

Legal professionals and witness statements from people with a suspected mental health diagnosis.

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## Abstract

Individuals with mental health problems are considered to be part of a group labeled 'vulnerable' in forensic psychology literature and the legal system more generally. In producing witness statements, there are numerous guidelines in the UK, designed to facilitate the production of reliable and valid accounts by those deemed to be vulnerable witnesses. And yet, it is not entirely clear how mental health impacts on reliability and validity within the judicial system, partly due to the diversity of those who present with mental health difficulties. In this paper, we set out to explore how legal professionals operating in the UK understand the impact of mental distress on the practical production of witness testimonies. Twenty legal professionals, including police officers, judges, magistrates and detectives were involved in a semi-structured interview to examine their knowledge and experience of working with mental health problems, and how they approached and worked with this group.

A thematic analysis was conducted on the data and specific themes relevant to the overall research question are presented. These include a) dilemmas and deficiencies in knowledge of mental health, b) the abandonment of diagnosis and c) barriers to knowledge: time restrictions, silence, professional identity and fear. Finally, we explore some of the implications of these barriers, with regard to professional practice.

KEYWORDS - mental health, witnesses, legal system, reliability, police

## INTRODUCTION

According to police identification, around 3-5% of witnesses who produce statements are deemed vulnerable, though some have estimated the figure to be closer to 54% (Smith & Tilney, 2007).

The variability in percentages of witnesses deemed vulnerable has been attributed to a number of factors, including problems in recording vulnerability, some victims not self reporting, disagreements amongst police and the Crown Prosecution Service (CPS) regarding vulnerability status and the police not giving the CPS sufficient information for them to apply for special measures (Aihio, Frings, Wilcock & Burrell, forthcoming). A mental health diagnosis is one type of psychological vulnerability to be considered by legal professionals when interviewing for witness statements, especially if the individual is distressed at the time of interview (Gudjonsson, 2010), and during court proceedings, as outlined by the Youth Justice and Criminal Evidence Act [YJCEA], 1999, which covers both vulnerable individuals and children. Yet despite an awareness of mental health difficulties in academic and official literature, special measures for vulnerable witnesses as suggested by the YJCEA 1999 are not always implemented in practice, and if they are, they are often applied late and recording of disabilities are often not detailed sufficiently (Charles, 2012).

The closure of the large asylums and the rise in community living for individuals with mental health difficulties has led to an increase in this group of witnesses. Furthermore, this group are not only deemed vulnerable by their mental health status, but often experience added disadvantage, due to poor housing and a paucity of supportive social networks (Barnett & Appelbaum, 2010).

Despite such recognized vulnerabilities, mental distress is only considered to be a risk factor, not a definable marker with respect to those deemed likely to provide unreliable or false evidence as outlined by the Achieving Best Evidence (ABE) guidelines, which once more covers all vulnerable individuals and children (Ministry of Justice [MoJ], 2011). Partly at stake are public and professional perceptions of a straightforward relationship between mental distress and (un)reliability and unpredictability more generally. Vulnerable witnesses are often aware of this perception (Crown Prosecution Service[CPS], 2009;), and may not report a crime due to the (reasonable) belief that they will not be taken seriously (Stobbs & Kebbell, 2003). Previous research has found that police officers and jurors hold negative attitudes and perceptions of witnesses with a mental health diagnosis, perceiving their testimony to be inherently less credible and redundant (Watson, Corrigan, & Ottati, 2004). And yet, little is known about the actual or specific psychological impairments and obstacles to reliable evidence associated with this group, beyond general statements regarding a greater propensity for stress, anxiety and the reactivation of previous trauma during periods of distress and undue pressure (Bull, 2010; Chappell et al, 2004). To our knowledge, there are no empirical studies exploring specific psychological functioning in persons with mental health difficulties during investigative interviewing. Memory, problem solving ability, and narrative coherence, all have the *potential* to impact on witness reliability, but the data on this simply does not exist. What is constituted as ‘vulnerable’ with respect to witnesses with mental health diagnoses is, therefore, somewhat sketchy and difficult to define. Furthermore, little is known about legal professionals’ understanding of what constitutes ‘potential vulnerabilities’ associated with mental distress. Furthermore, it is not clear how a diagnosis might impact on the way in which witness interviews are carried out.

The ABE guidelines generated in the UK recommends a number of measures to protect witnesses with a history of mental health problems when giving evidence, and to ensure they provide reliable and credible witness statements. Diagnoses of anxiety, schizophrenia, personality

disorder and depression are discussed in the ABE for their potential to influence witness reliability. Witnesses diagnosed with psychotic disorders, for example, are considered likely to give unreliable evidence if their delusional or hallucinatory symptoms are active at the time of interview. The Bradley Report (2009) also recommended a full assessment be given to those diagnosed with a mental disorder, such that cognitive abilities and other personality factors can be monitored to assess the likelihood of faulty information being provided.

Despite the recognition that mental health problems are potentially disruptive to the provision of reliable evidence, the ABE quite clearly states that a mental health diagnosis does not *preclude* the ability for witnesses to provide reliable evidence. The CPS (2009) also outlines that it is the ability to understand questions asked of them and give answers that can be understood, which is deemed by law to impact on the competence of a witness to give testimony, regardless of vulnerability. And in general, despite the existence of certain guidelines and recommendations, the assessment of psychological ability for individuals diagnosed with mental disorder are not entirely consistent, and additional support may only be considered necessary during times of crisis. Furthermore, a full life history, which may include previous episodes of trauma and victimization, may in fact be more relevant than the diagnosis itself, as histories of victimization are often evident in crime victims, with mental health difficulties (Crump, Sundquist, Winkleby & Sundquist, 2013; Pettit et al, 2013).

With this information in mind, the ABE recommendations state that an individual with mental health problems may require additional support to complete a witness interview task during a time of acute distress. This may involve facilitating anxiety reduction through the use of modified interviewing techniques and the potential involvement of an intermediary. However, under the current definitions by the YJCEA 1999, only a small number of cases involving witnesses with mental health problems actually qualify for the use of such special measures, which are seldom used for both police interviews and court proceedings (Charles, 2012). The aim of this study is to

explore legal professionals' perception of their own knowledge of mental health and its relationship to vulnerability in the context of interviewing witnesses, and whether they have sufficient knowledge of mental distress to be able to put some of these official recommendations into practice. We have included a diverse group of legal professionals, at each stage of the judicial process (from front line police to judges), to ensure that a plurality of perspectives operating across a broad range of legal activities is included. We expected that some of the potential differences in perspective are grounded in the different work settings, but we also anticipated some commonality, emerging from shared concerns around adhering to legal processes and upholding principles of justice. The complex relationship between mental health and the legal system is of interest at all levels, which is why we adopted an inclusive policy in this exploratory stage of the research.

#### *The attitudes and perception of front line staff on mental health*

Police officers often report that they do not receive enough training and information about mental health and find it difficult to approach situations involving persons who have a mental health problem (Psarra et al, 2008; Ruiz & Miller, 2004). The Vulnerable and Intimidated Witnesses: A Police Service Guide (MoJ, 2011) advises on prompts to be used by police officers in the UK to recognize vulnerable witnesses during the initial investigative interviewing process. There is, however, an initial obstacle that prevents the successful identification of vulnerable witnesses, as their vulnerability may not be disclosed or discovered until a later stage in the investigative process, if at all. This raises important questions regarding any additional support that may be required to produce reliable and valid testimony.

Although there has been a relatively small body of research on the perceptions and attitudes of legal professionals towards persons with a mental health diagnosis, there is a need for more in-depth research on the interactions between these front line professionals and this vulnerable group (Chappell & O'Brien, 2014).

On reviewing the available literature, the majority of research focuses on interactions between the police and individuals with a mental health problem in the context of being a suspect of crime (Teplin & Pruett, 1992). There has been little exploration of the beliefs, perceptions and attitudes of police and other legal professionals in respect of *witnesses* with mental health problems. The aim of this exploratory study is to delve deeper into professionals' knowledge about mental health difficulties and the types of knowledge they deem relevant in carrying out interviews with this witness group.

### *Interviews*

Verbal data were collected between December 2012 and March, 2013, via twenty individual semi-structured interviews. The interviews were recorded using a digital recording device and then later transcribed for analysis. An interview schedule was developed by authors one and three, based on their reading of previous literature and their theoretical knowledge of mental health issues, and the interview questions were specifically related to witnesses who were not being charged or investigated. We also used three scenarios relating to three crimes involving individuals with different forms of mental distress. This served as a prompt to guide the participants in their responses, and is a well used qualitative technique in empirical research (Willig, 2008). Throughout, the interviewer used prompts and encouraged exploration of the issues with the participants, in order to check for meaning and to ensure understanding. The interviews varied in duration from thirty minutes to one hour.

### *Participants*

Participants from a number of police forces, law firms and criminal courts across the South East

of England were invited to take part in the study, via email.

Eight female and five male police officers of varying ranks took part in the study. These included three police constables, six detective constables, and four detective sergeants (including one acting detective sergeant). Further, four (male) criminal lawyers (one of which was a trainee), two judges (both male) from the criminal law courts, and one magistrate (female) also took part in the study. All of the police officers had received training previously in the elicitation of evidence from vulnerable witnesses, although this experience was wide-ranging (from 'a couple of hours' to more extensive week long training events).

### *Analytical approach*

The interviews were transcribed in full. The qualitative data analysis software package *NVivo* was deployed to break down whole transcripts which contained large volumes of data into smaller manageable themed categories. The material was then coded with a specific set of analytic directives in mind. These were a) how interviewing witnesses with mental health diagnoses are performed – what concessions, if any, are implemented during the interview process b) whether legal professionals believe there are specific psychological impairments (e.g. memory, problem solving, thought cohesion) that should be taken into consideration and c) perceptions of 'vulnerability' with respect to witnesses with mental health diagnoses. After notating and coding the material with these questions in mind, the data were re-organised into themes, as well as considered in the light of literature which could help to contextualize the analysis. A thematic analysis (Braun & Clarke, 2006), in particular one of a more 'theoretical' and 'latent' persuasion (rather than 'inductive' and 'semantic') was chosen to organise the data, through the identification of major themes. This thematic decomposition was achieved by carefully following Braun & Clarke's (2006) six stages of analysis. This involved familiarising oneself with the data via repeated readings of the transcripts, generating initial codes by paying close attention to

meanings embedded in every line of talk, followed by matching the initial codes together to form candidate themes and sub-themes. Each of the authors were involved in discussions around whether the theme titles and definitions adequately captured the essence of the data.

It could be described as ‘theoretical’, as the data were read and notated from the beginning of the process of analysis in terms of how mental health and vulnerability was understood, constructed and accounted for by the participants. Nevertheless, the interpretation produced was also ‘inductive’, in the sense that the final reading produced was based on close reading of the material, and not on previously fixed ideas about what the final themes would be. Interpretation also explored the implicit meaning of the material, rather than a more descriptive, ‘semantic’ reading. The validity of the findings was ensured, using conventional qualitative procedures, including group analysis by all researchers and peer review, to ensure the analysis is sufficiently grounded in the data (Creswell & Miller, 2000).

#### *The study*

An interview study was conducted, using a semi-structured interview schedule, and the use of scenarios depicting a number of examples involving witnesses and suspects with a diagnosed mental health problem. The scenarios were used to stimulate discussion in the interviews, and are a well-recognised technique in psychological research (Braune & Clarke, 2013). The research team generated the scenarios, using information presented in the literature and using examples of potential issues relating to mental health, outlined in the ABE. After reading the scenarios, each participant was asked to discuss each one before being asked to discuss a number of semi-structured questions about issues relating to the relevance of mental health in respect of witness statements, such as a) issues relating mental health to witness reliability b) the level of distress at times of witness interview c) the importance of previous trauma in the life of the person experiencing psychological distress and a recent crime and d) whether perceived enduring ‘deficits’ in memory, problem solving or reasoning are perceived to affect witness credibility in individuals diagnosed with mental health problems.



## *Analysis*

We have restricted the following analysis to three themes, though many more emerged, including a) the impact of medication on recall, b) memory and trauma, c) suggestibility of witnesses with mental health difficulties and d) the illegitimacy of milder forms of distress. The themes presented in this paper permit us to address the earlier main research question relating to levels of knowledge among legal professionals and the way knowledge is used to make judgments relating to witnesses with these types of vulnerabilities.

The key themes identified here are a) Knowledge of mental health problems: dilemmas and deficiencies b) Beyond diagnosis: life history and context and c) Barriers to knowledge: time restrictions, silence, professional identity and fear.

### **Knowledge of mental health problems: dilemmas and deficiencies**

All participants in this study have been given the obligation of dealing with and offering services involving persons with mental health problems. However, although there is acknowledgement that knowledge about mental health issues is increasing slowly amongst officers at the detective level, a number of these individuals believe they have not been given the sufficient education and training necessary to manage this responsibility:

I've had no formal training...we get given some pamphlet which is what usually happens or sort of, like, there is some initiative and a poster goes up on the wall and it says right, schizophrenics all do this and people with bipolar do this and so when dealing with them you have got to be careful not to do x. That is usually the way police deal with these issues and it is dreadful...woefully inadequate.

Police Constable

I just don't know enough really...I have never had any training in it yet we see these things [mental illness] all the time, sometimes the people we deal which are clearly very emotionally and mentally disturbed, traumatised, whatever...I often feel like a bit of a fraud...

Detective Constable

Oh yes, now this is a real problem as far as I am concerned. The higher, more specialized you become, obviously there is some degree of learning about mental health, but it is very minimal even here. I know that in uniformed divisions, it doesn't exist at all.

Detective Sergeant

I suspect at the moment, and certainly from my experience of being a uniformed officer and looking at the profile of people doing that role now, I'd suggest that there is probably not enough knowledge. There is certainly no formal training and so... I'd think you'd need a reasonable level of knowledge around mental health to be able to do your job as a police officer

Police Constable

From the extracts above, it is clear that there is some concession in providing information relating to mental health issues, but this is often in the form of a presentation of materials, which has to be worked through independently, without any guidance on how to use the information to full effect. Many of the professionals confessed to never having opened the course materials and suggested that only those who were interested in the topic would do so. Despite this reported lack of training in mental health issues, investigative officers do appear to have knowledge of mental illness, but most of it was from media sources, which have been found to increase prejudiced attitudes towards mental health problems in previous literature (see Philo, 1994). A number of authors have pointed to the media as promoting ideas of unpredictability and dangerousness in newspaper reports, in particular (Harper, 2005). Such informal and limited knowledge also means professionals are left to fill in gaps and speculate about the nature of the mental health difficulty and its impact on the witness' ability to provide an accurate statement. This can include filling the gaps with 'intuition' or 'picking up signs', without knowing fully how to interpret them. When asked, 'where does your knowledge about mental illnesses come from?' participants report a variety of sources, but mostly from media sources and the personal/familial experiences:

Well, it comes from many places...it is sort of out there isn't it, I think. You read about it in newspapers...there are some really great documentaries, television documentaries that give, that give interesting accounts, perspectives on these types of disorders.

Police Constable

There's been quite a lot of stuff in the media, maybe just articles I've read in, you know, the Daily Mail.

Police Constable

They [the officers] may have relatives who are autistic or have a mental health disorder. So again they will come and say 'you know, I think this might be what is happening. I think he is this.' They go "oh yeah I didn't think of that. I don't know anything about it, do you know anything about it?". No. I will do a quick Google check on the phone. Oh yeah it might be this. Straight away let's get down to check them out.

Detective Constable

In terms of training, formal knowledge of mental health issues was treated with a degree of skepticism, and secondary to less formal ways of knowing that were based on professional competency and personal experience, which many found difficult to articulate. For investigating officers, identifying any potential mental health difficulties/concerns amongst witnesses is part of daily routine, despite a lack of formal knowledge about mental health. Officers speak of enormous pressures when carrying out their duties (*'addressing mental health problems are actually not really a priority'*) and thus are forced to make very quick assessments of the individuals they encounter. Identifying mental health concerns are seen as secondary to other tasks such as ensuring full and accurate statements are given and recorded. Investigating officers rely on a number of techniques to assess mental health. Officers describe this sense of 'just knowing' about the emotional well-being of witnesses as 'a copper's nose', 'something inside', 'intuition', 'an instinct deep inside', and 'just a feeling':

It's a gut feeling, it's God, I can't describe it. I... I.... feel like, I am pretty astute on just picking up very, very minute details in people's behaviour. I do not switch off. I like people watching. If I am in a coffee shop and I just like looking around. I do not switch off from this job, which is not good. I live and breathe it....and I just know.

Police Constable

It's one of those ones where, as a police officer sometimes you drive down the street and you go "something, that's not right" and it's difficult always to quantify exactly what it is, in your head, but if you really sat and analysed it you could go "it's this or that" I think it is difficult, but as humans we always are interacting with other humans and you do pick up a lot on the person you are talking to, and it's small little signs that you might

pick up on that let you know.

### **Detective Constable**

I am just interested in people and I think the more you take an interest in people the more you learn about how the human form works, operates. You just gain that knowledge when things are not right...its deep within, part of the character. Always had it...I try to work out is it from mum, is it from dad, is it from my grandfather who was quite high up in Dublin police many years ago. You know, goodness knows. I tell you what I am glad I have got it.

### **Detective Constable**

I think with experience comes a familiarity. My clients, as you can imagine, display a variety of behaviours that one might consider peculiar...associated with some mental health diagnosis or another. I don't just take a [mental health] professionals view of it into account...I am looking for indicators myself. I need to know how this individual might come across in a courtroom...first impressions count – does this person come across as reliable or don't they. For me, nothing is more useful than my own personal familiarity with people.

### **Criminal Defense Lawyer**

One participant, however, managed to locate the problem in the way in which mental health problems were often set up in the training in binary terms, as people 'having or not having' them. They thought it more beneficial to contextualise the individual's difficulties and treat mental health problems on a continuum with the rest of the population.

For me, it's more about understanding than having formal knowledge... It's more about having understanding, it's more about being empathetic and understanding that people have causes of different problems, some of which are mental health-related... some of which are clinical, some are sub-clinical, but I suppose it's more important, I think, to have that empathetic and sensitive approach to all the people you meet. My only worry about it all is that if you talk about mental health problems, again you'll get more of that "oh right, that person's got mental health problems" like it's a binary thing. This is the whole problem I have with the debate on mental health I suppose, we talk about it in very binary terms don't we? "This person has mental health problems, this person doesn't", as if that means something, as if it necessarily affects your response, are they really actually understanding that mental health is a continuum that people's mental health ebbs and flows. I think it is more important to be sensitive and be aware of mental health in general terms, than necessarily have specific knowledge about a particular condition...

## **Detective Sergeant**

Indeed there was a view among a number of participants that formal diagnostic categories of mental disorder were unhelpful in assessing competency in providing witness statements, because of the crude manner in which they delineated individuals.

One particular dilemma faced by professionals was being able or unable to distinguish between real and false cases of mental health problems, due to a lack of prior knowledge.

Researcher: When they [your clients] use that term [depression] with you, when they say I am depressed regardless of whether they have a diagnosis or not, how does that make you feel?

Participant: You almost become inured to it, so do the rest of my clients apparently. Bear in mind I suppose the majority of our clients we are involved in their case for a fairly short period. ... So you know it is all part and parcel, I must say it has almost got the point where it is not something I would even mention to the magistrates if they [a client] say they were depressed. Short of something that was very articulate, if they had a proper diagnosis or on medication and have been for some time because perhaps particularly linked, it almost isn't worthy of mentioning. You almost think that you are going to have the magistrates raise eyebrows in disbelief.

## **Criminal Defense Lawyer**

You have to try and sort of distinguish between those that fester depression and those who are perhaps properly, seriously, deeply clinically depressed and in need of constant medication.

## **Magistrate**

The participant above makes a clear delineation between 'festering' depression and properly, seriously, deeply and clinically depressed. It is widely recognised in the mental health literature that depression can be constituted as either a real biological illness, or something that persons of a 'weaker constitution' have (Cromby & Harper, 2005). In the latter case, the perception is that individuals do not have genuine cause for complaint and should be treated with suspicion (Cromby, Harper & Reavey, 2013).

For detectives whose frontline duties involve first contact with witnesses, determining whether an individual is genuine about their claim to be 'mentally ill', is equally as problematic. Furthermore, standardised labels and categories (such as the DSM and ICD) were equally viewed

with suspicion and caution, as they were likely to be misused and misunderstood by professionals and witnesses. This in turn was linked to the belief that mental health problems were somehow less common, or resulting from the witness lying to achieve a desired result.

I think we are very wary about, I mean people come in and say all sorts of things but unless you have had a proper diagnosis it's dangerous to banter those terms about. We see quite a number of people who say they are bipolar, or have a personality disorder, schizophrenia is more rare but a number of people seem to have those sorts of issues and I just think, well, surely not all of them can have these disorders.

**Detective Constable**

Of course, there are times when you think hang on a minute, is this person lying to me...people will say pretty much anything, I hear it all the time, if they feel things are not going their way, or something like that.

**Lawyer**

Interestingly, though gaining an official diagnosis was believed to partially solve the problem of whether an individual witness was feigning mental health problems, the issue of diagnosis posed further dilemmas for professionals. One such dilemma was whether diagnostic categories of mental disorder were useful when practically carrying out interviews with witnesses.

### **Beyond diagnosis: life history and context**

The use of mental diagnostic categories in everyday speech amongst investigating officers is reported as 'not particularly useful' and the use of such psychiatric and medical terminology is for the large part, absent. Some participants did on the other hand report the use of other colloquial terms to refer to those who demonstrate signs of mental illness and instability, such as 'nuts', 'bonkers', 'schizo', 'he's a Wacko Jacko' (presumed reference to pop-musician Michael Jackson), and 'away with the fairies'.

..no, I don't use categories like that...are you talking about DSM categories? I don't like it anyway. It is a bit of a devise issue. Is it really useful for identifying sets of behaviours? What does that really tell you? Nothing at all. (laughing). I have got very little time for it...

**Detective Constable**

A number of participants either refused to deploy diagnostic categories or treated them with caution, as it was believed to be more important to contextualise difficulties, by first of all assessing the impact of interviewing on the person with a mental health diagnosis. Understanding the context of the interview and the potential stress inducing response it may evoke in individuals is presented in the following extract as far more useful than simply adhering to check list of diagnoses or symptoms. More importantly, service users themselves should be consulted as to the best of course action whilst in the care of the judicial system.

Because I think it's fine to have the academic "this is what it is" but is that what is going to necessarily impact upon our role with individuals with that? And I am aware you know, it differs from individual to individual due to circumstances, the nature of the diagnosis, what has contributed to it, how it has been managed, everything else. But I think you need that general awareness of what there is, what the key issues are, but also because at the end of the day we are... our job is to engage with people, perhaps when they are at their most vulnerable and to accompany them through a process that is not very victim- and witness-friendly. It's very difficult, it's very lengthy, and it puts a lot of demands on victims and witnesses, and I think it would be very helpful sometimes to hear from people with mental health diagnoses, and perhaps even better, people with mental health diagnoses who have been thorough the system, and who has been through they can say "this is how I felt when I was interviewed".

**Detective Sergeant**

Part of not wanting to adopt a medical language was linked to a lack of expertise and confidence in their own knowledge base, as well as acknowledging that context and the individual's circumstances were the primary source of information deemed relevant.

Does that help us [labelling a person with a specific mental illness]? Ultimately unless you are an expert, I would argue from a lot of the health professionals working in the field that I have spoken to, I am not convinced that all them [mental diagnostic categories] are necessarily where they are going with it, but mental health issues are incredibly complex and ultimately people are individuals. What you are dealing with is, you are dealing a person who happens to have psychosis, schizophrenia whatever. They are a person first and foremost.

**Detective Constable**

Of significance here is the perceived lack of utility in using diagnostic categories to determine vulnerability in the context of interviewing a witness. A number of participants discussed dealing with mental health problems at a 'practical', rather than diagnostic level, when it came to assessing the individual's need for help in the interviewing process. However, it was not clear what such practical help entailed.

We might use those terms, but we don't really understand them that well, and I don't find it particularly useful because I meet people who have a variety of conditions I've been told about, but to me in some ways I'm just trying to make a practical assessment of whether I can offer you any help. So when you're ill, I think, it doesn't really matter, and often people will talk to me about the fact that they're bipolar, and yes, I can understand how that's contributed to the situation you find yourself in.

### **Detective Sergeant & Specialist Interviewer**

Competency during interview, thus, was something to intuit, rather than to pre-assess, using any formal set of criteria. The rejection of formal systems of categorisation was also linked to a lack of confidence and variability in adherence to sets of diagnostic criteria, among trained psychiatric professionals. Engaging with a witness with mental health problems was again considered to be the priority, though once more, participants were unable to articulate how this might be achieved.

The problem is a lot of people get labelled a lot of things and you think well so you are telling me he is schizophrenic, what does that really mean? They are telling me he is bipolar. Obviously I have done a little bit a study in with my Masters into these diagnostic labels and often psychiatrists differ heavily between what one person would deem to be a schizophrenic. Even looking at high profile cases for instances this Brethick or the guy who shot that 100 students in Sweden wherever, they are arguing with him about whether he is mentally ill or not. Potentially what disorder he is suffering from. I think if they can't even decide then how on earth I am going to interpret their decision and I think sometimes you have just got to try and ignore the label that they have been given. Talk to them and see how they engage with you and see how competent they are in interview. A schizophrenic person might be from what I understand about schizophrenia, one day they may be fine talking to you about something or they might give you a completely coherent account up until one point where you will get something a bit odd. You just do not know because every person is so different. I try and just take each person individually and try and engage with them on a level that they are able to engage with me on.

### **Detective Constable**

Others note the limitations of mental illness labels, favouring instead practical solutions to



complex life situations, which were considered more important in assessing a person's vulnerability:

The question "does it [the use of categories] make any difference?" is an interesting one. In some ways I sympathise because I think "you've got a mental health problem that has contributed to a situation that has made you unhappy and has resulted in all sorts of things" and in some ways it doesn't really matter too much to me what it is, and exactly how it works, because I can see from what you've told me that this is the problem, this is the end effect of a variety of things coming together, including your mental health problems, that have resulted in this. And the answers that I've got to offer aren't really contingent upon your problems at all. In some ways they're fairly straightforward, simple. We can take you out of that situation, we can get you to a refuge, we can get you this help and that help, so I don't think it makes a big difference, interestingly...I suppose if you talk about the mainstream of policing, there might be a complete lack of understanding of mental health, the gaining of which would have a big impact on how they conducted their work, to a degree.

### **Detective Constable**

The use of diagnostic labels raised a number of dilemmas for professionals, and signalled a further deficiency in the knowledge base of professionals working with vulnerable witnesses. Rather than receiving a checklist of diagnostic categories or symptoms, the participants describe the need for a more nuanced and contextualised reading of mental health problems to facilitate a more sensitive engagement with individuals with these particular needs. The next section, however, discusses some of the barriers to the production of such nuanced and contextualised knowledge that participants identified.

### **Barriers to knowledge: time restrictions, silence, professional identity and fear**

Time restrictions and a general lack of interest have all been reported as barriers to officers attaining sufficient knowledge about mental health issues. In the views of these professionals, too much autonomy is given over to professionals to develop their own knowledge base of mental health problems. And yet due to time restrictions, many doubted that professionals developed this knowledge to a sufficient level.

People are, they don't have a minute. I mean, sometimes people are lucky to get food

some days, they're lucky to get 3 or 4 hours sleep when there's something major happening. So there's the lack of time to be able to sit and discuss these things, because my experience with other professions, there is the time that I have had to discuss options, to talk about issues that are arising within that professional experience. Whereas I do find here, okay, [name of police station] is incredibly busy, but there isn't the time and there isn't even the willingness to have these discussions.

#### **Detective Constable**

A lot of the learning and training input now is in the form of Internet packages that you are asked to do in your spare time. A lot of people do not have that spare time, and I think a lot of that has been overlooked, and generally training, and all of that, the budget has gone down. Completely down the swanny. It's quite difficult to get input on things like that. Maybe there's something available there, but an officer would have to use their initiative and go and look for it, erm, and even then, like I say, anything that I have seen from the police... Like I say, I am not an expert in mental health, I don't have a clinical background or anything like that but anything that I've seen I have found the information to be quite poor, very low-level and it, you know, it doesn't engage people because it is well below their abilities, to be quite honest.

#### **Detective Sergeant**

In addition to time constraints, a further barrier was the quality of the information provided to deal with situations involving persons experiencing mental health problems. Even though many professionals had received a basic training package that they were required to access in their own time, a number of participants identified issues with the type of information they were encouraged to use, in the context of identifying witnesses with mental health problems. Providing a basic checklist of mental health difficulties, for example, was seen to be an unproductive way of disseminating information to professionals believed to be more sophisticated in their thinking on the topic of mental health.

It [existing information on mental illness available to investigating officers] is not very well informed and it's pitched at the wrong level, I think, for the audience that they've got. It's quite basic, and I think people are a lot more, people are aware of things and they do pick up on things. They may not immediately identify mental health problems, but they will identify that there's a problem, and some will come and discuss that with colleagues and talk about potentially what the issues are. Some of them don't, I mean you can have people repeatedly presenting to the police.

#### **Police Constable**

Such a mode of dissemination, that relies on the autonomy of the professions to engage with the material further decreases professional levels of engagement. As one participant notes, if you want further information, it is difficult to know where to go to obtain it, which then leads to significant demotivation:

This information [about mental health issues] is not freely available. It's not easy to access it. I think you have to really have an interest in this sort of thing...you have to want to know about mental illness, those vulnerabilities, be interested in the topic to really get anywhere...I know some officers who are very interested in that and will know about it, but I would say that there are more people who, who are, they don't have an interest.

#### **Detective Constable**

At an organisational level, not having an adequate cultural climate within which to discuss mental health issues was considered to be a significant barrier to enhancing knowledge of the area. This was attributed to a number of factors, including fear, masculine identity and maintaining a distance between their own mental health issues and that of their clients. The organisational culture of the police more generally was seen to serve as a scaffold for such anxieties. The desire to maintain a social distance from persons with mental health problems has been found in other studies in the US (Broussard et al. 2011) and the UK (Pinfold et al, 2003), and is considered to be one of the factors influencing the quality of interactions between the police and this group of individuals. This could be a crucial component in the interviewing of vulnerable witnesses especially, as good rapport is considered to be imperative to successful witness interviewing practices (Collins, Lincoln & Frank, 2002; Vallano & Como, 2011). Here we found more examples of fear, anxiety and organisational support for shrouding the issues of mental health in silence.

It's funny, in terms of discussing mental health generally, I find within the police, any discussions around that are enmeshed with (long pause) with, with... people are reluctant

to talk about mental health. Erm, there's an incredible fear among officers, you know, about kind of accepting that mental health is something that can affect anybody. And this incredible fear about relating too much to mental health issues. For example, stress, depression, things like that, there does seem to be a huge reluctance to be (long pause), they can empathise, but, you know, keep it impersonal, don't relate to it. Therefore you don't have many discussions about what mental health means to an individual, what their perception of it is, what experience they have of it, other than when it comes up on a case-by-case basis and needs to be addressed. Which, yeah, it's a bit unusual, it's definitely an issue within the culture that's for sure.

### **Detective Sergeant, Anti Victimisation Unit**

As mentioned before, the issue of fear and silencing was also linked to specific versions of masculine identity within the police, which was perceived to serve as a significant barrier to knowledge and engagement with mental health issues. The stereotypical version of hegemonic masculinity (the tough, silent man, who does not divulge personal information) has been well documented in the sociological literature, in terms of how it limits officers' engagement with what are considered to be 'soft' or 'feminine' issues such as sexual and domestic violence and mental distress (Barrie & Broomhall, 2012). Here detectives viewed this promotion of hegemonic masculinity as a further barrier to engaging with mental health within the witness interviewing process.

I think there is an issue about speaking about mental illness amongst male officers particularly, which is silly really. There is this image of a cop, most of them have wanted to be cops for their whole childhood, all their lives, so there is this image, especially amongst male uniformed officers, those who are new to the job. It's definitely a man's job, being a cop, the big cop, men are tough and all that. Women can be more, erm, women are allowed to, women are softer and can talk about it.

### **Detective Constable**

It's funny, cos I was talking to [name of colleague] about this the other day and was saying how some young male officers here who are the stereotypical, hard man officer and they play to that, they like it I think, how they avoid, well not avoid, but you can tell there is a reluctance...feelings of discomfort, discomfort about engaging in conversation about mental health, which leads to bad practice.

### **Detective Constable**

With mental health confined to the realm of the personal, due to a lack of an organisational cultural engagement, it could be left to the individual to raise the issue of their mental health in

the context of a witness interview. What might be a public implementation of a policy such as the UK ABE thus becomes a matter of private judgment based on the individual's personal and emotional reaction to the topic.

Many professionals admitted that raising the issue of mental illness with witnesses during the course of their investigations could be a task that was far too daunting, so best avoided and left to the witness to raise it where necessary.

I think the issue of mental health is a very private one...it is part of that persons make up, their identity...sometimes related to deeply personal experiences in the past. I know some people [colleagues] who would be uncomfortable with that, asking about mental health issues, so they don't.

**Detective Constable**

I try to avoid the subject unless the person is unable to communicate with me or there is something else seriously wrong with them.

**Police Constable**

Interviewer: Do you ever ask about a person's mental health status when you take a statement from them, when you're talking to them?

There's been a couple of times where I have, yes. Like, the other day, I asked "do you have any mental health issues" as it was quite clear that she did, and she said "oh yeah, I'm schizophrenic". But I don't usually ask that directly, you know...I did with this particular person because it was very obvious. But no, usually, I don't ask about that. It's quite embarrassing, you know, asking about those deeply personal things. Usually, a relative or someone in the home might mention it, usually.

**Detective Constable**

To summarise, when it comes to knowledge of mental health, a number of professionals highlighted the inadequacy of the knowledge provided by organisations to deal with mental health issues in general, and more specifically in the context of producing witness statements. A number of significant barriers to engaging with the knowledge were also discussed, including a too basic level of knowledge, organisational culture and a fear of addressing mental health issues, as a result of wishing to maintain a social and personal distance from the topic. Such a failure to know how to engage with issues of mental health was thus of concern to many professional we

interviewed, in terms of gaining the reliable witness statements.

## Discussion

All participants agreed that identifying witnesses with mental health problems was fraught with difficulty, unless the signs of mental distress were palpable and undisputed, and only occurring in extreme circumstances, such as times of crisis. However, a number of participants explained that their knowledge of mental health problems was either lacking, gained from media sources only, or based on intuition, which cannot be easily measured. When formal knowledge was presented as an option, via training, a number of participants expressed doubt about the utility of such knowledge in real world settings, and complained about there being a disjuncture between academic knowledge (which was viewed in the most part, with suspicion) and the realities of the practical context, where snap decisions were essential. It was proposed by participants that adhering to strict guidelines about a person's formal diagnosis could easily be undermined by them holding more than one diagnosis, the inability of mental health professionals to agree on the diagnosis, and the current mental state of the witness. For example, a number of participants believed that 'symptoms' of disorder were only relevant if they were present at the time of the statement, and even then were heavily dependent on contextual factors, such as the manner of questioning and the individual's level of support at the time of interview. A small minority suggested a more nuanced reading of the relevancy of a person's mental health might be facilitated, through the use of the World Health Organisation Disability Assessment Schedule (WHODAS), which measures an individual's current level of emotional and mental functioning. Moreover, participants called for a level of training that goes beyond the presentation of medical diagnostic categories, so that the context, including levels of social support, distress at the time of interview and previous history of victimization might be taken into account at interview. Categorising individuals in binary terms, as 'possessing or not possessing' a mental health problem was viewed as a stumbling block to field relevant knowledge. The training of legal professionals should thus take into account how knowledge on mental health is received and then

applied in the field, with a focus on context, practicality and immediate relevance in witness interview settings.

## Appendix

What do you do? Could you tell me a little about the work you do and the contact you have had with vulnerable witnesses?

What do you understand by the term ‘vulnerable’ in relation to witnesses? Why do you think people with mental health diagnoses in particular would be considered vulnerable?

What sort of things would you typically look for in establishing whether or not someone was vulnerable?

When would you think it necessary to bring in an intermediary if you thought someone was vulnerable?

What do you understand by the term ‘mental illness’ or ‘mental health problems’? (Prompt: do you think of it as a disease? As something that can be managed? A problem with how people think about themselves and the world?) Which term do you tend to use?

Why do you think people with mental health issues have become unwell? Get them to talk about their general views of mental health and illness – causes etc.

How do you think people’s mental health status impacts on the kind of work you do? Maybe we could think back to the stories I provided before the interview? What do you think is going on in story 1, 2 or 3?

Would you consider medication a relevant factor in an individual’s ability to provide a witness statement?

- In terms of length of the interview?
- In terms of memory or other psychological factors – decision-making, problem solving, memory?

What obstacles does a person’s level of distress present when it comes to gathering evidence as soon after the event as possible?

Do you find mental health diagnostic categories helpful when making decisions on someone’s ability to provide evidence?

Would there be any point at which you would consider discontinuing the process of interviewing? Again thinking back to the stories....

## NARRATIVE COHERENCE

Achieving Best Evidence or the ABE talks about the importance of narrative coherence in establishing witness reliability. What counts as good narrative coherence for you? Do you think

that the characters in the stories demonstrated good narrative coherence?

What sort of thing would you put in place to establish narrative coherence (e.g. some kind of test of measure)? Talk me through the kinds of things you do to encourage this when interviewing? If you could provide examples that would be brilliant.

- When someone is distressed?
- Goes off topic
- Reluctant to engage
- Their narrative is fragmented

In terms of people with mental health diagnoses, do you think there are any specific obstacles or barriers that affect people's ability to remember? Again, please do refer to the stories...

Do you think there might be certain individuals with mental health problems who might be more open to suggestibility – from others around them, or during the interview itself?

When you suspect someone is more open to suggestibility – firstly, how do you recognise this? What are the measures that have worked best for you in avoiding suggestibility in the interview itself?

What do you think is the relationship between the actual witness evidence and other forms of evidence? Do you tend to put more or less trust in a witness statement if this is the only form of evidence you have? Thinking back to the stories, what might be the causes for concern in relation to the testimonies put forward?

## TECHNIQUES

How do you judge the length of an interview? If someone has clammed up, and you know they have a particular mental health diagnosis, do you have certain probes or other techniques you use to encourage narrative flow?

How do you manage anxiety, or people becoming emotional in these situations?

- sad/upset
- agitated
- angry
- abusive

Try to ask them if they use different techniques for people from different backgrounds. You could do this by asking them to refer back to the case studies and ask them to consider changing the individual's gender, class, race or age.

## PREVIOUS VICTIMISATION AND TRAUMA

Do you think previous experiences of victimisation and trauma affect an individuals witnessing abilities?

- Psychologically?
- Biologically?
- Socially?



If you are aware prior to the interview, or become aware during the interview, that someone has a history of say child sexual abuse, would that make a difference to how you would approach the interview?

- in what ways?

If this is the first time they had talked about their experience, would this also make a difference?

Again, try to probe them about gender or age, and how those factors might impact on their actions.

Do you think previous experiences of victimisation and trauma might impact on people's ability to remember?

- In general?
- More specifically in relation to more recent traumatic events?
- Do you think these experiences might be a barrier to accuracy?
- Do you think they might inform a present event, in a positive way?
- Might multiple episodes of abuse or victimisation colour the recall of the present event? (see Billy's example)

Throughout the interviews, we should keep prompting the interviewee to return to the scenarios to identify any specific 'symptoms' characteristic of certain 'vulnerabilities'.

## IDENTITY

How do you think individuals with mental health diagnoses see themselves?

- as 'unbelievable'
- as unreliable
- as weak
- as uber victims?
- as 'ill' or 'mad'

How might these expectations that they have (which they do have according to the research) affect the interview process?

How might you manage these expectations? Can you give any examples of doing this?

How does the process of dealing with people with mental health diagnoses affect you as a practitioner? Again refer back to the scenarios.

- When they're giving you very little or nothing?
- When their narrative is incoherent or really divergent or difficult to follow
- When they are distressed – how does that make you feel?
- Have you had any become distressed/angry/withdrawn/rambling/incoherent? What have you done in those situations? If they haven't or are struggling, bring them back to the scenarios.

What might help you in carrying out the process of interviewing vulnerable witnesses?

- suggestions for change
- Tighter policies
- More training
- Greater knowledge of mental health???

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