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POWER AND THE SOCIAL CONSTRUCTION OF SERVICE USERS AND CLINICAL PSYCHOLOGISTS

Section A: Power in the Therapeutic Relationship: From Modernism to Postmodernism in Psychological Therapies

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Summary of the MRP

Section A reviewed the conceptual understandings of power in relation to the therapeutic relationship. Theoretical and empirical literature from both modernist and postmodernist perspectives on power in the therapeutic relationship was identified and examined. The limited number of identified empirical studies on the topic highlighted the need for further research in the area. The review considered the suitability of postmodern research methods to examine the process of power in the therapeutic relationship as opposed to examining the effects of power from a modernist research approach.

Section B introduced the topic of power in a context of professional requirements and recovery issues. The rationale for investigating the social construction of service users and clinical psychologists in articles was provided. Foucauldian Discourse Analysis was described as the chosen methodology to identify the dominant discourses. It concluded by discussing the results, limitations and practical implications of the study.

Contents

Section A

Section B

List of Tables

List of Appendices

Section A

Power in the Therapeutic Relationship: From Modernism to Postmodernism in

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Abstract

This review investigates the theoretical and empirical literature provided by modernist and post-modernist perspectives on power in the therapeutic relationship. Investigating power in the therapeutic relationship is important due to ethical responsibilities of the clinical psychology profession and the potential of the inherent power imbalance in therapy to reproduce social inequalities. The history of the clinical psychology profession as young and with a need to establish itself was linked to the propensity to adhere to dominant positivist scientific methods as a knowledge base for practice. Similarly, structural and post-structural theories of power were linked to modernist and postmodernist research respectively, illustrating how power is thought of differently depending on the epistemological assumptions of the researcher. A limited number of studies investigated the use of power in the therapeutic relationship, suggesting a need for further research in this area. The review discusses the suitability of postmodern research methods to examine the process of power in the therapeutic relationship in comparison to examining the effects of power from a modernist research approach.

Keywords: Therapeutic relationship, power, clinical psychology, modern, postmodern.

Power in the Therapeutic Relationship: From Modernism to Postmodernism in

Psychological Therapies

The commitment to work within a recovery approach in mental health services has been clearly stated since the 2007 joint position paper "A Common Purpose: Recovery in Future Mental Health Services" (Care Services Improvement Partnership, 2007). Here, the aspiration and goal was stated that practitioners and service users should become partners, where "mental health staff, people who use services and carers can work collaboratively to optimise recovery possibilities (Care Services Improvement Partnership, 2007, p. 25).

The clinical psychology profession might see itself as naturally suited to work within the recovery approach, and might even view itself as relatively egalitarian compared to the psychiatric profession. The psychiatric profession does after all impose diagnoses that have little scientific basis (Boyle, 2007), and adds stigma to the problems of people with mental health difficulties (Angermeyer & Matschinger, 2003; Thornicroft, Rose, Kassam & Sartorius, 2007).

Despite the above, it is questionable whether clinical psychology can be so complacent. It has perhaps had to adopt the medical diagnostic system in order to be part of the medically dominated mental health system (Chesire & Pilgrim, 2004). Arguably, it has also colluded with psychiatry's control agenda in producing approaches such as 'compliance therapy' (Kemp, David & Hayward, 1996) to ensure that service users continue to take medications that have severe side effects (Middleton & Moncrieff, 2011). Some have argued that clinical psychology should take more of a stand against the social injustices behind much of mental distress (Johnstone, 2000) rather than remain so closely in step with psychiatry's overly biomedical and individualist approach to human misery (Harper & Speed, 2012; Rapley, Moncrieff & Dillon, 2011).

POWER IN THE THERAPEUTIC RELATIONSHIP

In recent years, family therapy and narrative fields have increased their publications of discursive research on therapy and on the therapeutic relationship (Sinclair, 2007; Tseliou, 2013). Amongst a broadening literature that continues to increase our understanding of what happens in the therapeutic relationship however, power issues have received relatively little attention (Kuyken, 1999; Oddli & Ronnestad, 2012; Proctor, 2002). Additionally, the use of power seems an under-researched topic in the clinical psychology field. Although theoretical aspects of power in the therapeutic relationship have been considered by some authors, empirical research on and understanding of power dynamics as a stand-alone therapeutic process remains scarce (Guilfoyle, 2005; Roy-Chowdhury, 2006). The increased use of discursive research on the therapeutic relationship has signalled a possible change in the dominance of modernism towards more inclusion of postmodernist theories when approaching practice (Spong, 2010), especially in the field of narrative and family therapy.

On the topic of power, this review will argue that the emerging shift in theory and practice has been two-fold: Firstly, power in the therapeutic relationship has moved from not being visible in a modernist paradigm, to attempts of making visible and neutralising power as a structural concept in postmodern approaches. Secondly, power has been theorised as a post-structural concept in an attempt to 'un-demonize' power in the interest of opening up new avenues in therapy. It will be argued here that adopting a social constructionist stance has the potential to shape the theory and practice around power dynamics in the therapeutic relationship. The concepts of modernism and postmodernism will be explained as part of the review.

The questions posed are:

How is power accounted for in clinical psychological theory and practice?

How can we negotiate power in the therapeutic relationship?

This review starts by defining the key terms discussed in the review before briefly positioning the clinical psychology profession in a socio-historical context. Arguments for why investigating power in the therapeutic relationship is important to the clinical psychology profession are presented, followed by a wider examination of theories of power. Modernist and postmodernist theories and research on power in the therapeutic relationship are reviewed and compared from a clinical psychology perspective where possible, including different therapeutic approaches. Foucauldian Discourse Analysis has been suggested as particularly suited to investigate social power dynamics (Parker, 1992; Willig, 2008). Therefore, the use of power-related discourse analysis within a postmodernist paradigm will also be discussed.

Definitions

Some of the central terms discussed in this review are 'patient', 'therapist', 'therapeutic relationship', and 'power'.

Patient and therapist. The terms Patient and Therapist are familiar to most in the field of psychology. Similar labels such as 'Service User', 'Client', 'Clinical Psychologist', or 'Psychotherapist' could also be used. These terms might at times not provide adequate representations of the constructs being discussed, and may even at times reinforce existing discourses with implications of social power and the lack of it. It is, however, not an aim of this review to highlight discourse, but rather discuss the role that the theories of modernist and postmodernist methodologies might have in the study of power in the therapeutic relationship. There is no consensus in the literature on which terms to use for those receiving psychological therapy, and various terms will be used interchangeably, reflecting the variability in the literature discussed.

The therapeutic relationship. Different therapeutic models have various ways of seeing and using the therapeutic relationship (Flaskas, Mason & Perlesz, 2005). Cognitive-behavioural therapy (CBT) for example, often uses the term 'working alliance', and it has been suggested that the main goal of the working alliance is specifically to facilitate cognitive change (Casey, Oei, & Newcombe, 2005; Giovazolias, 2004). In contrast, psychodynamic models also use the term therapeutic relationship to refer to the transference and the countertransference, aiming to identify patterns repeating from early parent-child relationships (Bion, 1963; Klein, 1975).

To summarise, it has been suggested that CBT uses the working alliance to maximise the chances of cognitive change, whereas psychodynamic approaches use the therapeutic relationship itself to discover what needs changing. These differing views on what constitutes a therapeutic relationship might impact on the type of research instigated on the therapeutic relationship, depending on how the term is defined. As this review does not aim to investigate the therapeutic relationship per se, but rather the acknowledgement and awareness of power related to the therapeutic relationship in psychological research, a broad definition of the therapeutic relationship as provided in a paper by Gelso and Carter (1985) will be used. Their definition suggests that the therapeutic relationship consists of "the working alliance, transference/countertransference, and the real relationship" (Gelso and Carter, 1985, p. 157). Gelso and Carter (1985) further define the working alliance as an "emotional alignment that is both fostered and fed by the emotional bond, agreement on goals and agreement on tasks" (Gelso and Carter, 1985, p. 163). They define the transference/countertransference as "a repetition of past conflicts (usually but not always beginning in childhood) with significant others such that feelings, behaviors, and attitudes belonging rightfully in those early relationships are displaced; in therapy, the displacement is unto the therapist (Gelso and Carter, 1985, p. 170)". The countertransference was defined by

Langs (as cited in Gelso and Carter, 1985) as "one aspect of those responses to the patient which, while prompted by some event within the therapy or the therapist's real life, are primarily based on his past significant relationships; basically they gratify his needs rather than the patient's therapeutic endeavours (Gelso and Carter, 1985, p. 176)". Lastly, the real relationship was defined as "something that exists and develops between counsellor and client as a result of the feelings, perceptions, attitudes, and actions of each toward and with the other" (Gelso and Carter, 1985, p. 185).

The term 'power' will be covered in a separate section on theories of power further on. The next section will look at power in relation to the clinical psychology profession, and reasons why the study of power might be important.

Background

Clinical Psychology and Power

Clinical psychology, like psychology more broadly, is a relatively young profession, separating itself from psychoanalysis in the early to mid- twentieth century, when logical positivism had a strong foothold. This was seen in the emergence of behaviourism, experimentalism and statistics as shapers of clinical evidence. Logical positivism, behaviourism and experimentalism all fall under the umbrella term of modernism, which will be covered in the next section. From the 1950s onwards, clinical psychology broadly added cognitive therapy and an eclectic skills-set to its portfolio. All therapies used in practice were labelled as evidence-based by virtue of academic rigour, allowing the profession to align itself with the medical professions. This alignment probably increased the status and power of clinical psychology, and is currently drawn on in many professional situations ranging from NHS salary negotiations to professional candidate interviews (Cheshire & Pilgrim, 2004).

Why Study Power in the Therapeutic Relationship?

Several authors have argued the need to study power in the therapeutic relationship. Goldberg (2001) argued that power was the most neglected issue in therapists' training, caused by a denial and reluctance of the psychotherapy profession to see power dynamics as a crucial concern for therapy. Proctor (2002, p. 67-73), a clinical psychologist, exemplified how power processes have been concealed by therapeutic labels such as 'collaborative' and 'objective' in CBT. Similarly, family therapists have discussed and attempted to neutralize the therapeutic power imbalance by 'co-constructing' and taking a 'non-expert position' in therapy (Sutherland, 2007). Whereas Goldberg saw this concealment and reframing as dishonest, Proctor (2002a) and Sutherland (ibid) attributed the concealment to how therapists theorise power in the first place. Those working in these 'collaborative' ways suggest that far from engaging in mere subterfuge, they are in fact addressing possible power imbalances (Anderson, 1997; Anderson & Goolishian, 1992).

The study of power in the therapeutic relationship has also been championed as an ethical responsibility by Kuyken (1999), Proctor (2002a) and Brown (1997) amongst others. These authors have argued that inattention to or complacency about the issue of power in therapy allows a superficial adherence to the codes of ethics, leaving the profession open to be used to influence the client, using power instrumentally to improve outcomes, or indeed serve other ends.

Hare-Mustin (1994) illustrated how the inherent power imbalance in the therapeutic relationship could be used to reproduce social inequalities in therapy sessions. For example, Hare-Mustin (ibid) gave examples of dominant discourses appearing in the therapy room, such as the male sex drive discourse. This discourse constructs men's sexual urges as natural and compelling in comparison to that of a woman, creating an expectation for the man to be

pushy and aggressive in seeking satisfaction. If left unchallenged in the therapy room, such a discourse would sanction and repeat social inequalities as experienced by women.

Theories of Power

Structural theories of power fit into the context of modernism, an overarching philosophical trend originating from the eighteenth-century Enlightenment era. It professes a belief in science as representing truth, and in language as a true (objective) representation of the world. Emphasis is put on following a strict positivist-empirical model in order to observe reality without imposing any influence upon it (Cosgrove & McHugh, 2008). It has been suggested that modernism, as used in mental health, also tends to adhere to dualistic thinking, such as right/wrong, body/mind and ill/well (Clegg, 1989, p. 7). In clinical psychology, structural theories of power are often relevant when illustrating how power can sometimes be inherent in the pre-existing structural positions (i.e. roles) in the therapeutic relationship. For instance, in the case of clinical psychology, governmental bodies (structures) certify the professional as being an 'expert', meaning that the words and opinions of the clinical psychologist will be given more weight than those of a 'non-expert' client (Proctor, 2002). Some of the main structural theories of power are covered below.

Hobbes' (1839) concept of power formed the foundation of how power is usually defined, and continues to be defined. He saw power as a tangible possession setting the scene for one person or group of people to have power over another person or group of people. The person with more power could exert control over the person with less power (Clegg, 1989, pp. 22-29). Other structural theories are proposed by Machiavelli, Weber, Marx, Arendt and Humm. These will not be covered here.

Although a theory that described power as structures in government, Arendt's (1963) structural conceptualisations of power was stretched towards post-structural theories in that power was seen as relational and not necessarily negative.

Feminist theories of power were initially structural in that power is seen as unitary and unidirectional, meaning power is held by men and exerted over women (Humm, 1992, p. 1). Both institutional power over women and the more invisible power differences in everyday life are challenged. French (1985) extended feminist theories of power towards post-structuralism by distinguishing between 'power-to' and 'power-over'. 'Power-to' indicates ability, capacity and a kind of freedom, whereas 'power-over' indicates domination and coercive authority. 'Power-over' is presented as dynamic within relationships rather than a possession. More recently, Butler (2006), and (less recently) Frug (1992) have stipulated postmodern feminist theories of power, arguing amongst other things that sex and gender is not natural or determinate, but constructed through language. In being constructed through language, the 'realities' constructed are also open to resistance and political struggle.

Post-structural theories of power fit into the context of postmodernism, an overarching philosophical trend that could be seen as a contrast to the assumptions posed by the modernist perspective. The postmodern philosophy rejects all claims that following scientific methods will discover a 'true' understanding of the world, questioning the changing nature of knowledge (Burr, 1995; Gergen, 2001; Lowe, 1991). The postmodern approach argues that 'reality' is constantly changing and in creation through language and practice (Bloor & Wood, 2006; Cosgrove & McHugh, 2008).

As Foucault remains by far the most influential and cited person when power is discussed in a post-structural framework (Hook, 2007; Proctor, 2002) this section will focus on his writings on the topic. Foucault's main contributions to postmodern thought have been

the rethinking of discourse, power, and knowledge (McHoul & Grace, 2002). Although these three concepts cannot be fully separated in his writings, the following paragraph attempts to focus on Foucault's writings on power. Foucault's concern with power could be described as an attempt to establish the ontological foundations of the present (Clegg, 2002, p. 153). Foucault himself was reluctant to create a theory or method related to power. He believed that the state and powerful institutions created 'regimes of truth' that served to regulate people's lives (Gatrell, 2005). Further, Giddens (1991) explained that due to the fluidity of power, individuals can challenge both the social structure and dominant ideologies if they are aware of the inequalities currently affecting them. Discourses are explained by McHoul and Grace (2002) as certain, specific ways (and not others) that we can speak, write, or think about social objects or practices (such as madness), located in a specific historical period.

Foucault (1967) specifically linked the concept of power to therapy in his book 'Madness and Civilization'. Here Foucault argued that individuals with psychological problems or those afflicted by 'madness' started to represent 'unreason' for the first time during the Enlightenment when it was to be feared as an antithesis of reason. He further argued that this fear of madness has persisted into the modern day, and can be seen in 'pseudo-medical perspectives' which help to externalise the feared parts of ourselves into others. Further, Foucault argued that this construction of madness is perpetuated by a web of social practices in both institutions and everyday interactions, focusing on illness and cure (Foucault, 2006). Thus the link between networks of power and the psychology profession has already been highlighted to some degree by Foucault. In the sense that 'madness' or mental health problems have been constructed by societal-wide discourses, the therapeutic relationship most likely represents only a small aspect of the network of power-relations affecting people involved with the mental health system of today.

Methodology for Locating Papers

A range of literature search terms related to the key terms of therapeutic relationship, power, therapist, and patient were generated for a systematic literature search (See Appendix A). A search of PsycInfo, CINAHL, ASSIA and Medline (1980 – February 2014) aimed to ensure a broad cover of the literature. These databases were searched for 'power' AND 'therapeutic relationship', 'power' AND 'therapist', 'power' AND 'patient', with several alternative search terms included. The exclusion criteria were: not peer-reviewed, foreign language, use of the term 'power' with a different meaning such as nuclear power, a focus on the therapeutic relationship with the term 'power' first addressed as part of the discussion section, use of the term 'power' to denote a statistical calculation, and studies referring to 'power' and 'the therapeutic relationship' outside of a psychological therapies framework. The inclusion criterion was: Study addressed the issue of power in the therapeutic relationship through any type of methodology.

Out of 136 papers, four papers met the inclusion criteria. One paper included a discourse analysis on the subject matter, three papers offered theoretical discussions, and a fourth paper was an experiential account of psychoanalysis. The references of these articles were examined for further articles of relevance, and a further cross-reference exercise was performed by investigating the related articles and the citings the articles had received on Google Scholar. This produced a further six articles. Three offered discourse analyses, two more offered theoretical discussions, and the last two offered qualitative and quantitative investigations into power in the therapeutic relationship. The articles were divided into groups based on whether their research methods and conceptualisations of power appeared to fall within a modernist or postmodernist epistemological framework.

Several papers reported on research that emphasised the importance of the therapeutic relationship in therapy. Most of the papers that mentioned power tended to centre on

outcome studies where power was discussed at the end as a potential influence on the

outcome. These papers were excluded from the review.

After the initial search a new search was conducted including the terms 'psychoanalytic'

AND 'psychodynamic' specifically as part of the search detailed above. One paper was

identified as fitting the inclusion criteria, outlining two frameworks of power to be used to

explore power issues in psychoanalysis.

Identified Literature

Personal Experience Account

One paper fell slightly on the outside of the modernist/postmodernist criteria. The

following paper by Proctor (2002b) offered a perspective of being a service user in therapy

whilst also being a member of the clinical psychology profession. It is included here as it fell

within the inclusion and exclusion criteria, and that it adds a unique contribution to the

literature.

Proctor, a clinical psychologist, published a personal account of her experience of

power in the therapeutic relationship as a client (2002). Her account tells of how she felt

unable to discuss her feelings towards her psychoanalyst without those feelings being

interpreted as transference. Disagreement with interpretations were seen as evidence of

defences, and left her feeling unable to trust her own knowledge.

In regards to her experience of the working alliance, she experienced it as if the

therapist allied herself with the part of Proctor that wanted to stay in therapy. In contrast, she

experienced that the parts of her that wanted to leave therapy were discouraged and

questioned.

Proctor also described the lack of acknowledgment by her therapist that they were in a real relationship outside of transference. This felt oppressive in that she was left with little power to define her own reality in the therapeutic situation.

Proctor acknowledged that at the time of therapy she had little knowledge of the different types of psychoanalytic therapies available and in retrospect she would have liked to have challenged her therapist more. However, most people seeking out therapy have far less knowledge about the therapeutic model than the therapist, and will be in a position of less structural power than the therapist.

Proctor's personal account highlights the potential of clients feeling powerless even when the therapist is well-meaning and has belief in their therapeutic model. It also demonstrates how a therapeutic model might lend itself to oppressive practices unless a conscious effort is made to avoid them.

This account does not attempt to generate new theory, and is based on the author's subjective experience of therapy. It does focus on the experiences of power differential in therapy, which is relevant for understanding and thinking about power in the therapeutic relationship in general. It raises questions of how power differentials are played out in therapy, how these situations are experienced and negotiated within the therapeutic relationship, and how common this experience may be for both service users and therapists. Whilst gross abuses of power are often addressed by disciplinary or legal frameworks, less obvious exercise of power may be more common than is generally recognized.

Research in the Modernist Tradition

In this section I will analyse papers that fall within positive science based on modernist methodologies. Two empirical papers were identified in this tradition. The first

one, by Rennie (1994), reported on a grounded theory study of fourteen psychotherapy clients, indicating that a major category in a client's recollections of therapy surrounded the client's deference to the therapist. For example, the clients were concerned about criticizing the therapist and threatening the therapist's self-esteem. The grounded theory approach was that of Glaser and Strauss (1967), where the analysis is seen as discovering the theory hidden in the data. This approach is generally argued to be based on a positivist epistemological view (Willig, 2008), thereby categorising it as falling within the modernist tradition.

The representativeness of the psychotherapy clients was questionable in that psychotherapists who were willing to participate (in itself a common representativeness issue) used their own unrecorded inclusion criteria to pick clients. The author acknowledged that the author being sole data analyst might decrease the objectivity of analysis. The study did not address what the therapist's recollections were, which would have been useful as a comparison. This study made a good attempt at mapping the influence of authority on the therapeutic relationship by investigating instances in therapy where structural power differences between client and therapist could be found.

Reandeau and Wampold (1991), investigated clients' involvement in brief therapy in relation to the power (interpersonal influence) exhibited by the therapist. They suggested that in cases where the alliance on the Working Alliance Inventory (WAI) was measured as good (high score), the therapist had initially made more high-power verbal communications such as giving direct advice to the client during sessions. Where the working alliance was low, there was less involvement during the remains of therapy, and the clients were less likely to increase their score on the WAI as therapy progressed. The study's main aim of including power as a variable was to investigate what factors influenced involvement and the working alliance in therapy. The authors concluded that power dynamics were a factor that can influence involvement. The Reandau and Wampold paper illustrates how the use of a position

of authority as an effect of power might influence the trajectory of the therapeutic relationship. The study was a case study of only four clients in brief therapy, which makes it difficult to generalize. The authors suggest further experimental studies to quantify the difference between levels of alliance and levels of involvement.

The definition of power in the therapeutic relationship was interpersonal influence, and was detected by using the Penman Classification Scheme, analysing transcripts of therapy sessions. This system had reported inter-reliability tests of about .70 (Cohen's kappa), but no other reliability tests were reported. The study did not report any measures of clients' pre-conceptions of therapy, which might have influenced responses to the therapeutic interactions. Further, the clients who were selected by the therapists with no criteria might represent a particular portion of people going to therapy

The two studies above illustrate the knowledge that has been produced by approaching the issue of power in the therapeutic relationship from a modernist stance. This type of knowledge could be directly useful for therapists, influencing their approach in therapy by choosing to give either high-power messages in the beginning of therapy if there is a risk that the working alliance would be low, or by being aware of how often clients tend to silently defer to their therapists. This surveying of structural power mechanics could be useful.

Critique of the modernist approach. The lack of studies from the modernist tradition focusing on the issue of power seems to support the earlier mentioned claims of Goldberg (2001), Guilfoyle (2003) and Proctor (2002a): The historical dominance of modernism in the field(s) has somehow concealed the issue of power in the therapeutic relationship. For example, Proctor (2008) critiqued the way in which the CBT model addresses the issue of power in therapy. The CBT model was linked to the principles of

modernism and rational thought and it was suggested that CBT takes a structural approach to power, leaving little room for individual agency. Further, Proctor challenged the CBT model's view of therapists' ability to remain objective during therapy. She acknowledged that some authors (Telford & Farringdon, 1996) have questioned the objectivity, but she goes on to explain that this questioning was not followed up with any considerations for how to explore this in the therapists' position in the relationship. Proctor (2008) continued her critique by arguing that the collaborative relationship advocated by the CBT model expects the client to conform to the therapist's approach (CBT) and agree to take part in the activities suggested by the therapist. She points towards Lowe's (1999) article arguing that 'collaboration' is impossible in the therapeutic context, where the therapist has more institutional power, and the client is entering 'the institution' of CBT. Her conclusion is that CBT confuses collaboration with patient compliance, and that CBT needs to re-examine its views and practices of power to avoid domination and abuse, even where unintentional. It becomes another 'technique' which if done right, will facilitate successful uptake of the CBT concepts.

Linking this critique to the modernist research studies by Rennie (1994) and Reandeau & Wampold (1991) above, clearly some modernist research looks at power issues in the therapeutic relationship, contributing to the overall evidence base. Finding that 'expressions of power increases the working alliance and involvement in therapy also raises some interesting questions of the use of power not mentioned by the authors. If 'power speech acts' were knowingly used by therapists to increase the working alliance, could it be seen as a useful way of using power in therapy, or would it be seen as manipulative and oppressive? The two studies talk about power as a tangible, static therapeutic factor that can be easily measured. This approach to studying power might become complicated and difficult to apply as conditions of therapy keep changing, both in context and within sessions.

Research in the Postmodernist Tradition

Seven papers were identified: four theoretical papers and three empirical papers. The methods used were qualitative and included post-structural concepts of power. Some of the papers critiqued CBT's views of power, other papers discussed the merits of taking a postmodern stance when considering power, and finally some papers reported on the use of postmodern methods to investigate power in therapy.

Theoretical contributions. In Brown (2006), knowledge and power are situated in the therapeutic relationship from a narrative perspective. Brown argues that from a postmodern perspective, narratives are not only structures of meaning, but structures of power as well. Taking up a Foucauldian position on power, Brown argues for the acknowledgment and sharing of some existing knowledge (albeit socially constructed) in therapy. She portrays this sharing as a 'golden middle-way' between the all-knowing therapist and the not-knowing therapist, including the client in a more powerful position of partially knowing. She criticises Anderson's (1997) view on neutralising power in narrative therapy as an attempt to write out existing structural power dynamics.

Brown further describes how Foucault's view on power as fluid and present in all fields of our lives leaves space for personal agency and counter-discourses to take place. Brown also argues that objectivity should not be a goal in therapy, but rather the deconstruction of the social discourses the client and the therapist live by would enable evaluation and generation of new or alternative discourses. It is argued that therapists need to take a position in order to challenge dominant and often unhelpful discourses, avoiding reifying dominant discourses in therapy. She outlines an approach where the social agenda

and institutional practices of modernism are acknowledged as impacting on the therapeutic space, and knowledge is partial, located (often in the therapist), and never neutral.

Finally, Brown argues that the therapy professions need to move away from the view of power as negative and oppressive. In other words, she is arguing for an adoption of post-structural theories of power.

Although Brown's chapter summarises an emergent view within narrative therapy, she unfortunately does not make it clear to the reader what a position of 'partially-knowing' by therapist and client might look like in therapy. It might be that experienced narrative therapists might be able to directly apply her recommendations in the sense of trying to not adopt a not-knowing position. Some use of transcribed therapeutic extracts might however have illustrated her points more clearly. She fails to mention research on the topic, and makes no suggestions as to what research and what actions might promote a 'partially-knowing' approach in narrative therapy.

Given its alignment with postmodern philosophies, Guilfoyle (2005) considered whether narrative therapy was able to stimulate resistances to dominant discursive practices within the therapeutic relationship. Following on from a 2003 empirical study analysing a transcribed therapeutic extract, Guilfoyle used some of the results to further theorise, suggesting ways forwards concerning power issues in narrative therapy.   Drawing on Foucault's principles, he proposed four ideas for uncovering therapeutic power operations with the end goal of revealing cultural and institutional discourses. Firstly, the 'Power as a productive force' concept separates power from its effects ('effects' referring to the more common conceptualisation of power as 'having power over' a person, 'having influence' or a 'higher power of persuasion'). Conceptualising power as productive allows discussion of the production of discourses, practices, subjects and power relations. 'Secondly, considering the

'power-knowledge integration' concept , Guilfoyle argued that the institutionalised position the therapist is in, which bases itself on pre-existing discourses around scientific evidence and expert knowledge, informs both therapist and client in how to arrange the therapeutic relationship even before entering the first session. It is therefore futile to analyse the therapeutic relationship purely from what happens in narrative therapy. Even if analysing and modifying therapeutic interactions in such a way as to democratise and neutralise power dynamics took place, there would still be the overarching positions of the therapist and the client to conform to. Thirdly, by considering the 'power-resistance relationship', Guilfoyle argues that narrative therapy allows instances of resistance in therapy to become relevant as opposition to dominant cultural discourses. Fourthly, the 'Power in context' concept considers that therapeutic power is shaped by social, cultural, discursive and institutional forces which take place 'outside' the therapeutic relationship. ;

Guilfoyle lists some questions that consider which aspects of power are being opposed in instances of resistance in narrative therapy when the client says 'no' in some way or another: Does the resistance challenge the way in which therapy is delivered and the discourses behind it? Does it challenge the therapist's right to the position as holder of knowledge? Or does it challenge the psychological discourses used in the therapeutic setting? Asking these types of questions might prevent a professional 'entitlement' to overcome resistance, in which such resistance is included in the 'psychological knowledge' discourse of the setting as linked to the reasons the client sought out therapy. With the above questions suggested as useful ways of analysing resistance in therapy, an observable application of the questions might be a direction for future research. Guilfoyle's paper poses a similar conceptualisation to power and narrative therapy as Brown's 2006 paper. Both papers' conceptualisations of power assumes (with some references) that narrative therapy focuses on

neutralising power differences. It might have been useful to question further whether this is the case both in theory and in practice.

Another theoretical contribution by Guilfoyle (2007) outlined two frameworks of power to explore power issues in psychoanalysis. One framework was Habermas' view of psychoanalysis as an emancipatory practice, an externalising view according to Guilfoyle, which positions critique and psychoanalysis outside of power relations. He contrasted this with Foucault's view on power, arguing that it provides a more intrinsic way of analysing power in human interactions. He went on to suggest that by using Foucault's view on power, the psychoanalyst might approach resistance in therapy from a more inquisitive stance, moving away from a predetermined limitation on meaning. Guilfoyle acknowledges the difficulties that psychoanalysis would encounter by openly discussing power dynamics and positions with clients. Given its' tradition of not explaining in detail how each 'step' of the therapy works, an inherent power difference is difficult to overcome, a conflict not resolved by Guilfoyle.

In an attempt to understand more about the process of therapist power, Sutherland (2007) compared the conceptual differences of therapist power and positioning in narrative therapy, collaborative therapies, and solution-focused therapy. She noted that narrative therapy tends to pursue a political agenda to challenge social injustices, that solution-focused therapy tends to pursue pragmatic agendas, and that collaborative therapies (explained as variants of Family Therapy by Sutherland) tend to develop an agenda collaboratively. She concluded that discursive therapies place an emphasis on flattening the hierarchy in the therapeutic relationship by presenting their knowledge as relative. A useful conceptual comparison of theoretical and practical approaches to power in therapy, it suggests a possible avenue for future empirical research that might increase the range of implication that could be drawn from this study.

Hare-Mustin's (1994) seminal paper on postmodern analysis argued that dominant discourses needed to be identified by the therapist so that they were not re-enacted within the therapy room. She provides examples of how dominant societal discourses were brought into therapy under the guise of individual 'presenting problems'. She identified a 'marriage between equals' discourse in a case where a married couple needed help with their son's bed-time routine. In this case, where both husband and wife were working, the wife ended up doing the household chores whereas the husband kept domain in the garage. In order to remain within a 'marriage between equals discourse' in society, the differences of their effort into the household was constructed as differences in personality. The husband described himself as 'laid-back' and 'easy-going', whereas the wife was 'compulsive' and 'well-organised'.   Consequently, at the end of the day the wife was left exhausted and unable to deal with the needs of her child without assistance. The wife was left in a position where she had to seek out help because she was not 'doing her job'. Hare-Mustin provided several examples of discourses being brought into therapy, deconstructing the 'problems' of the individual.

Hare-Mustin's contribution to the research on power in the therapeutic relationship was to highlight the need to identify discourses in therapy so as to not strengthen the social influence those discourses were already imposing on clients. Although the use of clinical case studies helps exemplify discourses present in clients' presenting issues, it would have been informative to learn more about the process of developing self-reflexivity, which Hare-Mustin advocates as a way of challenging the assumptions of dominant discourses.

Empirical contributions. In his 1998 study, Kogan analysed one Solution-Focused Therapy (SFT) interview being roleplayed and video-taped at a conference. The video showed the role-play of a married white couple in therapy to address their couple issues. After repeated viewings, three 12-minute segments durations were transcribed following

Conversation Analysis (CA) conventions (identified as a type of discourse analysis by Kogan). Following the CA process, the author identified patterns describing strategies used to manage or transform the discourse.   The analysis identified particular therapist strategies, which constructed the possibilities for solutions and limited the meanings that could be produced. Although Kogan did not explicitly set out to investigate power in the therapeutic relationship, his analysis covered it due to explicit influences by Foucauldian principles. By looking at the interaction during therapy sessions, the power dynamics within that situation was discussed. A critique of this study might be the unrealistic setting of the therapy session. Also, questions might arise to the authenticity of content for generalising the findings. Nevertheless, the interview provided material from which the discourse analysis identified unequal distributions of agency between the role-playing 'couple' who took part in the 'sessions'. From the viewpoint of this thesis, it would have been interesting to see a stronger emphasis on the power dynamics within the therapeutic relationship and some thoughts of what place resistance had in the dialogue.

In his 2003 paper, Guilfoyle explored power in the therapeutic relationship in dialogical therapies, explained by Guilfoyle as constructionist therapies that focus on dialogue. He provided a fictitious interaction between friends, and an extract from a transcribed dialogical therapy case to answer his research questions: "… (1) whether the removal of power is necessary for dialogue to occur, and (2) whether such removal can ever be successful". He does not explicitly explain the analytic method he uses, but makes references to Foucault's take on power when explaining the power dynamic and play taking place in the extracts. He highlighted that power in therapy does not stem from 'expert' language, but that expert language and power are inseparable in the sense that the position of an expert has already been established through the cultural and historical trend of endowing power to knowledge. Guilfoyle argued that power does not obstruct therapeutic dialogue if

seen from a Foucauldian perspective. By using a therapeutic extract, he demonstrated how

using 'discursive uncertainty markers' in a therapeutic setting works differently than if it is a

setting between friends. The positional power of the therapist creates a need to insert

uncertainty and relativity in therapy, which is not needed in an everyday dialogue. As

therapists tend to hold more of the relative power, resistance becomes more difficult, and a

lack of uncertainty from the therapist's point of view risks creating a monologue where the

patient becomes passive. Guilfoyle concluded that within the therapeutic relationship, the

client has access to power in the form of resistance, but that varying personal and social

histories and social influences create a dynamic fluctuating picture of the effects of power.

He recommends further exploration of how broader discursive and institutional processes

might impact on the dialogues and relationships with clients. Guilfoyle used first a fictitious

extract from a conversation to illustrate resistance to a proposition between friends, before

analysing an extract from an actual therapy session. The use of more therapy transcriptions

would have added emphasis to the points he made. Guilfoyle added to the above study with

his 2005 conceptual paper (as seen in the theoretical contribution section above). In his 2005

paper he discussed in more detail how a Foucauldian / postmodern concept of power may

further elucidate concealed power processes in narrative therapy and the therapeutic domain.

Guilfoyle (2002) also argued that power mechanisms in therapy related to client

resistance are both ethically problematic and concealed from view. He further argued that

therapy as an institution exemplifies a dominant discourse which embraces both client and

therapist. This in turn allows the therapist to 'overcome' resistance based on the supposed

knowledge base. It also fosters the reproduction of a power dynamic where both client and

therapist behave as if one of them is an expert.

Using discourse analysis, Guilfoyle (ibid) analysed interviews with eight therapists,

focusing on their reactions to a scenario set in two different contexts. One scenario illustrated

a client's resistance to talk about being late to therapy, and the second scenario illustrated a lawyer's resistance to talk about being late for a professional meeting. Therapists were shown to turn the client's resistance to talk into a therapeutically meaningful action in relation to the therapy setting, and accepting the lawyer's right to privacy in the professional's meeting scenario. Based on the power afforded to the therapist in the therapy setting, Guilfoyle argued that it would be inaccurate to focus only on discursive strategies in an attempt to solve the power imbalance in the therapeutic relationship. An attempt to do so might further increase the visibility and justification for therapy as a dominant institution, making it more difficult to imagine alternative ways in which to address human misery. Rather than looking solely at discursive strategies in therapy, Guilfoyle argued that materiality (the physical and prescribed space where therapy happens) also influenced which discourses became possible. Without the support of this materiality, the positionings of therapist and client changed. With a change in subject position, the power afforded to them changed as well. The lawyer refusing to expand on his reasons could do so without being contested, whereas the client's judgment of what to share was not to be trusted. Therefore it can be argued, in order to understand what power is afforded to therapists and client, the wider web of discourses surrounding the therapeutic relationship needs to be considered. Guilfoyle does not inform the reader how the eight therapists were selected, their background, level of expertise or the therapy model used in either the scenarios or by the therapists, limiting the generalizability of the findings.

Discussion

Based on the above studies, it seems little empirical research is aimed at investigating power in the therapeutic relationship. Additionally, four out of the seven postmodern papers were written by Guilfoyle, suggesting a lack of breadth of research on the topic.

Rennie (1994) and Reandeau and Wampold (1991)'s modernist studies provide useful information about the ways in which structural power differences impact on the therapeutic relationship. This avenue of investigating power could be useful for identifying further clinical implications. The drawback might be the elusiveness of power as a concept and the dangers of creating an illusion that the use of power in therapy can be controlled or pre-empted. A modernist stance might search for a 'truth' about power through quantification and measurements. It is questionable whether a concept that seems to avoid attention can be so easily captured.

The papers investigating power from a postmodern perspective provided interesting examples of how to identify power dynamics within therapy, but could have benefitted from including more data analysis from naturally occurring text. Several of the papers offered at least partly fictitious or role-played text. Conceptually intricate and varied, the postmodern papers were at times difficult to digest. However, the resulting portrayal of power in the therapeutic relationship was broad, flexible and encompassing. For instance, one paper included structural power as an influence on the overall web of power present in and around the therapeutic relationship. This broad conceptualisation of power might lead to higher reactivity to power-dynamics in therapy. By actively investigating with the client how the power differences are created, the differences need not be eliminated, only acknowledged and kept in mind.

Where the modernist approach to power offers a measurable procedure for investigating power in the therapeutic relationship, postmodernist approaches to studying power seem to ask questions about the process of power, of how it works in therapy. Questions posed from a modernist stance seem to operationalise and quantify power, figuring out a structure of its impact on therapeutic outcome. The method of studying power then, will change depending on the research questions being posed, and how power is defined.

Both modernist and postmodernist perspectives of power offer potentially rich avenues to expand knowledge about both structural and post-structural power dynamics. However, more empirical studies appear to be needed to expand on this knowledge base for practical purposes of informing the therapeutic profession. A majority of the research discussed above failed to include an empirical element, focusing on conceptual discussions of power. Although conceptual discussions are important and necessary to ground further research, empirical research should not be overlooked.

Implications for Clinical Psychology

In answer to the initial review questions posed, this review appears to have highlighted the elusiveness of power in the therapeutic relationship. Given that clinical psychologists will draw on several therapeutic approaches in the course of their careers, most therapeutic modalities are relevant when discussing power issues. Consequently, it would seem likely that clinical psychologists adopt the theories of power that lie implicitly within the philosophical background of each approach. For instance, with CBT, its modernist foundations would indicate a structural conception of power, theoretically leaving the clinical psychologist with restricted options of how to address the issue. Were CBT to decide that the issue of power was important enough to merit research and change to practice, it is not unlikely that the compulsion to stay in a modernist paradigm would lead to a plethora of outcome based studies resulting in direct guidelines on how to structure the power-relationship effectively. Clinical psychologists are however able to borrow and integrate principles from several approaches at once depending on the needs of the client. Hence an eclectic approach can also be taken to the concept of power. Unfortunately, it is widely accepted that the currently dominant discourse is that of modernism, in spite of a continued commentary from postmodern approaches. This dominance impacts not just how clinical

psychologists are asked to do their practice, but also the 'default' style of thinking about power in its broader sense.

There is an opportunity for clinical psychology to apply different models of power in a flexible way. The challenge lies in identifying situations and practices where dominant discourses impact on the power dynamics of patient-therapist, making these discourses visible, and finding ways of increasing opportunities for resistance to take place in a Foucauldian sense of the word resistance. The research on the topic of power in the therapeutic relationship includes numerous references to Foucault and discussion of how viewing power as fluid, productive and positive may benefit our approach as therapists to the therapeutic encounter, thereby benefiting the client.

Implications for Research and Practice

Based on the scarce research on power in the therapeutic relationship above, it might be beneficial to further study or survey instances and ways in which clients and therapists perceive the difference in structural power as part of the therapeutic relationship.

With regard to postmodernist research, due to the encompassing nature of Foucault's writing, and his own reluctance to develop a postmodern 'method', some of the research articles discussed above which did not follow a clear methodology, could easily appear to be opinion pieces. They do however clearly outline the theory of postmodern enquiry, which in the case of Foucault seems to merge with the method. Discourse analysis as a method of research has also been codified and presented as a set of procedures including quality criteria (Parker, 1992; Willig, 2008). The offers of illustrative actual therapeutic scenarios and transcripts were however useful when trying to follow the authors' analysis. Further identification of broader discourses affecting power in the therapeutic relationship would be useful. Discourse analysis can inform therapy through focusing on broader social structures,

practices and power relations (Spong, 2010). Dominant discourses are most likely re-created

and strengthened through multiple parts of society as claimed by Foucault. Further

identifying how discourses favouring and maintaining institutional power of the therapist

might create new avenues where joint resistance can take place. Analysis of therapeutic

facilities, government documents, the reporting of news stories, popular movies, professional

publications and guidelines are all potential sources of the creation and maintenance of

discourses.

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Section B

The Social Construction of Service Users and Clinical Psychologists in Clinical

Psychology Forum Articles:

A Foucauldian Discourse Analysis

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APPENDICES

Abstract

Background

Power issues in the relationship between service users and clinical psychologists have received little attention from a postmodern perspective. The recovery approach and the scientist-practitioner model creates an argument for investigating power dynamics in academic and practical disseminations.

Aims

This study aimed to investigate the social construction of service users and clinical psychologists in articles.

Method

Twelve articles and opinion pieces written by clinical psychologists and service users were sampled from publications of a widely disseminated UK clinical psychology practitioner magazine. A Foucauldian Discourse Analytic method was used to identify dominant discourses and alternative discourses.

Results

The analysis identified dominant economic, technical-rational and expert discourses as constructing service users and clinical psychologists. Alternative discourses identified were expert by experience, caring, and recovery.

Conclusions

Analysis of sampled articles found variations in availability of discourse and subjectivity. Dominant societal discourses were reproduced and strengthened. A need for clinical psychologists to make conscious choices in practice is suggested. The context of writing for the selected practice magazine likely influenced discourses that were readily available to be drawn upon, thereby tending to reproduce more dominant discourses. The

APPENDICES

study highlighted the negotiation of dynamic power relations taking place by service users

and clinical psychologists in written dissemination.

Keywords: Power, service users, clinical psychologists, Foucauldian Discourse Analysis,

discourses.

Clinical Psychology and Power

To date, little research has investigated power issues in the relationship between service users and clinical psychologists (Kuyken, 1999; Oddli & Ronnestad, 2011; Proctor, 2003). This might seem incongruous considering the Health and Care Professions Council's (HCPC) standards of proficiency for practitioner psychologists states clinical psychologists must "understand the power imbalance between practitioners and clients and how this can be managed appropriately" (2012, p. 6). A limited evidence base of how "power imbalance" (ibid) is created, maintained and managed could limit clinical psychologists' ability to adhere to such a standard. Further, guidance from The British Psychological Society (2001; 2008) highlights the importance of working within the reflective practice model for personal and professional development. Lastly, the reflective practice model (Lavender, 2003) is included in training criteria for UK professional accreditation, alluding to power issues by advising reflection on the impact clinical psychologists have on others (ibid). The present study aimed to investigate whether approaching the issue of power from a post-structural viewpoint might add to the current knowledge base on power between service users and clinical psychologists.

Service User Empowerment and Personal Recovery

During the last five decades, a social movement of service users, mental health system 'survivors' and working professionals in the mental health field have been working towards more empowerment of service users as active agents in their recovery journey (Lakeman, Cook, McGowan & Walsh, 2007). Further, best practice guidelines advocate working within a recovery approach (National Institute for Mental Health in England [NIMHE], 2004; 2005), in which service users are viewed as active participants in their own recovery journey rather than passive recipients of medical treatment. This journey is personal to each individual (Anthony, 1993; Slade, 2009).

APPENDICES

The appearance of the recovery approach ethos and its implications for practice is a hitherto unconsidered area. Given that clinical psychologists train to work in a scientist-practitioner model (Shapiro, 2002), there is an argument for scrutinising language used in articles read by clinical psychologists.

Perkins and Slade (2012) argued that all professionalism can be problematic in mental health services. As it privileges the professional's knowledge above that of the service user regarding what will help, it is reasonable to consider that the service user holds 'expertise by experience' and deep self-knowledge that has often been overlooked by professionals. As Trivedi and Wykes (2002) highlighted, 'insight' usually means accepting a professional's explanation over personal understanding. Whilst clinical psychologists often highlight the collaborative stance taken in practice (Westbrook, Kennerley & Kirk, 2011), it is argued the profession tends to accept medical diagnostic categories rather than promoting more nuancy to understanding people's difficulties (Bentall, 2004). There is increasing evidence of their limited reliability and harmful social consequences (Bentall, 2012; Link, Cullen, Struening, Shrout & Dohrenwend, 1989). The above arguments highlight the need to evaluate our own practice and avoid complacency.

Post-structural Theory of Power

Danziger (1994) illustrated how psychological research moved from considering the subject as active agent to passive participant during the 20th century as psychology sought scientific status. Whilst this status is not necessarily problematic, it entails alignment with structural, unidirectional theories of power, which sees power as oppressive and limiting but also as a fixed, 'true' object to be possessed (Proctor, 2002). In this view, acknowledging imbalances or differences in power between service user and clinical psychologist might be seen as acknowledging clinical psychology practice as oppressive because it assumes clinical

psychologists have more power over service users. Foucault theorised differently on the relations of power. Avoiding concretising the concept of power, he analysed how relations of power are exercised through multiple social practices and institutions (Foucault, 1980), exemplifying the productivity and fluidity of power.

An example of Foucault's discourse analysis is his argument that individuals afflicted by 'madness' started to represent 'unreason' for the first time during the Enlightenment when it was feared as an antithesis of reason (Foucault, 1967). He argued this fear of madness has persisted into the modern day in 'pseudo-medical perspectives' which help to externalise the feared parts of ourselves into others. Further, Foucault argued this construction of madness is perpetuated by a web of social practices in both institutions and everyday interactions, focusing on illness and cure (Foucault, 2006). Arguably then, it is only by becoming aware of the enactment of power relations in talk and text, as forms of social action, that we can fully understand the power dynamics thus enacted or question taken-for-granted assumptions about social positions and power (ibid).

Foucauldian Discourse Analyses of Disseminated Material

Some social research has used Foucault's writings on power to investigate power relations in published material. Peers (2012) analysed journal articles, book chapters and historical analyses, indicating that discourses on rehabilitation, "freak-show", and mainstream sport colluded to create and maintain an unequal relationship of power wherefrom to experience disability. Using Foucauldian Discourse Analysis, Hui and Stickley (2007) examined literature and policies, exploring the concept of mental health service user involvement in mental health nursing policy and practice, finding differences in discourses used by service users and the government. Lastly, Hollin and Larkin (2011) analysed a governmental green paper called 'Care Matters' and social worker discussions about foster-

placement breakdowns, suggesting that the government paper constructed foster carers as professionals rather than parental figures. It was argued a professional discourse positioned foster parents in conflict with the attachment discourse foster-placements were built around, potentially confusing foster-parents about their remits as to how to be parental figures for their foster-children. To date there is no available research analysing written dissemination and discussion of research and practice within the clinical psychology profession.

Rationale for the Present Study

By making use of Foucauldian Discourse Analysis to analyse text representing dissemination and discussion of practice within clinical psychology, one might illuminate assumptions clinical psychologists might unknowingly take- for -granted, and discover new 'ways of being' for both professionals and service users. A more creative space for mental health research and practice might result, where increased awareness of dominant discourses and less available alternative discourses might increase ability to make 'conscious/informed choices' of how to position oneself and others in practices such as academic disseminations, therapeutic conversations, professional conversations, policy meetings and in meetings with commissioners. Identifying discourses available to authors of research or practice-related articles might add to our understanding of power relations that can be both intentionally and unintentionally enacted by talk and text in the service user – clinical psychologist relationship.

Research Questions

1.   How are service users and clinical psychologists socially constructed in a sample of research articles and opinion pieces read by clinical psychologists?

2.   Which institutions and power relations are strengthened and subverted by the discourses in use?

Methodology

Foucauldian Discourse Analysis

Foucauldian Discourse Analysis shares its epistemological position with other discourse analytic approaches in that 'knowledge' and 'truth' are created and sustained by social processes, assuming a social constructionist epistemological position.

Consequently, the direction of explanations or descriptions about the world becomes a type of social action, dependent on historical, social and cultural assumptions that are currently in use (Gergen, 1985). With social constructionism, "the explanatory locus of human action shifts from the interior region of the mind to the processes and structure of human interaction" (Gergen, 1985, p. 269).

Discourses are defined as "sets of statements that construct objects and an array of subject positions" (Parker, 1992, p. 5). Foucault argued that some discourses are more available than others in society, and that this has consequences for people within that society, in the sense of a 'discursive economy' (Willig, 2008, p. 112). Having more discourses available affords the person more power and choice.

Foucauldian Discourse Analysis identifies wider socially dominant discourses, and facilitates analysis of how these discourses position the various discursive objects in the text. By doing so, Foucauldian Discourse Analysis aims to make available understandings of how power relations play a central role in our everyday lives (Parker, 1992, p. 5). The everyday life in question is that of articles read in a practitioner journal – arguably part of the everyday life of many clinical psychologists and likely to challenge or reinforce extant discourses.

APPENDICES

Design

This was a qualitative design collecting and analysing data from published research articles and opinion pieces from a practitioner journal. Contributions to the Clinical Psychology Forum focus on research and practice issues related to clinical psychology. After initial sampling and preliminary analysis of five articles, a discriminate sampling of seven additional articles focused on including text produced by service users and other authors that might exemplify a greater diversity or contrast in use of discourses. Sampling in discourse analysis, as with other qualitative approaches, seeks diversity rather than representativeness to ensure that important variations are captured (Mays & Pope, 2000).

Sample

Inclusion and exclusion criteria. Articles from Clinical Psychology Forum between 2011-2014 with references to service users and/or clinical psychologists were included in the sample. An initial sample of five articles was randomly drawn from the population sample. An additional seven articles / opinion pieces were purposively sampled to include service users as authors. Articles not mentioning service users or clinical psychologists were excluded to avoid influencing the analysis. Articles written by authors personally known to the researcher were excluded to avoid influencing the analysis.

Sample characteristics. Twelve articles were included in the study as detailed in Table 1. Six were research articles, two of which included service user participation in the write-up. Six of the articles were opinion pieces, one of which was written by a clinical psychologist and five by service users.

Sampling Rationale

It was decided to sample from only one publication. A clearer answer to the research questions could be provided by focusing on one particular section of the 'web' of social

practices, as explained by Foucault (2006). The Clinical Psychology Forum constituted a

section of the web written largely by and for clinical psychologists, and therefore likely to

contain discourses shared by clinical psychologists. Sampling other journals was considered,

but no obvious selection criteria were easily identified. The research questions did not aim to

map discourses related to service users and clinical psychologists more broadly (i.e. the

whole web of discourses constituting the social construction of clinical psychologists and

service users). Rather, this particular research concerned the discourses in use in clinical

psychology articles read by practitioners. From within the population defined as the Clinical

Psychology Forum, given the recent increase in articles written by service users, diversity

within the sample was ensured by selecting written submissions by both clinical

psychologists and service users. However, the research focus was not on whether different or

similar discourses might be evident in articles with sole service user authors or contributors

compared to those authored by clinical psychologists, and indeed the discourses that could be

drawn upon would be influenced by the positioning of the authors by and to Forum. This

possible 'pre-positioning' (before any writing is submitted) will be reflected upon in both the

Results and Discussion. Due to Forum containing both research articles and opinion pieces it

seemed important to sample both types of articles.

APPENDICES

Table 1

Sampled Articles for Analysis

Number	Topic	Year	Author	Author status	Type of Paper
1	Assessing need	2011	Thew, Dyson, Chafer & Frizelle	Clinical psychologists	Research article
2	Service development in psychosis service	2011	Raune & Law	Clinical psychologists	Research article
3	Home treatment and carers	2012	Cosham, Johnstone, Openshaw & Gilligan	Service user and clinical psychologists	Research article
4	Long-term conditions and IAPT	2012	Hawkes, Ruddle & Freeman	Clinical psychologists	Research article
5	Families -Service user feedback	2012	Graham, Evans, Chivers	Clinical psychologists	Research article
6	Service users within the Division of Clinical Psychology	2013	Riddell	Service user	Opinion piece
7	Service user involvement	2013	Clarke	Service user	Opinion piece
8	Critical psychology manifesto	2014	Riddell	Service user	Opinion piece
9	Service user involvement	2014	Hemmingfield	Service user	Opinion piece
10	Service user involvement	2014	Mudie	Service user	Opinion piece
11	IAPT critique	2014	Pilgrim	Clinical psychologist	Opinion piece
12	Solution focused therapy for tinnitus	2014	Bray, Kay & Bold	Service user and clinical psychologists	Research article

Quality Assurance

The quality assurance standards used in this paper were those stipulated by Mays and Pope (2000).

Reflexivity: An early bracketing interview (Ahern, 1999; Rolls & Relf, 2006) identified some of the researcher's assumptions and expectations of the research. These assumptions were kept in mind throughout, along with continuous challenging of interpretations during supervision.

Personal position: What brought me to this work was a belief in a power imbalance between service users and mental health professionals. I believed understanding more about this power imbalance would further enable me approach my work in an ethically viable manner (See Appendix B).

Audit: One supervisor read through one of the articles, and came up with similar thoughts on the discourses in use. The findings were discussed regularly in supervision as the discourses reached saturation.

Grounding in examples: Illustrative quotations are included as part of the results section.

Ethical Considerations

As the articles were already public, no ethical approval was needed. An Ethics Review Checklist (Appendix C) was completed and approved by Canterbury Christ Church University's Research Governance Manager, as shown by a letter of confirmation (See Appendix D).

APPENDICES

Analysis of an article could be unsettling for originating authors in spite of choosing to publish. However, Foucault rethought the idea of authorship. Instead of seeing the author function as the creative force behind the text, Foucault explained that the author does not generate discourses. Instead, wider social discourses generate subjects (like authors), and these discourses influence what possible subject-positions the author can adopt within the text (Foucault, 1977). The discussion will also consider this.

Analysis of Data

The researcher read each article at least twice, familiarising with the content. Appendix E provides a sample article with notations. The analysis focused on service users and clinical psychologists as the discursive objects following Willig's six steps (2008): Discursive constructions, Discourses, Action Orientation, Positionings, Practice and Subjectivity. Appendix F contains a table illustrating the above steps. Particular attention was paid to the presence and non-presence of wider social discourses, alternative discourses, and how identified discourses positioned service users and clinical psychologists. Discursive acts were identified, especially considering the context of the publication being analysed. A second analysis stage was added, applying the last three steps of Parker's guidance on Foucauldian Discourse Analysis to the main discourses identified. This was to ensure inclusion of Foucault's emphasis on how discourses reproduce power relations and supports institutions (Parker, 1992).

Although data were primarily interpreted by the researcher, second readings of the material by supervisors followed by discussions led to some modifications of the overall interpretation. However, there is no claim to an objective single 'truth' being discovered through the analysis. It is rather one type of reality as seen by the researcher and supervisors.

It is hoped sufficient quotations are included, allowing readers to test the reading themselves. The original articles are in the public domain.

Results

Overview

Three major dominant discourses were identified in the texts. Each major discourse will be described separately, with illustrative extracts from the texts. Although the analysis followed Willig's six steps (2008), this section reports only those findings that were most relevant in answering the research questions. The numbers (e.g. 1, p. 12) following the quotations indicate the article as numbered in Table 1, and the page number(s) the quote was taken from.

An Economic Discourse

Definition. The first discourse concerns emphasis on financial reasons for performing research and decision-making for provision of mental health services. This includes implied or overt cost-benefit reasoning such as reducing workload, hastening recovery and treating more people. This is illustrated below.

> One role, which is thought to be cost-effective (Wykes et al., 2008) as it may reach the largest number of clients, is group Cognitive Behaviour Therapy (G-CBT)…..A pilot three-session psycho-education group (N= 20, across five groups) and a pilot five-session Anxiety and Sadness group (N=9, across two groups) has recently been run and completed by the assistant psychologist. This has freed the qualified clinical psychologist to plan G-CBT for other problems. (2, p. 24 and 27).

The above quote constructs clinical psychologists as a financial commodity or resource needing to be used efficiently and which is stretched, not meeting everybody's needs, as the psychologist was 'freed' by the assistant psychologist. It also constructs service users as customers of a service.

> Psychological treatment, when offered at all, given the paucity of psychologists and appropriately trained staff in audiology services, is frequently cognitive behavioural therapy-based (CBT-based), as exemplified in the works of Laurence McKenna and colleagues (e.g. McKenna, Baguley & McFarran, 2010). (12, p. 32).

The above quote draws attention to the 'paucity' of psychologists in the service, implying that there is a lack of resources.

> Long-term conditions (LTCs) are affecting increasing numbers, causing considerable costs to the individual and NHS. The benefits of psychological intervention have been demonstrated, and the need to develop services is vital.......The cost to the NHS is also considerable, accounting for approximately 50 per cent and 75 per cent of GP consultations and inpatient stays respectively (4, p. 16).

Here, the cost of service users to the NHS is pointed out along with the introduction of psychology intervention as a proven method of improving long term conditions. Service users

and clinical psychologists are positioned as pieces in an economic discourse where the goal is to minimise cost.

> This is particularly important in times when the austerity measures in the NHS in England have been a threat to clinical psychology services. Clinical psychology is seen as expensive and psychology is sometimes perceived as something that anyone who has flicked through Atkinson and Hilgard (1975) can provide (9, p. 9).

In the above quote, clinical psychology is talked about in the context of the current economy, as expensive and under assessment of its financial value.

> What is rarely understood is the long-term benefit of building a strong working relationship with carers now in order to reduce the workload in the long-term. Our involvement with these professionals guarantees a speedier recovery of the client, which is an outcome we can all be proud of (3, p. 22).

In the quote above, service users are discoursed as costly, and clinical psychologists are discoursed as part of the solution. An economic discourse is used in order to justify the importance of service users and carers and mental health professionals working together. The first three quotes (appearing in articles written by clinical psychologists) illustrate the economic discourse with references to: cost-effectiveness; a lack of adequate numbers of psychologists; and the costs the service user poses to the NHS. This discourse constructs a

reality lacking in financial resources, which can only be fixed by falling in line with government guidelines of efficiency. Efficiency is seen as 'sacred' and not challenged. Psychologists must work efficiently to maximise output compared to input. In quote four, the service user is constructed as a financial burden to society, thereby linked to the economic discourse as a financial problem to be solved.

The fourth and fifth quotes above were written by service users, and construct a financial threat to the funding for clinical psychologist work, also linking 'improvement' of service users to financial efficiency.

Power relations and subjective positions given rise to by this discourse. Through the economic discourse, clinical psychologists are aligned with 'higher powers' such as the government, commissioners and budget-holders. Those psychologists and services that are able to work efficiently will be paid by results (Department of Health, 2012), as befits the underlying competitiveness of the economic model, thereby retaining power. Achievement is measured in numbers/clients.

As well as aligning with the economic discourse, service users and carers in the above quotes are discoursed as in alignment with clinical psychologists, joining in a supposed goal of creating efficiency and value for money. This is quite likely related to the context of the publication (Clinical Psychology Forum), and might therefore be seen as a discursive act on behalf of the authors. Authors with either background might experience limited options of what types of discursive acts they can easily perform within this authoring context. It might be assumed that if what was being said was overly critical or oppositional to clinical psychology, the opinion piece or research article might not have been published, or might be heavily criticised. Also, the dominance of the economic discourse may render it difficult to discuss social relations between service users, carers and clinical psychologists without

drawing on it. The economic discourse, however, also opens up a way of seeing the world where service users and carers are positioned as useful to the profession, thereby acquiring more power and status.

Limitations and alternative discourses. One service user written article made use of a caring discourse less prominent in other articles. This article responded to a recent manifesto by a critical psychology group advocating for less adherence to a medical model of mental health treatment. Below are some quotes from the article illustrating a caring discourse.

> At the same time, I was assigned a new psychiatrist who was warm, caring and honest. By warm and caring, I mean she seemed to genuinely care about me. It was the combination of receiving genuine and caring warmth that did the trick (8, p. 10).

In the above quote the word care is used four times and linked to recovery for the service user. The service user is discoursed as an individual having a caring relationship with a mental health professional. The mental health professional (psychiatrist), despite the portrayal of an individual psychiatrist as a caring individual, is discoursed as follows:

> It surprises me that the profession of clinical psychology is still in thrall to psychiatry, yet clinical psychology is capable of offering a more holistic, caring and person-centred approach to our distress (8, p. 10).

This quote constructs clinical psychologists as having the power to influence the care provided to service users but being hampered by their inferior social position compared to psychiatry. It positions service users as spectators of the relationship between psychiatry and clinical psychology.

The caring discourse appears mostly in service user contributions rather than clinical psychologists'. Approaches to a caring discourse in articles written by clinical psychologists contain references to either improvement in technique or superior efficiency and outcomes achievable through approaching service users' problems in a certain way. It seems the economic discourse positions the clinical psychologist with little space to express caring towards service users other than an efficient mechanism of change. Discoursing caring as technique affords clinical psychologists the right to align themselves with the powers that be, reclaiming a more powerful professional status than purely caring for others might offer. Wider societal discourses often devalue the activity of caring (Daykin & Clarke, 2000). Connecting caring to other more valued discourses constructs a reality where caring is given a price-tag. Again, the context of a professional publication can be expected to influence how it is written. The use of a caring discourse as an alternative to the economic discourse seems to represent an ideological dilemma of how clinical psychology approaches its task of working with service users. The economic discourse constructs both clinical psychologists and service users as numbers in a financial puzzle that need to be balanced out, whereas the caring discourse constructs both as humans that benefit from care and shared emotions.

A Technical-Rational Discourse

Definition. The second discourse capitalises on the privileged position positivist science is given (Danziger, 1994; Lavender, 2003), with its extended technical procedures that in turn are related to service users. Talk of evidence-bases tends to assume validity in

using numbers and quantification to rationalise approaches to care. Categories are used

describing the service user and manualised procedures are set in place to regulate and control

delivery of care instead of relying on reflective practice for decision-making. Technical

rationality was first defined by Schön (1987).

> Monitoring procedures within CAMHS- the CAMHS Outcome Research Consortium
>
> (CORC) is a collaboration between CAMHS services in England aiming for a
>
> common model of routine service outcome evaluation….Measures are taken from
>
> three key perspectives: the child, the parent/carer and the practitioner. Data from
>
> CORC is analysed centrally in order to evaluate treatment outcome…….An
>
> information sheet had been given to clients at the initial appointment informing
>
> them that their anonymous data could be used for research purposes (5, p. 13-14).

Here, service users are constructed as having predictable, measurable features and

experiences. Service users are constructed as anonymous numbers to be entered into the

machine. Clinical psychologists are not mentioned and seem superfluous to the process,

thereby positioned as bystanders without a say.

> There is a good evidence base for the use of cognitive behavioural therapy (CBT) in
>
> managing numerous conditions such as chronic pain and diabetes (e.g. Morley,
>
> Eccleston & Williams, 1999; Norris, Engelgau & Narayan, 2001) (4, p. 17).

Clinical psychologists are constructed as scientist-practitioners relying on mostly positivist science when approaching chronic pain. Service users are positioned as containers for conditions rather than individual people.

> The ILG has been using this interim period as an opportunity to examine previous work and activity, and explore what parts of that may best be carried forward to mirror and serve the DCP Executive's Strategic Objectives, and our own, below:…The group [Interim Leadership Group (ILG) of the Service User and Carer Group of the Division of Clinical Psychology (DCP)] has worked hard to define its form and function, describing it in the form of a concrete proposal laid before existing DCP member networks and the Executive at the Representative Assembly in York…….Although most of how DCP members work, certainly in terms of therapies, is heavily influenced or dictated by National Institute for Health and Care Excellence (NICE).. (10, p. 50)

> It is the end user of services – the person – who deserves to be put in the centre of their care. In the DCP, members are fortunate enough to have a formal structure that, through giving service users and carers a platform, is helping to do this (6, p. 48).

In the quote(s) above, service users are constructed as needing to adopt a certain language and membership in the DCP to communicate with clinical psychologists through a formal process. Clinical psychologists are positioned as following procedures for delivering services.

The Technical-rational discourse appeared in all articles irrespective of how authors identified themselves in terms of practitioner, service user or carer. References are made to

systems of scientific, methodical procedures professing quality assurance as defined by the same positivistic assumption: Objects of concern can be measured and operationalized.

Power relations and subject positions given rise to by this discourse. By having access to a scientific-rational discourse and knowledge of how science is put into practice, clinical psychologists and the profession are positioned as having social power; Power to tell service users what their difficulties are and how their problems change/improve according to their scores on psychological inventories etc. From a professional context, it is believed that the 'true' way to categorise and measure service users and deliver services can be found with rigorous adherence to a scientific approach. This discourse might position clinical psychologists in conflict with their ability to provide individual formulations, service user engagement and consideration of the individual's wider context. In this regard, power is taken away from the clinical psychology profession. This discourse depersonalises, constructing the service user as research object to be figured out, rather than people to make relationships with. It also depersonalises the psychologist, who becomes a recording instrument and operator of mechanisms. Such a discourse might limit the possible expectations service users may have of their care. Receiving emotional support and care through human connections becomes a less likely way-of-being as a service user. Service users may gain some social power by aligning with this discourse, but only within a "formal structure". This both facilitates and limits social power: the discourses available within this context and through writing for a practitioner journal seem constrained. Even placing service users "at the centre of their care" seems to be something owned by "members" of the DCP who bestow a "platform" to service users, which otherwise would not exist.

APPENDICES

Limitations and alternative discourses. An alternative discourse to the technical-rational discourse referred to a recovery discourse of mental illness as personal rather than scientific.

My own recovery from 'mental illness' began when I realised I needed to focus on getting better…But what really kick-started my recovery was joining Alcoholics Anonymous, which I quickly realised had other benefits for me (i.e. structure, acceptance and warmth from others who had similar difficulties) (8, p. 10).

The quote above exemplifies a focus on individual, personal routes to recovery and a service user collective, rather than a trajectory following best-evidence treatment models. The person refers to service users finding their own way to deal with mental illness, which in the quote included finding support in unexpected organisations, such as Alcoholics Anonymous.

The design of Care and Treatment Planning (CTP) similar to the Care Programme Approach (CPA) was contracted out to Lincoln University, who worked tirelessly with all statutory bodies and the Third Sector to produce a document which has the concepts of Recovery and Patient-centred Care explicitly displayed throughout (like a stick of rock!). Outside of the DCP, but heavily informing its work, I have worked extensively on the creation of the CTP, and its subsequent, legally prescribed delivery of training to all staff (10, pp. 50-51).

The quote above extracted from an article written by a service user seems to encompass both a techno-rational and a recovery discourse. How the recovery approach is being discoursed suggests that it is being conventionalised to become part of a mechanistic application. Whilst it is likely that staff training and activity is more person-centred and recovery-orientated, the work is discoursed in Clinical Psychology Forum in a way that gains social position for the recovery discourse by aligning it with a more powerful discourse. None of the activities written about will exactly mirror how they are discoursed in a journal, but to the extent that widely disseminated journal writing helps reproduce dominant discourses, they are likely to have social influence.

The two alternative discourses around recovery shown in the quotes above also position the service user at a distance from the technical-rational discourse, allowing more choice in how to act and be in an environment where the technical-rational discourse is dominant. The recovery discourse might potentially increase power for service users as the discourse emphasises refusal to specify a certain approach or process to expect for individual recovery from mental health problems. Additionally, it might place more responsibility on service users to take an active part in their treatment. Such an increase of agency for service users might again impact positively on the wider stigmatising discourse of mental illness being akin to madness and lack of reason. The second quote however illustrates how service users might become part-contributors to the technical-rational discourse in the process of promoting recovery. The recovery model is made legally prescribed in order to be implemented into practice. This could be a reflection of Forum context rather than what happened in the setting described, but that is unknown.

APPENDICES

An Expert Discourse

Definition. The third discourse concerns the claims to ownership of knowledge and expertise that is somehow 'better' than other knowledge. Certain types of knowledges are legitimised as 'truer' than others by professional monopolies and pre-existing rules of how knowledge should be established.

Locally at Intree, the impact of psychological interventions are maximised by being part of a 'patient pathway', wherein all patients are first screened by audiologists. Audiologists are themselves empowered to work psychologically, having received some psychological training (in SF and CBT) and being in receipt of ongoing supervision from the clinical psychologist (12, p. 35).

They [CBT-groups] are facilitated by two members of staff (pre-dominantly psychology assistants or IAPT-trained Low Intensity Practitioners), who receive regular training and consultation from the service's clinical psychologist who specialises in physical health. Professionals from other disciplines (e.g. physiotherapy, nursing, dietetics) also provide input on some of the courses, disseminating their specialist knowledge (4, p. 17).

In the above quotes, clinical psychologists are constructed as experts with knowledge that can be only partially taught to other professional groups. The use of "empowerment" of audiologists by providing psychological knowledge illustrates a literal example of the link between knowledge and power relations.

Measures used were the Hospital Anxiety and Depression Scale (HADS; Zigmond &

Snaith, 1983), Brief Illness Perceptions Questionnaire (BOPQ; Broadbent et al.,

2006), Self-Efficacy for Managing Chronic Disease Scale (SEMCDS; Lorig et al.,

2001), Multidimensional Scale of Perceived Social Support (MSOSS; Zimet et al.,

1988), and the Brief COPE (Carver, 1997) (12, p. 30).

In the above quote, clinical psychologists are constructed as experts using specific measures

only they know how to use. Service users are positioned as containers of illness symptoms,

who can be figured out by the experts' administrations.

National guidelines recommend the provision of 'psychological and emotional

support' to patients recovering from cardiac events (NSF Coronary Heart Disease,

2000; NICE: Specifying a cardiac rehabilitation service, 2009; NICE CG48, 2007) (1,

p. 29).

In the above quote, the use of national guidelines constructs clinical psychologists as experts

who rely on best evidence for how to deliver services.

Power relations and subjective positions given rise to by this discourse. Through

the expert discourse, clinical psychologists are positioned as best placed to help service users

with their mental health needs, and best placed to know what would be the best approach. By

being experts, clinical psychologists are more likely to be listened to and their opinions are more likely to be accepted as 'right' by other powerful social groups, enabling them to speak with confidence about psychological issues. It also allows them to speak on behalf of service users. Service users are positioned as less knowledgeable and less able to make decisions about their care than clinical psychologists, becoming passive agents in their care

Limitations and alternative discourses. Clinical psychologists were discoursed as experts, but contradictions to the expert status were evident when clinical psychologists wrote about working within a person-centred and recovery-led approach. Being an expert at the same time as letting the service user lead could be argued to stand in opposition to each other. This contradiction might indicate a dilemma between the professional role of being an expert and the recovery discourse. An alternative discourse as shown in the quotes below was experts by experience.

> I am not a psychologist. Instead my response is from the perspective of one who has experienced mental distress/psychological distress/mental illness – whatever you want to call it. Consequently, I have been a psychiatric patient (or 'accessed secondary mental health services' as I have learned to call it), service user, person with lived experience (any of those terms fit) for most of my life (8, p. 8).

In the above quote, the service user is discoursed as possessing a unique knowledge and experience which is different from that of the psychologist.

> Person-centred care is, rightly I believe, at the top of many agendas at this time, regardless of where health and social care policy is decided. It makes sense therefore,

to work with those who have become experts by their own   experience and to strive to

reach higher standards of care in partnership with those   who know what it feels

like to be on the receiving end of services (7, p. 50).

The above quote constructs service users as useful and knowledgeable contributors to

achieving person-centred care. Service users are discoursed as being experts on their own

lives, regardless of what psychological theories clinical psychologists might be applied to that

person. This alternative discourse could be argued to claim expertise and knowledge in the

same way that clinical psychologists do, thereby falling within the expert discourse. Or, the

personal experience of the service user is not based on pre-existing 'truths' that have a long-

standing and widely claimed superiority in mental health care. It is still a discourse rendered

to be at a lower level of sophistication and trustworthiness by the expert discourse that is

based on scientific principles, for example in the operation of Cochrane reviews and NICE

guidelines. The use of the experts by experience discourse might increase the powers

afforded to service users. By also claiming to be experts, the question of expertise and what

that means is put into focus by all actors. If clinical psychologists accept the expertise of

service users (they already do in several instances), it might lead to more user-led initiatives

in changing services.

Further Analysis

By following Foucault's writings on power (Parker, 1992), this section focuses on an

overall analysis of the process where the six main discourses identified are produced and

reproduced. The use of certain discourses may reinforce some institutions whilst subverting

others.   The deployment of the discursive economy by service users and clinical

psychologists in the context of the Clinical Psychology Forum is examined. The effects and benefits of employing certain discourses over others are considered.

Economic discourse and caring discourse. When the economic discourse guides content in articles, governmental institutions such as budget-holders and commissioners profit in several ways. Firstly, the use of the discourse within a clinical psychologist context reinforces the financial ideology that 'everything comes down to money'. By reinforcing this, the governmental institutions gain power in their relationship with clinical psychologists, to control and influence how mental health services are developed and managed.

At the same time as the economic discourse is strengthened and reproduced within the clinical psychology context, the institution of clinical psychology and the caring discourse are weakened if only by being largely absent or less prominent in the articles. These contrasting discourses open up and close down what can be thought about and done in the work with service users. For clinical psychologists, using the discourse in the Clinical Psychology Forum might serve several purposes. Claiming efficiency and cost-reducing qualities increases the legitimacy of the profession over other professional groups, indirectly emphasising the expertise of the field. Additionally, aligning with financial targets and issues might increase the influential power of what clinical psychologists want to say. In general, use of the economic discourse validates the limited resources allocated to mental health services. This in turn guides budget holders on amount of spending. Service users as a social institution are devalued by the economic discourse, in that they become a financial burden to society rather than people who would welcome help and caring relationships. In turning the service user into a customer of a regular service like a bank customer, efficiency appears to come at the cost of individualisation of care. Clinical psychologists then need not focus on caring for service users, who are positioned as less able to demand a caring, personable approach. The economic discourse focuses on the finite availability of financial resources,

whereas the caring discourse focuses on something immeasurable from a monetary perspective. The use of a caring discourse reintroduces the importance of meaningful personal relationships between clinical psychologists and service users, in an attempt to regain some power in the relationship in question.

Technical-rational discourse and recovery discourse. The technical-rational discourse facilitates social control over both service users and clinical psychologists by dictating monitoring systems and practical procedures (like step-by step manuals) that need to be followed in order to ensure correct delivery of service to the service users. Following a positivist scientific discourse allows institutions like clinical psychology, medical professions and governmental bodies to justify research looking for a 'true' way of categorising and treating service users. In the attempt to do so, the everlasting quest generates a need to remain systematic and treat everybody 'the same' to avoid any 'confounding variables' to upset the experiment of finding the 'one right' way to treat people. Hence, the institutions have a prerogative to implement a network of prescribed, mechanistic procedures that removes focus away from the service user, as discovering and delivering the right procedures become the main goals.

Whilst in some ways benefiting from using this discourse in the Clinical Psychology Forum by legitimising the profession, clinical psychologists could also be seen as untrustworthy, as their work must be founded on procedures and prescribed knowledge. This, might signify distrust in their ability to do their jobs, without external forces guiding and monitoring their work. The effect might be an increasing use of outcome measures, auditing of client contact and generally less flexibility in psychological approaches

One might suggest that service users benefit from clear and scientifically based systems for service delivery, but only with the assumption that they have clearly delimited

disorders with clear treatments and the only need is for these to be delivered. If in fact what troubles service users is something more along social and relational lines, then a purely technical-rational approach may fail them (Cromby, Harper & Reavey, 2013). By using the recovery discourse in the Clinical Psychology Forum service users might benefit from getting a bigger say in what therapy might be right for them. They might also gain rights to expect a closer relationship to their therapist / clinical psychologist. But like psychologists themselves they may also lose power by aligning with a techno-rational discourse.

Expert discourse and expert by experience discourse. Using the expert discourse reinforces, clinical psychology as an institution by positioning clinical psychologists as necessary and in possession of unique knowledge. Service users as an institution become subverted as they are positioned as non-experts, thereby having to defer to the 'better-advised' clinical psychologists. As clinical psychologists arguably align themselves with more powerful professional groups such as the medical profession and the government to gain power (Cheshire & Pilgrim, 2004), these institutions also benefit from the expert status of clinical psychologists. The reproduction of a need to validate people's abilities by assigning expert statuses strengthens the status of those institutions, which already have expert status themselves, and the power to regulate the assigning of expert status to professional groups. By employing the expert discourse in the Clinical Psychology Forum, clinical psychologists benefit by adding weight to their opinions. In terms of social positioning powers, service users may not benefit from clinical psychologists being discoursed as experts if it devalues the experts by experience discourse. Their discursive economy shrinks, in that their experiences as service users have less legitimacy. Using the experts by experience discourse in the Clinical Psychology Forum could be seen to increase the influential power of service users when negotiating their care.

Discussion

This section first considers the influence context might have had on discourses identified in the analysed articles. It then continues by relating the results to the research questions and the literature referred to in the introduction. It then discusses the limitations of the study, followed by the implications for future research and practice. The paper finishes with a summarising conclusion.

The Influence of Context

The type of discourses identified in this study are very likely influenced by the context of publishing, where alignment with 'powerful entities' could be seen as a discursive action to maintain credibility and support for what is being said by individual authors in the Clinical Psychology Forum. This is not necessarily a conscious choice, since many such discursive actions are performed in the context of 'taken-for-granted' notions of important social institutions and imperatives, as seemed to be demonstrated in many of the texts. Although not particularly surprising, this is in itself of interest and potential importance to note and comment on, given that one might expect a practitioner-generated and practitioner-disseminated outlet such as the Clinical Psychology Forum could privilege a more creative and wider-ranging set of ideas. In some ways it does, given the range of opinion-pieces it carries in addition to research articles that follow a more conventional form and content.

That said, a different type of context might have produced entirely different discourses. Service users, in particular, writing in this membership publication might write from a minority position where a need to not stand out or be too critical might have been felt, leading to the uptake of some similar discourses as clinical psychologists. Nevertheless, the identified discourses are there (at least in this reading of the material), and the potential consequences of their use in published material merits some thought. No attempt was made to

provide a 'true' representation of the inner motivations of the individual authors, since Foucauldian discourse analysis is concerned with highlighting 'taken-for-granted' social constructions and the social institutions they produce and reproduce, rather than attempting an objective cause-effect analysis.

Relating the Results to the Research Questions

Question one: How are service users and clinical psychologists socially constructed in a sample of research articles read by clinical psychologists?

Clinical psychologists were constructed as pre-occupied with financial issues and fulfilling externally imposed requirements. The resulting position of less autonomy and a stronger similarity to financial professions might be a difficult position to hold for clinical psychologists, especially considering the blurring that might take place of how the service user is thought about The ways-of-seeing and the ways-of-being in the world made available by the economic and the caring discourse are arguably not compatible. Changes in power relations between these discourses might have potentially large effects on service users, such as being allowed to promote their own opinions more in therapy or in contact with services.

Clinical psychologists were constructed as followers of procedure and owners of procedural experience. They were also constructed as experts in a privileged position of knowing about psychological reality, and as having the means to discover the truth of what the best procedure might be.

Service users were constructed as financial burdens, pieces of the machinery, and non-experts, conflicting with traditional caring discourses. The dominance of the economic discourse might make it difficult for service users to imagine not going through 'the process' as taken for granted by more powerful institutions.   The technical-rational discourse

constructed service users as passive participants in line with Danziger's (1994) argument of how psychological research moved from considering the subject/service user as active to a passive participant during the 20th century. As argued by Lakeman et al. (2007), the expert discourse constructed service users as non-experts waiting and depending on action from clinical psychologists. The counter-discourse of experts by experience introduced in service user led articles constructed service users as experts and as having a specialist knowledge that could only be acquired through experience. This strengthens Perkins and Slade's (2012) argument that expert knowledge by professionals might 'hide' service users' self-knowledge and expertise.

Question two: Which institutions and power relations are strengthened and subverted by the discourses in use?

In relation to research question number one, some of the notable power relations are described below.

Service users and clinical psychologists. The varied constructions of what knowledge and expertise constitute were seen to position service users and clinical psychologists with more or less power and choice in how to be in and how to see the world. Although discourses such as the caring discourse, the recovery discourse and the experts by experience discourse might strengthen the service user institution, dominant discourses in the articles also seemed to reproduce and strengthen the power of clinical psychologists and service users' relative lack of power. As mentioned earlier, dominant discourses are frequently reproduced power manifestations (Foucault, 2006). The challenge for institutions subverted by a discourse (in this case service users) is to avoid voiced alternative discourses being subverted and incorporated into the dominant one. For instance, will clinical psychologists become experts in the process of drawing out service users' expertise (from

experience) as part of treatment? Arguably, these two discourses (clinical psychology experts and experts by experience) might merge, reducing the strength of the madness discourse that is still linked to a split between reason and unreason (Foucault, 1967). As experts by experience claim specialist knowledge, and knowledge is linked to rational and reasoned thinking, the conceptual link between madness and unreason might weaken. Experiencing mental health problems might not elicit negative assumptions about service users' reasoning abilities, as is often the case as discussed by Morrison et al. (2014).

The alternative discourses in the articles appeared to subvert the institution of clinical psychology. Conversely, introducing alternative discourses such as a caring discourse and a recovery discourse might prompt clinical psychologists to re-focus.

Clinical psychologists and 'higher powers'. When an economic discourse was in play, clinical psychologists were constructed as powerful in that they were 'falling in line' with the taken for granted assumptions of the three discourses, such as the financial urgency contained within the economic discourse, the procedural urgency taken for granted in the technical-rational discourse, and the right to ownership of expertise taken for granted in the expert discourse. At the same time, the three discourses would detract from the power held by clinical psychologists by undermining the autonomy and trust in the claimed expertise by those same demands for efficiency, following of procedures and requirements of expertise. All are arguably in subjugation to the higher power of government with its political imperatives for efficiency savings.

Clinical psychologists appeared to be simultaneously strengthened and weakened by the dominant discourses in use. Due to clinical psychologists' adherence to dominant discourses, power seemed afforded to clinical psychology by the government and commissioners, who were simultaneously strengthened by the discourse reproduction.   The

dominant discourses are according to Foucault (2006) a mechanism of social control. Clinical psychology could arguably be seen to secede decision-making to the government and commissioners. At the same time, a clear hierarchy can be seen, where this loss of power grants clinical psychology more power over service users.

Professional and Clinical Implications

This paper suggested that societal discourses available to people and institutions influence the flow of power and availability of subjectivities. The appearance of dominant discourses in articles published in the Clinical Psychology Forum suggests a need to critically reflect on the discourses that are created and reproduced in clinical psychology practice Changing dominant discourses might not be the goal, but awareness of which are used by individuals in clinical or professional settings might help clinical psychologists make informed choices of how to work together with service users. Power is not always oppressive and cannot be given to someone. We can however choose not to take it away.

A practical example might be authoring research articles in the Clinical Psychology Forum taking up alternative discourses identified in this paper. Justifying why an article is written, referring to a caring discourse rather than an economic one might lead to positive changes in content and effect.

Another implication is that the clinical psychology profession seems to have a choice of how to use power and status: The choice of rejecting dominant discourses (thereby losing the power these afford), and/or promoting the alternative discourses mentioned above, affording more power to service users but potentially losing power for clinical psychology. Perhaps there is growing scope for an alliance of power – and hearing more often from service users who become clinical psychologists and clinical psychologists who also have expertise by experience (Shepherd, Boardman & Burns, 2008).

APPENDICES

Clinical psychology might also wish to consider the conflict between dominant discourses portrayed in academic disseminations in this study and the reflective practice role that has been cited as a strength of the profession (Lavender, 2003).

In regards to research implications, future research identifying discourses in other spheres of the service user-clinical psychologist relationship would further map the web of power dynamics.

Limitations

Because the articles are written, it is impossible to see which positions are taken up by service users and professionals reading the articles. We can consider positions offered or created by the articles, and theorise what might happen by clinical psychologists offering these subject positions to their face-to face interactions with service users.

Another limitation is a tendency to present discourses and alternative discourses as opposites in constant conflict, as well as presenting service users and clinical psychologists as separate institutions. A paper with the space to consider these 'groups' as several locations on a continuum would be preferable. On some occasions expert discourses would position both clinical psychologists and service users as experts with the same assumptions of knowledge. On other occasions service users and clinical psychologists would constitute one institution. For instance, many clinical psychologists are also service users. The above limitations were allowed due to space constraints and to exemplify and illustrate the discourses. Another limitation was sampling from one publication instead of a wider pool of publications including service user led ones. This was discussed in the methodology section and at the start of the Discussion section.

APPENDICES

Reflexive critique. In this particular investigation, the researcher was a trainee of the professional group that was being researched (I do not identify as a service user at present). Attempting to understand what being a clinical psychologist might mean during clinical training, my values and perceived expectations of practising a 'neutral' stance might have flavoured my approach to the research topic My own identification with one of the groups being researched and the power differences that I have witnessed in practice might have biased me towards noticing discourses linked to increases or decreases in positions of power whilst doing my analysis. Identifying with the institutional group wielding more power in the context of academic literature might have biased me towards identifying discourses positioning service users with fewer ways of being. As a trainee I might also have identified with service users in a less powerful position, defending myself by becoming more critical of the profession. This 'bias' was already present during the development of the research questions, meaning the research itself was inherently reflecting on clinical psychology.

During the thesis process I realised I was mourning the loss of an NHS that had in my opinion drifted away from a public service ethos to a market-driven one, privatisation and IAPT being key ingredients in this change. This might have sensitised me to related discourses in my interpretation. Hopefully careful reading and re-reading of the text, checking I did not miss important discourses limited such a transfer. Discussions in supervision sessions considered other possible readings. Quotes shown in the results section hopefully illustrate the presence of the identified discourses.

Considering the findings of this study, I wonder how much thought I gave to positions afforded to clinical psychologists as opposed to service users. There is an inherent conflict of interest where I did not want to research myself out of a job/profession/position of power. I wonder would the paper be written differently by service users.

Conclusion

When a Foucauldian discourse analytic method was applied to a sample of articles published in the Clinical Psychology Forum, three dominant discourses emerged. These concerned a societal emphasis on economics, the technical and rational base of mental health services, and the importance of expert knowledge. Whilst more research is needed, this study highlighted the presence of power dynamics in the service user- clinical psychologist relationship in a sample of articles in one academic and practical dissemination. Similar or connected power dynamics may be present in other parts of the wider web of social practices surrounding this particular relationship. This might prompt useful reflection within the profession about our taken-for-granted discourses and the extent to which, in reproducing them in different contexts, we reproduce sometimes unhelpful power dynamics.

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Appendices

Appendix A: Literature Search Terms

Term	Synonyms
Patient	Service user, client, participant, subject
Professional	Psychologist, clinical psychologist, therapist, mental health professional,
Power	Power, disparity, equality, authority, restraint, influence, control, difference, imbalance, authoritarian, passive, collaboration,
Relationship	Social, Relationship, social relations, social interactions, collaborative New therapeutic relationship
epistemology	Structural, post-structural, modernist, post-modernist

Appendix B: An Abridged Version of the Reflexive Research Diary

December 2011

After reading through the emailed documents of potential MRP supervisors and what type of projects they would be interested in, I contacted Sue. She stated she was interested in research on service users and also professional issues. I prepared a proposal about investigating the ethical dilemma around legal containment and creating a trust in the therapeutic relationship for the research interview panel, and one of Sue's topics sounded fairly similar to this. Talking to her, we agreed to investigate how service users and clinical psychologists are constructed in academic dissemination.

March, April 2012

Writing up the proposal, we decided to analyse the text using Foucauldian Discourse Analysis. I'm trying to read Foucault, but it is very difficult to know whether or not I understand it. His writing style is quite unusual.

July 2012

My grandmother passed away and my son is ill. Not a good month. I had to ask for an extension to complete the asked for changes to the MRP proposal.

September 2012

After making amendments to my proposal I got approval through.

October 2012

I completed the initial sample, getting a friend to help me pull the different references out of a hat. I realised I had to exclude articles by people I knew as I instantly felt anxious about analysing their work.

November-December 2012

My son has been constantly ill with infections. He is not sleeping at night and I am completely exhausted. I can't make myself do any work at night, and because we both need family time in the weekends I am not getting any work done on the thesis. It is very frustrating, but I am confident there is plenty of time left to get started.

January-March 2013

My annual leave and study days are eaten up by trying to complete the Critical Review. I barely have enough time to do the other coursework, let alone the MRP! I am starting to feel more stressed as time goes by.

June 2013

I complete a bracketing interview with a friend from the cohort to map out my assumptions about my study. It looks as if my childhood background and experiences have made me into someone who is always keen to fight for those disadvantaged. I already knew this, but the impact it might have on my study is important. I might approach the papers with the service users in my mind as the 'powerless' ones, dichotomising clinical psychologists as the baddies and service users as the goodies. As this is not what the study is about I will have to refer back to my interview to ensure I don't go that way by accident. It is also contrary to the method of my MRP, which uses power as a more changing force rather than as something

negative held by clinical psychologists. I will have to remind myself not to think about power in the usual way.

I am expecting to find a lot of illness/medical discourse from the analysis as that is one of the main critiques of clinical psychological practice and other professions that I am hearing a lot about lately. Although I will not find the discourses until I start analysing so I might be surprised.

July 2013

After reading through my initial sample and relating it to my proposal I feel pretty confident that I can start analysing it. I start analysing, and it is very tough going. I want to focus on the power issues in particular, as that it the main reason I wanted to do a Foucauldian analysis, but it is really difficult to know whether I am doing it right or not. Whilst reading through the first five articles, was struck by the thought that I have to learn a new language, the language of discourses in order to do my research. This language is a certain type of knowledge, which puts me in a position of power when talking to people who has not yet learned the language of discourses yet. How would someone not familiar with DA be able to voice resistance of my findings?

I am finding this process very frustrating and have decided to do some work on section A instead, as that might make things clearer. If I can focus section A on power it might prepare me more for the analysis. Other course work is still taking all my time to complete, and I am getting frustrated and feeling guilty for not doing more, even though I'm mostly too tired most of the time due to a lack of sleep.

APPENDICES

October 2013

Working out the outline of section A has been really difficult. There does not seem to be much material on my topic, and even though that is a good thing as it emphasises the need to do more research in this area, it makes me feel as if I'm clutching for straws content wise, even though my supervisors reassure me this is ok, and that what I have so far will be enough to write a literature review. I'm also turning paranoid that somehow I have done the search wrong, and there actually is a lot of research on this topic hidden away somewhere where I can't find it. I am spending too much time on searches. The Forge suite at Salomons is absolutely freezing in the evenings, and I can't get any work done at home because of my son's bed-time routine being all over the place at the moment. The Forge does not feel very safe either, as I am usually the only person in the building and the windows are right next to the road. I'm feeling angry with the whole process, and missing the lovely warm tech suite we used to have down at the main house.

The one good thing is that there are no other coursework to complete between now and the deadline, which means any spare time I have can be used on the MRP.

November 2013

Section A is starting to take shape. I'm finding the topic of power very interesting, and am so glad I picked this topic for section A, as it has made me think and prepare for section B a lot more. Even so, I am finding that what I read from books and articles keep pulling me away on tangents, where I can spend a whole evening thinking about a related topic before realising it is not related enough to be included in the piece of work I am doing. Although it is probably useful overall, it is inconvenient because I have so little time that is just mine to do study. I am starting to question whether I will be able to finish the MRP on time, knowing that working over the weekends is not an option because of my son. The moment he gets less

time with me, he becomes generally unhappier, and apart from making me feel guilty, it also makes me more exhausted and less able to work in the time that I do take.

January 2014

I finish the first draft of section A and get good feedback on it which makes me feel a lot more positive about completing on time.

February 2014

The flu strikes the household and my son and I are sick over two weeks, removing the possibility of getting any work done. I am feeling very fed up, and keep going just because I am too tired to stop to think about how impossible things are. Eventually I get some energy back.

February-March 2014

I use my annual leave to take several weeks off placement so that I can immerse myself in the analysis. On starting I find that even though I have read up on how to do it previously, the process is not straight forward at all, and extremely time-consuming. There are so many steps to go through following Willig, and on average it takes me a day and a half to analyse one article, although the first week was spent trying to analyse but realising I needed to read more Foucault and more about doing the analysis.

I am constantly plagued with worries that I might not be doing it right, even though there isn't supposed to be 'a right way' of doing it. In the end I keep focusing on my research questions as I go along. I also worry that after finding a recurrent theme of discourses, confirmation bias makes me spot them quicker in the following articles. I spend a lot of time double checking for other emerging discourses, and see that there is some smaller differences

in the discourses between service user and clinical psychologist articles which are included in the analysis.

I am enjoying the process on one level, and it is interesting to see that I am not getting the expected discourses (illness/medical discourses). They are there to some degree, but other more dominant discourses stand out more. It is very interesting, and nice to finally be at the stage where I am actually expanding on a field of knowledge, or finding out about something that has not yet been figured out. It is also nice to be at Salomons with other trainees who have done the same as me, block-booked their annual leave. I am finding it much easier to get going once I can come into Salomons during daytime over several days and find a rhythm.

Appendix C: Notated Articles

Proposal to map, monitor, and meet clinical psychological need in Early Intervention in Psychosis services

David Raune & Suzanne Law

This paper illustrates how clinical psychologists might proactively map, *dynamically* monitor, *and then more widely meet key psychological needs of clients in Early Intervention in Psychosis services using a programme of group Cognitive Behavioural Therapy.*

[handwritten: c.p.s as proactive + dynamic]

CLINICAL PSYCHOLOGISTS have traditionally been and typically remain reliant on referrals from non-psychology staff such as psychiatrists or Care Co-ordinators. Yet these referrers may have limited knowledge of the evidence base of psychological interventions and refer according to diagnostic categories. Further, the referring clinician typically has no data on the prevalence of different types of psychological problems in their local client population to guide their clinical prioritisation. Given this, there is a case for clinical psychologists themselves to take a more prominent role in deciding which clients to select, to select clients based on specific psychological problems rather than diagnostic categories, and to prioritise referrals based on ongoing psychological need prevalence data in the local client population. This is what Harrow and Hillingdon's Early Intervention in Psychosis Service (EIPS) has recently begun.

[handwritten margin notes: — between prof. groups? — c.p.s as experts } cps is needing to take more control over clients. — c.p.a as able to be more prominent. as organises GS different from medical staff/psychiatrists ① ②]

Service context
There are 151 EIPS across the UK (Iris, 2010) and it can be expected that nearly all of those teams employ at least one clinical psychologist. The Harrow and Hillingdon EIPS accepts clients who are between the ages of 14 and 35, who have experienced psychotic experiences for at least one week, and who are within six months of episode onset. Our EIPS Clinical Psychology service comprises one full-time clinical psychologist, an assistant psychologist, and two part-time clinical psychology trainees (one a first year and the other on a specialist third year placement).

as can see need as expert

c.p.s role

Identifying need

Given that our EIPS begun 18 months ago but the clinical psychologist (D.R.) has only recently joined, it was likely that there would be a high backlog of unmet psychological need in the service. It was therefore deemed prudent to first identify the scale and type of this need in the client population. In the context of this paper 'need' refers to a psychological problem that interferes to a clinical level with an individual's ability to function adequately in key life domains and which has a relevant psychological intervention that can potentially meet the need. Previous studies illuminating psychological needs at first episode psychosis have tended to focus on broad psychiatric indicators such as diagnoses or total scores on psychiatric measures (e.g. Archie et al., 2005). However this does not provide the psychological detail necessary to inform the planning of a clinical psychology service. The Department of Health (2001) recommends that EIPS's employ one clinical psychologist per approximately 150 clients. We therefore suggest that clinical psychologists should focus on surveying and then targeting the distress and disability associated with the key specific psychotic and emotional problems. We also suggest that the latter is not defined by psychiatric categories but instead by psychological science, such as the five basic emotions (Power & Dalgliesh, 2007), including emotion-related needs (e.g. self-esteem). Other professionals within the team can manage the wider social consequences of the core psychological problems (e.g. employment specialist).

23

③ *c.p. as only one who can meet the need?*

① ③ - *as sometimes not beneficial*
- *s.u. as needing to have a solvable problem.*

Portrays s.u. since not enough?

④ *p.s as working differently from psychiatry*

c.p. as scientific

mental health
s.u. as isolated individual

Handwritten annotations (left margin):
(7) s.u. as changeable
(8) c.p. as mindful of costs
(4) positivist

Printed column:

Monitoring need

As psychological need may change over time within an individual and across the whole client group, it is necessary to devise an efficient method of prospectively and dynamically monitoring the existing caseload's psychological need over time as well as the needs of the new clients accepted into the team.

Meeting need

Once identified, psychological need can potentially be met by utilising the various roles of a clinical psychologist in an EIPS (DCP, 2005). One role, which is thought to be cost effective (Wykes et al., 2008) as it may reach the largest number of clients, is group Cognitive Behaviour Therapy (G-CBT). Some clients who present with greater complexity might require an in-depth individualised approach or might be unsuitable for group work for other reasons. However, Saska et al. (2009) reviewed the effectiveness of individual versus group CBT for early course psychosis and concluded that although data are currently sparse, group CBT generally appeared to produce superior outcomes. They speculate on possible reasons for this, including that young people early in the course of psychosis might be less receptive to individual CBT due to greater uncertainty about their mental health problems. Saska et al. also discuss how G-CBT provides additional therapeutic factors which might be particularly important for facilitating young people's acceptance of the therapeutic model such as peer-to-peer interactions, identification, and modelling.

Running groups focusing on specific psychological problems may enhance group clinical effectiveness (Livingstone & Wykes, 2010). For EIP clients there is an emerging evidence base for auditory hallucinations, emotional-related need and psycho-education groups (e.g. Newton et al, 2005; McCay et al., 2006; Rund et al., 2007). Group-CBT specifically aimed at distressing delusions and negative 'symptoms' has a small evidence base for use with clients with chronic psychosis (e.g. Landa et al., 2006; Johns et al., 2002) although none yet for EIP clients. We therefore set out to map, monitor and

Handwritten annotations (right margin):
(6) c.p. as needing to be efficient.
(7) c.p. as having many roles
(4) client group
seeing variation in complexity need
(5) s.u. w/ high complexity need individual approach.
[contradiction?]
s.u. as not always in a good position for individual therapy
(8) s.u. as better via therapy model — need to accept model
(3)
positivist
(9)

then begin to meet the local psychological need through G-CBT.

Method

Demographic and diagnostic information was collected from the clients computerised hospital record (Table 1). In order to identify the prevalence of key specific psychological needs a survey checklist was compiled with a total of 26 items, covering identification of client's core psychotic and emotional needs (see Table 2). The data was collected by interviewing care coordinators on an individual basis for about 30 minutes each, a total of approximately five hours work. It was collected between 17 August 2010 and 9 September 2010.

An Excel data file was created to map out the backlog and monitor clients psychological need as it would enable, with the use of a simple formula, automatic update of figures as new information is inputted. The data was then analysed using the formulas in Excel to produce results showing the percentages of clients experiencing each psychological need (Table 2).

Results

Caseload demographics (Table 1)

At the time of the survey there were 105 clients on the case load, which will increase to about 210 by the end of year three of the service for the borough, which has a population of 458,394 (London Directory, 2010). The average age of EIPS clients was 23 (males 22 and females 24). Ethnic background of the caseload was: 41 per cent (N = 43) White, 38 per cent (N = 40) Asian, 15 per cent (N = 16) Black and 6 per cent (N = 6) from other ethnic backgrounds.

Caseload diagnostic labels (Table 1)

The most common diagnostic label at 46 per cent (N = 48) was Schizophrenia spectrum disorder.

Core psychotic features (Table 2)

Sixty-two percent (N = 65) had at least one current psychotic problem. One fifth (N = 20) of the caseload were currently experiencing auditory hallucinations, about one quarter (26 per cent, N = 27) were experi-

APPENDICES

Table 1: Caseload demography and diagnostic labels (N = 105)

Demographics	% (N)	Diagnostic label	% (N)
Male	68 (71)	Schizophrenia spectrum disorder	46 (48)
White	41 (43)	Depression/ Mania/ Bipolar	12 (13)
British	32 (34)	Diagnostically uncertain	10 (11)
Other	7 (7)	Acute and transient psychosis	10 (10)
Irish	2 (2)	Drug induced	7 (7)
Asian/Asian British	38 (40)	Unspecified nonorganic psychosis	7 (7)
Other	22 (23)	Delusional disorder	3 (3)
Indian	12 (13)	Acute stress	2 (2)
Pakistani	3 (3)	Disturbance activity and attention	1 (1)
Bangladeshi	1 (1)	Severe mental & behavioural disorder associated with puerperium NEC	1 (1)
			25
Black/ Black British	15 (16)		
African	11 (12)		
Other	3 (3)		
Caribbean	1 (1)		
Mixed: White and Black – Caribbean	3 (3)		
Other Ethnic Background	2 (2)		
Other Ethnic Background – Arab	1 (1)		

25

13

David Raune & Suzanne Law

encing delusions, 40 per cent (N = 42) were experiencing insight impairment, and 40 per cent (N = 42) were suffering from at least one current negative 'symptom' (with the most common being lack of motivation).

Emotional-related problems (Table 2)
Over half of the caseload (52 per cent, N = 55) had at least one emotional problem, with the most common being anxiety (47 per cent, N = 49). 38 per cent (N = 40) were experiencing problems with their self-esteem, and 30 per cent (N = 29) were identified to be at risk.

Discussion
Our survey has shown how the prevalence of key psychological needs in an EIPS can be mapped quickly and monitored dynamically across time. This type of survey has additional potential benefits such as raising staff aware-

ness of their clients' psychological needs and potential use in wider MDT service planning (for example, by quoting risk data to make a case for adequate funding provision).

To meet the identified psychological need the clinical psychology staff in Harrow & Hillingdon's EIPS offer a limited amount of individual bio-psycho-social CBT with the most complex or high risk clients and guidance to other staff on individual cases (e.g. psychological formulation), and provide staff teaching sessions on CBT for psychosis. However, given the scale of unmet psychological need identified (for example, 65 clients were suffering from a current key psychotic problem and 55 were suffering from a current emotional problem) in comparison to the number of qualified clinical psychologists (N = 1), it was decided that running groups would be the best way to efficiently meet the

Table 2: Prevalence of selected key psychotic and emotional-related problems in an Early Intervention in Psychosis Service (N = 105)

Core psychotic features		Emotional related problem	
Problem	% (N)	Problem	% (N)
Current auditory hallucinations	19 (20)	At least one current emotional problem	52 (55)
Past auditory hallucinations	53 (56)	Anxiety	47 (49)
Current delusions	26 (27)	Sadness	26 (27)
Past delusions	64 (67)	Disgust	8 (8)
Current negative symptoms	40 (42)	Happiness	1 (1)
Lack of energy	24 (25)	Anger	19 (20)
Emotional blunting	23 (24)	Too low self esteem	36 (38)
Reduced pleasure	25 (26)	Too high self esteem	2 (2)
Lack of motivation	32 (34)	Risk	30 (29)
Poverty of speech	9 (9)	Lethal self harm	2 (2)
Unable to plan for the future	26 (25)	Non lethal self harm	5 (5)
Other negative symptoms not mentioned above	24 (25)	To others	9 (9)
		From others	7 (7)
Current impaired insight	40 (42)	Self neglect	13 (14)
		Accident	8 (8)

14

largest amount of psychological need. The evidence also suggests that G-CBT may provide superior clinical outcomes as well as additional social and normalising benefits.

Group Cognitive Behavioural Therapy programme

Our G-CBT programme is in the early pilot phase but will expand over time and target the key psychotic and emotional needs. In line with the literature we will run small groups (e.g. Miller & Mason, 1999), which can be run simultaneously as each G-CBT syllabus is created and as frequently as demand dictates. At any point in time only a certain percentage of clients with a clinical-level psychological need will be willing and/or able to attend each group. Reasons for not attending have included individuals recently gaining employment, returning to education, being an inpatient or being currently unwilling for other reasons. Any client who has a need but has either previously declined or not yet attended the G-CBT program will be targeted, at an appropriate time over their three year period with the EIPS, using a 'persistent assertive in-reach' approach.

A pilot three-session psycho-education group (N = 20, across five groups) and a pilot five-session Anxiety and Sadness group (N = 9, across two groups) has recently been run and completed by the assistant psychologist. This has freed the qualified clinical psychologist to plan G-CBT for other problems. Even though current auditory hallucinations were identified to be one of the lowest current psychological needs in terms of prevalence, due to their highly distressing nature (e.g. Chadwick & Birchwood, 1994) and the strong CBT evidence base (Wykes et al., 2008) a pilot eight-session G-CBT for distressing auditory hallucinations (N = 6) was prioritised. We have so-far completed six out of the eight sessions with 33 out of the 36 possible attendances. A shorter three-session group for past auditory hallucinations (N = 53, to be run over several groups) is also planned to start soon. This will be run by the third year clinical psychology trainee and the assistant psychologist and will focus on prevention of voices and management should the voices

[Handwritten annotations in margins:]

as flexible

(11) C.p. seen as good decision makes

(12) as effecting better outcomes

— fall in line with research

(13) c.p. as fulfilling all needs

(16) C.p. as providing holistic service contradiction to bottom of p. 23,

c.p. as target and determined

(14) c.p. as symbolic of resource — contradiction elsewhere?

c.p. as prioritising

return. Due to the absent G-CBT evidence base specifically for delusions, negative 'symptoms' and insight at first episode psychosis, it was decided that more time would be required to develop a G-CBT format, so these will be planned in the future. In response to the prevalence data (Table 2), other future groups that might be run include anger, too-low self-esteem and risk. Given the high percentages of clients from different ethnic backgrounds it is important to use G-CBT for psychosis in a culturally sensitive way (as reviewed by Rathod et al., 2010).

Although there are barriers to implementing groups at first episode psychosis, such as engagement, these can be overcome (e.g. Spidel et al., 2006). Across the three G-CBT groups so far 83 per cent (N = 29/35) of clients who attended once went on to re-attend the same group on a subsequent week. Overall, clients have attended 72 per cent (111/155) of the maximum number of sessions (psycho-education 49/74 (66 per cent); Anxiety & Sadness 29/45 (64 per cent); Current Distressing Auditory Hallucinations 33/36 (92 per cent). Therefore, the three types of groups developed and run so far show feasibility and broad client acceptability. After our pilot phase of creating and running all groups once, these groups will be refined based on client feedback and then formally evaluated for clinical effectiveness. In the near future we will also be looking to survey and meet the clinical-level psychological need of the carers.

Limitations

One of the limitations of the survey we carried out was to use a questionnaire that has not been validated for the detection of psychotic and emotional problems at first episode psychosis. However, the psychiatrists and Care Coordinators can be expected to be reasonably accurate at judging the presence of their clients needs in terms of gross clinical-level psychotic and emotional problems. The survey also does not look at the full range of psychological needs, so a further survey could be conducted to look at others such dimensions of personality difficulties.

APPENDICES

Conclusion

The approach we advocate for clinical psychologists in an EIPS, which we illustrate in this paper, is to more <u>proactively</u> identify psychological need, map need in terms of <u>psychological rather</u> than psychiatric concepts focusing on key psychotic and emotional problems, dynamically monitoring those psychological needs, and then meeting the psychological need by using a G-CBT approach. We also call for clinical psychologists to contribute more practise-based evidence for specific psychological problems to

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28

17

the EIPS G-CBT literature, particularly for delusions, negative 'symptoms' and insight.

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25

(i)

Service User & Care Liaison Committee Column

Coordinated by Barbara Riddell

Real people, real experiences, realigning the profession: Review of service user and carer partnership within the DCP

AT THE TIME of writing the DCP is going through a process of reviewing and reinvigorating its committees and the service user and carer partnership is no exception to this. For the last seven years the DCP has benefitted from the work of the Service User and Carer Liaison Committee (SUCLC). We have had our share of achievements and have grown in influence but sometimes have felt as if we were an afterthought rather than an integral part of the fabric of the Division.

The SUCLC has always consisted of people passionate about making a difference to health and well-being. There are many areas of work for users and carers in an organisation as large as the DCP. But we need to know:

- where best to concentrate our efforts;
- what is within our ability to change and challenge; and
- when change might not be possible.

Working successfully as individuals, we recognised that we needed to bolster our collective voice and move forward with common purpose.

The DCP Executive and SUCLC took the decision early in 2013 to suspend the ordinary working of the committee so that we could look at these issues and others. The review process has included looking at the history of the group, where we are right now, where we would like to be, and the next steps to achieve this.

A service user and carer group was first proposed by the DCP in 2002. Supported by an external consultant, a committee of four

Handwritten annotations:

s.u. as 'by-product' *unnatural*

1) *natural disease*

s.u. as passionate

— s.u. as not to be excluded. needs to be stated?

(1) natural disease as natural, not unnatural

positive disease?

— s.u. as in need of guidance

— s.u. as realistic - holding back, not wish (similar to Cashian et al where same user wrote a section negative floating point)

more power

s.u.s becoming part of DCP is different dynamic to s.u.s discussed as/in research articles.

service users and three carers with experience in mental health, physical disability and learning disability was established, alongside nine professional representatives. In 2006, the SUCLC was born with the committee's overarching aim being:

...political penetration of the DCP subsystems and committees which in turn should influence professional practice.

The SUCLC became a UK-wide group in 2008, appointing two members from each of the devolved nations, and it is in Northern Ireland and Scotland that the SUCLC, in partnership with DCP colleagues, has been able to work most effectively with external agencies including government, building relationships at the highest levels.

There have been a number of successful partnerships over the last seven years with representatives from the SUCLC being key members of UK and National Executives; Policy Unit; Professional Governance Panel; Professional Standards Unit; Faculty of Psychosis & Complex Mental Health; Faculty of Children, Young People and their Families; Faculty of Psychology of Older People; Faculty of Race and Culture; and the Committee of Training in Clinical Psychology, amongst others.

SUCLC colleagues have been effective in influencing key internal and external policies in addition to contributing to a number of DCP documents, including the recent high profile diagnosis position paper, a forthcoming user and carer leaflet

Handwritten annotations:

③ political ideas

- exercise of power, as far-reaching, expanding force

- su.s and c.p.s as partners 'effective parties' reaching for power together

s.u.s on c.ps. as equal?

s.u.s or c.p.s? c// c.p.s then is it less remarkable?

+ c.p.s - s.u. as effective, good at what they do.

procedures of exclusion.

Barbara Riddell

on formulation, and publications on bipolar, psychosis and, currently in process, one on depression.

The SUCLC has also added a powerful user and carer voice to that of their professional partners by contributing to key government consultations such as: New Ways of Working, the Bradley Report, Shared Vision, NICE consultations (including Common Mental Health Disorders) and The Mental Health Strategy for Scotland 2012–15. Internally, the SUCLC has also contributed to revised standards for Doctoral programmes in clinical psychology

At present we have two service user representatives in Northern Ireland, one in Wales, two in Scotland and one in England. At the moment we do not have any representatives appointed primarily because of their experience as a carer and we are considering how best both service user and carer issues would be served within our new structure.

Another issue about which we are very aware is the need to support DCP England to come to terms with the new commissioning structures in a climate of austerity. As such it is essential that each Branch has a clear service user voice. We know that many Branches and other member networks have service user and carer links that are independent of the SUCLC. However, we do not know where these are strong and demonstrating good practice, where they would benefit from support, or indeed, where they do not exist. To find out what sort of links different member networks have with service users and carers we plan to audit current user and carer partnerships across all four nations.

Our new vision for service user and carer partnership is: 'To be a driver for change, influencing the direction of travel of clinical psychology; weaving user and carer experience throughout the DCP and the profession'.

Some of the ways of achieving this include:
■ strengthening the voice of users and carers in the design, delivery, development and evaluation of effective psychological services;

18

Handwritten marginal annotations:

? Does this mean when it says SUCLC it means only Individual service users and carers?

S.U,s as needing to work a certain way evaluated

procedure, bureaucracy

① Voice, vision, - natural disease └ bodily senses that connects one to the outside world. feeling isolated? └ strengthen bond w/ natural discourse?

S.U. as adding something with power, as powerful

S.U. as offering support to c.p.s, economic discourse ⑤⑤5 natural discourse ①

— Sounds like a policy. - S.W. as policy makers!! political ③③

21

- working with psychologists to deliver a more effective, person-centred service;
- shaping and embedding policy – internally and externally – especially early intervention and prevention;
- questioning current ways of working;
- shaping the new workforce – getting it right at the start;
- encouraging transparency;
- raising awareness of and promoting best practice; and
- championing issues of equality and diversity and improved accessibility for all)

To develop the structure necessary for this, an Interim Leadership Group (ILG) has been established comprising:

Jude Clarke (DCP Scotland), Kitty O'Kane (DCP Northern Ireland), Jo Hemmingfield (DCP England), Simon Mudie (DCP Wales), Frances Baty (DCP clinical psychology member) and Richard Pemberton (DCP-UK Chair). However, delivering on this vision also requires active support from DCP members.

In the next few months all remaining SUCLC members will continue to partner member networks whilst the ILG looks at how a new committee and structure might work more effectively in partnership to improve health and well-being. By September the ILG will have agreed upon a proposal for how this may be done and will put it to the DCP Executive for consideration.

In this time of massive change to services and (threats) to jobs, it is understandably easy to lose sight of why one is doing what one does. All of the Division's service user and carer representatives have benefitted from the help of a clinical psychologist and are grateful for the contribution they made to help them move on in, and with, their lives, and to live a life that is as fulfilling as it possibly can be. It is the end user of services – the person – who deserves to be put in the centre of their care. In the DCP, members are fortunate enough to have a formal structure that, through giving service users and carers a platform, is helping to do this. However, the ILG recognises

that it cannot and ought not to do all of this: instead service user and carer representatives within the Division need to work in partnership – with existing networks and organisations as well as professionals. Quite how we achieve this is taxing but exciting.

We look forward to a renewed approach to working together where real people's real experiences are woven throughout everything we in the DCP – and you as members of the profession – do.

Interim Leadership Group of Service User and Carer Representatives of the DCP
To contact the interim leadership group, please e-mail Helen.Barnett@bps.org.uk.

economic discourse
(and reinforced)

Appendix D: Tables of Analysis Steps

Analysis 3

Context – new service, c.p. recently started

Paper: Raune & Law			
Clinical psychologists/services		**Service users**	
Willig steps			
Discursive constructions			
0. As experts			
1. need to take over more of client care		1. As needing to be 'fixable'	
2. better suited than psychiatrists to select clients		2. As sometimes not fixable.	
3. As best suited to identify need		3. as having core psyc. Problems.	
4. Necessary to plan services, psychiatry not enough.		4. having changing needs	
5 using scientific methods		5. high complexity needs individual approach	
6. needed for efficiency	6 + 4- interaction	6. Not always suitable for individual therapy	
7. encompassing many roles	7+7 compare	7. S.u two roles, attending treatment and giving feedback.	
8. Mindful of costs		8. as needing to accept CBT model	
9. As positivist scientific		9. As having psychotic problems	
10. As problem-solving	10+10 interaction	10. as having overwhelming needs	
11. holistically minded	11+3 contradiction	11. As diverse	
12. Effecting better outcomes			
13. Fulfilling all needs	13+ 10 contradictions		

14. CP as stretched resourse			
15. Inclusive of su.s in development			
16. 'Doing it all'			
Discourses		1 and 4 the same?	
1. Economic discourse	6, 8, 14,	1. Causality / isolative discourse	3, 6
2. Expert knowledge discourse	0, 1, 3, 4, 5,	2. Progression/linearity discourse	1, 2, 8
3. Positivist discourse	9, 12	3. Burden discourse	4, 10, 11
4. Perfectionist discourse?	6, 7, 10, 11, 13, 16	4. Illness discourse (same as #1	9, 3
	Caring discourse is lacking		
Action orientations (at the end of doc because more wordy			
Positionings			
1. Have to be savvy businessmen, can't ignore costs			1.s.u. able to change problem by focusing on individual factors
2. Have more power, have a say, weight behind words, can advice.			2. s.u. should get better, c.p. do not hold all responsibility
3. Alignment with power and rationality, strenghtening argument for CBT.			3.Responsibility to take up challenge.
4. Need to uphold good standard, assurance of job security?			4.C.p.s can find a cure. (And should keep looking for one)

APPENDICES

Practice			
Closes down			
1. Focusing on less cost effective treatments			1. Venues that might help individual
1. Focusing on individualising care			2. Ability to sit with uncertainty/ non progress
2. Listening to others, admit uncertainty.			
3. Ability for independent thinking.			
4. Humility			
Opens up			
1. Collectively shared language for arguing needs.			
2			
3.Alignment, shared language, (to make c.p. understood in mdt for instance)			
4. Opportunities to guide other professionals.			
Subjectivity			
1. Small part in bigger machine, no say.			1. Fault is in me. Different from others
2. Confidence, assurance, certainty			2. Expected to get better from treatment.
3. Certainty, competency			3. Don't expect help with everything
4. Pressure to perform			4. I can be cured by an expert.

Context – new service, c.p. recently started

Stage 3: action orientation

c.p.- Economical discourse – Is being used to **justify** the use of CBT groups, due to efficiency and savings in cost – attributes responsibility for using cbt groups to lack of resources.

Expert knowledge discourse – Is being used to portray c.p. as essential and irreplaceable part of the service around psychological needs, and that their approach is based on knowledge.

Positivist discourse – is used to lend weight to the expert knowledge discourse (collapse them?). Their evidence base is founded on logical, rational approach and has superior claim to being 'true' over other approaches.

Expert advantages – Selling the usefulness of c.p.s and their unique skills-set, flexibility etc. Irreplacable

S.u.s

1. Causality / isolative discourse – locates the 'problem' as coming from within the s.u., then. Excludes wider system.

2.Progression-discourse – Places impetus on s.u to improve on trajectory, fall in line with expectations based on science. At the same time acknowledged that clients are 'inconvenient', so takes responsibility away from c.p. when done't go according to plan. C.p.s may feel burdened by responsibility.

3. Burden discourse – The changing and overwhelming needs of the s.u makes the job of the c.p harder/ challenging. Writing off responsibility for when cannot meet needs.

4. Illness discourse – The s.u. suffers with an illness. Need expert administration from c.p.

APPENDICES

Analysis 8, Riddell

Willig steps	Paper: Riddell			
	Clinical Psychologists	**joint**	**Service Users**	
Discursive constructions			**0. As effective, good at what they do.**	
			1. Afterthought, 'by-product' of DCP	
			2. As natural part of DCP	
			3. As passionate	
		reasonable, not mad:	**4. As needing realistic knowledge and aims**	
			5. As expanding force	
	16. As partners with s.u.s		**6. As partners with c.ps**	
		18. As effective (successful) partners/ partnership, reaching for power together, united.		
		19. As equal partners?		
		20. As influencing high profile policies and consultations		
	17. As adding power to s.u.s		**7. As adding power to position of c.p.s**	
	21. As providing platform for s.u.s		**8. As offering support to C.ps**	
			9. As being aware of 'climate of austerity'	

			10. As self-evaluative (audit), good practice of network, self-governing	
			11. As having voices and vision, sight	
			12. As policy makers	
			13. As mimicking existing social structures to organise themselves within DCP.	
			14. As grateful to c.p.	
			15. Lucky to have DCP	
				Discursive constructions
Discourses			**1. Natural discourse**	**1, 2, 11**
			2. Positivist discourse	**4,**
			3. Political /influential discourse	**5, 6, 7, 12, 10, 21**
Context-CPF guidelines			**3. Grateful discourse**	**14,15**
			5. Qualified knowledge discourse.	**13,**
			6. Economic discourse	**9,**
			7. Professional disocurse	**0**

APPENDICES

Discourses /action orientation/positionings

1.   Natural discourse. This discourse portrays the s.u. as a natural part of the 'fabric' of the DCP, or the profession ,at the same time as this assumption is doubted, or questioned, by saying it sometimes feels as s.u. involvement has been an afterthought. <u>Contradiction</u>

2.   Positivist discourse – This discourse locates the s.u as realistic, within the rational realm of the 'players' that have power, as opposed to being in the 'mad' camp of irrationality.

3.   Political/ influential discourse – This discourse locates the s.u.s as having a right to speak and speaking up on important issues, not being side-lined. Action orientation is to not appear complaining/ in less power?

4.   Qualified Knowledge discourse – This discourse locates the s.u. as a 'speaking subject' in a privileged position. It is like a counter-discourse within the psychology system. It locates the s.u. as owners of a social structure that controls the flow of discourse from that structure. This structure (ILG) is built on the platform of procedures required to join the politics. (Is it a proper platform or just a soapbox-speaker?) As being built on social structures that are seen as 'true' sources of information/ knowledge, credibility is given to what is said.

5.   Economic discourse – This discourse locates s.u.s as being aware of the effects economical difficult times might have on c.p,s but also a slight worry that su/s will be forgotten. By placing c.p.s in an economic discourse it is shown that there is a **conflict of interest/ dilemma?** , that of 'threats to jobs' and 'massive changes to services;, and that of the service user.

1. Natural discourse
2. Positivist discourse
3. Political /influential discourse
3. Grateful discourse
4. Qualified knowledge discourse.
5. Economic discourse

Practice – Possibilities for action – Can speak up! Can have indirect impact on patient care. Is relying of DCP structure, still on borrowed power or creating a 'new' relationship of equals? Or opening up for more fluidity at least?

Subjectivity – Can feel supported to speak up, feel powerful, influential. (although curious snippet in the end of how grateful su.s are to c.ps)

APPENDICES

Appendix E: Journal of Mental Health Submission Guidance

Instructions for Authors
Journal of Mental Health is an international journal adhering to the highest standards of
anonymous, double-blind peer-review. The journal welcomes original contributions with
relevance to mental health research from all parts of the world. Papers are accepted on the
understanding that their contents have not previously been published or submitted elsewhere
for
publication in print or electronic form.
Submissions
All submissions, including book reviews, should be made online at Journal of
Mental Health's Manuscript Central site at http://mc.manuscriptcentral.com/cjmh . New users
should first create an account. Once a user is logged onto the site submissions should be
made via the Author Centre. Please note that submissions missing reviewer suggestions are
likely to be un-submitted and authors asked to add this information before resubmitting.
Authors will be asked to add this information in section 4 of the on-line submission process.
The total word count for review articles should be no more than 6000 words. Original articles
should be no more than a total of 4000 words. We do include the abstract, tables and
references
in this word count.
Manuscripts will be dealt with by the Executive Editor, Professor Til Wykes, Department of
Psychology, Institute of Psychiatry, De Crespigny Park, London, SE5 8AF, United Kingdom.
It
is essential that authors pay attention to the guidelines to avoid unnecessary delays in the
evaluation process. The names of authors should not be displayed on figures, tables or
footnotes
to facilitate blind reviewing.
Book Reviews. All books for reviewing should be sent directly to Martin Guha, Book
Reviews
Editor, Information Services & Systems, Institute of Psychiatry, KCL, De Crespigny Park,
PO
Box 18, London, SE5 8AF.
Manuscripts should be typed double-spaced (including references), with margins of at least
2.5cm (1 inch). The cover page (uploaded separately from the main manuscript) should show
the
full title of the paper, a short title not exceeding 45 characters (to be used as a running title at
the
head of each page), the full names, the exact word length of the paper and affiliations of
authors
and the address where the work was carried out. The corresponding author should be
identified,
giving full postal address, telephone, fax number and email address if available. To expedite
blind reviewing, no other pages in the manuscript should identify the authors. All pages
should
be numbered.
Abstracts.
The first page of the main manuscript should also show the title, together with a

APPENDICES

structured abstract of no more than 200 words, using the following headings: Background, Aims,
Method, Results, Conclusions, Declaration of interest. The declaration of interest should acknowledge all financial support and any financial relationship that may pose a conflict of interest. Acknowledgement of individuals should be confined to those who contributed to the article's intellectual or technical content.

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Keywords
Authors will be asked to submit key words with their article, one taken from the
picklist provided to specify subject of study, and at least one other of their own choice.
Text.
Follow this order when typing manuscripts: Title, Authors, Affiliations, Abstract, Key
Words, Main text, Appendix, References, Figures, Tables. Footnotes should be avoided
where
possible. The total word count for review articles should be no more than 6000 words.
Original
articles should be no more than a total of 4000 words. We do include the abstract, tables and
references in this word count. Language should be in the style of the APA (see Publication
Manual of the American Psychological Association, Fifth Edition, 2001).
Style and References.
Manuscripts should be carefully prepared using the aforementioned
Publication Manual of the American Psychological Association , and all references listed
must
be mentioned in the text. Within the text references should be indicated by the author's name
and
year of publication in parentheses, e.g. (Hodgson, 1992) or (Grey & Mathews 2000), or if
there
are more than two authors (Wykes et al ., 1997). Where several references are quoted
consecutively, or within a single year, the order should be alphabetical within the text, e.g.
(Craig, 1999; Mawson, 1992; Parry & Watts, 1989; Rachman, 1998). If more than one paper
from the same author(s) a year are listed, the date should be followed by (a), (b), etc., e.g.
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The reference list should begin on a separate page, in alphabetical order by author (showing
the
names of all authors), in the following standard forms, capitalisation and punctuation:
a) For journal articles (titles of journals should not be abbreviated):

Grey, S.J., Price, G. & Mathews, A. (2000). Reduction of anxiety during MR imaging: A
controlled trial. Magnetic Resonance Imaging, 18 , 351−355.
b) For books:

Powell, T.J. & Enright, S.J. (1990) Anxiety and Stress management . London: Routledge
c) For chapters within multi-authored books:

Hodgson, R.J. & Rollnick, S. (1989) More fun less stress: How to survive in research. In
G.Parry
& F. Watts (Eds.), A Handbook of Skills and Methods in Mental Health Research (pp. 75−
89).
London:Lawrence Erlbaum.
Illustrations should not be inserted in the text. All photographs, graphs and diagrams should
be
referred to as 'Figures' and should be numbered consecutively in the text in Arabic numerals
(e.g.
Figure 3). The appropriate position of each illustration should be indicated in the text. A list
of
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APPENDICES

where prompted on submission, and should make interpretation possible without reference to the text. Captions should include keys to symbols. It would help ensure greater accuracy in the
reproduction of figures if the values used to generate them were supplied.
Tables should be typed on separate pages and their approximate position in the text should be

indicated. Units should appear in parentheses in the column heading but not in the body of the

table. Words and numerals should be repeated on successive lines; 'ditto' or 'do' should not be used.

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If the article is accepted, authors are requested to submit their final and revised version of their manuscript on disk. The disk should contain the paper saved in Microsoft Word, rich text format (RTF), or as a text or ASCII (plain) text file. The disk should be clearly labelled with the names of the author(s), title, filenames and software used. Figures should be included on the disk, in Microsoft Excel. A good quality hard copy is also required.

Proofs are supplied for checking and making essential corrections, not for general revision or alteration. Proofs should be corrected and returned within three days of receipt.

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