescent Mental Health Service. In this job, I was able to make interventions with a range of children and their families to address some of the difficulties they were experiencing and the possible implications that these were having on the child. Working with children at different stages of their development was a very enriching experience and again issues of the relational bond to their parent were in the forefront of my mind.

Thereafter, I worked as an assistant psychologist in a recovery unit for adults experiencing enduring mental health problems; a medium secure hospital with both men and women; and am now currently on placement as a trainee clinical psychologist in a Community Mental Health Team (CMHT). Throughout my work in adult mental health, a number of issues have become apparent to me.

Firstly, I noted how many of my patients' difficulties and behaviours were similar to those I observed in children and adolescents, transposed onto adult issues such as problematic romantic relationships. I also perceived that little emphasis was placed by many practitioners on the patients' developmental history or, possibly even more worryingly, on their family, friends and other important relationships.

Most of all, however, I was perplexed at how mental health colleagues appeared to have little hope for patients' with a diagnosis of Borderline Personality Disorder (BPD). It seemed from my perspective that, if a patient had been diagnosed with BPD, professionals would dread working with that patient. This type of response is highlighted in many texts. Freeman *et al.* (2005) for example, stated that "few categories seem to strike as much fear into the hearts of clinicians as does the term borderline personality disorder" (p.1).

Through reading and speaking with colleagues, I began to understand some of the challenges involved in working with patients diagnosed with BPD. I was also interested to observe that many of the symptoms and behaviours characteristic of people with BPD were akin to those of children diagnosed with attachment disorder, particularly the pattern of drawing people in, and then pushing them away. These observations and my curiosity in this area have driven me to focus my essay on the contribution of attachment theory to the formulation and treatment of BPD.

I will begin by briefly describing attachment theory and BPD and will then identify connections that have been made between them. I will go on to explore some of the ways that attachment theory has been applied to the formulation and treatment of BPD. In analysing this, I noticed a recurring theme in the process of treatment for people with BPD: the emphasis placed upon the therapeutic relationship. The discussion will focus on this relationship, as part of which I will highlight various therapeutic approaches. I will not analyse these at length although am aware that they are worthy of detailed exploration in their own right. Finally, I will explore the implications of attachment theory's contribution to the formulation and treatment of BPD on service users and therapists and highlight some of my own reflections.

Overview of Attachment Theory

Attachment theory is an ethological and evolutionary theory, originally introduced by Bowlby (1979) to understand the complex role of relationships in human development. Bowlby's theory suggests that young children develop patterns of attachment which are influenced by interactions with their primary caregivers, usually a parental figure, within the first two years of life. The primary caregiver's behaviour and responses to the child are highly significant in the development of the child's

pattern of attachment. According to this theory, the pattern of attachment developed serves to create a system of thoughts, feelings and behaviours, known as the internal working model, which is thought to organise personality development and subsequently act as a reliable predictor of communication style and behaviour in future relationships.

Through observing infant-mother attachment in an investigation known as the Strange Situation, Ainsworth *et al.* (1970) identified and described three principal patterns of attachment. These patterns have been referred to in numerous texts using a number of different terms. To summarise, the various texts (e.g. Ainsworth *et al.*, 1970, Bowlby, 1988, Cassidy & Berlin, 1994) identify the following patterns of attachment.

Secure patterns of attachment are developed by children who have confidence that they will receive help, nurturance and emotional warmth from their primary caregiver at times of need. Caregivers of these children are most likely to be sensitively responsive and available to the child and to provide both safety and stability. Securely attached children are able to explore the world freely from the safe secure base provided by their primary caregiver. This group is often classified as type B.

Insecure-resistant patterns of attachment are developed by children who are unsure how their caregiver will respond to them. Caregivers of these children are available at times, but are not always responsive and do not provide consistent emotional warmth. This pattern is further promoted by periods of separation and where abandonment is used as a threat. These children alternate between clingy and demanding behaviour and displaying anger and resistance. Preoccupation and ambivalence toward their caregiver is characteristic of children in this category. This group is often classified as type C.

Insecure-avoidant patterns of attachment are developed by children who expect to be emotionally rejected when they seek help or care. Caregivers of these children tend to reject or ignore the child when they are approached for comfort. These children tend to emotionally withdraw from their caregiver. Children in this category might attempt to become emotionally self sufficient as their internal working model develops. This group is often classified as Type A.

Main *et al.* (1981, as cited in Bowlby, 1988) highlighted a fourth pattern of attachment to describe those children whose behaviour during the strange situation assessment procedure seemed to be a disorganised version of insecure-resistant and insecure-avoidant patterns. These children seem confused and unable to relieve their feelings of anxiety. They perceive their caregiver as either frightened or frightening. Children in this category appear unsure whether to approach or withdraw from their caregiver, a concept known as an “approach-avoidance dilemma”. This pattern of attachment has frequently been linked to physical abuse and neglect by the parent. This group is often classified as Type D. I will use the terminology D(C) to refer to disorganised/resistant styles, and D(A) to refer to disorganised avoidant styles.

According to Attachment Theory, children who experience consistent rejection by their caregivers respond by withdrawing in attempt to protect themselves. Those children who experience inconsistent parenting respond in a way that is both pursuing of comfort (clingy) and rejecting of their caregivers (angry). These responses are considered to be the child’s attempt to keep safe. In the insecure attachment styles, these strategies might be at least partially successful for the child. In the disorganised form however, it is likely that no strategy at all would be helpful. Regardless of how helpful the child’s coping strategies are, the internal working model suggests without corrective experiences, these children are likely to respond to other people in their life using similar patterns, and therefore set up relational styles similar to those found in these early familial interactions (Bowlby, 1988).

Overview of Borderline Personality Disorder

The prevalence of borderline personality disorder (BPD) is estimated to be approximately two percent of the adult population, approximately seventy-five percent of whom are young women (National Institute of Mental Health, 2007). As well as being highly prevalent, it is highly debilitating. It is estimated that patients with BPD account for twenty percent of inpatients on mental health wards, ten percent of outpatients (National Institute of Mental Health, 2007) and six percent of patients seen in primary care (Levy, 2005).

To identify what is meant by BPD, I referred to the Diagnostic Statistical Manual for Psychiatric Disorders, Fourth Edition (DSM-IV, 1994, as cited by Borderline

Personality Today, 2007) as it is more widely used than the International Classification of Diseases, version 10 (ICD-10, 1999) in respect of this “mental disorder”. I felt that it was important to use diagnostic criteria to define BPD as this encapsulates the range of symptoms people with diagnosis might present.

There appear to be three key components to a diagnosis of BPD. These are impulsivity, difficult and unstable relationships and affective instability. The DSM-IV (as cited by Borderline Personality Today, 2007) states that for a diagnosis of BPD, five or more of the following criteria have to be met:

1. Frantic efforts to avoid real or imagined abandonment.
2. A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation. This is called "splitting."
3. Identity disturbance: markedly and persistently unstable self-image or sense of self.
4. Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating).
5. Recurrent suicidal behaviour, gestures, or threats, or self-mutilating behaviour.
6. Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days).
7. Chronic feelings of emptiness.
8. Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights).
9. Transient, stress-related paranoid ideation or severe dissociative symptoms.

Levy (2005) describes BPD as “characterised by a pattern of chaotic and self-defeating interpersonal relationships, emotional lability, poor impulse control, angry outbursts, frequent suicidality, and self mutilation” (p.959), a description that is probably well recognised by professionals working with patients with this diagnosis.

Connections between Attachment Theory and Borderline Personality Disorder

Connections between attachment theory and personality development were identified by Bowlby himself. Bowlby (1979) believed that “many forms of disturbed personality functioning reflect an individual’s impaired ability to recognise suitable and willing figures and/or an impaired ability to collaborate in rewarding relationships with any such figure” (p.104). Bowlby defines a suitable figure as someone who is able to provide a secure base. He explained that “such impairment can be of every degree and take many forms: they include anxious clinging, demands excessive or over-intense for age and situation, aloof non-committal, and defiant independence” (p.105).

Bowlby (1977, cited in Levy, 2005) believed that childhood attachment is at the root of a range of adult dysfunctions including personality disorders and further he proposed that disordered personality traits develop from an insecure attachment style. Bowlby (1973) therefore “not only postulated that early attachment experiences have long-lasting effects that tend to persist across the lifespan, but are among the major determinates of personality organization and pathology” (cited in Levy, 2005, p.967).

A number of papers have explored specific links between attachment theory and BPD, and, not surprisingly to me, having noticed similarities myself, have tended to suggest a link between BPD and insecure or disorganised attachment styles. Levy (2005) reviewed a number of studies that examine the relationship between attachment patterns and BPD. In summary, he found an inverse relationship between scores on borderline dimensions and secure attachment across all studies. Many authors report specifically on which type of attachment style is related to BPD.

Levy (2005) reported that studies that used self-report measures consistently found a significant negative correlation between the traits of BPD and secure attachment and a significant positive correlation between the traits of BPD and both fearful avoidant (A) and preoccupied (C) attachment styles. He highlighted that earlier interview studies he reviewed found BPD to be linked with preoccupied and unresolved attachments, “especially angry preoccupied and fearfully preoccupied” (p.973). The

more recent studies in his review found no connection with one specific attachment style.

However, in a recent study Holmes (2005) does link BPD with a specific pattern of attachment. Holmes (2005) explored the links between the traits of disorganised attachment style (D) and the criteria for the diagnosis of BPD. He suggests that the traits seen in disorganised patterns of attachment mirror the criteria for BPD, with the approach-avoidance dilemma being central to both. Holmes (2005) supports his propositions with the findings of Hobson *et al.*, (2002, as cited in Holmes, 2005) who “found that a group of patients suffering from BPD (as opposed to Major Depressive Disorder) were almost entirely classified as unresolved/preoccupied on the AAI” (Holmes, 2005, p.183). The AAI (Adult Attachment Interview) is an interview designed to assess adults' patterns of attachment (Cassidy & Shaver, 1999). “Unresolved” is one such pattern and mirrors the traits seen in children with disorganised attachment. The “preoccupied” label is reminiscent of descriptions of the insecure –resistant. It is therefore possible these adults might well have been classified as disorganised/resistant, type D(C) as children.

Stroufe (2005) reports preliminary findings from a longitudinal study investigating the place of infant attachment in human development through following infants from birth through to adulthood. The study found a clear relationship between attachment history, the growth of self-reliance, the capacity for emotional regulation, and the emergence and course of social competence. In addition, the study revealed that particular attachment patterns had implications for both normal development and pathology. Stroufe (2005) identified a longer term goal of this study as linking attachment history with personality disorders, suggesting a lack of certainty in this area.

These connections support my initial inclination that attachment theory does have strong links with BPD, but there does not seem to be enough evidence or consistency to suggest that it is related to type C or D(C) as I would have thought from my observations of child and adult behaviour. It is possible that traits of BPD can be understood by more than one specific attachment style as well as other factors during development e.g. later relationships, such as with teachers, peers, and other relatives.

In terms of formulation and treatment, I am unsure whether a connection, beyond that of BPD and insecure attachment is necessary. Perhaps the contribution of attachment theory is best used in an attempt to understand some of the developmental aspects of BPD and some of the difficult internal states that patients with BPD experience. A less definitive connection such as this may in fact prevent professionals from making assumptions about individual patients and their relationship styles, and therefore encourage them to use attachment theory more collaboratively with patients in the formulation and treatment process. This approach may lead to a more accurate formulation as, although patients with BPD have met criteria for a diagnosis, their individual symptoms and histories will vary significantly. Perhaps a consistent feature for patients with BPD is their preoccupation with safety, developed from an inability to trust others caused by their experience of their primary caregivers in infancy.

The contribution of Attachment Theory to the Formulation and Treatment of Borderline Personality Disorder

There are currently no clinical guidelines for the treatment of BPD. A need however, has been identified, and following a referral from the Department of Health (DoH), the National Institute of Clinical Excellence (NICE) are currently developing the clinical guidance which will provide the NHS with recommendations for best practice.

Currently, BPD is treated through a number of different approaches. These include dialectical behaviour therapy (DBT) (Lineham, 1993), schema-focussed therapy (Young *et al.*, 1990), cognitive analytic therapy (CAT) (Ryle *et al.*, 1997, as cited in Winston, 2000) and psychodynamic approaches (Holmes, 2004). Each of these approaches consider the patients' early experiences, including their relationship toward their primary caregiver, providing further evidence that attachment theory is valuable in the process of formulation and treatment of BPD.

DBT (Lineham, 1993) proposes that patients with BPD have deficits in interpersonal and self-regulatory skills which arise partly from invalidating environments during their upbringing. The goal of DBT is to teach patients new skills to deal with their intense

emotions. This is achieved through a high level of therapist involvement, including telephone contact outside of working hours.

The function of the schema-focussed approach (Young *et al.*, 1990) is to identify and modify the patients 'early maladaptive schema' that are characteristic of patients with BPD. The goals for therapy are to build upon the client's 'healthy adult mode', care for 'the abandoned child', reassure and replace the 'detached protector', conquer and drive out the 'punitive parent', and help the 'angry child' to learn appropriate ways to express emotions and needs. Schema therapists incorporate Bowlby's notion of the secure base into their work with patients with BPD, whereby the therapist serves as a 'secure base' from which the client is able to explore the world and in doing so, rework their internal working models.

CAT assumes that inadequate parenting prevents patients with BPD from being able to integrate states of self. CAT encourages patients to make connections between their early experiences and their current behaviour. Through a collaborative therapeutic relationship, patients learn new and healthier ways of relating to others and self-states are identified (Winston, 2000).

Psychodynamic therapy generally uses the clients' transference relationship (the client responds to the therapist as if the therapist were an important person, such as a primary caregiver) to provide insight and eventually change the emotional and cognitive patterns that have developed (Diamond *et al.*, 2003). From a psychodynamic perspective, Holmes (2004) argues that the "approach-avoidance dilemma" observed in patients with BPD is manifested in disturbed transference/counter-transference interactions between the therapist and client.

While, as shown above, the inclusion of early "invalidating environments" and "inadequate parenting", together with the development of "early maladaptive schema" is reminiscent of the difficulties of children who fail to develop a secure attachment, the main theme that stands out for me within these different treatment approaches is the therapeutic relationship in the treatment of BPD. This is demonstrated in the need, described above, for a high level of therapist involvement, the therapist modelling "care for the abandoned child" and also providing a "secure base", the requirement for a "collaborative therapeutic relationship" or a "transference relationship". Conceptually, this seems logical. Given that the unsafe relationship in infancy might well be a primary cause of adult BPD, it might be

considered that a corrective, safe relationship, possibly with a therapist, might be a way of helping people with BPD.

A number of other papers focus on attachment and therapeutic relationships. Relationship work for the insecurely attached child, with both a therapist, and with their primary care giver, is used to help children with attachment difficulties. Hughes (2004) describes a psychological treatment based on attachment theory for maltreated children and young people who had failed to develop healthy attachments toward their caregivers. The goal of treatment is that through attunement with therapist and caregiver, children are able to activate aspects of self that had previously been blocked and therefore begin to develop an integrated sense of self. These young people might well be at risk of developing BPD in the future. I would suggest that interventions based on attachment theory at a young age could prevent a future diagnosis of BPD.

Byng-Hall (1997), like those who work with insecurely attached children and their carers, suggests that "a family therapist can provide a temporary secure base for the whole family during therapy" (p.29). He proposes that once this secure base, albeit temporary, has been established, the family are then able to establish and strengthen their family base, from which they are able to explore problem solving techniques that will maintain following therapy.

Lord (2007) has found a systemic approach to working with patients with BPD very useful. In this approach, members of the treatment team create a "reparative therapeutic family system" (p.204). Through this system, a safe environment is created for the patient from which, they can grow and heal.

Through clinical observations and psychotherapy consultations, Gunderson (1996) also found that reliable, but not excessive responsiveness of therapists can help to diminish feelings of feared aloneness experienced by patients with BPD.

Lastly, Pine (1985, cited in Bender *et al.*, 1995) highlighted the significance of patients' attitudes toward the therapist. He states that "change comes about through the use the patient makes of the therapist, whether the therapist wills it or not—in parallel to the use the child makes of the parent. The patient uses the therapist as an object of identification, a source of education, and a source of confirmation" (p.220).

Implications for Service Users and Therapists

While the therapeutic relationship might be the healing vehicle for the patient, it can have its difficulties for the therapist, as suggested above in the disturbed counter-transference of therapists. Bender *et al.* (2003) investigated attributes of mental representations of therapists by patients with specific personality disorders, including patients with BPD. They found that those patients with BPD “exhibited the most difficulty in creating a benign image of the therapist” (p.219). This could explain therapist’s “dread” of working with patients with BPD, as the patients cast them in a harmful role.

Holmes (2004) suggests that the transference/counter-transference interaction might be addressed by “meta-cognitive monitoring”, an approach derived by Main (1995, as cited in Holmes, 2004) for working with children classified as disorganised (D). Meta-cognitive monitoring is a process whereby the therapist recognises their overwhelming feelings of counter-transference and interprets these feelings as a representation of the patients needs or emotional state. The therapist then uses this interpretation in therapy to initiate a “conversation about conversation” which introduces “the BPD sufferer to the possibility of a shared language of intimacy” (Holmes, 2005, p.188).

In order to deal with these difficult counter-transference issues, therapists will need to ensure they themselves maintain supportive relationships in both their professional and personal lives. Good supervision and team working will be paramount when working with patients with BPD.

Another implication of this approach is that patients with BPD might struggle to form a relationship with their therapist due to finding relationships of any kind so terrifying. Patients may expect to be “rejected, criticised, or humiliated” (Bowlby, 1988, p.143). With this in mind, I suspect drop out rates might be high. Therapists may therefore need to find ways to encourage continued engagement including explicitly stating the boundaries of the relationship, as well as possibly allowing for higher than normal non attendance without closing the case. Boundaries, while seeming to contradict an attachment style relationship, might make the relationship “safe enough” for a patient to remain in therapy, and, allowing occasional non-attendance might be essential within these boundaries.

The Department of Health (DoH) in 2002 sought service users' thoughts and views on services for people with personality disorders. The DoH report highlights that service users are very aware of the negativity connected to the diagnosis of BPD. Many of the service users had been called time-wasters, difficult, manipulative, bed-wasters or attention-seeking. Some service users felt that a more appropriate description would be "attachment-seeking". The report states that service users "often sought basic acceptance and someone to listen to them" (p.1). In addition, 'The need for attachments (friendships and other relationships) was recognised as an important ongoing need for all' (p.2). An attachment based formulation and treatment plan might therefore be one way of listening to and accepting service users need for attachment.

The contribution of attachment theory to the formulation of BPD may also help to mitigate the negative connotations that are associated with the diagnosis. Identifying a patient with BPD as an 'abandoned child' (in adult form) might be a more attractive concept to both service users and therapists.

It is also important to consider diversity. Social status, gender, age, ethnicity, disability, language and power difference are all issues that may have implications for service users and therapists. Coleman *et al.* (1995) for example, found that ethnic minority patients preferred therapists from a similar ethnic background to themselves. This highlights how important it is to explore difference with patients, especially in the context of an attachment based therapeutic relationship. Patterns of attachment are also likely to be culturally different, and what is perceived to be problematic in one culture, might be regarded as normal in another. It will be important to consider of this in formulation and treatment to reduce assumptions when working cross-culturally, and with difference in general.

Conclusion

While there is some evidence to suggest that BPD links back to particular patterns of attachment, the research in this area is inconclusive. The results of Stroufe's (2005) longitudinal study may shed further light on this connection.

The majority of literature regarding the contribution of attachment theory to the formulation and treatment of BPD is theoretical. A number of theories identify the use of attachment theory in formulation and treatment and, interestingly, of the therapeutic relationship.

I am inclined to think that the contribution of attachment theory is very important for the formulation and treatment of this adult disorder. The similarities between insecure patterns of attachment and traits of BPD would suggest to me that attachment theory can be used to hypothesise on patients' thinking, beliefs, and assumptions. I would suggest that further research in this area could identify further important evidence of links between BPD and attachment styles and may encourage therapists to consider attachment theory in formulating a patient's problem and inform practice.

It appears that the contribution of attachment theory informs and aids the therapeutic relationship which seems integral in the process of treatment for patients with BPD. Whilst I think that attachment theory provides a valuable contribution in this area, I would stress that it is not the only aspect to be considered in the formulation and treatment of BPD. It may be more useful in some cases than others, depending on an individual's circumstances.

I will be interested to see whether the contribution of attachment theory and/or importance of the therapeutic relationship to the formulation and treatment of BPD are included in the clinical guidelines currently being developed by NICE.

My research in this regard has developed my awareness of attachment theory and how it might contribute to formulation and treatment in a variety of different approaches. This awareness is likely to impact upon my clinical work, not just in the context of BPD, but with patients exhibiting a variety of presenting problems. It might be useful to apply attachment theory to all patients experiencing interpersonal difficulties, regardless of whether a diagnosis of BPD has been given. I am more likely to consider patients' early relationships in the formulation of their current difficulties, and expect that I will consider the nature of the therapeutic alliance and how this might contribute toward therapeutic outcome to a greater extent.

I hope that I will also be more aware of my own, possibly counter-transferential, feelings in therapy, and the impact of these on the therapeutic relationship. I intend

to explore many of these themes in supervision, and to consider how I might incorporate them into my own clinical practice.

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Professional Issues Essay

Identify some key ethical dilemmas for multidisciplinary team working. Using examples from your practice and relevant theory and research, show how these dilemmas might be explored, understood, and addressed.

January 2009

Year II

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Introduction

My interest in ethical dilemmas within multidisciplinary teams (MDTs) began with my first employment in mental health as a health care assistant in an inpatient eating disorders unit shortly after my undergraduate degree. The MDT was led by a psychiatrist and comprised many different professions. Very soon, I observed clinical practice by experienced nursing staff that I saw as unethical: for example allowing a clinically underweight patient extra time on the exercise bike as a 'treat' and using the possibility of a patient being tube fed as a threat.

I was fortunate to have supervision with a clinical psychologist, and was therefore able to reflect and act on these issues. The power imbalance of being an unqualified, new member of staff struck me and I became aware of the power struggles between and within professions, and between professionals and patients. Thereafter, as an assistant psychologist and now as a trainee clinical psychologist, I have been a member of five further MDTs, each structured differently, with different client groups, and within various settings.

While I have experienced effective team working, I have also learnt that the nature of MDT working can lead to a high prevalence of ethical dilemmas. I chose this essay title firstly because I felt it would be a valuable opportunity to reflect on my own experiences and also to explore issues within MDT working further by relating them to psychological theory and considering how they might be addressed. As the direction of the Health Service is changing, in particular through the introduction of 'New Ways of Working' which has implications for professional groups within the NHS, including Applied Psychologists, I also thought it would be useful to consider my own position in relation to MDT working.

Outline

I will begin this essay by introducing the concept of the MDT and its origins in healthcare as this helped me to understand the possible origins of the challenges that occur in MDTs. I will then explore some of the ethical dilemmas that can occur in MDTs by considering some of the challenges identified by research into MDT working and some of those which I have encountered. Exploring and understanding the origins of ethical dilemmas can be useful when considering how such dilemmas might

be addressed. As it is not possible to consider all possible challenges or dilemmas within this essay, I will focus on those most pertinent to my experience and review of the literature.

Ethical issues are complex and can be addressed in a number of ways. Again, because of the confines of this essay, I have chosen to consider how such issues might be addressed by exploring how a systemic approach could be employed to improve team functioning. I will also discuss the potential role for clinical psychologists within this process and how I hope to apply such ideas to my current practice and in my future career when I may have more power to influence MDT working.

Multidisciplinary Teams

In 2000, Health care policy in the UK stated: *“Radical changes are needed in the way staff work to reduce waiting times and deliver modern, patient-centred services”* (Department of Health, 2000, p.82). Role changes and more flexible team working between different clinical professions were highlighted as two of the changes required to reform health care provision. A review of the research evidence into team work in primary care found that benefits included more clinically and/or cost effective services; more satisfying roles for health care professionals; a more responsive and patient focussed service; improved organisation and planning; and avoidance of duplication and fragmentation (Royal Pharmaceutical Society of Great Britain and British Medical Society, 2000).

The emphasis has since been on reducing boundaries between professions and blurring roles with multidisciplinary, interdisciplinary, multi-professional and inter-professional working. As highlighted by Caldwell (2006), these terms are used interchangeably and it is often unclear what they mean in practice. This can cause confusion within and between teams as terms and policies are open to interpretation.

Policy changes have also highlighted a number of challenges for team working. *“Structural, historical, and attitudinal barriers can and do contribute to difficulties which inhibit team work. Problems can arise from competing demands, diverse lines of management, poor communication, personality factors, plus status and gender*

effects" (Royal Pharmaceutical Society of Great Britain and British Medical Society, 2000, p.5).

Challenges and Ethical Dilemmas within MDTs

Challenges such as those above have been found in research and, from my own experience, I am aware that they can cause ethical dilemmas due to causing patient harm and inefficient use of resources. Exploring these challenges can be helpful when considering how to address ethical dilemmas. I have organised the challenges into three categories: boundaries, role blurring and professional identity; role dominance, status and power; and differing value bases between professions. However, there is significant overlap between each category.

Boundaries, Role Blurring and Professional Identity

While blurred roles and a more flexible approach to team working is recommended, a number of negative consequences have been linked with this. Brown *et al.* (2000) used qualitative methods to investigate the issue of boundaries (between professions) and roles within three interdisciplinary mental health teams. Findings indicated that boundaries were present between the different professional roles and while some degree of role blurring was evident, many professionals sought to preserve their professional identity. They concluded *"If policymakers and managers are genuinely keen to promote flexible, generic working, they will have to take very seriously the possibility that the new, flatter, less demarcated structures are actually encouraging boundaries rather than eroding them"* (Brown *et al.*, 2000, pp.433-434).

Jones (2006) investigated the impact that the development and implementation of a care pathway for patients with a diagnosis of schizophrenia would have on a MDT. The rationale for implementing this approach was to help structure care and define how it is delivered by different professions, and to draw discipline groups together. The care pathway approach is also cited as good practice for managing the care of patients with complex psychiatric presentations (Department of Health, 2002). However, Jones' analysis (which focussed on inter-professional challenges) found that developing the care pathway within the MDT created discomfort among team members in terms of: changes in roles and role ambiguity; conflict between

professional groups where roles overlapped/blurred; lack of confidence and competence in carrying out their role; and cognitive dissonance between previous training and current expected role which encouraged a 'protectionist mentality'.

Rather than bring professionals together, Jones (2006) suggests that the different professional groups approached patient care delivery from their individual professional perspective, with the view that their remit was unique. Disconcertingly, the findings also suggest that professional identity issues seemed more important to professionals than patient outcome.

Professional issues related to blurring of boundaries have arisen within my own practice, as an assistant psychologist within a new recovery service. The model of working was based upon an occupational therapy model, and all staff were expected to fulfil generic roles despite the varied training and 'expertise' amongst the different professions, which (as described by Jones, 2006), brought about discomfort, confusion and tension. It was made clear that a psychological perspective was not valued within the team and we were often criticised for undertaking research or utilising supervision rather than having continuous direct client contact.

As the service developed, many inter-professional jealousies became apparent, including differences in bandings of professions, misunderstanding of the various professional roles and their different training backgrounds and confusion as to how the different professions would work together. At first, this conflict caused the various professions to divide and hold separate meetings, as if in search of their identity. Gradually, communication between the professions improved and a process began whereby the roles of the various professionals within the team were established. As one of the two psychology professionals in the team, I felt challenged to highlight the potential contribution (e.g. psychological formulation) of psychology to MDT working, and I thereby gained a better awareness of the needs and roles of other professionals. Slowly, communication improved and the various disciplines were more widely valued and utilised within the team, and better consultation and joint working therefore developed.

This experience highlighted a number of ethical dilemmas. Firstly, the ambiguity of the movement toward generic team working led to a very literal interpretation of the term 'generic'. This brought about the expectation that the majority of professions would 'give up' their professional identity and adopt roles they were not trained to do or confident in, which conflicted with their personal and professional values. This

poses a dilemma in terms of the quality of service delivery, choice of treatment and risk to service users and professionals.

Secondly, the inter-professional conflict arising from unclear roles and diminished professional identity became more significant than service delivery, thereby sidelining the needs of service users and carers. It is interesting that both unclear boundaries (as in this example) as well as rigid preservation of professional identity (Jones, 2006), can compromise a patient needs-led approach.

Role Dominance, Status and Power

Caldwell (2006) explored nurses' perceptions of MDT work in acute health-care. Nineteen nurses were interviewed and Caldwell used direct observations to record their interactions with other members of the MDT. Caldwell found that the nurses expressed a considerable scepticism about the MDT concept and, "...described the multidisciplinary team as a 'complete myth', 'idealistic', and 'shambolic'" (Caldwell, 2006, p.362). Three barriers to effective teamwork were identified: "different perceptions of teamwork"; "different levels of skills acquisitions to function as a team member"; and "the dominance of medical power that influenced interaction in teams".

A further discomfort for the participants in Jones' (2006) study was professional dominance. This led to an overt "power complex" within the group, for example because one profession's voice was "outnumbered" by that of another profession. Such issues were particularly evident to me in the recovery service discussed above. The MDT in this instance was led by an occupational therapist which was also the dominant profession within the MDT, therefore holding role dominance, status and power. This created an ethical dilemma as it caused the various 'outnumbered' resources that were potentially available to service users to be under-utilised when, from a psychological perspective they could at times have been used more effectively and in an evidence-based way. For example, cognitive behaviour therapy (CBT) is the recommended treatment for people with schizophrenia according to The National Institute of Clinical Excellence (NICE, 2006) and yet was not initially offered to service users with this diagnosis despite the team being resourced to do so. This example also highlights the importance and influence of leadership in teams.

Status and power issues, and particularly the dominance of medical power, have long been recognised in mental health teams. Johnstone (1993/1997), a clinical

psychologist, wrote an article for the clinical psychology forum which demonstrated her frustrations of working with colleagues who support a medical understanding of mental distress. She highlights how power and status within teams can cause intelligent professionals to lose their confidence when it comes to challenging a psychiatrist and suggests that an “MDT is only multidisciplinary if you agree with it [the medical understanding], *unidisciplinary if you don't*” (Johnstone, p.33).

Gelsthorpe (1999) published a follow-up to Johnstone's (1993/1997) article. While also only coming from the perspective of a clinical psychologist, his article highlights similar frustrations from relationships with colleagues, in particular medical colleagues, and suggests a “psychosocial” view of working in the system whereby our distress is “*an honest emotional reaction to circumstances*” (p.16). While Johnstone and Gelsthorpe's articles offer some valid and inspiring ideas regarding MDT working, their one-sided arguments could create a further division between professions as the value of psychiatry seems to be unrecognised. Considering the value of multiple perspectives might be more helpful, especially for service users who value and benefit from both psychological and medical interventions.

It is also important to consider diversity more generally within MDTs, as diversity is at the core of this approach and can create power and status dilemmas. For example, age and gender have been particularly significant to me in my role as a trainee clinical psychologist, as I have found that the assumptions made about me as a relatively young female and a ‘trainee’ has at times left me in a less powerful position compared to my older, often male colleagues. This can be challenging, both when offering an alternative perspective and in being heard. I have also noted the power imbalance that can occur between ethnic majority and ethnic minority groups in teams. If not addressed, the power issues that attitudes towards difference may create can cause dominance in one or more perspectives, limiting the different voices and available resources.

Differing Values between Professions

Issues of confidentiality are common ethical dilemmas in mental health services. The notion of confidentiality can be interpreted differently across professions, and the varied professions operate according to their own value bases in relation to confidentiality (Jenkins, 1999). Furthermore, the various professions within a MDT

may face ethical dilemmas where their professional value base conflicts with the pressures to share information in complex organisational contexts such as the NHS, which is under constant public scrutiny.

Jenkins (1999) explored the contrast between a therapeutic perspective of confidentiality (where it is seen as an interpersonal contract between the client and the therapist) and a structural model of confidentiality within medical and primary care settings (which incorporates risk assessment and sharing information within MDTs). Jenkins highlights the dilemma that can occur when therapeutic professions provide services in MDTs and operate with different value bases, for instance the medical profession. The resulting dilemmas can include conflict between maintaining confidentiality and the promotion of client care, and the possible intrusion of such organisational factors on the therapeutic relationship.

Similar issues are discussed by Brown (2006). He notes that psychotherapists face dilemmas within MDTs as their value of almost complete confidentiality within the therapeutic framework is compromised by increasing demands to share client information with other professionals in MDT working. Brown (2006) studied how counsellors experienced legal and ethical dilemmas and constraints within their work and found that those working in private practice rather than in multi-agency working within larger organisations had more freedom from the constraints of the "outer world", i.e. those enforced by the organisational context including managers, commissioners and other professionals.

The differing values professionals place on boundaries with service users can create further ethical dilemmas for MDT working. For example, from my experience, I perceive that some professionals value a 'befriending' role, whereas others, including clinical psychologists, tend to value firmer boundaries whereby disclosure of personal information would be minimal and only occur if it was considered to be in the client's best interest. This may give rise to an ethical dilemma where it is assumed that the various professionals are offering the same generic service when, in practice, service users are receiving very different approaches not primarily tailored to their needs but led by unspoken professional (or personal) values.

Furthermore, service users are likely to feel confused where different professionals approach boundaries differently. This became apparent to me in the recovery service described above, and while I noticed that the different values and approaches each had their place within the service, these 'good' intentions clashed and the role

blurring meant that the different approaches and value bases were not effectively utilised.

How Dilemmas in MDT'S might be Addressed

Some of the ethical dilemmas resulting from possible challenges within MDT working are less evident and harder to address or resolve than those within one profession. In my experience, this is partly because ethical issues do not become overt but are overshadowed by more obvious tensions within the team, and partly due to the different approaches and professional standards of various professions.

All health and social care professions have some form of code of conduct and most professions have their own particular code to which they are required to subscribe, e.g. for psychologists, the British Psychological Societies (BPS) Code of Ethics and Conduct (2006). Owen (2001) proposes that, as most professionals are bound by the code of conduct of their own profession and the NHS, a clear, shared ethical principles to help with ethical reasoning in MDTs is needed. He argues that a single code of ethics for MDT working would "*promote conformity of action*", "*balance opposing forces*" and "*provide quality of care*" (Owen, 2006, p.365).

While I would agree that a shared code of ethics might promote conformity of action, I believe that a more proactive approach is also required to address challenges in MDTs. When considering how meeting such challenges might be addressed, I reflected on my experiences within my current placement in child and adolescent mental health where systemic approaches are employed to help children and families to resolve challenges within their family system. I came to question why professionals, especially those with 'expertise' at employing such methods did not apply them to the challenges within an MDT system. Having seen how useful systemic approaches can be when working with family systems, I felt it might be valuable to consider how such approaches might be applied in the context of an MDT. In reviewing the literature, I was surprised that I was unable to find an article that explored the application of systemic ideas to teams.

Systemic Ideas

Structural Family Therapy, developed by Minuchin in the 1960's, is a systemic way of conceptualising distress and dilemmas that occur in relationships. The aim of Structural Family Therapy is to explore the organisational characteristics of a family system, the family subsystems, and the overt and covert rules that underpin choices and behaviour within a family. Intervention aims to change the organisational patterns within a family, particularly where communication and behaviours are or have the potential to be unhelpful, abusive or neglectful (Vetere, 2001). Of the key features of this approach highlighted by Vetere (2001), those that refer to subsystems seemed most pertinent to me when considering MDTs rather than family systems, in that tasks are carried out within bounded subsystems (such as sibling and parental subsystems) which are organised hierarchically in a way that regulates power within and between them.

Boundaries of a subsystem are the explicit or implicit 'rules' which define roles and protect the differentiation of the subsystem. Clear but flexible boundaries between and within subsystems in this approach are seen as essential to healthy functioning. As Vetere notes, *"Family subsystems might include: parental, couple, parent-child, grandparent, male/female, organised by history, power, hobbies, interests and so on. Relationships between and within subsystems can be described as affiliations, coalitions, with patterns of conflict resolution, detouring, enmeshment and disengagement"* (p. 134). Unhealthy enmeshment can occur when boundaries are unclear, and disengagement occurs when boundaries are overly rigid (Cory, 1996). Enmeshment and disengagement can similarly be applied to the experience in teams when blurring of boundaries or over rigid professional identities interfere with delivering a patient centred, needs-led service.

This approach suggests that identification of roles and clear, yet flexible boundaries, including clear unified hierarchical structures are essential to healthy functioning within a family system. Within teams there are likely to be horizontal professional subsystems, where 'rules' (based on common training and codes of ethics) are likely to be implicit, and possibly not recognised by other subsystems. There are also likely to be vertical subsystems. For example, managers might be equivalent to the 'parental subsystem' and members of the team equivalent to the 'sibling subsystem'. The goals of structural family therapy are *"the creation of an effective hierarchical structure"* (Cory, 1996, p.394) and the development of clear boundaries which allow

for individual identity and good communication between and within subsystems. As with 'dysfunctional families', poorly functioning teams will result when managers of the different professional groups do not have a voice; if the management team do not present a united front to the 'sibling subsystem'; when one or more of the professional subsystems are disregarded; or where a team is totally enmeshed.

Williams and Fullford (2007) list a number of markers for good practice in designing and delivering CAMHS. Markers include effective management and negotiated, agreed protocols for relationships; and collaboration with explicit recognition of roles and constraints. They recommend that the workforce is "*sustained by a positive organizational culture*" (p.239). These ideas complement ideas from structural family therapy and could be helpful in developing MDTs by introducing structures and processes that encourage subsystem formation and identity, beneficial hierarchy, and good communication between subsystems. Such structures are likely to require inter-disciplinary, intra-professional and management meetings and reflective discussions. Once teams are established, outside facilitators with systemic 'expertise', could facilitate healthy functioning of subsystems. However, it is important to recognise that the value of such structures and outside facilitators will vary between professionals and may depend on previous experience, training and professional identity.

Ideas from other schools of systemic therapy also lend themselves to overcoming challenges and resolving ethical dilemmas in MDTs. for example, a social constructionist view. According to Gergen (2002, as cited in Salmon and Faris, 2006), social constructionism is a metatheoretical position that describes how a person's sense of 'reality', as they know it, is achieved. Social interaction, and in particular the language used between people are seen as processes that construct a shared version of knowledge. The possibility of developing an alternative construction of the self and others through language is fundamental to this view. According to Dallos and Draper, (2000, as cited in Salmon and Faris, 2006), joint actions, mutually constructed meaning, acknowledging the importance of power and exchanging ideas or feedback can be promoted through an emphasis on context and internal processes. Applying such a perspective to MDT working might enable the often unacknowledged processes to be highlighted through reflective practice, and lead to the development of a shared meaning or acceptance of multiple meanings. This is similar to the aims of narrative therapy which, while allowing the problem to

elucidate, also enables the development of alternative meaning through the discovery of 'unique outcomes' and the recognition of resources (Morgan, 2000).

Both the structural and social constructionist approaches require more explicit communication. Towards the end of my adult mental health placement, a reflective group led by an external facilitator was introduced for the MDT to discuss team dynamics and process openly with the hope of reducing tensions that had become apparent following some structural changes. While I was only able to attend one meeting, feedback from staff was positive and I noticed a decrease in office 'gossip' and interpersonal tensions. It is possible that the space to communicate openly reduced anxieties and helped to create a more cohesive team.

The Potential Role for Clinical Psychologists

As with most professions in health care, the role of the clinical psychologist is evolving. The 'New Ways of Working for Applied Psychologists' document (2007) proposes that, in the future, psychologists will deliver less therapy, provide more consultation and take on leadership positions. In view of this, clinical psychologists are likely to hold increasing power within teams and therefore have the potential to influence how they are led. As clinical psychologists are trained in a wide range of psychological theory, they could be ideally placed to introduce psychological ways of thinking such as systemic ideas into teams, either through direct leadership or through consulting with teams and managers. A drawback is the inter-professional rivalry that might occur as a result. It will therefore be important for clinical psychologists to recognise their role within the process, rather than assuming an "expert" position, for example through using the framework of second-order cybernetics, which is consistent with the reflective teams approach in family therapy. In this framework, the reflections and explanations offered are seen as shaped by the observer, rather than from an objective 'expert' position. Emphasis is placed on the mutual connection between the observer and the observed (Hoger *et al*, 1994).

In addition, clinical psychologists are trained to observe and reflect on group process and again, in doing so, appreciate their role within the process. This is therefore an aspect of their role which could be better utilised in teams and become more explicit. Research and service evaluation of team functioning are also areas where clinical psychologists could have an impact. Dissemination of findings might help a team

develop a clearer picture of its needs when considering how particular issues could be addressed. As always, time constraints and lack of resources may be challenges when conducting research, but trainee clinical psychologists and assistant psychologists could take on this role.

At a recent cross-year 'away day' at university, trainees were asked to think about some of the challenges they have experienced in MDTs from a psychological perspective and to consider ways in which training might help us 'put our heads above the parapet' and be comfortable to stand up and be counted. The challenges that were discussed mirror some of the challenges discussed within this essay: for example, the challenge of establishing one's role within a team, particularly being a part-time trainee and temporary team member. Having considered role definition and some of the negative consequences that role uncertainty can have in teams, I found this day helpful when considering how I might carry the ideas from this essay forward into my role, and the skills I might need to do this effectively. I realised that, as a trainee, my contributions to team meetings are relatively minimal. I believe that this is partly due to a lack of confidence to speak up, and partly because of the perceived power imbalances within the teams. While these are both issues that will change over time as I develop my skills and confidence and eventually qualify, I realised that these 'draw backs' could also put me in quite a powerful position as I can potentially use my position of 'not knowing' to be curious and open up conversations, and query team dynamics in a safe way.

In terms of how the training course might support and prepare us for MDT working, it was suggested that we receive teaching from the various professions we are likely to work with in practice. This idea resonated with me as it might help at the early stages of all professions (if implemented more widely) to learn about the differences and overlap of roles, including how the different professions are being influenced by political drivers. Learning about the different professions during training might help to improve communication and respect for diversity in the workplace, help to reduce inter-professional rivalry and help the different professions to feel valued. While implementing such training might prove difficult in terms of resource limitations, I suspect that it might be more easily implemented within teams, either within an induction or as an ongoing process as roles continue to develop and change.

Conclusion

Through drawing on research and personal experience, this essay has identified some of the ethical dilemmas that can occur in MDTs. Most significant to me is the dilemma whereby team and/or professional needs are prioritised over patient needs and service delivery. I have explored some of the challenges that can occur in teams and result in ethical dilemmas and used systemic ideas to consider possible ways in which these issues might be explored and addressed.

Ethical dilemmas are an inevitable part of working in MDTs and in mental health services more generally and, by their very nature, there are no simple 'solutions'. If there were, ethical dilemmas they simply would not exist. In my opinion, addressing such issues requires a more creative approach, inclusive of all professions, such as the systemic ideas discussed in this essay.

By exploring this area and developing a greater awareness of some of the issues related to MDT working, I believe it is essential to explore the way in which members of different professions work together as this has become central to service delivery, especially as the NHS continues to reform and promote team working.

While MDT working has the potential to benefit service delivery by offering a range of perspectives, the focus of this essay has been on the challenges and ethical dilemmas that can result from this way of working. It has highlighted to me how such challenges can compromise patient care. I would therefore suggest that the challenges and ethical dilemmas that can result from MDT working, as well as the its effective functioning, is an area in which further research would be beneficial and that it should remain on the agenda for all professions.

I plan to approach dilemmas that arise in MDT working from a 'curious' position (as recommended as a therapist position within family therapy, Cecchin, 1987) in my role as a trainee in the hope of highlighting such ideas and, ultimately, facilitating change. I also hope to carry these ideas forward with me in my future career and utilising the 'power' I may assume to be more explicit about the agenda, while remaining aware of my own perspectives and beliefs and how they interact with the rest of the team's.

Finally, I was surprised and relieved to find that some of the concluding comments of a review focussing on management and performance, specifically related to health teams (Michie & West, 2004), reflected the nature of some of my own findings and

suggestions: *"Leadership plays a crucial role. Organizations should train leaders to ensure that their primary focus is on people management. This means reducing chronic anxiety and anger among employees, promoting optimism and confidence, developing people's skills, helping them manage conflict, building trust within and across teams, and ensuring alignment around the objective of achieving the best possible organizational outcomes"* (p.105).

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PROBLEM BASED LEARNING REFLECTIVE **ACCOUNTS**

Problem Based Learning Reflective Account I

“The Relationship to Change”

February 2008

Year I

Introduction

This reflective account will outline the context of the problem based learning (PBL) exercise, the original task, and the approach we took to it. I will divide my reflections into four phases as, on reflection, I have drawn parallels between our group process and Tuckman's (1965) forming, storming, norming and performing team performance model. I will then discuss my response to our feedback before summarising.

The context and original task

In the first week of training, the cohort was divided into four case discussion groups. Our first task was to conduct a PBL exercise, entitled 'the relationship to change'. We had six weeks to work on the task before presenting our work to the other groups and the course team. Each group was assigned a facilitator who would attend approximately half the group meetings.

My group eventually took a political approach to the task. We discussed how political drivers are influencing the role of the clinical psychologist. We focussed specifically on 'New Ways of Working', as we felt this was pertinent to us at this stage in our careers. We discussed whether the NHS was reactive or proactive to the various changes and considered how the changes might affect service users and various professionals in the NHS.

The 'New Ways of Working for Applied Psychologists' document proposes that in the future, psychologists will deliver less therapy, enabling them to provide more consultation and take on leadership positions. We hoped to initiate thinking amongst our fellow trainees about their own roles within the NHS, the impact these changes might have on them, and the type of clinical psychologists they wanted to become.

Phase 1

On hearing about the task, I was concerned about my competency. Having been accepted into clinical training following two previous attempts, I was wondering whether I deserved my place. I am now aware that I was not alone in having these thoughts, but at the time I felt isolated and found the task daunting.

The diversity of the group was striking to me. We varied in age, life experience (I was aware that two members of the group had children), background, and gender. Whilst I had worked with diverse groups before, mainly in multi-disciplinary teams, my experience of being part of a group of psychology peers (for example, assistant psychologist's groups) was limited to people more similar to myself, who I could relate to easily. I was interested in how the diversity would affect the dynamics of the group.

Our first task was to allocate the roles of 'chair' and 'scribe', roles suggested in problem based learning tutorials by Wood (2003). I did not want to volunteer for either role as I was hoping for more guidance from the facilitator at this stage in the group process. I wanted to take more of an observer role to gauge expectations and consider how I might be accepted into the group. I was afraid that remaining quiet would be perceived negatively, so I was relieved when other group members volunteered.

Looking back I can see how my thoughts and feelings at this initial stage reflect the 'forming' stage of Tuckman's (1965) team development-model. At this stage, he proposes that group members are highly dependent on the leader for guidance and direction. Roles and responsibilities are unclear and the tolerance of the group and the leader is tested by individual members. The need to distribute roles, and to collaborate at this early stage in the process increased my anxiety as it threatened the guidance I felt in need of.

A similar pattern occurred when I started my placement. Low confidence, anxiety and the fear of negative evaluation by my supervisor caused me to spend a lot of time observing my supervisor and other colleagues. This helped me to develop my identity and role within the team, which I am now an active member of.

I'm aware that time will be more limited on future placements as they will be halved in duration. I will therefore have to find a way to adjust to new teams more quickly in order to meet the demands of the course.

My group had an open discussion about what 'the relationship to change' meant to us. It was through this discussion that we decided to take a political approach. Our facilitator encouraged this, and perhaps instrumental in our decision to take this forward. Initially, I was concerned about the political direction we were taking as I

knew little about the topic and was not passionate about it. However, I was relieved to have the guidance from our facilitator, and thought it was a useful topic to learn more about.

Phase 2

As diversity within the group became more apparent, I found myself becoming frustrated. I noticed that the male in the group had a different learning and communication style to the females. The females tended to take a conversational approach to discussions and apply concepts to personal experience and emotions. The male applied his ideas to various models which he presented in the style of a teacher.

In addition, I noticed that group members with less experience in a psychology context used language that was different to mine when discussing service users. I had been used to a shared language with previous psychology colleagues and found this difficult.

These differences seemed to restrict collaboration within the group and delayed our ability to find a focus for our presentation. We moved backward and forward with ideas, with some conflict between group members.

With hindsight, I can see that it was not the diversity that caused problems, but how the group handled it. Instead of learning from one another, which might have served to enrich our experiences, we fought against it. I think that the pressure of the deadline and our individual anxieties may have contributed to this, but it is a learning point for our group which I plan to raise before our next group task.

I have thought about these issues in relation to my clinical work. I usually discuss issues of diversity with my clients, but less so when difference has seemed less obvious, for example, socio-economic background, age, and gender. I have learnt that all difference has an impact on relationships and collaborative working. Addressing difference openly might create a more constructive environment for facilitating change and help individuals to feel valued and respected. This is also important to consider when working within multi-disciplinary teams.

A lack of focus caused me to take a more dominant, directive role in our third group meeting. Whilst this seemed useful, I felt uncomfortable after this meeting, afraid that I had been too pushy. While some members of the group said that they were pleased to have a more specific focus, I was aware that my change in approach may have unsettled the group.

I relate this phase of the group process to the 'storming' stage of Tuckman's model. At this stage he proposes that the group finds it difficult to make decisions and are attempting to establish their roles within the group in relation to other members. He also states that it is important for the group to have direction and a focus to avoid becoming distracted by relationships and emotions. This may have been another motivation behind my apparent need for a focus.

Phase 3

With more focus, I began to enjoy our group meetings. We all appeared more relaxed and I felt a sense of cohesion emerging. We began to find humour in our differences and seemed to value one another's opinions more.

Our facilitator suggested we consider possible views that various groups of people might have of 'New Ways of Working'. We decided to present these views by assuming various roles for our presentation. For example, I took on the role of a general practitioner working for the NHS. We negotiated the roles for the presentation without conflict and helped one another consider our individual contributions.

I relate this phase to the 'norming' stage of Tuckman's model. At this stage, the group develops its working style, agreement and consensus is generally formed, roles and responsibilities become clearer and teams may engage in 'fun' and social activities.

Phase 4

We were the last group to present. I remember sitting through the other presentations feeling anxious, but feeling support from my group. There was air of

competitiveness between groups, which seemed to unite us as a group more strongly. We had all put a lot of effort in to the task and all hoped to do well.

Watching the other presentations, I was pleased that our topic was quite different, but also quite concerned that people might find our presentation boring in comparison.

I felt that the presentation went quite well and seemed to be well received by the audience. We discussed the presentation afterwards and gave each other positive feedback which felt very supportive.

I relate this phase to the 'performing' stage of Tuckman's model. At this stage, teams are clearer about why and what they are doing. They have a shared vision, work with more autonomy and towards a shared goal. Team members also tend to care for one another.

Feedback

Receiving the group feedback was significant to me. Looking at the feedback now I can see that it was very positive, but at the time I only focussed on what I perceived as negative. Our feedback highlighted that we could have used a greater variety of methods when presenting. I realised that I was so worried about the content of the presentation for fear of getting it 'wrong' that I had abandoned my creativity, a trait I value in myself. I found myself dwelling on this.

On reflection I have been able to relate my response to literature on cognitive biases, and how this might impact on my clients' interpretations of information and events, which I am now mindful of. For example, Eysenck's Four Factor Theory (1997, as cited in Yiend, 2004) proposes that anxious people have attentional and interpretive biases in four domains including information about the external environment and information about their own behaviour. These biases exaggerate the threat of external and internal information.

Summary

We chose a topical and relevant subject that I feel has been useful to me in considering my career. Prior to this task, I considered my future role as a clinical psychologist to be mostly concerned with therapy. I have since taken on board the idea of leadership and am grateful to have learnt that I am capable of becoming a leader and have since become confident to take on roles where I am required to be more authoritative. I plan to seek opportunities to develop these skills and continue to 'change'.

My reflections have enabled me to consider a range of clinical issues with more empathy. I had strong emotions at various stages of the process, particularly at the beginning. These are emotions I am potentially taking into a therapy room with a client, and emotions that my clients are potentially bringing. It will be important for me to notice my emotions that could become unhelpful. This process has already begun through use of supervision and through becoming more comfortable with 'not knowing', now aware that process is more important than having the 'answers'.

I am currently planning to co-facilitate a hearing voices group. I am looking forward to being part of, and observing the group process. I am particularly interested in whether, as a facilitator, group members will be looking to me for guidance and direction, and if so, how I will cope with my new role and the change in 'power'.

I found this task useful, particularly given this opportunity to reflect and learn from it. Working as part of a small group has been enriching and I have felt valued and supported. I suspect that as a group we will move more fluidly between the various stages of Tuckman's model in the future, as our goals change.

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Problem Based Learning Reflective Account II

Working with People in Later Life, their Families, and the Professional Network

February 2009

Year II

Context

While this is the second problem based learning reflective account, this was the third problem-based learning task for my cohort. Despite two or three continuous members, group membership and the tasks had varied and my experiences had been very different. I was therefore intrigued to discover who would be in my group and the task itself. We soon learnt that our groups would be a combination of second and third-year trainees. The task was presented to us as a group, and I remember being surprised that I didn't recognise the majority of third-year trainees, which highlighted to me how divided the cohorts were. I was glad to have the opportunity to get to know them and benefit from their experience and was curious about their feeling working with us and whether they felt they had something to gain. I also had concerns about how we might work together, particularly given the potential power difference between the two cohorts.

Within the first meeting, it became apparent that power was unlikely to be a problem for us. With training in common, we had a lot to discuss and bond over very quickly and it soon felt like a cohesive group. This common ground seemed to enable us to embrace our differences. Knowledge and skills were not assumed on the basis of our year of training, but instead on what we as individuals brought to the group by virtue of our diverse experiences gained prior to and during training. I found this refreshing as, since starting training, I had felt frustrated that our experiences prior to it at times seemed to be unrecognised or undervalued.

I have since considered whether our ability to recognise and value our differences was easier at this stage of training, in contrast to our first year where there seemed to be a degree of competitiveness between trainees, perhaps itself a side-effect of the competitive application process. I felt safer within this group and did not feel the need to prove myself as I had done the previous year. I suspect that other group members, in particular the third-year trainees may have had similar feelings due to their increasing independence as they approach qualification. I was pleased to notice that my confidence within the group had increased as, while I had been aware of it increasing in a clinical and professional capacity on placement, I was less sure of myself in the context of university and academic work. I was also conscious that my increased confidence may have been attributable to the absence of a course team facilitator, as in previous PBLs I had found myself withdrawing in their 'powerful' presence for fear of being negatively evaluated.

The Task

The task involved working with people in later life, their families, and the professional network. We were given background information and informed that our task was to consider what the problem was, who had the problem and what might happen.

The background information included details regarding what appeared to be a complex family system which hinted at child protection and capacity issues; physical and psychological distress; and issues related to culture, religion and different generations. There also appeared to be a number of different professionals and agencies involved. Our group discussed the information provided and shared a sense of feeling overwhelmed by the breadth of it, particularly considering our time limitations.

Our initial feelings reminded me of how I have felt in my clinical work when presented with a complex referral or assessment. Clinical experience and discussions in supervision have helped me to recognise that, whilst depth of information can feel overwhelming, such information can be crucial particularly for multi- and inter-disciplinary team working. Communicating and sharing such information can have serious implications, as recently highlighted in the reviews following the sad death of Baby P.

Having reflected on this after the PBL task, I recognise the skill involved in holding such a range of information in mind when working with clients and other professionals. It can be easy to overlook information, that could prove crucial. Having considered such issues, I have become more appreciative of the wide range of areas covered in our training and the importance of identifying links between them, including across the life span.

My awareness of the unique breadth of training for clinical psychologists has increased and has highlighted to me a further way in which I can potentially contribute to multi- and inter-disciplinary team working, in the hope of reducing divisions between services, an issue highlighted by Singh *et al* (2008) regarding child and adult mental health services.

Our Approach

We decided to divide the work by each investigating a different area of the task. This seemed to be effective and, in our next meeting, we began to define our ideas based on our initial thoughts, our research and the prompt questions. Due to the complexity of the case, we found ourselves drawn to systemic ways of thinking and hoped that intervention with such a case would include working closely with other professionals, and include the perspectives of the service user and their family.

Working in partnership and providing service user centred care are identified as essential capabilities required for best practice in mental health services in the 'The Ten Essential Shared Capabilities - A Framework for the whole of the Mental Health Workforce' document published by the Department of Health (2004). A recent review also found that, "Many studies indicate that an increased involvement of service users leads to better care, better treatment compliance, improved health outcomes and higher levels of patient satisfaction" (Stringer *et al*, 2008, p. 678). However, our awareness from clinical experience was that, in reality, this did not always happen. We were particularly aware that service users' perspectives and involvement in services were often unheard or tokenistic.

This led to discussion of some less positive experiences including unethical practices we had experienced in the workplace, for example professionals undermining one another and where service users had not been invited to their ward rounds. Passionate views amongst the group caused us to focus on how such a case might be discussed within a 'bad' multidisciplinary team and how such discussions might be perceived by the referred service user and their family. While we had all experienced very effective and positive multi-disciplinary team and collaborative working, we felt it important to highlight the ethical challenges and power differences that can occur in and between teams and between professionals and service users.

The Presentation

We spent the following sessions planning our presentation. It interested me to note that the females in the group preferred a more creative and experiential approach than the only male who preferred a more logical, structured style. This was also evident in the formal role he took in our earlier meetings, for example taking minutes,

a role that nobody else had assumed. While this difference might be attributable to gender, for me it highlighted differences in learning styles.

Within his learning style model, David Kolb described four different learning styles: diverging, assimilating, converging and accommodating. I can relate the male group member's style to the assimilating preference for a concise, logical approach, and the female group members' style to the accommodating preference, for a more experiential approach. I am also aware that, inevitably, there would have been a great deal of individual difference between all of our styles. Kolb suggests that knowing our own and others' learning styles (which might vary in different situations) enables one to tailor learning to that preferred style in a given situation. These ideas seem particularly relevant to clinical psychologists given their various roles in which they hope to influence others' thinking, for example supervising, training, consulting, and in clinical work with clients.

While knowing everyone's preferred learning style in every given situation might not be possible, I think it is important to be mindful of such differences. I have recently been working with a child referred for Cognitive Behaviour Therapy (CBT). It quickly became apparent that he was unable to access my initial approach which was very psycho-educational. By identifying this quickly and discussion in supervision, I was able to adapt my style and focussed more on drawing and imagery in sessions. While it was possible to adapt my style in this context, it could be more challenging to adapt facilitation style in a group context encompassing multiple learning styles. It will therefore be important to be mindful of and explore such issues with group members in order to tailor the group accordingly.

The male in our group, although somewhat reluctant, volunteered to adapt his preferred style to try something more creative. I was concerned that he might have felt outnumbered and pressured to do so, but he soon appeared to be enthusiastic about the different way of working.

I suggested video recording a referral meeting where we would each assume a different member of the multi-disciplinary team to discuss the case, which seemed to be well received. While I did not feel the need to prove myself, I felt reassured that my ideas seemed to be welcomed and accepted and was pleased to feel I was contributing the group.

We decided to present a stereotypically 'bad' multi-disciplinary team, both for impact and to add humour. We hoped that our audience might relate this to some of their own experiences and consider their own roles in teams. Using video meant that we could also represent the different members of the family and show their response to the meeting so that both systems were represented. We hoped that this would cause the audience to think about how they might influence effective communication, collaborative working and hearing service users, families and carers voices in services. We hoped to demonstrate the expert position of the service users we work with and how professionals can also learn from them and their resources.

Everyone showed enthusiasm and put effort into the preparation. We dressed up for our roles and had a lot of fun making the video. On the day, our presentation seemed well received and, to our relief, provoked some laughs from the audience where we had hoped. We received positive feedback, particularly for including the service users' voices and provoking thought. Constructive feedback included a lack of demonstration of theory within our presentation. I realise now that, while we had considered theory and policies, we did not consider incorporating these into the presentation. I will be mindful of this in the next PBL task as those presentations that did include theory helped to inform the audience of the process their group went through. With hindsight I realise that, had we incorporated all our learning styles, we would have developed a stronger, more integrated presentation.

Summary

I have learnt a great deal from this task. It has raised my awareness of issues that arise in later life, including generational and cultural issues, but also how important my knowledge and skills are in different areas of clinical practice and how they can be transferred. In particular, this task has increased my awareness of service user involvement and the discrepancies that seem to exist between recommendations and current practice. I have therefore considered how I might be able to influence the degree and nature of service user and carer involvement in teams I work in, and how I can consider such issues in the design and implementation of my major research project.

I had a very positive experience in my group: both in gaining from all the group members and by feeling that I contributed to the task and others' experiences. The

importance of respecting group members for their individual contributions, rather than making assumptions about skills or knowledge due roles, status or profession, was the most significant message for me in the context of future work in teams. I have since continued to interact more with both third and first year trainees and feel that divisions between the cohorts have reduced. As a result, I have found university to be a more enjoyable and supportive environment.

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Problem Based Learning Reflective Account III

Assessment of the Effectiveness of Improving Access to Psychological Therapies (IAPT)

February 2010

Year III

Introduction

This was the final Problem Based Learning (PBL) task that my cohort would undertake during clinical training and the second PBL task for which groups were made up of a combination of second and third year trainees. This account will discuss my reflections in relation to the task, our approach, group process, and how this has contributed to my personal and professional learning.

The Task

The task we were given related to Improving Access to Psychological Therapies (IAPT), a programme commissioned by the Department of Health in response to the economic arguments proposed by Lord Layard (Department of Health, 2008). We were provided with some background information about IAPT and our task was to consider ways in which we might consider its effectiveness. Initially, I felt quite disappointed about the task we had been given, as I considered the subject to be quite dry. However, I was also aware that this was a current and important change to the way in which psychological therapies are delivered in the UK and was therefore able to see it as a learning opportunity that would be of value to me.

Group Formation

I was looking forward to working with the second year trainees as I had found working with a different cohort the previous year rewarding. Our first meeting was relatively short, giving us little time to get to know one another or to discuss the task. With the various other demands on our time at this stage in training, I was keen to use the little time we had effectively. However, while I enjoyed meeting the second year trainees, it became apparent to me in this meeting that some group members, from both year groups, did not share this view as they did not discuss the task at all. My frustrations with the group continued in subsequent meetings, and were related to group members arriving late, or not contributing to the task. Rather than address this in the group I initially found myself withdrawing, almost in protest.

I realise that I have felt similarly in previous group tasks and at various team meetings and have recognised that I value good time keeping and view it as respectful. In this instance, I noticed how I was also influenced by my expectations of how a trainee clinical psychologist 'should' behave, such as to contribute to group work, perhaps a value I have about behaving professionally. In the past I have found practical solutions helpful, for example negotiating boundaries, which have helped to reduce tensions. On this occasion, I found it helpful to question my value judgements, where they had come from, and how they were influencing the way in which I related to others. I think this was helpful to me as I found my negative feelings uncomfortable and did not want to be perceived unfavourably. Consciously observing the way in which I behaved enabled me to recalibrate my behaviour and relate differently to other group members.

Reflexivity

At the time I would have considered this process to be reflective practice. However, recent teaching on 'self reflexivity' which involves thinking about how our own identities influence our hypothesis and interventions (Burnham, 1993) has led me to question whether this was what I had unknowingly been practicing. According to Chinn (2007), reflexivity is subtly different to reflectivity. Reflexivity involves an appreciation of one's own social position, preferences and desires, and how they might impact and constrict what can be known. It was through recognising and appreciating my own position and personal values and the impact of these on the way that I related to others that seemed to enable me to reduce biases in my thinking.

As soon as I was able to step back from this position and open up my curiosity, I was able to recognise the differences in the group, for example, the various experiences, cultures and identities that were present. From this position I was able to value hearing different perspectives, and learn from others. Realising that all group members had different values, priorities and demands on their time, including different levels of anxiety and confidence, perhaps influenced by the potential power difference between the two cohorts, also helped me to think and feel more positively about other group members.

Becoming more aware of different values in the group enabled me to notice some of the assumptions that I had made about other group members. For example, I assumed similarities between us as a result of our appearance and our shared career choice. However, I now recognise that, at least initially, my assumptions disabled my curiosity. Reflecting on this has highlighted to me that I am more likely to make assumptions about people who appear similar to me than those who appear different. I hope that through reminding myself of the acronym the Social GRRAACCEESS¹ (Burnham, 1993) I will be more curious about people who appear similar to me as well as those who appear to be different.

Reflecting back on my internal processes at the time has also made me curious about the internal processes of other group members and the influence of these various processes on our interactions as a group. It has occurred to me that it may have been useful if we had been more open with one another throughout the task which may have also helped us to bond more as a group. I believe this to have been a weakness of the group, particularly at the earlier stages, and therefore a potential learning point for all group members.

Leadership

To manage my anxieties about completing the task in the allocated time, I made a conscious practical decision to assume the role of 'chair' in our group to ensure we remained on task and kept to time. While I did not label myself the 'chair', I did check out with other group members whether this was helpful or not, as I did not want to impose my structure onto the group. The feedback that I received was that it was helpful, in that we were able to use our time more efficiently which also left space for fun. While I genuinely believed that most group members valued my role, and may have learned from it (for example, I noticed some of the second years become more assertive and help focus the group), I did question whether some group members found me to be controlling at times.

Adopting this role in the group surprised me as I perceive my usual style in groups to be more natural: rather than taking on particular characteristics or specific skills e.g.

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¹ Gender, Religion, Race, Age, (dis)Ability, Culture, Class, Education, Employment, Sexuality, Spirituality.

developing an agenda, I would more typically hold on to my values and use my natural skills and abilities to influence others more subtly. While I hadn't previously considered myself to be a 'leader' which had concerned me given the current drive to encourage psychologists to become leaders (British Psychological Society, 2007), On reflection, I would relate my more natural style in groups to my understanding of 'authentic leadership' (George, 2004).

The more directive style I assumed on this occasion highlighted to me the potential role for different leadership styles depending on group members, process and context. However, it will be important to be mindful that leadership style might have a negative impact on team morale and service user satisfaction (Corrigan, Lickey, Campion & Rashid, 2000; Corrigan & Garman, 1999). It will therefore be important to be a self reflexive leader.

Approach to the Task

We initially approached the task by doing some individual research on IAPT to feedback to the group. The value of learning more about IAPT, and the significant timing of doing so became even more apparent to me as I started my new placement in a specialist Traumatic Stress Service. One of the principal aims of IAPT is to support Primary Care trusts to implement National Institute for Health and Clinical Excellence (NICE) guidelines for people suffering from depression and anxiety disorders, including Post Traumatic Stress Disorder (PTSD) (Department of Health, 2008).

Engagement in this task enabled me to understand discussions related to IAPT while on placement and feel more confident to contribute constructively. My placement experiences have also enabled me to consider the impact of IAPT on a real service and on real service users and the implications of this, which has made it more pertinent to me. For example, referral routes and assessment procedures for people presenting with PTSD are currently being reviewed and negotiated between the Traumatic Stress Service and regional IAPT managers.

Our individual and group exploration of IAPT led us, quite collaboratively, to focus our presentation on qualitative approaches to evaluating IAPT. One group member was particularly passionate about service user involvement which led to a rich discussion

about our own experiences of how service users' and carers' voices are often unheard or misinterpreted through the limited methods in which services are often evaluated. We therefore decided to demonstrate how, through the use of qualitative as well as quantitative measures, the voices of service users, and other stakeholders might be heard more effectively.

While I am usually mindful of service user and carer involvement, this group member's passion resonated with me and I have since taken more interest in service user and carer involvement within services. For example, I recently met with a service user representative from a service user group (designed to enhance service user involvement in service delivery) to discuss ways in which service users can become involved in service delivery and to consider possible issues related to designing a carer group at my current placement.

Presentation

Different group members had different preferences for the style in which they wished to present. Through incorporating didactic methods, role-play and interaction with the audience, I believe we managed to incorporate and respect all group members' preferences. I greatly valued the diversity of the different styles brought to the presentation, and I would hope to similarly employ a variety of techniques in future presentations with the hope of engaging a diverse audience.

Prior to our presentation, it became apparent to me that I felt far less anxious about presenting than I had in previous years. I believe that this was partly due to an increase in my confidence, but I also wonder whether the opportunities to present over the last couple of years have habituated me to presenting. Noticing this has instilled conviction in me in the usefulness of habituation training, which is especially relevant in my current work in a Traumatic Stress Service (Vaughan & Tarrier, 1992).

Before presenting, we shared some of our reflections. It was notable that group members shared similar reflections, for example the value of learning about IAPT and learning from different experiences in the group, especially across cohorts. I also noticed that our group seemed cohesive and supportive of one another at this point. Our presentation seemed to run smoothly and was well received. On reflection, I wonder whether our group had sequentially moved through the various stages of

Tuckman's (1965) Forming, Storming, Norming and Performing team performance model. In the 'performing' stage of Tuckman's model, teams are clearer about why and what they are doing, have a shared vision, work towards a shared goal, and are more caring of one another which seemed to represent us at this stage. It might have been beneficial to discuss group process in relation to Tuckman's model as a group. This is something I would consider suggesting in future groups that I am part of, especially longer term groups.

Final Reflections

I appreciate that I have learnt a great deal from the task itself, the group members and having had the opportunity to write this account. I have also become more aware of the importance of familiarising myself with current changes within the NHS and the potential impact that such changes might have on service provision, service users, and of course myself, currently and in my future career as a clinical psychologist.

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PERSONAL AND PROFESSIONAL LEARNING
DEVELOPMENT GROUP (PPLDG) PROCESS
ACCOUNTS: SUMMARIES

**Personal and Professional Learning Development
Group Process Account I**

Summary

September 2008

Year II

PPLDG Process Account I Summary

This account discusses my reflections on my experience of my PPLD group throughout the first year of training. Attention is paid to the initial stages of our PPLD group, the structure and content of group sessions, the development of the group throughout the course of the year, the ending and some hopes and expectations for the group's future.

A number of themes emerge within the report. The most significant of these to me was the role of and relationships with the facilitator which is addressed throughout. I felt that our facilitator took a dominant and powerful position which initially seemed to inhibit me. However, I reflect on how over time, this perceived power difference helped me to develop and become more confident working with people whom I perceive as more powerful than me and recognise my own worth and potential. The role of and relationships with the facilitator is also discussed in relation to leadership style, individual and group expectations, transference and countertransference.

Other themes discussed within the account include the negotiation of boundaries within the group, my contributions to the group, and learning from others which directly contributed to the development of my clinical practice. For example I discuss how one group member presented a narrative approach to clinical work which subsequently inspired me attend a workshop based on narrative therapy, and begin to integrate narrative ideas into a cognitive behavioural intervention that I had begun to carry out on placement.

**Personal and Professional Learning Development
Group Process Account II**

Summary

July 2009

Year II

PPLDG Process Account II Summary

This account discusses my reflections on my experience of my PPLD group throughout the second year of training. I felt that I gained most from these groups in the second year through observing group process and dynamics. Group process was rarely discussed inside the group and therefore the majority of my learning came from my reflections outside of the group, especially following its ending. I found this difficult as some of my emotional reactions to the group were quite distressing. For this reason, this process account focuses more on my reflections on the group process and dynamics over the past year, and on my perceptions of how the group and I have developed over time, than on the content of sessions. It also highlights learning points and relevance to clinical and professional practice.

While it was possible to consider the group process and dynamics from a number of perspectives, I found myself paying most attention to the interactions and patterns between group members, probably because of my placement at the time whereby I was working as part of a family therapy team. This account therefore focuses predominantly on considering systemic (in particular structural family therapy), and other interaction models which enabled me to give meaning to the group process. In addition to an introduction and some final reflections which include my hopes for the future of the group, my reflections of the group process and dynamics are organised into four subheadings. I have called these: 'boundaries'; 'cybernetics'; 'subsystems'; and 'drama triangle'.

Clinical Dossier

OVERVIEW OF CLINICAL PLACEMENTS

Title   **Adult Mental Health Core Placement**
Date   **September 2007 – September 2008**
Setting   **Community Mental Health Team (CMHT), Early Intervention for Psychosis Service (EIS)**

This placement was primarily based in a CMHT. My role included working with clients with severe and enduring mental health problems, including working age adults presenting with a range of difficulties (e.g. depression and anxiety, schizophrenia, bipolar disorder, OCD, BDD, substance misuse and borderline personality disorder) across a range of settings, including outpatient, inpatient, the community and clients' homes. I primarily worked with clients within a cognitive –behaviour framework, however also explored and implemented systemic ideas within my work, in particular ideas from narrative therapy and solution focussed therapy. As well as individual work I co-facilitated a Hearing Voices Group, conducted joint assessments with members of the MDT and undertook an audit of the referral process for clients with a primary diagnosis of depression.

My role within the EIS included carrying out psychometric assessments, a cognitive behavioural intervention, and co-facilitating a family intervention aimed at supporting family members during the early stages of psychosis.

Title   **Children and Young People Core Placement**
Date   **October 2008 – March 2009**
Setting   **Child and Adolescent Mental Health Team (CAMHS)**

This placement was based in a CAMHS team where I worked with clients from Tier 2 and Tier 3. My role involved working with young people and their multi-generational families with a range of presenting difficulties, including Autistic Spectrum Disorders, ADHD, Conduct Disorder, OCD, Depression, Anxiety, Phobias and Self Harm. During this placement I continued to develop my CBT skills and also further developed my systemic competencies. For example, I worked with one client using narrative therapy, and co-facilitated a family intervention using a systemic approach. I also developed skills at adapting my approach to meet the developmental stage of my clients, which included working creatively with a range of materials. My role also involved psychometric assessment using a range of measures, school observations, systemic information gathering, taking in-depth developmental histories, working with

social services and other relevant professionals. Within this placement I also developed my psychoanalytic thinking through attending a multidisciplinary psychoanalytic special interest group, which reading and discussing psychoanalytic literature relevant to the client group, or to the wider organisation.

Title   **People with Learning Disabilities Core Placement**

Date   **April 2009 – September 2009**

Setting   **Psychology and Challenging Needs Service**

During this placement I worked with people with a broad range of cognitive functioning from across the life span as well as people with different levels of adaptive and social functioning, those with Down's syndrome, and those on the autistic spectrum. My role was extremely varied and included administering, scoring and interpreting a range of neuropsychological assessment tools to ascertain cognitive functioning; one-to-one therapy with clients and their families dealing with transitions, loss and bereavement; and conducting formal observations and functional analysis within residential settings. My role also included co-working with a range of professionals including Behaviour Analysts, Speech and Language Therapists and Nurses.

This placement also provided the opportunity to work as part of a family therapy team where I worked with a number of families as part of a reflective team and with one family of five as the lead therapist. While I continued to develop my CBT skills within this placement, I especially developed my systemic skills, which I also applied to my wider role. For example, I facilitated a reflective group for nursing staff in a residential setting, using a systemic approach.

Title   **Advanced Competencies Placement**

Date   **October 2009 – March 2010**

Setting   **Traumatic Stress Service (TSS)**

This placement was within a specialist TSS in London. The service is national and whilst most referrals come from within the catchment area, assessment and treatment is also offered to people throughout the UK. This role therefore involved working with a diverse population, including clients from a range of cultures, ethnic

and socio-economic backgrounds. Through this I gained experience of working with clients who do not speak English and developed skills at working therapeutically through the use of interpreters.

In this role, I conducted specialist assessments, formulations and interventions for adults presenting with Post Traumatic Stress Disorder (PTSD), often of a complex nature. I worked therapeutically with survivors of a range of traumas, including assault, torture, war, road traffic accidents and fire. During this placement I developed advanced CBT competencies which included the use of reliving, restructuring within reliving, and imagery work. I also gained experience of conducting an intensive intervention alongside my supervisor whereby we delivered fourteen hours of CBT with a client within four days, which included a visit to the site of the trauma. In addition to CBT, I developed skills in the application of narrative exposure therapy with a survivor of persecution (conducted through a Serbian interpreter) and co-facilitated a psycho-education group for clients waiting to commence therapy.

Title   **Older Adults Placement**
Date   **April 2009 – September 2009**
Setting   **CMHT for Older People**

This placement was based within a Community Mental Team for Older People. My role involved working with older adults with both functional and cognitive difficulties. In this role I independently facilitated a Therapeutic Support Group for clients with depression and anxiety and offered assessment and intervention with clients and carers presenting with issues pertinent to later life, such as loss, bereavement and transitions. I also co-facilitated Cognitive Stimulation groups for clients with dementia. My role also included administering, scoring and interpreting a range of neuropsychological assessment tools and standardised psychometric measures to ascertain cognitive functioning and recommending the appropriate support.

CLINICAL CASE REPORT SUMMARIES AND
SUMMARY OF ORAL PRESENTATION OF CLINICAL
ACTIVITY SUMMARY

Adult Mental Health Case Report I Summary

Cognitive Behavioural Therapy with a 47 Year Old Woman Presenting with Obsessive Compulsive Disorder

This case report discusses the assessment, formulation and intervention of a 47 year old white British female (Helen) which I carried out during my adult mental health placement in a community mental health team (CMHT). The majority of this work was carried out jointly between myself and my supervisor, although I also met with Helen for three one-to-one sessions throughout the process, which are also discussed.

Helen had a history of involvement with mental health services but was referred for psychological assessment in this instance due to experiencing mood swings and thoughts about harming her grandchildren. Her symptoms appeared consistent with obsessive compulsive disorder (OCD), specifically obsessional thoughts.

The cognitive behavioural model of OCD was used in the formulation process as it seemed an appropriate framework to conceptualise Helen's difficulties (Christensen *et al*, 1987) and is also recommended by the National Institute of Clinical Excellence (NICE) for OCD.

The cognitive behavioural intervention planned to address Helen's difficulties is outlined and her progress discussed. At the time of writing the report, therapy with Helen was ongoing. Outcome to date and a future plan are therefore discussed. Other potential conceptualisations of Helen's difficulties are also presented. For example, Helen's difficulties are discussed from the perspective of attachment theory (Bowlby, 1979) and systemic theory. I also discuss my own reflections with regard to the process, and the impact of the work on my own learning.

Word Count: 232

Adult Mental Health Case Report II Summary

Cognitive Behavioural Therapy with a 63 Year Old Man with a Diagnosis of 'Paranoid Schizophrenia'

This case report discusses the assessment, formulation and intervention of a 63 year old white British male (Ben) which I carried out during my adult mental health placement in a community mental health team. The client had a diagnosis of Paranoid Schizophrenia and a long history of mental illness. The most significant cause of his distress was the voices he was hearing. However, he had also seen some disturbing things, e.g. faces in the curtains, felt unsafe and was suffering from depression.

Based on the initial assessment, the evidence base and NICE recommendations, cognitive behavioural (CBT) framework was used to conceptualise his difficulties which was a collaborative process. Models for the formation and maintenance of psychosis (e.g. Nelson, 2005) are discussed. However, the formulation we developed was influenced by the cognitive model of depression (Beck, 1976) and the cognitive ABC model (Chadwick et al, 1996).

The intervention, outcome to date, and future plan are also discussed. Whilst a cognitive-behavioural framework was used to conceptualise Ben's difficulties, my approach was also informed by social constructionist ideas, and of narrative therapy (Denborough and White, 1999) which are discussed. My reflections on the process, which include addressing some ethical issues and the influence on my own learning are then presented.

Word Count: 206

Children and Young People Case Report Summary

An Extended assessment using psychometric measures of a 7 year old girl referred by the Special Educational Needs Coordinator (SENCO) due to ongoing behavioural concerns

This case report discusses an extended assessment of a 7 year-old girl (Cara) who was initially referred to the Child and Adolescent Mental Health Service (CAMHS) due to ongoing behavioural concerns in school. Following initial assessment, a number of hypotheses were derived, those related to the individual and those that related more to the system.

Due to the complex, multi-faceted nature of the Cara's presentation, which included some behaviour which appeared to be consistent with an autistic spectrum disorder, it was agreed that I would conduct an extended assessment to assess her current and future needs.

The extended assessment comprised of an interview with the Cara's SENCO and teacher, an observation of her in school, and several assessment tools (including the Wechsler Intelligence Scale for Children 4th Edition UK Version (WISC IV) to carry out a cognitive assessment, the Conners' revised parent and teacher rating scales to screen for an attention deficit disorder (ADD), and the Spence Children's Anxiety Scale (SCAS) to assess overall levels of anxiety.

Recommendations were made to the client's school and parents following the extended assessment. Issues related to psychometric testing, what I would do differently and what I have learnt from carrying out the work are discussed within the critical evaluation.

Word Count: 206

Advanced Competencies Case Report Summary

Intensive Cognitive Behaviour Therapy with a 47 Year Old Woman Presenting with Post-Traumatic Stress Disorder

This case report provides a summary of the work that I carried out alongside my supervisor with a 46 year-old lady (Karen), with post-traumatic stress disorder (PTSD) whose symptoms were related to a knee injury which occurred as she went to sit down on a bus at which point her patella spontaneously displaced causing her severe pain, fear, terror and thoughts that she was going to die. The work was carried out during my advanced competency placement in a specialist traumatic stress service.

The hypotheses derived were based on Ehlers and Clark's (2000) cognitive model of PTSD and due to the client's circumstances and resources available, the treatment offered and carried out was an intensive form of cognitive behaviour therapy (CBT) for PTSD, a treatment option devised by Ehlers and Clark's clinical research group whereby the majority of therapist-assisted work is completed within one week.

Following an assessment with a clinical psychologist within the team which is summarised, the treatment package comprised of a preliminary 2 hour session the week before, 14 hours of therapy over the course of four days, and to date, two follow-up sessions, at 2 weeks, and 5 weeks. The interventions used, process issues and outcome are discussed as well as my own reflections on the experience, including my learning.

Word Count: 214

People with Learning Disabilities Oral Presentation of Clinical Activity Summary

Systemic family therapy with a 26 year old woman with Down Syndrome and her family

This presentation aimed firstly to address and discuss my development as a clinical psychologist to date. I considered my development in respect of my clinical work, my academic and research competencies and my professional capacity.

The clinical case that I chose to present reflected my development in a number of areas. The case I chose was one whereby I was the lead therapist in a family therapy team with Jess a 26 year old White British who has Down Syndrome and her family. Through this case presentation I aimed to demonstrate my development in terms of working systemically in a family therapy team, working with families rather than individuals, and working with people with learning disabilities, a previously unfamiliar client group to me.

A systemic approach was outlined and the evidence base with regards to working systemically with people with learning disabilities was presented. The rationale for systemic family therapy with this particular family was then outlined, followed by an overview of the way in which we worked. For example, with a lead therapist and reflecting team, with pre, post and within session reflections, and working with what the family brings.

The case itself was then presented which included an introduction to the family through the use of a genogram, an overview of relevant background information, the referral, formulation, intervention and outcome. The presentation also included a 5 minute video clip of a session, chosen to demonstrate engagement, multiple narratives and collaborative working with the team and the family. The clip chosen also served to highlight some of the family interactions that led to the hypotheses.

In summary, Jess and her family were referred due to her family's worry that she had begun to physically "hit out" at them. It became apparent through therapy that the family were referred at this time due to feeling stuck in a negative spiral, whereby they felt unable to manage Jess' behaviour which was causing family members to argue, feel hopeless and unhappy. There appeared to be two dominant narratives in

the family; firstly that Jess was an eternal child, and secondly, that they were failing in their roles as carers. The intervention employed worked well for the family. They reported feeling less 'stuck', interactions were improved, and Jess was no longer "hitting out".

Within the presentation I outlined some of the systemic approaches that I employed as the lead therapist. In addition to working with a reflecting team, these included noticing events that stood outside of the family's problem story (the discovery of unique outcomes), remaining curious with regard to multiple narratives, and paying attention to hierarchy and subsystems within the family. I also discussed some of the challenges and learning points that I encountered, such as engaging someone with limited verbal abilities, working with 5 people, as opposed to one, and working with power differentials. Finally I discussed the impact of the piece of work on me, and the various influences that this piece of clinical work had on my ongoing development.

Word Count: 500

Research Dossier

Research Log

1	Formulating and testing hypotheses and research questions	✓
2	Carrying out a structured literature search using information technology and literature search tools	✓
3	Critically reviewing relevant literature and evaluating research methods	✓
4	Formulating specific research questions	✓
5	Writing brief research proposals	✓
6	Writing detailed research proposals/protocols	✓
7	Considering issues related to ethical practice in research, including issues of diversity, and structuring plans accordingly	✓
8	Obtaining approval from a research ethics committee	✓
9	Obtaining appropriate supervision for research	✓
10	Obtaining appropriate collaboration for research	✓
11	Collecting data from research participants	✓
12	Choosing appropriate design for research questions	✓
13	Writing patient information and consent forms	✓
14	Devising and administering questionnaires	✓
15	Negotiating access to study participants in applied NHS settings	✓
16	Setting up a data file	✓
17	Conducting statistical analyses	✓
18	Choosing appropriate statistical analyses	✓
19	Preparing quantitative data for analysis	✓
20	Choosing appropriate quantitative data analysis	✓
21	Summarising results in figures and tables	✓
22	Conducting semi-structured interviews	✓
23	Transcribing and analysing interview data using qualitative methods	✓
24	Choosing appropriate qualitative analyses	✓
25	Interpreting results from quantitative and qualitative data analysis	✓
26	Presenting research findings in a variety of contexts	✓
27	Producing a written report on a research project	✓
28	Defending own research decisions and analyses	✓
29	Submitting research reports for publication in peer-reviewed journals or edited book	✓
30	Applying research findings to clinical practice	✓

Qualitative Research Project Abstract

**The reported training experiences of a group of male
clinical psychology trainees and their perceived
experiences of being on a female majority course**

May 2008

Year I

The reported training experiences of a group of male clinical psychology trainees and their perceived experiences of being on a female majority course

Abstract

Within the field of psychology females traditionally outnumber males, both at undergraduate and post-graduate level. In addition, research suggests that female students on these courses outperform their male minority peers. This suggests there is a need to explore how male psychology students experience being a minority gender. This study looked specifically at the experiences of male clinical psychology trainees doing a doctoral level course and their perceived experiences of being on a female majority course. Five male clinical psychology trainees at the University of Surrey were interviewed and an IPA approach was adopted as a framework for the study. Analysis identified three superordinate themes. Male trainees identified both advantages and disadvantages of being a male minority; however it was felt that the most pertinent theme to emerge was the *questioning of minority gender status as an influential factor*. The implications of these findings are discussed within the context of enhancing understanding of male trainees' experiences within a female majority course.

Service Related Research Project

**An audit of the information received in referral letters
from primary care to an adult CMHT for service user's
with a primary diagnosis of depression**

July 2008

Year I

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ABSTRACT

Objectives

This study aimed to investigate the information contained in referral letters from primary care to an adult Community Mental Health Team (CMHT) within an NHS Trust for people with a primary diagnosis of depression. The information collated was based on the recommendations for treatment in the National Institute of Clinical Excellence (NICE) guidelines for depression. A subsidiary aim of the study was to elicit information about the decision making process for accepting or declining referrals through discussion with the team and to consider how, if at all, this process could be improved.

Design

A retrospective audit of referral letters.

Data Source

All referral letters received between January and March 2008 where the primary diagnosis was depression were included in the study. 52 referral letters in total were audited.

Main outcome measures

Descriptive statistics were used to demonstrate the proportion of letters that contained the identified information in the NICE guidelines.

Results

Findings indicated that the information received in referral letters from primary care for people with a primary diagnosis of depression varied and was inconsistent. For example, only 6% of the referral letters stated a diagnosis and 44% included information about risk to self.

Conclusions

Recommendations for future development of the referral process are discussed. Clinical implications include greater consistency of service delivery to clients with a diagnosis of depression in primary and secondary care. Limitations and areas for future research are also highlighted.

Acknowledgements

I would like to thank the CMHT for allowing their service to be involved in this study and for their participation in the team discussion. I would also like to thank Dr Laura Simonds and Dr Emily Winchurch for their valued supervision and guidance and Barbara Earl and Suzanne Collins for their assistance with data collection.

INTRODUCTION

Approximately one quarter of the population report experiencing some form of mental health problem, and the majority of those report depression and anxiety (Orner *et al*, 2004). Depression affects between 5% and 10% of individuals in the UK (Singleton *et al* 2001) and accounts for over half of the cases that are presented to GP's (Orner *et al*, 2004). This study is concerned with the information that an adult Community Mental Health Team (CMHT) receives in referral letters from primary care for clients with a primary diagnosis of depression. The information collated is based on the recommendations for treatment in the NICE guidelines for depression.

Variation and inconsistencies in health care delivery has led to the development of national treatment policies and clinical guidelines (The Department of Health, 1998). The NICE guidelines reflect nationally agreed patterns and standards for the identification, treatment and management of depression in primary and secondary care in an attempt to reduce variation and inconsistencies (Shaw *et al*, 2005). The NICE guidelines for depression describe a stepped-care model which draws on the different needs of people with depression and provides a framework for the organisation of service delivery at various levels with the aim of supporting clients, carers and professionals in identifying and accessing the most effective interventions. The model distinguishes between the characteristics of an individual's depression and their personal and social circumstances in its recommendations for treatment. Recommendations include that individuals with recognised (step 1), mild (step 2), moderate or severe depression (step 3) receive services at primary care level, which includes assessment, watchful waiting, guided self-help, computerised CBT, exercise, psychological interventions, medication and social support. Each step assumes interventions have been received on the previous step. The NICE guidelines recommend involvement of secondary care for individuals who have depression that is treatment-resistant, recurrent, atypical or psychotic, and those at significant risk (step 4). They recommend that referrals to secondary care are based on an assessment that considers risk of suicide, the degree of functional impairment and the presence of significant co-morbidities or specific symptoms (NICE, 2004).

Research into the impact of clinical guidelines on mental health care delivery in primary care has found that guidelines have little, if any, impact on the detection, accuracy of diagnosis and treatment of mental health problems (e.g. Upton, Evans, Goldberg, & Sharp, 1999). Secondary care services rely on receiving referrals from

primary care. Shaw *et al* (2005) investigated the impact of guidelines which made recommendations on the content of GP's referral letters to psychiatrists and CMHTs. They compared the content of referral letters from GP practices that had been exposed to guidelines with those that had not and found that exposure to the guidelines had minimal impact on the information provided in the referral letters. Initiatives such as The Hampshire Depression Project (Stevens, Kinmonth, Peveler & Thompson, 1997) have also attempted to address the disparities in the detection and treatment of mental health problems, in particular depression, by providing an education program for GPs about the recognition and management of depression. Thompson *et al* (2000) found that, while this educational project was well received by the clinicians, it did not significantly improve GPs' ability to recognise depression or improve outcome.

Context of the Study

The project arose following informal discussions with various members of the CMHT about large case loads and pressures on staff time. Dissatisfaction with lengthy referral meetings was expressed, mainly because it was felt that these meetings were taking time away from supporting clients directly. Attendance at a referral meeting proved that there was little consistency regarding how much information the CMHT was receiving from primary care at the point of referral. As a result, staff seemed to be spending time investigating and discussing referrals at length before they were able to determine an appropriate response. Further information, gathered through contacting other professionals or through assessing clients, was often required before such a response could be established. This process is time consuming and often results in referrals being sent back to primary care.

A large proportion of clients supported by the CMHT suffer from depression. Through discussions with staff it became apparent that, of those clients with a primary diagnosis of depression, there were wide variations in the treatment they had received prior to their referral to the CMHT. This project was targeted at investigating the information received in referral letters for people with a primary diagnosis of depression and the process in which a response to the referrals is determined. It is hoped that recommendations will be made that will help to reduce variation and inconsistencies in the referral process and improve communication between primary care and the CMHT.

Objectives

The main objective of the study was to find out how many of the referral letters received by the CMHT from primary care for clients with a primary diagnosis of depression contained information on the factors that the NICE guidelines recommend are considered at referral from primary to secondary care (e.g. severity of depression).

Subsidiary aims of the study were to meet with the professionals in the CMHT to feed back the results of the study and discuss the following:

1. The factors that lead the CMHT to decide whether to accept or decline referrals of clients with a primary diagnosis of depression.
2. The current process behind making these decisions.
3. The information that is helpful to receive at referral level and the perceived obstacles to this.
4. In what ways if any, could the CMHT adapt this process, to reduce variation and its effectiveness.

It was hoped that the data gathered from the referral letters and the discussion with the team would provide a more accurate picture of the current referral process and identify elements of the process that the service would like to improve. The findings from this consultation are presented in the discussion of this report.

METHOD

Setting

The audit was carried out in an Adult CMHT in a directorate of an NHS Trust operating in a region of a city. The CMHT was a multi-disciplinary team consisting of Community Psychiatric Nurses, Approved Social Workers, Support Workers, Psychiatrists and a Clinical Psychologist. The CMHT provide support to an ethnically diverse population with a range of moderate to severe mental health needs.

Data

Referral letters received by the CMHT from primary care between January 2008 and March 2008 for all clients with a primary diagnosis of depression were included in the audit. 52 referral letters were audited in total.

Ethics

It was not considered necessary to obtain ethical approval for the study as it involved a systematic critical analysis of information and procedures used for treatment (Department of Health, 1993) and therefore fell within the remit of clinical audit.

The proposal for this study was developed in consultation with the NHS Trust's Clinical Audit Committee who sent information and guidelines for conducting an audit and approved the study before it commenced.

The CMHT were informed at a team Clinical Governance meeting that the audit would be taking place. The local clinical governance committee was also consulted. The identity of all clients whose referrals were selected for the audit remained anonymous and confidential. Staff members that took part in the team discussion were informed that their individual responses would remain confidential. The collective responses from the staff team that are reported were agreed and anonymity of staff members has been preserved.

Procedure

The good practice standards outlined in the NICE guidelines for the treatment of depression were used to develop an audit record sheet (Appendix 1). The record sheet also included basic demographics, including the source of the referral. The record sheet was deemed to be satisfactory by the Trust's Audit Department and a clinical psychologist.

All referral letters received by the CMHT from primary care between January and March 2008 were closely read and those that identified depression as the primary diagnosis were selected for the audit². This sample size was selected as a representative proportion (one quarter) of the total number of referrals for people with a primary diagnosis of depression received by the CMHT over a period of one year.

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² As few referrals stated a diagnosis of depression (as highlighted in the results section), referrals that suggested depression as the primary presenting problem, for example through describing symptoms of depression (as outlined in the NICE guidelines) were also selected. See Table 1 in Appendix 2 for examples of the descriptions provided within the referral letters from a sample of those included in the study.

Each referral letter selected was allocated a code to ensure anonymity was preserved. The record sheet was then used to audit the referrals.

RESULTS

Descriptive statistics were used to demonstrate the source of the referrals and some basic demographic information such as the gender, ethnicity and age of the clients referred (see Table 2), and to demonstrate the proportion of referrals that incorporated the information identified in the audit tool (See Table 3).

Table 2: Demographic information included in referral letters received by the CMHT between January 2008 and March 2008 for clients with a primary diagnosis of depression.

Information Audited		Percentage	Total Sample (n=52)
Source of Referral	General Practitioner (GP)	92	48
	A&E	6	3
	Probation Service	2	1
Gender	Male	33	17
	Female	67	35
Age category in years	18-23	10	5
	24-29	17	9
	30-35	15	8
	36-41	25	13
	42-47	13	7
	48-53	6	3
	54-59	10	5
	60-65	4	2
Ethnicity	Caucasian	2	1
	Not Stated	98	51

Table 2 shows that the majority of referrals received between January and March 2008 for clients with a primary diagnosis of depression were from GPs. The gender divide was approximately one-third male to two-thirds female and the greatest proportion of clients referred fell in the age bracket 36-41 years. The mean age was 37.8 (SD=2.98). Only one of the 52 referrals provided information about ethnicity.

Table 3: The proportion of referral letters that provided information on the various factors outlined in the audit tool

Questions/Factors	YES	N	NO	N
Was a clear diagnosis stated?	6%	3	94%	49
Was the severity of depression stated?	6%	3	94%	49
Was information about past medication stated?	60%	31	40%	21
Was information about current medication stated?	69%	36	31%	16
Was information about other interventions tried e.g. therapy stated?	40%	21	60%	31
Was information about whether the client had benefited from interventions stated?	40%	21	60%	31
Was information about risk to self stated?	44%	23	56%	29
Was information about risk to others stated?	4%	2	96%	50
Was information about functional impairment stated?	38%	20	62%	32
Was information about co-morbidities stated?	50%	26	50%	26
Was the reason for referral specified?	19%	10	81%	42
Was the client's choice of treatment stated?	29%	15	71%	37

Table 3 shows that very few letters (6%) stated either a diagnosis or the severity of depression. The information provided in the referral letters most frequently was past medication (60%) and current medication (69%). Only 40% of the letters provided information about other interventions e.g. psychological therapies or whether the client had benefited from previous interventions. 44% of the letters provided information about risk to self, while only 4% provided information about risk to other people. 38% of the letters provided information about functional impairment, 50% provided information about co-morbidities, only 19% stated the reason for referral and 29% stated the client's choice of treatment.

DISCUSSION

Findings

The findings from the study support results of previous research: that the presence of clinical guidelines has little impact on practice (Upton, Evans, Goldberg, & Sharp, 1999, Shaw et al, 2005). There was clear variation and inconsistencies in the information received in referral letters from primary care despite the recommendations for the treatment of depression in primary and secondary care in the NICE guidelines.

Team Discussion

Following the initial investigation, the results were fed back to the CMHT and discussed to address the subsidiary aim of the study. This occurred on the 20th June 2008 at a weekly team meeting as agreed by the team manager. The team welcomed the feedback and the opportunity to consider what action should be taken. A letter of thanks from the CMHT is included in Appendix 3. It was agreed that the nature of the information currently received and the processing of it should be addressed.

The team responded as follows:

1. The factors that lead the CMHT to decide whether to accept or decline referrals of clients with a primary diagnosis of depression are those highlighted in the stepped-care model in the NICE guidelines for depression.
2. The current process behind making these decisions involves contacting referrers and other agencies that might be involved in the referred client's case and searching the client's electronic notes to gather sufficient information, based on the stepped-care model to determine an appropriate response.
3. The information that is helpful to receive at referral level is that based on the factors that the NICE guidelines recommend are considered at referral from primary care and treatment of clients at secondary care. Perceived obstacles to this included a lack of awareness of referral guidelines in primary care and

receiving non-specific (e.g. "quite depressed") information in referral letters thus delaying the referral process and impacting both professionals and clients. There was a general consensus that these obstacles occur due to anxiety around mental health issues in primary care.

4. Suggestions for improvement of the referral process included providing a referral form for primary care services to use when referring clients, providing an information sheet with prompts for primary care to refer to and feeding back the results of this study to raise awareness.

Only 38% of the referrals audited were taken on by the CMHT. The findings of the study and team discussion would suggest that, of the 62% of referrals not taken on, time would have been spent by staff in the CMHT gathering further information in order to come to an informed decision based on the NICE guidelines, only to send them back to primary care.

Limitations

The findings from the study are concerned with one CMHT and the primary care services in the same catchment area and therefore cannot be applied directly to other areas. The findings are limited in that they only capture whether the identified information had been communicated, and not the depth of the information communicated. In addition, the study does not inform us why the information provided in referral letters for people with a diagnosis of depression from primary care is inconsistent.

The NICE guidelines for depression set out recommendations for treatment at primary and secondary care but do not provide specified recommendations for the content of referrals. This might, in part, account for the inconsistencies found.

It would have been useful to consult with the team regarding information (other than that assumed by the NICE guidelines) that they would find helpful to receive in referrals and to have included this in the audit tool as there may have been service-specific factors that were missed. For example, since completing the study, a system for referrals deemed urgent was highlighted to the researcher and it may have been useful to consider this within the study.

Finally, due to other commitments and staff absences, not all staff members were present at the team meeting. Therefore, not all staff members' views are represented in this report. All staff within the CMHT will however have access to the report.

Recommendations

A tool (e.g. referral guidelines) based on the team discussion and the stepped-care model in the NICE guidelines may be developed for use in primary care (in particular GP practices) and the CMHT to make the referral process clearer and ensure consistency in the transition of patients from primary to secondary care. Such a tool could improve communication and potentially filter out inappropriate referrals and/or inappropriate acceptance of cases, thereby reducing the number of clients taken on by the CMHT who are more appropriately suited to treatment within primary care.

Further research into whether these findings are transferable to referrals for other presenting problems might be beneficial.

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APPENDIX 1: Audit Record Sheet

Audit tool incorporating good practice standards outlined in the NICE guidelines to analyse the content of referral letters from primary care to secondary care where depression is the primary diagnosis.

Clinical audit methodology

- All referrals and re-referrals to the CMHT where depression appears to be the primary diagnosis/presenting problem received between January 2008 and March 2008
- For each referral complete the audit tool
- Where there is ambiguity, make a written record of the information available on the audit for discussion
- On completion of data collection, discuss with team the process of accepting/not accepting referrals

BACKGROUND INFORMATION

Date of referral

Who was the referral from?

How was the referral received?

e.g. post, fax etc

Any other information attached to the referral? (If yes, please outline)

Outcome of referral

Is the information provided in the referral sufficient enough (according to the stepped care model) to accept or decline the referral?

SERVICE USER DETAILS

Gender

Age

Ethnicity (if stated)

CONTENT OF REFERRAL TO THE CMHT (SECONDARY CARE)

Has a clear diagnosis been stated? Y N

If yes, what is the diagnosis?

If no, what is the description of the problem?

Has there been a formal assessment of the severity
of depression using either a self report questionnaire Y N Not Stated
or rating scale?

Is the severity of depression stated? Y N

If yes, please describe

Is the referral at the appropriate level of severity for secondary care (Treatment-
resistant, recurrent, atypical and psychotic)? Y N

Is there is a significant risk to self? Y N Not Stated

Is there is a significant risk to others? Y N Not Stated

Is there a degree of functional impairment? Y N Not Stated

If yes, please describe

Is there presence of significant co-morbidities
or specific symptoms? Y N Not Stated

If yes, please describe

Has information been given about medication tried in the past? Y N

If yes, Please describe

Has information been given about present medication? Y N

If yes, please describe

Has information been given about other interventions tried (e.g. psychological)? Y N

If yes, please describe

Does it state whether the service user has benefited from previous interventions?   Y   N

If yes, please describe

Does it state whether the service user benefits from current interventions?   Y   N

If yes, please describe

Has other information been given about the service user's past experience of treatment?   Y   N

If yes, please describe

Is the referral due to a lack of response to earlier treatment?   Y   N

Is the service-user's choice of treatment stated?   Y   N

Additional information/comments:

APPENDIX 2: Table 1 – Example of presenting problems

Table 1: Examples of how the presenting problem was described in the referral letters when a clear diagnosis was not provided

“...very low mood, feels unable to cope”

“...symptoms of depression”

“...bad state of depression”

“...quite depressed, diagnosed with depression 2 years ago”

“...become increasingly depressed over last few months”

“...feeling low for past few days”

“...low mood and suicidal ideation”

“...very depressed and downhearted, withdrawn from family life”

“...suffering from depression and anxiety intermittently”

“...very low and depressed...thinking of self harming”

APPENDIX 3: Thank you letter from the CMHT

Wednesday 9th July 2008

Dear Sharon,

On behalf of XXX CMHT I would like to thank you for all your hard work completing the Depression Audit. We found your feedback at the team meeting useful and plan to use this to influence our referrals system in the future.

XXX CMHT

PsychD Clinical Psychology Major Research Project

Sharon L. Newman

**A Narrative Analysis Investigating the Impact of First
Episode Psychosis on Siblings' Identity**

Date of submission: 19 July 2010

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Year III

ABSTRACT

This study is a narrative analysis of the accounts of four siblings (aged between 17 and 24 years of age) of people who had experienced a first episode of psychosis within the last three years. The main research aims were to hear how the participants talked about their experiences of their brother's or sister's first episode of psychosis, and to explore the impact of this experience on their sense of themselves and identity.

The study drew on different types of narrative analysis, particularly integrative approaches. Semi-structured interviewing was used to create four stories. Participants were encouraged to tell their stories however they wanted. All of them spoke about their life prior to the onset of their brother's or sister's psychosis, and their life since this time, including their thoughts about their future.

A summary of each story is presented, followed by a case study analysis of each account which highlights the core narrative, tone and genre identified. A cross analysis, highlighting similarities and differences between the accounts is then presented. The cross analysis identified differences in genres between the narrative accounts which appeared to be based on gender. The two genres were interpreted as 'a call to manhood' and 'phoenix rising'. Similarities across the narrative accounts were also identified and an overarching genre of 'rites of passage' was identified.

All four 'rites of passage' seem to be characterised by entering the journey as young people behaving as young people do, and emerging from the journey changed, either as men with responsibilities, or women with a passion that inspires their life. The main findings are discussed in relation to rites of passage as a concept, narrative identity and adversarial growth.

Finally, the clinical implications, limitations and the influence of conducting this research on my own life story are outlined. One of the main clinical implications refers to the way in which siblings are perceived and approached by services. This was highlighted by the unique journey that each sibling in the current study appeared to move through, and their key role in the care-giving and recovery of their sibling. Further clinical implications were concerned with potential therapeutic interventions with siblings, and resources and information provided by services.

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1 INTRODUCTION

1.1 Overview

This study aims to contribute to literature by developing the understanding of the possible impact of first episode psychosis on siblings, and in particular on siblings' identity or self concept. This has, as yet, been largely overlooked in the literature and it is hoped that this research will help services to better understand siblings' experiences and highlight factors to consider when working with families affected by psychosis. It is also intended to promote the wider development of Early Intervention Services (EIS) and how they work with families, especially siblings, and to contribute to theory development concerning the effects of severe mental illness on family members. The onset of a psychotic illness, and first contact with mental health services, is an important area for further research because change is recent, possibly traumatic and likely to be very significant to family members.

This introduction aims to present some of my experiences that have influenced my interest in this area, and some of my assumptions and expectations about the potential findings. It also seeks to provide a critical review of the literature related to first episode psychosis and the family, and to highlight the relevance of research designed to explore siblings' experiences. While there is published literature related to siblings of individuals with physical health needs and chronic illness (e.g. Gallo *et al.*, 1992; Kramer, 1984; Smith, 1998) and intellectual impairment (e.g. Doody *et al.*, 2010; Petalas *et al.* 2009), this study focuses on siblings of individuals with severe mental illness.

The concept of identity will then be introduced, including an overview of realist, social and social constructionist approaches. The narrative approach and philosophy will also be introduced and discussed in relation to identity, the development of narrative identity and severe mental illness. Finally, the qualitative methods, theoretical rationale and research questions of the current study will be outlined.

The articles included in the literature review were identified through computerised searches on the databases MEDLINE and PsychINFO. Search terms used included 'first episode psychosis', 'early onset psychosis', 'schizophrenia' and 'mental illness' cross referenced with the terms 'siblings', 'brothers', 'sisters', 'parents', 'mothers', 'fathers', 'carers', 'family', 'identity', 'self*', 'narrative' and various cross reference

combinations. Studies were prioritised depending on relevance to the current study. Additional articles were derived from a reference list analysis of those articles most relevant to the study, or where articles were recommended by supervisors and other professionals familiar with the field.

1.2 Influences for carrying out this research

My initial interest in this area stems from my personal and professional experiences. To clarify my own values and biases, I will present a brief overview of experiences that I believe may have influenced my motivation for conducting this research, my method of analysis and the overall thesis. It is hoped that this will help readers to consider the potential influence of my experiences on this research.

1.2.1 Personal influences

I would define myself as a White British female, aged twenty-nine years of age. I have one sibling, an older sister who is thirty-two years of age. While I do not have a sibling with a diagnosis of psychosis, during part of my childhood and adolescence I witnessed the experiences of a close family member, with whom I lived, cope with, and recover from severe mental health difficulties. Inevitably, throughout this time I also had direct experience of the impact of this on the family system. I believe that this experience, as well as other significant changes to my family life (e.g. the divorce of my parents as a child, which led to the development of a much loved large and perhaps 'unconventional' family) has impacted on my own development, the choices I have made in life, and more broadly, the person I have become. Reflecting on these experiences has highlighted how important my relationship with my sister was, and is, to me and how influential a sibling relationship can be.

1.2.2 Professional influences

An important aspect of the person I have become is my professional identity, or role as a trainee clinical psychologist. Prior to clinical training, I gained experience of working with clients with severe and enduring mental health difficulties, including

'schizophrenia'. My clinical interest in psychosis grew during my adult mental health placement in my first year of training, during which I had the opportunities to work in a specialist EIS (for psychosis). This included a family intervention as part of the family inclusive approach, during which it struck me that neither the individual with psychosis nor their siblings, although invited, chose to attend.

1.2.3 Assumptions and expectations

I have no doubt that my personal experiences influenced my choice of career and interest in the impact of mental illness on family members, and that my clinical experience in a specialist EIS influenced my decision to focus this research on psychosis and the family. The assumptions and expectations that I brought to this work include, firstly, that mental illness within the family will impact on the identity or roles of all family members, including siblings, in different ways and at different times; and secondly, that siblings are likely either to be neglected with regard to support offered, or potentially opt out due to the influence of stigma.

While I will inevitably have brought my own perspectives and assumptions to this work, I believe that this dual perspective of personal and professional experience and motivation, along with the capacity for ongoing reflexivity was valuable to this research. As discussed by Thornhill *et al.* 2004, a dual perspective can help to overcome potential professional 'failure of imagination' (Kirmayer, 2003), thereby reducing the potential for mistrust and suspicion between service users, or in this case participants and professionals. I am also aware, however, that my role as a trainee clinical psychologist conducting this research as part of my doctorate might have influenced participants' perceptions of me³.

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³ This issue is addressed as part of my methodological considerations.

1.3 First episode psychosis and the family

1.3.1 Early Intervention in psychosis: A family inclusive approach

The effect of psychosis on an individual and their significant others can be debilitating. The mean age of onset of symptoms of psychosis is 22 years, with the majority of first episodes occurring between 14 and 35 years (Department of Health, 2001). In England, the Department of Health (2001) recognised a need for the development of specialist EISs for young people with first episode psychosis, and set targets in their plan for the NHS to establish fifty EISs in England by 2004. A detailed plan for the development of these services is included in the Department of Health's (2001) "Mental Health Policy Implementation Guide".

The Department of Health has recognised a wide range of implications that first episode psychosis can have on the individual and family members. "Psychosis is a debilitating illness with far-reaching implications for the individual and his/her family. It can affect all aspects of life – education and employment, relationships and social functioning, physical and mental wellbeing. Without support and adequate care, psychosis can place a heavy burden on carers, family and society at large" (Department of Health, 2001, p.46.) The plans for the development of EISs for psychosis highlight and advocate a family inclusive approach. This includes involving family members and significant others in the assessment and treatment process as early as possible; and being offered psycho-education, family therapy and support.

A family inclusive approach is also advocated in The National Institute of Health and Clinical Excellence (NICE, 2002) guidelines for the treatment and management of schizophrenia, and is likely to alleviate stress and burden within the family. However, research suggests that, despite guidelines, provision of services varies (Sin *et al.*, 2005; Stalberg *et al.*, 2004). Research has also found that the 'family inclusiveness' approach seems to exclude siblings, focussing more on parents and carers (Stalberg, 2004; Sin *et al.*, 2005; 2007).

1.3.2 The importance of a family inclusiveness approach

Emotional impact on families

The initial onset of psychosis has a profound, even traumatic, impact on the individual and their family (e.g. Jackson *et al.*, 2004; Patterson *et al.*, 2002; Sin *et al.*, 2005; Mo *et al.*, 2008) with families experiencing high levels of distress, burden, anxiety, depression and economic strain (Barrowclough *et al.*, 1996; Schene *et al.*, 1994). Family members have been shown to report the highest rates of distress at the onset of psychosis, rather than during a chronic course of illness (Martens & Addington, 2001).

Traditionally, research has focussed on the concept of expressed emotion ("EE"; Brown *et al.*, 1972), which refers to the amount emotion is expressed within a family. Studies have suggested a relationship between EE and the prognosis of an individual's mental illness, and specifically that high EE is a strong predictor of relapse in patients with schizophrenia (Kavanagh, 1992).

Research has also found that high family EE is present at the first episode of psychosis and is associated with greater levels of avoidant coping, higher subjective burden and lower perceived patient interpersonal functioning (Patterson *et al.*, 2000; Raune *et al.*, 2004). Research has suggested that carers' appraisals, rather than factors related to the individual's illness, are influential in determining high EE (Scazufca & Kuipers, 1999; Raune *et al.*, 2004); and that family members' appraisals of the impact and consequences of the illness on themselves are a significant predictor of poor psychological wellbeing for the family member, rather than the severity of symptoms themselves (Addington *et al.*, 2003; 2005). These findings, particularly the impact of carers' appraisals at first episode psychosis, are therefore likely to be important factors for family work in EISs.

This suggests that supporting families is important for the psychological wellbeing of family members, but literature on EE also highlights the importance of supporting families in benefiting the person with psychosis' mental health. Both of these areas therefore appear to be important for EISs to consider. While the above studies focus on parents' and carers' appraisals, these factors also potentially affect siblings either directly, with regard to the ways in which they appraise themselves, or indirectly, via the impact of their parents' appraisals on the family system.

The role of families

When a young adult experiences a first episode of psychosis, parents' roles often shift from being parents of young adults developing independence and needing their parents less, to carers of adult offspring who have become highly reliant on them. Research indicates that parents/carers of adult children with first episode psychosis provide an extensive range of support to their offspring (Sin *et al.*, 2005) and play a major role in their recovery (Addington *et al.*, 2005). It is perhaps not surprising then that parents, carers and other family members often risk of neglecting their own needs (Lepage, 2005). This is likely to impact on the well-sibling who might neglect their own needs, and suffer from being sidelined or neglected in the family.

Research has highlighted the importance of parents/carers in initiating (Lincoln *et al.*, 1998) and sustaining contact with mental health services (Sin *et al.*, 2005). This is particularly important given the developing evidence base which supports the value of intervening early in the course of psychosis (see Drake, Haley *et al.*, 2000; Loebel *et al.*, 1992; McGlashan, 2000).

Research exploring parents' and carers' needs and their experiences with mental health services has been instrumental in shaping the development of specialist EI services (Sin *et al.*, 2007). Future research with family members will therefore be crucial to continue this important development of services. For a more thorough review of the literature related to the impact of a first episode of psychosis on the family see Addington *et al.* (2005).

Family intervention

Given the profound impact that first episode psychosis can have on family members, it is encouraging that research has found that family intervention at the early stages of psychosis can have a positive impact (see Addington *et al.*, 2005; Buksti *et al.*, 2006; Dixon *et al.*, 2001; Fjell *et al.*, 2007; Jepperson *et al.*, 2005; Mullen *et al.*, 2002). This research highlights the importance of including families when working with people with early psychosis. However, (nearly) all of the literature highlighted so far asked only parents for their views. The following section will therefore introduce the importance of siblings, provide an overview of the literature related to siblings and

severe mental illness, and discuss the minimal research related to siblings and first episode psychosis.

1.4 Siblings

In addition to upsetting the family equilibrium, mental illness in a sibling can also intensify inherent emotions in siblings' relationships (Barak & Solomon, 2005). The sibling bond is distinct and often the longest lasting relationship within families (Stalberg *et al.* 2004) with varying degrees of intimacy and investment throughout life (Dunn, 2000). The unique affinity of sibling relationships, described by Barak and Solomon as a "love-hate relationship", means that siblings can have a considerable effect on one another. Shared life experiences, a common genetic background, and an opportunity for connection and competition mean that sibling relationships can be a major determinant of self-esteem and identity formation (Cicirelli, 1995). Abrams (2009) summarises this unique relationship well, "As siblings, whether close or distant, are fellow travellers through the life-cycle. They share unique, private knowledge about their parents and families, possess a common genetic base, and carry the history of the nuclear family. They may be best friends, playmates, and soul-mates or competitors, mentors or mentees, nurturers or nurtured, the ones with whom to fight or settle conflict, and positive or negative role models" (p.306-307).

Despite the unique bond amongst siblings, research exploring the experience of siblings whose brother or sister has a diagnosis of psychosis, or severe mental illness, is scarce with most research focussing on the experiences of parents and spouses (e.g. Jungbauer, 2002; Foldemo *et al.*, 2005). To date, some research has explored the impact of severe and chronic mental illness on siblings, but very few published studies have looked at siblings' experiences of the onset of psychosis in a brother or sister. These studies are reviewed below.

1.4.1 Siblings and severe mental illness

Studies which have paid attention to siblings' experiences have highlighted the impact of psychosis and severe mental illness in the family on siblings and the need for their unique experiences to be recognised and addressed by services (e.g.

Landeen *et al.*, 1992; Barak & Solomon, 2005; Stalberg *et al.*, 2004; Barnable *et al.*, 2006), as siblings often report feeling overlooked by mental health services (Lukens *et al.*, 2002; Marsh *et al.*, 1993).

Through five focus group interviews, Lukens *et al.* (2004) explored the unique needs and concerns of nineteen adult siblings (sixteen female/three male) with a brother or sister with severe mental illness. Their findings indicated how acutely aware siblings were of the affect that their brother's or sister's illness had on them, both directly and in relation to their family of origin. Siblings portrayed complex feelings of fear, anger, guilt, loss and loneliness associated with the presence of an emerging mental illness in a brother or sister. Lukens *et al.* (2004) also noted the cumulative impact of a brother's or sister's illness on the siblings' evolving sense of self, with participants reporting that their sibling's illness had "affected their sense of person-hood deeply and on a daily basis" (Lukens *et al.*, 2004, p. 492), as well as having added a thick layer of complexity to their lives and thoughts about the future. This study provides a useful contribution to research investigating well-siblings' perspectives on mental illness, but only represents a limited sample of predominantly middle, or upper class white women and cannot therefore be taken as representative of a more diverse range of siblings.

Friedrich, Lively and Rubenstein (2008) developed a closed-ended questionnaire, the Friedrich-Lively Instrument to Assess the Impact of Schizophrenia on Siblings. This aimed to examine adult siblings' perspectives on the helpfulness of coping strategies, and the relative importance of mental health services in coping with schizophrenia. 746 siblings' responses were included in the study. The most important coping strategies identified were psycho-education, a supportive family, and seeing the ill-sibling suffer less. While siblings identified services for their ill brother or sister as the most important, they also wanted support in terms of answering their own questions and clarifying their role in future care.

These conclusions mirror earlier findings by Landeen *et al.* (1992) who developed a 14-item questionnaire to investigate the practical concerns of 88 well-siblings of individuals with schizophrenia with regard to information, support and practical skills. They found that siblings wanted more specific information about schizophrenia, particularly regarding prognosis. Concerns about the brother or sister's future independence, and with difficulties in communicating and problem solving with their brother or sister were also raised. This study found that a workshop for siblings

helped to increase knowledge about schizophrenia, and also enabled siblings to begin to build trusting relationships with mental health professionals and other siblings of individuals with schizophrenia with whom they could share experiences.

Using a self report questionnaire, completed by 52 siblings of patients with schizophrenia and 48 comparable controls, Barak and Solomon (2005) found that siblings of individuals diagnosed with schizophrenia reported more intense negative feelings towards their brother or sister, in particular stronger feelings of helplessness, sadness, pity and worry. They also reported higher levels of objective and subjective burden, expressed more shame and were less ready to expose themselves to others, suggesting that the sense of shame or stigma associated with having a brother or sister with schizophrenia impairs the sibling's self-esteem or self-image. The authors suggest that working through the mourning process of having a brother or sister with schizophrenia may be impeded by the possible progressive nature of the illness, and siblings' lack of understanding of the illness.

As parents of mentally unwell children age, siblings often become a vital source of support, or even become the primary caregiver (Lohrer *et al.*, 2007). The roles and instrumental burden for siblings who choose to provide care for their ill brother or sister has been explored. For example, Greenberg *et al.* (1999) used a questionnaire to collect data from 61 siblings of adults with serious mental illness, and 119 siblings of adults with "mental retardation". They found that two-thirds of siblings of people with mental retardation expected to be involved in future care-giving compared to one-third of siblings of those with mental illness. The study found that competing family responsibilities limited the involvement of siblings in care-giving, whereas closeness to the family of origin led to greater sibling involvement.

A study by Hatfield & Lefley (2005) found that nearly all of 60 adult siblings of people with mental illness who answered a survey expected to be involved in future care giving. Most did not know what that involvement would entail, but expected it to be more social and emotional support than instrumental help. Other studies (e.g. Gerace *et al.*, 1993; Greenberg *et al.*, 1999; Reinhard & Horwiz, 1995) have shown a range of response and involvement, which varies depending on familial circumstances and the evolving nature of the sibling relationship. Again, these findings highlight the complexity of siblings' roles and relationships, and that services need to be mindful of these factors.

A further theme that has emerged in literature associated with siblings of individuals with severe mental illness is a fear of possible heredity. In a qualitative study, Stalberg *et al.* (2004) interviewed sixteen siblings of patients with schizophrenia and found that the onset of psychosis in a sibling activated both fear of heredity and thoughts and feelings about earlier experiences of psychiatric illness in the family. They found that many siblings expressed fears of becoming mentally ill themselves, and that siblings seemed to struggle with thoughts about 'bad genes' within the family. Wanting to be strong for the family and worrying about their own health appeared to make it harder for some siblings to cope with their experiences.

Findings which suggest that siblings require further information and support are also reflected in a sibling survey by Rethink (Canning, 2006) in response to its members concerns that siblings of people with severe mental illness were not receiving enough support. Rethink received 264 responses and feedback rated access to advice, information and support as inadequate. Encouragingly, Rethink set up a website designed specifically to address the needs of siblings as a result.

In spite of adversities, research has also highlighted positive gains for siblings who have grown up with a brother or sister with a severe mental illness (Stalberg *et al.*, 2004). For example, in a qualitative study, Kinsella *et al.* (1996) interviewed 10 adult siblings and 10 adult offspring of individuals with mental illness to explore three general areas: coping skills, needs and strengths. Coping skills that emerged included constructive escape, seeking support from others, acquiring information about mental illness to better understand their relative, and self-censoring own behaviour. Needs identified as significant, particularly in childhood and adolescence, included information or explanations about their relative's mental illness, support groups, individual attention and inclusion in the treatment process. Strengths identified included: increased independence or self reliance, creativity, increased empathy and tolerance, increased resilience, assertiveness, and a broader spiritual perspective, whereby they spoke of "a heightened gratitude for life and an eagerness to live more fully" (Kinsella *et al.*, 1996, p. 29). Interestingly, all the siblings interviewed perceived themselves to have grown in a positive way as a result of their experiences.

The above studies have highlighted the important impact that severe mental illness might have on a well-sibling, but represents the experiences of having grown up/been closely involved with a sibling over the course of illness. Little attention has been

paid to siblings' experiences at the onset of an illness and the unique experience of the change and disruption that this causes.

1.4.2 Siblings and First Episode Psychosis

While research investigating the experiences of siblings of first episode psychosis is scarce, recent chapters in books concerning EI in psychosis suggest a growing interest in siblings' needs and experiences (see Smith, Fadden & O'Shea, 2008; Smith, Fadden & Taylor, 2010). Furthermore, the Canadian Mental Health Association recently produced and published a guide providing information, ideas and resources for siblings of young people with psychosis, guided by the reflections and experiences of siblings from three EISs in Canada (Mulder & Lines, 2006).

Despite this, apart from a qualitative study presented at the Division of Clinical Psychology annual conference in London (Fisher *et al.*, 2004), there currently appears to be only one published study which has exclusively explored the experiences of siblings of individuals with first episode psychosis (Sin *et al.*, 2008), and research has found that the 'family inclusiveness' approach to EIS for psychosis seems to neglect siblings (Stalberg, 2004; Sin *et al.*, 2005; 2007).

Fisher *et al.* (2004) interviewed five siblings of individuals who had recently experienced a first episode of psychosis. They found that these siblings shared similar experiences to siblings of individuals with a long term mental illness, except that siblings of individuals with first episode psychosis were less aware of genetic vulnerability and less involved in practical care for their brother or sister. These findings are discrepant with previous studies of clients from first episode services. For example, previous research has found that service-users with first episode psychosis often perceived their siblings to be a valuable resource with regard to engagement in recovery and normalising activities (Birchwood, 2003) and providing opportunities for socialising (Stein & Wemmerus, 2001). This discrepancy could be due to the complexity of siblings' roles and relationships within the family, and/or the small sample size used in Fisher *et al.*'s (2004) study

In the one published study so far, Sin *et al.* (2008) conducted a qualitative study to understand the experiences and needs of siblings of individuals with first episode psychosis. This research arose following a study that focussed on caregivers of

people with first episode psychosis in Berkshire, England, in which it was revealed that siblings' needs in the service were overlooked (Sin *et al.*, 2005). In this study, ten siblings were interviewed and a number of key themes were highlighted, for example:

- emotional impact, whereby all siblings reported feeling overwhelmed by the psychological impact of their brother's or sister's onset of psychosis and by the impact of it on their own lives and emotional wellbeing;
- relationships in the family, which centred around siblings' concerns for others, particularly younger siblings, their parents and their own relationship with their sibling with first-episode psychosis; and
- siblings' roles and coping patterns, for example, supporting their parents as primary care-givers and encouraging and supporting social activities and engagements.

These conclusions support previous findings from research focussed on carers which highlight the support that siblings offer their parents, as secondary caregivers in engaging their brother or sister in normalising activities (Birchwood, 2003; Sin *et al.*, 2005).

In common with research investigating siblings of people with severe mental illness, Sin *et al.* (2008) discovered that siblings were also able to identify positive gains from their experiences of having a brother or sister with first episode psychosis, including enhancement of personal development, developing close sibling bonds, and greater resilience within the family.

This study provides useful initial insight into siblings' experiences of their brother or sister's first episode of psychosis, but gives less information about how siblings make sense of their own experience of their sibling's psychosis and how, if at all, their experiences have impacted on their personal sense of identity or self concept.

1.4.3 First Episode Psychosis and Identity

As noted above, the onset of psychosis is most likely to occur during a critical period in a person's development with the majority of first episodes occurring between the ages of 14 and 35 (Department of Health, 2001). During this time, a person would

usually be increasing their independence, moving away from their families, and according to Erikson (1968) identity development is central at this time in life. As noted by Lepage (2005), is also often a period of optimism, confidence and hope for the future. The onset of psychosis is therefore likely to significantly affect and possibly disrupt these natural processes in an individuals' life. Indeed, Wisdom *et al.* (2008) found that the onset of mental illness was associated with a loss of self or loss of previously held identity, which needed to be overcome or at the very least managed to obtain hope for recovery.

The onset of psychosis is also likely to occur during a critical period in a sibling's development (late adolescence to early adulthood) and therefore may also affect a sibling's development. Siblings are also likely to be aware of the stigma associated with mental illness and, as described by Sin *et al.* (2008), siblings might be particularly sensitive to a brother or sister's disability during adolescence (Jewell & Stein, 2002; Seltzer *et al.*, 1997). This awareness and sensitivity to stigma surrounding mental illness may cause siblings to question their own views, values, and potential stereotypes, and might therefore challenge their developing, or already constructed beliefs about mental illness, their brother or sister, and themselves.

It is also possible that societal stereotypes or the construction of gender roles, family roles and mental illness might influence siblings' involvement with their mentally ill brother or sister, their role and the development of their self concept. Research investigating family experiences of individuals with severe mental illness has suggested that gender is associated with the frequency of care-giving for a brother or sister, in that female siblings are more frequently involved in providing care (Greenberg *et al.*, 1997; Lohrer *et al.*, 2007). These findings have been discussed in the literature in relation to the socialisation of female gender roles as caregivers. Gender roles and society's view of gender may therefore also impact siblings and contribute to their sense of self and identity at the early stages of psychosis.

As yet, no research has explored the impact of first episode psychosis on siblings' sense of self/identity, an interesting and potentially important area. Research has highlighted the impact that first episode psychosis can have on family members, but siblings' experiences and needs have been largely neglected to date. The existing research in this area indicates that there are some similar impacts on siblings, but also some unique differences. This is a relatively new area of investigation, with

many gaps, particularly in relation to the effect on the sibling at a crucial point in their own development.

1.5 Self and Identity

1.5.1 Realist approach

The concepts of 'self' and 'identity' are difficult to define. Within the more traditional 'realist' approaches to self and identity, it is implicitly assumed that 'the self' exists as an entity that can be 'discovered' and 'described' much like any object can be. For example, personality theorists such as Costa and McCrae (1992) view self as a relatively stable concept. Such approaches assume that self and identity are fixed, 'pre-existent' and separate to the social or interactional world (Crossley, 2007).

1.5.2 The social self

Unlike the realist view of self, the symbolic interactionist tradition claims that individuals adopt and enact multiple roles in society in order to negotiate meanings, status and position in everyday social life (Stets & Burke, 2005). This perspective argues that the multiple ways in which people interact with others in the social world are central to the development of a sense of 'self' and the construction of social identities, and thus the development of a sense of 'self' is seen as a social process. (Mead, 1934).

This perspective appears more progressive than the traditional sense of self as a stable concept as it would suggest that identity is not seen in isolation and is subject to change. Furthermore, 'multiple role identities' have been found to offer people a variety of guides for their behaviour which, in turn, offers greater meaning to people's lives (Thoits, 1983, 1986).

1.5.3 The social constructionist approach

The social constructionist approach to the study of self and identity also challenges the more traditional 'realist' approaches. The social constructionist approach

proposes that there is no 'one' truth or reality, and similarly that there is no 'one' description of self or identity.

Identity is seen as wholly dependent on the language and linguistic processes that people use in their everyday lives to make sense of both themselves and others. Thus, identity is assumed to be socially constructed (Burkitt, 1991), and subject to 'deconstruction'. The concept of 'self' is therefore seen as a fluid interactional process, subject to continual change. Self is understood as a phenomenon characterised by interpretation, variability, relativity, flux, and difference (Crossley, 2007). As personal experiences differ in relation to historical, cultural and practical contexts, from the social constructionist perspective it is not possible to make universal claims about the concept of 'self'.

The social constructionist approach to the study of self and identity shares with developmental theory the suggestion that people learn through interacting with their environment (including people, objects and phenomena encountered in the world). Through reflecting on their interactions, individuals actively construct understanding from their experiences in ways that make sense to them (DeSantis & Housen, 2000).

A number of researchers have highlighted problems with the social constructionist approach to self and identity. For example, Parker (1992) argues that the idea of self as a social construction does not tell us what is happening inside a person when they reflect inwardly which distinguishes between the individual and the social.

Similarly, Craib (1998) argues that post-modernist approaches exclude the notion of a personal identity and therefore suggest that people are incapable of experiencing an internal life or self. Furthermore, Florka (1999) suggests that the post-modern self does not account for the experiential self, the self which cannot be put into words and Dunne (1995) argues that language and context are emphasized to the extent that 'self' becomes 'engulfed, if not annihilated' (p.140) (see Crossley, 2007).

1.6 A narrative approach

Following increased interest in language in the 1980s (Murray, 2003), social scientists have started to pay much more attention to narrative. According to narrative theory (e.g. Murray, 1999; Sarbin, 1986), we live our lives through the creation and exchange of narratives (Murray, 2003). While social constructionist in

its framework, the narrative approach also appreciates and maintains “a sense of the essentially personal, coherent and ‘real’ nature of individual subjectivity” (Crossley, 2007, p. 133). This resonates with me and is therefore the approach I will adopt.

Murray (2003) defines a narrative as “an organised interpretation of a sequence of events” (p.113). The primary function of narrative is to organise the unorganised or to bring order to disorder and give it meaning. The creation and exchange of narratives through story telling therefore enables people to bring order to potentially chaotic or disrupted lives (Murray, 2003). Within health psychology, researchers have used the study of narrative to explore the ways in which people make sense of and adjust to the disruption of illness or disability (e.g. Murray, 1997).

Narrative has also been used to explore the ways in which people make sense of, adjust to and recover from a severe mental illness, including first episode psychosis. For example: Thornhill *et al.* (2004) used narrative analysis to explore the accounts of individuals who described themselves as either recovered or recovering from psychosis; Perry *et al.* (2007) used interpretive phenomenological analysis to explore the narratives of individuals within 8 months of experiencing their first episode of psychosis, focussing on experiences of hope; and Barker *et al.* (2001) explored the narratives of individuals with a diagnosis of schizophrenia and their close family members to explain the process of developing schizophrenia.

The study by Barker *et al.* (2001) explored the narratives of parents only., The narratives concerned their perceptions of their loved ones’ development of schizophrenia, including the impact of their loved ones’ sense of self, as opposed to their own personal experiences or sense of self during this time. This study is useful in that it considers the narratives of family members but it does not provide information regarding the parents’ personal experiences or the impact of severe mental illness on their sense of selves or identity.

1.6.1 Narrative and self/identity

Questions about self and identity are central to narrative psychology. The narrative approach to self suggests an intrinsic connection between temporality, interaction and morality (Taylor, 1989). This perspective suggests that self and morality are

intertwined so much so that self is defined by the things that matter to us, or by our values.

Storytelling is believed to play a central role in establishing and maintaining identities. For example, McAdams (1985) argued that narrative is at the core of our self-definition, and that identity is a life story. Life stories are believed to make sense of one's past, present and anticipated future (McLean, 2008). It has been proposed that meaning making is one of the major processes by which identity is constructed and occurs when we share our memories with others (McLean *et al.*, 2007).

"Narrative not only brings order and meaning to our everyday life but, reflexively, it also provides structure to our very sense of selfhood. We tell stories about ourselves to ourselves and to others. As such, we create a narrative identity" (Murray, 2003, p.115-116.) McAdams (1985) refers to longitudinal consistency in a life story as 'identity stability' and a revision in a life story as 'identity transformation'.

According to Pals (2006), difficult life experiences during adulthood constitute a challenge to one's narrative construction of identity. As part of a longitudinal study with college-educated, predominantly white women, Pals (2006) focussed on 83 participants each of whom provided a narrative at the age of 52 years of their most difficult life experience since college. He found individual differences in how participants responded to challenges related to pathways of personality development that began in the participants' young adulthood and continued through to late mid-life. Pals suggested that, "narrative integration of exploratory narrative processing and coherent positive resolution may create an enduring sense of positive self transformation within narrative identity, fostering a mature sense of well-being that is enriched rather than threatened by the most difficult experiences of adult life." (p.1106).

1.6.2 Development of narrative identity

According to Erikson (1968) it is during adolescence when identity development is the central task. Theories that conceptualise identity as a narrative life story suggest that adolescence and young adulthood is the time during which a sense of identity through narrative is developed and that, as people grow older, new experiences are

integrated into one's understanding of self and thus narrative identity is continually revised (Kroger, 2000; McAdams, 1993).

As described by McLean (2008), life-span theories propose that there are two basic ways in which integration of new experiences across time can occur: firstly, one can perceive a change and therefore revise one's identity; and secondly that one can perceive stability and therefore confirm one's pre-existing identity. Both perceptions are believed to serve to develop a sense of personal continuity because the pre-existing self must be referred to in either process. It is through storytelling or narrative that an individual integrates experience to explain in what ways they have either changed or stayed the same (Pasupathi & Mansour, 2006).

Habermas and Bluck (2000) propose that narrative identity or life story develops through the mechanism they termed "autobiographical reasoning". Autobiographical reasoning is a self-reflective process through which people link events in the past and the self, through thinking or talking, to understand who they are and create a life story (McLean *et al.*, 2007). As highlighted by McLean (2008), due to cognitive development and the social pressures to define the self, adolescence is theoretically the time in life when individuals begin to engage in autobiographical reasoning.

Some research has found gender differences in autobiographical reasoning, such as Thompson *et al.* (1996) who found that women reported their memories to be more personally revealing than men reported. Gender differences have also been discussed in relation to narrative development in childhood (McLean, 2008; McLean & Breen, 2009). For example, parents are more likely to discuss emotions, particularly sadness, with daughters than with sons (Fivush *et al.*, 2000). As discussed by McLean (2008), Fivush (1991) suggests that such differences may enable daughters to resolve negative affect more effectively than sons, enabling them to develop a more elaborative self concept.

McLean (2008) conducted a study to examine narrative identity in individuals during late adolescence to young adulthood and in individuals aged over 65 years. The full sample consisted of 134 participants, 85 in the younger group and 49 in the older group. Her analysis found that participants in their late adolescence and early adulthood told more stories representing change compared to the older group who told more stories representing stability, which might suggest that older people are more fully integrated in their self representations. Her study also examined gender differences and found that females reported more processing and thematic

coherence, suggesting that females may have an advantage in the development of life story or narrative identity. A further study by McLean & Breen (2009) found that, while there were no gender differences in the process of meaning making, gender differences did exist in the process of telling memories in that females were more likely to report telling their memories for relational reasons.

Other than the possible impact of early experiences with parents and gender differences on the development of narrative identity, research has also highlighted the importance of the listener. For example Pasapathi & Hoyt (2009) examined the impact of conversational storytelling on the development of narrative identity in late adolescence. They found that individuals in late adolescence and early adulthood were more likely to construct meaning-laden interpretive accounts of their everyday experiences when they have a responsive listener such as a friend. These findings suggest that relationships are likely to play an important role in the formation of narrative identity, particularly during late adolescence and early adulthood.

It would therefore appear that, while narrative identity can be regarded as a social construct as a result of storytelling and having a responsive listener, it is also dependent on the subjective experiences and cognitive processes of the individual, suggesting an interaction between the internal or personal self and the social, interactional self. Furthermore, gender and early experiences of conversations with parents or caregivers appear likely to impact on an individual's self concept.

1.7 Theoretical rationale

Siblings' experiences of first episode psychosis and the impact of their experiences on their self-concept and identity have been largely neglected in the literature. The main reason for this study is therefore to hear the untold stories of siblings, with particular focus on how they talk about themselves. It is hoped that hearing their stories and exploring how they tell them will contribute to an understanding of the impact of such an event on their self-concept. This has potential implications for how specialist EISs are organised and delivered, especially with regard to a family-inclusive approach. This study will also have implications for other family members in terms of understanding the possible impact of first episode psychosis on siblings, which might in turn impact on understanding and relationships within the family.

1.8 Current research questions/aims

- To hear the personal stories of siblings (aged 16-25 years) of individuals who have recently experienced a first episode of psychosis
- To develop understanding about the possible impact of siblings' experiences on their self concept/identity
- To contribute to the development of theory concerning the effects of severe mental illness on family members

2 METHOD

2.1 Setting

The research took place within an NHS Trust's EIS in a borough of London. The EIS is a specialist mental health service designed to offer assessment and treatment for young people aged between 16 and 35 years who are experiencing, or have recently experienced, a first episode of psychosis. It also offers help to the young people's families.

2.2 Ethical approval

The study was reviewed and given a favourable opinion by the Brompton, Harefield and NHLI's Research Ethics Committee (Appendix 1) and the University of Surrey Advisory Committee on Ethics (Appendix 2). The main ethical issues related to confidentiality, sensitive issues, reducing the potential for and managing distress, and anonymity and recording of interviews (see Appendix 3 for further description). The study was also approved by the relevant NHS trust Research and Development Committee (Appendix 4).

2.3 Procedure

2.3.1 Identification of participants

Potential participants were recruited from the EIS caseload and included all clients with siblings who were on the caseload during the six month course of the study (between October 2009 and April 2010). My field supervisor identified potential participants by screening the caseload at the EIS to identify clients with siblings who met the inclusion criteria below:

1. Male or female
2. Between 16 and 25 years of age (*as the study is concerned with the impact of first episode of psychosis on siblings' identity during late adolescence and early adulthood*)

3. Living with or actively involved in sibling's life at time of onset of sibling's psychosis
4. Ability to consent

Participants were excluded if they had a recognised diagnosis of mental illness or learning disability. Participants were also excluded if they could not be interviewed without the need for an interpreter as English is my first language. The use of translators may have compromised understanding and interpretation of meaning, which could have affected the quality of the analysis (see Appendix 5 for a flowchart of this process).

2.3.2 Recruitment

Potential participants were provided with an invitation to participate in the study (Appendix 6) and an information sheet about the study (Appendix 7) either by the field supervisor if the sibling was already directly involved with the EIS, or by the service user or parents if they, but not the sibling, were engaged with the service. If service users or parents were approached, they were also provided with an information sheet outlining the details of the study (Appendix 8). Participants who were interested in taking part in the research provided their contact details to the field supervisor and gave their consent for their contact details to be passed to me. Potential participants were given a minimum of 24 hours to decide whether they were interested in taking part before being contacted by the researcher. Written consent was obtained prior to conducting the interviews (see Appendix 9 for the consent form).

2.3.3 Participants

During the course of recruitment, between October 2009 and April 2010, the caseload at the EIS service included 72 clients. Of these, ten clients were identified who had a sibling who met the inclusion criteria to take part in the study. All ten potential participants were invited via their parents or sibling to take part in the study. Of the ten eligible, 6 agreed to be contacted by the researcher. Five agreed to take

part in the study and interviews were arranged. Of the five who agreed to take part in the study, one person did not attend the interview on two occasions.

Four participants took part in this study. Narrative research frequently uses small sample sizes, as it is concerned with gaining insight and understanding within a specific social context, rather than proving something about a phenomenon (Flyvbjerg, 2006) or attempting to create generalisable data.

Participants were asked to complete a brief demographic questionnaire following their interview (Appendix 10). Table 1 presents brief demographic details of the participants. Detailed information is not provided here, in order to preserve anonymity.

Table 1: Participants' Demographic Information

Participant	Name*	Age	Gender	Ethnic Group	Duration since onset of sibling's psychosis	Level of Education
P1	Luke	17	Male	White, British	1 Year	Up to 18 Years
P2	Nick	24	Male	White, British	3 Years	18 + Years
P3	Sarah	20	Female	White, British	2.5 Years	18+ Years
P4	Hannah	22	Female	White, British	1 Year	18 + Years

* Names have been changed.

All research interviews were conducted between December 2009 and April 2010.

2.3.4 Interviews

Narrative interviews are designed to offer people an opportunity to provide a detailed account of a particular experience (Murray, 2003). My interview style was therefore intended to be open and flexible, with the hope of enabling participants to tell their story however they wished. I explained that the idea of the interview was for participants to provide an account of their personal story during the time in which their brother/sister experienced a first episode of psychosis, and that I was particularly interested in hearing what life had been like for them. I also explained that, while I had some prompt questions that I might ask to help guide them in telling their story, they should feel free to tell me their story in whatever way they wished and to begin wherever they felt most comfortable.

The interview schedule took the form of a semi-structured interview and was developed following consultation with the field and academic supervisors⁴. The interview schedule was used as a guide to ensure that particular areas were covered in each interview, while allowing space to “follow feedback idiosyncratically” (Burck, 2005).

Prompt questions covered a number of areas, including asking the participant about their life before their brother or sister became unwell, their life when they first learnt that they were unwell, their life at the current time, their relationship with their sibling, other family members and peers, and in what ways, if any, their sense of who they are and what life is about had changed. Prompt questions were included as and when needed, either to help participants who preferred more structure to the interview in telling their story, or to further guide discussion to specific areas of interest. As participants often spoke about target topics without being prompted, I did not always follow the questions on the schedule in the order specified.

In addition to prompt questions, I summarised and reflected upon what the participants said and also introduced supplementary questions such as ‘why do you think that is the case?’ or ‘could you give me an example of that?’ where appropriate to obtain clarification. All interviews were audio-digitally recorded and transcribed verbatim⁵.

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⁴ See Appendix 11 for the Interview Schedule

⁵ See Appendix 12 for an example transcript

2.3.5 Analysis of the data

There is no agreed way in which to conduct a narrative analysis (NA). Approaches vary depending on the investigator and the research questions. As stated by Riessman (2008): "Variability is the rule, for future investigators will not find a similar toolkit of research practices, but instead a broad range of perspectives adapted for different research aims" (Riessman, 2008, p.138).

My analysis drew upon and adapted ideas and approaches employed by a number of narrative writers. In particular I drew on the integrative approaches employed by Murray (2003) and by Thornhill *et al.* (2004). I similarly opted to take a holistic approach whereby I initially took each narrative account as a whole to represent narratives in a wider sense (as discussed by Fludernik, 1999), as opposed to selecting discrete sections of text that meet specific criteria for being 'storied', an approach used by Labov (1972). I then looked across the narrative accounts to consider commonalities and differences.

My analytical approach can be divided into four phases which will be discussed below. The four phases are as follows:

1. Reading/re-reading of the story
2. Writing a short summary of each narrative
3. Identification of narrative genre, core narrative and tone
4. Identification of commonalities and differences across narratives

Phase 1: Reading/re-reading of the story

Reading and re-readings of the transcripts allowed me to develop an overall sense of the person's story (Dallos & Vetere, 2005) and enabled me to familiarise myself with both their structure and content (Murray, 2003 p.120.) As suggested by Riessman (1993), I also hoped that the stories themselves would invite thought as to the best way to bring out the key elements.

Phase 2: Writing a summary of each narrative

The second phase of the analysis drew upon the descriptive phase of Murray's constructivist approach (2003). After reading and re-reading each story Murray (2003) recommends writing a short summary of each narrative, designed to identify and illustrate the key features. This process assists in gaining a sense of the underlying orientation, form or genre of the narrative and therefore seemed to be the natural next step in the analysis, especially as I aimed to keep each story intact and maintain a holistic position. I considered dividing each narrative into a three-part story, as recommended by Murray (2003). However, rather than impose a beginning, middle and end, I adapted this approach by writing the short summaries in temporal order so as to construct a coherent summary for each participant.

Phase 3: Identification of narrative genre, core narrative and tone

The third phase of the analysis drew on the narrative method employed by Thornhill *et al.* (2004) in a study in which they analysed the narratives of individuals who described themselves as either recovered or recovering from psychosis. In their study, they analysed narrative genre, core narratives and tone in each account. These are discussed in turn below.

Narrative genre

Thornhill *et al.*'s (2004) approach was informed by work on narrative analysis that focuses on narrative form or 'genre' (e.g. Gergen & Gergen, 1983; Lacey, 2000; Mischler, 1986; Todorow, 1990). As discussed by Thornhill *et al.* (2004), the analysis of narrative genre has commonly been used in research examining "illness narratives" (e.g. Crossley, 1999; Frank, 1995), narratives about coming to terms with a disability (Gray, 2001), and narratives about mental illness (Hyden, 1995; Stern *et al.*, 1999). To analyse narrative genre, like Thornhill *et al.* (2004), the key question I asked when reading the transcripts was 'What kind of a story is this?' This enabled me to consider various aspects of the story including plot development, structure and the use of language.

Initially I considered fitting my analysis of narrative genre into categories that had already been produced by other writers. For example, I considered using the

progressive, regressive and stable forms identified by Gergen & Gergen (1986). However, I found these forms quite restrictive, and while they could be applied broadly, they did not reflect the intricacies that had emerged in these participants' stories. I therefore decided to develop my own narrative genres to represent more accurately the complexity of the genres that emerged for me during the analysis.

Core Narratives

This aspect of the analysis was informed by the approach described by Mischler (1986). In common with both Thornhill *et al.* (2004) and Mischler (1986), rather than attempt to develop a core narrative that would fit all four accounts, I chose to summarise each story in its own right, using a few words or phrases that were spoken by the narrator (e.g. *"everything happens for a reason"*). While the core narratives identified are influenced by the subjective response of the researcher, I chose to use words or phrases spoken by the narrator to ground the analysis.

Narrative Tone

Thornhill *et al.* (2004), Crossley (2000) and McAdams (1993) suggest that narrative analysis should also involve characterising something about the narrative as a whole, and suggest a focus on narrative tone. This phase involves further reading and re-reading of the text in order to identify the dominant tone/s. "Narrative tone is conveyed in both the content of the story and in the manner in which is told" (McAdams, 1993, p. 48.) In addition to the manner in which the story is told by the narrator, once again, the researcher's subjective response to the story plays a key role in the analysis. I limited myself to three key narrative tones per story to portray those tones that were most prevalent in each.

Phase 4: Cross-Analysis

The final phase of my analysis involved conducting a cross-analysis. Having analysed each narrative account independently, I asked myself what I had learnt more broadly about the impact of a first episode of psychosis on siblings' identity.

This phase involved reading across the narrative accounts, and taking a step back to recognise similarities and differences in the genres.

2.4 Methodological considerations

Whereas quantitative approaches aim to achieve a state of objectivity and neutrality, whereby data can be interpreted independently, narrative approaches, like other qualitative approaches, assume that the data, the selection of the analysis, and the interpretation and presentation of the findings are deeply influenced by the researcher (Crossley, 2007). Therefore narrative and other qualitative approaches do not work with the same concept of representativeness as most quantitative methods. Instead, the aim is to produce data which is detailed, 'information rich' and in context to fully appreciate and understand complexities of meaning.

Rather than assume an objective 'truth' with regards to practice and interpretation, Polkinghorne (1988) argues that, in narrative research, the concept of validity generally refers to being "well grounded and supportable" (as cited in Crossley, 2007, p.143). Similarly, Riessman (2008) argues that qualitative analysis requires researchers to make arguments to persuade audiences of the trustworthiness of their data and interpretations.

Elliott *et al.* (1999) summarised their understanding of the "publishability" guidelines for qualitative research in the social sciences. I chose to use their guidelines because, as discussed by Dallos & Vetere (2005), their criteria are summarised in the context of what qualitative and quantitative paradigms hold in common, and therefore promote an attitude of cooperation across the different traditions. An overview of the ways in which I have addressed their criteria follows below.

1. Owning one's own perspective

I have attempted to be open and transparent about my own influences and position in relation to the research. As previously mentioned, I am aware that my role as a trainee clinical psychologist, conducting this research as part of my doctorate, might have influenced participants' perceptions of me. For example, they might have perceived my role to be that of a 'professional' working for the EIS. To address this, I

attempted to remain mindful of potential power dynamics and aimed to be transparent in my approach and motivations. Participants were made aware that they could say as much or as little as they felt comfortable to and I sought informal verbal feedback following each interview.

2. Situating the sample

Basic descriptive data about the participants has been provided to enable readers to judge how relevant the findings might be to their practice.

3. Grounding the main findings in examples

I have provided direct quotations from the interview transcripts to ground my main findings. It is hoped that this will allow the reader to examine the fit between the data and my interpretations and also to entertain possible alternative interpretations. Example transcript excerpts, showing the development and progress of my analysis are included in Appendix 12.

4. Providing 'credibility' checks

There are a number of potential strategies that can be employed to meet this guideline. Strategies I employed included a reciprocal 'independent audit' (Dallos & Vetere, 2005) and the use of supervision.

The reciprocal 'independent audit' involved me and two colleagues reading, interpreting and discussing a sample of each other's data, presenting our emerging independent analysis (to check whether the approaches we were taking made sense and whether we were able to follow each other's analysis trail), and feeding back some of the interpretations we had each made, highlighting areas that made sense and any differences of opinion. Both colleagues made sense of my emerging analysis and fed back their own interpretations, which corresponded to my own. In addition, a small section of my first transcript was discussed at a Narrative Group meeting where interpretations that were made mostly corresponded with my own.

I also discussed each phase of my analysis with both my field and research supervisors who read each transcript. Both supervisors believed and made sense of my interpretations. I also discussed my analysis in a three-way meeting with my academic supervisor and a further colleague who had experience in the use of narrative methods. This discussion drew my attention to the coherence of my interpretations (i.e. the link between core narrative, tone and genre). All discussions enabled me to consider different perspectives which I accommodated as I continued to revise my original analysis.

5. Coherence of the data

Both Riessman (1993) and Elliott *et al.* (1999) highlight the need for arguments and findings to be presented in such a way that preserves the subtleties in the data and allows the reader to get a sense of its structure (Dallos & Vetere, 2005). This guideline was met through receiving regular feedback from my supervisors on my analysis, grounding the main findings using direct quotations from the transcripts and carrying out 'credibility' checks. The coherence of the findings will also be evaluated by readers of the research themselves.

6. Accomplishing general versus specific tasks

The main task in the current study was to explore the impact of first episode psychosis on siblings' identity. Therefore, the analysis, and discussion is specific in its focus. For these reasons I have not commented on more general findings.

7. Resonating with readers

To meet this criterion, my supervisors provided feedback on their experience of reading the analysis.

3 RESULTS

The results are presented in three parts. Part 1 presents a brief summary of each story, designed to illustrate the key features identified by the researcher, such that the reader will become orientated to the participants' narratives. A more thorough version of each story can be seen in Appendix 13 where quotes from the text are included to ground the analysis. Part 2 presents the findings from the individual analyses of core narrative, tone, and genre. Part 3 presents the findings from my cross-analysis, which focuses on commonalities and differences, in particular related to genre across the narrative accounts.

3.1 Part 1: Short Summaries of Participants' Stories

1) Luke (17 years)

Luke is a seventeen year old white British male. He has an older brother and a younger sister and was living at home with his parents and younger sister at the time of the interview. Approximately one year previously Luke's brother had experienced a first episode of psychosis while he was travelling. It was a "*shock*" to Luke when his brother became unwell and Luke experienced a period of roughly six months which he described as particularly "*tough*". During this period, Luke spent a lot of his time with his brother, taking on responsibilities, and putting his own life "*on hold*". Luke recognised that he had "*gained a lot more respect*" for his parents through this experience and also learnt that he is "*capable*" of far more than he had ever realised. At the time of the interview Luke was feeling hopeful about his brother's health, but also suggested he had some concerns about potential "*relapses*".

2) Nick (24 years)

Nick is a recently married twenty-four year old white British male. He has a younger sister, aged nearly twenty-one, who had experienced a first episode of psychosis approximately three years ago. At this time, Nick was in his final year at university and lived away from home. He heard about his sister's illness about one month

following the onset because his parents decided to wait until he had finished his exams. Nick said he was fully supportive of the decision. When Nick learnt about his sister's illness he became *"very much involved"*, mainly through offering his parents advice and opinions regarding her care. Nick spent time investigating his sister's illness on the internet and through reading books to try to establish the *"causes"* and the *"appropriate action"* to help her and advise his parents. Nick also explored to what extent psychosis might be *"genetic"*. He discovered some *"very good resources"* and thought that it might be helpful if mental health services recommended similar resources to families. Nick felt that the experience had brought his family closer together.

3) Sarah (20 years)

Sarah is a twenty year old white British female. She is the middle child with two brothers, the older brother being one year older than her. Sarah's older brother had been given a diagnosis of depression approximately four years ago. Around two and half years ago, just before she started university, Sarah's brother had experienced a first episode of psychosis. At this time, Sarah lived at home with her mother, father and both of her brothers and was studying for her A Levels, which included an A Level in psychology. Sarah was not particularly close to her family prior to her brother's illness. When Sarah's brother became unwell, Sarah and her family found it a *"weird and confusing"* time and Sarah found it *"distressing"* to see him become *"so different to normal"*. Sarah became frustrated with others who appeared ignorant to mental health issues and hoped that she might be able to contribute towards changing other people's views about mental illness through her future career.

4) Hannah (22 years)

Hannah is a twenty-two year old white British female. Hannah has an older sister aged twenty-three years. Hannah grew up with her sister and mother. Hannah and her sister left home to go to university at the same time because Hannah's sister deferred a year. While they went to different universities they remained in contact during this time. Hannah *"loved"* her first year at university, enjoying her new-found freedom. However, during her second year at university, one of her friends appeared to become mentally unwell and in the same year he *"tragically died"*. Hannah had

found it “devastating” seeing her friend go through this “bad experience”. After his death Hannah and another friend searched the internet seeking “an explanation” for his behaviour. The following year, Hannah recognised similar behaviour or ‘symptoms’ in her sister and spoke to her mother about it. While worried for her sister, Hannah also felt “lucky” to have recognised her sister’s symptoms so that she could get help early. Hannah developed a belief in “fate” and hopes to make the most of her health and her life, rather than dwell on the past, and recognised she can get frustrated with her sister for not embracing life.

3.2 Part 2: Case Study Analysis of Core Narrative, Tone, and Genre

Table 2 presents the findings from my case study analysis of core narrative, tone and genre. This is followed by a brief description of each account, to support my findings.

Table 2: Results of analysis of core narrative, tone, and narrative genre

	Core Narrative	Tone	Genre/Form
Luke (17)	<i>"I had to put it all on hold"</i>	shock, pragmatic, ambivalent	dutiful brother
Nick (24)	<i>"one step removed"</i>	inquiring, pragmatic, reflective	stoic quest
Sarah (20)	<i>(I, they) "don't really kind of understand"</i>	shock, empathic, passionate	survivor to reformer
Hannah (22)	<i>"Everything happens for a reason" (?)</i>	accepting, ambivalent, passionate	out of darkness

Luke

The core narrative identified in Luke's story was *"I had to put it all on hold"*. Luke used this phrase when talking about the impact of his experience on his friendships. He said *"...Um, it's not really changed other friendships, I had to put it all on hold for a while, but then after that, it's all just carried on as it was before..."*. This narrative was frequently present in Luke's story as he often referred to time being taken from his own life in order to spend time being with and looking after his brother. Luke said *"...it kind of took a big chunk of my life, because I spent so much time with him, either in the hospital, or just talking to him...and it took away quite a lot of my free time..."*.

The most significant tones identified within Luke's narrative were:

- 'shock', a term he used in response to his brother becoming unwell
- 'pragmatism' illustrated by his practical, 'doing' approach in response to his brother's illness; for example, he said *"...while he was travelling he took too much stuff, and then that's where it all started to kick off from, then with that, ur, me and my dad basically had to go over to [name of city] to try and pick him up and convince him, to come back..."*
- 'ambivalence' which seemed apparent in relation to his 'dutiful' role towards his brother and own life aspirations; for example, he said *"I've got re-takes in January so I've really got to keep more focussed on that, which is why I'm hoping for no more relapses"*.

The overall genre of Luke's story appeared to be one of a 'dutiful brother', as his dutiful role towards his brother was prevalent throughout, and appeared to override his own hopes and aspirations.

Nick

The core narrative identified in Nick's story was *"one stepped removed"*. Nick used these words to explain the role that he took on in the family when his sister became unwell. He said *"...pretty much from day one I took on, well took on, that, the sort of, well because I was that one step removed, I knew I had to be very strong and not*

emotional about this, which is something that isn't too unlike who I am anyway". Nick's perspective that he was "one stepped removed" seemed integral to his role/identity within his family. The position of "one stepped removed", both in a physical and emotional sense, appeared to help Nick to cope and to support his family which seemed integral to his story. He said "...from the perspective that I am that one stepped removed, being older and not living at home and that sort of thing, I don't think that it has been a huge amount to cope with..."

The key tones identified throughout Nick's story were:

- 'inquisitive', which was evident through the research that Nick had already carried out with regards to psychosis and through his enquiries during the interview; for example he said *"I do wonder actually whether, because I know there's actually, in terms of looking at the demographics of people who do have psychosis, it's often, it's often people from sort of similar backgrounds to my sister, sort of quite high achieving, um, push themselves too far and then have difficulties, and I wonder actually whether you find that siblings are, of a similar nature in general and therefore would deal with things...I don't know whether that link holds, deal with things in a similar way, I'm not sure?"*
- 'pragmatic' which was recognised in Nick's narrative with regard to his non-emotional stance *"...I've known always that it's, it's sort of my role not to be emotional and not to be worried.."* and practical and 'inquisitive' approach to his sister's illness *"...with my sister being ill, you ask questions such as, she's being really demanding, she's refusing to help with X, Y and Z, she's you know, been asleep all day – to what extent is that her illness, to what extent if that is her illness is that something we should pick her up on..."*
- 'reflective' as illustrated by the above inquisitive and contemplative quotes

The genre that best seemed to suit his story was one of a 'stoic quest' to find the appropriate facts to help his family and himself cope and respond to his sister's psychosis.

Sarah

The core narrative identified in Sarah's narrative was (I, they) *"don't really kind of understand"*. Initially she uses these words to describe her initial response to her

brother becoming mentally unwell. She said *"...actually seeing someone in your house go through it, a member of your family go through it was just sooo different... it just comes, so much more real, you don't really kind of understand quite how like different, hard it is, I guess to cope with that like when you hear about it, like what it is, like"*. Sarah refers to herself, her family, and others 'not understanding' throughout her story. Towards the end of her story Sarah explains how frustrated she is with other people for not understanding about mental illness. She said *"... quite a few people just have this very sort of, very un-understanding attitude which really frustrated me..."*. Sarah's personal experience and frustration with other people's lack of understanding about issues related to mental illness led her to wish to influence people's opinions in her future career. For example, she said *".... [I] just hope that I can do something in like, in my dissertation, in you know, like in my PhD later on, I don't, in whatever that would hopefully change this whole kind of a, people's perceptions..."*.

The key tones identified in Sarah's story included:

- 'shock', portrayed both by what she said, for example *"...it was just really, really shocking..."* and the way in which she spoke, for example, her narrative was initially very disjointed *"...sort of like getting these thoughts and just clearly like irrational thoughts and like, not normal, and so I guess, for us, it was just, it was, cause also my brother's just so, the difference, the weirdness, it's the fact that his normal character and what, like he was, when, he had these episodes was just completely different like..."*
- 'empathy' which seemed to be towards her brother, and others with mental illness, for example she said *"...once you know someone that has it, that has some sort of a mental health, like problem, and you do open up to a couple of people, you just find out actually how common it is, so, I guess you're just very, like aware of how, of the fact that it can happen."*
- 'passionate' which appeared to be especially related to bringing about change; for example, she said *"...it's just like made me very sort of, like made me wanting to kind of just help the whole, the whole issue of it, like just wish that I could do something..."*

The genre that appeared to summarise the type of story that Sarah told was 'survivor to reformer', reflecting how Sarah overcame the initial shock and distress with the

hope of, as mentioned previously, contributing to the reformation of others through her career in psychology.

Hannah

The core narrative identified in Hannah's story was *"everything happens for a reason"* (?). Hannah used this phrase to describe her outlook on life and the way in which she has made sense of both her sister's illness and the previous illness and death of a close friend. When talking about her friend that died she said *"...I'm quite...not grateful for it, but I think everything happens for a reason, and I became more aware of [sister] and maybe me and mum...got her help in time because I'd already experienced it with someone else, there's just kind of interlinks and stuff like that"*. This narrative is evident throughout Hannah's story, and was shaped by her experiences of both her friend's and sister's mental health difficulties. Hannah said *"I'm a massive believer of like fate and like things are meant to be, like if I went to a job interview and I didn't get it like I wouldn't be too down on myself, I'd be like, it's not meant to be, and I think that's probably what I got from the last two years of my life anyway..."*.

The key tones identified in Hannah's narrative include:

- 'ambivalence', which seemed apparent when Hannah spoke about whether she wished to know more about her sister's illness; for example, she said *"I don't really know too much about it, I don't really know much information about it, I've never like really sat down and spoke to her about it, I don't know whether that's because I don't want to personally know because I don't, not because I'm being selfish, but the less I know the less it affects me"*.

A question mark has been included following the identified core narrative *"everything happens for a reason"* (?), to draw attention to the 'ambivalent' tone that was present in Hannah's narrative.

- 'accepting' and 'passionate', which seemed to be in relation to accepting life events and being passionate about living life to the full and finding meaning; for example she said *"I think that ever since that happened I think 'you're still alive, you're still here, you can do whatever you want with your life, like someone lost their life that was just as good as you' and I think that's why I'm unsympathetic"*

towards it, cause I'm like 'come on, you've got the rest of you're life to make what you wanna be, if you wanna do it you'll do it.'"

The overall genre of Hannah's story was identified as 'out of darkness'. The 'darkness' that Hannah appeared to emerge from was the experience of seeing her friend become ill and then die, which caused Hannah to question life.

3.3 Part 3: Cross-Analysis

Through reading and re-reading the narrative accounts, it struck me that, while unique in their individual genres, there appeared to be differences in genres related to the participants' gender. I have interpreted the genre of the male participant's stories 'call to manhood', and the female participant's stories 'phoenix rising'.

An overarching genre that came out of further cross-analysis of the accounts was 'rites of passage'. Figure 1 presents a diagrammatical version of the cross-analysis. These findings will then be presented more fully, using quotes from the narratives to ground the interpretations.

Figure 1   Results of the cross-analysis

Male Participants' Narratives: 'Call to Manhood'

The genre 'call to manhood' represents my interpretation that both Luke's and Nick's narrative accounts demonstrated roles of responsibility in relation to their families, which is also evident in the 'pragmatic' tone of the stories. While similar in genre, the process of the 'call' was different in each narrative. For Luke, the younger brother, the 'call' appeared to be a shock, and for Nick, the older brother, the 'call' appeared to be a continuation of a life stage transition that he had already commenced. This was evident through Nick's age (24 years, compared to Luke, 17 years) and his circumstances, as he was leaving university and preparing to start employment at the time of his sister's illness.

When describing their response to their sibling's first episode of psychosis, which in each case appeared to include taking on responsibilities within the family, both Luke and Nick described themselves as doing what they had to do, as though they were 'stepping up to the mark'. For example, Luke said:

"...then with that, ur, me and my dad basically had to go over to [name of city] to try and pick him up and convince him, to come back, which was probably one of the toughest weekends I've been through in a while..."

"...I had to deal with my brother..."

"I always had to find out how I could deal with it next"

Similarly, Nick said:

"...so obviously I've taken a few days off work to try and get home to look after her..."

"...there was a completely defined role that I needed to take on and therefore, naturally I took that role because that was sort of what was required..."

"...I knew I had to be very strong and not emotional about this..."

Doing what had to be done in the family seemingly went alongside a change in both Luke's and Nick's roles in relation to their sibling with psychosis. For example, Luke's birth order role as the younger brother shifted to a temporary older brother role while his brother was ill. In relation to his brother, Luke said:

"I had sort of gone from younger brother to older brother"

"I've had to look after my brother"

"...you've got to worry about what he's doing, and whether that could end up going bad or not"

Nick's role as the older brother seemed to become enhanced. While talking about his sister, Nick said:

"...once all this happened I very much took on that more older brother role and was much more involved in her life on more of an emotional basis I guess, in again trying to be a support sort of thing..."

"... I'm much more ready to check to make sure she's ok and to actually be a support to her..."

Perhaps more significantly, both Luke's and Nick's roles appeared to change through increased responsibility in relation to their parents. They both appeared to have developed relationships with their parents that involved more mutual respect. For example, in talking about his parents Luke said:

"I've gained more respect for my parents"

"They're willing to let me go out and do kind of what I want to do now"

"I think I have proved to them that I'm able to kind of deal with more difficult situations"

And Nick said:

"...my parents and I are definitely in a, in a sort of a two-way thing...what we do is sort of speak to each other for advice and our opinions on things, and so I think at the time that my sister became ill I was old enough to, for them to consider me as another adult who they could speak to..."

"...so I will always, I will always have been, yeah I guess reassuring my mum or being not, not being emotional so that her emotions don't spiral sort of thing"

Nick's role change also appeared to include trying to provide himself and his parents with information about issues related to his sister's illness. For example, he said:

"I think it's, I feel it's worth being informed and trying to work out how best to help her sort of thing..."

"...I don't know whether it's a generation thing but it comes less naturally to my parents, they're more happy to accept whatever care is given as the appropriate care rather than to learn or at least learn or work out exactly why certain drugs are being given or why..."

Having discovered information and resources that he had found helpful, as well as pass this information onto his parents, he took a pragmatic approach whereby he suggested that services offer these resources to other families. He said:

"...certainly as a sibling I've never had any sort of contact about what resources are out there and worth reading or finding out about"

"so I think that's something that, there is a gap there. I don't think....you need...yeah more just for information really, if information's out there, being pointed in the direction of information is very very sensible"

With the increased responsibility, and changing family roles, both Luke and Nick seemed to recognise they had more resources and abilities. In particular, this could be seen in Luke's narrative as an early call to manhood, as he had not previously appeared to have begun this transition. For example, Luke said:

"Something I've realised about myself is that I can take a lot more than I ever thought I could handle..."

"...the main thing that that 6 months had done is it's made me grow up and stuff because I've been given a lot of responsibilities to do, I've had to look after my brother, so it's changed me in the way I think of things. I think very differently now, like, what could this then cause or something like that..."

"...it's kind of made me take a lot more challenging steps, like with the grades and stuff, that sort of made me think that I can get the grades to go on to uni, because of the real worry about my grades last year, that I wouldn't actually get my predicted grades now."

In Nick's narrative, this recognition could be seen as an appropriate transition to manhood. As he was finishing university at the time his sister became unwell, he had already developed competency and skills in enquiry and saw it as his natural role to pass on his findings to his parents. Nick said:

"I think I'm probably more ready to investigate those things, to question those things and then discuss them with my parents. And then also, I think also, tied to that, my parents probably just aren't just aware of what information's out there..."

Nick was also discovering skills and resources through his employment. He said:

"I wonder whether, because through work I've also been on various, various um sort of work based psychology courses where you sort of do this sort of stuff as well [R - Mmm, oh ok] so I don't know to what extent I'd pick that up anyway through that..."

Female Participants' Narratives: 'Phoenix Rising'

The genre 'phoenix rising' represents my interpretation that both Sarah's and Hannah's narrative accounts demonstrated a journey through very difficult and distressing life events, which they attempt to make sense of, and from which they both emerge as they find personal meaning. Sarah's and Hannah's accounts also had some similarities in tone, both expressing passion in what I have interpreted as personal meaning.

While similar in genre, Sarah's and Hannah's journeys appear to commence at different points. For example, Sarah's shock, distress and confusion appeared to relate to her brother's onset of psychosis, whereas Hannah seemed to have begun this phase of her journey prior to her sister's onset of psychosis, when a close friend who also appeared to have a mental illness died the year before.

In relation to her brother's onset of psychosis, Sarah said:

"I was just really just confused by it all, just a bit like 'what's going on? Something's obviously not normal' but it's just like, like at the time I was just like confused and weirded out by it I guess."

"...it was just weird like no one understood it at all, and um no one could make sense of it."

"...it was just so like distressing because it was so just like different to normal and what he's normally like."

"...it was just really, really shocking..."

And in relation to her friend's illness and death a year before her sister's onset of psychosis, Hannah said:

"Um, god, I think the initial shock, like of someone...dying, I think that's the hardest thing to take in, cause, it's been nearly, I think it's three years this summer, so, it's about two and half years now, and I think it still doesn't feel real, it's the initial shock of trying to accept something is the hardest thing I think, like trying to accept that it's real and you have to deal with it..."

"I'm thinking back to when, my friend as well, and I'm trying to relate it back because he had a really bad experience of like, thought he was like a messiah, and he was like, it's devastating to listen to one of your best friends and stuff, but with [sister], I know it's not as bad but I kind of related it to the two, just extreme thinking and extreme behaviour..."

In a similar way to Nick, both Sarah and Hannah attempted to make sense of these experiences. Sarah was able to draw on her knowledge of psychology to help her to make sense of her brother's illness. Her prior knowledge of psychology and attempts to make sense of her brother's illness went alongside her changing role in the family, in particular in relation to her parents. For example, Sarah said:

"I think also because I do study psychology in particular, like I think they're very, erm, they kind of, I guess, because they don't know really anything about it, I kind of at one point knew more than they did sort of thing before, and stuff so, it was kind of so I definitely got closer to my parents sort of thing because we'd speak about it and kind of try and get more points of view and like, like ideas on how to help him and stuff..."

Initially, Hannah attempted to make sense of her friend's illness and death by searching on the internet. For example, Hannah said:

"...me and my best friend, we did some research after it happened to see what like behaviour like, on the internet and stuff, but you're not really too sure how accurate it can be, but we did some research on the behaviour he was showing and bipolar did come up often and we read a little bit up on it."

This research and her prior experience of seeing her friend become ill helped Hannah to later recognise and make sense of her sister's symptoms when she experienced a first episode of psychosis. She said:

"...I think if I hadn't experienced that with my friend I'd just be like 'oh she's fine she just needs to talk to someone', but because alarm bells started ringing like instantly, once I heard the same kind of, um I think [sister's name] thought, something to do with God, like she saw a nun walking down the street and she thought it was God coming to her and things like that and as soon as that, them two similarities, I was like no, there's, something's not right..."

Hannah's role or status also appeared to change in relation to her sister and mother. For example, Hannah said:

"...you can't really mess around with her [referring to sister] as much, she takes things like to heart a little bit more than she usually would and mum fusses over her a little bit more than she used to and stuff so, so they, and when she's there it's more about her than it is about me, but it doesn't really bother me, I don't really need my mum's attention at the age of twenty-two, it's just, it's different, it can be different..."

A sense of frustration with others was common to both Sarah's and Hannah's narratives. For example, once Sarah had accepted and adapted to her brother becoming ill, she became frustrated and angry with people who she considered to be ignorant to mental health issues. She said:

"...people need to be more aware of what it is like to have it, and to live with it, like for the person and for the family, and it's just like, coz I don't think anyone, like when I first mentioned it to a couple of people, like, they, just, they don't really know what it is, they can't understand it..."

"...I think quite a few people just have this very sort of, very un-understanding attitude which really frustrated me, really frustrated me at the time and I remember getting into quite a few, like, very angry at quite, at a couple of people like who would come out with some things that I didn't, that I didn't like to hear..."

Hannah's frustration appeared to have arisen because of a change in the way in which she viewed life given her experiences. Hannah found it very frustrating that her sister had a different outlook on life. She said:

"...I think that ever since that happened I think 'you're still alive, you're still here, you can do whatever you want with your life, like someone lost their life that was just as good as you' and I think that's why I'm unsympathetic towards it, cause I'm like 'come on, you've got the rest of you're life to make what you wanna be, if you wanna do it you'll do it', so maybe that's what happened and that's why I've been like that..."

Hannah also found it frustrating that her mother seemed to support and encourage her sister's way of coping. She said:

"...I think in that sense I like kind of sometimes got a bit frustrated with her that she [referring to sister] was sitting and moping around and mum was fussing around her like she was a four year old or something..."

Having experienced and made sense of these distressing life events, at the time of the interviews both Sarah and Hannah's narrative accounts appeared to suggest that they were rising from their despair with new personal meaning. In keeping with Nick's narrative, Sarah wanted information about mental health to be shared with others:

"I just think that all this, you know all this sort of information should be shared if there's something that someone finds that helps or helps them to get better or motivates them in a certain way like..."

However, whereas Nick, shared his new-found information with his parents and suggested that services offer this information to families, Sarah showed a desire to become actively involved in spreading the message to others and seeing how she could potentially use her career to make a difference. For example, she said:

"...it's definitely kind of made me, cause I'm interested in doing like clinical psychology and it's just like made me very sort of, like made me wanting to kind of just help the whole, the whole issue of it..."

"...it's kind of like made me very sort of like, personal experience, it's made me wanna help people really with it and help the whole, like put more, like get more research for it I guess."

Hannah's attempt to find meaning in both her friend's illness and death, and her sister's psychosis, seemed to go alongside a change in state and outlook on life.

"...I think I've changed as a person like, so much in the last two years, ever since losing my friend. I think I've kind of, not, not got a value for life, you know when people are like 'ahh I've got such a value for life now' but I think, I think it almost drives me to do what I want to do and if I want to do it then I'll do it..."

"I think things that happen in your life probably, not necessarily, I think, change you as a person but just make you more aware of what you want and things like that."

Hannah also developed a belief in fate which appeared to influence her view of life and help her to make sense of difficult experiences. She said:

"...I think I've had a lot, a lot of time to think about things, and a lot of time to think about myself and, well, I didn't ever believe in fate before, but I think it's quite calming in a sense..."

"I think everything happens for a reason, and I became more aware of (sister) and maybe me and mum...got her help in time because I'd already experienced it with someone else, there's just kind of interlinks and stuff like that."

Overarching Genre: Rites of Passage

While there were individual differences amongst all four participants' narratives, and interpreted differences in genres between the male and female accounts, the narratives could all be considered as a journey through difficult times which, as discussed, changed their role or status in their family or society. This could be considered as an unexpected 'rite of passage'. While both Nick and Sarah highlight the possibility that change might have naturally occurred as a result of their life stage (see below), this unexpected experience seems to have accelerated and significantly impacted their journeys.

For the male participants, the journey, or 'passage' appears to be one from 'boy to man', and for the female participants it appears to be more associated with a growth into 'personal meaning'. All four 'rites of passage' seem to be characterised by going into the journey as young people doing what young people do, and emerging from the journey as changed, either as men with responsibilities, or women with a passion that inspires their life. For example:

Luke: *"...It's like um, say before this all happened, if somebody asked me 'do you think you could deal with this set of stuff?' I'd probably have said no, because it's quite a full on thing, but just going through it and realising that I can actually deal with*

this stuff, it's really kind of made me think that I am able to do a lot more than what I thought I could do previously"

Nick: *"...it's certainly meant that I've got a lot more patience with her and, yeah I'm much more ready to check to make sure she's ok and to actually be a support to her I think in a way that I just, I just wouldn't have felt the need to before she'd become ill, so from that perspective it's good..."*

Sarah: *"...as a person I'm definitely a lot more grateful, I think, which I didn't really appreciate before, partly true I guess of growing up, but this experience as well, um, yeah I don't know, yeah it has it's definitely shaped a lot of what I want to do, what I want to become, what I want to do with my future..."*

Hannah: *"...if you can achieve what you want to achieve, once you've been through all this stuff then I think you can get through anything, I'm a massive believer of like fate and like things are meant to be, like if I went to a job interview and I didn't get it like I wouldn't be too down on myself, I'd be like, it's not meant to be, and I think that's probably what I got from the last two years of my life anyway..."*

4 DISCUSSION

This section aims to: summarise the analysis addressing the original research questions; discuss how the findings relate to previous literature; consider potential clinical implications; discuss the identified limitations of the research; and finally, present ideas for future research.

4.1 Summary of analysis

This study explored the co-construction of four siblings' stories whose brother or sister had experienced a first episode of psychosis within the last three years, in order to understand the impact of this experience on the sibling's own identity. The stories were read with a view to analysing genre, tone and core narrative. While all accounts and experiences were unique, a cross-analysis of the accounts, including close analysis of the language, plot development and structure of the stories, allowed similarities and differences across their narratives to be recognised. A genre difference was identified between the male participants' and the female participants' narratives, whereby the male participants' narratives were characterised as a 'call to manhood', and the female participants' narratives were characterised as 'phoenix rising'. Similarities across the narratives were also identified and all four stories were characterised as 'rites of passage'.

The term 'rite of passage' represents the journey of 'change' that each participant appeared to talk about. Each was characterised by the experience of adversity, as a result of their brother's or sister's first episode of psychosis; change to either their role or status in the family/society; and a developed sense of self or purpose. For the male participants, the journey, or 'passage' appeared to be one from 'boy to man', and for the female participants it appeared to be more associated with a growth into 'personal meaning'. For three of the participants, the 'rite of passage' seemed to be characterised by embarking on the journey as young people doing what young people do, and emerging from the journey as changed, either as a man with responsibilities, or women with a passion that inspires their life; while the fourth, the oldest of the participants, appeared to incorporate this experience into a more usual, in his culture, 'rite of passage' into manhood.

Most previous qualitative studies that have investigated the impact of mental illness on well-siblings, including one study that investigated siblings' experiences of first episode psychosis (Sin *et al.*, 2008), focus specifically on the thematic content of siblings' accounts. Conversely, the analysis in the current study sets out to keep each story intact and maintain a holistic view, and in doing so identifies the features in the stories that appear most salient to the participants. While content was crucial to the analysis, attention to core narratives, tone, and genre enabled a rich and unique level of interpretation which makes important additions to research focussed on the impact of mental illness, and in particular first episode psychosis on siblings' identity.

4.2 Theoretical considerations

The journey that each of the participants in this study appeared to move through was constructed as a 'rite of passage'. Rites of passage typically involve four phases: separation, preparation, transition and reincorporation of new roles and rewards (Gennep, 1908, as cited in Quinn *et al.*, 1985). The transition itself usually involves some form of ceremony, although this varies across cultures (Delaney, 1995). Many cultures have clear expectations or rituals that signify movement from adolescence to adulthood. All rituals generally include literal and spiritual cleansing, physical transformation, offerings, prayers, and blessings, traditional food and dress, and traditional musical instruments and songs e.g. Bar Mitzvah in Judaism, Walkabout in Australian aboriginal culture, Vision Quest in native American cultures and initiation ceremonies in African and Amazonian tribes (See Delaney, 1995 for an overview of five specific rites of passage).

In contrast, the transition from adolescence to adulthood in conventional Western cultures is far more diffuse. As discussed by Quinn *et al.* (1985), while sequential transition points for adolescents and young adults within families, or expectations of young adults that might also serve as developmental markers (for example, learning to drive, going to university, finding employment, having children of their own, getting married, leaving the family home) do exist, they are not fixed. Transition points that are more fixed are concerned with legal requirements, for example, age for sexual consent and voting age. However, while legal requirements exist, they do not imply change. For example, a person's first sexual experience or the first time they vote is

not fixed by age. While transition points are not entirely fixed, there does appear to be an expectation or dominant discourse in Western culture that individuals begin to develop a stronger sense of who they are and become more independent during adolescence.

Transition points marked in the Western world, while influenced to an extent by law, appear to be influenced far more by cultural expectations and dominant discourses in society. While developmentally, adolescence might be a time in life when people naturally become more aware of who they are, the more implicit expectation or dominant discourse is also likely to impact on young people's sense of themselves at this time in life, especially given the more unfavourable discourses that exist about alternative possibilities, for example remaining dependent on one's parents indefinitely, which is generally frowned upon. Societal expectations and blurred transitions during adolescence/early adulthood can influence family dynamics. This influence can be positive, for example through promoting family growth and functional change. However, when there is a lack of meaningful rites of passage or confusion and disagreement about rites of passage, families can become stuck (Quinn *et al.*, 1985).

The participants in the current study were between 17 and 24 years of age, and not surprisingly, all appeared to have been on a pathway to their own rite of passage which was preparing for, experiencing, or just about to leave university life at the time at which their brother or sister experienced a first episode of psychosis. Luke and Sarah were both studying for their A Levels, and Nick and Hannah were both in their final year of university. The way in which all the participants (in particular Luke, Sarah and Hannah) appeared to integrate this event into their life during this significant time in their development seemed to accelerate or strengthen the process of moving into adulthood. This was apparent as all participants seemed to have a strengthened sense of self and greater independence following this experience.

Luke's 'normal' 'rite of passage' (studying for his A Levels with the view of going to university) was postponed due to his role change when his brother became unwell. However, while his expected life had been put on hold, he appeared to have earned his place as an adult in the family earlier than that would perhaps have been the case.

Sarah was also taking A Levels, including an A Level in psychology, at the time her brother became unwell. Despite initial shock, she was eventually able to incorporate

her personal experiences with her academic learning, and chose to incorporate these two aspects of herself into her choice of thesis at university which she hoped would inform others about bipolar disorder. This incorporation is reminiscent of a calling to a vocation, to reform attitudes to people who have mental health difficulties. The experience, integrated with her choice of career, transformed her into having a purpose with passion.

Hannah had completed her first year of university when her friend died suddenly following mental health difficulties. This shock, and no doubt grief, affected her significantly, causing her to feel low and question the purpose of life and death. However, following this experience, she was able to recognise early symptoms of potential psychosis in her sister. These experiences, in particular connecting the events and her role in helping her sister, led Hannah 'out of darkness' as she developed a different, more spiritual, meaning to life, and a passion to 'live life' along with a desire for others to do the same.

Nick seemed to have the most stable sense of self. It is possible that this was connected with his age as the eldest participant and his level of independence at the time of the onset of his sister's first episode of psychosis. The fact that he had already undergone the rite of passage of going to university and obtained a degree might have influenced his expectation that he would take on a role of responsibility. He was at the stage of thinking about marrying his long term girlfriend, with which comes responsibility, and it seems that helping his birth family from the position of "*one step removed*", his core narrative, was perhaps incorporated more easily into his identity.

The extent to which the participants' identities appeared to change or develop as a result of their experiences can be related to life-span theories (McLean, 2008). It would appear that Luke, Sarah and Hannah perceived change and therefore responded by revising their identities; whereas Nick, while recognising change, was also able to perceive stability and therefore confirm aspects of his pre-existing identity. This finding could also be related to McLean's (2008) study which found that the way in which changes are integrated into the self differ by age. Participants in their late adolescence and early adulthood told more stories representing change and transition compared to the older group who told more stories representing stability, suggesting that older people have more fully integrated self representations. From this perspective, while Nick is still a young adult, the findings do suggest that he was

more fully integrated in his self-representations than the younger participants. It is also possible that maintaining a more stable sense of self was adaptive for Nick at a time of potential confusion and change to the family system.

This study also identified differences in genres between the male and female participants' stories. This appeared to be connected more with personal meaning and moderations made to life, rather than care-giving roles as identified in previous literature (Greenberg *et al.*, 1997; Lohrer *et al.* 2007). The females in the current study appeared to integrate their experiences such that they developed an enriched personal meaning, also characterised by passion; whereas the males appeared to integrate their experiences in such a way that they developed an enriched sense of self that related more to adopting responsibilities and was characterised by pragmatism. These interpretations could be related to the dominant discourses about gender in society, whereby females are more connected to emotional processing and males to logical processing. These findings could also be related to parenting and narrative development in childhood (see McLean, 2008; McLean & Breen, 2009), whereby parents are more likely to discuss emotions, particularly sadness, with daughters than with sons (Fivush *et al.*, 2000). It is important to note that while there appears to be connections between the male genres and female genres (in the current sample of four participants), this does not suggest there is an intrinsic gender difference, and recognition must be given to the prevailing discourses around gender that are likely to have influenced the narratives.

The findings appear to support the notion that difficult life experiences constitute a challenge to one's narrative construction of identity (Pals, 2006). While Pals' (2006) study (as summarised in the introduction) was concerned with adulthood, the findings from the current study would suggest that "narrative integration of exploratory narrative processing and coherent positive resolution may create an enduring sense of positive self transformation within narrative identity, fostering a mature sense of well-being that is enriched rather than threatened by the most difficult experiences" (p.1106) in adolescence and young adulthood as well as in adults.

The rites of passage identified in the current study, which seemed to develop the participants' sense of self or identity, and which all participants appeared to frame in a progressive way, also support previous studies that have found siblings to experience positive gains from their brother's or sister's mental illness (e.g. Stalberg *et al.*, 2004; Kinsella, 1996; Sin *et al.*, 2008). Furthermore, the overarching genre

'rites of passage' developed through cross-analysis of participants' stories in the current study appears to relate to genres or forms found in previous studies, including narratives of chronic illness (Frank, 1995), narratives of recovery from psychosis (Thornhill *et al.*, 2004), and narratives of addictive behaviours (Hanninen & Koski-Jannes, 1999). The rites of passage genre in particular appears to bear resemblance to 'quest' (Frank, 1995), 'personal growth' (Hanninan & Koski-Jannes, 1999) and 'enlightenment' (Thornhill, *et al.*, 1004) all of which included stories whereby individuals had overcome their internal and external constraints and become open to experience new possibilities and perspectives.

The idea that personal gain or growth can be found in suffering has long been recognized in philosophy, literature and religion (Tedeschi & Calhoun, 1995). A range of empirical studies has supported this notion, reporting positive change occurring following trauma or adversity. For example, positive changes have been reported following bereavement (Calhoun & Tedeschi, 1999), HIV infection (Bower *et al.*, 1998), cancer (Cordova *et al.*, 2001), sexual assault and sexual abuse (Frazier *et al.*, 2001). As summarised by Higginson & Mansell (2008), some of the positive outcomes identified in such studies include an enhancement of relationships, a change in the way people view themselves, and a change in life philosophy. These positive changes following adversity have been referred to as post-traumatic growth, stress-related growth, perceived benefit and thriving, and are collectively known as adversarial growth (Linley & Joseph, 2006). Adversarial growth might be a useful framework in which to consider positive changes experienced following mental illness in the family.

However, rites of passage include the experience of loss and distress, as well as progression and growth. As discussed by Quinn *et al.* (1985), rites of passage are common examples of role replacement which can bring jeopardy, for example through relinquishing rewards associated with a previous role, as well as adaptive advantages. In the current study, challenges or loss and burden were considered in the context of each individual's story and how they integrated and made sense of their experiences. The findings do not therefore appear to naturally relate to those of previous studies that have investigated family members and siblings' experiences of mental illness, which appear to have a primary focus on content. Previous studies appear to have been conducted within a paradigm that White & Epston (1990) refer to as a logico-scientific mode, whereby *"the particulars of personal experience are eliminated in favour of reified constructs, classes of events, systems of classification*

and diagnoses" (White & Epston, 1990, p. 80). This contrasts with the narrative mode, which privileges lived experience and considers the links between lived experiences to be the generator of meaning.

As with some previous studies that have investigated the impact of mental illness on family members (e.g. Barak & Solomon, 2005; Barrowclough *et al.*, 1996; Lukens *et al.*, 2004; Schene *et al.*, 1994), themes such as loss, burden and fear of heredity also emerged within the narratives in the current study. However, apart from Luke who "*put his life on hold*", these themes did not appear to be the core narrative for the participants. While Luke and all other participants spoke about loss and burden, and three participants spoke about issues related to fear of heredity, the way in which these experiences were integrated into their experiences appeared to influence a positive, more developed sense of self and meaning. When integrated into the whole story, rather than fragmented and investigated out of context, loss, burden and fear of heredity might be perceived as less problematic, and more symptomatic of transition.

4.3 Clinical implications

The findings from this study offer important implications for clinical practice.

Firstly, the findings have implications for the way in which siblings are perceived and approached by mental health services. Of particular relevance was the journey or rite of passage that each participant had appeared to move through following the onset of their sibling's first episode of psychosis. This journey was characterised by role change, which often appeared to impact the whole family system. While there were similarities between the stories, each person experienced this journey in their own unique way and it will therefore be important for services to be mindful of siblings' changing roles and sense of self when approaching them, as their needs will vary depending on the stage of their journey. Being mindful of this process might help clinicians to evaluate where siblings are in relation to this journey/transition and to be better able to assess what support, if any, might be most appreciated. Awareness of this process of change, which is likely to impact the whole family, might also help other family members to make sense of their experiences and reduce potential blame and conflict. Furthermore, roles within the family are likely to continuously evolve, so it might be helpful for services to offer support to siblings and

other family members at regular intervals, or perhaps to have an opt-in/opt-out system to meet the changing needs of family members, particularly siblings.

Secondly, the findings from this study have implications for potential therapeutic intervention with siblings. While the participants in the current study (as far as I am aware) managed to integrate their sibling's first episode of psychosis in such a way that their sense of self or wellbeing appeared enriched, other siblings, perhaps those who were less likely to take part in a study exploring their experiences, might require support from services to make sense of their experiences. The finding from this study would suggest that narrative therapy, introduced by White and Epston in the 1990s might be a helpful approach with siblings. Narrative therapy involves exploration of the client's dominant and 'problem saturated' story which has often acquired a 'truth' status. Through doing so, the therapist assists the client to deconstruct unhelpful 'thin' dominant discourses and develop alternative stories (or narratives) which recognise the client's resources (White & Epston, 1990), and create a 'thicker' narrative. Through the process of integrating a resourceful narrative, the client is considered to give new meaning to their lives and develop a healthier, richer, and less problematic sense of self. It is this richer, more resourceful story of their lives that enables people to see themselves differently and incorporate these aspects and connections into a coherent sense of self, or identity.

Interestingly, White and Epston (1990) have argued that interpreting and relating crises to some aspect of transition or 'rites of passage' in the person's life invites questions that locate the crisis in relation to three phases: 'the separation phase', whereby some aspect of the person's identity or role is no longer viable; 'the liminal or betwixt and between phase', which is characterised by some discomfort and confusion; and 'the reincorporation phase', which involves the arrival at a new status that includes new responsibilities and privileges. White & Epston (1990) argue that a receiving context based on the rites of passage analogy enables the crisis to be constructed in terms of progress, rather than regression, without denying distress (White & Epston, 1990). This is unlike the analogies drawn from the tradition of positivist science whereby the crisis would be interpreted as some form of breakdown or regression.

Thirdly, the findings have implications regarding resources and information provided by services. All participants in the current study at some stage of their journey appeared keen to investigate issues related to mental health to aid their and their

families' understanding. Participants used a variety of methods to meet this need, including using the internet, reading books and talking to others who had undergone similar experiences. Nick was the only participant to have mentioned learning from the EIS itself. While Nick did not feel he needed therapy, he did express a desire to have been provided with information from the service, and recommended that the service provide such information for all families going through this experience. These findings add to the current literature which suggests that well-siblings of individuals with schizophrenia, and in this case, first episode psychosis, desire information about their brother's or sister's illness (e.g. Friedrich *et al.*, 2008; Landeen *et al.*, 1992).

Furthermore, all participants appeared to play a key role in the care-giving and recovery of their sibling. This occurred both directly, and indirectly through support and advice offered to parents. This supports Birchwood's (2003) findings that siblings of individuals with first episode psychosis are often perceived to be a valuable resource for their brother or sister with regard to engagement in recovery and normalising activities. This further supports the potential benefit of services developing resources and information or at least a sign-posting service to meet the needs of siblings. Given the helpful roles that siblings can take in response to their brother or sister's first episode of psychosis, it might also be helpful for services to highlight this, for example by informing siblings and families that siblings often take on these roles and offering support and information specifically with regards to this aspect of siblings' roles.

4.4 Limitations

This study has been effective in exploring the potential impact of first episode psychosis on siblings' sense of self/identity. However, several limitations may be evident.

The approach to the analysis and the interpretations of the data were, as in most qualitative approaches, deeply influenced by my own perceptions and values. The trustworthiness of the results might therefore be criticised. However, I have attempted to address this issue throughout the research process, by following Elliot *et al.*'s (1999) guidelines for the publication of qualitative research, as discussed in the

methodology section. While I carried out credibility checks through colleagues and supervisors, the analysis could be criticised for not having sought feedback on the analysis and my interpretations from the participants themselves, known as 'respondent validation' (Dallos & Vetere, 2005).

The study could also be criticised for its relatively small number of participants. Having interviewed only four participants, all from the same ethnic group and similar socio-economic status, the generalisability of the findings to the population might be questioned. However, as previously acknowledged, this study does not claim to represent the impact of first episode psychosis on all siblings, however the findings can contribute to existing theory and generate further research.

It is likely that the participants that chose to take part in this study represent those siblings who have grown from the adversity experienced as a result of their brother's or sister's first episode of psychosis. However, while volunteers may have specific stories to tell, for example progressive stories with a 'happy ending', taking a holistic approach to the analysis may inform us of some of the potential difficult experiences of other siblings who choose not to share their stories and importantly, where the challenges might be.

4.5 Future research

This study is the first to explore the potential impact of first episode psychosis on siblings' sense of self or identity, and also the first to explore these siblings' experiences using narrative analysis. I believe that the rich interpretations that this approach enabled, especially with regard to developing an understanding of the impact on identity, supports the usefulness of narrative analysis as an approach to investigating the impact of adversity.

As previously mentioned, the participants in this study were all white British and from a similar socio-economic background. As such, their experiences and sense of self will have been influenced by the dominant discourses in their culture/society. Future research exploring the impact of first episode psychosis on siblings' sense of self and identity involving siblings from different backgrounds and cultures might therefore be a helpful contribution to the literature and increase understanding about the impact of culture and society on one's meaning making processes, and thereby increase the

cultural sensitivity of services. This would add to recent research which has explored the treatment experiences of care-givers of Pakistani origin, within the context of EI for psychosis (Penny *et al.*, 2009).

Finally, this study involved one interview at one specific point in time. A longitudinal study whereby participants are interviewed at different time points might contribute further to our understanding of the ways in which siblings integrate this particular experience into their sense of selves over time.

4.6 Final Reflections

Hearing participants' stories or journeys, and engaging in the analysis influenced me to reflect on my own childhood and adolescent experiences and consider the ways in which I have integrated difficult experiences into my own sense of self. While I was aware that my earlier experiences, in particular the divorce of my parents and experience of mental illness within my close family had affected me, I was surprised to realise that so many years on, I am continuing to integrate these experiences into my sense of self and sense of purpose in life, as evidenced by my choice of thesis topic. This increased my awareness of just how influential these experiences have been, and has helped me to connect with my past and the ways in which past experiences, my culture and society have influenced me over time. Interestingly I relate my story most closely to the female narratives in the current study. I too came 'out of darkness' with motivation and passion to help and inform others, and like Sarah chose psychology as one means to this end.

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6 APPENDICES

APPENDIX 1: Letter of ethical approval (NHS)

National Research Ethics Service **Brompton, Harefield & NHLI Research Ethics Committee**

Room W4/11, 4th Floor West
Charing Cross Hospital
Fulham Palace Road
London
W6 8RF

Telephone: 0208 846 7287
Facsimile: 0208 846 7280

03 August 2009

Ms Sharon Newman
Flat 2, 123A
Putney Bridge Road
Putney
SW15 2PA

Dear Ms Newman

Study Title: A narrative analysis of the accounts of siblings aged between sixteen and twenty-five years, whose brother or sister has recently experienced a first episode of psychosis.

REC reference number: 09/H0708/41

Thank you for your letter of 01 July 2009, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Vice-Chairman.

Confirmation of ethical opinion

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

Ethical review of research sites

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

Conditions of the favourable opinion

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

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

For NHS research sites only, management permission for research ("R&D approval") should be obtained from the relevant care organisation(s) in accordance with NHS research governance arrangements. Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>

This Research Ethics Committee is an advisory committee to London Strategic Health Authority
The National Research Ethics Service (NRES) represents the NRES Directorate within
the National Patient Safety Agency and Research Ethics Committees in England

Where the only involvement of the NHS organisation is as a Participant Identification Centre, management permission for research is not required but the R&D office should be notified of the study. Guidance should be sought from the R&D office where necessary.

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

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

Approved documents

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

Document	Version	Date
Flowchart, Appendix 10	1	01 July 2009
Response to Request for Further Information		01 July 2009
Letter of invitation to participant	2	01 July 2009
Participant Information Sheet: Appendix 5	2	01 July 2009
Participant Information Sheet: Information sheet for Service Users and Parents. Appendix 4	2	01 July 2009
Participant Consent Form	2	01 July 2009
Covering Letter		09 May 2009
Protocol	2	28 April 2009
Investigator CV		05 May 2009
Application	14888/37579/1/113	05 May 2009
Indemnity		21 July 2008
Dr Joanne Lym Billings's CV		07 May 2009
Dr Laura Simonds' CV		05 May 2009
Letter from Sponsor		16 April 2009
Interview guide	1	28 April 2009
Minutes from review of research proposal	1	03 November 2008
Demographic Information	1	28 April 2009

Statement of compliance

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

After ethical review

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

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

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

- Notifying substantial amendments

This Research Ethics Committee is an advisory committee to London Strategic Health Authority
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the National Patient Safety Agency and Research Ethics Committees in England

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

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

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nres.npsa.nhs.uk.

09/H0708/41

Please quote this number on all correspondence

Yours sincerely

Dr Derek Gibson
 Chairman

Email: adriana.fanigliulo@imperial.nhs.uk

Enclosures: "After ethical review – guidance for researchers"
Copy to: Ms Mary John, Clinical Psychology Course Director, Department of Psychology, University of Surrey, Guildford GU2 7XH
 Ms Enitan Eboda, South West London & St George's Mental Health NHS Trust., c/o Division of Mental Health, St George's University of London, Cranmer Terrace, London SW17 0RE

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 The National Research Ethics Service (NRES) represents the NRES Directorate within
 the National Patient Safety Agency and Research Ethics Committees in England

APPENDIX 2: Letter of Ethical Approval (University)

Dr Adrian Coyle
Chair: Faculty of Arts and Human Sciences Ethics
Committee
University of Surrey

Faculty of
Arts and Human Sciences

Faculty Office
AD Building
Guildford, Surrey GU2 7XH UK

T: +44 (0)1483 689445
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www.surrey.ac.uk

Sharon Newman
Clinical Trainee
Department of Psychology
University of Surrey

18th August 2009

Dear Sharon

Reference: 357-PSY-09

Title of Project: A Narrative Analysis of the accounts of siblings aged between sixteen and twenty-five years, whose brother or sister has recently experienced a first episode of psychosis

Thank you for your submission of the above proposal.

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

If there are any significant changes to this proposal you may need to consider requesting scrutiny by the Faculty Ethics Committee.

Yours sincerely

Dr Adrian Coyle

Chair's Action

Ref: 357-PSY-09

Name of Student: SHARON NEWMAN

Title of Project: A Narrative Analysis of the accounts of siblings aged between sixteen and twenty-five years, whose brother or sister has recently experienced a first episode of psychosis

Supervisor: Dr Laura Simonds

Date of submission: 18th August 2009

The above Project has received NHS approval and expeditious ethical approval has been granted.

Signed:
Dr Adrian Coyle
Chair

Dated: 18th August 2009

APPENDIX 3: Main Ethical Issues

Confidentiality:

Service Users' files were only consulted by my field supervisor, a member of the care team at the EIS. I only had access to the information provided by participants that chose to take part in the study.

Limits of confidentiality were outlined in both service user/parent information sheets and in the participant information sheets. For potential participants, this will include the circumstances under which the researcher would need to share information with others (if the researcher feels that the participant is at risk themselves or is posing a risk to anyone else). Prior to conducting the interviews, participants were informed of their rights not to answer any of the questions and to withdraw from the study at any time.

Sensitive Issues:

Participants were informed that taking part in the study may cause them to become upset or distressed due to the nature of the topic. The information sheet highlighted that if I was worried that the participants had become upset or distressed, I would inform my field supervisor at the EIS. Participants were also informed that if they needed additional support as a result of taking part in the study, the EIS, would offer support where appropriate, or identify and liaise with more appropriate services to facilitate participants access to further support.

Reducing the potential for and managing distress:

Given the potential for participants to become upset during the interviews, precautions were taken to both reduce the potential for this and to manage distress. For example, I aimed to adopt an informal style of interviewing, as adopted by other researchers e.g. Finlay & Lyons (2000) & Booth and Booth (1998), in an attempt to create a relaxed atmosphere and reduce potential anxieties. I also spent time prior to each interview building rapport with participants to help to put them at ease and address any queries. Participants were also informed that they did not have to answer any questions that they did not want to and that they could tell their stories in their own way. Furthermore, all interviews were carried out in the community hospital where staff from the EIS were available should their assistance be required.

Anonymity and recording of interviews:

Anonymity was maintained throughout the research process. All names and potential identifying features about the participants were changed. All raw data were kept in a locked drawer in the researcher's home, labelled only with the participants' unique code. Consent forms were stored in a locked cabinet at the NHS research site. Audio recordings of interviews are also stored securely in the researcher's home and will be deleted twelve months following the completion of the study.

APPENDIX 4: Letter of Approval (R&D)

COPY

South West London and St. George's
Mental Health NHS Trust

Ms Sharon Newman
Trainee Clinical Psychologist
Flat 8
35 St. Johns Avenue
Putney
London
SW15 6AL

18 September 2009

Dear Ms Newman

Research and Development

Acting Director: Dr Andrew Kent
DIVISION OF MENTAL HEALTH
HUNTER WING
CRANMER TERRACE
LONDON SW17 0RE

R&D Co-ordinator: Ms Enitan Eboda
E-mail: eeboda@sgul.ac.uk

Direct Line: 020 8725 3463/2783
Fax: 020 8725 3538/2914

Research Title: A narrative analysis of the accounts of siblings aged between sixteen and twenty-five years, whose brother or sister has recently experienced a first episode of psychosis
Principal Investigator: Sharon Newman
Project reference: PF422
Sponsor: University of Surrey

Following various discussions your study has now been awarded research approval. Please remember to quote the above project reference number on any future correspondence relating to this study.

Please note that, in addition to ensuring that the dignity, safety and well-being of participants are given priority at all times by the research team, host site approval is subject to the following conditions:

In addition to ensuring that the dignity, safety and well-being of participants are given priority at all times by the research team, you need to ensure the following:

- The Principal Investigator (PI) must ensure compliance with the research protocol and advise the host of any change(s) (eg. patient recruitment or funding) by following the agreed procedures for notification of amendments. Failure to comply may result in immediate withdrawal of host site approval.
- Under the terms of the Research Governance Framework, the PI is obliged to report any adverse events to the Research Office, as well as the REC, in line with the protocol and sponsor requirements. Adverse events must also be reported in accordance with the Trust Accident/Incident Reporting Procedures.
- The PI must ensure appropriate procedures are in place to action urgent safety measures.
- The PI must ensure the maintenance of a Trial Master File (TMF).

Terms and conditions of Approval, version 1.1 02/03/2010

- The PI must ensure that all named staff are compliant with the Data Protection Act, Human Tissue Act 2005, Mental Capacity Act 2005 and all other statutory guidance and legislation (where applicable).
- The PI must comply with the Trust's research auditing and monitoring processes. All investigators involved in ongoing research may be subject to a Trust audit and may be sent an interim project review form to facilitate monitoring of research activity.
- The PI must report any cases of suspected research misconduct and fraud to the Research Office.
- The PI must provide an annual report to the Research Office for all research involving NHS patients, Trust and resources. The PI must also notify the Research Office of any presentations of such research at scientific or professional meetings, or on the event of papers being published and any direct or indirect impacts on patient care. This is vital to ensure the quality and output of the research for your project and the Trust as a whole.
- Patient contact: Only trained or supervised researchers holding a Trust/NHS contract (honorary or substantive) will be allowed to make contact with patients.
- Informed consent: is obtained by the lead or trained researcher according to the requirements of the Research Ethics Committee. The original signed consent form should be kept on file. Informed consent will be monitored by the Trust at intervals and you will be required to provide relevant information.
- Closure Form: On completion of your project a closure form will be sent to you (according to the end date specified on the R & D database), which needs to be returned to the Research Office.
- All research carried out within South West London & St George's Mental Health NHS Trust must be in accordance with the principles set out in the Department of Health's Research Governance Framework for Health and Social Care 2005 (2nd edition).

Failure to comply with the conditions and regulations outlined above constitutes research misconduct and the Research Office will take appropriate action immediately.

Please note, however, that this list is by no means exhaustive and remains subject to change in response to new relevant statutory policy and guidance. If you have any queries regarding the above points please contact Enitan Eboda, R&D Co-ordinator, on 020 8725 3463 (St. George's), e-mail: eeboda@sgul.ac.uk.

Yours sincerely,

Dr Andrew Kent
Research & Development Director
Chair, Research & Development Committee

Terms and conditions of Approval, version 1.1 02/03/2010

APPENDIX 5: Identification of Participants (flow-chart)

Flow Chart Highlighting Identification and Recruitment of Potential Participants

*Inclusion Criteria:

- Has a sibling who has experienced a first episode of psychosis in the past 3-24 months
- Male or female
- Aged between 16 and 25 years
- Living with or actively involved in sibling's life at time of onset of sibling's psychosis
- Ability to consent

Exclusion Criteria:

- A recognised diagnosis of mental illness or learning disability
- People that can't speak English without the need for an interpreter

APPENDIX 6: Invitation to Take Part

Department of
Clinical
Psychology

Invitation to take part in a study

Title of project: Siblings' accounts of their brother/sister's first episode psychosis

Dear .....,

I am interested in understanding the experiences of siblings who have a brother or sister who has experienced a first episode of psychosis within the last 2 years and would like to invite you to participate in a study I am conducting.

If you are not currently working with the Early Intervention Service, your brother/sister/parent, who is currently working with the Early Intervention Service has been provided with some information about this study and agreed to pass this information about the study on to you for your consideration.

I believe this is an interesting and worthwhile topic which has had little research attention. I would value your help in understanding the experiences of siblings in relation to their brother or sister's first episode of psychosis and the impact, if at all, this might have on their own lives. I hope that the results from this study will contribute to a better understanding of how siblings like you experience this event in their lives and so influence how we organise and deliver services to siblings and wider families within early intervention services.

I have enclosed an information sheet about my research study. It is entirely up to you to decide whether or not you wish to take part in the study. If you do not wish to take part you will not be contacted again regarding the study. I appreciate your time in reading the information sheet and considering participating in this study.

Thank you for your time.

Sharon Newman

Trainee Clinical Psychologist

APPENDIX 7: Participant Information Sheet

Department of Clinical
Psychology

Participant Information Sheet

Title of project: Siblings' accounts of their brother/sister's first episode psychosis

My name is Sharon Newman. I would like to invite you to take part in a research study as part of my clinical psychology training. Before you decide it is important for you to understand why the research is being done and what it would involve. Please take time to read the following information carefully and feel free to ask me any questions you may have about the study before you decide whether or not to take part. Talk to others about the study if you wish before deciding whether or not to take part.

What is the aim of the study?

The aim of this study is to learn about your life and your experience of your sibling's first episode of psychosis and the way it has influenced your life. There has been little research on this and I hope that learning about your experiences will influence how we organise and deliver services to siblings and wider families within early intervention services.

Why have I been chosen?

Jo Billings, Clinical Psychologist at the Richmond Early Intervention Service is approaching all service users, siblings, or parents who are currently engaged in the service where the identified service user has a sibling who meets the study's inclusion criteria. Inclusion criteria include: being aged between 16 and 25 years and being in regular contact with your brother or sister. Regular contact is defined as at least once weekly.

You have been invited to take part in the study either through your brother, sister or parent/s who are currently working with the Early Intervention Service in Richmond

or directly through the Early Intervention Service if you are currently working with the service. While you might have been approached to take part in the study through a family member and you are free to discuss this with them if you wish, your decision to take part or not in the study is your decision and will be kept confidential.

Do I have to take part?

No, it's up to you to decide. After reading this information sheet, you can decide whether or not to take part. If you decide to take part, I will ask you to sign a consent form to show you have agreed to take part. You are free to withdraw at any time, without giving a reason. This would not affect the standard of care you or any members of your family receive.

What will happen to me if I take part?

I will arrange a time with you for you to attend an interview with me where I will ask you to tell your account of your brother/sister's first episode of psychosis and how, if at all, this has affected you. You will be asked some prompt questions but will be free to tell your story in whatever way you wish. The interview will last up to 90 minutes and will be held at the Richmond Royal Hospital. With your permission the interview will be audio recorded and then transcribed.

Will there be any financial costs involved?

No, all postage costs are covered and reasonable travel costs to and from the Richmond Royal Hospital from your home will be reimbursed on the day of your interview.

Will there be any risks or discomfort?

There are no anticipated risks or discomfort involved in taking part in this study. Talking about this topic may cause you to feel upset or distressed. You need not answer any particular questions if you do not wish to. If you do become upset or distressed and would like help, the Early Intervention Service will offer you support, or will help you to find the most appropriate support to meet your needs.

What are the possible benefits of taking part?

We cannot promise the study will help you but we hope that the information we get from this study will help raise awareness of the experiences of people like yourself whose brother or sister has experienced a first episode of psychosis and so influence how we organise and deliver services to families within early intervention services.

Who do I speak to if problems arise?

You can contact the researcher to discuss any matters relating to this project at the following

Sharon Newman

Trainee Clinical Psychologist

Surrey and Borders Partnership NHS Trust

Clinical Psychology Department

University of Surrey

Guildford

GU2 7XH

Email: S.Newman@surrey.ac.uk

Tel: 01483 689441 (weekdays 9-5pm)

Independent advice can be sought from

Dr Sue Thorpe

Research Director

Clinical Psychology Department

University of Surrey

Guildford

GU2 7XH

Email: S.Thorpe@surrey.ac.uk

Tel: 01483 682916

If you wish to complain about any aspect of the study you can do this through the University of Surrey complaints procedure. Details can be obtained from the University.

Will my responses be kept confidential?

Yes, we will follow ethical and legal practice and all the information about you will be and handled in confidence. Only the researcher and supervisors will have access to the information collected during the study.

The audiotapes will be stored in a secure place and destroyed at the end of the study. The transcripts will be anonymised so that any personal information that could potentially identify you will be changed or left out to protect your confidentiality. The anonymised transcripts will be password protected for the duration of the study and then stored safely at the University of Surrey for a period of 10 years. Following this the transcripts will also be destroyed.

The only circumstance in which the researchers would need to share personal information about you with other professionals is if they have reason to believe that you or any other individual is at risk of harm.

What will happen to the results of the study?

As the study is being done as an educational project, it will be written up and made available in the University of Surrey library in 2011. You are welcome to visit the library and see it there. In addition to this, the findings may be written up as an article and submitted for publication in a national journal. You will not be personally identified in any report or document about this study.

Who has reviewed the study?

All research in the NHS is looked at by independent group of people, called a Research Ethics Committee to protect your safety, rights, wellbeing and dignity. This study has been reviewed and given a favourable opinion by the Brompton, Harefield and NHLI's Research Ethics Committee.

What do I do next?

If you want to participate in the study, please contact the researcher, Sharon Newman, by telephone or email:

Email: S.Newman@surrey.ac.uk

Tel: 07985614836 (weekdays 9-5pm)

Or, if you would like to be contacted by the researcher, please complete the attached slip and post it back in the envelope provided (freepost). You can keep this information sheet for yourself.

Thank you for taking the time to read this information sheet.

Title of project: Siblings' accounts of their brother/sister's first episode psychosis

Name: .....

I am interested in taking part in this study and would like to be contacted by the researcher to discuss it further.

I would prefer to be contacted by phone and the number I can be contacted on is:
.....

I would prefer to be contacted by email and my email address is:
.....

APPENDIX 8: Information Sheet for Service Users and Parents

Information Sheet for Service Users and Parents

Title of project: Siblings' accounts of their brother/sister's first episode psychosis

My name is Sharon Newman. I would like to ask you to invite .....
to consider taking part in a research study as part of my clinical psychology training.

The aim of this study is to learn about siblings experiences of their brother or sister's first episode of psychosis. There has been little research that has explored siblings' experiences of their brother or sister's first episode of psychosis. It is hoped that gaining a greater awareness of how siblings experience this event in their lives will influence how we organise and deliver services to siblings and wider families within early intervention services.

What do I do next?

If you would like to invite ..... to consider taking part in the study please pass on to them the information that will be provided by a team member at Richmond Early Intervention Service.

It will then be entirely..... decision as to whether or not to take part in the study. In line with ethical and legal practice, whether or not ..... decides to participate in the study will be kept confidential. This means that while ..... may choose to discuss or not whether to participate with you and/or others, the researcher and Early Intervention Team will not be able to discuss this with you without their consent.

Whether or not you decide to invite ..... to take part in the study and whether or not they then decide to take part or not will not affect the standard of care you or any members of your family receive.

You can contact the researcher to discuss any matters relating to this project at the following

Sharon Newman

Trainee Clinical Psychologist

Surrey and Borders Partnership NHS Trust

Clinical Psychology Department

University of Surrey

Guildford

GU2 7XH

Email: S.Newman@surrey.ac.uk

Tel: 01483 689441 (weekdays 9-5pm)

Thank you for taking the time to read this information sheet.

APPENDIX 9: Consent Form

Participant number: _____

Consent form

Title of project: Siblings’ accounts of their brother/sister’s first episode psychosis

Names of researchers: Sharon Newman, Jo Billings, Laura Simonds

Please initial box

1. I confirm that I have read and understand the information sheet dated 24th June 2009 (version 2) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason.

☐
3. I agree to the interview being tape recorded and transcribed.

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

☐

Name of Participant	Date	Signature
_____	_____	_____

Name of Person taking consent	Date	Signature
_____	_____	_____

(When completed, 1 for participant, 1 for research site)

APPENDIX 10: Demographic Questionnaire

Participant number: _____

Demographic Information

Title of project: Siblings' accounts of their brother/sister's first episode psychosis

Please take a few moments to complete the following information.

1. What is your sex?   *Please ✓ the appropriate box*

☐

Male

☐

Female

2. What is your age? _____

3. What is your ethnic group? *Choose ONE section from A to E, then ✓ the appropriate box to indicate your ethnic group*

A   White

☐

British

☐

Irish

☐

Any other white background, please write in

_____

B   Mixed

☐

White and Black Caribbean

☐

White and Black African

☐

White and Asian

☐

Any Other Mixed background, *please write in*

_____

C Asian or Asian British

☐

Indian

☐

Pakistani

☐

Bangladeshi

☐

Any Other Asian background, *please write in*

D Black or Black British

☐

Caribbean

☐

African

☐

Any Other Black background, *please write in*

E Chinese or other ethnic group

☐

Chinese

☐

Any other, *please write in*

---

4. Education Level:

☐

Up to 16 years

☐

Up to 18 years

☐

18+ years

5. Duration since sibling's onset of psychosis: _____

Thank you for taking the time to complete this form

APPENDIX 11: Interview Guide

Interview Guide

Title of project: Siblings' accounts of their brother/sister's first episode psychosis

The researcher will explain that the idea of the interview is for participants to provide an account of their personal story of their life during the time in which their brother/sister experienced a first episode of psychosis. The researcher will explain that they are particularly interested in hearing what life has been like for them during this time. For example:

"As you know, you have been invited to participate in this study as I am aware that your brother/sister has experienced a first episode of psychosis.

I am interested in hearing your personal story of this time in your life. I am particularly interested in finding out what life has been like for you.

I have some prompt questions that I might ask during the interview to help guide you in telling your story but please feel free to tell me your story in whatever way you wish and you can begin your story wherever you feel comfortable"

If participants require a prompt at this stage, the researcher will ask an open question, for example "Please tell me what life has been like for you having a brother/sister who has experienced a first episode of psychosis"

Prompt Questions

- Please tell me about your life before your brother/sister became unwell.
- Please tell me about your life when you first learnt that your brother/sister was unwell.
- Please tell me what happened after this and what life was like for you.
- Please tell me what life is like for you at the current time.
- Please tell me in what ways, if any, your relationship with your sibling, other family members and your peers has been affected.
- Please tell me in what ways, if any, your sense of who you are and what life is about has changed.

In addition to prompt questions - The researcher will reflect upon what the participants say and introduce supplementary questions designed to obtain clarification e.g. 'Why do you think that is the case?' or 'Could you give me an example of that?'

APPENDIX 12: Transcript Excerpts

Demonstrating the Development of the Narrative Analysis

INTERVIEW 1

472

473 I: And is that the period of time he spent in hospital that you mentioned that you
474 were going to see him.

475

476 P: Yeah, I'd go for about 2 hours with my parents or something like that. It was
477 very tiring because I'd finish school, at let's say 6, head straight over to
478 Tooting which is quite a trek away, and yeah, so yeah, stay there for about 2
479 hours and then just go back.

480

481 I: Yeah.

482

483 P: So it took a bit of time, but yeah, I've managed to get through to the other side
484 more or less in fact (tearful).

485

486 I: Yeah...more or less?

487

488 P: Yeah, more or less, yeah.

489

490 I: So, um, for you, it's been, you know, the last year has been, a really big year.
491 you said it's taken a chunk of your time...and it's been
492 scary...and...shocking as well, you mentioned, as well. I'm just wondering
493 what life's like for you like now...how's your life at the moment?

494

495 P: It's pretty much back to normal I'd say, because my brother's now gone off to
496 uni so that takes a big chunk away from things that can distract me now

Time back now
- moving on, progressing.

LOSS OF TIME

LIFE ON HOLD
V. BUTIFUL / SUPPORTIVE
OF BROTHER.

TIME AGAIN
- LIFE ON HOLD.

Ambivalence?
in Tone

Progressive
moved on
Coped

Re-integration?

Ambivalence
re-iterated

Pragmatic tone
matter-of-fact.

INTERVIEW 1

447 I: That's a good friendship?

448

449 P: Yeah yeah, that's really important to both of us.

450

451 I: Mmm, and what about other friendships?

452

453 P: Other friends? Um, it's not really changed other friendships, I had to put it all

454 on hold for a while, but then after that, it's all just carried on as it was before.

455 But I didn't actually tell that many people, coz we tried to keep it quite like to

456 the family, not let it spread out too much, which kind of got harder once the

457 accident happened. But, we've not exactly kinda advertised it, just tried to

458 keep it a bit more personal, so only about one or two of my friends actually

459 know...about it.

460

461 I: I just wanted to...you referred to the accident, is that what happened in (name

462 of city) when you brother became unwell?

463

464 P: No, it's when he fell out the window, he broke both his legs.

465

466 I: Ok, ok...when did that happen?

467

468 P: That happened...last February, so he was in hospital until like April, yeah so it

469 was about 3 months, but it was quite a long time for him, because he got very

470 bored of just being stuck in there, because he couldn't walk or anything like

471 that for about 2 months.

SENSITIVE,
EMPATHY FOR
BROTHER

TIME - "PUT IT ALL
ON HOLD"

DUTIFUL

Stigma?
Shame?

Family
Secrets/
Cohesion?

PUTTING LIFE ON HOLD

- CONSISTENT MESSAGE -

CORE
NARRATIVE?

Pragmatic tone

v. matter-of-fact
masking emotion?

First mention of accident
details

- too painful?
- processed?

LONG TIME FOR BROTHER
TOO. SENSE OF LOST
TIME.

INTERVIEW 1

447 I: That's a good friendship?

448

449 P: Yeah yeah, that's really important to both of us.

450

451 I: Mmm, and what about other friendships?

452

453 P: Other friends? Um, it's not really changed other friendships, I had to put it all

454 on hold for a while, but then after that, it's all just carried on as it was before.

455 But I didn't actually tell that many people, coz we tried to keep it quite like to

456 the family, not let it spread out too much, which kind of got harder once the

457 accident happened. But, we've not exactly kinda advertised it, just tried to

458 keep it a bit more personal, so only about one or two of my friends actually

459 know...about it.

460

461 I: I just wanted to...you referred to the accident, is that what happened in (name

462 of city) when you brother became unwell?

463

464 P: No, it's when he fell out the window, he broke both his legs.

465

466 I: Ok, ok...when did that happen?

467

468 P: That happened...last February, so he was in hospital until like April, yeah so it

469 was about 3 months, but it was quite a long time for him, because he got very

470 bored of just being stuck in there, because he couldn't walk or anything like

471 that for about 2 months.

SENSITIVE,
EMPATHY FOR
BROTHER

TIME - "PUT IT ALL
ON HOLD"

DUTIFUL

Stigm
Sham

Famil
Secre

cohesi

PUTTING LIFE ON HOLD

- CONSISTENT MESSAGE -

CORE
NARRATIVE

Pragmatic tone

v. matter-of-fact
masking emotion

1
first mention of accident
details.

- too painful?
- processed?

LONG TIME FOR BROTHER
TOO, SENSE OF LOST
TIME.

INTERVIEW 2

COPED BY ROLE
OF "ONE STEPPED
REMOVED"

445 P: Hmm, er, I think that, yeah, as I said, from the perspective that I am fant one
446 stepped removed [R - mmm], being older and not living at home and that sort
447 of thing, I don't think that it has been a huge amount to cope with in [R -
448 yeah] the same way that my parents... if you asked them that question I think it
449 would be interesting to find the answer [R - yeah], I don't, it's incredible the
450 way that they've coped, but I think, yeah, I think all of our personalities are
451 kind of, I think that we just tend to get on with things, we don't tend to get too
452 upset by things [R - yeah], erm... yeah I don't think, that, it's a strange one
453 because I don't think I've had to do anything active to cope if that makes
454 sense?

ROBUST,
NON-EMOTIONAL?

CURIOUS
INQUIRING

REFLECTIVE

456 I: Mmm, no, but then that suggests to me that there's something about you and
457 your personality that that gets you through... that enables you to not have to
458 make too many changes to enable you to accommodate this...

459
460 P: ...yeah, yes, yes and I think it's, I remember, and I can't remember who and it
461 may even have been [clinical psychologist] who showed something to my
462 parents who then showed me this idea of people with... I think it was a
463 graph... I don't know if you know what I mean... it was erm, people, sort of,
464 you could, er it's sort of... ability to deal with stress, and then, amount of
465 stress or something, I think it was some sort of graph?

PRAGMATIC
APPROACH

- LOOKING
FOR

ANSWERS /

AN UNDERSTANDING

467 I: Mmm, yeah... I think you might be referring to stress vulnerability?

468

SEEKING
KNOWLEDGE

INTERVIEW 2

Sense of sister becoming unwell
Reflective - making

469 P: I think possibly yeah, with this idea that, so you can have and I've probably
470 totally misinterpreted this, but in the way that my sister before she became ill
471 [R - mmm] she was actually somebody who could cope with an awful lot of
472 stress and actually it was that that meant she took on too much stress [R -
473 mmm] and then she became ill, but before she became ill, erm, the analogy
474 was given - a soldier in war being, having incredible resilience to stress but
475 then if they did get overloaded it would be er, they could potentially have post
476 traumatic stress disorder [R - mmm] or whatever else, rather than somebody
477 who has a very low threshold for stress and would then have small cycles
478 rather than a ... I don't know if you've ... I've probably misinterpreted that?

479
480 I: It sounds as though it's made sense to you?

TAKING IN NEW
INFORMATION - IMPORTANCE
OF KNOWLEDGE
+ SHARING KNOWLEDGE /
UNDERSTANDING

482 P: Yeah, yeah, so in that way, my family can be and certainly my sister is, well at
483 least she was before she was ill [R - mmm], very sort of robust, sort of, for
484 things that we can cope with if that makes sense [R - yeah, yeah] and it would
485 take something major, in the way that my sister had that major thing that sort
486 of pushed her so, where she couldn't cope [R - yeah], whereas say for
487 example my wife is somebody much more who, she will, she could cry, say 3
488 or 4 times a week, be emotional 3 or 4 times a week [R - mmm] and then be
489 able to release that built up stress [R - mmm] and then be ok again a few hours
490 later in a way that my family would never do that in the same way [R - ok], so
491 I think from that probably explains for me at least, why [R - yeah] it's been
492 sort of quite ok, I don't know if that, to deal with this, just because it's been
493 within a, it's within something I've been able, within something I've been able

Applying
theory
to other
family
members /
wife
- provides
some
certainty /
stability

EXPLANATION
V. IMPORTANT

PRAGMATIC

1 Interview 03

2

3 I: Ok, alright then, so you know, you've been invited to participate in the study
4 because I'm aware that your brother has recently experienced a first episode of
5 psychosis, erm, and really what I'm interested in hearing is your personal story of this
6 time in your life, so, wherever you want to start you can start, erm, and really I'm
7 particularly interested in what life's been like for you. [P: mmhm] So I've mentioned
8 I've got some prompt questions that I might ask to help to guide you to tell your story,
9 but really just tell your story in whatever way you wish, starting wherever you feel
10 most comfortable. Ok? (pause) So really, it's over to you if you feel able to begin..?

11
12 P: um, Ok, well the first, I guess the first time when I remember that things got
13 a bit weird and it wasn't normal, was when like he was already been diagnosed with
14 depression but um we were on holiday and, um we were coming back from like a
15 restaurant or something and there was like a bang or something, and he, um, he
16 immediately was like "someone's trying to shoot me, someone's like", sort of like
17 getting these thoughts and just clearly like irrational thoughts and like, not normal,
18 and so I guess, for us, it was just, it was, cause also my brother's just so, the
19 difference, the weirdness it's the fact that his normal character and what, like he was,
20 when, he had these episodes was just completely different like, and I guess that why it
21 was just so like distressing because it was so just like different to normal and what
22 he's normally like. I like, um, he came, yeah, he like, he went, he went, he wouldn't
23 like, he was literally like "someone's going to shoot me, someone's trying to, we need
24 to get in the house, we need to get in the house" we were like on the way back, we got
25 inside and um like everyone was just a bit confused um because I guess like no one

v. fast speech
disjointed at times
difficult to follow consistently at times.

SHOCK!
WEIRD

SPOKE WITH
PASSION /
EMOTION

Detailed
story

- fast pace
- unprocessed?
Raw emotion / shock.

Struggle to
understand
- so "different"

INTERVIEW 3

NO ONE KNOW
- SHOCK
NOT KNOWING

SHOCK

LACK
OF
UNDERSTANDING

26 knew, no one knew that this like what he was going to be diagnosed with later was
27 what he got [I - mmm], it was just weird like no one understood it at all [I - mmm],
28 and um no one could make sense of it and then like I didn't know but apparently he
29 was like up all night crying downstairs and stuff and that obviously when we found
30 out, were like shaken up and a bit like, well it's just not nice [I - mmm] to have to, to
31 your brother like that.

V. strong impact
EMPATHY
PASSIONATE

CONCERN FOR BROTHER

32
33 I: Mmm, and how, how long ago was it: that that initial...

34

35 P: ...that was like 4 years ago.

36

37 I: So about 4 years ago [P: yeah] so you'd have been about 16?

38

39 P: Yeah, yeah, yeah that's about right.

40

41 I: Mmm, and what was it like for you seeing your brother like that, you said it
42 was a big shock and he...

processing / reflecting
on experiences
while talking

43
44 P: ...It was just, just distressing, I guess that then it wasn't as, it wasn't as, I
45 didn't feel it as much as when his proper episode came like a year and a half later [I -
46 mmm] when he actually got diagnosed with it, because that was a bit like, it
47 happened, it happened, it was on holiday, it happened that, I was just really just
48 confused by it all, just a bit like "what's going on? Something's obviously not
49 normal" [I - mmm] but it's just like, like at the time I was just like confused and
50 wierded out by it I guess but like, um it happened on holiday but then I didn't really, I

making
sense
of
experiences

Lack of understanding
SHOCK / CONFUSION

INTERVIEW 4

671 P: She's worried about my health and my well being and things like that.

672

673 I: Your sister?

674

675 P: Yeah, yeah, yeah, so, but I'm not so sure. I like, maybe, if it happens it

676 happens [I - mmm], there's nothing I can do about it, at the moment I'm healthy, I'm

677 well, and whatever the definition of healthy is and stuff like, but I think I'm well and

678 I'm and I think that's why I do set, like targets and such high standards for myself

679 cause I'm just like, regardless of my past and what's happened, like I will achieve

680 whatever I want to achieve [I - mmm] and won't let anyone ruin it [I - yeah], so

681 maybe that helps.

MOTIVATED
PASSIONATE
MOVING FORWARD

DETERMINED

682

683 I: Mmm, so perhaps your unawareness of how health can be affected [P - yeah] has

684 driven you to set yourself high, you know, standards [P - yeah], and expectations, to

685 continue to achieve and get what you want out of life [P - yeah], yeah.

686

687 P: But then if it happens, it happens, doesn't it, I'm not going to sit and worry

688 about it.

ACCEPTING

689

690 I: Mmm, yeah. Ok, um, I suppose we've probably talked about this quite a bit,

691 but I was just wondering if, in any other way, your sense of yourself, or who you are

692 or what the future holds, has been shaped by your experiences?

693

694 P: Um, yeah, probably, I think so, I think that, definitely with the future. I think I

695 will never, if I wanna do something, or if I think, maybe I want to do it or I want to try

acceptance
of life

INTERVIEW 4

Sense of
change.

696 something, then I'm probably more likely to do it now than I was two, three years ago
697 [I - mmm]. Or, yeah, no, the present, definitely like I can, there's been times where,
698 I'm not saying I was, from that moment like when stuff happened to me, that I was
699 driven, like I had a really down year, and I almost like, was like "oh, what's the point
700 sort of thing". — Dark times in past
Sense that moved on from
that time.

702 I: Was that in the last couple of...

703

704 P: ...my second year at uni, cause it happened in the first year, my first year
705 summer, so the beginning of the second year, so I think there was time when I was
706 like "I can't do this" but then I thought, I don't think my friend would want to sit there
707 and watch me do that just cause they're not here any more, so I think from then, I did
708 obviously experience the lows and I think I, I'm not saying that I'm over it cause I
709 don't think you ever get over anything like that, but I think I've, over the last year,
710 maybe in my third year, going back to uni, I learnt a lot about myself and that, I learnt
711 how to deal with it, rather than to, I don't think you can ever get over things like that,
712 but I learnt how to deal with how I feel about it, and I think of it as a positive thing
713 now rather than a negative [I - mmm], so trying to get a positive out of something
714 negative that happened. positives from adversity

715

716 I: Mmm....what helped you to learn to deal with it when you went back to uni?

717

718 P: Um, god, I think the initial shock, like of someone...dying, I think that's the
719 hardest thing to take in, cause, it's been nearly, I think it's three years this summer, so,
720 it's about two and half years now [I - yeah], and I think it still doesn't feel real [I -

v. emotive / passionate tone.

friend dying

reflective

Accepting

accepting

sense of
development

APPENDIX 13: Short Summaries of Participants' Stories

1) Luke (17 years)

Luke is a seventeen year old white British male. He has an older brother and a younger sister and at the time of the interview was living at home with his parents and younger sister. Approximately one year ago Luke's brother experienced a first episode of psychosis while he was travelling. Prior to his brother becoming unwell, Luke explained that his brother would do *"traditional older brother things"* which included taking Luke to parties and pubs and buying him beer every now and again. It was a *"shock"* to Luke when his brother became unwell. There was a period of approximately six months which Luke described as particularly *"tough"* and *"intense"* but he *"just managed to deal with it"*. Luke explained that his brother's illness *"took a big chunk"* of his life because he *"spent so much time with him, either in the hospital, or just talking to him"*. Luke *"had to put it all on hold for a while"*.

Luke explained that he *"had to look after"* his brother and that he had a *"lot of responsibilities to do"*. Initially he went abroad with his dad to try to *"convince"* his brother to come home. Once home, he visited his brother frequently in hospital and cared for him at home. For example, Luke said *"he'd come through to my room, like at 4 o'clock in the morning, and I would just have to chat to him and settle him down"*. Luke's responsibilities also included shielding his younger sister from *"the bad stuff"*.

On reflection, Luke recognised that through this experience he had *"gained a lot more respect"* for his parents, and had also developed a *"stronger"* relationship with a close friend. Luke's experience of supporting his brother through a first episode of psychosis also taught Luke that he is *"capable"* of far more than he had ever realised which is enabling him to take more challenging steps in his own life. For example, he said *"Something I've realised about myself is that I can take a lot more than I ever thought I could handle..."* and *"...it's really kind of made me think that I am able to do a lot more than what I thought I could do previously"*. At the time of the interview Luke was feeling hopeful about his brother's health. He said *"I'm really hopeful, that he'll probably be better quite soon"*. However, Luke had *"a big year"* ahead due to forthcoming exam retakes, and was therefore *"hoping for no more relapses"*.

2) Nick (24 years)

Nick is a twenty-four year old white British male. He has a younger sister, who at the time of his interview was *"just about to turn twenty-one"* years of age. Nick's sister experienced a first episode of psychosis approximately three years ago when Nick was twenty-one. At the time of her first episode of psychosis, Nick was in his final year at university and lived away from home. Nick heard about his sister's illness *"about a month after it happened"* because it was around the time of his *"finals"* and his parents decided to wait. Nick accepted this decision and said *"I was fully supportive of that decision...straightaway"*.

When Nick did learn about his sister's illness he became *"very much involved"*, mainly through talking on the phone more often with his parents *"offering advice and opinions regarding her symptoms and how to care for her"*. Although for a brief period on his return from university he became the *"primary person looking after her"*. Nick married his long term girlfriend and moved out of the family home yet continued to offer support to his family and his sister from a position of *"one-step removed"*. Throughout, Nick spent time investigating his sister's illness on the internet and through reading books to try to find out the *"causes"* and the *"appropriate action"* to take to help her and advise his parents.

Nick also explored to what extent psychosis might be *"genetic"*, and which aspects might be *"lifestyle"* in order to give him answers to help him with choices in his life, such as the way to react to stress and other possible, as yet unknown, risk factors. He said *"...I suppose a question that I've had to explore is to what extent is this genetic and do I have to be careful of my own lifestyle, and taking on too much in my own lifestyle, and I think that's something that I'd say to some extent I haven't worked out, I'm very lucky to have, well one, a not too demanding job compared with my peers and friends..."* Nick discovered some *"very good resources"*, and he recommended that it might be helpful if mental health services recommended similar resources to families. While this experience impacted Nick's relationship with his sister, in that it *"widened the age gap"* between them, Nick also felt that the experience had brought his family closer together. For example, Nick said *"...in terms of positives, certainly I think that bringing my family closer together, being I think we erm sort of empathise with each other a lot more than we did"*.

3) Sarah (20 years)

Sarah is a twenty year old white British female. Sarah is the middle child with two brothers, the older brother being approximately one year older than she is. Her older brother was given a diagnosis of depression approximately four years ago. Approximately two and half years ago, just before starting university, Sarah's brother experienced a first episode of psychosis. At this time, Sarah was living at home, with her mother, father and both of her brothers and was studying for her A Levels, which included an A Level in psychology. Sarah was not particularly close to her family prior to her brother's illness and spent most of her time with her friends. She said *"I was never really the sort of person that was that close to my like family that much, I was always just sort of I'd always be out with my friends..."*

When Sarah's brother became unwell, Sarah and her family found it a *"weird and confusing"* time and Sarah found it *"distressing"* to see him become *"so different to normal"* and felt very *"sorry for him"*. She often wondered when things would get back to normal. She said *"...it just seemed like it was never going to end, like 'when is it going to get back to normal?', and stuff"*. Sarah also felt *"kind of guilty"* that she was managing to meet the various milestones in life that her brother had been unable to achieve because of his illness. Sarah said *"...it just felt so bad that he couldn't, just like everything I completed he wanted to but couldn't..."* As a result she kept many of her achievements more private.

Sarah became frustrated with others who appeared ignorant to mental health issues. She said *"I think quite a few people just have this very sort of, very un-understanding attitude [I – mmm] which really frustrated me..."* Sarah realised that they did not understand and hoped that through her future career she might be able to contribute towards changing other people's views about mental illness. For example, she said *"...I'm interested in doing like clinical psychology and it's just like made me very sort of, like made me wanting to kind of just help the whole, the whole issue of it..."* and with regard to her undergraduate dissertation she said *"we've just had to decide what our dissertation is going to be on and all that sort of stuff, which I'm actually doing 'this' basically, so I'm actually doing it on bipolar, so I guess it's always interesting for me to sort of to read more about and look into and stuff"*. Sarah also changed her own lifestyle as a result of this experience *"I guess it's made me sort of try and be a bit more calm as a person, because given I know that stress can affect people in such a way..."* Sarah also recognised that this experience had brought her closer to

her family. She said *"...I wasn't really that close to my family sort of person, so it made me appreciate them a lot more..."*

4) Hannah (22 years)

Hannah is a twenty-two year old white British female. Hannah has an older sister aged twenty-three years. Hannah grew up with her sister and mother and the three of them got along well. Hannah and her sister were *"really, really close"* when they were growing up. They left home to go to university at the same time because Hannah's sister differed a year. While they went to different universities they remained in contact during this time. Hannah *"loved"* her first year at university, enjoying her new-found freedom. However during her second year at university, one of her friends began to portray *"extreme thinking and extreme behaviour"*. Hannah found it *"devastating"* seeing her friend go through this *"bad experience"*. In the same year, her friend tragically died when on holiday. While her friend died tragically, following his death, Hannah and her friend searched the internet in attempt to find *"an explanation"* for his behaviour, and noticed that *"bipolar"* came up a lot. The following year, while Hannah was in her third year at university, Hannah noticed that her sister started to text her *"quite random"* and *"extreme"* things which reminded her of her friend's behaviour. Hannah thought *"something's not right here"* and spoke to her mum about it. Hannah had moved back home following university and was living with her mother, step-father and sister. While worried for her sister, Hannah also felt *"lucky"* to have recognised her sister's symptoms so that she could get help. Hannah's sister was looked after at home. Hannah did not know too much about her sister's illness or treatment and was not sure she wanted to know too much. She got frustrated with her sister and mum at times because they dealt with things differently to Hannah. Hannah believes in *"fate"* and hopes to make the most of her health and her life, rather than dwell on the past.