Middlesex University Research Repository:
an open access repository of
Middlesex University research

http://eprints.mdx.ac.uk

In Search of Knowledge and Understanding

Working with individuals suffering from serious mental illness and their families

Abstract

Working with individuals suffering from serious mental illness and their families

This research study describes a journey taken by ten health care professionals on an educational course, the English National Board for Nursing, Midwifery and Health Visiting (ENB) A28, which aimed to enable them to develop the therapeutic skills and confidence to work effectively with the families/carers of individuals suffering from a major mental illness. Their previous education and training had not equipped them to meet the clinical demands now made of them since the focus of mental health care relocated from hospital to the 'community'.

The course was based in a Family Intervention Service provided in an Inner London Mental Health Trust whose clinicians had developed a treatment model which they termed 'psychosocial' and combined systemic theory, expressed emotion research findings and limited behavioural methods.

Grounded Theory was the chosen research method for this study as it was important to be able to access the experience and views of each student as they emerged. The students were interviewed twice, using a semi-structured interview schedule; at the beginning of the course and within three months after its completion. The questions posed at interview were informed following a pilot study of eight of the previous year's students.

The students concluded that three elements in the course teaching had most contributed to achieving their aims; theory, practice and live supervision.

The role of management and its influence in the clinical life of the students emerged as important. Consequently eight managers were interviewed and revealed the degree to which they supported both the students and the aims of the course. On this depended whether the Trust's clinical services would be able to maximise the benefits from its investment in this educational resource.

A retrospective study by questionnaire, and subsidiary to the main investigation, is reported on in Appendices A through F. It focussed on the experience of students who had successfully completed the course during the previous years since its validation. As in the main study, the questionnaire was formulated from information given following a pilot study of eight of the previous year's student group. The aim was to ascertain the long term effects on their clinical practice. The results were analysed using a descriptive analysis technique. Although there had been changes to the original course, the findings were similar to those in the main study and showed the importance of theoretical understanding and supervised practice.

Overall, the findings indicate that the respondents valued the systemic approach which was the cornerstone of the educational experience and continued to exert an influence on their practice. They gained an awareness of the extent to which social and family systems impacted on the lives of individuals during the lengthy course of major mental illness.

Acknowledgements

Working with Families
of the Long-term Mentally Ill

Thesis Structure and Contents

3.   Chapter 3 — The Research Settings and Subjects

Chapter 1 — Introduction

1.1 Introduction to the Study

Until the advent of the concept that the majority of mental health care should be given in the community and the closing of large mental hospitals, mental health services had predominantly given care and treatment to those suffering from a major mental disorder on an individual basis, frequently disregarding family influences and needs. Minuchin (1988) reported that some psychiatrists advocated the view that the family was a 'repressive force' and Laing (1960) believed that families were even the actual cause of the illness, in the 'presenting patient'.

In line with service expectations, nurses had been trained and educated in the needs of the individual.

For many years, 'family therapy' was considered by many as a 'specialism' or an elitist way of working practised by the few to benefit the families of individuals who had not been 'labelled' psychotic.

A shift in the attitudes of some mental health practitioners occurred following the publication of research by Brown and Rutter (1966) which linked high emotional involvement between family and patient with relapse rates following treatment of a serious mental illness. Further studies over the next two decades were carried out confirming that emotion expressed by relatives to a person suffering from schizophrenia was of overwhelming importance, especially when the emotion was characterised by critical comments: hostility, warmth and over-involvement and the term Expressed Emotion (E.E.) was formulated (Leff, Kuipers, Berkowitz, Eberlein-Vries, and Sturgeon, 1982).

The research had significance to nurses working in the community, particularly those working in rehabilitation services, although it failed to make an immediate impact. Following guidance by the Department of Health on continuing care in the community of mentally disabled people (D.O.H., 1994), mental health workers were increasingly responsible for working with families at every stage of care involving families, carers and other individuals concerned in the patient/client's social system.

It was questionable that nurses in particular had sufficient knowledge and skills to work with families in their social system. This was most clearly evident in the

findings and recommendations following independent inquiries into homicides committed by persons receiving mental health care: Clunis, Gray, Mabota, Mursell, Gadher and Walsh, to name but a few (see Appendix L). From such evidence, it was agreed that further education and training was necessary to facilitate clinicians in their work with families/carers in a structured way and to increase their confidence to work systemically in a variety of clinical settings and in the home.

To meet these needs, the ENB validated the educational programme English National Board for Nursing, Midwifery and Health Visiting (ENB) A28 in 1994. From now on, throughout this text, this course will be referred to as the 'ENB A28'. This was a pioneering course, based in a service known as the Family Project, provided by one of the Inner London Trusts. It termed its treatment model as Psychosocial and combined traditional systemic family therapy methods with the E.E. research findings. Its aims were to reduce the risk of relapse in individuals suffering from a serious mental illness and so improve the quality of care provided for those individuals in the community as well as help for the family/carers.

It was recognised that the course had been running for four years when this study took place and that during that period, moderate changes to the course had and would continue to be inevitable. However, these factors do not detract from this study of the experiences of a group of students who embarked on an educational journey of one year.

1.2 Aims and Rationale of the Study

The study aimed at identifying the reasons why health care professionals applied to take the ENB A28, what were their needs from the course, their educational experience of the course, how they considered their practice might change on its successful completion and any difficulties which they envisaged in applying new ways of working.

It was also considered important to gain information from the service managers who supported each student's application: their reasons for giving their support and their expectations of the students' increased range of skills relevant to work with family/social groups in the community.

The third aim was to critique the ENB A28's current model and its relationship to practice in order to evaluate its robustness for equipping students to work with families/carers in the community or in hospital services.

A general aim was to consider and suggest ways in which the findings might influence the educational preparation of professional groups in their work in Mental Health services.

1.3 Methodology

The qualitative methodology chosen to carry out the major part of this research was based on grounded theory and will be discussed in more detail in Chapter 4 p. 67. The theory, an integrated process of data collection, analysis and inference meant that these activities continued throughout the research process rather than in discrete stages. Evidence was derived inductively and continuously until the data was saturated and emerging hypotheses enabled the development of theory. The purpose of the methodology was to understand and describe rather than explain cause and effect.

The method used within this framework was to conduct semi-structured interviews with a group of ten students within three months of the commencement of the course and on its completion and eight of these students' clinical managers in the second half of the course. A pilot study of seven other students was made prior to the interview schedule to inform the questions to be asked.

In addition, data from 20 previous students of the programme were obtained by questionnaires following a field study of five other students whose comments helped refine the questions. Characteristics of the student population, e.g. average age and professional grouping, were presented using descriptive statistics; bar charts and histograms. The students' experiences, both during and since completing the course, were subjected to descriptive analysis. The findings from this part of the study have been placed in Appendix B.

Ethical clearance was obtained from the Trust's ethical committee. All participating students and managers were asked to sign a written agreement before interviews took place and questionnaires retained anonymity (see Appendix G, p. 189 and Appendix H, p. 190).

1.3.1 The Initial Literature Search

The differences in the purpose of a literature review between qualitative and quantitative research will be discussed fully in Chapter 4, Methodology.

Grounded theory, which is used in the study, is a qualitative and inductive method of analysis in which data are approached without a preconceived framework or theoretical position. This enables theory to evolve during the study and not be constrained by existing theories. However, views differ among grounded theory researchers as to how strictly this concept may be applied to a literature review. Glaser (1992 p. 35) is of the opinion that only unrelated literature should be accessed at the beginning of a grounded theory project, for example "reading for styles and English formats". In contrast, Strauss and Corbin (1990, pp. 48, 49) recognise that researchers bring to an enquiry a considerable background in professional and disciplinary literature and that relevant elements of previous theories, pertinent to their own study, might be incorporated.

This was particularly important in this study as I had been interested in family work over many years and had explored the relevant research literature. It would have been impossible to ignore the body of knowledge I had accumulated or fail to recognise that I had preconceived ideas in relation to the study of the ENB A28. However, I was also aware that my interest in evaluating the ENB A28 course was as much determined by the need to identify both its weaknesses as well as its strengths as a means of ensuring its increasing value to the service.

Family work has only received limited interest from clinical practitioners and educationalists and therefore it was important that the findings in this study were judged to be an unbiased account of the students' educational experience undertaking Course No. ENB A28 by those who remain sceptical about this form of therapeutic intervention. To help with my concerns, I accessed the work of Morse and Field (1985), who identify the personal attributes required of the qualitative researcher. They view the researcher as an 'instrument' whose ability will determine the amount and quality of the data. They focus on the ability of the interviewer to establish rapport and gain the trust of the informants as well as the researcher's interview techniques.

They conclude (p. 117) that the depth of the data analysis will depend upon the researcher's "sensitivity, perceptivity, informed valued judgements, insights and knowledge."

How I dealt with these personal aspects of data collection in this study will be discussed in Chapter 4. Methodology, (see p. 76) and illustrates the value of an Initial Literature review.

I then used the literature to place the study in context and began by an examination of the documentation which gave a historical perspective to developments which had taken place in mental health care, the proposed changes in the service and how within this context the ENB A28 was established.

Government policies which directed the closure of the large mental hospitals and the change in the provision of care from large institutions to care in the community were studied (see p. 12). These policies stressed that the needs of those suffering from serious mental illness should be given priority over other conditions as recipients of available resources. They also stressed that the needs of families and carers should be considered in mental health care planning as never before. The National Health Service Plan (July 2000) places further emphasis on this requirement. The classification of mental illness has always been the subject of debate among health care professionals. The purpose of this study was to examine an educational provision to prepare staff to work with individuals suffering from serious mental illness and their families. I focussed, therefore, on the definition provided in the report, published by HMSO (1992), entitled The Health of the Nation: A strategy for health in England (see p. 13) and reviewed the literature which provided most recent descriptions and causation of the disorders and their treatment with special reference to family therapy and family intervention. literature reporting on the application and outcome of different treatment modalities used in family therapy and family intervention was considered.

While considering the service context in which the ENB A28 functioned. I also examined the educational perspective and the reasons why health care professionals might think it necessary to access such a course. I made a detailed examination of the curricula from the General Nursing Council for England and Wales (GNC, 1974). The English National Board for England and Wales (ENB, 1982) and the competencies of the United Kingdom Central Council for Nursing, Health Visiting

and Midwifery (UKCC, 1995) which had governed nurse education over the previous three decades.

I continued to access the literature throughout the study, as new issues arose in the data. Particular issues which emerged related to culture, gender and ethnicity in family work.

Chapter 2 — The Context of the Research

2.1 Personal Context

My interest in family therapy began as far back as the early 60's when I worked at a hospital which provided psychological treatment based on psychoanalytic principles and renowned for its approach of treating individuals within a family context. Women, for example, who experienced mental health problems in their mothering role were admitted for treatment with their babies, older children and — wherever possible — accompanied by their husbands, who stayed in the hospital while continuing their employment activities. The families therefore were kept together while tensions and conflicts within the family unit could be discussed with clinical staff while sharing support from the therapeutic community (Stanner. 1965, p.108).

I left this hospital to advance my career and was appointed sister-in-charge of a Department of Psychological Medicine at a London teaching hospital which included working in mainstream psychiatry; but its teaching remained an influence on my clinical practice. I convened a group to psychologically support individuals who had suffered mental health problems over many years and continued to receive physical methods of treatment for conditions such as severe depression. Although it was not appropriate to use 'interpretations' as in the psychodynamic model, it was possible to link earlier family experiences to how members of the group responded to present stresses and sometimes maintained the depressive symptoms. It is now common practice for mental health nurses to be involved in group work using a variety of models, but this was not normally considered part of the repertoire of nursing skills before 1968. In that year a report published by the Health Services Council recommended that selected nurses should be trained to give psychological support, individually and in groups (Health Services Council. *Psychiatric Nursing: Today and Tomorrow*. 1968).

During the 80's, I held a variety of nursing posts, from ward sister to senior clinical manager in an acute mental health inpatient service in another London Health Authority which eventually received Trust status. Most of the patients suffered clinical conditions diagnosed as schizophrenia or bipolar affective disorder and many were well-known to the staff because of their frequent readmission to hospital following relapse.

It was at this stage that I became familiar with the research work of Leff and Vaughn (1976 and 1985), known as the expressed emotion studies, which established a strong link between the level of expressed emotion (EE) shown by relatives and the outcome of a schizophrenic illness.

This seemed extremely relevant to nurses who were beginning, in the light of the community care proposals (DHSS, 1981, 1985, 1989, 1991, 1994), to play an increasingly important role in preparing people for discharge from hospital, which included ensuring good community support to prevent relapse. I undertook an in-depth search of the literature while studying on the ENB 870, Introduction and Understanding Research. It strengthened my belief in the value of the work to nurses, particularly those working with the long-term mentally ill. Similarly, when practising as a clinical nurse specialist in rehabilitation I took the relevant ENB course, Rehabilitation of the Mentally Ill. My course work centred on the prevention of relapse, which I had, by this time, concluded was an essential component of rehabilitation.

Because of the nature of my job, it was now possible to convert an interest into action. However, my previous experience of family work had enabled me to understand and interpret the impact of past family experiences and marital relationships on the presenting problems which emerged while working with an individual. This did not involve working with the interactions of family members within a group which would include the person identified as the 'patient'.

I turned for help to the Family Intervention Project (FIP) which was an established service within the Trust provided by a small team of consultant psychiatrists and family therapists. One of the consultants had taken part in the early EE studies while the other members of the team came from a 'traditional' family therapy background.

They invited me to observe their weekly treatment sessions and in time to be actively involved. The team was passing through a period of transition as it accepted its responsibilities to the Trust to treat more families with a member suffering from a major mental disorder. They were also concerned at the lack of interest shown by nurses in general, particularly those who worked in inpatient services. The few who were interested were not allowed the time to attend the FIP sessions. As a means to overcome this problem, my support as a senior person was

gained for the development of a six months 'in house' educational course. On its completion, nurses valued it highly but complained that it would not carry weight on a curriculum vitae, as it was not convened under the aegis of a recognised educational body. An approach was made to the Principal of the College of Nurse Education, who enthusiastically agreed to approach the English National Board for England and Wales to approve a recognised course. The responsible education officer was interested to take the issue further and agreed to set up a validation panel on receipt of a proposed curriculum from the Principal, which in the event was completed in record time. As the proposed course was — in the words of the ENB — 'service led', I was asked to attend the validation and in turn requested that I should be accompanied by one of the therapists: so in 1992, ENB A28 was validated. This positive decision was made on the basis that unlike other established family therapy courses, the ENB A28 focussed on the needs of the long-term mentally ill and was in tune with the principles of care in the community.

Six months after the validation, I was appointed as Head of Nursing in the Trust and therefore in an ideal position to give both the Project and the ENB A28 maximum support. This was to be important during a time of financial constraints on educational resources.

When the particular College of Nurse Education which had organised the course closed, I was responsible for finding an alternative educational provider and eventually, negotiations with Middlesex University were successful. In the year following my retirement from the NHS, the university afforded me the opportunity to undertake a research project concerned with working with families of the long-term mentally ill, which was to include an evaluation of the ENB A28.

2.2 Historical Context

A continuous decline in the population of psychiatric hospitals took place from the late 1950's onwards when a group of drugs named the Phenothiazines was introduced into clinical practise (Grinspoon and Greenblatt, 1961, Cited in Clare, 1978, p. 61).

These drugs, still in use today, as with newer ones, exert an ameliorating effect on the symptoms of schizophrenia and result in most patients becoming more amenable to a range of psychological interventions and support.

In 1959, the government passed a new Mental Health Act, (Mental Health Act, 1959). Its emphasis was on voluntary admission to hospital. Patients would receive as much treatment as possible on that basis and be allowed to take their own discharge from hospital, at any time, unless assessed to be a risk to their own health and/or other people's safety. This was termed the 'open door policy.'

However, by the early 80's a significant number of people were still being cared for in large mental hospitals, situated on the outskirts of towns and cities, built in the Victorian era or during the early part of the 20th century. It was in such environments that many had resided for a major part of their lives, having lost all contact over time with their social roots, and rejected by their families who, in line with society's attitudes and beliefs, considered mental illness a stigma.

Although plans were being advanced for the eventual closure of such institutions (Audit Commission, 1994), time was required to formulate ideas on how to prepare the residents for their transfer to a range of accommodation, sometimes domestic size, in an unfamiliar community, and frequently without the back-up of the social life provided in their present environment.

The impact these changes would have on the lives of both the recipients and providers of care within the asylum system was considerable. It was in these hospital environments where the majority of mental health nurses received their education and training to become Registered Nurses for the Mentally Ill (RMN General Nursing Council for England and Wales, 1974). In latter years, prior to their closure, student nurses were afforded the opportunity to gain 'community' experience but this was extremely limited compared with the extensive experience they received of a hospital 'community'.

When the proposed changes determined that rehabilitation programmes for the long-term mentally ill should be introduced into hospital treatment plans (Royal College of Psychiatrists, 1981), extensive training programmes had to be introduced for Mental Health practitioners (ENB Rehabilitation of the Mentally Ill). This was not only to prepare patients to gain independence and integration in the 'community' but also to develop personal skills so that they too could function away from the support of the Institution.

These priorities provided little scope for even well-motivated staff to develop clinical practices which included psycho-social intervention techniques. This was

because, in the main, families never, rarely or infrequently visited their relatives in mental hospitals, the concept of 'working with families' by ward staff in particular, did not exist.

During the closure programme and since, individuals whose illness had been of more recent onset or subject to periods of relapse were treated in acute mental health units from where they were discharged back into the community to live with either families, friends or carers or as residents in single persons' hostels (Audit Commission, 1994).

Some members of the 'asylum' staff chose to work in these units, others were transferred to set up small community units providing long-term care, but many others went to work in community teams and day care facilities where energies were directed not only at monitoring individuals' safety in the community but using interventions to prevent relapse and re-admission to hospital. For many staff to work with families/carers to achieve these aims was a new experience, for which nothing in their previous experience or education/training had sufficiently equipped them.

2.2.1   Review of Relevant Nursing Educational Documents

A scrutiny of the syllabus of training for the professional register during the 1970's and 1980's reveals a limited recognition that the families/carers, the patient and the professional staff need to work together to resolve problems and that a process for developing these specific skills is required. The emphasis in the two syllabi was on the individual, with the family as a separate unit whose needs must be considered but separate from the relative who is mentally ill. This philosophy may reflect the social isolation of so many patients, still resident in large institutions, who had been deserted by their families and that only a theoretical understanding of 'working with families' would be considered relevant by the educational bodies. Wing (1984) reported that during the period when the majority of individuals suffering from mental illness were cared for in large institutions, they received decreasing numbers of visitors as the years progressed. (See p. 27 for family influences in schizophrenia).

2.2.2. Syllabus of Training For Professional Register RMN

1.   **The General Nursing Council for England and Wales 1974 (GNC, 1974)**

Throughout the syllabus the word 'family' occurred only three times and in the context of its reactions to mental illness and hospitalisation. In contrast there were two large sections dedicated to the nurses' role in OCCUPATIONAL THERAPY.

2.   **The English National Board for England and Wales 1982 (ENB, 1982)**

In this syllabus 'family therapy' was the last mention in a long list of specialised techniques. The importance of understanding and working with family interactions came in the last section of the document entitled 'knowledge base.'

There was no recognition in the syllabi that the students required to practice specific skills to understand and work with families.

3.   **The United Kingdom Central Council (UKCC) for Nursing Midwifery and Health Visiting Diploma of Higher Education (Project 2000) Mental Health Branch**

There is some advancement in this syllabus. Students must demonstrate competence in implementing a care plan for clients and families through the application of professional knowledge and skills but "professional knowledge and skills" implies that working with family interactions is part of a general repertoire whereas this area of work needs to be focussed.

2.3 Recent Government Policies Relating to Mental Health Care

Many professional groups had, over time, deplored the 'institutional system' of care, sometimes providing primitive living conditions for the residents and too frequently poor nursing standards.

But progressive, organisational change was very slow, although the aim of the Mental Health Act (MHA, 1959), and reinforced later in MHA 1983, was to provide care in the community for most people who suffered mental health problems and supported by hospital care where necessary.

A model District Service, described in DHSS Better Services for the Mentally Ill (1975), stressed the need for the provision of a range of services and accommodation in the community. There was also encouragement for the resettlement of the institutions' long-stay residents.

The government signalled an acceleration of this policy when in 1981 a consultative document *'Care in the Community'* stated that, 'most people who need long-term care can and should be looked after in the community.' Of importance, it also stated that family and carers should be involved. This was followed in 1989 by *Caring for people: Community Care in the next decade and beyond* (DHSS, 1989). But it was when the government introduced the Care Programme Approach (1991) (CPA) that the responsibilities of health care professionals were clarified as never before. Four main elements were identified:-

1.   Systematic assessment.

2.   The formulation of a care plan which identified health and social care needs.

3.   The appointment of a key worker to monitor care.

4.   Regular review to involve changes to the care plan when necessary.

Of importance was the increasing emphasis that CPA placed on the involvement of carers in the care plan. It was recognised that carers provide the majority of care for mentally ill people and their contribution to meeting users' needs should be explicitly recognised in the care plan.

Yet, in spite of this guidance, the professional groups were slow to engage in this system of care. The Health of the Nation (1992) reported — five years after the official implementation of CPA — that many District Health Authorities had failed in their obligations.

Continuing reports from Independent Inquiries into a homicide by a Mentally Ill person HSG (94) 27 (see Appendix L, p. 194) have demonstrated a failure on the part of the professional teams to consider the needs of families and carers, too frequently with disastrous results.

The Government policy document affecting Mental Health Services entitled "The National Framework for Mental Health (September 1999)," addresses the needs of adults up to 65 years and is founded on knowledge-based practice and partnership

practice between those who use and those who provide services. It key purpose has been:

To work with individuals, families, groups, communities

> 'to provide equitable and non-discriminatory services which promote
> mental health, address mental health needs, manage risk and provide
> appropriate support to people with mental health needs and their
> carers.'

It sets out the required National standards, National service models, plans for local action and national programmes for implementation as well as performance indicators to support effective performance management.

One important standard focuses on the needs of those who provide regular and substantial care. They must have an assessment of their caring, physical and mental health needs, repeated on at least an annual basis and along with the service user be involved in the planning and delivery of care. Each carer must have a written copy of the agreed care plan.

Of relevance to this study is a statement in the National Service Framework document which makes it clear that as well as hospital beds psychotherapeutic interaction services must be available when required. This includes work with families. The document pays particular attention to mental health promotion and the discrimination and social exclusion associated with mental health problems. This will be referred to later in this study when cultural issues are discussed. The needs of health service workers as viewed in the document will be addressed later under issues relating to education, training and support and supervision.

2.3.1. People who Suffer from Serious Mental Illness

The National Framework (see p. 13) addresses gaps in current services to people with severe and enduring mental illness. This concern is a repeat of an earlier Government policy which stated that mental health services must target their resources and efforts first and foremost on the severely mentally ill (The Health of the Nation 1996). The term included those diagnosed as suffering from schizophrenia or a severe affective disorder, those who suffer disability as a result of their illness and are unable to care for themselves.

2.4 Serious Mental Illness and Treatment Regimes

2.4.1 Schizophrenia

2.4.1.1. Introduction

The term schizophrenia is applied to a number of different concepts. There is still disagreement amongst psychiatrists world wide on a strict theoretical definition. Some characteristics would be labelled schizophrenic by most psychiatrists but not all. The World Health Organisation (1973) set up an International Pilot Study on schizophrenia which showed that an 'operational' definition could be made. By using a standard technique for interviewing patients (Wing, Cooper and Sartorius, 1974), groups of psychiatrists in nine countries in different parts of the world identified similar groups of patients who had received a diagnosis of schizophrenia on clinical examination by local psychiatrists.

There was no expectation that the group of conditions identified as schizophrenic conformed to a single disease entity but the advantage of a central operational definition provided a basis for listing hypotheses about causation, pathology, treatment and prognosis.

The International Classification of Disease (ICD) (295) defines schizophrenic psychosis as a group of psychoses in which there is a fundamental disturbance of personality, a characteristic distortion of thinking, often a sense of being controlled by alien forces, delusions which may be bizarre, disturbed perception, abnormal affect out of keeping with the real situation and autism. Nevertheless, clear consciousness and intellectual capacity are usually maintained.

Since the term schizophrenia was first introduced in a historic paper (Bleuler, 1908, cited in Wing and Wing, Eds. (1982), P. 253), the aetiology of the condition has been pursued with intensity and diversity. Although there have been many authoritative studies on the subject, its precise cause remains obscure.

2.4.1.2. Causative Factors

Research into the causes of schizophrenia has occupied international scientists for over a century and findings have ranged extensively from inheritance to epidemics of Influenza.

Twin studies throughout the world gave credence to the view that schizophrenia was caused by a genetic abnormality. Twins can be monozygotic (MZ) - derived by the division of one fertilised egg and therefore genetically identical or dizygotic (DZ) - derived from two fertilized eggs and therefore no more genetically alike than siblings. The concordance rates - that is the extent to which twins share the same trait - were significant to the debate. A major study at the Maudsley Hospital (Gottesman & Shields, 1972) confirmed that concordance rates for schizophrenia were 40% to 45% for MZ twins compared with 10% of DZ twins.

The fact that the concordance rate was not 100% did not convince environmental researchers that a genetic factor alone was responsible for the condition.

An increasing interest in the field of biochemical research centred on the neurotransmitters and the enzymes responsible for their metabolism. The importance of transmitter imbalance as the basis for abnormal behaviour was recognised.

Other factors which were implicated as the cause of schizophrenia were birth injuries and the season of birth. Babies born in the winter months were believed to be more likely to develop schizophrenia.

Sociological research provided evidence that schizophrenia had long been associated with social deprivation and low socioeconomic status. Those who began life in higher socioeconomic groups may have suffered a decline in status and earning capacity due to their illness and drifted to areas of social deprivation. This became known as the 'drift hypothesis', a term first discussed in the 1970s (Hare, Price & Slater, 1972). Consistently higher rates of schizophrenia continue to be diagnosed in immigrant groups and will be discussed fully in a later chapter.

With the increasing theoretical influence of psychoanalysis during the second half of the last century, impaired emotional development giving rise to psychological disturbance gained importance as a factor in the causation of schizophrenia. Every new theoretical concept was challenged and a clear division existed between researchers who continued to investigate possible organic causes and those who believed that the illness was purely a psychological one caused by emotional disturbance and deprivation.

This conflict of opinion became known as the "nature/nurture" debate and has only recently narrowed with increasing knowledge of the role of genetics in disease processes in general and accumulating evidence that both genes and the environment play a role in the aetiology of schizophrenia (Vaswani. Kapur, 2001). No single gene according to Meltzer (2000) causes schizophrenia and the dominant model for the condition is the result of multiple genes interacting with each other along with environmental influences. Environmental influences may take many forms and in combination with the interplay with genetic influences this has opened up an increasing number of research possibilities.

Yolken *et al.* (2000) have discussed evidence that retroviruses which are biologically complex infections agents are capable of cellular infection and subsequent integration into the host genome. They may affect the transcriptional regulation of adjacent genes and result in alterations of neural functioning. The identification of a retroviral component of schizophrenia would therefore, according to these researchers, be consistent with the genetic, environmental and neurodevelopment of the disease.

Brown (1999) also supports the view that genetic defects combined with early environmental insults may account for the developmental abnormalities in schizophrenia. As the previous researchers, Brown focuses on neurodevelopmental research and in this respect the increasing importance of searching for the causal mechanisms at the biochemical and molecular level.

On the other hand, Munk-Jorgensen, Ewald (2001). while acknowledging the concentration on the two closely connected directions — that of the genetic element and the search for environmental factors — are of the opinion that the most interesting results of the latter have focussed on damage to the immature brain during pregnancy and delivery.

Schiffman, Abrahamson, Cannon, LaBrien, Parnas, Schulsinger. Mednick (2001) reported on a review of research on the relationship between the environmental risk of developing schizophrenia and early rearing factors such as family dysfunction and parental loss or separation. The findings were mixed but became clearer when the vulnerability resulting from a genetic liability to schizophrenia was taken into consideration. This emerged when the researchers studied children who had a family history of schizophrenia. The authors concluded that when combined with a

genetic risk for schizophrenia, disruptive early rearing circumstances contribute significantly to later schizophrenic outcome.

An important finding originating from behaviour genetics over the past 15 years has been that genetic factors influence individual differences to environmental risk (Rutter *et al.,* 1997 and 1999; Rutter & Spilberg, 2002).

In spite of these findings there have been none, until recently, relating to the genetic effects on differential parenting. Carbonneau *et al.* (2002) studied a sample of 1,117 like sex pairs (318 MZ males, 407 MZ females, 190 DZ males and 202 DZ females) within their family environment. Measures of "within family environment" were collected using interviews with both parents separately and twin versions of the Twin Inventory of Relationships and Experiences (TIRE; Carbonneau *et al.,* 2001). Their study selected four factors that described family interactions: differential parent criticism including punishment, mother's preference including which twin received more attention, a similar factor for father's preference and dominance between twins. One example in the findings of a complex piece of research was that of parental criticism. The environmental variance was much greater in DZ than MZ pairs although parents did show differential criticism with MZ pairs. It was concluded that some of that variance must be attributed to non-genetic factors and is an important aspect of the ways in which the interplay between nature and nurture operates.

In the introduction to their research the authors commented on how little is known about which dimensions of the family environment are influenced by genetic factors and specifically the influence of family characteristics in the development of psychopathology. Previous work has already noted that children's behaviour influences the responses of people with whom they interact (Scarr, 1992).

However, what is new in the present research is that it provides evidence for the notion that genetically influenced features of child behaviour lead them to create or shape their own differential environment within the family. In their concluding comments, the authors postulated that it was possible that a risk factor for the development of psychopathology (not specifically schizophrenia) may be strongly genetically influenced but its effect to be largely environmentally mediated. This particular piece of research (which is discussed extensively from p. 27 to p. 31) has implications when considering the value of family and social intervention

programmes in the treatment and maintenance of people who suffer from major mental illness. Both forms of interventions aim to reduce the 'environmental risk'.

It also demonstrates that this and similar research is helping to reduce the 'family blame culture' which has existed in part since the 1960's when a psychiatrist, R.D. Laing (1960; 1964 with Esterson) published work in which he placed the onus on families for one of their members developing a mental illness.

2.4.1.3. Clinical Presentation of Schizophrenia

Over recent years, the majority of psychiatrists have paid attention to the symptomatological criteria described by Schneider (1976, cited in Wing and Wing, Eds., p. 6) as essential for the diagnosis of schizophrenia. These are known as 'first rank' symptoms and although not regarded as of theoretical value, they are considered important when making a diagnosis. 'First rank' symptoms are present when: patients hear their own thoughts spoken aloud; hear voices which comment on their behaviour; have a feeling of their body being influenced by outside forces; have feelings of thoughts being removed or foreign thoughts being inserted into the mind; feel that thoughts are broadcast to other people; feel that emotions, drives and intentions are dictated by external forces.

If the onset is abrupt, there is a sudden appearance of abnormal behaviour, usually in response to the development of delusions and/or hallucinations. The person exhibits marked fear in response to these new and strange experiences.

The acute florid state may develop unchanged for many years in spite of intermittent remissions, or it may subside leaving a chronic defect state.

These differ from the florid symptoms which are readily identifiable by abnormal behaviour in that there is absence of normal behaviour. They are sometimes referred to as negative symptoms and in the past were also associated with institutionalisation but with present emphasis on community care such states can develop just as readily in sheltered accommodation.

There are several types of defect which may occur together or may be more pronounced in one individual than another. There may be a lack of initiative where the patient appears to lose the ability to initiate action, or a lack of energy, a feature which results in patients carrying out movements slowly. Coupled with physical slowness is a retardation of mental activity. A prominent feature is a progressive

lack of interest even in the patient's previous specific interests. There is a lack of emotional responsiveness, social withdrawal and a loss of social skills. The latter particularly causes distress to families. Table manners are lost, appearance becomes dirty and dishevelled, washing and bathing is neglected rendering the patient malodorous.

Frequently the patient needs to be detained under the conditions of the Mental Health Act 1983 in a safe environment which offers support and safety to the patient and sometimes other people.

Increasing interest has been taken by clinicians and researchers during the last two decades to into early warning signs of schizophrenia known as the Prodromal period.

The term PRODROME refers to a period when subtle changes in thought, affect and behaviour precede the development of frank psychosis (Yung *et al.*, 1995)

PRODROME in this context has been further defined: INITIAL PRODROME is the period of time which lasts from the first change in a person's psychological and behavioural state to the development of first rank symptoms (Loebl *et al.*, 1992), whereas RELAPSE PRODROME denotes the pre-psychotic period before a relapse occurs in those patients with an established psychotic illness (Herz & Melville, 1980; Birchwood *et al.*, 1989; Malla *et al.*, 1994).

The importance of early diagnosis and management of psychotic disorders has long been recognised (Cameron, 1938). However, it is only during the last two to three decades that a systematic, researched approach to prodromal symptoms has been used in clinical practice. The prodromal approach to impending psychotic illness is to identify the earliest signs and offer timely and effective intervention to arrest progression.

This approach has been practical to implement in relation to the RELAPSE PRODROME which most researchers estimate as a period of 4 weeks (Herz & Melville, 1980; Birchwood *et al.*, 1989; Malla *et al.*, 1994) before psychotic symptoms become apparent. Psychological and behavioural changes followed by frank psychotic symptoms within that period can safely be assessed as related.

However, clinical practice in relation to INITIAL PRODROME is entirely different. There is much uncertainty concerning the time interval of the prodrome. The few

researchers who have made an estimate (Varsamis & Adamson, 1971; Hafner *et al.*, 1992A, 1992B, 1993, 1994; Hamrecht *et al.*, 1994) considered that it takes a minimum of 52 weeks, even years, before psychotic symptoms become apparent. Clinicians are faced with a dilemma. Early symptoms are vague and could be attributable to other underlying conditions such as anxiety states, particularly in the 18-19 year-old age group, when problems frequently first arise. Should intervention techniques be offered on the basis that a possible or probable long-term outcome may be a schizophrenic illness but at the same time risk raising anxiety and social prejudice if time proves this is not the problem? (Falloon, 1992).

Resolution of this dilemma is important because of the longer term damage to the individual if treatment is delayed; poorer outcome, longer illness duration and longer till remission of symptoms (Loebel *et al.*, 1992). The Northwick Park study of 253 first episode patients (Johnstone *et al.*, 1986) revealed that 26% took over a year to receive treatment and had a higher relapse rate over the following two years than those with a briefer period of untreated illness.

In contrast, there has been considerable research directed to RELAPSE PRODROME. According to Birchwood, Spencer and McGovern (2000), this begins with non-psychotic phenomena such as depressed mood, withdrawal, sleep disturbance occurring early and in predictable order followed by increasing levels of emotional disturbance before frank psychotic symptoms appear in less than 4 weeks. An earlier study by Tarrier, Baraclough and Bamrah (1991) revealed similar findings. 56 patients suffering from schizophrenia were followed up for 9 months. The Psychiatric Assessment Scale (PAS) (Krawiecka *et al.*, 1977) was administered at monthly intervals. Sixteen patients who relapsed during this period showed a significant increase in PAS symptoms of depression and hallucinations the month before relapse.

The prodrome has been shown to be an important element in the management of schizophrenia. The prevention of relapse is crucial, as each occurrence may result in the growth of residual symptoms (Shepherd *et al.*, 1989) and accelerating social disablement (Hogarty *et al.*, 1991).

Methods which have been shown to be effective for relapse prodromal symptoms will be further discussed in Section 2.4.1.6, under B. Psychological Treatments (see page 24).

2.4.1.4. Treatment Aims

Treatment plans for individuals suffering from schizophrenia will need to be adjusted as the clinical picture changes during the progress of the illness. Therefore, good clinical/social assessment protocols must be in place. The complexity of its causation and clinical presentation require that a number of treatment options are available to individuals as well as a recognition of their particular needs to facilitate their rehabilitation in the community. These factors are important to identify as research findings have shown that family/social relationships are crucial in preventing or reducing the frequency of relapse.

2.4.1.5. Psychological Assessment

A.   Initial Assessment

Services which are directed to the care of individuals during the acute form of the illness when the most disturbed symptoms are manifested must consider safety and containment both to the individuals and those who care for them. However, it is during the period that an assessment is begun that there is a need to consider the social systems which support the individual in the community. Social system theory will be discussed later.

B.   Assessment of Rehabilitation Needs

Each patient must have a detailed assessment of both clinical and social needs and a care plan which identifies how these needs are to be met and by whom. In order to prevent or minimise the frequency of relapse, the particular stress or stressors making that person vulnerable need to be identified. This may be more difficult than it seems because it is apparent in clinical practice that events which give rise to stress in one person do not do so in another and some individuals may not respond adversely to conditions or events which to others would be catastrophic, such as the death of a near relative. In an early study Birley and Brown (1970) studied the frequency and type of events which occurred during the three months preceding the onset of an acute episode of schizophrenia, whether the first episode or a relapse, and the three months before an interview with people not suffering from the condition.

60% of patients had experienced an event three months before onset compared with 15% of control subjects. But of interest is that some of the precipitating events in

the patients' lives were what others might describe as happy events. such as getting engaged or married.

It appears from such a study and experience in clinical practice that people who suffer from schizophrenia are sensitive to emotional arousal whether happy or sad, and indicates the importance of evaluating environmental factors which in view of current research in the aetiology of schizophrenia is particularly significant.

2.4.1.6. Treatment Methods

Treatment methods may be divided into pharmaceutical, psychological and family interventions and will be discussed under these headings.

A.   Pharmacological Treatments

Pharmacological treatment during the acute phase of the disorder has provided the only known means of controlling the distressing symptoms of schizophrenia and allowing the patient to become more amenable to psychological support. The drugs in use have been major tranquillisers. traditionally from the Phenothiazine group. However, they have resulted in patients suffering most unpleasant side effects such as extra-pyramidal ones and tardive dyskinesia.

A newer atypical anti psychotic drug named Clozapine has been preferred by many patients as it results in fewer of these side effects but has a risk of causing agranulocytosis. In a research study of 80 patients suffering from schizophrenia who were aged 18 to 60 years from four German hospitals, Angermeyer *et al* (2001) found that Clozapine helped them to feel better. They considered that it was superior to conventional neuroleptic drugs because it stopped them suffering the extrapyramidal motor side effects. Of the negative effects, hyper-salivation was a problem for some.

Once a more chronic form of the disorder has developed, treatment shifts from containment to maintenance medication, consideration of sociological factors, social interventions, cognitive behavioural therapy and rehabilitation.

Many at this stage are maintained on depot anti-psychotics which require monthly injections and monitoring of the drug's efficacy, dose and side effects. However, they do produce the same adverse side effects as oral anti-psychotics and some

consider that unless compliance is a major problem, patients should be encouraged to take oral atypical anti-psychotics.

B.   Psychological Treatments

Until recently, psychotic disorders, particularly schizophrenia, have been viewed as primarily biological disorders and only amenable to biological treatments. However, eventually it was considered to even entrenched clinicians that it was acceptable to introduce systems which concentrated on the reduction of negative symptoms of schizophrenia such as social skills deficits.

Token Economy, a form of behavioural 'engineering,' was used to reverse such negative symptoms. Based on operant conditioning which immediately rewards desirable behaviour, trained nursing staff would reward desirable social behaviour such as self care skills with tokens which could later be exchanged for a pleasurable activity such as television viewing. Good results were achieved but may have been as much due to the increased amount of staff time and interest invested in the patient which the technique involved (Baker et al., 1977).

Operant conditioning was also used in the treatment of the positive symptoms of schizophrenia, for example delusions, again involving increased time spent on therapist/patient interaction.

Social skill training (SST), a more sophisticated approach to modifying the social functioning of psychotic patients received much attention. The main focus of this approach was to view social functioning as a set of skills which had to be learned and practised. Therefore the social deficits experienced by patients suffering from schizophrenia could be taught and patients trained in their execution (Liberman et al., 1989; Halford & Hayes, 1991). Good results were obtained during the training period but were more difficult to generalise.

Behavioural approaches have been greatly developed since earlier rudimentary attempts at treating psychotic symptoms. These included aversion therapy which involved a patient giving himself an electric shock every time he heard his 'voices'.

During the last decade the introduction of Cognitive Behavioural Therapy (CBT) approaches has gained increased acceptance in mainstream psychiatric practice

(Durham *et al.*, 2000). The treatment of families using these approaches has gained considerable interest (Tarrier, 1996) and will be discussed fully later in this chapter.

In general, CBT is practised in community-based services. One exception has been a study reported by Drury (1994) in which the therapist attempted to implement a CBT approach with a sample of acute in-patients, some of whom were experiencing their first episode of psychosis. In the study, some patients were allocated either to an intensive CBT programme or an equally intensive programme of activities. The results demonstrated that the length of stay in hospital was approximately half that of the control group and that the time to reach a 50% reduction in symptoms was also half that of the control group.

This study has obvious benefits, not only to the patients involved but to the hospital service whose financial costs could be reduced. However, the longer term benefits to patients and the services need to be evaluated

Another study which also demonstrated benefits to the service as well as patients, but this time with outpatients, was carried out by Tarrier *et al.* (1998) who compared intensive CBT and routine care with supportive counselling or routine care alone. The study involved 87 patients aged 18 to 65 years of age who suffered from chronic schizophrenia.

CBT involved coping strategy enhancement, training in problem solving and strategies to reduce relapse risk. Supportive counselling involved developing a relationship that fostered rapport and unconditional regard. Routine care was standard psychiatric management with medication and outpatient monitoring.

The results showed that CBT led to a decrease in both number and severity of symptoms. The decreases were greater than those of patients who received supportive counselling while routine care alone showed slight increases in number and severity of symptoms. Clinical improvement was achieved by more patients who received CBT than patients in the other two groups combined.

This study also showed the benefits to the service of using CBT programmes as well as supportive counselling. The total number of hospital days for routine care group patients was 204 compared with one day in each of the CBT and supportive counselling groups. CBT was shown to have reduced relapse at one year compared with standard treatment.

Early work in the treatment of the symptoms of major psychiatric illness such as hearing voices focussed on operant procedures which aimed at distracting the individual from the particular symptom. This was and remains in line with psychiatric teaching which dissuaded nurses from reinforcing these symptoms by their discussion.

In contrast, therapists using current CBT, combined with neuroleptic medication, emphasise the importance of focussing on rather than distracting from the symptoms as an important process of therapy. Understanding the relevance or meaning to the patient is important to their remediation (Haddock *et al.*, 1997).

This view is supported by Turkington and Kingdon (1997), who consider that the engagement of a person suffering from schizophrenia in discussion ab out their symptoms is essential to their recovery, relapse, compliance and coping. The model which they teach is based on a description of the following: thoughts can cause feelings and behaviour, thoughts are amenable to change which in turn changes the behaviour.

However, Perlman and Hubberd (2000) have reported success in a small programme of patients from a psychiatric day hospital who were provided with a variety of coping strategies to shift attention away from hallucinations: 7 out of 9 patients noted improvement in their symptoms.

As part of treatment programmes for individuals suffering from schizophrenic illness, attention must be given to the identification of prodromal symptoms as a means of preventing future relapse. There is considerable variability between individuals in the nature and timing of early warning signs (Birchwood *et al.*, 1989, Jorgensen 1998). Account must be taken of those individual variations to be clinically useful.

Birchwood, Spencer and McGovern (2000) aimed to construct a hypothesis about an individual's relapse 'signature' as part of a treatment programme. This describes a set of particular symptoms which occur in specific order over a particular time period which serve as early warning signs of impending psychotic relapse. Patients are encouraged to review, either alone or with the support of the family members, any noticeable changes in their thoughts, perceptions, feelings and behaviours leading up to their most recent episode. Part of treatment uses Cognitive therapy which focuses on the meaning with which patients invest their symptoms and the

evidence they hold for their beliefs. The authors admit that the methodology may not be suitable for all individuals suffering from schizophrenia but for many it offers the promise of a reduction in the negative biological and psychological consequences of psychotic relapse.

Targeted CBT was used in a research trial by Gumley, O'Grady, McNay *et al.* (2003) to question whether this form of intervention prevented relapse of schizophrenia compared with usual care in people with prodromal symptoms. They concluded that targeting CBT to people with schizophrenia whose prodromal symptoms increase may reduce relapse rates and hospital admission compared with usual care.

C.   Family Intervention

Current research has shown that schizophrenia is most likely to be caused by both genetic and environmental factors, of which family and social relationships are strongly implicated. Consideration is now given in some mental health services to providing family and social therapeutic interventions as part of continuing community care programmes.

Various models have more recently been introduced to the therapeutic repertoire of skills required by clinicians to work with individuals suffering from a major mental illness. Previously, traditional family work addressed the needs of families whose 'presenting' member suffered from psychological conditions which required treatment and support but were not identified as a 'major mental illness'.

Since the mid '70s there have been a number of reported family studies whose focus has been not only on treatment but investigations of wider issues such as possible precipitating factors within family/social relationships or the benefits of educating front line clinicians such as CPNs to work with families.

These studies will now be discussed; the early EE research (Vaughn & Leff, 1976), later EE research (Leff *et al.*, 1982), education of CPNs (Brooker, Barrowclough and Tarrier, 1992) and a description of the traditional family therapy models as these influenced the teaching on the ENB A28.

D. Early Family Studies

Primary work by Brown (1958, 1959) forty years ago established that environmental influences, in particular the emotion expressed by relatives to sufferers of schizophrenia, were strongly implicated in relapse and re-admission to hospital.

Brown and Rutter (1966) developed a sophisticated measurement instrument which became known as the Camberwell Family Interview (CFI) which allowed trained interviewers to assess, reliably and validly, emotional relationships within families over a defined period of time. The actual scales of emotion were of two different types: ratings of observed emotion e.g. warmth, hostility and emotional over-involvement; and frequency counts of the number of positive or critical remarks the relative made about the patient over a four-hour period. The term over-involvement was considered by Brown, Birley and Wing (1972) and they designed a study which paid attention to measuring its components. The term was precisely specified and expressed emotion (EE), substituted.

E. Later Studies

Since Brown's early work, a number of retrospective studies took place which sought to demonstrate a relationship between post-hospital relapse in patients suffering from schizophrenia and their home environments where Expressed Emotion could be either HIGH or LOW. Generally it was established that relapse occurred more frequently in High Expressed Emotion homes (HEE) but that by reducing face to face contact and the administration of maintenance phenothiazine medication a protective effect was exerted (Leff and Wing, 1971).

Vaughn and Leff (1976) shortened Brown's measure of expressed emotion (CFI) to two hours, but demonstrated that the single most important predictor of relapse was the number of critical comments made by the relatives about the patient, confirming the finding of Brown *et al.* (1972).

In a study of 43 schizophrenic patients discharged from three London psychiatric hospitals, Vaughn and Leff (1976) found the relationship between EE status of relative(s) and subsequent rates of relapse was highly significant: relapse in HEE homes was forty percent but in Low Expressed Emotion homes (LEE) only six percent.

A method of social intervention which could measure and teach families where there was a member suffering from schizophrenia was designed by the researchers (Leff *et al.*, 1982). The aim of the programme was to reduce the level of EE in relatives and to reduce face to face contact between HEE relatives to less than thirty five hours a week. It was hoped that by these means relapse would be prevented. The programme was researched with encouraging results, (Leff *et al.*, 1982.)

A group of 23 patients rated by the researchers to be at a high risk level of relapse, i.e. those in contact with a HEE relative for more than 35 hours a week, was randomly assigned to either a treatment group or a control group. All patients continued to receive medication. The control group continued to receive out-patient care. The treatment group was offered a programme of education, relatives groups and family therapy.

2.4.1.7. Details of the Programme in the HEE Studies
A.   Education

A programme was introduced to teach relatives that negative symptoms such as apathy, inertia, lack of energy and loss of social and personal hygiene skills were an integral part of the illness.

The intention was to reduce the relatives' critical comment.

B.   Family Groups

Family groups comprising HEE and LEE relatives were formed. These provided emotional support and enabled families to share coping strategies.

C.   Relatives Group

Therapeutic sessions were held with patients and relatives in their own homes. Social interventions designed to lower EE included this advice: if single, to live away from home; if married, attendance at a day centre or a day hospital to be considered.

D. Research Findings of the HEE Studies

Nine months later, of 12 patients belonging to the control group, 50% had relapsed. Only one patient (that is 9%) in the experimental group had relapsed.

The same study was repeated two years later (Leff, Kuipers, Berkowitz, Eberlien, Sturgeon, 1985). The results showed a cumulative relapse rate over the entire two years of 62% for patients from HEE families and 20% for patients from LEE families.

The EE research stimulated considerable interest and further developments in family intervention therapy. However, there was some criticism of the EE research in that the level of EE was made at a particular time and therefore could only be considered a "snapshot" in family relationships which might fluctuate over time.

E. Further Research Studies in Family Therapy

Following the initial trials in London by Leff and colleagues, others took place during the next decade in the U.S.A., Australia and Germany. They used a variety of techniques, either alone or in combination, but all with the primary aim of reducing the risk of relapse in the illness of a member of the family suffering from schizophrenia.

Tarrier and Barrowclough (1988) and Tarrier *et al.* (1989) carried out a trial in Salford which was strongly influenced by the behavioural therapy movement. They believed that for relatives to become rehabilitators and to assume that role, they needed management skills in order to reduce stress in the home environment and to encourage positive levels of functioning in the patient.

Two studies were completed in the U.S.A.; Falloon and colleagues (1982) and Falloon *et al* (1985) were influenced by the EE research and by previous work on social skills training which they applied to family settings using methods to improve communication with the family accompanied by a problem-solving format to enhance these skills. Hogarty *et al.* (1986-1991) combined a psycho-educational form of family therapy and, similarly to Falloon, used social skill training focussed on the patient's ability in dealing with his/her family as well as relationships in the community.

In Australia, Vaughn and colleagues (Vaughn *et al.*, 1992) came from a behavioural therapy tradition and used the model of Hogarty and colleagues to reduce the risk of HEE which they viewed of paramount importance. They carried out these interventions without the patient being present and the study was of shorter duration than other studies.

An entirely different methodological study was made in Hamburg by Kottgen *et al.* (1984). This was carried out in a group format using psycho-analytical techniques. Similarly to the method used in the Vaughn study, only the relatives took part.

The results of follow-up at 9-12 months showed that all but two were able to demonstrate significant reduction in relapse rates.

However, neither the Hamburg study (Kottgen *et al.* 1984) nor the Sydney study (Vaughn *et al.* 1992) was able to demonstrate significant benefits from their interventions. Both these studies differed markedly from the successful trials. Neither involved the patients in their interventions.

The studies which demonstrated a significant reduction in relapse rates at 9 to 12 months also reported that after 24 months a significant benefit had been maintained, although there had been an increase in the number of relapses.

2.4.1.8. Cognitive Behavioural Family Therapy (CBT)

Although many clinicians continued to use a variety of interventions based on the EE findings, others considered that the beliefs and cognition of relatives could be better targeted by a more cognitive approach to family management. (Barrowclough and Tarrier, 1992).

A.   Training Studies Using CBT

In the School of Nursing at Manchester University, Brooker set up a project in 1988 to train community psychiatric nurses (CPNs) in family management methods and to evaluate the effectiveness of this training. This was of particular interest because this was the first time that community psychiatric nurses were mentioned in the context of family intervention research.

In the initial trial (Brooker, Barrowclough and Tarrier. 1992), nine CPNs in the experimental group were trained in the Barrowclough, Tarrier family management

intervention. This group, as well as nine other CPNs in the control group were trained in clinical assessment methods.

The course was of six months' duration and consisted of didactic and workshop teaching and clinical supervision throughout the six months. The continuous clinical supervision was considered an essential constituent of the course and was led by clinical psychologists experienced in the area.

At evaluation, patients and families reported small in-patients' symptomatology; depression, anxiety, delusions and physical retardation improved in patients managed by the CPNs. Of significance, the relatives of patients in the experimental group showed a decrease in the presence of minor psychological symptoms and this may indicate a decrease in the subjective burden of care.

In a subsequent study, Brooker and colleagues (Brooker *et al.*, 1994) carried out a trial in which the family intervention was taught by Falloon and his colleagues. The patients who received intervention showed a significant improvement in both positive and negative symptoms and an increase in social functioning. There was also evidence of a dramatic decline in hospital usage.

Both studies indicate the positive benefits of training CPNs in family intervention.

In comparison, in Australia a study of family intervention training was carried out by Kavanagh and colleagues (Kavanagh *et al.*, 1993), who trained mental health workers in a cognitive-behavioural approach. However, the training had little impact on clinical practices. According to Tarrier (in Haddock & Slade, 1996, pp. 227-228) there were two possible reasons why the training programme produced such poor results. Successful training requires progressive supervision and that teaching is unlikely to result in skill acquisition in the absence of guided practice. A second important factor, according to Tarrier, is the requirement for a commitment from health service management to facilitate the training and practice of the new approach.

2.4.1.9 Traditional Family Therapy Models Relevant to the Study of the ENB A28

The three major family therapy models are: systemic, structural and strategic.

A. Systemic Family Therapy

The systemic approach to family therapy is a traditional method which, unlike the clinical studies previously discussed, has not until recently focussed on the needs of families in which the identified patient suffered from a major mental illness. The changes it has made in its approach to meet health service needs and the changing social patterns of family structures will be discussed later.

Family therapists who work in the Family Project were trained and continue to use traditional family therapy models in combination with the clinical application of the EE studies and a behavioural problem-solving approach.

Systemic thinking which underpins this approach can be of value to clinical staff working in units where individuals are acutely ill and not amenable to any form of family intervention at this stage of the illness.

> *'Family therapy has been developed by clinicians who have adopted some of the main assumptions of SYSTEMS theory.'* HAYES 1991

A system is defined as a set of units or elements standing in some consistent relationship or interactional stance with each other (Steinglass, 1978 cited in Paolino and McCrady, Eds., p. 305).

> *'Family therapy has broadened the focus of treatment from the individual to the family. It contends that individuals are best understood by examining their relationship to others and the environment with which they interact.'*

The universal goal of the 'family therapist' is to remove the symptom (the presenting problem), alleviate family distress and clarify communications. It is recognised that change occurs either by altering the pattern of interaction between family members or changing what they believe the problem to be.

There is a concentration on the present rather than the past, emphasis on insight is reduced and action is promoted. The therapist's role is essentially that of a 'change agent'.

B. Structural Family Therapy

The development of this school of family therapy is generally credited to the family therapist, Salvador Minuchin (1974).

It contends that families develop structures, e.g. patterns in which they relate, to carry out functions; bread winner, care giver, disciplinarian. There is an assumption that there are an unconscious set of rules based on the family's culture and social demands which govern people's behaviour. During transition in their life cycles families need to reorganise their structures and roles and renegotiate the rules. Where there is inflexibility and difficulty in accommodating to such changes, conditions are created whereby one member may become symptomatic.

A family who presents with a symptomatic member will be assessed by the way transactions between its members take place. If these transactions are dysfunctional the goal of therapy is to restructure the family so as to create conditions for greater flexibility. The aim (Minuchin, 1974) is towards establishing a normal family structure in which the boundaries between and around generations is clear. Individuals need to establish independence appropriate to age and yet feel a sense of belonging to the group.

C. Strategic Family Therapy

Names associated with this school of family therapy are Haley and Madanes, (Haley, J., 1970 and Madanes, C., 1981, cited in Hayes, 1991, pp. 32-33). They are of the belief that families tend to organise themselves around a repetitive sequence of interactions.

Problems that occur following a poor adjustment to critical points in the family's life cycle will continue to respond to any disruption, by interacting in its traditional pattern of problem resolution. The problem may be intensified by the family's efforts to control it and results in the solution becoming the problem.

The goal in therapy is to disrupt self-reinforcing cycles that act to maintain the symptom and to introduce the conditions of more appropriate transactional patterns to develop. Vicious cycles may then be turned into virtuous ones (Wender, 1968).

Strategic Therapists tend to be 'directive' in their approach to achieve change which is their major goal. Tasks for the family are set, based on careful assessment of the family and using the family's language.

D. The Similarities Between the Three Models

All three models: structural, strategic and systemic believe in the importance of disrupting the pattern of the family's interactions in which the symptom is embedded in order to effect change. Therapy is focussed on changing the underlying patterns of interactions or rules and beliefs. Interventions relate to the present and not the past. Communication at verbal and non verbal level is a major focus. In this way, the therapist studies how family members interact together (Kaslow, 1987).

One of the aims of the family therapist is to alleviate family distress. For families caring for an individual who has an enduring mental illness, that distress may be enduring.

2.4.1.10. Burden of Care

Earlier family intervention work focussed on the means to prevent the frequency of relapse and the consequent re-admission to hospital of a family member suffering from severe mental illness. The family/carers were involved as partners in achieving that aim and their feelings and needs were only taken into consideration as they might exert an effect on the presenting problem.

Increasing recognition of the need to pay attention to what is called "the burden of care" has been highlighted in the Government's strategy for mental health (September 1999). Standard 6 (See p. 13). There have been examples, influenced by the EE studies, where families were educated about the condition of schizophrenia and attempts made to understand people's beliefs about the illness.

Organisations such as the National Schizophrenia Society produced booklets (Leff, Berkowitz. Eberlein-Fries and Kuipers, 1995 reprint of 1988 edition) to give further information to families/carers. However, gaining a degree of understanding about

the nature of the problem does not entirely relieve the stress involved in caring for a person suffering from such a disabling condition.

It has long been recognised that the negative symptoms of schizophrenia are the ones which cause the greatest frustration to carers. In a significant study of nurses at the Maudsley Hospital in London (Berkowitz, Heinl, 1984), the researchers discovered that nurses experienced more difficulty, both practically and emotionally, in dealing with the negative symptoms such as refusing to get out of bed and maintaining basic standards of personal hygiene than the positive symptoms such as hallucinations and associated disturbed behaviour. Negative symptoms are associated with chronic, probably enduring forms of the disorder and it is at this stage that individuals are cared for in the community, a situation intensified by the "de-institutional" movement.

As the closure of the large mental hospitals which had served communities in London exerted an effect on family life, Fadden, Kuipers, and Bebbington, (1987), drew attention to evidence which suggested that relatives carry a considerable burden.

Recent studies in other countries confirm this evidence. In the U.S.A., a study by Greenberg, Greenley, McKee, Brown, Griffin-Francell (2001) of 81 mothers of adult children (aged 42 to 82 years) revealed that the subjective burden of coping with a person suffering from severe forms of mental illness resulted in low levels of physical well-being. In Italy, Manning (2000), using structured assessments measuring objective burden, revealed 67% of carers suffered psychological problems.

Cultural issues were identified by Wong (2000) in a study of stress factors and mental health in relatives of patients suffering from schizophrenia in Hong Kong. Results following interviews using structured questionnaires showed that carers experienced most stresses related to the management of negative symptoms such as neglect of personal hygiene and these resulted in poorer mental health. Family shame was a significant factor in the findings as culturally, the Confucian work ethic is of great importance.

2.4.1.11.   Interventions

Brooker *et al.* (1992) reported in a six-month trial of family management (see p. 31) that relatives showed a decrease in minor psychological problems. However. Barrowclough, Tarrier, Lewis *et al.* (1999) conducted a 26-week needs-based psychosocial intervention service for carers using techniques for both CBT with families and CBT with patients suffering from psychosis. The study was followed up after 12 months by Selwood, Barrowclough, Tarrier *et al.* (2001). The findings showed that CBFI for patients suffering from schizophrenia and their carers was better than standard treatment for reducing relapse at one year. but that the number of needs identified by care-givers did not differ between CBFI and family support.

It may be that the needs of those involved in "Carer Burden" cannot be met or changed within one year. However. it might be unrealistic to expect that the burden can be easily lightened.

The focus of research has been on the families/carers of those who suffer from schizophrenia. The families of people who suffer from an affective disorder also carry a burden although theirs may be of periodic intensity.

2.4.2.   Affective Disorders

2.4.2.1. Introduction

Affective disorders, sometimes known as mood disorders. belong to a group of functional psychoses which are primarily identified by a change in an individual's mood which becomes either elevated as in mania or lowered as in depression. Other symptoms can be considered as consonant with the mood change.

These conditions were first termed manic depressive psychoses by Kraeplin (1899). The views he then presented continue to be accepted. Manic depressive psychoses have more recently been divided into bipolar and unipolar disorders. Patients who have attacks of both mania and depressive psychoses are referred to as suffering from bipolar disorder and patients who had recurrent attacks of mania alone or depressive psychoses alone are referred to as suffering from unipolar disorder.

However. in America the term 'bipolar' relates to patients who have had an attack of mania, whether or not they have ever been depressed; unipolar is restricted to

patients who have had episodes of depressive illness but no episodes of mania. There are also some differences between American and European psychiatrists in the method of categorizing depression. While European psychiatrists retain the concept of depressive psychoses, American psychiatrists include 'secondary' depression: a depressed mood which may follow another psychiatric disorder including alcoholism and a history of sociopathic personality.

2.4.2.2. Causative Factors
A.   Genetic Influences

As reported under Schizophrenia (p. 16) attention is now focussed on the role of genes in the aetiology of the major mental illnesses. (Meltzer, 2000) notes that as in schizophrenia, there is evidence that no single gene causes bipolar disorder and that multiple genes interact with each other along with environmental influences.

Crow (October 1986) provided an alternative concept to the majority of researchers; psychosis is a continuum extending from unipolar, through bipolar affective illness and schizo-affective psychosis, to typical schizophrenia, with increasing degree of defect. However, according to this concept, the genes predisposing to psychosis have a degree of stability that ensures that the form of the psychosis tends to remain the same within families.

As in schizophrenia, environmental influences may include physical as well as psychological and sociological ones. Physical influences may include severe bacterial infection, biochemical disorder and hormonal changes.

B.   Biochemical

It has long been suggested that biochemical changes may be important in the aetiology of certain depressive and manic disorders. In recent years three have been the focus of attention; the role of biogenic amines, the importance of endocrinological changes and changes in ion distribution and transport across cell membranes. In the 1950s it was discovered from animal experiments that antidepressant drugs were capable of raising the concentration of the amines; noradrenaline, dopamine and 5 hydroxy tryptamine in the cases of the monoamine oxidase inhibitors or potentiating their effect at the central synapses by blocking their re-uptake into the neurones in the case of the tricyclic drugs. This resulted in

the theory that depression was caused by a reduction of the activity of the amines at the central synapses while mania could result from an increase in such activity. Studies over the last thirty years have led to a clarification of the role of the amines as synaptic transmitters. State and trait abnormalities in serotonin functions in major depression have recently been reported by Bhagwagar, Whale and Cowen (2002).

C.   Hormonal Changes

Abnormalities in endocrine secretion have been reported in depression since the 1960's. Early studies concentrated on the adrenal corticosteroids. Both cortisol excretion and secretion rates are increased in some severely depressed patients.

D.   Sociological

There has been a large volume of research over the past 20/30 years considering social factors as predisposing to affective disorder, particularly depression, although some research does not distinguish between 'psychotic' and 'neurotic' depression. Of particular importance to the researchers has been the relationship between life-events and depression with varying results.

E.   Expressed Emotion Studies in Affective Disorders

As well as the extensive studies conducted in many countries investigating EE relapse in schizophrenia, there has been a growing literature concerning the role of EE in unipolar and bipolar depression (Hooley, Orley, Teasdale, 1986).

Butzloff and Hooley (1998) consider that EE may play an even more important role in the course of mood disorder than in schizophrenia. A number of studies which examined the relationship between EE and relapse in patients with major mood disorders all found a positive association between EE and relapse (Hooley, Orley, Teasdale (1986) and Miklowitz, et al. (1998)).

2.4.2.3 Clinical Presentation of Affective Disorders

MANIA

Mania (and the less serious form Hypomania) is characterised by elevation of mood, pressure of talk, overactivity and expansiveness or grandiosity. The cheerful patient displays an infectious hilarity, with frequent peals of laughter and proclaims

to listeners, 'I'm on top of the world.' Sustained euphoria is unusual and the mood may be at times labile and capricious. Irritability is common and even mild frustration will lead to anger, hostility and aggression. The elevated mood may be interspersed with episodes of depression, tearfulness and sadness lasting from a few minutes to a few hours.

A.   Speech and Thought

Patients who are manic talk excessively, at times almost incessantly. The pressure of speech is often rapid and the voice unnecessarily loud.

In severe cases, the patient experiences a 'flight of ideas', the thinking leaps from topic to topic with changes of direction accompanied by puns and rhymes influenced by chance distractions from the environment (e.g. the colour of the doctor's tie).

Many patients express frank delusions: the majority are grandiose and may be classified according to criteria used by Leff, Fischer and Bertelsen (1976) and still in use today:-

Delusions of special abilities: the patient can cure all sick people

Delusions of grandiose identity: the patient is of royal blood

Delusions of wealth: the patient is a millionaire

Delusions of special mission: the patient is to solve problems of world poverty

B.   Activity and Behaviour

Overactivity is characteristic of mania and is often unproductive, the patient embarking on another task before completing the previous one. In the severest of cases, patients engage in a constant frenzy of activity. Disinhibition is also characteristic of mania. A combination of these disturbed behaviours leads to extravagant spending; lavish hospitality, expensive clothes, large cars. Sexual drive is often increased, sometimes leading to promiscuity. Excessive drinking is common. In the community, the lifestyle of the patient suffering from this condition can lead to financial and social ruin.

C.   Physical Symptoms

Insomnia is a cardinal symptom but it is not associated with fatigue. The patient wakes refreshed. The appetite is usually good although a few patients neglect eating because of their capacity at mealtimes to be distracted by other interests.

D.   Insight

Patients who suffer from mania commonly refuse to admit they are ill and consequently resent being admitted to hospital.

E.   Effects on Family Life

The manic patient's disordered behaviour places an enormous emotional and financial pressure on the family, leading sometimes to marital breakdown.

DEPRESSIVE SYNDROMES

Depressive illness is primarily a disorder of mood with a variable number of associated symptoms such as weight loss and poor concentration.

Patients frequently describe their depression as like a black cloud which has enveloped them. They feel low in spirits, sad, miserable and unable to stop crying. Sometimes the mood is described in physical terms: a heavy weight on the head, oppression in the chest, a feeling of pain. Severe depression is intensely unpleasant, a psychic pain which is less bearable than even the severest physical pain previously experienced (Gibbons (1960) cited in Wing and Wing, Eds., 1982, p.105). Everything in the world looks black, the future is hopeless and the patient helpless. Neither good news nor bad affects the patient's melancholy. There is no source of pleasure. Symptoms are worse in the morning (diurnal variation) with a degree of lightening later in the day. This pattern is characteristic of this syndrome (endogenous) and is uncontrollable without medical intervention.

The combination of inexplicable gloom and uncharacteristic associated irritability is often particularly difficult for relatives and friends to bear (Gibbon, 1982).

A. Speech and Thought

Psychomotor retardation which affects both speech and thought is present. Typically there is a reduction in the amount and rate of speech. The voice is monotonous and the patient pauses before answering questions. The voice may fade away before the sentence is completed. The content of thought in depression comprises one or more of three main themes; guilt, hypochondriasis and poverty. The disorder ranges from anxious preoccupation to delusional conviction.

In pathological guilt, the patient blames himself without justification; the illness is his fault...he has let down his family. Attention is focussed on some minor peccadillo which has become exaggerated in the present. Delusions of guilt are held with full conviction. The patient has brought shame and disgrace on his family, he has committed an unforgivable sin, he is damned and rightly so.

Similarly, some patients are preoccupied with their bodily functions and ruminate on the possibility that some physical disease might be responsible for their symptoms.

Preoccupation with money is a common symptom. The patient may worry about or exaggerate minor financial difficulties from which delusions of poverty may develop and a conviction of financial ruin.

B. Activity and Behaviour

In terms of motility, the patient may be retarded or agitated. Retardation is a decrease in purposive movement. The patient is slow in all actions, the gait is slow and laboured. In the extreme form of retardation stupor occurs in which the patient is mute and fails to react to external stimuli.

In contrast, the patient may experience marked agitation, exhibiting purposeless motor restlessness, pacing up and down, wringing of the hands or rocking backwards and forwards. Retardation and agitation may be regarded as polar opposites, but can co-exist.

C. Suicide

This is an ever-present risk in depression. Suicide is sometimes preceded by the murder of members of the family, especially young children.

Barraclough and Harris (2002) described for the first time the epidemiology of homicide followed by suicide incidents for England and Wales (1988-1992). Of all homicides committed during that period, 19% of child deaths occurred in homicide/ suicide incidents by pre-menopausal mothers. The children were aged from babies to 4 years.

2.4.2.4. Treatment of Affective Disorders

Good treatment of affective disorder involves a detailed assessment and balanced employment of all types of treatment: physical, psychotherapeutic and psychosocial intervention.

A. Physical Treatment

The main treatments available are tricyclic antidepressants, selective serotonin re-uptake inhibitors (SSRI's), monoamine oxidase inhibitors (MAOI's) (for mild depression only) and electroconvulsive therapy (ECT). Severity is the best guide to initial treatment. For the most severe depression with marked agitation and depressive delusions and where there is refusal of food and fluids, ECT is considered by many as the first choice. Due to a weight of opinion that as a life-saving measure from the risk of suicide, no other treatment is comparable. There is a delay of 21 days before antidepressant medication is effective and this is the most critical period of the illness. Controversy around this form of treatment has existed because of possible brain damage. However, Devanand, Dwork, Hutchinson (1994) reported little current evidence that ECT can produce permanent Hippocampal or other structural brain damage.

For moderate depression, either tricyclic antidepressants or SSRI's, in most cases, are the treatment of choice. In normal individuals the tricyclics produce mild sedative effects and the SSRI's less so. Antidepressants raise the levels of neurotransmitters in the brain. Depression causes fewer of these to be released.

The pharmacotherapeutic choice in mania is limited to the neuroleptic drugs and lithium. The antipsychotic drug in common use is chlorpromazine which is valuable for its sedative properties.

B.   Maintenance Therapy

Lithium was first used in the treatment of mania by Cade in 1949 but it took 20 years for it to be adopted for common usage. Among its possible modes of action are effects on amine neurotransmitters. Its efficacy has been demonstrated in acute mania, prevention of mania, bipolar and severe unipolar depression.

Lithium is used in longer term maintenance programmes. Double blind studies found that high relapse rates of 30-50 per cent after early withdrawal from tricyclic medication were halved by continuation treatment with Lithium (Coppen and Peet, 1979, cited in Wing and Wing, Eds., 1982, p. 171).

The course of affective illness varies. The decision to use longer term maintenance therapy depends on the frequency of recent episodes, for example two in two years or three in five years.

Bipolar illness tends to respond better to lithium than unipolar so the indications for its use are stronger. The destructive social consequences of mania strongly indicate that a programme of lithium maintenance should commence after a single episode.

C.   Psychotherapeutic and Psychosocial Interventions

Since it is important to avoid life's strains and since pharmaceutical maintenance does not protect against their effects, psychosocial interventions are vital to provide support in management of bipolar affective disorder.

Marriage and parenthood are inevitably affected by mania and depression, according to Bennett, a pioneer of the Rehabilitation movement (1982, cited in Wing and Wing, Eds., 1982, p.175). Unlike patients who suffer from schizophrenia, those who suffer from affective disorder are not isolated so that their impairment has an immediate effect on the many persons with whom they have intimate contact. In both forms of the illness, members of the family are forced into a reversal of their previous roles and not all relatives are able to cope. Additionally, the emotional reaction of family members to the symptoms of the illness cannot be underestimated. During manic episodes, the family must bear the embarrassment of

social disinhibition and its consequences and during the depressive phase of the illness the family feels worthless in its attempts to lighten the patient's mood. At worst, they might experience guilt as to whether they might be the cause of the misery.

Social casework has centred on such support to the family, offering advice, encouragement, reassurance, the reduction of guilt, and help to modify the environment. family intervention techniques are now able to provide a more dynamic approach which aims to prevent relapse.

D.   Cognitive Therapy

A stream of published articles illustrate the potential of cognitive behavioural therapies in the treatment of depression (Beech, 2000).

Emery and Tracyl (1987, cited in Beech, 2000, p. 345) defined the therapy which is based on the theory that recognises the reciprocal relationship between cognitive, behavioural, somatic and emotional systems as 'a series of strategies that relieve psychological suffering by correcting distorted and maladaptive thinking.' It has been suggested that cognitive behavioural therapy is only suitable for reactive depression and inappropriate for severe psychotic depression (Stewart, 1994). Robins and Hayes (1993) listed characteristics associated with poor response to the form of therapy which included severe interpersonal disturbance, family dysfunction, and chronic marital discord.

However, Kuipers, Garety and Fowler (1996), an outcome study of cognitive behavioural treatment for psychosis (cited in Haddock and Slade eds. Cognitive Behavioural Disorders) have reported the value of using cognitive behaviour therapy to reduce the impact of the associated problems of a major affective disorder on the lives of those who suffer. The clinicians list three main goals, which include a reduction in the distress and interference which arises from persistent psychotic symptoms, to increase the individual's understanding of psychotic disorders, and reduce the occurrence of dysfunctional emotions from feelings of hopelessness and negative self image.

E.   Expressed Emotion Studies

The findings of the EE studies (p. 39) will probably exert a longer term effect on treatment methods.

2.5 Summary and Discussion

Successive government policies have addressed the needs of people who suffer from major and enduring mental illness which as defined includes schizophrenia, a severe affective disorder, and those who suffer disability as a result of their illness.

Theories as to the causation, aetiology. clinical manifestation and treatment of these conditions have been discussed, particularly the significance of the accumulating evidence that the interaction of genes with the environment play a role in the aetiology of major mental illness. The relevance of this evidence as to how mental health care workers assess the needs of individuals who suffer from one of these conditions as well as their families and carers was considered. Whatever the cause, the physical symptoms of such illnesses are extremely distressing and the accompanying behavioural and emotional disturbance exert considerable impact on social, work and family relationships.

In the light of current genetic/environmental research which demonstrates that genetic factors influence individual differences to environmental risk (p. 17), the importance of therapeutic interventions which include family/carers may be considered of even greater significance. Good therapeutic results have already been achieved in clinical areas where the EE (p. 1) and CBFT (p. 31) research has been applied. These findings have demonstrated the value of using family therapy as part of community care programmes.

The following chapter concentrates on the social and professional environment in which the research study took place. As an introduction, details are now given of the time scale of the study and its relationship to contemporary health service policy.

2.5.1 Time Scale of Study and Relationship to Contemporary Health Service Policy

```
┌─────────────────────────────────────────────────────────────────┐
│ RESEARCH PROGRAMME                                                │
│                                                                   │
│   Students              Semi-Structured Interviews                │
│      PILOT STUDY            July 1997                              │
│      MAIN STUDY                                                    │
│          1ˢᵗ stage         October 1997 - December 1997           │
│          2ⁿᵈ stage         October 1998 - December 1998           │
│   Management Study      Semi-Structured Interviews                │
│      INTERVIEWS             Throughout 1999                        │
│   Retrospective Study   Questionnaire                             │
│      PILOT                  July 1999                              │
│      MAIN                   February 2000                         │
└─────────────────────────────────────────────────────────────────┘
```

RESEARCH PROGRAMME	
Students	**Semi-Structured Interviews**
PILOT STUDY	July 1997
MAIN STUDY	
1st stage	October 1997 - December 1997
2nd stage	October 1998 - December 1998
Management Study	**Semi-Structured Interviews**
INTERVIEWS	Throughout 1999
Retrospective Study	**Questionnaire**
PILOT	July 1999
MAIN	February 2000

Government policies relating to changes in mental health care set out in Sections 2.3 and 2.3.1 (see pages 12 and 14) provided the backdrop to the organisation of the ENB A28 which was validated in 1994. The present study began in July 1997 and three years later showed that those policies were exerting considerable effect on the practice of mental health clinicians who worked in the Health Authority responsible for the Family Project.

In the intervening years, transfer had taken place of hundreds of patients from the local Victorian mental health institution to either domestic size accommodation or to community developments where students on the ENB A28, some of whose previous experience was only that of institutional care, had taken up established posts.

These included a variety of day care services and numerous mental health teams. The later were made up of a cross-section of all the professions working in mental health, although the core group was community mental health nurses (CPNs). However, even the CPNs had been required to reconsider their practice in the light of DHS requirements in *Health of the Nation* 1996 (see page 14). A census of CPNs

taken by White (1990) revealed that throughout the UK, the CPNs' caseload included only 27% of individuals suffering from schizophrenia. This was an indication of challenges facing practitioners who had not focussed on this major clinical problem and who had also to consider the needs of the families of the sufferers.

A quote from a member of a Community Mental Health Team (CMHT) interviewed during the pilot study illustrated how recent health service policies were impacting on practice:

> 'Community care completely changed the way we worked - we were
> in the client's own homes surrounded by family and significant
> others and I needed to be able to work with families.'

By the end of the main study, "Community Care" was well established.

The final retrospective study by questionnaire involved all students who had undertaken the course from its beginning. Their responses gave information on their experience of the course and its relevance to current clinical practice within the framework of changes in mental health policies over the period studied.

Chapter 3 — The Research Settings and Subjects

3.1 Similarities and Differences in Three London Community Mental Health National Health Service Trusts

Each Mental Health Service provides for a clearly defined 'catchment area': so defined that street numbers might determine areas of responsibility. The nature of the catchment area determines the priorities of the service to be provided, the specific skills required by the staff to practice effectively and which, in turn, makes demands on educational institutions to provide the relevant teaching.

Three London Trusts were represented by the students in the study. Each of the Trusts shares similar demographic features and the problems faced by Mental Health services in London: Two of the Trusts are classed as Inner London where there is increasing morbidity (Audit Commission, 1994) and pressure on the services particularly hospital provision. All three care for people from a variety of cultures and ethnic backgrounds. These include new immigrants from India, particularly Bangladesh, Bengal and Somalia, well-established Afro-Caribbean and Cypriot communities and refugees from Eastern Europe.

Numerous residential tower blocks are features of the landscape and provide homes to families and single parents while older properties have been converted into numerous flats and single accommodation. Within this rich and varied social environment, the traditional nuclear family, as understood by many, is less represented, certainly among the population presenting for mental health care.

The closure of the large mental hospitals has resulted in many long term residents for whom the three Trusts have responsibility and who have been separated from their families, being re-housed in local, domestic sized accommodation and looked after by a team of 'carers'. Others may live in single persons' hostels run by care workers. There are many examples of such residential services in all the Trusts and within this range of provision some residents have been able to find a 'substitute family' but others may live on the streets.

All the Trusts are characterised by areas of social deprivation. One is among the most socially deprived in the country (Jarman and Hirsch, *Jarman underprivileged*

area scores, 1992, in Thorncroft, G., Brewin, C. and Wing, J., 1992). As earlier reported, p. 16, social deprivation has long been associated with higher rates of schizophrenia in the community. Thirty years ago, the Psychiatric Rehabilitation Association (Lomas, Ross, Watson and Wilder, 1973) estimated the prevalence of schizophrenia in this Trust as 2 to 3 times the national average.

In work carried out in a second of the three Trusts, the researchers were also able to associate the prevalence of schizophrenia with social deprivation. (Pantelis and Campbell, 1988).

Family life of people who suffer from schizophrenia may be severely stressed by the nature of the condition (Berkowitz and Heinl, 1984); an additional problem for immigrant groups in whom higher rates of schizophrenic illness have been reported (Kulhara and Chakrabarti, 2001) and whose family systems may differ from those of the indigenous population. It was therefore important to this study to consider the various family structures associated with the different cultures represented in these socially deprived areas covered by these Mental Health Trusts.

3.2 Family Structures and their Diversity

The 'family' has long been regarded as the basic unit of social organisation although its structure may vary from society to society (Haralambos and Holborn, 1995). The smallest family unit is known as the nuclear family and consists of a husband, wife and their children. The name extended family is given to units larger than the nuclear family but related by marriage or adoption.

The popular image of the conventional family and one idealised by politicians of the major parties is that of a legally married couple with two or more children with the male partner being the predominant breadwinner. However during the previous two decades there has been a reduction in the proportion of people living in such households from 59% in 1981 to 50% in 1992 (HMSO Social Trends, 1992) and a correspondingly marked increase in single parent households. Attitudes towards marriage and co-habitation are different to those held by previous generations and one-third of women have babies before they marry. There has also been a change in attitude towards those whose sexual orientation differs from the majority and has allowed gay and lesbian couples to live together more openly and in some instances nurture a family.

Gorell Barnes (1998) has argued that increasing family diversity has required a change in the way therapists should think about their work with families and this afforded an opportunity to explore variations in family forms which indicate an understanding of the many different ways in which families are "created, constructed and maintained."

Reconstituted families are formed after divorce and re-marriage and lead to various combinations in which the children of one or other of the spouses or partners may live together in the newly reconstituted families.

The implications of these social changes on the education and training of mental health care practitioners to work with families will be discussed later in the study.

3.2.1 Cultural and Ethnic Diversity and Mental Health Issues

Ethnicity can be seen as one of the most important sources of family diversity in Britain (Haralambos and Holborn, 1995). Many ethnic groups have settled in Britain, some well established and others more recent refugees from war, fear, famine and natural disasters. Cross-culturally, the word 'family' has a wide range of definitions. Particularly in Africa where kinship systems and marriage patterns create family shapes and values which vary among regions and between groups (See Sarah Norton-Staal, ISSUES, Children and families, http://www.unhcr.ch/issues/ children/rm09512.htm).

Immigrants and families who find refuge in countries such as Great Britain suffer while they adjust to a new life (Papadopoulos 2001), and an unfamiliar culture and kinship and kinships systems. One such group, Somalians, have found refuge in Greater London but also in two of the Trusts represented in this study. Many of the women and children escaped war conditions in their own country, leaving their menfolk behind.

Even among the well established ethnic minority groups such as the West Indians who have settled in this country, there are those who experience difficulty in adapting and coping with the dominant culture, which for some results in a high level of environmental stress.

According to research discussed in chapter 2 p. 22, environmental stress in individuals who are vulnerable may result in the development of a major mental illness.

Bhugra, D., Mallett, R. and Leff, J. (1999) observed that the inception rates of schizophrenia among the Afro-Caribbeans are well elevated when compared with white populations. Social factors, they calculated, played a more important role in the aetiology of schizophrenia in the group. Lack of early attachments and prolonged separation from one or both parents and mediated through low self esteem.

In a world-wide study, Kulhara and Chakrabati (2001) discussed cultural aspects of schizophrenia, including cultural facets of epidemiology, aetiology, phenomenology and the course and outcome of the disorder. They reported that the results of multinational and multi-centric studies conducted by the World Health Organisation show certain cross-cultural similarities, such as incidence/prevalence and differences such as clinical manifestations. They considered the most striking finding was the benign course and outcome of schizophrenia in developing countries compared with developed ones. The authors concluded that culturally determined processes are at least partly responsible.

In Nigeria, Ohaeri, J. and Fido, A (2001) reported that over two-thirds of psychiatric caregivers 'felt glad' in their caring role. Most families were thought to be supportive, and gave the impression that caring had made emotional ties closer, in contrast to the British culture in which a person suffering from schizophrenia may be rejected or separated from their families.

3.2.2 Summary

The three Mental Health Trusts involved in this study were responsible for the health care in parts of London where people from a variety of cultures and ethnic backgrounds lived side by side with people from the indigenous population whose backgrounds and family life were also diverse. Two of the Mental Health Trusts cared for individuals who suffered from a higher level than the national norm of the major mental illnesses (See Section 3.1), to which adverse environmental factors contribute.

The importance of the role of families in providing care and reducing the risk of relapse has already been discussed. Working with families, either by intervening in family relationships or providing support is now considered a necessary element of community care but as previously discussed, this area of clinical work has become more complex due to changes in society's view of 'family' life and the diverse kinship systems and marriage patterns experienced by the ethnic minority groups.

The systemic approach to family therapy can be applied to diverse relationships because it involves the social systems in which each individual is placed. Systemic family therapists, according to Gorell Barnes (see p. 51), are increasingly aware of the need to be more inclusive in 'family' work so that single parents, gay and lesbian couples and families from different ethnic groups are treated.

3.3 The Treatment Setting

The Family Project was established in the early 80's and at the time of the research was located in an outpatient department of a London teaching hospital. It comprised a team of four: two consultant psychiatrists and two family therapists. The Medical Director was one of the researchers in the EE follow-up studies and the second consultant a specialist in family therapy. Of the two therapists, one had been trained to rate EE levels and both had extensive experience in working in a traditional family therapy paradigm.

These four clinicians established an environment in which families were treated and students educated. They termed the Project's clinical approach as 'Psychosocial' and its aims to be:-

> *To improve the care of individuals with major mental illness by working with patients and those closely involved with them to reduce relapse rates, avoid hospitalisation and maintain the optimal health of all its members. The model being developed is particularly relevant to Community Care and the breaking down of barriers between hospital and community.*
>
> *The Project recognises and makes central the burden of those caring for, or dependant on, people with major mental illness by offering information and support to carers and other family members.'*

It is one which it continued to develop while working to achieve its aims of meeting the needs of the service. These had already been modified in the light of community care and government requirements to direct resources to the care and treatment of individuals with a serious mental illness.

To facilitate this process, the Project provided regular workshops in addition to family therapy sessions which were attended by patients, families, carers and key workers, where information was disseminated and experience shared.

Family members were fully informed before family therapy begins on the conditions of treatment and their consent is obtained which included permission to video record each session.

The treatment suite was made up of two adjacent rooms; the family group room and the viewing room. A one way mirror was positioned on the connecting wall. The family and the therapist, who may be a student on the ENB A28, was viewed through the mirror by another member/members of the team and students. Contact with the therapist was made via the mechanism of microphone/ear piece as a means of offering constructive criticism, advice and support while the treatment was in progress.

Families were invited to see the viewing room and meet members of the supervisory team if they choose to do so.

This style of supervision known as 'live supervision' has always been considered necessary even by very experienced family therapists as it is only too easy to become part of the family's ingrained belief systems. For students there is the additional benefit that such support may help to increase their confidence to practice new and developing skills. Live supervision is a cornerstone of family therapy and exerts a strong influence on the family work carried out in the Project.

It is unlikely that the majority of students on the ENB A28 would have previously experienced this form of supervision but as members of one of the caring professions they would have been otherwise monitored throughout their working lives. 'The caring professions have a responsibility to supervise their members so that the public is protected from unsafe practitioners.' (Hector, 1973)

3.4 Supervision in the Caring Professions

There are three distinct areas of supervisory responsibility which must be discharged; professional, clinical and managerial. While there is broad agreement on what constitutes professional and managerial supervision, the area of clinical supervision has in recent years been open to discussion and debate. (United Kingdom Central Council for Nursing, Health Visiting and Midwifery (UKCC), 1995). Students would continue to receive all other elements of supervision in their place of work, probably unrelated to their work in the family project.

3.4.1 Managerial Supervision

Managers exercise their managerial responsibility by monitoring (clinical audit) and reviewing clinical practices in order to improve the quality of patient/client care. The process provides an opportunity to establish an effective communication system between manager and practitioner and for clinicians to gain a valuable insight into managerial systems of working. The management of resources and time are of particular relevance to practitioners. Senior clinicians are subject to Individual Performance Review (IPR) on a yearly basis. Many strands of management supervision are brought together during this process.

3.4.2 Professional Supervision

Practitioners must at all times be aware of their responsibilities as accountable professionals. These responsibilities involve developing practice, knowledge and values. To achieve such aims, practitioners require continuing education and professional development. Supervision affords the practitioners the opportunity to identify their particular needs.

3.4.3 Clinical Supervision

Unlike professional and management supervision which are associated with specific functions, clinical supervision is also concerned with the practitioner's feelings, attitudes and beliefs. Clinical supervision is a practice-focussed, professional relationship involving a practitioner reflecting on practice, guided by a skilled supervisor (UKCC, 1996). This process facilitates the practitioner's development through critical discussion within a relationship of acceptance and trust. The person being supervised must feel sufficiently secure to reflect on practice and recognise and articulate areas of personal limitation as well as employing remedial action to

maximise strengths. Such a relationship which encourages self-awareness helps the practitioner to gain insight into some of his/her attitudes and prejudices but also gives guidance as to how the knowledge can be used. This approach will support the practitioner who might otherwise resist admitting personal weaknesses and skill deficit, as would be the position in management supervision where the supervisor is the person to whom the practitioner is marginally accountable.

Clinical supervision is essential as a means of validating the helping relationship (Sundeen, Stuart, Rankin and Cohen, 1985) and an important system of support to the care-giver (Benfer, 1979). Proctor (1986, *A co-operative exercise in accountability*, in Marken and Payne, Eds., 1986) considered the process to be restorative, providing supportive help for professionals working constantly with stress and distress

The term 'emotional labour' is used increasingly to describe the way health care professionals provide emotional support to patients and clients while coping with their own feelings of distress engendered by providing emotional care.

The original term was first described by Hochschild (1983) who suggested that "emotional labour involved the suppression of feeling in order to sustain an outward appearance that produced a sense in others of being cared for." She extended this position further by stating that the employer regulated a degree of control over the emotional activities of workers through training and supervision.

Smith (1992), in her doctoral research, investigated how nurses learn to care and used the concept of emotional labour to provide a language with which to describe and investigate the "uncodified" skills associated with nursing care. In a recent study on nurse education, nursing practice and emotional labour in the contemporary NHS, Smith and Gray (2000) reported on the Royal College of Nursing Clinical Leadership programme (RCN 1998, RCN 2000). According to the authors there are strong linkages between the programme which enhances the concepts of mentorship, the importance of helping clinical leaders work through emotions and emotional labour. These aspects of the course can be linked to clinical supervision.

According to Tarrier (chapter in Haddock & Slade, 1996) the success of Brooker *et al.*'s (1992) programme for training mental health practitioners in family interventions using a cognitive-behavioural approach depended on the progressive

clinical supervision which the students received. In comparison Kavanagh and colleagues (Kavanagh *et al.*, 1993), using a similar cognitive behavioural approach without the benefits of clinical supervision reported little impact on clinical practice.

A.   Group Supervision

This is one of several models of clinical supervision which the UKCC (1996) considers effective.

It is a model used in the Project, along with live supervision. A group of students would be supervised by one of the family therapists.

B.   Who Provides Supervision?

The major part of professional supervision is subsumed under clinical supervision, whether individual or group. The supervisor should have relevant practice experience as well as the necessary skills, qualities and characteristics, including listening, facilitating constructive reflection and guiding practitioners to appropriate outcomes (UKCC, 1996).

There is general consensus that the responsibilities of clinical supervision cannot be provided by a person to whom the practitioner is managerially accountable (UKCC, 1995).

While clinical supervision is not a managerial control system (UKCC, 1996), links which establish boundaries between clinical supervision and management are important to reduce the risk of conflict between managerial objectives and professional development

3.5   The Educational Programme: ENB A28
3.5.1   Working with Individuals Suffering from a Serious Mental Illness and their Families

The course was validated for one academic year. Ten students were to be offered places although the course was validated for 12. The team considered that the level and quality of supervision for each student would be compromised beyond that number. The educational body for nurses which validated the course was the English National Board for Nursing, Midwifery and Health Visiting (ENB). It

Chapter 3 — The Research Settings and Subjects — The Educational Programme
— ENB A28 Working with Individuals suffering from
a Serious Mental Illness and their families 57

recognised that in mental health, nurses work in multi-professional teams and therefore agreed that other disciplines could participate.

The submission document to the ENB set out the course rationale, which included a statement on the urgent need for more health care professionals to have the necessary knowledge and essential skills for family intervention focussed on and specific to the needs of families having a member with a major psychotic illness. It goes on to say, 'the proposed course therefore seeks to train mental health care professionals, in both in-patient and community settings, to work with families in order to maintain psychotic patients within the community or to increase the rate and success of return to the community from hospital. The course provides the opportunity for psychiatric nurses to develop with skilled help and support a more co-operative relationship between the patient and his/her family, thereby lessening the isolation and burden for the family and increasing the patient's autonomy and independence.'

The course was divided into four units designed to maximise the integration of theory and practice throughout. It began with an initial period in which old and new theoretical perspectives were addressed and moved on to the central part which facilitated the incremental development of theory-skill based practice which would take the student from the position of knowledgeable observer through to skilled practitioner. The course was completed by a period of consolidation, during which the student was encouraged to reflect and critically evaluate his/her course experience.

Teaching was by lectures, interactive lectures, discussions, video presentations followed by the observation of live supervised practice. Finally the student worked as therapist to a minimum of two families under live supervision. The student was formally assessed in areas of theory and practice. Early assessments related to the students' understanding of the theoretical concepts and family therapy models which underpin practice. Video presentations on their own family work were part of the student's final assessment. The final written examination included essays and multiple choice questions.

Central to the whole course was the 'pastoral' care which students required to support them during stressful periods on the course. See Section 3.3 and specifically pp. 54 ff. for details of the supervision process.

Chapter 3 — The Research Settings and Subjects — The Educational Programme
— ENB A28 Working with Individuals suffering from
a Serious Mental Illness and their families 58

3.6 Selection of Students

As already mentioned, the ENB A28 was open to 10 students a year. These places were mainly taken up by staff working in the Trust responsible for the Family Project but during the year this study was made, two other Trusts were represented. Applicants for the course were interviewed by a panel comprising a family therapist, the course tutor and a senior nurse representing the service. The interview had two main aims:-

A. As a selection process which sought to identify those individuals who, on completion of the course, would contribute to the development of clinical practice in their part of the service.

B. To prepare the applicants for the intellectual and emotional demands the course would make should they be successful.

The academic requirements were considered greater than many other courses of one year duration and the time the students must spend on private study to reach the required standards in all the elements of the course considerable.

The students also experienced pressure on their available time as they were required to attend the Project for the equivalent of a day per week for study and family work as well as coping with the responsibilities of their employment.

Additionally they were required to treat a minimum of two families during the year. It was recognised that the families referred to the Project were difficult to treat and students invariably experienced this aspect of the course as stressful, especially as their clinical competence was exposed during treatment sessions to the guidance of the observation team, some of whom would be members of their peer group. Although such guidance was intended to be constructive, it may have been perceived as critical, especially by more experienced practitioners who previously felt pride in their clinical abilities.

Applicants were asked if they had considered the effect family work might have on their own emotional life; the experience might evoke a painful reaction if there have been problems within their family. This would not mitigate against acceptance on the course as long as the applicant understood the implications and felt able to access and use clinical supervision to prevent or overcome such problems.

Good communication skills are vital when dealing with disturbed families. Applicants needed to demonstrate at interview that they had the potential for engaging therapeutically with people who are under duress.

They were also required to have the agreement of their manger to attend the course.

3.7 A Perspective on the Role of Management and its Influence on Course Students

Two findings in an investigation (Antobus and Kitson, 1997) prompted by the Royal College of Nursing into nursing shortages and low morale were relevant to the environment in which the students taking the ENB A28 practised. The quality of individual nurses according to the RCN investigation had a more direct effect on the quality of patient care than that of employers (managers) and of particular relevance, access to professional development and training was an important factor in ensuring that nurses continued to work in the health service. These two issues, namely the relationship between managers and senior clinicians and the need for clinicians to have the opportunity for further education and training were ones which received attention from both students and tutors during the year this study took place. The RCN, as a consequence of the findings in the investigation carried out by Antobus and Kitson, developed a clinical leadership programme (RCN 1998; RCN 2000) to focus on the leadership skills of senior clinical nurses and their roles to improve nursing practice, particularly in other members of the ward team.

Thirty-five trusts throughout England and Wales are now involved in the programmes. Clinical Leadership at the time of this study was not in general a valued skill. Clinicians of all grades were under the control of managers whose service objectives may have been in conflict with clinical/professional needs. (Further discussion to follow, p. 61)

The students required study leave which, according to the Trust's educational and training guidelines, only the manager was able to grant; The course, of a year's duration, had an impact and pressure on the service. Additionally, time out from the place of work had to be allowed for family therapy sessions.

The work of the family project was not well understood in the service and many believed that it was a highly specialised form of treatment for the select few. Consequently, the perception was that the course failed to meet the service criteria

that educational resources should be directed to prepare staff for the care of the long-term mentally ill. Others who were better informed understood that the aims of the Project were to provide treatment to that particular group of sufferers and meet the needs of carers as well as families.

These different perceptions related to whether students received full or 'token' support in their application or even whether it was at all agreed. The word 'manager' related to a variety of individuals from a variety of backgrounds. some professional, others not, as well as differences in their attitudes and beliefs and position in the organisation.

In 1983, a new system of service and clinical management was introduced in the NHS (*NHS Management Inquiry*, Griffiths. 1983). Until that time. each profession managed its own. The profession most affected by the change was nursing, which had historically been managed in a hierarchical structure. To progress from one level of management to the next required two years spent at each while gaining significant experience (Salmon, 1967). In contrast, the philosophy of general management was to centre on the management of the service rather than individual professional groups. The general manager could be recruited from NHS management services or from any of the professions. Emphasis was to be placed on an individual's personal qualities and management skills, either proven or potential, rather than the possession of a body of knowledge and experience.

Ward sisters were replaced by ward managers. The role was diverse with priorities divided between managerial and professional aims. Patterns of work changed from 'shift' working to 'office hours' and the office space provided distance from the general ward activity. Staff nurses became the senior clinical nurses in the team, some of limited experience, replacing the clinical expertise of the ward sister. However, the ward manager did have a proximity to the practitioners and was therefore in an advantageous position to assess the changing needs of the service and the new skills required of the practitioners to meet these changes.

The new structures increased the conflict between managerial and professional aims which were correspondingly greater in relation to the seniority of the manager (King's Fund 1985. Balogh and Bond 1991. Rafferty 1993, all cited in Lorentzen and Bryant. p.275), particularly in nursing because promotion often distances managers from direct clinical practice. In the period following the implementation

of the Griffiths (1983) report, tensions occurred between senior clinical nurses and nurse managers on the one hand and general managers on the other. These are well documented (Robinson, Strong and Elkan, 1989, Owen and Glenister, 1990, Strong and Robinson, 1990, all cited in Lorentzen and Bryant, p. 275). Some nurse managers moved to positions in general management but whether this shift benefited or weakened functional nurse leadership is open to debate (Lorentzen and Bryant, 1997). Those who were appointed had frequently branched into management relatively early in their career, having taken advantage of the increasing facility for early promotion without progressing through the rigorous preparation of their predecessors which required a substantial period of time after qualifying spent consolidating clinical practice in a number of services and specialities. Without that, inexperienced managers lacked a global perception of the nursing service and therefore the professional and training needs of those for whom they were responsible.

For disciplines other than nursing who wished to access the course, the position was comparable. The majority came from community mental health teams which comprised psychologists, doctors, social workers, occupational therapists and nurses. Team management was provided by a member of one of the disciplines who would make decisions which affected professional issues in each of the others. To confuse the issue further, members of each discipline received their clinical supervision from professional heads of service who did not 'manage' the practitioner.

It is possible that during supervision both supervisor and supervisee agreed that attendance at the ENB A28 would be advantageous as a way forward. However the team manager who may not be of the same opinion held the educational budget and although unlikely to go against the decisions of a professional head of service may not provide the level of psychological support the student required.

This is a need of all students. The responsibility of management was not only to decide whether or not to give permission for a staff member to apply but whether to offer a student who successfully completed the course the support to introduce new systems of care in their practice

3.8 Profiles of Ten Research Subjects

3.9 Students

Ten students were selected to take the ENB A28 during the Academic Year 1997-1998. All disciplines who practised, in Mental Health Services were represented: Nursing, Medicine, Psychology and Occupational Therapy.

The breakdown was as follows:

Male (M)

Female (F)

A.   Nursing

Ward Manager (F)

Charge Nurse (F)

Charge Nurse (M)

Senior Nurse (M)

Senior Nurse (F)

Senior Nurse (F)

B.   Medicine

Senior Registrar (M) [This student, after completing 80% of the course, left to take up a clinical post out of London].

C.   Occupational Therapy

Community worker (F)

D.   Psychology

Health care worker (F)

E. National Vocational Qualification

Health care assistant (M)

F. Service Areas Represented

Rehabilitation Services	1
Acute admission ward	2
Secure unit	1
Day care	1
Women's Crisis Project	1
Disturbed mother and baby unit	1
Mental health team	2
Medical regional rotational appointment	1

The students' ages ranged from late 20's to early 50's. Their basic professional qualification was obtained during one of three decades: 60's, 70's or 80's. Therefore no nurse was trained under the Educational System Project 2000. The nurses' training schools were widely distributed geographically: London and the Home Counties; other counties in Southern England as well as Northern Ireland. The medical member of the group qualified on the Continent of Europe.

The students came from a variety of cultures and nationalities: English, Irish, Scottish, Spanish, Chinese, Bengali and East African.

3.10 Managers of the Students

Consultant Psychiatrist (M)

Head of Nursing (Trust) (F)

Community Mental Health Team Manager (M)

Specialist Mental health Unit Manager, disturbed Mother and Baby (F)

Project Manager (Women) (F)

Ward Manager - Secure facilities (M)

Ward Manager - Acute Psychiatry (M)

Ward Manager, Acute Psychiatry (F)

Six of the eight managers in total came from a nursing background. With the exception of the Consultant Psychiatrist and the Head of Nursing, the managers worked closely with the students they each supported on a daily basis in a clinical environment. The Head of Nursing did not work directly with a student on this course but in a previous position had worked with several over a period of two/three years.

Several cultures were represented in the management group: British, Black African, Indian and Chinese.

Chapter 4 — Methodology

4.1 Selection of Research Method

I began this study by considering the most appropriate method of research to be used. This involved a scrutiny of the literature which outlined a number of possible research methodologies and compared examples of the methods used in published research.

However, it was important to understand the personal experience of the students who undertook the course, their view of its content and how its value was perceived by the students and the managers of the service who allocated their educational resources. I concluded that I needed a methodology which allowed the data to emerge rather than imposing a structure which would constrain the data. This I considered particularly important to reduce the risk of possible personal bias as a result of my long association with the Family Project (see p. 8). It was for these reasons that I rejected the methods of data analysts, for example Jones (1985) who begins the process of analysis by identifying categories based on general comprehension of the data before proceeding to a fuller categorisation. In this approach, an attempt is made at grasping basic themes in the data and absorbing them as a whole. Dey (1996) believed that most data analysis falls between this approach and that of Glaser and Strauss (1967) who advocated a line by line analysis, sometimes even broken down to part of a sentence. Dey is of the opinion that a flexible compromise allows the analysis to develop in a holistic way and is an 'attractive' method if there is some structure to the research such as in policy issues.

In my final choice of research method, I was influenced by the work of Smith (1992) who, in her seminal study *Emotional Labour: How Nurses Learn to Care*, used the research methodology of Glaser and Strauss (1967) to analyse the part of her research which involved observation and semi-structured interviews with nurses and ward sisters. Analysis took place using a named 'theoretical sampling' method which in grounded theory is described as the joint collection, coding and analysis of data which informs the researcher in decisions to be made concerning further data collection. Comparative analysis was also used to check that data obtained from a

variety of settings such as ward and classroom and groups of students and ward sisters showed similar trends.

4.2 Grounded Theory

The term 'grounded theory' was developed by two sociologists, Glaser and Strauss (1967) who were members of the Chicago School of Sociology and whose aim was to produce research that would be of value to the professions by developing solid theory which fitted with reality.

The theoretical base from which they developed grounded theory is 'symbolic interactionism'. This theory stresses that human behaviour is developed through interaction with others by means of continuous negotiation and re-negotiation. Human action is purposeful and based on the meanings that the individual has for them. The primary purpose of grounded theory is to generate an explanation of human behaviour which is grounded in the data.

The aims of Glaser and Strauss of producing research that would be of value to the professions (Strauss & Corbin, 1990, p.25) has been a success as judged by the fact that grounded theory techniques are increasingly used to undertake qualitative research, according to Priest, Roberts and Woods (2002, p.32), writing in the *International Journal of Research Methodology in Nursing and Health Care*, published by RCN Publications.

Grounded theory is an inductive method of analysis which is the process whereby a general rule is inferred from a series of empirical findings which are discovered and verified through systematic data collection and analysis of data related to an identified phenomenon which, in grounded theory, is the central idea. The aim is to generate theory through examination of data in subject areas that may be difficult to access with quantitative research methods. Data collection, theoretical sampling and analysis occur simultaneously as the study progresses.

4.2.1 Overview of Terms Used in Grounded Theory

I will give a general overview of the meaning and application of the terms DATA COLLECTION METHODS and ANALYSIS, as used in a grounded theory approach, before proceeding to the particulars and examples of their application in this study.

4.2.1.1 Data Collection Methods

The major data collection methods in grounded theory are interviews and field observations. Other data collected as essential to grounded theory methodology are memos which are written about ideas and literature which is accessed as part of an ongoing process to verify developing theory.

A.   Interviewing

The aim of in-depth interviewing, as in all qualitative research is to give respondents the opportunity to describe their experience in their own words in order to ensure that the data reflects the respondents' concerns. Interviews may be unstructured or semi-structured. Unstructured interviews are used when the researcher knows little about the topic to be studied and is therefore in no position to prepare relevant questions in advance. It is important, therefore, in this instance for the researcher to allow the participants to 'tell their own study' (Morse and Field, 1996 first published 1985).

Semi-structured interviews are given when the researcher has knowledge of the area under investigation but is interested to explore the experiences of the research participants. The research questions are asked according to a schedule, a research instrument, which provides structure to the interview while allowing space for the participants to consider their responses. I used this form of interviewing in this study.

B.   Field Observation

Field observation refers to methods of generating data which involves researchers immersing themselves in a research setting and systematically observing dimensions of that setting, interactions, relationships, actions and events.

Debate on this method of data collection has centred on the participant/observer dimension: how far should researchers participate in the situation which they study and conversely whether or not it is possible or desirable to observe without participation (Burgess, 1982 and 1984, cited in Dey, 1996, pp. 50-51 ; Hammersley and Atkinson, 1983 cited in Mason, 1998, p.60).

Field notes taken as part of the data collection ensure that a record is made of the observers' analysis of their own role in and experience of the research setting.

These include a record of their interactions and emotional responses to events which take place during the period of observation as these might influence the analysis of their findings.

Participant observation was the key research method used by Smith (1992, p.147) in her study of Emotional Labour: how nurses care.

The use of participant observation as a research method when studying nurses during clinical practice was demonstrated to be of value. I was therefore 'tempted' to use the same in this present study but rejected the option because of my concern for the students' well being in view of the possible stress they might additionally experience during 'live supervision' of their treatment of families (see page 54).

C.   Memos

Memo writing is at the centre of the grounded theory method. It is more than simple note-taking. Questions, thoughts and hypotheses are recorded and facilitate the development of theory. Memos are about ideas and give the researcher freedom to think.

D.   Literature

In grounded theory, the literature is treated as another source of data which should be examined and analysed. Access to literature is ongoing and concepts reported in published material are examined at various stages throughout the duration of the study. These are compared with and support those in the researcher's developing theory and can be used to address issues of reliability and validity (see p. 73).

In comparison, quantitative research is more likely to test existing theory. Literature is predominantly accessed, reviewed and critiqued prior to the commencement of a study. It enables the researcher to identify research in the area of specific interest and gaps in understanding.

However, it has to be acknowledged that all research looks for gaps in understanding. Some qualitative research also tests theory at the second phase of the research process by referencing the literature in appropriate places to give validation of the accuracy of the findings.

4.2.2. Theoretical Sampling

Theoretical sampling in grounded theory is the process of data collection for generating theory. The researcher jointly collects, codes and analyses data in order to develop a theory as it emerges (Glaser, 1978). The data collection process, therefore, is influenced by the outcomes of the emerging analysis. The process proceeds through successive stages which are determined by changes in the criteria for selecting interviewees according to what has been learned from previous data sources. Participants are therefore chosen as needed rather than before the research begins.

4.2.3. Data Analysis

The method of data collection and analysis used in grounded theory is named the CONSTANT COMPARATIVE METHOD, and every piece of data is compared with every other piece of relevant data derived from interviews, observations and memos and verbatim transcriptions from tape recordings, allowing categories to be identified. A category is a conceptual element of a theory and the characteristics of a category are referred to as the properties. Categories are analogous to variables in quantitative research and are commonly used to describe a class of individuals, events or situations which have certain characteristics in common. To have meaning, they must be capable of being uniquely defined. By studying these in different occurrences, their similarities and differences can be identified, thus refining the definition of a specific category or leading to the generation of new ones. When no categories emerge, this is termed SATURATION.

4.2.4. Theoretical Development

The means by which various categories are linked are known as theoretical constructs. One means of identifying them is by asking questions of the categories so as to move from lower to higher levels of abstraction. specifically 'what is the category conveying?' It is necessary to weave the coherent parts into a coherent entity which has meaning both to the researcher and those who contributed to the data.

The central process of building theories from data begins with an attempt to examine the wider issues surrounding the topic under study. Only when the wider context has been established should more focussed investigation begin.

Strauss and Corbin (1990) described coding as part of a process of interpretation and analysis. The initial one which they termed 'open coding'. During this operation, data are broken down, examined, compared, conceptualised and categorised.

The second stage, termed 'axial coding', is a set of procedures whereby data are put back together in new ways following 'open coding' by making connections between categories. This is achieved by the use of a coding paradigm and is the approach I used to develop my paradigm model, involving: conditions; context; action/interactional strategies; and consequences. Causal conditions are the events or incidents which lead to the development of a phenomenon which is the central idea around which a set of actions or interactions are related.

The specific properties of a phenomenon are known as its context and are the locations of events relating to it along a dimensional line. Action/interactions are strategies devised to manage or respond to a phenomenon under a specific set of perceived conditions. Consequences are the outcomes of actions and interactions.

Selective coding in Strauss' model is the final stage and involves integrating categories to form a grounded theory. The integration takes place at a higher, more abstract level of analysis. This is accomplished by: explicating a story line; relating subsidiary categories around the core category by means of the paradigm; relating categories at the dimensional level; validating these relationships against data; and finally filling in categories that may need further refinement or development.

The story line which I explicated and around which subsidiary categories related was a 'Search for knowledge and understanding.' By means of the paradigm, I related categories at the dimensional level, for example, the intervening conditions which act to either facilitate or constrain the strategies taken within a specific context which in this study is the ENB A28. At each stage, I validated these relationships against data I had obtained.

As defined in grounded theory, a story is a descriptive narrative about the central phenomenon of the study and the story line is the conceptualisation of the story. This becomes the core category which is the central phenomenon around which all other categories are integrated.

The following simple diagram illustrates the linkages in developing a theory using the grounded theory model.

```
(A) CAUSAL CONDITIONS → (B) PHENOMENON → (C) CONTEXT →
(D) INTERVENING CONDITIONS → (E) ACTION/INTERACTION STRATEGIES →
(F) CONSEQUENCES.
```

A detailed diagram of the Paradigm model demonstrating how theoretical development took place in this study is to be found at the end of this Chapter linking it to the Chapter on Findings, pp. 91 and 137

To summarise, the broad definitions of terms used in Strauss' model (Strauss & Corbin 1990) are:

The PHENOMENON - the central idea about which a set of actions is related.

The CAUSAL CONDITIONS - the events or incidents which lead to the occurrence or development of a phenomenon.

The CONTEXT - the location of events or incidents pertaining to the phenomenon.

The INTERVENING CONDITIONS - the structured conditions which bear on the action/interactional strategies relating to a phenomenon. They facilitate or constrain the strategies taken within a specific context.

STRATEGIES - the actions/interactions devised to manage or respond to a phenomenon under a specific set of preconceived conditions

OUTCOMES - the consequences of actions/interactions

This chapter so far has summarised the development of 'grounded theory' by Glaser and Stauss (1967) and the reasons why I chose grounded theory as my research method. An overview of the terms used in the development of theory has been given. Before proceeding to how these terms were specifically applied in my own study of the ENB A28, I will discuss two issues which need to be considered before this can begin; ethical considerations and the criteria to be used to demonstrate that the findings are valid and reliable.

4.2.5. Ethical Considerations

At the commencement of a research study, ethical approval must be sought from the relevant institutions involved.

Details of the proposed research study were sent, as a matter of courtesy, to the relevant ethics committee of the Mental health Services Trust and later to meet the requirements of the North London Research Consortium.

All those interviewed were asked to sign a form which gave consent to be interviewed and in return they received a signed guarantee that all information given at interview would be confidential and the material, taped interviews, would be stored in a place of safety (see Appendix G, p. 189 and Appendix H, p. 190).

It was a theme which was underlined at a meeting held with the students 1997/1998 at the beginning of the research programme. This was of particular relevance because of my known personal contact with the tutors on the ENB A28 and past working relationships with their managers.

4.2.6. Validity And Reliability

4.2.6.1 Comparison Between Qualitative and Quantitative Research

The research approaches of quantitative and qualitative research place different emphasis on the attributes of validity and reliability. The criteria for both are more contested in qualitative research than in quantitative research. For example, one area of concern in assessing a piece of research is whether it can be generalised beyond the sample for which it was derived. Qualitative research methods involving in-depth interviews, transcription and analysis are time consuming. Data, therefore, from far fewer subjects is obtained than a quantitative researcher would obtain during the same period. It can be argued that the experiences of a small number of interviewees cannot represent those of a larger group of individuals who share similar interests. On the other hand, the information gained from each subject during in-depth interviews is far deeper and richer than a researcher using quantitative methods is likely to obtain.

The sample for the current study is numerically small, but as the study progressed, further data sources were identified and selected for inclusion in the study, by using

the methods outlined under Theoretical Sampling (see section 4.3.2) and Triangulation (see sections 4.2.6.2 Validity and 4.3.2.1. Retrospective Study). Other significantly researched studies for example Brooker *et al.* (1992) were also small. In that study, a cognitive behavioural approach and a quantitative research method were used to conduct an initial trial of teaching nine community psychiatric nurses techniques in family intervention. In a subsequent study (see p. 31) 10 CPNs were involved (Brooker *et al.*, 1994), .

The methods favoured by quantitative researchers to test for reliability are not appropriate for the qualitative researcher. For example, reliability is sometimes measured by the quantitative method by observing the consistency with which the same methods of 'data collection' produce the same results. The logic being that if the same phenomenon is measured more than once with the same instrument, then the same result obtained is more consistently reliable.

4.2.6.2 Validity and Reliability Applied in the Study

The validity and reliability of the data obtained during qualitative research are integral to a grounded theory approach which seeks to generate rather than verify theory from the data. Validity is implicit when data are simultaneously collected, handled and analysed to shape ongoing data collection and to develop and confirm working hypotheses (Smith, p. 159).

Validity and reliability are the criteria upon which the veracity and availability of research findings are judged and are important in all research although the methods of achieving this will vary depending on the type of research.

Validity underpins the entire research process and refers to the degree to which the research is 'measuring' or explaining what it claims to be measuring or explaining. Reliability refers to the degree of consistency or accuracy with which the instrument (used under similar conditions) measures the attributes under investigation.

In order to be valid, a measurement must be reliable. Reliability is a pre-condition of validity and an unreliable measure can never be valid. On the other hand, reliability does not guarantee validity.

The key method of ensuring the validity of the processes in qualitative analysis is the use of triangulation. This involves comparing the outlooks of research subjects by testing the validity of theories from the different perspectives of different

subjects or different forms of data from the same subjects. In its broadest sense, the term refers to the use of a combination of methods to explore research questions from different angles and in a multi-faceted way (Mason, 1998, pp. 148-149).

The data in this research study have been analysed by using two research methods:-

1.   Grounded theory for the semi-structured interviews with

    (a)   students on the ENB A28 during the first 3 months of the course and within 3 months of its completion;

    (b)   managers of the students during the second half of the course.

2.   Analysis of a questionnaire circulated to previous students who had taken the course since its validation by:-

    (a)   Descriptive analysis

    (b)   Content analysis

Reliability is ascertained when the data recurs in a number of settings and from a number of participants. The manner of data collection and analysis which sharpens ongoing data collection is discussed on p. 68

The students who provided data in this study worked in three different Mental Health Trusts and within each of the Trusts worked in a variety of different settings ranging from secure accommodation to rehabilitation services and from hospital to community services.

The questionnaires were completed by mental health professionals who had participated in the course since its validation. For some who contributed, this meant a gap of six years.

The numbers of research subjects were, as previously mentioned, relatively small. This course was the first of its kind and had only been operational for six years at the time of the study. The style of teaching which included 'live supervision' was teacher intensive which limited the student group to ten. These numerical limitations were in contrast to the great diversity of characteristics within the groups of students; culture, age, experience, professional discipline, clinical knowledge of a large variety of work settings in different geographical locations which enriched the data.

Data for qualitative research are passed through a method of interpretation by the researcher. This may be considered unreliable in relation to validity. The subjects interviewed may interpret events in contradictory ways. However, the Constant Comparative method used in grounded theory entails the constant comparison of incidents with incidents and incidents with categories until a theory emerges that is capable of explaining variation in the data. (See p. 70 of this study).

The researcher using qualitative methods may have a personal bias in how findings are interpreted. I needed, therefore, to be constantly aware of my role in the research process and subject myself to critical scrutiny as a means to prevent personal bias during the interpretation of the data. During the later stages of the research process, I once more returned to the literature to validate my findings (Strauss & Corbin, p. 52).

4.2.7 Strengths and weaknesses of Grounded Theory in comparison with other methodologies

Grounded theory as a research approach, like many other research approaches has inherent weaknesses as well as strengths. Any methodology needs to be compared with other methodologies in order to fully distil the nature of its worth.

Philosophers who have attempted to distinguish between the humanistic realm (meaning and understanding) and the realm of science (exploration) have argued that the interpretation of human actions can never be accomplished by the methods employed in the natural sciences (Kenny, 1997). In social science, Hollis (1996) has identified four keys to analysing social action:-

1. Individualism, which proposes that the social world should be analysed into particulars (agents or actions)

2. Holism, which proposes that the social world should be analysed into structures (cultures or systems)

3. Exploration, which makes the case for naturalistic explanation of the social world, because it serves the natural sciences so adequately

4. Understanding, which argues that social beings view social life from the inside and therefore the social sciences must make sense of it by doing likewise.

The first two 'keys' distinguished individualism from holism and the third and fourth from exploration and understanding.

The second distinction challenges the assumption that either scientific explanation or interpretative understanding are in some way superior. It has been the task of qualitative researchers in the field of social science to argue for the equal place of interpretative understanding.

Therefore, Grounded Theory seeks to take a structural approach to combining Hollis' first two 'keys' to analysing social action, that is Holism and Individualism, and an explanation of both in relation to each other.

Grounded Theory came from the Chicago School of sociologists influenced by the theory of symbolic interactionism which challenged the dominance of traditional science methods within social science.

The methodology sought to close the gap between social theory and empirical research by examining real life actions and the underlying explanations that practitioners use (Smith, 1997). The essential difference between Grounded Theory and other qualitative methodology is that it resides within the second key, namely Holism, whilst Phenomenology seeks to understand a social being's view from inside. Grounded Theory takes as its field of enquiry the individual and his relationship with social systems. This is in contrast to Ethnography, which seeks only to view and describe social systems from the outside.

4.2.7.1 Issue of Sampling

Within natural sciences, a sample has to represent a wider population in order to be able to statistically analyse data and generalise findings.

If the research is concerned with meaning and understanding rather than explanation, sampling has a different meaning. Sampling in relation to Grounded theory is what is called Theoretical because no population is specified at the beginning of the study.

This study, because of the nature of the research question, did have a population in mind. The population was the students who had experienced the ENB A28 during a particular year, although the role of the students' managers and the experience of previous students on the ENB A28 became increasingly significant and as a result became part of the study. In that sense, it could be argued that it is not Theoretical sampling, although it could be called opportunistic sampling or convenience sampling. It would have been possible to consider the term Theoretical Sampling if the research had chosen to study other centres in which this type of training was being conducted. However, according to Strauss and Corbin, a site or group to study must be chosen. This is directed by the research question and therefore is indeed Theoretical Sampling. Its weakness is that the selected group may have to be small because of the area under investigation and the findings therefore may not be viewed as representative.

4.2.7.2 Concepts of Generalisability, Validity and Reliability

Quantitative research is concerned to establish that respondents are representative of wider populations, so that the findings can be generalised. This means, in essence, that the research can be applied to other populations. In fact, much research departs significantly from this ideal. Glaser & Strauss (1967) advocated that the qualitative researcher should give less attention to meeting statistical sampling criteria in assessing the adequacy of a sample; rather the researcher should be much more concerned with the issue of whether and what the sample contributes to the investigator's theoretical framework. In this view, Grounded Theory does not seek to be preoccupied with representativeness.

If the aim of the research is to generalise the findings to similar groups of people and other situations, then reliability and validity need to be demonstrated. Whilst formal definitions of reliability and validity have been established in quantitative research, some researchers dispute their applicability while others offer their own criteria for assessing the usefulness of reliability and validity.

According to Field and Morse (1996) the social context in which data are collected is important when considering reliability and validity. Validity has also been interpreted differently within the other various qualitative methodologies (Baker *et al.*, 1992). In phenomenology, for example, validity arises from the extent to which the findings truly reflect the lived experience of the participants. For grounded

theorists, validity comes from the usefulness of the theories being generated. Ethnographers, on the other hand, seek to refine and reformulate theories from the data being generated. Validity is therefore implicit when data are simultaneously collected, handled and analysed to shape ongoing data collection and to develop and confirm working hypotheses and/or reformulate theories.

Most textbooks define validity in terms of the extent to which a test, questionnaire or other measuring instrument is really measuring what the researcher intends to measure. There are, however, a number of other ways of assessing validity. These include face validity, content validity, criteria validity and construct validity.

Reliability is concerned with consistency and replicability by which a measure will always give the same results over time across groups and if different researchers were involved in collecting and processing data. Within these broad definitions, two types of reliability can be identified:-

Internal - internal consistency of measure

External - which refers to the scope for applying a measure in a variety of settings and within a range of different groups. This methodology and indeed this study does not seek to be externally reliable.

Internal reliability in this study is, according to Grounded Theory, ensured by the constant comparative method. Other researchers have sought alternative ways of defining validity and reliability.

They use concepts such as truthfulness, credibility, transferability, dependability and confirmability to discuss the true value of their findings.

I will discuss these concepts in relation to this study in the concluding section of this thesis.

4.3 The Application of Data Collection, Theoretical Sampling and Analysis in This Study

4.3.1 Data Collection Methods used in this Study of the ENB A28

4.3.1.1 Interviews

Following the initial discussion with the students, I wrote to each of them to gain their agreement to be interviewed and offering a choice of possible venues.

All ten students responded positively, but organising a timetable for the interviews was much more of a problem than I had anticipated. There was little opportunity during the students' study days as the programme was tightly scheduled. The only available time was during the 1 hour lunch break which was the preferred choice of many of the students. With their manager's agreement, four selected to be interviewed in their place of work.

Interviews conducted away from the controlled environment of the Family Project proved to be both an exciting and frustrating experience. Exciting because of the activity generated by the service area and frustrating because there were occasions when the activity was so frenetic that I felt the pressure and identified with the demands of the service which provided for the needs of the mentally ill, so much so that at times I felt embarrassed in adding to that pressure. Additionally, travelling distances added a further dimension to the exercise; 1 hour walk through the industrial maze of North West London but a pleasant journey to Docklands via a narrated journey on the Light Railway.

Listening to tapes following interviews, I was also made aware of the extraneous noises which surround people as they work. Unaware at the time of recording, it was a surprise to hear so much interference on the tapes adversely affecting their quality; clanging ambulance bells, heavy lorries pounding past, the incessant ring of telephones and the banging and hammering of builders ever present in London hospitals. I also had little control over where the interview took place but the room usually designated was one which in the service goes by the name of either 'quiet room' or 'group room'. These are furnished similarly: armchairs and low tables so arranged as to provide an environment in which anxious patients may relax and express painful feelings. The environment also afforded relaxation to the

interviewees but their backward position in an armchair did not always allow for their voices to project as well as they might. However, to view and feel the pressure of the environment in which the students worked and where they would practice any new skills learned on the ENB A28 gave an additional perspective to the study.

English was not the first language of four of the students and although at the time of the recording the meaning of their responses was clear this was not always the case when it came to the transcription. Body and hand movements and facial expression might have added more meaning to the content of the interviews than I realised. This is a form of participant observation, a research method used by Melia (1982) to observe her interviewees' reactions during interviews. Other qualitative researchers, for example Smith (1992) have since applied the participant observer role when interviewing. In her research thesis, *The Emotional Labour of Nursing*, Smith interviewed students and their teachers.

Field notes made following interviews were added to the transcription.

A.   Interview Framework

I aimed at developing a style of interviewing which would enable the student to speak freely and so facilitate the expression of ideas which had not previously emerged and which could then be compared with other interviews.

My first question was very general and centred around the reasons why the student had been interested in applying to take the ENB A28. This proved to be a good question to begin the interview, as it was one which they had already answered at their selection interview. It allowed the interviewee time to relax and become acclimatised to the tape recorder and the presence of a researcher.

I wished to avoid giving the student the impression that they were being questioned according to a tight format which reflected my own agenda. The questions as far as possible were 'open ended' and asked in the sequence relevant to the progress of the interview. This afforded the interviewee 'space' but consequently meant that as an interviewer I needed to maintain boundaries over the interview so that I could compare one interview with another. (See Appendix I, p. 191 for interview schedule).

The first round of interviews with the students gave an indication of their needs and expectations of the course in the light of their previous lack of training and education in family work and informed the questions to be asked in the second round. Emerging themes were noted. The second round of interviews included verification with each student of issues raised in their first interview. Changes in their perception of issues raised over the year were noted and the data from one student's interview compared with themes which had emerged with another.

The first question relating to the reasons why a student had applied to take the ENB A28 produced comparable responses; lack of knowledge, skill and confidence to work with the families of those suffering from major mental illness. During the second interview, they verified that these were the important issues which they needed to address. However, the theme which emerged over the months was a recognition of a process which had enabled them to achieve their educational aims of acquiring confidence, knowledge and skills in family work. This theme I named the 'Process of Learning' which involved the interaction between Theory, Practice and Live Supervision (see p. 102)

B.   Interviews with the Managers

Interviews with the students' service/clinical managers took place at the end of the course. There had been some changes to the original group. One had left the country, another had moved to another part of the service and been replaced, a third agreed to be interviewed but eventually never was available and one other failed to respond. Eight managers were interviewed in all. The questions centered around what they wished for the students and can be found in Appendix J.

They were all written to in the same way as the students, explaining the reasons for the research, the confidential nature of the research, the fact that it would be taped and last for 45 minutes. (see Design of the Study p. 85). Before the interview began, they signed an agreement to be interviewed which was then countersigned by me to confirm its confidential nature.

The style of the interview was similar to the one I aimed for when interviewing the students but I needed to be aware that because they were to be interviewed once there was only one opportunity to explore and clarify variations in the data. As is

characteristic of many mental health nurses, the managers were very forthright in their replies.

4.3.1.2 Literature

A number of issues emerged throughout the interviewing process which required further study:-

The demographic picture of the three London Trusts (see p. 49) made clear that the traditional nuclear families who accessed mental health care were in a minority. On the other hand, the services had increasing contact with families from ethnic minorities and families which had been reconfigured as a result of divorce and separation. I consequently studied cultural diversity and family structures (see Section 3.2).

The emerging importance of 'live supervision' to the learning process and the way clinical supervision was being used to support the students' emotional response to the course emerged as crucial. This revealed issues relating to the general practice of supervision of mental health professionals and possible conflict between 'clinical' and 'managerial' supervision (see Supervision in the Caring Professions, p. 55).

The impact of managerial responsibilities on educational resources emerged as important. On several occasions, members of clinical teams reported that although they had expressed a wish to attend the course, their service manager had not supported their application. (See The Role of Management, p. 60).

Students in this study learnt to practise family work in very specific conditions: one way screen, viewing room and 'live supervision from qualified family therapists. In practice, family work is frequently conducted in the families' sitting room. Throughout the course, the students were exercised in thinking how they would apply the theoretical knowledge to their basic clinical practice.

A review of literature relating to the theory/practice gap has been ongoing during the study. One of these studies has particular relevance. Cook (1991) considered that the possible reason for the gap between theory and practice is due to conflict between nursing theory which underpins nursing practices which benefit patients and psychological theory which underpins certain nursing practices aimed at

defending the nurse against excessive emotion and anxiety (see Selection of Students, p. 59).

4.3.1.3 Memos

Throughout the research study I wrote memos for my use on a range of relevant issues from impressions of recording sessions detailed thoughts and ideas on emerging themes in the data and their meaning to the study. These memos were written as ideas came to mind wherever I might be; local cafés, travelling on trains or preparing a meal. These were all retained and used as I began to write up aspects of the study which began very early in the process.

Four memos made during the research year became increasingly significant as they provided further evidence that the environment in which students practised impacted on their ability to maximise the teaching on the ENB A28.

A memo written after the final interview I conducted with Student 1, a ward manager, noted that he expressed anger in words and body posture against the middle managers who had failed to recognise or give him positive feedback for the changes he had introduced to the ward's clinical practices. He failed to understand their lack of support in view of both the NHS Plan (See p. 12) and the Trust's commitment to family work.

Student 5 (according to a memo written after her final interview) demonstrated her disappointment with managerial indifference to her course work. She was despondent and apparently depressed. This was in stark contrast to her first interview, when she brimmed with enthusiasm with ideas that she might, over time, be influential in converting her community team to family work. However, her enthusiasm for this way of working had not diminished and she had made plans to leave her present post and work in a team specialising in family and children's work.

In comparison, notes written on the first interviews of Students 2 and 7 commented on their lack of confidence. Student 7 was unsure she would be able to achieve the educational requirements of the course and Student 2 was unsure of her abilities to be able to convince her team, although she was the ward manager, of the value of the systemic approach when caring for people who are isolated in the community as a result of long term mental health problems.

Notes on both students made after their final interviews reported stark changes in their presentation at interview. They were both supremely confident and enthusiastic. Student 7, who at the first interview considered herself to be 'somewhat brain dead' was planning to prepare for a higher degree in family therapy while Student 2 showed excitement at her ability to change the views and clinical practices of the clinical team for which she is responsible.

Both these students received managerial support, team collaboration and, in the case of Student 7, combined managerial support and collaboration in family work.

4.3.2 Theoretical Sampling in this Study

Theoretical sampling is the term usually employed to describe the manner in which data sources are identified and selected for inclusion in a study. (See p. 70). Initial decisions are based upon general understanding of the area under investigation, in this instance the students on the ENB A28 1997/1998. Other individuals, groups or situations are selected to provide comparison data once theory has been generated. As theory emerged it became increasingly important to the study to include the clinical/service managers who were responsible for the students. Eight members of this group were interviewed.

One emerging theme during the interviews with the students related to the application of the course teaching in both the short and longer term. It became important to investigate how previous students evaluated the educational experience of the ENB A28 and its impact on their current clinical practice (please see p. 86).

Within this framework, taped semi-structured interviews were the main source of data. The central part of the study related to the experience of students. They were interviewed twice; the first interviews took place during the first quarter of the course and the second ones within two months following its completion.

A pilot group of seven students who completed the course the previous year agreed to be interviewed before the commencement of the main study. Transcripts of these interviews were analysed using a thematic content analysis technique. The emergent themes informed the construction of an interview schedule for the semi-structured interviews with the key informants.

The interviews in the main study were of 45 minutes duration. The tapes were transcribed, data coded and categorised. The emerging themes were presented back

to the students for clarification at the next interview and a return to the literature was made to seek further clarification.

Themes identified in the student group were used to construct a schedule to interview the service/clinical managers who had supported their application to take this period of study. The taped interviews with the managers were transcribed and analysed as before.

The final interview transcripts of students in the main study were studied, analysed and categorised.

4.3.2.1 Retrospective Study

In theoretical sampling in grounded theory, the researcher decides what further data to collect and where to find them based on data already collected, coded and analysed. During interviews with students and managers, issues arose in several instances which raised concerns over the future application of the course teaching to clinical practice. The students recognised that they depended very much on the support and cooperation of managers to work effectively but by the end of the course, this, in several instances, was not apparent. Of the managers interviewed, two were critical of some aspects of the course: one considered it too expensive, both financially and in staff time and the other was unconvinced that the teaching on the ENB A28 could be generalised to basic community care.

As part of the method of triangulation, I decided to make a retrospective study, by questionnaire, of all students who had completed the ENB A28 since its validation. Therefore, two research techniques using different methods asked the same questions at different points of the programme's development. The questions in the retrospective study aimed to gain information relating to the overall effect which the teaching on the ENB A28 had exerted on the clinical practice, particularly the systemic approach on the clinical practice of previous students in the short and long term and whether or not the findings confirmed those in the main study.

Details of the investigation and findings of the Retrospective Study will be given in the Appendices A through F, separately from the main study. There was a six year gap between the first group of students who took the ENB A28 and the group of students who took part in this study and during that period inevitable changes to the course had taken place.

4.3.3 Analysis of Interviews

"Constant Comparative" method (see p. 70) was used to analyse the interviews.

I first listened to the tapes in their entirety at the earliest practical time after their recording. This afforded the opportunity to note comparisons between my observations made during the interview and the recording of voice alone. I then replayed particular passages before the transcribing process began.

Once typed, I immersed myself in the data by working through it line by line underlining parts or whole sentences identifying key themes.

It was then necessary to condense the data into analysable units by creating categories. The process referred to as coding is a means of generating concepts from the data.

I used simple, broad codes in the first instance to reduce the data to manageable proportions and to facilitate the retrieval of data segments categorised under the same code. By using colours I created a simple system of identifying data segments throughout the transcripts which related to specific codes. Every code was given a colour and every sentence or part of a sentence was underlined in a matching colour.

At this stage of the analysis the codes centred around and were influenced by the questions posed during the semi-structured interviews. Emerging themes were noted. These were then checked in the second round of interviews and data from one student compared with another.

The transcripts from the second interviews were coded in a similar way to the first followed by a detailed, line by line, study of the comparisons between the two interviews, that is at the beginning and at the end of the course.

For example, the first question I asked was very basic and posed as much to help the students relax as it was a means of gathering data. However, the responses which came from that question (Research questions p.191) were surprising in their intensity and gave direction to a number of various themes. The group comprised a number of senior and experienced practitioners representing each of the major mental health care professions; only one had received any form of education and training for work with families. This had resulted in their reported feeling of failure

to work as safe practitioners in an area of clinical activity which was required following the introduction of *Caring for people: Community Care in the next decade and beyond* (DHSS, 1989) (See page 13); "I didn't know if I was doing it properly," "I don't know how I didn't break up some families"; examples of comments from two of the students. They were all looking to achieve

KNOWLEDGE, SKILL, CONFIDENCE

AND UNDERSTANDING

These themes were checked in the second interview and had gained in strength during the year as they compared their abilities before the course began and their newly acquired skills which were clinical, professional and personal. From the data given me by the students, I developed the category the students' need to search for 'KNOWLEDGE AND UNDERSTANDING' as the PARADIGM - the core category around which all other activities related.

The students' view of what constituted a family was an example of how one group compared with another during the first interview. There was a marked contrast between those who believed 'family' was either a nuclear one or related through marriage and those whose view of 'family' extended to friends, carers and partners of the same sex.

In comparison with the second set of interviews, the differences had narrowed to the extent that the students' thought of 'family' in terms of systemic 'systems'. Of significance was the effect that learning and thinking of cultural diversity had influenced the change.

At this stage, I examined the data closely to identify themes which reflected the students' views rather than providing answers to questions. Further themes emerged. This was part of a reconceptualisation and regrouping of the data which provided a new set of categories. Strauss and Corbin (1990) termed this axial coding and defined it as a set of procedures in which data 'are put back together' in new ways.

During the first interviews the students discussed as individual topics: their experience of live supervision, their efforts in 'grappling' with the theoretical principles underlying family therapy and anxieties about treating families. During the second interviews the students spoke of a total experience which I analysed as

the 'learning experience on the ENB A28.' The individual elements of their first interviews merged into one cohesive whole; each part interlocking with the other. (See Research Questions p. 191)

I was then left with a number of categories, each made up of rich data and relevant to answering the key research questions in the proposal.

At this point, I retraced my steps to a position in the process of analysis to one where I needed to begin to make connections and integrate the considerable quantity of data I had obtained.

To help me think the process through, I took a large piece of paper 59.4 cm x 42 cm (A2 size) and began listing the responses I had received from my research questions beginning with the first: "Why did you want to take the ENB A28?"

Common to all the responses was a recognition that the students did not have the necessary clinical skills to work in a way which 'community care' now required and they were able to identify what they needed the course to provide. In a short time, my piece of paper was covered with columns of data, each linking with another but related to the central issue of educational needs. A picture I was given was of their professional experiences in the 'old asylum' system where families never visited and where consideration to individuals' social system was minimal. Strauss and Corbin (1990) considered the necessity for the research to 'explicate a story line' which is the conceptualisation of a descriptive story about the central phenomenon or category. This piece of work was the beginning of my story line. However, I was far away from 'grounding a theory'. I once more returned to the literature and among other texts I studied Strauss and Corbin (1990) once again. This time the 'Paradigm Model' made an impact which it had not done previously; I recognised that the "chart" showing my findings which I had produced some months earlier to help me sort out my thinking was an unrefined version of the same. I then felt confident to develop my theory on the Paradigm model.

The diagram model is repeated on page 137 to illustrate how the findings in this study are summarised in Chapter 8.

The following chapters 5, 6 and 7 are ones which report the findings in this study.

Chapter 5, "The commitment to learn", relates to the students' educational and psychological needs and experiences including their relationships with their

managers. Chapter 6, "What is a family" is concerned with the needs of families, their changing role in society and the students' perceptions of what constitutes a family. The findings in each chapter are presented step by step in the Paradigm model.

For example, in Chapter 5, the students began by giving their reasons for wishing to access the ENB A28. These included the required changes in clinical practice following the transfer of the majority of mental health care from the Institution to the Community. These findings comprised the CAUSAL CONDITIONS in the Paradigm which led to a search for Knowledge and Understanding, the core category - the PHENOMENON.

Similarly, in Chapter 6, for example, the findings demonstrated that the students were increasingly aware of working with reconfigured families and with families from different cultures. The findings were another component of CAUSAL CONDITIONS leading to their expressed wish to seek "Knowledge and Understanding," the PHENOMENON.

Each set of findings in both these chapters is presented side by side with a small diagram which illustrates each sub-category and its linkage to the CORE CATEGORY – the PHENOMENON.

Chapter 7, "New ways of seeing" presents an overview of the OUTCOMES in each component part of the Paradigm. The findings included reports on the degree to which the course had exerted an influence on the way the students thought about their clinical practice.

4.4 Summary

This chapter first discussed the overall terms used in grounded theory and specifically how they were applied in this study of the ENB A28. Details were outlined of how data were collected using the 'theoretical comparative' method, including an outline of a retrospective questionnaire study of previous students as part of this technique (Findings have been produced in Appendix B). Finally, details of the methods used to analyse the data were given and how the 'Paradigm Model' (Strauss and Corbin, 1990) was followed to develop a theory.

A SEARCH FOR KNOWLEDGE AND UNDERSTANDING - THE PARADIGM MODEL

CONDITIONS → PHENOMENON → CONTEXT ⇄ INTERVENING CONDITIONS → STRATEGIES → OUTCOMES

CONDITIONS

CHANGES IN MENTAL HEALTH CARE

Asylum → Community

Family Involvement

FAMILY AND CULTURAL DIVERSITY

CLINICIANS ILL-PREPARED FOR CHANGED PRACTICE

Limited:

Education   Training

Experience

PHENOMENON

A SEARCH FOR:

KNOWLEDGE

SKILL

CONFIDENCE

GAIN IN

UNDERSTANDING

OF:

FAMILY RELATIONSHIPS

PERSONAL RELATIONSHIPS

PROFESSIONAL RELATIONSHIPS

CONTEXT

LEARNING ENVIRONMENT →

FAMILY PROJECT →

A28

INTERVENING CONDITIONS

Commitment to Learn "I need to know more"

Conflict of Roles

Service Provider — Student — Family Member

Pressure of Time Clinical responsi-bilities

balance parental responsi-bilities with clinician & student roles

emotional pressure meeting deadlines of assessments

Managerial Influence → Encouraging

→ Unsupportive

STRATEGIES

The Process of Learning

Practice Treatment of families

Theoretical Understanding

Live Supervision

Emotional support and group supervision

OUTCOMES

New ways of seeing Self-awareness

Confidence

Knowledge

Skill

To change clinical practice to include families at all stages of caring process

Changes in meaning of "family": Relating Family Systems Theory in wider context

Inclusion of carers, partners and friends

Different family situations in ethnic minority groups

Effecting changes in work environment

Influenced by Managerial style

Rigid Unsupportive Inflexible to change

Creative Supportive Open to change

Chapter 5 — The Commitment to Learn

As discussed at the end of Chapter 4, the findings of the analysis of student interviews are presented according to the Paradigm Model (see adjacent page).

5.1 The Reasons Why the Students on the ENB A28 Became Committed

CONDITIONS ➡ **PHENOMENON**

⬇

CHANGES IN
MENTAL HEALTH
CARE

Asylum ➡ Community

⬇

Family
Involvement

**FAMILY AND CULTURAL
DIVERSITY**

CLINICIANS
ILL-PREPARED FOR
CHANGED PRACTICE

Limited:

Education   Training

Experience
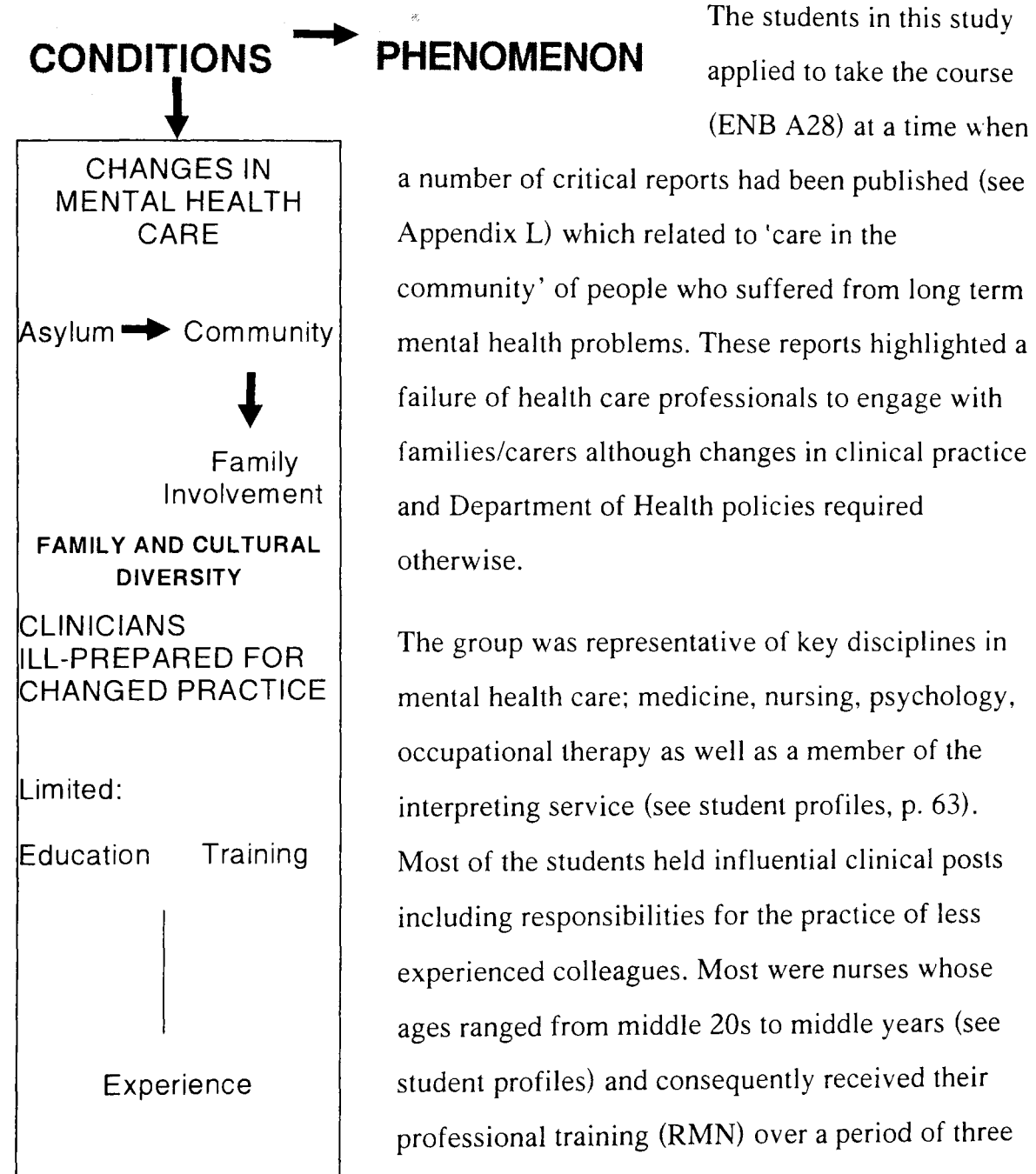
The students in this study applied to take the course (ENB A28) at a time when a number of critical reports had been published (see Appendix L) which related to 'care in the community' of people who suffered from long term mental health problems. These reports highlighted a failure of health care professionals to engage with families/carers although changes in clinical practice and Department of Health policies required otherwise.

The group was representative of key disciplines in mental health care; medicine, nursing, psychology, occupational therapy as well as a member of the interpreting service (see student profiles, p. 63). Most of the students held influential clinical posts including responsibilities for the practice of less experienced colleagues. Most were nurses whose ages ranged from middle 20s to middle years (see student profiles) and consequently received their professional training (RMN) over a period of three decades (reference ENB Syllabi). Their training schools were widely distributed geographically; London and the Home Counties, other parts of Southern England and as far afield as Northern Ireland. The medical member of the group qualified on the Continent of Europe.

The students in early interviews gave their reasons for attending the course: required changes in mental health practices following the closure of 'asylums' and developments of 'community care', the requirement therefore to work with family systems and the students' awareness that because of limited education/training they lacked the necessary skills.

These were the CONDITIONS, (see definition on p. 72 and diagram previous page), which led to the PHENOMENON category in the PARADIGM model.

With one exception, none had received education/training in family therapy or family work during basic professional training, other than perhaps one lecture which couldn't be recalled. Student 8, who was the exception, had a work placement involving families while studying for a degree but could not remember if she was taught or practised particular theoretical models: 'It was a long time ago.'

The explanations the students gave for this omission included:

Student 2 (qualified in the 1960s):

> *There was no such thing as family therapy in my day.*

Student 4 (qualified in the late 80s):

> *No interest in families where I trained.*

Student 1 (trained in early 70s), of particular relevance to present changes in practice:

> *Psychiatric hospitals were in the countryside, families were in the city. The Patient was dumped in shame.*

Student 6 (trained in the 80s):

> *No family work, no family unit, as asylum environment a million miles away from community and family.*

5.1.1 Reasons for Taking the Course

The theme running through the interviews was students' concerns about their level of skills and ability to work with families/carers now required of them in the clinical setting in which they worked.

> *With increasing contact with families, I found myself quite stuck at times.*
> **Student 3**

> *I didn't know whether I was doing it properly.*
> **Student 4**

> *I meet family members and relatives during the week and am aware of deficiencies in my skills to involve families in treatment.*
> **Student 6**

A summary of the 'findings' from the interviews with the students showed that although they qualified over a period of three decades and in different hospitals distributed throughout England and Northern Ireland, none had received the relevant training to work with families/carers of the long term mentally ill. They needed to develop specific skills and understanding.

→ **PHENOMENON** →

↓

A SEARCH FOR:

KNOWLEDGE

SKILL

CONFIDENCE

GAIN IN

UNDERSTANDING

OF:

FAMILY
RELATIONSHIPS

PERSONAL
RELATIONSHIPS

PROFESSIONAL
RELATIONSHIPS
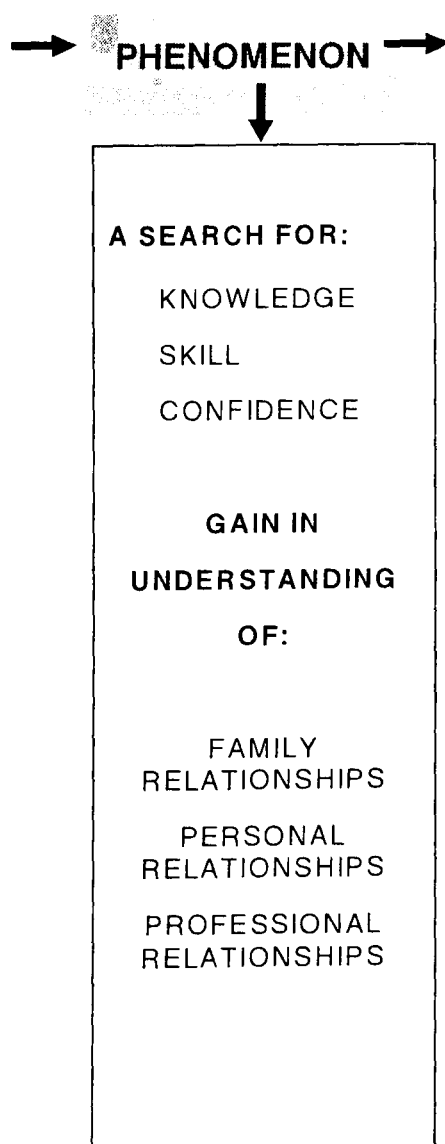
5.1.1.1 What They Needed the Course to Provide

Running parallel with their concerns was an expressed need to gain the skill and confidence to bring families into their work with individuals, particularly to gain an understanding of relationships which cause stress within the family.

All students expressed the need to understand the theoretical models which underpin family work so as to enable each to acquire the skills to work in a confident manner.

Students 1 and 3 used the words 'theoretical understanding' to enhance the understanding of family work and ensure safe practice whereas students 2 and 4 'needed' theory to set standards and guidelines in

practice. In comparison, Student 6 needed 'a knowledge base' to gain the necessary skills in family work.

Gaining confidence in the way they worked was of particular importance to the other students.

A search for knowledge, skill and confidence and gaining an understanding of family relationships and personal growth are the key elements of the PHENOMENON (see diagram previous page). The students were also concerned about their working relationships with colleagues and had anxieties about disturbing the clinical balance between stability and change. This will be discussed in OUTCOMES (see diagram p. 141 and in the PARADIGM model. pp. 91 and 137).

5.1.1.2 How to Involve Colleagues in Their Place of Work

The early experiences on the course had led the students to consider how they might involve their colleagues in their place of work in the new way of working.

Students 1, 3 and 10 considered that not only had they team support in taking the course but individual members of the team valued the opportunity of discussing issues related to family work., on the other hand, was aware of the support and interest of her colleagues in general but felt responsible and somewhat apprehensive for introducing to them the concept of 'family'. Student 2 hoped that she would be able to facilitate her team to involve themselves in the family relationships of their patients but at an early stage of the course was not certain of the outcome.

Teachers on another systemic therapy course involving theoretical and skill development and live supervision noted similar reactions in their students. They took account of the fact that not only did the trainees express the wish to acquire more knowledge, expertise and the chance to practice but they also experienced the dilemma of finding themselves disturbing the balance between stability and change in a way which, for example, Students 2,4,5,6 and 8 noted would probably affect their network of relationships (Campbell, Draper. and Huffington, 1993, p.82).

In this study, the students' expectations of the course reached further than the issues already discussed in detail. They also hoped that the course would facilitate their personal growth and offer a wider vision of mental health care.

5.1.1.3 Personal Growth

Although Student 1 was a very experienced practitioner and had already taken a number of post-registration courses, he spoke of a need to be 'enriched' by the ENB A28. He was looking for another dimension to previous studies which could be compared with Student 9 who viewed the course as a means of exploring 'something new'. His interests had been very biological. In comparison, Student 3 was hoping for an attitudinal change towards family therapy and family therapists. The early weeks on the course had already made her more conscious of family processes but her initial assumptions that family therapy was directed to two-parent, white heterosexual relationships by therapists who were mainly male and white, had not changed so far.

The effect of the course on how the students were able to re-think their attitudes and beliefs will be discussed further in Chapter 7.

5.2 The Managers' Perspective

5.2.1 Aims of the Course

Six of the eight managers interviewed supported the students' reasons for attending the course, the CONDITIONS (See diagram p. 92) and what they hoped to gain, the PHENOMENON (See diagram p. 94). Five of the managers had either during the course or in previous clinical posts worked with the students as members of the same clinical team. Of the remaining three, one provided close supervision but the other only showed peripheral interest.

Two of the managers interviewed had a limited understanding of what the course had to offer and these findings will be discussed later under the heading INTERVENING CONDITIONS (Diagram on p. 103) and in the PARADIGM model (pp. 91 and 137).

Several had hopes that the course would address the needs of diverse cultural and family structures and will be discussed in OUTCOMES (see diagram on p. 141 and the PARADIGM model on pp. 91 and 137.

Manager P was one of the managers who had previously supported nurses to take the course and had been impressed by the marked difference in their clinical work on its completion. It was not just their family work but their clinical practice in

general which compared favourably with the performance of others in the team. Whereas after basic training many nurses retained bias and prejudice, those who had taken the ENB A28 were equipped with understanding which enabled them to work through difficult relationships with patients and still come out unscathed.

Their nursing documentation reflected a much tighter collaboration between their roles as primary nurses and the families. They were confident and successful in this approach and had an impact at every stage of the patient's admission. Although the ward had not undertaken a detailed statistical analysis of re-admission rates, there was some evidence that the length of time between re-admissions, as measured from previous years, had been increased since the nurses who had taken the course involved family work in their practice.

This manager concluded that the course brought a much needed dimension to mental health nursing.

Similarly, Manager J had previously supported nurses for whom she was responsible and was favourably impressed by the changes she observed in the clinical practices of these nurses after they completed the course. One ward sister reviewed the way she thought about her work and her relationship with the team in general and as a result showed more creativity in her approach across a broad area of clinical activity. In collaboration with a community nurse who had also completed the course, she extended the boundaries of ward life to the community and vice versa.

Manager B had worked with four colleagues who had completed the course over a period of time. She had concluded the course was 'marvellous' and valued it highly not just to enable staff to work with an individual family but to generalise the skills to better understand the relationships and dynamics within the ward 'community' and clinical team. Given the opportunity, she would like to take the course herself as she believed this would make her a better manager.

Managers A and T were comparable in that they were both responsible for small, specialist units and had both completed a course in family work. One had taken the ENB A28 and the other an introductory course in systemic therapy. They had each taken the principles of systemic theory and used it as the basis of the way in which

they organised the work of their units; complementing the individual work of one practitioner with one family.

Manager C was responsible for medical education and believed the course enabled doctors to move away from their concerns about what was going on INSIDE somebody rather than what was going on BETWEEN people: the difference between seeing someone as a Schizophrenic or as a person with schizophrenia.

In comparison, Managers R and H held much narrower views on how they judged the value of a course such as the ENB A28. Neither had been the person to support the students' course application. In the case of Manager R, the decision had been taken by a more senior manager in the organisation and Manager 8 had taken over the management of his ward after the application had been endorsed by the previous incumbent.

Manager R admitted that he did not know much about the ENB A28 and at what level it was 'pitched'. He considered that finding time to undertake family work would be difficult for a front line team. He agreed that working with families was an everyday function but depended on where 'you want to take your practice,' whether specialist or general. He did not have any aims for the student influencing other team members and believed that if she wanted to work with families and children further, she needed to move to a more specialised field than the present team. Similar ideas were expressed by Manager H who explained that one person on the ward had already completed the ENB A28 and that two persons were a 'luxury'; 'all that money on one person for a year, having all that study time'. He considered the ENB A28 was unnecessary on his type of ward which didn't work across the community. It was very expensive and the amount of study time had to be taken into account.

To underline the comparison with the other managers; the value of the course for R and H related entirely to their understanding that the course was of use only if students were involved in specialist treatments of traditional families. Although Manager R did admit during interview that he knew little of the course content, he nevertheless failed to shift his position that if his student wished to concentrate on working with families she would need to be part of a 'specialist' team.

The link between the level of management support and level of clinical effectiveness will be discussed further in Chapter 7.

5.2.2 Managers' Hopes for their Students

The managers' aims for supporting a member of their clinical team were in comparison with one to another as diverse as the area of clinical activity represented in the student group.

Manager P was responsible for a charge nurse who he supported in order for him to be able to establish a small programme on the ward which would involve working with families in conjunction with the mainstream work on the ward and which he envisaged would enrich the work of the team as a whole. One specific aim he wished the student to address was to highlight the problems of carers and help them understand the nature of schizophrenic illness.

In comparison with Manager P, Manager J had responsibilities for an entire nursing service. From previous experience of working with colleagues who had taken the course she knew that the course carried rewards and benefits for any manager who wished to improve patients' 'clinical life'. In the district she worked at the time of the interview, there were more people to be found living in family networks than in her previous experience. Clinicians were therefore working with patients/clients who were living either with their first families or within newly configured ones. As part of her professional responsibilities she decided to make an assessment of the clinical skills staff required to work effectively. It became clear that they needed to provide a service to the long term mentally ill who were actually living in a family structure. Practitioners needed, therefore, to be educated and trained in a range of interventions which involved the family. She was 'amazed' when making an assessment of the clinical skills staff required at the general level of ignorance regarding the social and family systems in which people lived and the impact this had one on the other. It was for these reasons that she supported two clinicians to apply for the course.

In contrast, Manager B had a very specific aim for supporting a particular member of her team to take the ENB A28. He was Bengali speaking and the ward served a strong Bengali community. She considered the student and the families would

certainly benefit from improving his skills. Other benefits to the ward team would also accrue (see p. 96, 'Managers' Perspective').

The expectations of the students of Managers A and T were again comparable (see p. 97).

Manager T had recently set up a new community service and had decided to use the systemic model as a basis for the work of the service. She was supported in planning this development by a senior nurse who also expressed an interest in applying to take the course. The manager thought that this was a perfect opportunity to get the project moving and through her introduce systemic principles to the team.

Her expectations at the end of the course were that the student would have confidence to use basic skills in family meetings, using 'family' in the widest context, and introducing such meetings as a regular feature in the service. She also hoped that the student would be able to teach residents the general principles of systemic family work.

Similarly, Manager A encouraged a 'whole family' approach in the philosophy of her unit and supported a member of her team to take the ENB A28 because she wished her to be more involved with patients and their families. When the course was completed, she hoped that the student and herself would be able to work co-operatively to establish teaching sessions for other team members on a regular basis.

In comparison, doctors spend much of their clinical time in isolation from a 'team' of others. Manager C was particularly interested in the medical staff acquiring skills in family work. Relatives and carers were frequently present when doctors made home visits and he was of the view that not all of them handle these situations very well because they didn't understand the issues or how to deal with them. He did not believe that doctors had to jettison their early learning but needed to learn that in addition there are other ways of helping a person and their carers with schizophrenia; it is a question of what and why the condition had arisen, what needed changing and how. He had been amazed at how much change had been effected, even in people and situations which he had considered to be intransigent.

His expectations of the student on the course would be that at the end, he took on families and developed these skills. He had been amazed at the confidence students found in learning these new techniques.

Although Manager R showed very little understanding of the aims of the course, he did offer his ideas on what he expected of his student on completion of the course. His expectations would be directed to the way the student had the ability to focus on her client as well as listening to everybody in the family and being aware of the dynamics within the family. She would need to be able to filter information and not get 'caught up' in the family 'mess'. especially when there was a challenging person within the family to care for; a need to filter out what was relevant, what was irrelevant and acknowledge one's limitations.

In comparison, Manager H offered no ideas on what he expected of a student on the course. He even rejected the idea that the two nurses in his team who were very good at working with conflict and issues related to expressed emotion within the 'family of patients on the ward' had been influenced by their work on the ENB A28.

Managers were concerned that the course should address the needs of families from ethnic minority groups. These and related issues will be discussed in Chapter 6.

To summarise, this first part of Chapter 5 has dealt with the reasons why the students applied to take the ENB A28 and both the students' and managers' expectations. There will be a final summary at the end of the chapter. The second part of the chapter will focus on the students' educational experience.

The diagram on the following pages illustrates a tripartite learning process which will be discussed at length in the next section under the heading of The Learning Experience.

Diagram A

Overlapping Elements
in the process of learning

Theory

Practice

Live
Supervision
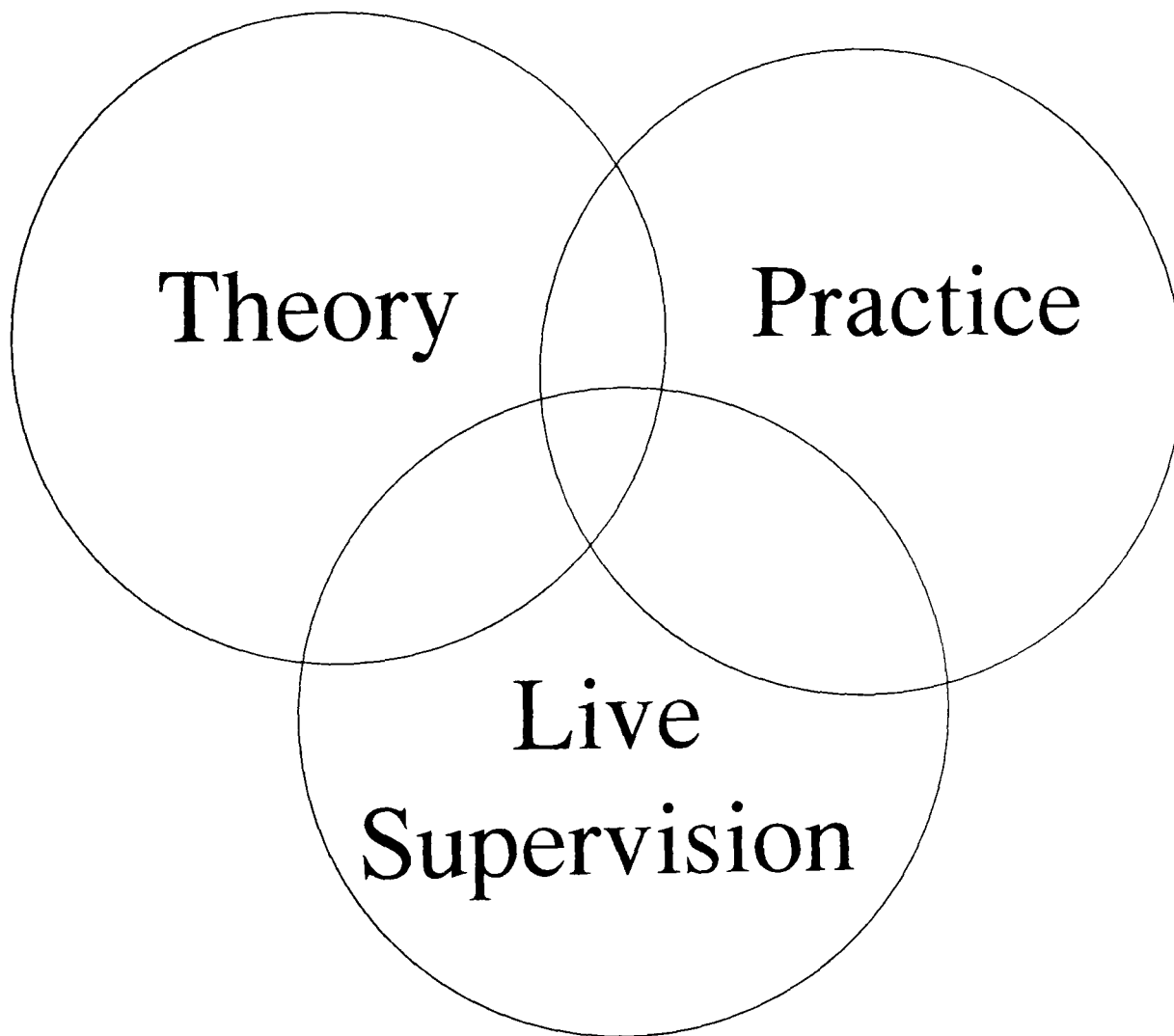
5.3 The Learning Experience

5.3.1 Context

As the students reflected during the final interviews on their experience of the training programme, the CONTEXT (See diagram this page and the PARADIGM model, pp. 91 and 137). Three elements (STRATEGIES in the PARADIGM model, see diagram adjacent) emerged as essential to what they all agreed had been a successful learning experience both professional and personal. These three elements were theory, practice and live supervision. Of importance was the inter-relationship between all three elements (see Diagram A, p. 102). Educationally the students acquired the skills to work with families safely and personally they gained in confidence to think independently and challenge previously held beliefs concerning clinical practice.

The relationship between personal constructs (ways of thinking) and nursing behaviour is well documented (Watts 1988). It has also been demonstrated that educational programmes can enable nurses to develop more complex constructs in relation to their patients (Franks, Watts and Fabricius, 1994).

5.3.2 Intervening Conditions

There were examples in the professional lives of the students which influenced their capacity to learn and assimilate the complex theoretical content of the course. These included the lack of available time to study and reflect due to the demands of their routine clinical practice, exacerbated in some instances by a lack of understanding from their

CONTEXT

```
        LEARNING
      ENVIRONMENT
           │
           ▼
     FAMILY PROJECT
           │
           ▼
          A28
```

INTERVENING CONDITIONS

```
Commitment            Conflict
to Learn              of Roles
"I need to
know more"


Service      Student   Family
Provider               Member

Pressure of            balance
Time                   parental
Clinical               responsi-
responsi-              bilities
bilities               with
                       clinician &
                       student
                       roles


        emotional pressure
        meeting deadlines
        of assessments

                   Encouraging
    Managerial
    Influence
                   Unsupportive
```
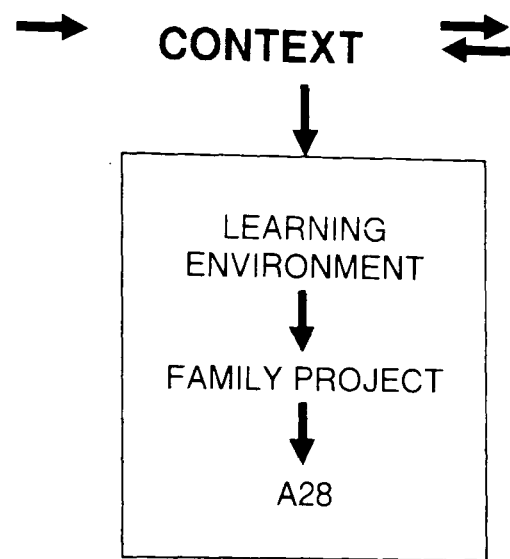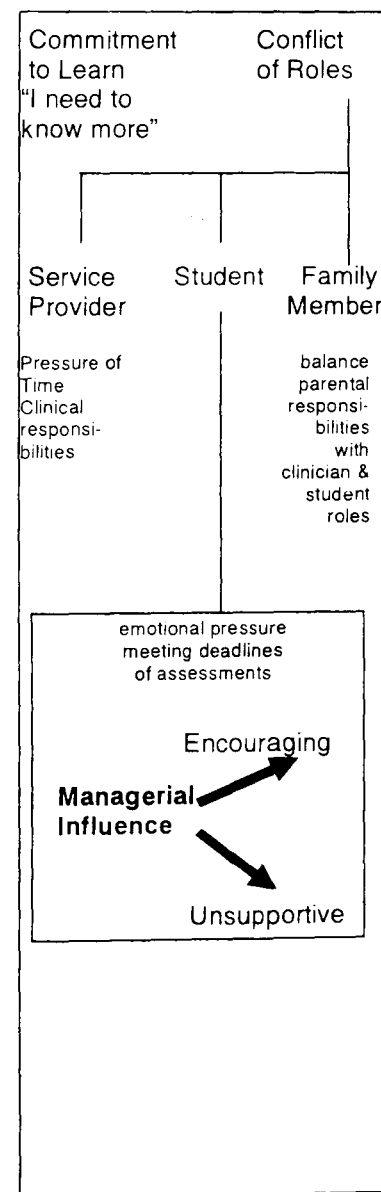
immediate and senior managers. As an example, Student 8 recounted an altercation she had with her managers when she was required to work in the hospital unit both before and after the formal lecture period set out on the University educational programme (Study Day). The student insisted there was a difference between 'doing a course' and 'doing a course successfully' and that she needed the time and space after the session to reflect and work on the course assignments. The managers conceded but the student felt they still lacked understanding.

In comparison, the manager of Student 10 recognised his academic and linguistic difficulties and re-arranged his work schedule so as to afford him maximum time for study.

However supportive the managers were to the students, nevertheless they all experienced considerable psychological pressure and anxiety as they tried to balance their responsibilities of senior clinical practitioners in their place of work with the role of a student grappling with the complexity of new ways of learning and occasional tension within the student group (see LIVE SUPERVISION, p. 107).

5.3.3 Strategies

(See diagram this page)

5.3.3.1 Theory

As reported earlier (p. 94) all the students expressed a need to gain an understanding of the theoretical models which underpin family therapy.

This element was introduced early in the teaching programme and made an immediate impact on the students. The majority experienced some difficulty in

➡ **STRATEGIES** ➡

⬇

making sense of the various theoretical models available even to the point where three students were confused and overwhelmed by the choice.

Student 2 was concerned that she might confuse the various models during one session while Student 4 expressed her difficulties with a deep sigh... 'So many different models, such a lot to learn.' Student 9 admitted to being overwhelmed
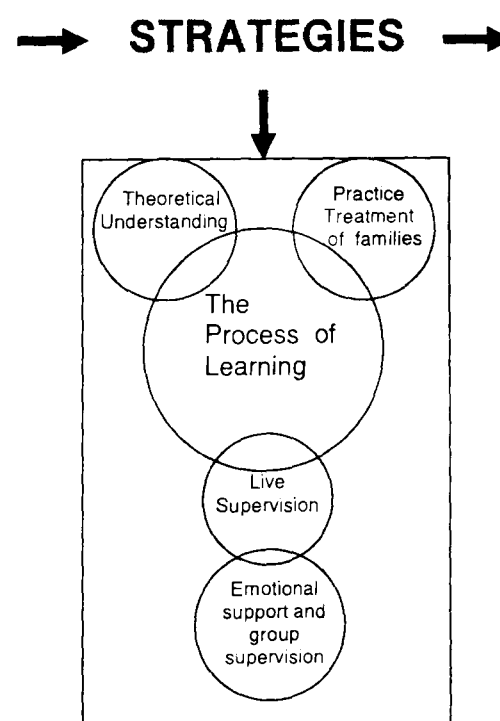
with the content of the course. His clinical role was extensive without the possibility of delegation to someone else to give him more time for studying so his only solution was to purchase the recommended books on the reading list and spend the Christmas holidays studying them.

In comparison, Student 3 said she had already learnt a tremendous amount which she had begun to use in her place of work. Similarly, Student 1 soon recognised the relevance of family therapy models to his daily work and he felt he was 'growing all the time'. This was in spite of his concerns that his previous training in the behavioural therapy model might interfere with the way he applied this new teaching.

In comparison with the early interviews, those which took place on completion of the course showed that the students had not only advanced in their theoretical understanding of family therapy but they were also confident in its execution. They had developed a level of sophistication which enabled them to discriminate between the various models and apply the most appropriate to their particular areas of practice.

Students 2 and 7 considered the families' background and culture before deciding on a particular model to use, while Student 5 spoke of the greater 'repertoire' of skills the course had given her. In comparison, Student 1 concluded that one model took prominence over others. This, the Psycho Educational o ne, was the most applicable to the clinical work on his ward which specialised in caring for people during the most acute phase of mental illness, some recently diagnosed for the first time.

Student 4, who was initially confused by the number of models to choose from, agreed that 'everything had fallen into place...after a while the technique flowed.'

5.3.3.2 Practice

In the early stages of the course, the students expressed different views on what they considered to be the appropriate time for the integration of theory and practice, that is when they treated 'their first family'.

Several students would have preferred a greater theoretical input before they began. Student 6 was the most vociferous on the subject: 'after a little theory. during one

week in school, we were expected to work with families — this was quite a shock.' She did, however, admit that another week or two was insufficient and with a laugh 'probably not another two or three months!'

In comparison, Student 7 was of the firm belief that theory and practice had to go hand in hand and would like to have had an earlier opportunity of doing more practical work underpinned by theory. 'Some techniques need to be practised.'

The other students did not share these concerns, although they admitted feeling apprehensive prior to their first family sessions. By the end of the course, all the students were confident in their practice and in the final interviews, only Student 2 remained critical of this aspect of the early teaching experience.

Student 4 had completely reversed her opinions. 'the actual experience of practical work with families from the beginning of the course was absolutely brilliant rather than learning so much theory and trying to combine it with practice. If we had learnt all theory and didn't see families until the end of the course I couldn't have connected the two.'

This student was one of three; the other two were Students 7 and 8 who, after satisfactory completion of the ENB A28, were able to join the second year of a Diploma course in family therapy. They soon noted a difference between their personal/professional development as clinicians working with families and those of the Diploma students who spent the first year of that course learning theory without the practice. One of the ENB A28 students reported, 'They have anxieties about seeing families and wonder how they are going to approach them — will they say the wrong thing? We felt it didn't matter if we said the wrong thing, you can learn from your mistakes.'

A second student reported 'One thing I've noticed during the second year (with people on this course who did not see families during the first year) is how lucky we were to be given the opportunity to work with families for a year. Although the Diploma students are academically ahead, when it comes to presenting a family, I'm very comfortable. I can talk about a family and the way they interact and what was going on in a session. The Diploma students who are just beginning to see families are struggling to see interactions and patterns of relationships. I'm very

lucky, although I'm not so academically advanced it's more important to have been given the family work.'

As part of their educational programme, the students were taught by videotape review of the families who they had treated. This method of teaching was considered by all students as extremely valuable. For example, Student 5 found that 'looking at the tapes afterwards, thinking about how I inter-reacted with the family and then being able to discuss it with the experienced practitioners, I learnt so much.'

This was also the experience of two students reported on by researchers on another systemic family therapy course (McCann and Down, 2000, cited in Gorell Barnes, Down and McCann, 2000, p.59) who particularly valued this method of teaching.

The third element of the learning process was the one which proved to be the important link which made sense of theoretical concepts and their practical application to distressed families.

5.3.3.3 Live Supervision

(See STRATEGIES diagram, p. 104 and PARADIGM model, pp. 91 and 137)

For a general discussion of issues relating to the general practice of supervision of mental health professionals and UKCC guidelines 1996 and 1997, see Supervision in the Caring Professions (p 55).

One student had identified the value of live supervision during her first interview. On that occasion, Student 3 articulated: 'It's been excellent for two reasons; when you are seeing families there is supervision going on as it happens and there is immediate feedback. It has been very beneficial, I have learnt a lot, it's been very supportive. What I like about it is the two sides; the feedback and the criticism.'

During the course, live supervision was provided in groups of three students and a family therapist. This was in line with other systemic family therapy courses. Gorell Barnes, Down and McCann (2000) concluded that a component of a comprehensive training programme was the shift away from working with individual trainees to working with small groups of trainees. Hodas (1985, cited in Gorell-Barnes, Down and McCann, 2000, p. 45) believes that 'group contexts' for training maximises

learning potential since the training therapists can learn both by doing and watching others.

These views compare with the students' experience on the ENB A28. Student 4 spoke of the impact of 'working as a team and watching others of my small supervisory team working. We shared a lot of experiences.' Other students also mentioned aspects of the supervision group. Students 1 and 5 discussed the usefulness of discussing issues as a group and of the value of watching others work.

McCann and Down (2000, cited in Gorell Barnes, Down and McCann, 2000, p.59) reported on comments made by two students on a family therapy workshop which they organised. Each student came from a separate department of child and adolescent psychiatry. They too mirrored comments made by the students on the ENB A28. These students initially identified their needs and expectations of the course; to gain confidence and skills to work with families. Practitioners such as Heath (1982, cited in McCann, 2000, p. 45) or Schwartz, Liddle and Bremlin (1988, cited in Gorell Barnes, Down and McCann, 2000, p. 30) held the view that the supervisor is not only responsible for teaching specific skills but that these must be taught in ways that ultimately foster trainee competence and independence.

During their first interviews, the students, without exception, lacked confidence and were apprehensive about their lack of relevant skills. Their supervisor had become a central figure in this new experience.

There was a marked contrast in their attitudes in their final interviews. Student 1 summarised the transition as follows:-

> 'It was like moving from a continuum of total dependancy to becoming very independent. Live supervision was like a safety net which the supervisor holds on to, to make you go slowly'; but eventually, 'I listened to her suggestions but used them when I wished to do so. But at first I really needed her.'

Other students spoke of developing their own style during the process of supervision, especially if they considered the supervisor was 'too brilliant to match.'

Student 9 felt there was no way she could emulate her supervisor. Similarly, Student 3 considered one supervisor was 'so amazing' she couldn't use all his techniques: 'there was a cut out point.'

Student 5 highlighted live supervision as the most important feature of how she learnt on the ENB A28. But while listening to more experienced practitioners, she tried to develop her own style of working.

These students were not unique in their personal search for a therapeutic style of their own. This was also an important aim for the two other students already referred to who participated in a training family therapy workshop (McCann and Down, 2000, cited in Gorell Barnes, Down and McCann, 2000, p.59.). They both concluded that working as part of a training team had facilitated this process.

In spite of the advantages of a live supervision group, tensions did arise. Student 4 spoke of tensions which had occurred in her group because they all had such different ideas coming from very different backgrounds, cultures and sexual orientation but at the end they respected each other's different opinions — there were alternative ways of looking at the same situation.

Both sets of students, that is those on the ENB A28 and those on the family therapy workshop reported the high levels of anxiety they felt when in the treatment room with a distressed family and being watched by the supervisory team behind the screen. Student 6 on the ENB A28 described it this way:-

> 'If you have four or five people watching you it becomes more persecutory really, it's a feeling you are under the spotlight. You're being criticised, you are being judged and you could be found wanting.' She likened her feelings to what the families must be feeling when they turn up for the first session. He concluded by saying, 'It's intimidating at first, but it's something people get used to.' She used the word people to include both the therapist and the family.

During her final interview, she exuded confidence and considered she had the skills to work effectively in her clinical practice. (The students' perceptions of how they learnt are summarised in the diagram overleaf).

THE STUDENTS' PERCEPTIONS OF HOW THEY LEARNT
ON THE ENGLISH NATIONAL BOARD A28
(ESSENTIAL THREE ELEMENTS CO-EXISTING)

Live Supervision

Treatment of Families
(Practice)

Psychological
Support

Questioning Skills
(Circular)

Learning
Experience

The Process of Learning

Systems
Theory

Expressed Emotion
Studies

Psycho-Educational
Model.

Theoretical
Understanding
(Theories most relevant
to their practice)
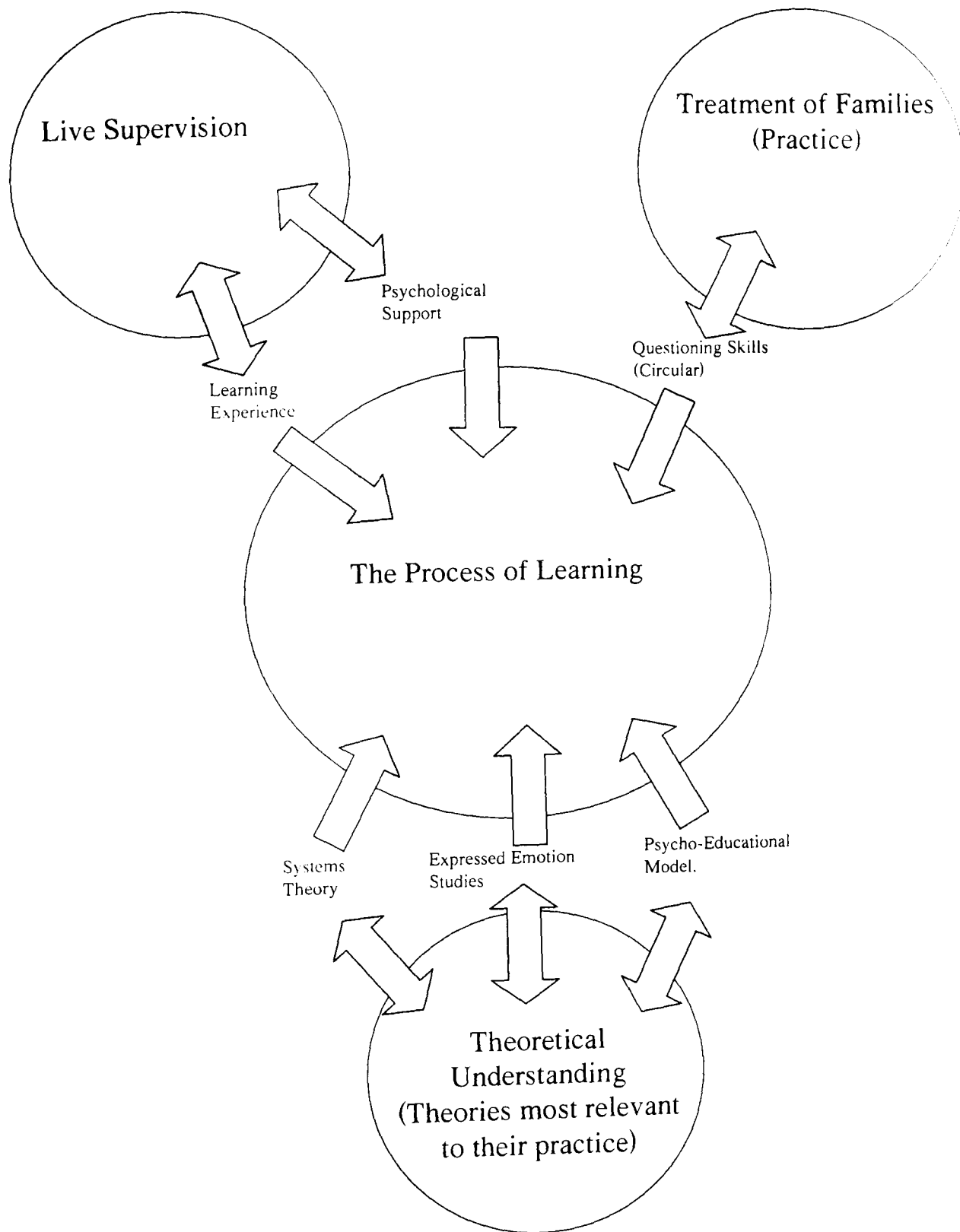
The preceding page 103 shows in diagrammatic form how the students considered that their educational experience of the teaching programme on the ENB A28 contributed to the process by which they learnt the skills and confidence to work with individuals who suffer from major mental illness and their families/carers. They considered that the three elements of the programme – theory, practice and live supervision – were the main significant contributory factors to their mastery and confidence.

The next sections will to into greater detail in the analysis of these various aspects and examine the entire learning process together with its context in further depth.

5.3.4 Outcomes

At the beginning of the course, the students were motivated to set out on an educational journey with commitment to learn ways of working confidently and effectively with the families of the long-term mentally ill. On the journey, they experienced many pressures, both psychological and academic but with one exception they completed the course. Student 9 took up a clinical appointment outside London and had to withdraw from the programme two-thirds of the way through.

The words of Student 3 can best summarise the 'Process of Learning' on the ENB A28.

> 'I soon realised that my previous approach to families before coming on the course could have split families up. By the end, I felt I had both the theory to work on, the confidence to work with a family with enhanced skills, while retaining my internal person.'

OUTCOMES

New ways of seeing
Self-awareness

Confidence ⟶
Knowledge ⟶   To change
Skill ⟶   clinical practice
                 to include
                 families at all
                 stages of caring
                 process

Changes in meaning
of "family":
Relating Family
Systems Theory in
wider context

Different
family
situations in
ethnic minority
groups

Inclusion of
carers,
partners and
friends

Effecting changes in
work environment

Influenced by

Managerial style

Creative
Supportive
Open to change

Rigid
Unsupportive
Inflexible to
change

5.4 Summary

Sections 5.1 and 5.2 of this chapter described the changing clinical environment in which mental health care practitioners were required to work. These were the CONDITIONS in the Paradigm model which led the students to search for the relevant knowledge and skills to practice effectively and safely. This central category in the study was the PHENOMENON in the Paradigm model.

Section 5.3 focuses on the CONTEXT of the Paradigm model, which is the learning environment, and illustrates how the different family therapy models taught on the ENB A28 provided theoretical understanding when integrated with supervised practice. Clinical supervision provided the psychological support required to manage adverse INTERVENING CONDITIONS of the paradigm model and maximise supportive ones.

The three elements THEORY, PRACTICE AND SUPERVISION (see p. 103 for diagram of "The Students' Perceptions of How they Learnt on the ENB A28") were the STRATEGIES (p. 104 and Paradigm model, pp. 91 and 137) which enabled students to integrate systemic thinking to practice, OUTCOME (p. 141 and Paradigm model pp. 91 and 137).

This chapter has discussed the educational aspects of the course ENB A28 from the perspective of students and managers. The next chapter focuses on the subjects of the course, the 'family'. What does the term mean in multi-cultural Britain to-day, and in a society which has gone through drastic changes since the end of World War II. Do these changes have implications for 'family therapy'. These issues will be discussed in the next chapter.

Chapter 6 — What is a family?

6.1 Various Concepts

CONDITIONS ➡

⬇

```
┌─────────────────────────────┐
│        CHANGES IN           │
│      MENTAL HEALTH          │
│          CARE               │
│                             │
│  Asylum ➡ Community         │
│                             │
│           ⬇                 │
│                             │
│         Family              │
│       Involvement           │
│                             │
│  FAMILY AND CULTURAL        │
│       DIVERSITY             │
│                             │
│  CLINICIANS                 │
│  ILL-PREPARED FOR           │
│  CHANGED PRACTICE           │
│                             │
│                             │
│  Limited:                   │
│                             │
│  Education    Training      │
│                             │
│                             │
│                             │
│                             │
│        Experience           │
└─────────────────────────────┘
```
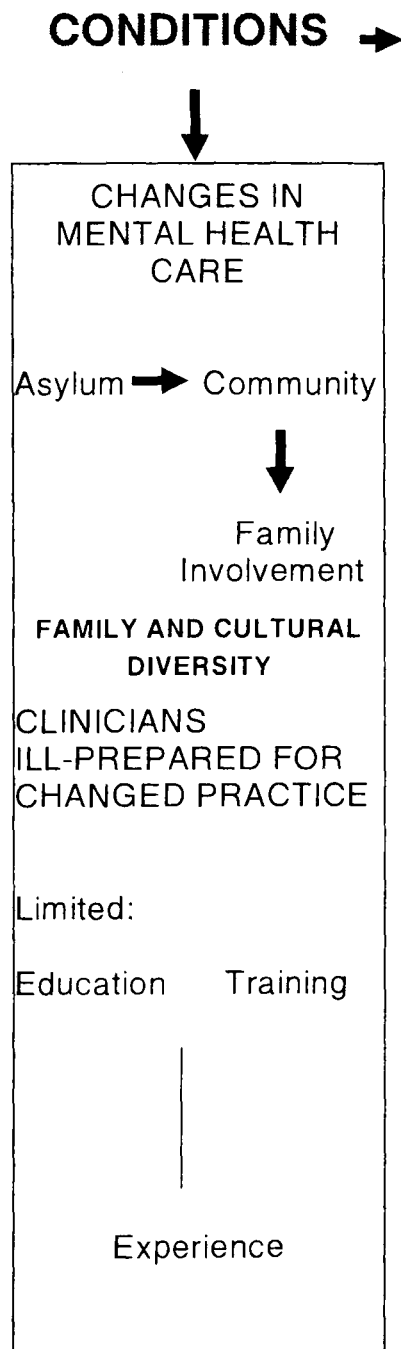
Culture, ethnicity and gender; each has an influence on the concept of 'family' which is held by different societies and individuals within them.

The students on the ENB A28 applied to take an educational course based on family therapy and to learn and practice family intervention techniques. However, they all worked in Mental Health Trusts in the Capital, known to be home to a higher than average number of single persons and ethnic minority groups, some of whom live in diverse family situations (See Section 3.2 Family Structure and Cultural Diversity, p. 50). In addition, a number of the students as well as their managers originated from different ethnic groups or cultures.

Professionally, they were required to work less with individuals who were part of a traditional 'British' family, the nuclear family, than they were to provide care and treatment to those who were isolated in the community as a result of long term mental health problems and consequential rejection by their families.

Students and managers were concerned, therefore, that the teaching on the ENB A28 should address family issues relating to ethnicity, culture and gender and that consideration should also be given to the role of professional carers, particularly those in long term care, as to the appropriateness of the title 'substitute families'.

→ PHENOMENON →

↓

```
┌─────────────────────┐
│                     │
│  A SEARCH FOR:      │
│                     │
│   KNOWLEDGE         │
│                     │
│   SKILL             │
│                     │
│   CONFIDENCE        │
│                     │
│                     │
│   GAIN IN           │
│                     │
│  UNDERSTANDING      │
│                     │
│     OF:             │
│                     │
│                     │
│                     │
│    FAMILY           │
│  RELATIONSHIPS      │
│                     │
│   PERSONAL          │
│  RELATIONSHIPS      │
│                     │
│  PROFESSIONAL       │
│  RELATIONSHIPS      │
│                     │
│                     │
└─────────────────────┘
```
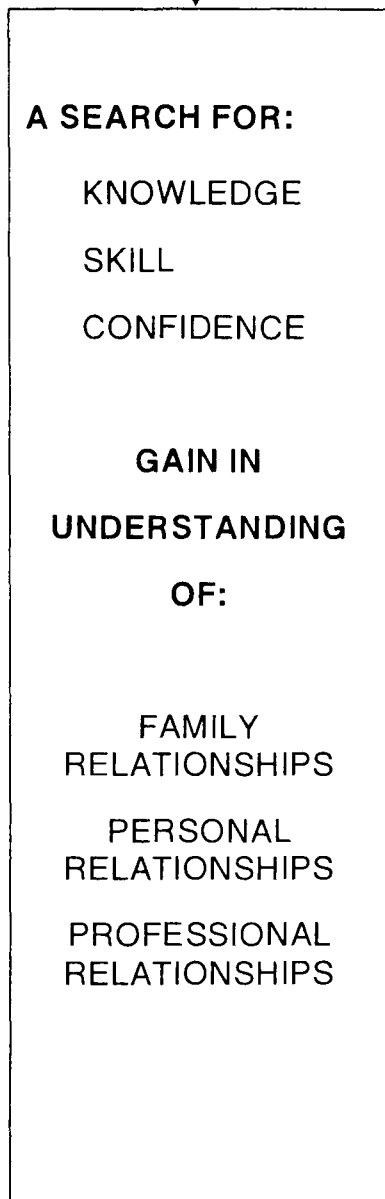
Influenced by the Feminist agenda, the concept of family has required revision due to diversification in the construction of family life over the past two decades. (Gorell Barnes and McCann 2000, cited in Gorell Barnes, Down and McCann, 2000, p. 17). This has been influenced by changes in patterns of co-habitation, childbearing and marriage. The needs of single parents, reconfigured families following divorce and separation, same sex couples and cultural diversity must be considered along with those of the nuclear family.

Original family therapy training was based on a theory of the family as a stable, two parent social system. Early 'systems' thinking (Jackson, 1965) was developed around notions of unitary coherence in family structures and function.

This understanding of what family therapy has to offer patients/clients is still commonly held and may influence whether or not a course such as the ENB A28 is of considered value.

This was true of the views of Manager R, who came from the Indian sub-continent. He expressed considerable concern as to whether the student who was a member of his community team could apply any of the teaching on the ENB A28 as so many of their clients came from ethnic groups such as Somalian whose family structures were diverse.

The life experiences of two of the students had also influenced the way they considered 'family diversity' and their expectations of the teaching on the ENB A28. One was in the process of a divorce and was preoccupied with thoughts of second families and how the children from each then formed part of two. A second student

considered that a friend of the same sex was more family than the birth family and hoped that teaching on the course would address the needs of same sex couples and their families. This student was also appalled at the way clinical colleagues dismissed the idea of referring same sex couples to family therapists if their situation required it, on the basis that same sex couples could not be considered a 'family'.

As reported in Students' Profiles (p. 64), a number originated from a variety of ethnic and cultural backgrounds and when first interviewed, three in particular (1, 9 and 10) experienced considerable difficulty in thinking of 'family' in any other way than that understood in their own culture.

As a way of illustrating what he believed his concept to be, an African student gave details of his own extensive family. All members of this family were related either by blood or by marriage and he had not thought beyond these boundaries. His concepts were similar to those of a student who came from the Indian sub-continent and who had very entrenched ideas on the constituents of family. In comparison, a student who came from a traditional, continental European background 'laboured' during the interview in considering the possibility that a family could be more than either the nuclear or extended family but remained convinced. He recognised that during his work with people who were isolated as a consequence of a serious mental illness that others must provide the role of the 'family' but considered it more appropriate if another term was used. He firmly rejected the notion that professional carers could ever be considered a 'family'.

In comparison with these three students whose views were influenced by a rigid ethnic/cultural background, a fourth student from an Eastern culture equally traditional had very relaxed views on how 'family' should be defined. She was even comfortable with the concept of family being extended to professional carers. This student worked entirely with individuals who suffered isolation as a result of their illness. One reason she gave for applying for the course was to learn how to facilitate the relationship between such individuals and professional carers in after-care hostels. She defined family as "a group of people living together, not necessarily parents or grandparents. People living together as a group, or like good friends living together and looking after each other or in hostels or care homes. If they are together for some time and looking after each other. I see that as family."

The other students, for example Students 4 and 7, came to the course with a traditional white British view of family but within a very short time expanded their ideas to include friends and other social support systems. Their views changed as they interacted on the course with fellow students from different cultures and ethnic backgrounds and also while observing the treatment of groups from other cultures and ethnic backgrounds as well as same sex couples. These are themes which will be developed later in this chapter.

```
                    ──►  CONTEXT  ⇄
                               │
                               ▼
                     ┌───────────────────┐
                     │                   │
                     │     LEARNING      │
                     │   ENVIRONMENT     │
                     │        │          │
                     │        ▼          │
                     │  FAMILY PROJECT   │
                     │        │          │
                     │        ▼          │
                     │       A28         │
                     │                   │
                     └───────────────────┘
```
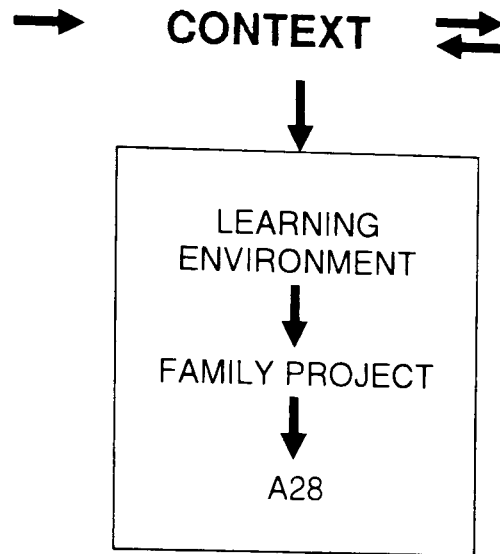
The learning environment, CONTEXT (see diagram), which was created by the design of the ENB A28, facilitated the students in their understanding of how cultural, ethnic and gender issues related to their work with families and their social systems.

As an example of how the environment facilitated learning, Student 4 spoke of how much she gained from working with individuals from different cultures and sexual orientation. The benefits of working with people from different cultures was also pertinent to the experience of Student 3 who valued listening to students in the group who came from ethnic and cultural minorities and who challenged lectures regarding the focus of a lecture and whether it could apply equally to a British, White family, a Bangladeshi family or one from another ethnic minority.

The sharing of such cultural and ethnic experiences is consistent with that of Gorell-Barnes (1998) who considers that working with colleagues from different ethnicities as well as with families from across the world, further increases sensitivity to the "plurality" of experience.

As previously discussed, the support of managers in the clinical environment could be crucial in a student's learning process: INTERVENING CONDITIONS (see diagram next page). There were examples of managers who supported a student because they wanted the specific skills taught on the ENB A28 to be used in the clinical environment for which they had responsibility.

The aims and hopes of managers for their students' experience on the course has already been discussed in the chapter entitled "Commitment to Learn", see p. 96. However, issues related to ethnicity and culture receive further mention.

Manager P, whose ethnic origins were East Africa, required a charge nurse to take the course to enable him to establish a small treatment programme on the ward to work with families and carers. This aim was precipitated by the admission to the ward of an increased number of patients who usually lived in family units and whose member regularly visited the ward. They were all from a range of ethnic minority groups. Commonly, patients were single, rejected by their families, and from white, British cultures.

The experience of Manager P compared with Manager T in that the only family groups visiting the ward came from an ethnic minority, in this instance Bengali. Otherwise the patients were single, isolated and white British. The Bengali student (see p. 96, The Managers' Perspective) shared his knowledge of the Bengali culture with the rest of the clinical team. Not only was he able to communicate with their families as few spoke English, but with Manager T's encouragement shared his knowledge of the Bengali culture with the rest of the clinical team.

In comparison with Managers P and T, Manager J took an overview of some of the issues relating to the ethnic minority groups in the community for which she was responsible. She believed they would benefit from the skills of clinicians trained in family work. She did not differentiate between the treatment of well-established London families and the new immigrant groups. This position might compare with the views of Down (2000, cited in Gorell Barnes, Down and McCann, 2000, p.61)

INTERVENING CONDITIONS

Commitment to Learn "I need to know more"

Conflict of Roles

Service Provider — Student — Family Member

Pressure of Time Clinical responsi-bilities

balance parental responsi-bilities with clinician & student roles

emotional pressure meeting deadlines of assessments

Encouraging

Managerial Influence

Unsupportive
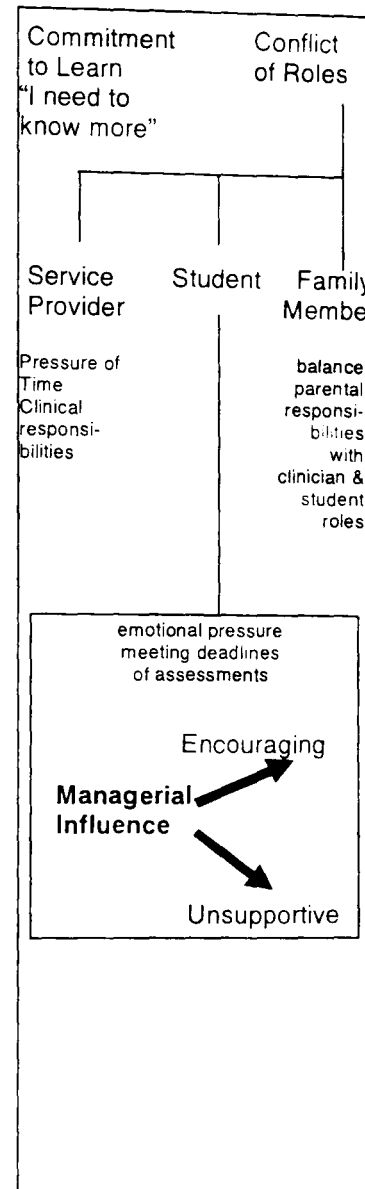
who suggested that it might be of greater relevance if trainees were facilitated in becoming culturally competent and sensitive in a way which could be generalised to working with people from many cultures.

In comparison, two other manages were unsupportive of their students.

Manager H was very clear when interviewed that he did not consider 'family work' to be an integral part of the clinical philosophy on the ward for which he held responsibility. Family work had nothing to offer any of the ethnic minorities, they either did not have a family in the country or they didn't wish to be referred for family work.

The concerns of Manager R have already been discussed in relation to family diversity. However, in his interview he also expressed other concerns relating to 'family', in particular what meaning was given to the term on the ENB A28. In cities like London there are a substantial number of ethnic communities who have different meanings of 'family'. Questions such as "Who is the most important member of the family?" "Who makes the decisions?" need, according to Manager R, to be posed when professional contact is made with the family group.

STRATEGIES

The Process of Learning

Theoretical Understanding

Practice Treatment of families

Live Supervision

Emotional support and group supervision
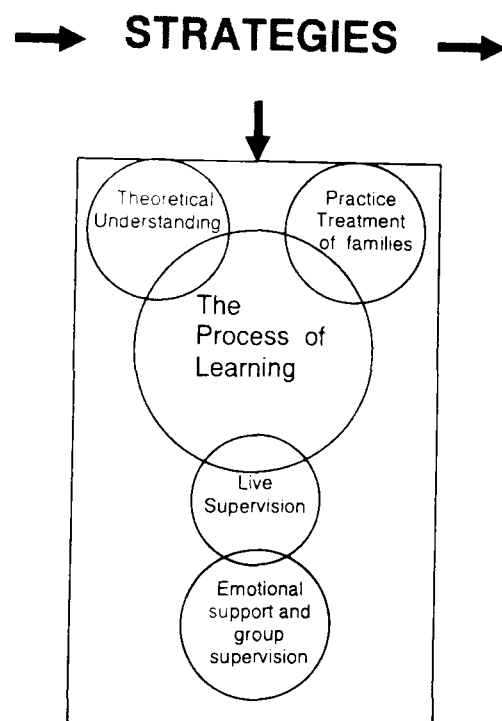
The Strategies (See diagram this page)

which enabled the students to think about cultural, ethnic and gender issues were the same as used in the 'learning process' p. 104: theory, practice and supervision.

Of all the theoretical models taught on the course, the systemic approach - whether used alone or in combination with other techniques - was deemed most applicable to the treatment of the many diverse family groups presenting for family work as well as the clinical management of individuals, many from the ethnic minorities admitted to hospital services during acute episodes of psychotic illness.

When asked what had contributed most to Student 6's expressed value of the course, he replied "The systemic approach - I find it helps me - systemic thinking sharpened up my thinking."

Additionally, course teaching and reading material provided by the tutors facilitated further understanding of how culture, ethnicity and gender impacted on therapeutic aims. The documents gave information of work that had been carried out with families from different ethnic groups. The multi-cultural/ethnic make-up of the student group added a further dimension to the discussion. See p. 114.

More recently, family therapists have had to consider their appropriateness to work across other cultures when therapeutic models had been developed based on a white, Western culture. "Earlier family work, therapy and models and techniques have historically often been seen as universal in application" (Down, 2000, cited in Gorell Barnes, Down and McCann, 2000, p.61).

During the course, some students had the experience of working with families from different ethnic/cultural groups. Of particular importance to their learning was the opportunity to observe the family therapists working with these families. In the words of Student 4, "They continued to learn from an orientation to people from different backgrounds as they observed the treatment of families from other than white British families — mainly Bangladeshi families."

As the course progressed, the numbers of families seen from different backgrounds and cultures were reported by the students to have increased.

Live supervision during treatment sessions supported the students through difficulties which may have arisen due to ethnic or cultural differences. Of importance to the learning process was the maintenance of the integrity of the student group. Group supervision provided an essential component of the course where differences between students of different cultures and sexual orientation could discuss possible tensions in the presence of a therapist. This proved very effective at holding conflict and enabling greater knowledge and understanding of these important issues in 'family work'.

In the words of Student 4,

"Working in small group supervision had an impact. Members from different backgrounds, cultures and sexual orientation shared different opinions, a few minor problems. In the end, respected each other's opinions and accepted they would not always agree."

This chapter has concentrated on the meaning of family in a changing multi-cultural, ethnic society and the requirements of practitioners and students to learn ways to work with families, whatever that might mean in particular family/social systems.

In their final interviews. the students discussed the outcomes of the course teaching and their learning of complicated ethnic, cultural, gender and sociological issues.

Some of the students had not fully considered at the beginning of the course the importance of these vital issues and the impact they would make on the teaching of the course.

OUTCOMES

New ways of seeing
Self-awareness

Confidence
Knowledge
Skill

To change clinical practice to include families at all stages of caring process

Changes in meaning of "family":
Relating Family Systems Theory in wider context

Different family situations in ethnic minority groups

Inclusion of carers, partners and friends

Effecting changes in work environment

Influenced by

Managerial style

Creative Supportive Open to change

Rigid Unsupportive Inflexible to change

The students fell into one of three groups in how they viewed the concept of family. There were those who came from rigid ethnic/cultural backgrounds and appeared, at interview, to be somewhat bemused to consider that others might have a different view. A second group came from a traditional British culture and the concept of the nuclear family. The third group comprised students whose concept had been modified by either personal experiences or the professional ones resulting from their work with individuals suffering from major mental illness and who consequently were now isolated in the community.

The East African student whose understanding of family was that of people related by blood or marriage dealt with the conflict between his culture and the course teaching by naming everyone in contact with the patient as 'carer'. He developed
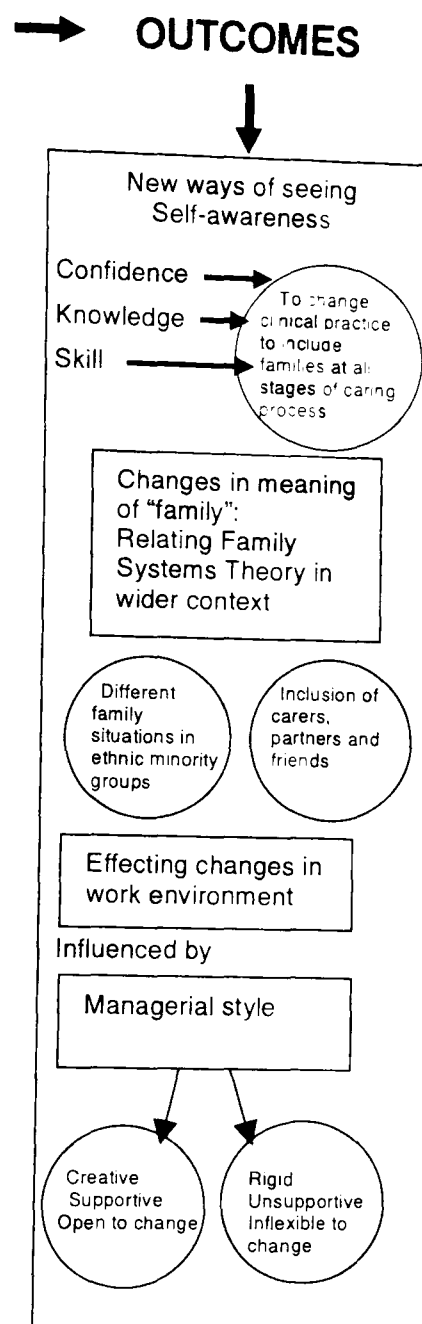
quite a passionate concern for the 'plight' of carers who he realised since taking the course had always been neglected by professional staff. In comparison, the Bengali student retained his cultural beliefs.

The students from a traditional British family background changed position entirely and within a short space of time after exposure to alternative views. Student 7 was affected by the needs of same sex couples and the number of homeless women admitted to the Unit where she worked. The course made an immediate impact on Student 4, who shifted from "nuclear" family to anyone who is important in the person's social system, whether friend or same sex partner.

There was an increasing level of cultural awareness among the student group as the course progressed.

Student 5 recognised the many cultural issues in her practice and that she was learning all the time. The course made her examine her prejudices and issues of race.

Student 7 was continually aware of ethnic issues; "the clients mixed and varied and the staff mixed and varied."

Student 4 was particularly affected by the impact of working in her supervision group with fellow students from various ethnic backgrounds and gender.

Student 3 began the course feeling very critical of the stance she believed family therapists held in relation to family, ethnicity and gender. It was dominated by "white, male therapists who believed in two parent families" and she had anxieties how this would affect the teaching on the ENB A28.

She finally had to admit that she was pleasantly surprised that these issues had been addressed, although 'gender' had received less attention.

The managers' views on culture/ethnicity in relation to their students and teaching on the ENB A28 was discussed earlier on pp. 118 to 119. The Bengali student who worked with the clinical team to enable them to gain and understanding of Bengali culture, himself gained in knowledge from work on the course and as a result his worth to the team considerably increased.

The student of Manager H who rejected the idea that on his ward family work had nothing to offer the ethnic minorities reported learning a great deal from the course

work on cultural issues but not once when interviewed related this learning to her ward experience.

Manager R expressed concern as to whether the ENB A28 offered relevant teaching to enable his student to work with people from diverse families and cultures. This contributed to a feeling that he devalued the course. The student recognised he never understood the work she was undertaking and gave her no support.

The subject of 'professional carers' came up for discussion in a number of both student and management interviews, particularly those clinicians working in long term care. From personal experience, there is much confusion as to how far 'substitute family' can or should be used.

6.2 Professional carers

One related outcome of the interviews with the students were their expressed views on whether or not clinicians could fill the role of a 'family', particularly in services which provided lay term care. Their responses varied but of importance the ENB A28 had enabled them to recognise that they may influence relationships between themselves and residents in a similar way to how H.E.E. family relations (see p. 28) impact on the course of a major mental illness in a family member.

There were differing views amongst the students regarding how far their caring role could be equated to that of a family. As previously reported, Student 9 was very clear in his mind that professional carers could not be considered family although he recognised the needs of isolated people with long-term mental health problems. But he considered that the term was a euphemism and another should be introduced. Similarly, Student 3 considered that although the domestic style environment in which she worked lent itself to being considered a home, in no way did she consider that she and the clients were members of a family.

In comparison, those who worked in long-term rehabilitation did consider that carers/clients constituted a family. Student 8 worked in an environment where residents had lived for many years and who in some instances required basic physical care provided by care workers who did indeed consider themselves to be mothers to the residents. This was particularly so when the residents were what Student 8 described as "needy". She had concluded that the carers she worked with did not

know how to relate to a resident other than in a "mothering" role. She contemplated the idea of teaching the team systemic principles and encouraging the use of a systemic family approach to their work. She had even considered whether this approach would enable residents to move on if staff gave up the role of substitute mothers.

Student 2 worked in a service for people with long-term mental health problems which referred patients to long-term care hostels if they had lost contact with their families. Because of the many years she had worked in this type of service, she had come to believe, as reported earlier, that hostel care workers provided a 'family'. She considered that one of her important roles was to facilitate the relationship between patients and their future carers.

Too frequently such patients were re-admitted to hospital because they refused to take medication. As a result they were "turfed out" of the hostel because the carers were unable to cope any more.

Following her experience on the ENB A28, she had worked with the nursing team for which she was responsible and had gained their cooperation and support to ensure that the hostel carers were involved in ward meetings to discuss prospective residents as well as those known to the hostel service. The carers had responded to these initiatives very positively.

An entirely different concept was that provided by Student 6, who believed that the clinical team created a working environment on a par with that of a family. Since completing the course, she had encouraged her colleagues to reflect more on their own clinical practice in the light of the EE research. She was of the opinion that the professionals' level of EE was high.

Only two students who worked in long term rehabilitation believed that residents and staff formed a 'family'.

6.3 Summary

This chapter has demonstrated that there are many different concepts to the meaning of 'family' among professionals, which reflects the confusion of society in general and parliamentarians during debates in the House in general. Such confusion adds to the difficulties in gaining acceptance for courses directed to working with families.

The changing concept of family influenced by changing patterns of co-habitation, childbearing and marriage has been discussed.

Some of the students changed or modified their perception of what constituted 'family' during the course, others had already modified their views through working with people who had severed links with family and friends as a result of their illness. Issues relating to cultural diversity and different family structures were of particular importance to both the student and managerial group. Members of both groups expected the teaching to address the specific needs of these families as the area in which they all worked served a multi-ethnic population. The students reported that they had derived benefit from working in their small supervision groups where they were able to share experiences and knowledge of cultural and ethnic issues.

There were differing views amongst the students as to whether professional carers could be considered family although they were all of the view that the principles of family therapy applied in their work with patient/client groups, for example the Expressed Emotion studies, where staff could exert the same influence as family relationships. One articulated the view that he believed all professional staff were HEE.

In general, students expressed the view that any member of the patient's/client's social system was considered family; "a family was a group of people living together, looking after each other and sharing trust" was the common understanding.

The next chapter moves on to consider the overall experiences of the students who participated in the ENB A28 and its impact on their personal and professional lives.

Chapter 7 — Different Ways of Seeing

In this final chapter discussing 'findings', the students give evidence on the effects the course has had on each of them as individuals and clinicians and how, in turn, these changes have impacted on their professional practice.

The students in this study set out on an educational journey to learn how to work effectively with the families of their patients/clients. For an overview, refer to the paradigm model adjacent. Their professional experiences had made them aware that the implications of community care had given them a wider range of responsibilities; hospitalisation and a course of medication was not sufficient to maintain individuals in their social systems, whether that was a traditional family, a single person's hostel or a life with friends. This rich source of non-professional carers also needed care: help to understand the nature of serious mental illness, advice on how to manage unsocial behaviour which may be a symptom of this condition and to recognise early signs of relapse in order to prevent further deterioration. Of greater importance was the need to establish a communication system which would facilitate an exploration of the relationships between the patient/client and those with whom they either shared their lives or were in contact. The research of Leff and Vaughn (1976 and 1985) previously referred to (pp. 8, 28 and 28) had demonstrated a link between relationships where high expressed emotion exists and relapse rates following treatment.

The students recognised they lacked these specific skills and the confidence to practise them. They expected to gain from the course a theoretical understanding of the underlying principles of family work and in time, with practice to feel confident. What they did not predict were the further reaching effects the course had on their person and individualism as a practitioner. The confidence they gained went beyond the application of skills to their core self, so that they were able to look again and re-evaluate previously held convictions, both professional and personal

7.1 Changes in Practice

Changes in the practical aspects of caring were particularly evident in the reports from students who worked in more "institutional" settings such as hospital wards and residential units, which catered for the needs of individuals with longer term mental

health problems. There was evidence that the degree and speed of change was influenced by the student's position in the organisation and the level of managerial support they received.

Care plans, although not standardised throughout the NHS, conform to a set of common principles but the overriding one focuses on the needs and rights of one individual — the patient/client. Relevant details of the social system which that individual comes from and to which he/she is likely to return would be at best marginalised and at the worst lost in other personal details in the documentation. The format of the documentation also influenced the manner in which patients were interviewed on admission; the details required determined the questions asked. However, Student 4 said that following her experiences on the course, her "eyes had been opened" and during the admission process, instead of just thinking of individuals with an illness, she also thought of their families, their friends and their social contacts. Instead of focussing in the documentation on psychiatric jargon, she described their behaviour and their presentation within the family. Before the course, she said she had been interested in families but "drew a line" at a certain stage in their involvement in a caring role. Since completing the course, she now believed they should be involved as much as possible. She asked details of family trees and included genograms in the documentation of patients for whom she had 'primary nursing' responsibilities, as she believed that asking these details was more helpful to patients than focussing on a nursing model.

She regretted that she had not yet had the opportunity of influencing the rest of the nursing team to change the documentation. The reason she gave for this omission was pressure of work and rapid turnover of staff.

In comparison, Student 2 was the ward manager of a team which was mature and stable and because of its isolation from the main body of in-patient services was, to an extent, self-sufficient. She had been successful since completing the course in effecting change in the way her team viewed the involvement of carers. Her priority throughout the course had been to find a way of persuading her team that working with family/carers was valuable. During the first interview, she expressed doubts that she would be able to convince them, although she was their manager. She gained in confidence as the course progressed and eventually achieved her aims by working with each member of the team on an individual basis. Clinical supervision provided

the opportunity and the 'space' when she could discuss and encourage each member of the team to spend time with carers, to view relationships from the side of both patient and carer, and to recognise that there were many factors which could affect a person's mental state. She complemented this style of teaching by designing a ward based training programme and made time for the team to share knowledge and relevant topics. To consolidate this new way of working the student (ward manager) developed the format of the ward care plans to include a section giving details of each patient's family, carers and social contacts. They also re-thought their practice in relation to the professional carers (see professional carers p. 123) with whom they had continuing contact.

Student 1 similarly to Student 2 and also a ward manager had made a considerable impact on the 'thinking of his ward team'. Before taking the course, he had placed all the emphasis of care on the individual patient. Just as Student 4 reported, he thought "he is the one who is ill... he's the root cause of the problem." Now he viewed the whole family and considered the family dynamics. He had managed to convince the multi-professional team that carers should be involved at all stages and as early as possible in a patient's treatment programme. Opportunity was offered for patients' carers to discuss their difficulties and an explanation given of the importance of this as a means of reducing the frequency of future re-admission to hospital. Previously, carers were only involved if they took the initiative and asked to be interviewed. Now the team took the initiative. This student was proud of his achievements, which included a change in the format of care plans to reflect the initial and continuing involvement of carers in the treatment process. However, the manager who supported his application to the course had since resigned to take up another position in the Trust. Following his departure, Student 1 had received no management interest in his work, he felt alone and isolated with no support. He considered that although the inclusion of carers was part of the Trust's strategy, it did not devolve down to local managers. "I don't get the impression that the Trust encourages people to use the skills that we have learned." Field notes made after this interview reported "professionally matured but sad, depressed and angry at a failure to be appreciated by managers."

Student 8 was also left feeling disappointed and angry when she was prevented by 'acting managers' from fulfilling the role mapped out for her by the previous

manager who had since left the Trust. The original plan had been for her to become a 'specialist' in family work for the benefit of professional carers and residents across the rehabilitation service. It was for this reason that she was supported in taking the ENB A28. She was not only prevented from taking on future work but was made to discontinue the treatment of two families which was underway.

However, in her own work the course had enabled her to change her whole thinking about the residents for whom she cared; different ways of working with clients, thinking about different ways of working with families, thinking about mental illness and its impact on the family members and in particular what level of stigma they might experience. She quoted an example of how much she had learnt and changed her approach to looking at clinical need. She had set out to gather information on an aspect of a resident's life to account for his repeated pattern of violence. She noted it reoccurred at the same time each year and in his 'ramblings' he mentioned dates. She was able to elicit that one was his mother's birthday and he became violent during a period of two months previous to that date. This link had not previously been recognised although he had been known in the service for years.

Student 5 worked in a community team and in that position was less reliant on a team approach than those working in clinical areas which provided 24 hour service. However she did have aspirations at the beginning of the course that she could influence the community team to think 'family' in the way it functioned but her manager gave her no support nor showed any interest in the course. "He just didn't understand". One or two of her team members did, however, show an interest but the overall team morale was low and combined with management disinterests she had given up. In addition, she had plans to leave London.

Her experience compared with that of Student 8. Although her early optimism had been thwarted by lack of management support she felt satisfaction in her own work. She now felt comfortable and confident to work with clients in their own homes and to examine and intervene in family relationships.

7.2 Support of Managers and Level of Effectiveness

Each of these five students showed that considerable changes in their clinical practice and the way they thought about their practice had taken place as a consequence of their participation in the ENB A28. They also showed that the

attitudes of some managers were rigid and inflexible to change, leaving students unsupported.

This pattern of managers being unsupportive of students to the detriment of their ability to apply new learning to the work environment is not unique to the ENB A28. Students on the Thorn Project have repeated similar difficulties especially when there had been a change in manager during the period of the course who did not share the same views (Personal Communication, Professor Julian Leff, Tavistock Clinic, June 28 01). In comparison with the position of the students already discussed, Student 6 received maximum support and interest from the team manager.

She worked as an individual practitioner in a day care team but unlike Students 5 and 6 was able to exert an overall effect on other members of the clinical team by raising their awareness and need to consider family work in their own practice. She used herself as 'a change agent' and encouraged her colleagues to look at the work around 'expressed emotion' and relating it to the clinical environment which staff create in the Day Hospital.

At interview she was convinced that the hospital was 'shifting' towards accepting this new way of working; children had been heard running around, nothing like that had happened before. In her own practice she had introduced systemic principles.

Students 3, 7 and 10 had also enjoyed managerial support to continue with work which they had already begun on the course. Student 7, who was taking the two-year Diploma course at the Institute, had formed a collaboration with a community nurse family therapist to treat disturbed mothers and their families and relatives. Her manager who had also taken the ENB A28 would also be involved. Student 10, on the other hand, was not a member of a professional group so was unable to work individually with families but his knowledge of the Bengali culture and his experience of taking the ENB A28 was used by his manager to teach the team how to manage Bengali families, as the ward received many Bengali speaking people.

Not one of the students interviewed had ceased to work in a systemic way since completing the course. Even some, such as Students 5 and 8, who had been disappointed by lack of management support to fulfil their initial expectations, were planning a long-term career as specialists in family therapy.

7.2.1 Changes in a Specific Area of Practice

Participation in the ENB A28 had facilitated the students to reconsider how they dealt with issues relating to Confidentiality. Clause 9 of the Code of Professional Conduct for the Nurse, Midwife and Health Visitor states:

> Each registered nurse, Midwife and Health Visitor is accountable for his/her practice and in the exercise of professional accountability shall: *Respect confidential information obtained in the course of professional practice and refrain from disclosing such information without the consent of the patient/client or a person entitled to act on his/her behalf, except where disclosure is required by law or by the order of a court or is necessary in the public interest.*

In view of this requirement by their professional body, nurses have exercised extreme caution when speaking to relatives/carers without the expressed permission of the patient. Family members have too frequently failed to understand why information regarding the patient's condition is being withheld. Limited communication has sometimes been interpreted by families as disinterest and neglect of their needs.

Difficulties in the relationship between families and members of staff are exacerbated when the patient for whom they are caring has made a specific request that the families should NOT be involved. Once documented, this decision may remain unreviewed throughout a person's treatment in spite of changes in the mental state. During the early stages of severe mental illness patients may experience negative thoughts and feelings; they are reluctant to eat, take medication, care for personal hygiene and have contact with other people. It is not unusual for a patient at the time to reject those close to them. This was well described by S, a medical practitioner interviewed during the pilot study.

Sometimes there are good reasons when families should not be involved, for example where there has been a history of sexual or physical abuse.

In extreme circumstances, patients may pose a risk to themselves or others; relatives then are particularly at risk. Clinicians working in the community and hospital staff responsible for someone who has left hospital without permission must then exercise professional judgment to act on a "need to know basis" and break the code of confidentiality. But such a decision is not taken lightly.

The students when interviewed during the research programme reflected on a range of experiences and views on how Clause 9 should be implemented. The approach of each student was to work with patients to accept their families' involvement but if this failed, to abide by the patient's wishes.

Student 3 considered that there was not sufficient professional support and advice to practitioners in these sometimes difficult circumstances. However, she was one student who, early in the course, had thought through the problem and had reached a point where she could consider a more flexible approach to the statement "I don't want my family involved." She asked patients to pause and consider the reasons; "Was there a particular problem?" As an example, she discussed a woman who, following their discussion, agreed to one meeting which turned into six and a resolution of some of her problems.

In comparison, Student 4 considered that before taking the course she was very constrained by Clause 9 in the way she communicated with families. By the end, she had come to believe that staff had to be more flexible and more "human". Her changed thinking changed her practice and she spent time with patients who resisted contact with their families with the aim of "figuring out" the difficulties in relationships between them and members of their families and the reasons why problems arose. One solution she offered was to offer herself as a mediator at a family meeting.

Similarly, Student 5 reported that she had previously taken a rather rigid position in relation to family involvement and that it was normal practice to leave a patient's initial, negative response unquestioned. Although on completion of the course she still found it difficult, she did nevertheless spend time encouraging her clients to accept their family.

Other students focussed during discussions with patients on the benefits to be derived by them if relationships with their families improved but finally they had to accept the patient's wishes.

From these responses, it can be seen that there is no easy course to take when confronted by competing priorities: patients' wishes, clinical needs and professional accountability have to be simultaneously considered. However, the students demonstrated that they had been able to take another view of their previous practice.

7.3   Finding Self in Family 'Circles'

An awareness of self has always been considered an important aspect of family work. As with other forms of therapy a psychological 'block' caused by a failure of therapists to face parts of themselves which they may find unacceptable may interfere with their work with others. However, there is disagreement how 'self' should be defined; either by 'multiplicity of selves' or a 'core self' (Gorell Barnes and McCann, 2000, cited in Gorell Barnes, Down and McCann, 2000, p. 17).

The students interviewed did not involve themselves in such comparisons but in their final interviews, words such as 'self', 'self awareness', 'self confidence' or other words of a similar nature were used frequently and particularly with reference to how self knowledge which they acquired on the course improved their practice.

Student 5 was very comprehensive in the way she expressed how the course helped her to become more self aware. "The course brought up for me...looking at myself and examining myself, how I work with people...being aware of my prejudices and how I relate to people generally, it made me question my boundaries when I'm working with clients, issues about my self identity and race, it brought up a whole lot of things that have influenced how I relate to clients. I've changed in some ways doing the course."

Student 3 had wanted to do the course because she needed the basic training. However, while on the course and similarly to Student 5 she described an "inner process" which made her much more aware of her attitudes, her thinking and her clinical approaches. She had become more reflective than she had ever been before and this had had an impact on her day to day practice.

The students' expressed need to acquire the confidence and skill to work with families has been a recurrent theme throughout the investigation. However. the self confidence which they eventually acquired went beyond that required to practice an identified skill to work with a family. At their final interviews, the students presented in a manner which exuded self confidence compared with their first.

For some, their new found confidence had exerted an effect on the thinking of their clinical teams. Three of the students, 1. 2 and 6, had discussed their intentions at their first interviews, but were very apprehensive about their ability to have any impact. All three worked in strong multi-professional teams headed by traditional medical consultants. "biochemical" in the words of one, and yet had confidently overcome resistance and made significant headway in enabling their teams to introduce a systemic approach to care.

In comparison, there were a number of examples of students who had grown in self confidence during the course in their individual practice. For example. Student 4 had the confidence to accept that it didn't matter if she said the wrong thing or that the treatment didn't work for everyone. In comparison. Students 6 and 7 were aware of a general increase in their self confidence. particularly when the course was over. Student 6 was aware that it had developed enormously as she recognised her ability to integrate the theory which she had learned with her own personality and style of working whereas Student 7 had her confidence boosted, her self esteem both professional and personal boosted and as a consequence her enthusiasm for her work increased. Student 10 was delighted that he had learnt to stop telling patients how to behave.

All the students said at some stage during their final interviews that as they gained in confidence they became increasingly independent of their supervisors even to the point of being able to challenge their advice. "I felt it's OK to say I'm not actually agreeing with that wonderful family therapist". from Student 4, similarly to Student 3 who held on to what she perceived to be happening within a particular family in spite of her supervisor's opposing view.

As the course progressed. not only did the students become increasingly independent of their supervisors' advice but they also became independent of their style of work. Initially the students were in awe of the skills they observed when watching the

family therapists at work but as they became increasingly self aware, they realised that they could not emulate the style of others. They had different personalities, different styles of work, different experiences and different clinical environments. As the students became more aware of their own "self" they all expressed the need to develop their own style of therapeutic work to match these differences. The two trainee therapists on a family therapy workshop reported earlier (McCann and Down, 2000, cited in Gorell Barnes, Down and McCann, 2000, p.57), also expressed the need to develop therapeutic styles of their own.

There was evidence that the encouragement and opportunity to 'think' while on the course contributed to the students' increasing self awareness; "we were made to think all the time — what is the tutor saying now? What does that mean? It was interesting to be able to think about things and feel free to say them — I didn't feel threatened in the group." These were the words of Student 4 who later developed her theme. "I have freedom to think, it's OK to have my own ideas about what's going on in the patient's life — before the course I thought I can't have my own ideas — it develops your whole thinking, I believe."

Similarly Student 3 reported she had become far more reflective than she had been. She thought about her attitudes and responses and took time to consider the meetings she would arrange with families. Before the course she would not have done that.

In comparison, Student 8 did not reflect on the course until right at the end when she realised she had changed. It was the whole process which had caused this, including developing her own thinking and looking at things differently as did Student 2.

Student 6, on the other hand, gave specific examples of how her thinking changed. She concluded that it was easier to focus on clients' omissions during therapeutic sessions rather than examining her own possible limited interventions — afterwards she would reflect on what she said and how that fitted with systemic thinking which she believed sharpened her thinking in general.

Many students reported that they had become much more aware of their personal relationships, for example with family and friends. Others focussed on parenting skills, networks of family relationships following marriage breakdown and same sex relationships. No students, however, spoke of their relationship with their family of origin, although at their interview for admission to the course they would have been

asked to consider if they foresaw any unresolved difficulties which might interfere with their work with families (see p. 59).

7.4 Summary

To summarise, the students did what they set out to do, that is to gain confidence in skills to work with families but not just as a way of performing a set of rituals.

They learned the skills which gave them the confidence to discriminate between different models and different methods and to think about their practice in a way which they had never done before. In particular, they were aware of themselves, which affected the way they viewed the problems of the families they were treating.

Each student concluded that they needed to develop their own style of work which 'fitted' the relationship between family and therapists. To ensure that this level of individualism was safe for family and practitioner, good clinical supervision, both live and individual, was essential. Even on occasions when therapist and supervisor may not agree, the fact that the system is securely in place, "the safety net" described by one student, enables individualism to flourish.

Chapter 8 presents and discusses the findings in this study within the framework of the Paradigm. (See p. 137)

A SEARCH FOR KNOWLEDGE AND UNDERSTANDING – THE PARADIGM MODEL

CONDITIONS →	PHENOMENON →	CONTEXT ⇄	INTERVENING CONDITIONS →	STRATEGIES →	OUTCOMES

CONDITIONS

CHANGES IN MENTAL HEALTH CARE

Asylum → Community → Family Involvement

FAMILY AND CULTURAL DIVERSITY

CLINICIANS ILL-PREPARED FOR CHANGED PRACTICE

Limited:

Education   Training

Experience

PHENOMENON

A SEARCH FOR:

KNOWLEDGE

SKILL

CONFIDENCE

GAIN IN

UNDERSTANDING

OF:

FAMILY RELATIONSHIPS

PERSONAL RELATIONSHIPS

PROFESSIONAL RELATIONSHIPS

CONTEXT

LEARNING ENVIRONMENT →

FAMILY PROJECT →

A28

INTERVENING CONDITIONS

Commitment to Learn "I need to know more"

Conflict of Roles

Service Provider — Student — Family Member

Pressure of Time
Clinical responsibilities

balance parental responsibilities with clinician & student roles

emotional pressure meeting deadlines of assessments

Encouraging

Managerial Influence

Unsupportive

STRATEGIES

Practice Treatment of families

Theoretical Understanding

The Process of Learning

Live Supervision

Emotional support and group supervision

OUTCOMES

New ways of seeing Self-awareness

Confidence
Knowledge
Skill

To change clinical practice to include families at all stages of caring process

Changes in meaning of "family": Relating Family Systems Theory in wider context

Inclusion of carers, partners and friends

Different family situations in ethnic minority groups

Effecting changes in work environment

Influenced by

Managerial style

Rigid
Unsupportive
Inflexible to change

Creative
Supportive
Open to change

Chapter 8 — Summary and discussion of findings

To summarise my findings, I return to the Paradigm model (adjacent) along the guidelines suggested by Strauss & Corbin (1990) (see p. 71).

The central plank or "PHENOMENON" of this research was the students' expressed need to acquire knowledge and skill to work confidently and safely with individuals suffering from severe mental illness and their families in a variety of settings, both clinical and domestic. The reasons why an experienced group of mental health care professionals considered they now required the additional educational experiences lay in the fact that changes to their practice were now required following the introduction of 'care in the community'. These reasons were, according to the paradigm model, the "CONDITIONS" and I referred to the literature to better understand the difficulties they faced. (Government proposals and guidelines consulted were as follows: DHSS (1975) *Better Services for the Mentally Ill*, HMSO; DOH (1981) A consultative document *'Care in the Community'*; DOH (1985) *Care in the Community*; DOH (1989) *Caring for people, Community Care in the next decade and beyond*; DOH (1990) *The Care Programme Approach*: and DOH (1994), *Care in the Community of mentally disabled people*. (See detailed discussion on p. 12)).

The Health of the Nation (1996) and more recently the Health Service Plan (July 2000) (See p. 5) gave precise responsibilities to involve families/carers in the preparation and delivery of care programmes. This resulted in professionals becoming involved in family and social relationships where previously professionals had focussed on individuals and maintained a distance from relationships in their social system.

Interviews with the students representing four professional disciplines, confirmed their lack of knowledge and experience in dealing with complex social relationships. They had received their basic education/training between 10 and 30 years earlier and in a variety of hospital/educational establishments in different geographical locations and yet they had one factor in common: it was that none had received the necessary training and experience to work with families.

I consulted a number of reports written following Independent Inquiries into Homicides committed by a person in Mental Health care (See Appendix L. p. 194), in which criticisms were made of the professionals for having failed to involve the families with disastrous results. The findings in these reports confirmed the professionals' lack of skill in this area of clinical activity.

The educational syllabi of first the GNC, followed by the ENB (see p. 12) confirmed limited expectations from these professional bodies. Nurse education during this period was provided in the main by the large psychiatric institutions where the majority of patients were distanced or deserted by their families and friends.

The students applied to take the ENB A28 to remedy the deficiencies in their previous education, a course centred in a family project of a Mental Health Trust. This provided, according to the Paradigm model, the "CONTEXT" of the research. The Project published its revised treatment aims at the time of the main study (see p. 53).

The course designed around these treatment aims, based on traditional family therapy principles, was academically, emotionally and practically demanding. Students were required to cope with these educational demands as well as carrying their individual responsibilities for providing safe, clinical practice in the service. These were the 'INTERVENING CONDITIONS' in the paradigm model. Management influences either encouraging or unsupportive became influential, according to the students when interviewed. At this stage, I reviewed the literature published after the recommendations of the Griffiths Report on management (see p. 61) had been implemented. Tensions between managers and clinicians, and general managers and nurse managers, were clearly noted in King's Fund, 1985, Robinson, Strong and Elkan, 1989, Owen and Glenister, 1990, Strong and Robinson, 1990, Balogh and Bond 1991, and Rafferty 1993, (all cited in Lorentzen and Bryant, p. 275). Such tensions were evident in the students' experiences.

'STRATEGIES' in the Paradigm model were the means provided for the students to meet their educational needs. The process by which they learnt how to work with

families included three elements; theoretical understanding, practice (treatment of families) and live supervision.

I studied the various theories underpinning family therapy and compared this literature with the students' learning experience and how they considered this could be applied to their practice. They considered the 'systems' theory and the expressed emotions studies of particular relevance and developing from the EE studies the psycho-educational model was important to those working with patients who were newly diagnosed as suffering from severe mental illness.

Important concerns were raised by students and managers which related to cultural issues in respect of the many ethnic minority groups for whom they had responsibility. I referred to published studies on family life in the particular ethnic groups which had set up home in these environments (see p. 50). The students who, as a group, were ethnically mixed reported gaining knowledge and experience from each other. This mirrored the experience of Gill Gorell Barnes (1998) (see p. 117).

Practice was the point where the students reported that the theory began to make sense. Their experience of treating families was compared with published reports (Gorell Barnes, G., Down, G. & McCann, D., 2000) of the experiences of two students on a systemic family therapy course which was comparable in that this course used the same teaching principles of students treating families with 'live' supervision. They considered, as did the students on the ENB A28, that during this practice experience, they were able to gain confidence and to develop their own style of work.

Live supervision provided the students with the essential element in the students' learning experience. It provided the link for them between theory and practice and provided a 'safety net' at times when they were uncertain of the way forward. However, it was an anxious experience for all the students as they worked under the critical gaze of a supervisory team — one which they shared with the students from the systemic family therapy course (Gorell Barnes, G., Down, G. & McCann, D., 2000). Emotional support in relation to course experiences was provided by group clinical supervision (See p. 55).

The last section of the Paradigm model covers OUTCOMES (See diagram this page). On completion of the course, the students reported gaining knowledge and skills and 'seeing' themselves in a different way. They had a new-found confidence, having developed self awareness, self confidence, self reflection and personal growth through a variety of experiences on the ENB A28, particularly live supervision. This confidence enabled them to review their clinical practices and to change them to include families and carers at each stage of the caring process. Their approach to their practice also changed from seeing a person with serious mental illness as an individual with a peripheral family and social contacts to seeing that person in the centre of a wider family and social system which may influence the development and outcome of the illness.

They had learnt that a systemic approach could be used to treat all family groups whether they were extended families following divorce and separation, single parents, same sex couples or the conventional nuclear family. Of particular importance was a greater awareness of the needs of families from different ethnic minority groups.

The majority of the managers interviewed were receptive to what the ENB A28 offered their students. They had plans on how these students could influence other members of their team to change practice.

In comparison, the attitude of some managers who were either interviewed or had an impact on the lives of the students on the course was very different. They demonstrated a wide gap in their understanding of 'family therapy' and what a course such as the ENB A28 had to offer. They failed to appreciate that 'family therapy' had adapted to social and cultural changes over the past decade (see the section on Family Structure and Diversity, p. 50). Therefore, they were unable to

OUTCOMES

New ways of seeing
Self-awareness

Confidence
Knowledge
Skill

To change clinical practice to include families at all stages of caring process

Changes in meaning of "family":
Relating Family Systems Theory in wider context

Different family situations in ethnic minority groups

Inclusion of carers, partners and friends

Effecting changes in work environment

Influenced by

Managerial style

Creative Supportive Open to change

Rigid Unsupportive Inflexible to change

accept that the course was relevant, as the majority of patients/clients for whom they were responsible had long been rejected by their families. See the similar experiences of students on the Thorn Project (p. 130). One of the few negative comments on the evaluation of the course supervised by course tutors related to lack of managerial understanding.

The students set out on an educational journey in search of Knowledge and Understanding. They ended the journey surprised by the extent of that knowledge and even more at how personal understanding could so influence their clinical practice.

I will now summarise the principles I followed to add rigour to the research process in this study. As discussed previously, (page 76), a number of qualitative researchers have preferred to use an alternative way of defining the terms validity, reliability and generalisability which are used by quantitative researchers.

Lincoln and Guba (1985) used concepts such as trustworthiness, credibility and transferability whereas Andrews *et al.* (1996), and Slevin and Sines (2000, p. 95) used the words truth/truthfulness (for validity) and consistency (for reliability) and transferability (generalisability). Taped semi-structured interviews formed part of my data collection. Each student was interviewed twice and each interview was analysed before progressing to the next. The grounded theory model used in this study (Strauss and Corbin, 1990) involved the Constant Comparative method, which entailed the constant comparison of emerging data. This method allowed me to verify my findings with previous data. I considered that concepts and categories which emerged over and over again were truthful (valid) and consistent (reliable).

As part of Triangulation, that is using more than one data collection method, I interviewed the students' clinical managers and carried out a retrospective study of all previous students who had completed the A28. Literature was also consulted as a data source throughout the research to verify emerging concepts and themes. "High levels of triangulated convergence" (Slevin & Sines, 2000) supported the truthfulness (validity) of my findings.

Finally, I refer to the Paradigm Model (Strauss and Corbin, 1990), a systematic approach which I used to analyse my findings and develop a theory. "Validating one's theory against the data completes its grounding." (Strauss and Corbin. p.133). See also previous discussion re generalisation and transferability (page 78)

The findings presented here are, therefore, not the result of family therapy training necessarily. They reflect a training which is a unique distillation of intense supervision and reflection on practice together with the integration of a sustained use of a systemic model of thinking. This internal model is taught to be used in all locations and with all patients/clients in individual and family work. It is the model in the mind of the worker that we have sought to describe and appraise. If we were to seek to evaluate this model as a formal family therapy training it would, of course, require a different form of research project which might involve comparisons with other models.

Chapter 9 — Discussion, Key Issues and Recommendations

9.1 Placing the recommendations in context

In this chapter I will consider the recommendations to be made following the presentation of the findings in Chapter 8 and discuss the issues which I suggest need to be addressed if a culture of involving the families and carers in the care of individuals suffering from major mental illness is to be introduced in mental health services.

The findings demonstrated that mental health care professionals in this study were limited in their level of competence to work safely and effectively within this model of care (PHENOMENON, A Search for Knowledge and Understanding). However, the findings also showed that there were examples of good support mechanisms in the service to facilitate clinical practitioners in developing new ways of working (INTERVENING CONDITIONS) and that the ENB A28 (CONTEXT) had been successful in enabling this group of students to acquire the necessary knowledge, skill and confidence to work with families (OUTCOMES). The students also spoke of limitations in the management of educational resources in the organisations where they currently practised and limitations to colleague support in the need to consider patients and clients as part of a social system when their care and treatment was planned. I considered, therefore, that the recommendations needed to focus both on the difficulties which face clinicians in implementing a new system of working, particularly those who had completed the ENB A28 and ones which reinforced existing examples of good practice.

The National Health Service Plan (July 2000, p.5) stressed that clinicians should involve families and carers in planing care and support for those individuals suffering from severe mental illness, a plan supported by mental health pressure groups for example SANE (Schizophrenia a National Emergency) but a major difficulty in their execution went either unrecognised or ignored: clinicians did not have the necessary skills to work with families or intervene in their relationships if therapeutically indicated. There were numerous courses available to provide clinicians with skills to practice various forms of psychotherapy, both individual and group, dynamic and behavioural, but attention to family work has been very

limited. There has been a failure to recognise that the skills to work with families are specific and cannot be carried out on the back of other therapeutic techniques. Information given by the students confirms this position. Experienced clinicians admitted their previous lack of skills: "I felt quite stuck at times". said one, "I didn't know how I didn't break up some families."

If these difficulties are to be overcome, the preparation of professionals to work in ways to include 'family' systems should begin at pre-registration level of education and be reflected in the syllabus in a more formal way than at present (See discussion of syllabi on p. 12).

More post-registration courses need to be established providing training in a variety of treatment modalities.

The course tutors for the ENB A28 were experienced family therapists from the systemic school and EE research[1]. They developed a model of teaching using traditional methods supported by live supervision to enable students not only to treat an individual 'family' in the community but also one which could equally be used by staff working across the entire range of service provision and with people from diverse families and cultures. Additionally, and running in parallel, the students were taught to think systemically. Even those working in secure facilities would be able to take cognisance of the social systems from where their patients came and consider how this might exert an effect on their clinical management, both in the short and long term involving families/carers at each stage wherever possible.

The establishment of educational courses designed to facilitate the involvement of families in care programmes would hopefully contribute towards a change in prejudicial attitudes towards families held by some clinicians across mental health services. Smith & Velleman (2002) are of the opinion that a culture of blaming families for actually causing a schizophrenic illness in one of its members (Laing &

---

[1]Expressed emotional research (E.E.) (Brown & Rutter, 1966) which linked high emotional involvement between family and patient with relapse rates following treatment of a major mental illness (p.1) and Systemic theory which contends that individuals are best understood by examining their relationship to others and the environment with which they interact, p.31. (Steinglass 1978 cited in Paolino and McGrady, Eds. p.305).

Esterson. 1964) has continued in the minds of some senior managers who left clinical practice years ago.

I was surprised to hear from one student when interviewed that he had changed his previously held conviction that families were to "blame".

There are other misconceptions relating to 'family work' which influence those in the organisation with responsibility for distributing educational budgets. Some students and managers interviewed during the course of this study were of the opinion that such misconceptions impacted on how the course was valued.

Of these, a common one is the view that family therapy is only directed to conventional nuclear families and has therefore no place in single persons' households or that of same sex couples (see p. 141). The lack of cultural awareness in relation to family life is an additional problem when Inner London Trusts are responsible for a multi-cultural community.

Within one Trust in particular, comments were received that the course was too expensive. The students required the equivalent of one day per week study leave and the ratio of teachers was 4 to 10. However, those who argued in this way did not take into consideration that half of the study time was taken up with either treating a 'family' or working as a member of the small group providing 'live' supervision to other students or therapists. Treating families and providing supervision for each other is a routine responsibility of the Project and the students only served to increase the throughput of the service.

It has to be accepted that clinical supervision is costly in terms of time both for the provider and the recipient.

However, there can be no attempt at rationalisation or 'cutting corners' when the issue of clinical supervision is considered. This is vital in family work for safe and effective practice (See p. 55).

As part of the treatment regime practised in the Family Project, the students were exposed to 'live' supervision as reported on p. 103. This was considered by students to be one of the three elements which provided the total learning experience. Clinical Supervision by trained family therapists was considered responsible for the successful outcomes of a course for CPNs in Manchester (Brooker. 1994). In comparison a similar course in Australia (Kavanagh and Yellowlees, 1995) had

little impact on clinical practice. One possible reason given by Tarrier (in Haddock & Slade, 1996, pp. 227-228) was the lack of progressive supervision which is required for successful training.

On completion of the course, the students on the ENB A28 must practise their skills in family work in a very different environment to that provided by the Project. The need then for good clinical supervision from trained therapists becomes imperative. This position is supported by Smith and Birchwood (1990) who, in a paper reporting on a model of family service provision in Birmingham, identified one of the key factors affecting the efficacy of family interventions within a routine psychiatric service to be that of supervision provided by appropriately trained staff. Again, this is in line with a plan for providing a family intervention service in Bath (Smith and Velleman, 2002) which also maintains that clinical supervision from trained family practitioners is vital.

It has been shown not only for the ENB A28 but other courses designed to introduce 'family' work into clinical practice that there are operational difficulties to overcome: training, provision of skilled clinical supervision and persuading others of its value.

Educational courses which involve teaching the skills required in family intervention techniques have in mind, a person suffering from major mental illness whose continuing care is most likely to be embedded in a Mental Health Service Trust. These are large institutional structures which determine and control through lines of managers the activities and personnel within its organisation. The role of management in the learning process has been a recurrent theme throughout this study (see p. 60).

Although there were many examples of managers who supported students on the course and facilitated them to exert change in their own clinical practice and that of others in their teams, there were those who exerted a detrimental influence on the students' capacity to maximise the teaching on the ENB A28. These findings compared with Baguley *et al.* (2000) who reported that 60% of former Thorn trainees gave lack of management support as the main difficulty in implementing psychosocial intervention (Prof. Leff personal communication).To overcome these barriers, one NHS Trust, when introducing family work within the Avon and Wiltshire Health Partnership NHS Trust (Smith and Velleman, 2002) decided on a

co-ordinated effort to successfully remedy the position. This was led by a small team comprising: a Nurse Consultant, the Director of Research and Development and a co-ordinator of the family service. They began by involving the Directors of the Trust Board followed by an active strategy to engage middle managers and clinicians. However, the size, complexity, family and cultural diversity, morbidity in the communities of the Inner London Trusts which results in heavy and competing demands on the services and budgets, militate against what would appear to be an ideal solution.

One of the students interviewed said that the Trust Executive supported family work but such support did not filter down to local management levels. The gap between the various tiers of management responsible for units widely dispersed throughout inner city conurbations and its execution at ward level in my experience is too great to expect 100% compliance. A sociological study (West et al., 1999) provides a possible explanation. The social networks of two groups of clinicians within the U.K., medical and nursing directors, were explored and it was revealed that there is less of a hierarchical dimension in doctors' relationships with colleagues than in nurses' relationships. Medical directors engage with very dense networks and are therefore able to exercise control over group members and rapidly effect change. In comparison, nursing directors have sparse professional support. This is particularly relevant in instances where the most junior manager, frequently from a nursing background, is responsible for the distribution of local educational resources, including study leave, has difficulty in establishing priorities between competing responsibilities and who, in addition, may be inexperienced, lack the required knowledge or may even be prejudiced against family work as a therapeutic model. The most prejudiced fail to avail themselves of the opportunity to increase their awareness of the benefits even though in the experience of the organisers of the ENB A28, these were made available.

Evidence from this thesis suggests that courses such as the ENB A28 and those already mentioned above become part of an educational programme in each Trust to further professional development. Ideally, these should involve managers at all levels but as this is probably an unrealistic expectation, it will be important to involve lead nurses/consultant nurses, who hopefully are already committed to this philosophy of care, at every stage from the allocation of educational resources, course planning and finally ensuring students receive the necessary support and

supervision on completion. The initiatives are vital to the development of systems theory within the organisation and particularly in community services. There have been far too many avoidable tragedies involving the families of mentally ill persons because mental health professionals failed to heed the families' concerns or even ignored their existence. Such tragedies may also involve other people such as neighbours or acquaintances unknown to professional workers if they have failed to take note of clients' social systems.

Systems theory had a strong influence on the way the ENB A28 was planned and continued to develop to meet the needs of the service and practitioners both within the institutions and the community. The course evolved very much as a compilation of several schools of thought and could be considered unique. It cannot be assessed in the same way as a course which has been designed to treat a particular family, for a defined period of time in a stable, clinical environment whose efficacy can then be linked to a therapeutic outcome and can then be evaluated using a quantitative research method.

When considering what recommendations to make following this study, a commonality of various issues emerged in this and other published works relating to the education of clinicians to work with individuals suffering from major mental illness and their families irrespective of the chosen paradigm, as well as some which were particular to the ENB A28. Although the ENB A28 may share similarities with other courses, it remains unique.

Before summarising the recommendations, I will address the issue of the size of the student group who participated in this study and whether because it was small the findings can be generalised. However, comparisons can be made with case study research which is a single, in-depth investigation. The single subject, as defined by Meiher and Pugh (1986) "is an individual, a group, an organisation or a society." According to Denzin (1978) the triangulation of methods is essential in case study research to build up a picture in which the context of the case is set.

The method of triangulation was used in the present study. The data were obtained from individuals representing each of the major professions involved in mental health care, a group of the students' managers provided an insight into why conflict may arise between managers and clinicians and a retrospective study of previous course participants (Appendices A through F). (The study was a descriptive one

from which certain theoretical generalisations can be made. The generation of theory is achieved by an in depth study of a number of cases. The aim is to make or infer a generalisation based on the plausibility of the link between the characteristics of the phenomena being studied, (Rolfe, 1998; Mitchell, 1983 cited in single case study, p.244, D. Pontin in *Research process in Nursing*. Blackwell Sciences, Oxford 2000).)

9.2 Summary of Key Issues and Recommendations

The key issues and recommendations from this thesis will be considered under three headings: education; clinical practice and supervision; and clinical service management.

9.2.1 Education

The role of 'families' and carers in health issues, particularly in mental health, has proved so important that an introduction to a way of working which includes rather than disregarding their contribution should begin at pre-registration level education in a more robust form than at present

Mental Health Trusts as a matter of priority need to accept responsibility for ensuring that educational resources are made available and mental health clinicians from all disciplines are encouraged to obtain the necessary skills to work with families as part of a professional development programme.

Middle and senior managers, particularly those responsible for allocating educational resources need to be appraised of the developments in this area of clinical activity if the requirements set out in the Health Service Plan (July 2000) are to be met. Family Therapists in the last decade have been sensitive to social changes which have affected the way families are structured (Gorrell Barnes, 2000), reconfigured following divorce, single parent households, gay and lesbian families and families from ethnic minorities. The needs of the members of all these groups must be considered if they are to be recognised as part of a social system supporting a person suffering from severe mental illness.

Educational courses set up to enable clinicians to work with families may develop from different paradigms; cognitive behavioural family therapy, E.E. research, systemic theory or a combination. What is important is that the teaching is applicable to nurses and other professionals working on acute units as well as

community based clinicians, who should have the skills to develop a programme of care for individual patients which is mindful of the social system from where they were admitted and where they would be returning to receive continuing care.

9.2.2 Clinical Practice and Supervision

As previously reported in Chapter 7. 'Different Ways of Seeing' (p. 126). each of the students reported ways their practice had changed, including how they were better equipped to cope with sensitive issues such as 'confidentiality' (p. 131) when dealing with families/carers.

The 'systemic approach' which was taught on the course enabled the students to consider the impact of external influences on the health needs of individuals, both in the acute stage of severe mental illness as well as over the longer term, during which family and social systems may change.

The clinical skills acquired and developed by the students while on the ENB A28 and their value to the mental health services overall as well as to individual families should be recognised and utilised.

Clinical supervision was provided 'live' for students on the ENB A28 and was considered by them to be the vital link in their learning process between theory and practice. This was already discussed in the findings, but because of its vital significance, requires repetition here. More than that, 'live' supervision held their anxieties and helped them gain an awareness of self which could be used to avoid the pitfalls when working with families whose relationships and communication have become disorganised as a result of one member of the family suffering from a major mental illness.

However, it has also been shown in this chapter, (see p. 147) that other forms of clinical supervision in family work are also necessary to effect good therapeutic outcomes and should be available on an ongoing basis. Recommendations to ensure that clinical supervision is available will be discussed in section 9.2.3 – Clinical and Service Management.

9.2.3 Clinical and Service Management

The students' capacity to fulfil their potential value to a mental health team can only be realised if managers demonstrate support to the practitioners and their recently acquired skills. If managers fail in this responsibility, valuable financial and human resources are wasted.

Clinical and Service managers must continually be aware that if mental health services are to meet their obligations to families and carers, as set out in the present Health Service Plan (July 2000), staff require further training to provide safe and effective practice.

To achieve these aims, managers must consult with and be prepared to accept advice from nurse consultants/leaders or the equivalent grade for Allied Health Professionals (AHPs).

Managers also must ensure that clinical supervision from trained family workers is available and that 'time out' from the service is scheduled for clinicians to receive this support and guidance. The accumulative evidence shows that it is essential for safe and effective practice and not a self-indulgent luxury as perceived by many senior clinicians and managers.

> ### IN CONCLUSION
>
> The findings of this thesis have shown that however experienced mental health practitioners are, they do not have the clinical skills required to work with individuals suffering from major mental illness and their families or carers unless they have received specific education and training in one of a number of models of family therapy such as provided by cognitive behavioural or systemic therapy and , of crucial importance, accompanied by continuing, appropriate clinical supervision provided by trained family therapists.
>
> The systemic model studied here can be recommended as it facilitates practitioners to be more aware of the family and social systems which influence individuals during the phases of illness, rehabilitation and possible relapse. It can therefore be recommended to managers who have responsibilities for providing a range of clinical services, both in acute mental health hospital units as well as community services, to the educators who must provide training courses to meet the various service requirements and to the clinicians who need not only knowledge and skills but also support to gain the confidence to work safely and effectively with the families and carers of the most vulnerable sufferers of major mental illness.

Bibliography

Ambelas A. (1979) 'Psychologically stressful events in the precipitation of manic episodes.' *Br J Psychiatry* 135: 15-21.

Andrews, A. *et al.* (1996) 'Validity in qualitative health care research: an exploration of the impact of individual researcher perspectives within collaborative enquiry.' *Journal of Advanced Nursing* 23:441-447.

Angermeyer, M.C., Löffler, W., & Müller, P (April 2001). 'Patients' and relatives' assessment of Clozapine treatment' *Psychological Medicine* 31:509-517.

Antobus, S. and Kitson, A. (1997), *Nursing Leadership in context: a discussion document*. RCN Institute.

Audit Commission (1994), *Finding a place. A review of Mental Health services for Adults*. HMSO

Baguley, I., Butterworth, A., Fahy, K., Haddock, G., Lancashire, S and Tarrier, N. (2000) Bringing into clinical practice skills shown to be effective in research settings: a follow-up of the 'Thorn' training in psychosocial family interventions for psychosis. In *Psychosis: Psychological Approaches and their Effectiveness* Edited by Brian Martindale, Anthony Bateman, Michael Crowe and Frank Margison. Royal College of Psychiatrists, Gaskell Publications.

Baker, R., Hall, J.N., Hutchinson, K. and Bridge, G. (1977) 'Symptom Change in Chronic Schizophrenic Patients on a Token Economy, a Controlled Experiment.' *British Journal of Psychiatry* 131:381-393.

Baker, C., Wuest, J. & Stern, P. (1992). 'Method Slurring: The Grounded Theory-Phenomenology Example.' *Journal of Advanced Nursing* 17(11):1355-1366.

Barrowclough, C., Tarrier, N., Lewis, S., Sellwood, W., Mainwaring, J., Quinn, J. and Hamlin, C. (1999) 'Randomised controlled effectiveness trial of a needs-based psychosocial intervention service for carers of people with schizophrenia.' *British Journal of Psychiatry* 174:505-11.

Beech, B. (2000) 'Cognitive behavioural approaches' *Journal of Psychiatric and Mental Health Nursing* vol. 7, pp. 343-354.

Benfer, P. (1979), 'Clinical Supervision'. *Perspectives in Psychiatric Care*, vol. 18, no. 1., pp. 13-16

Bennett, D. (1982). 'Management of Affective Psychoses' (Chapter) in *Psychoses of Unknown Origin* eds. Wing & Wing, Cambridge University Press. p.175.

Berkowitz, R., & Heinl, P. (1984) 'The Management of Schizophrenic patients: the nurses' view'. *Journal of Advanced Nursing*, Vol. 9, pp. 22-23.

Bertelson, A., Harvald, B. & Hauge, M. (1977). 'A Danish twin study of manic depressive disorder' *British Journal of Psychiatry*, vol. 130, pp. 330-351.

Bhagwagar, Z., Whale, R. & Cowen, P.J. (2002). 'State and trait abnormalities in serotonin function in major depression'. *British Journal of Psychiatry*, January 2002, Vol. 180, pp. 24-28.

Bhugra, D., Mallett, R. & Leff, J. (May-Aug 1999) "Schizophrenia and African-Caribbeans. A conceptual model of aetiology" - International Review of Psychiatry, Vol. 11 (2-3), 144-52, Carfax Publishers Ltd., UK.

Birchwood, M., Smith, J., MacMillan, J.F., Hogg, B., Prasad, R., Harvey, C. and Bering, S. (1989) Predicting relapse in schizophrenia: The development and implementation of an early signs monitoring system using patients and families as observers: A preliminary investigation. *Psychological Medicine*. 19:649-656.

Birchwood, M., Spencer, E & McGovern, D. (2000) Schizophrenia: early warning signs. *Advances in Psychiatric Treatment* 6:93-101.

Birley, J. & Brown, G. (1970), 'Crisis and life changes preceding the onset and relapse of acute schizophrenia: clinical aspects', *British J Psychiatr*, vol. 116, pp. 327-33.

Bleuler, E. (1908), 'Die Prognose der Dementia praecox (Schizophreniegruppe)'. *Alg. Z. Psychiat. Psychischgerichtl. Med.* vol. 56, p.436

Translated 1950 as Dementia praecox or the groups of schizophrenias. New York: International Universities Press.

Cited in Wing J. & Wing L. Eds. (1982) *Psychoses of uncertain aetiology*,
p.253

Brooker, C., Barrowclough, C. & Tarrier, N (1992), 'Evaluating the Impact of
Training Community Psychiatric Nurses to Educate Relatives About
Schizophrenia' *Journal of Clinical Nursing*, vol. 1, pp. 19-25.

Brooker, C., Falloon, I., Butterworth, A., Goldberg, D,, Graham-Hole, V. & Hillier,
V. (1994). 'The outcome of training community psychiatric nurses to
deliver psychosocial interventions.' *British Journal of Psychiatry*, 165, pp
222-230.

Brown, A.S. (1999), 'New perspectives on the neurodevelopmental hypothesis of
schizophrenia' *Psychiatric annals* 29(3), 128-130. Slack Incorporated, U.S.

Brown, G.W. (1958) 'Post Hospital Adjustment of Chronic Mental Patients'. *The
Lancet*, vol. 2, pp. 685-689.

Brown, G.W. (1959) 'Experience of Discharged Chronic Schizophrenic Mental
Hospital Patients.' *Millbank Memorial Fund Quarterly*, vol. 37,
pp. 101-131.

Brown, G., Birley, J. & Wing, J. (1972), 'Influence of family life on the course of
schizophrenic disorder; a replication. *British Journal of Psychiatry*, vol.
121, pp. 241-258.

Brown, G. & Harris, T. (1978), *Social origins of depression: A study of psychiatric
disorder in women*. London: Tavistock Publications.

Brown, G.W. & Rutter, M. (1966), 'The Measurement of family activities and
relationships: A Methodological Study', *Human Relations*, vol. 19,
pp. 241-263.

Butzloff, R. & Hooley, J. (1998), 'Expressed Emotion in Psychiatric Relapse, A
meta analysis', *Archives of General Psychiatry*, vol. 55, p. 551.

Cade, J. (1949) 'Lithium salts in the treatment of psychotic excitement.' *Medical
Journal of Australia*, 36, 349-52.

Cameron, D.E. (1938) Early schizophrenia. *American Journal of Psychiatry*,
95:567-578.

Campbell, D., Draper, R., & Huffington, C. (1993) *Teaching Systemic Thinking*, London: Karnac Books.

Carbonneau, R., Rutter, M., Simonoff, E., Silberg, J.L., Maes, H.H. and Eaves, L.J. (2001) 'The twin inventory of relationships and experiences (TIRE): psychometric properties of a measure of the shared and non-shared environmental experiences of twins and singletons' *International Methods in Psychiatric Research* 10:72-85.

Carbonneau, R., Rutter, M., Spilberg, J.L., Simonoff, E. & Eaves, L.E. (2002). 'Assessment of genetic and environmental influences on differential ratings of within-family experiences and relationships in twins' *Psychological Medicine* 32:729-741.

Clare, A. (1978), *Psychiatry in Dissent*, London: Tavistock Publications.

Coffey, A. & Atkinson, P. (1996). *Making sense of qualitative data*, London: Sage publications.

Cook, S. (1991). 'Mind the theory/practice gap in nursing'. *Journal of Advanced Nursing*, vol. 16, p. 1463.

Crow, T.J., Deakin, J.F.W., Johnsone, E.C. & Longen, A. (1976). 'Dopamine and schizophrenia', *Lancet*, vol. ii, pp. 563-566.

Crow, T.J. (October 1986) 'The Continuum of Psychosis and its Implication for the Structure of the Gene'. *The British Journal of Psychiatry* Vol. 149, pp.419-429.

Denzin, N. K. (1978). *The Research Act*. Chicago, IL: Adline.

Department of Health and Social Security (1975), *Better Services for the Mentally Ill*, HMSO

Department of Health, (1981) A consultative document *'Care in the Community'*

Department of Health (1985) *Care in the Community*, HMSO.

Department of Health (1989) *Caring for people, Community Care in the next decade and beyond*, HMSO.

Department of Health (1990) The Care Programme Approach HMSO. HC (90) 23

Department of Health (1994), *Care in the Community of mentally disabled people.* HMSO.

Devanand, D.P., Dwork, A.J. & Hutchinson, E.R. (1994) 'Does ECT alter brain structure?' *American Journal of Psychiatry* (151), 957-970.

Dey, I. (1996), *Qualitative Data Analysis, a user-friendly guide for social scientists.* London: Routledge, pp. 50-51.

Diploma in Higher Education for Nursing (Project 2000)

Drury, I.V. (1994). 'Recovery from acute psychosis' in M. Birchwood and N. Tarrier (eds.) *Psychological Treatment of Schizophrenia.* Chichester: Wiley.

Durham, R., Swan, J.F. & Fisher, P. (2000) 'Complexity and collaboration in routine practice of CBT. "What doesn't work with, when and how it might work better".' *Journal of Mental Health* 9(4), 429-444.

Emery & Tracyl (1987) cited in Beech.? Baker & Paul?

English National Board for England and Wales for Nursing Midwifery and Health Visiting (1982).

Fadden, G., Bebbington, P. & Kuipers, L. (1987) 'Caring and its burdens. A study of the spouses of depressed patients', *The British Journal of Psychiatry* 151: 660-667.

Falloon, I.R., Boyd, J.L., McGill, C.W., Razani, J., Moss, H.B., Gilderman, A.M. (1982), 'Family management in the prevention of exacerbations of schizophrenia: a controlled study', *New England Journal of Medicine* 306(24):1437-40.

Falloon, I., Boyd, J. McGill, C., Razani, J., Moss, H., Gilderman, A. & Simpson, G. (1985), 'Family Management in the Prevention of Morbidity in Schizophrenia: Clinical outcome of a two year longitudinal study', *Archives of General Psychiatry*, vol. 42, pp. 887-896.

Falloon, I.R.H. (1992) Early intervention for first episodes of schizophrenia: A preliminary exploration. *Psychiatry*, 55:4-15.

Field, P.A. & Morse, J.M. (1996, 2nd edition) *Nursing Research: The application of qualitative approaches*. Cheltenham: Stanley Thomas (Publishers) Ltd.

Franks, V.E., Watts, M. & Fabricius, J. (1994), 'Interpersonal Learning in Groups: An Investigation.' *Journal of Advanced Nursing*, vol. 20, pp. 1162-1169.

General Nursing Council for England & Wales (1974) *Training syllabus. Register of Nurses: Mental nursing*. London: General Nursing Council for England & Wales

Gibbons, J. (1960). 'Sodium and Potassium in depressed patients'. *Clinical Sciences*, vol. 19, p. 33.

Glaser. B. & Strauss, A. (1967), *The Discovery of Grounded Theory: Strategies for Qualitative Research*, New York: Aldine Publishing Company.

Glaser, B. (1978). *Theoretical Sensitivity*. Mill Valley, CA: Sociology Press.

Glaser, B. (1992), *Emerging vs. Forcing: Basics of grounded theory analysis*, Mill Valley, CA: Sociology Press.

Goldberg, E. & Morrison, S. (1963), 'Schizophrenia and Social Class'. *British Journal of Psychiatry*, vol. 109, pp. 785-802.

Gorell Barnes, G. (1998), *Family Therapy in Changing Times*, Basingstoke: Macmillan.

Gorell Barnes, G., Down, G. & McCann, D. (2000). *Systemic Supervision, a portable guide for supervision training*. London: Jessica Kingsley Publishers.

Gottesman, I. and Shields, J. (1972) *Schizophrenia and Genetics: A Twin Study Vantage Point*. London: Academic Press.

Greenberg, J.S., Greenley, J.R., McKee, D., Brown, R. & Griffin-Francell, C. (1993) 'Mothers caring for an adult child with schizophrenia: The effets of subjective burden on maternal health'. *Family Relations: Interdisciplinary Journal of Applied Family Studies* 42:2(April 1993), 205-211.

Griffiths, R. (1983) *NHS Management Inquiry*, DHSS, London.

Gumley, A., O'Grady, M., McNay, L., Reilly, J., Power, K. & Norrie, J. (2003) Early intervention for relapse in schizophrenia: results of a 12-month randomized controlled trial of cognitive behavioural therapy. *Psychological Medicine* April, 33:419-31.

Haddock, G., Bentall, P. & Slade, P. 'Psychological treatments of auditory hallucinations. Focusing on distraction,' pp. 50-51 in Haddock, G. & Slade, P. (eds.) *Cognitive Behavioural Interventions with Psychotic Disorders*, first published 1996, reprint 1997, New York & London: Routledge

Hafner, H., Riecher-Rossler, A., Hambrecht, M., Maurer, K., Meissner, S., Schmidtke, A., Fatkenheuer, B., Loffler, W. and van der Heiden, W. (1992a) IRAOS: An instrument for the assessment of onset and early course of schizophrenia. *Schizophrenia Research*, 6:209-223.

Hafner, H., Riecher-Rossler, A., Maurer, K., Fatkenheuer, B. and Loffler, W (1992b). First onset and early symptomatology of schizophrenia: A chapter of epidemiological and neurobiological research into age and sex differences. *European Archives of Psychiatry and Clinical Neurosciences*, 242:109-118.

Hafner, H., Maurer, K., Loffler, W. and Riecher-Rossler, A. (1993) The influence of age and sex on the onset and early course of schizophrenia. *British Journal of Psychiatry*, 162:80-86.

Hafner, H., Maurer, K., Loffler, W., Fatkenheuer, B., van der Heiden, W., Riecher-Rossler, A., Behrens, S. and Gattaz, W.F. (1994) The epidemiology of early schizophrenia: Influence of age and gender on onset and early course. *British Journal of Psychiatry*, 164(Suppl. 23):29-38.

Haley, J., (1970), 'Approaches to Family Therapy'. *International Journal of Psychiatry*, vol. 9, pp. 233-242.

Halford, W.K. & Haye, R.L. (1991). 'Psychological rehabilitation of schizophrenia: recent findings on social skills training and family psycho-education' *Clinical Psychology review* 11:23-44.

Haralambos, M. & Holborn, M.(1995), *Sociology, Themes and Perspectives*, 4th edition, London: Harper Collins.

Hare, E., Price, J. & Slater, E. (1972), 'Parental social class in psychiatric patients'. *British Journal of Psychiatry*, vol. 121, pp. 515-524.

Hayes, H. (1991) 'A Re-introduction to Family Therapy, Clarification of the Schools' *Australia and New Zealand Journal of Family Therapy*, vol. 12. No. 1., pp. 27-43.

The Health of the Nation: A Consultative Document for Health in England. (1991) London: HMSO.

Health of the Nation: A Progress Report. Report (1996) by the Comptroller and Auditor General HC 458 1995/96 14 August 1996.

Health Services Council, (1968) *Psychiatric Nursing: Today and Tomorrow.*

Hector, W. (1973), 'Is nursing a profession?' Chapter 3, pp. 60-61 in research monogram by Mrs Bedford Fenwick, London: Whitefriars Press Ltd.

Herz, M.I. and Melville, C. (1980) Relapse in schizophrenia. *American Journal of Psychiatry*, 137:801-805.

HMSO, *Social Trends 22* (1992), London: HMSO.

Hochschild, A. (1983), *The Managed Heart*, Berkeley: University of California Press.

Hogarty, G. E. , Anderson, C. M.,Reiss, D. J.,Kornblith, S. J.Greenwald, D. P., Javna, C. D. Javna and Madonia, M. J (1986). 'Family psychoeducation, social skills training, and maintenance chemotherapy in the aftercare treatment of schizophrenia. I. One-year effects of a controlled study on relapse and expressed emotion.' *Archives of General Psychiatry* 43:7, 633-642.

Hogarty, G.E., Anderson, C.M., Reiss, D.J., Komblith, S.J., Greenwald, D.P., Ulrich, R.F. and Carter, M. (1991) 'The environmental-personal indicators in the course of schizophrenia (EPICS) research group. Family psycho education, social skills training and maintenance chemotherapy in the aftercare treatment of schizophrenia. II. Two-year effect of a controlled study on relapse and adjustment.' *Archives of General Psychiatry* Vol. 48. pp.340-347.

Hollis, M. (1996) Philosophy of social sciences. In: *The Blackwell Companion to Philosophy* (eds. Bunnin, N. & Tsui-James, E.P.). Oxford: Blackwell Publishers, pp. 358-387.

Hooley, J., Orley, J. & Teasdale, J., (1986). 'Levels of expressed emotion and relapse in depressed patients.' *British J. of Psychiatry*, vol. 148, pp. 642-647.

Independent Inquiries into a homicide by a Mentally Ill person HSG(94)27

International Classification of Disease (ICD)

Jackson, D. (1965) 'The study of the family' *Family process*, vol. 4. pp. 1-20.

Jarman, B. & Hirsch, S., 'Jarman underprivileged area scores', (1992) in Thorncroft, G., Brewin, C. and Wing, J. *Measuring Mental Health Needs: Models to predict district psychiatric morbidity* London.

Johnstone, E.C., Crow, T.J., Johnson, A.L. and MacMillan, J.F. (1986) The Northwick Park Study of first episode schizophrenia: I. Presentation of the illness and problems relahng to admission. *British Journal of Psychiatry*, 148:115-120.

Jones, S. (1985), 'The Analysis of Depth Interviews', in R. Walker (Ed.) *Applied Qualitative Research*, London: Gower.

Jorgensen, P. (1998). Early signs of psychotic relapse in schizophrenia. *British Journal of Psychiatry*, 172: 327–330.

Kaslow (1987), cited in 'Re-introduction to Family Therapy, Clarification of Three Schools' by Heather Hayes (1991) *Australia and New Zealand Journal of Family Therapy* 12:1, at p.28.

Kavanagh, S., Schneider, J., Knapp, M., Beecham, J. and Netten, A. (1993) 'Elderly people with cognitive impairment: costing possible changes in the balance of care,' *Health and Social Care in the Community* 1, pp. 69-80.

Kavanagh, S.J. & Yellowlees, P. (1995) 'Telemedicine - Clinical Applications in Mental Health.' *Australian Family Physician* 24: 122-5.

Kenny, A. (1997) *The Oxford Illustrated History of Western Philosophy*. Oxford: Oxford University Press.

Kottgen, C., Sonnischen, I. & Mollenhaeur, K. (1984) 'Families HEE and relapse in young schizophrenic patients: results of the Hamburg-Camberwell family interventions study. *International Journal of Family Psychiatry* 5:71-82.

Kraeplin, E. (1899) *Psychiatrie.* 6th ed. Leipzig: Barth.

Krawiecka, M., Goldberg, D. & Vaughan, M. (1977). A standardized psychiatric assessment scale for rating chronic psychotic patients, *Acta Psychiatrica Scandinavica* 55:299-308.

Kuipers, E., Garety, P., Fowler, D., Dunn, D., Bebbington, P., Freeman, D. and Hadley, C. (1997) 'The London East Anglia randomised controlled trial of cognitive behaviour therapy for psychosis. I: effects of the treatment phase. *British Journal of Psychiatry.* Vol. 171, pp. 319-327.

Kulhara, P. & Chakrabarti, S. 'Culture and Schizophrenia and other psychotic disorders' in *Psychiatric Clinics of North America*, vol. 24(3), Sept. 2001, 449-464 (Published by W.B. Saunders, U.S.A.)

Laing, R. (1960) *The Divided Self: a study of sanity, madness and the family.* London: Tavistock Publications

Laing, R.D. & Esterson, A. (1964) *Sanity, Madness and the Family.* Harmondsworth: Penguin.

Leff, J. & Wing, J. (1971). 'Trial of maintenance therapy in schizophrenia'. *British Medical Journal*, vol. 3, pp. 599-604.

Leff, J., Fischer, N. & Bertelsen, A. (1976). 'A cross-national epidemiological study of mania. *British Journal of Psychiatry*, vol. 129, pp. 428-442.

Leff, J. & Vaughn, C. (1976) 'Schizophrenia and family life.' *Psychology Today*, vol. 2, pp. 13-18.

Leff, J., Kuipers, L., Berkowitz, R., Eberlein-Vries, R. & Sturgeon, D. (1982). 'A controlled trial of social intervention in the families of schizophrenic patients.' *British Journal of Psychiatry*, vol. 141, pp. 121-134.

Leff, J., Kuipers, L., Berkowitz, R., Eberlein-Vries, R. & Sturgeon, D. (1985). 'A controlled trial of social intervention in the families of schizophrenic patients: two year follow up.' *British Journal of Psychiatry*, vol. 146, pp. 594-599.

Leff, J. & Vaughn, C. (1985) *Expressed emotions in families* New York and London: Guildford Press.

Leff, J., Berkowitz, R., Eberlein-Fries, R and Kuipers, L. (1995 reprint of 1988 edition), 'Schizophrenia; notes for relatives and friends. *National Schizophrenia Fellowship leaflet.*

Leff, Professor Julian. Personal Communication, Tavistock Clinic. June 28 01

Liberman, R. & Bryan, E. (1977). 'Behaviour Therapy in a Community Mental Health Centre' *American Journal of Psychiatry*, vol. 134, pp. 401-6.

Liberman, R.P., De Risi, W.J. & Mueser, K.T. (1989) *Social skills training with psychiatric patients* New York: Pergamon Press.

Lincoln, Y. & Guba, E. (1985) *Naturalistic Inquiry*. Newbury Park, CA: Sage Publications.

Littlewood, R. & Lipsedge, M. (1978). 'Acute psychotic reactions in Africans.' *British Journal of Psychiatry*, vol. 132, pp. 106-107.

Littlewood, R. & Lipsedge, M. (1982). 'Some social and phenomenological characteristics of psychotic immigrants. *Psychological Medicine*, vol. 2, pp 289-302.

Loebel, A.D. Lieberman, J.A. Alvir, J.M.J. Mayerhoff, D.I. Geisler. S.H. and Szymanski, S.R. (1992) Duration of psychosis and outcome in first-episode schizophrenia. *American Journal of Psychiatry*, vol. 149 no. 9, pp 1183-1188.

Lomas, G., Ross, G., Watson, B. & Wilder, J. (1973) *Poverty and Schizophrenia*. London: Psychiatric Rehabilitation Association, pp. 3 and 13.

Lorentzen, M. & Bryant, J. (1997). 'Leadership in British Nursing: a historical dimension', *Journal of Nursing Management*, vol. 5, pp. 271-278. Blackwell Sciences Ltd.

Malla, A.K. and Norman, R.M. (1994) Prodromal symptoms in schizophrenia. *British Journal of Psychiatry*, 164:487-493.

Marken, M. & Payne, M. (Eds.), *Enabling and Ensuring*, Leicester: National Youth Bureau and Council for Education and Training in Youth and Community Work.

Mason, J. (1998) *Qualitative researching*. London: Sage Publications.

Meiher, P. and Pugh, E. (1986) 'The case study: a viable approach to clinical research. *Research in Nursing and Health* 9:195-202, cited in McMillan. I. and Roberts, P. (Eds.) (Winter 1999/2000) *Nurse Researcher* 7(2), p.5.

Melia, K.M. (1982) ' "Tell it as it is" — qualitative methodology and nursing research: understanding the student nurses' world." *Journal of Advanced Nursing*, vol. 7, pp. 327-335.

Meltzer, H. (2000) *Mental Health of Children and Adolescents in Great Britain*. London: Stationery Office.

Mendelwiza, J. & Rainer, J. (1977), 'Adoption studies supporting genetic transmission in manic depressive illness'. *Nature*, vol. 268, pp. 326-329.

Mental Health Act, (1959) HMSO.

Mental Health Act, (1983) HMSO.

Miklowitz, D.J., Goldstein, H.J., Nuechterlein, K.K., Synder, K.S. & Mintz, J. (1988) 'Family factors and the course of bipolar affective disorders' *British Journal of Psychiatry* 45, 225-231.

Minuchin, S. (1974) *Families and Family Therapy*. London: Tavistock Publications, p. 54.

Minuchin, S. (1988) *Families and Family Therapy*. London: Tavistock Publications, vol. 1, pp. 14-15.

Morse, J. and Field, P.A. (1985) *Nursing Research, The Application of Qualitative Research*. London: Chapman & Hall, pp. 116 and 117.

Munk-Jorgensen, P. and Ewald, H. (2001) Epidemiology in neurobiological research: exemplified by the influenza-schizophrenia theory. *British Journal of Psychiatry - Supplement.* vol. 40, s30-20.

The National Health Service plan – "a plan for investment, a plan for reform" (HMSO Cmnd 4818) Presented to Parliament by the Secretary of State for Health By Command of Her Majesty, 27 July 2000.

The National Framework for Mental Health : Modern standards and service models for mental health. (HSC 1999/223) London : Department of Health, September 1999.

Norton-Staal, S. Report on African refugee families 1995 published on the Internet on http://www.unhcr.ch/issues/children/rm09512.htm)

Ohaeri, J. & Fido, A. (2001) "The opinion of caregivers on aspects of Schizophrenia and major affective disorders in a Nigerian setting". *Social Psychiatry and Psychiatric Epidemiology* 36(10), 493-499, Germany: Springer Verlag.

Palozzoli, M., Cecchin, G., Boscolo, L. & Prata, G. (1978) *Counter Paradox.* New York: Arnson.

Pantelis, C. & Campbell, P. (1988) 'The South Camden Schizophrenia Survey' *Bulletin of the Royal College of Psychiatrists'* vol. 12, pp. 98-101.

Paolino, T.J. & McCrady, B.S. (Eds.) (1978), *Marriage and Marital Therapy,* New York: Brunner/Mazel.

Papadopoulos, R. (2001) 'Refugee families: issues of systemic supeervision.' *Journal of Family Therapy* 23 (4) 405-422.

Paykel, E., Myers, J., Dienelt, M., Klerman, G., Lindenthal, J. & Pepper, M. (1969). Life events and depression, a controlled study. *Archives of General Psychiatry,* vol. 21, pp. 753-760.

Paykel, E. & Rowan, P. (1974) 'Recent Advances in Research on Affective Disorders' in *Recent Advances in Clinical Psychiatry,* Edinburgh: Churchill Livingstone

Paykel, E. & Tanner, J. (1976) 'Life events, depressive relapse and maintenance treatment', *Psychological Medicine* vol. 6, pp. 481-485.

Paykel, E. (1982) 'Life events and early environment' in Paykel, E. (Ed.) *Handbook of Affective Disorders*, Edinburgh: Churchill Livingstone.

Perlman, L. & Hubbard, B. (Winter 2000) 'A self-control skills group for persistent auditory hallucinations.' *Cognitive and Behavioural Practice*. 76(1) 17-21. Published by the Association for the Advancement of Behaviour Therapy, U.S.A.

Perris, C. (1966) 'A study of bipolar and unipolar recurrent affective disorder' *Acta Psychiatrica Scandinavica* vol. 44, 238-248.

Pollitt, J. (1972) 'The relationship between genetic and precipitating factors in depressive illness' *British Journal of Psychiatry* vol. 121, pp. 67-70.

Pontin, D. (2000) *Research Process in Nursing* Oxford: Blackwell Sciences.

Priest, H., Roberts, P. and Woods, L. (2002). "Qualitative Approaches, Nurse Researcher" *International Journal of Research Methodology in Nursing and Health Care*. RCN Publications, Vol. 10, No. 1.

Proctor, B (1986) 'A co-operative exercise in accountability' in Marken, M. & Payne, M. (Eds.), *Enabling and Ensuring*, Leicester: National Youth Bureau and Council for Education and Training in Youth and Community Work.

Robins & Hayes (1993), 'An Appraisal of Cognitive Therapy' *Journal of Consulting and Clinical Psychology* 61: 205-214.

Royal College of Nursing (1998) *Clinical Leadership Programme*.

Royal College of Nursing (2000) *Clinical Leadership Programme*.

Royal College of Psychiatrists (1981), *Psychiatric Rehabilitation in the 80's*. London: Royal College of Psychiatrists.

Rutter, M., Dunn, J., Plomin, R., Pickles, A., Maughan, B., Ormel, J., Meyer, J. and Eaves, L. (1997). 'Integrating nature and nurture: implications of person-environment correlatives and interactions for developmental psychopathology.' *Development and Psychopathology* 9:335-364.

Rutter, M., Spilberg, J., O'Connor, T. & Sminoff, E. (1999). 'Genetics and Child Psychiatry: 1 Advances in quantitative and molecular genetics.' *Journal of Child Psychology and Psychiatry* 40:3-18.

Rutter, M. and Spilberg, J. (2002). 'Gene-environment interplay in relation to emotional and behavioural disturbance' *Annual Review of Psychology* 53:463-490.

Salmon (1967) *Structure for Nurse Management*, Department of Health.

Scarr, S. (1992) 'Developmental theories for the 90's, development and individual differences' *Child Development* 63: 1-19.

Schiffman, J., Abrahamson, A., Cannon, T., LaBrie, J., Parnas, J., Schlusinger, F., & Mednick, S. (2001). 'Early rearing factors in Schizophrenia.' *International Journal of Mental Health*, 30, 3-16.

Schneider, K. (1976) cited in Wing, J. & Wing, L. (Eds.) (1982) *Psychoses of uncertain aetiology,* London: Cambridge University Press, p.6.

SchoolNet Digital Collection Programme, Industry Canada, Somalis in Canada (published on http://www.schoolnet.ca/collections/somalia/role.html)

Scullion, P. "Effective dissemination strategies" (2002) *Nurse Researcher.*

Sellwood, W., Barrowclough, C., Tarrier, N. *et al.* (November 2001). 'Needs-based cognitive-behavioural family intervention for carers of patients suffering from schizophrenia: 12-months follow-up.' *Acta Psychiatrica Scandinavica* 104:346-55.

Shepherd, M., Watt, D., Falloon, I, *et al.* (1989) The natural history of schizophrenia: a five-year follow-up study of outcome and prediction in a representative sample of schizophrenics. *Psychological Medicine*, (Suppl. 15), 46.

Slevin, E. & Sines, D. (2000) 'Enhancing the truthfulness, consistency and transferability of a qualitative study: utilising a manifold of approaches.' *Nurse Researcher* 7:2, 79-97.

Smith, G. and Velleman, R. (2002) 'Maintaining a Family Work for Psychosis Service by Recognising and Addressing the Barriers to Implementation.' *Journal of Mental Health*, 11:5, 471-479.

Smith, J. and Birchwood, M. (1990) 'Relatives as partners in the management of schizophrenia: the development of a service model.' *British Journal of Psychiatry*, 156, 654-660.

Smith, P. (1992), *The Emotional Labour of Nursing, How Nurses Learn to Care*. Basingstoke: Macmillan Press.

Smith, P., ed. (1997) *Research Mindedness for Practice*. Churchill Livingstone, London.

Smith, P. and Gray, B. (2000) *The Emotional Labour of Nursing: How Student and Qualified Nurses Learn to Care. A Report on Nurse Education, Nursing Practice and Emotional Labour in the Contemporary NHS*. South Bank University Faculty of Health, April 2000.

Smith, P. and Gray, B. (2000) *Report on the Royal College of Nursing Leadership Programme*. (RCN 1998, RCN 2000).

Stanner, S. (1965), *Elements of Psychiatry for Nurses*. London: Heinemann Medical Books.

Stewart, J.E. (1994), 'The cognitive model and treatment of depression', *Professional Nurse*, vol. 9, pp. 376-380.

Strauss, A. (1987), *Qualitative Analysis for Social Scientists*, New York: Cambridge University Press, pp. 58-64.

Strauss, A. & Corbin, J. (1990), *Basics of Qualitative Research, Grounded theory and procedures and techniques*. London: Sage Publications, pp. 65-74.

Sundeen, Stuart, Rankin & Cohen (1985), *Nurse-client interaction* St. Louis: Mosby Company, Toronto. Chapter 10, p. 309.

Tarrier, N., Barrowclough, C., Vaughn, C., Bamrah, J., Porceddu, K., Watts, S., Freeman, H. (1989), 'Community Management of Schizophrenia: a Two-Year Follow-up of a Behavioural Intervention with Families' *British Journal of Psychiatry*, 154: 625-628.

Tarrier, N., Barrowclough, C. & Bamrah, J.S. (1991) Prodromal signs of relapse in schizophrenia. *Social Psychiatry and Psychiatric Epidemiology*, 26:157-161.

Tarrier. N. (1996) in *Cognitive Behaviour Interventions with Psychiatric Disorders*. Ed. Haddock, G. and Slade, P. London: Routledge, 1996.

Tarrier, N., Yusupoff, L., & Kinney, C. (August 1 1998). 'Randomised controlled trial of intensive cognitive behaviour for patients with chronic schizophrenia' *BMJ*, 317:303-307.

Thorncroft, G., Brewin, C. and Wing, J. *Measuring Mental Health Needs: Models to predict district psychiatric morbidity* London.

Turkington, D. & Kingdon, D. (1997 reprint) chapter in Haddock, G. & Slade, P. (Eds.) *Cognitive Behavioural Interventions with Psychotic Disorders* London, Routledge.

United Kingdom Central Council for Nursing, Health Visiting and Midwifery (UKCC), (1996), *Position Statement on Clinical Supervision for Nursing and Midwifery*.

Vaswani, M. & Kapur, S. (2001) 'Genetic basis of schizophrenia: trinucleotide repeats an update,' *Progress in Neuro-Psychopharmacology & Biological Psychiatry 25* (6), pp. 1187-1201.

Vaughn, C. & Leff, J. (1976). 'The measurement of expressed emotion in the families of psychiatric patients', *British Journal of Social and Clinical Psychology*, vol. 15, 157-165.

Vaughan, K., Doyle, M., McConhaugly, N., Blaszaynski, A., Fox, A., Tarrier, N. (1992). 'The Sydney Intervention Trial, a controlled trial of relaties counselling to reduce schizophrenic relapse.' *Social Psychiatry and Psychiatric Epidemiology* 26:16:21.

Varsamis, J. and Adamson, J.D. (1971) Early schizophrenia. *Canadian Psychiatric Association Journal*, 16:487-497.

Varsamis, J., and Adamson, J.D. Early schizophrenia. Canadian Psychiatric Association Journal. 16:487-497, 1971.

Walker, R. (Ed.) *Applied Qualitative Research*, London: Gower.

Watts, M. (1988), *Shared Learning*, London: Scutari Press.

Weller, M. (Ed.) (1990) *International Perspectives in Schizophrenia*. Libbey, J.

Wender, P.H. (1968) cited in 'Re-introduction to Family Therapy, clarification of three schools' by Helen Hayes (1991) *Australia & New Zealand Journal of Family Therapy* 12:1:27-43.

West, E. *et al.* (1999) 'Hierarchies and cliques in the social networks of health care professionals: implications for the design of dissemination strategies.' *Social Sciences and Medicine*, 48:56, 33-46.

White, E. (1990) *Community Psychiatric Nursing. The National Survey*. Bristol: CPNA Publications.

Wing, J. & Wing, L. (Eds.) (1982) *Psychoses of uncertain aetiology*, London: Cambridge University Press.

Wing, J., Bennet, D. & Denham, J. (1964), 'The Industrial Rehabilitation of Long Stay Schizophrenic Patients', *Medical Research Council Memorandum No. 42*, London: HMSO.

Wing, J., Cooper, J. & Sartorius, N. (1974), *Description and classification of Psychiatric Symptoms*, London: Cambridge University Press.

Wong, D.F.K. (2000) 'Stress factors and mental health of carers with relatives suffering from schizophrenia in Hong Kong: Implications for culturally sensitive practices. *British Journal of Social Work* 30(3), 365-382.

World Health Organization (1973) *Report of the International Pilot Study of Schizophrenia. Vol. 1*. Geneva: WHO.

Yolken, R.H., Karlsson, H, Yee, F, Johnston-Wilson, N.L. & Torrey, E.F. (2000), 'Endogenous retroviruses and schizophrenia' *Brain Research Reviews* 31(2-3) 193-199, Elsevier Science Publishers BV Netherlands.

Yung, A.R., McGorry, P.D., McFarlane, C.A., and Patton, G. (1995) The PACE Clinic: Development of a clinical service for young people at high risk of psychosis. *Australasian Psychiatry*, Vol. 3 pp. 345-349.

Appendices

Questionnaire survey of students who had previously participated in the Educational Programme ENB A28

Appendix A — Sample and Method (Retrospective Study)

As previously discussed on page 86, as part of triangulation, a questionnaire was piloted to a group of five students who took the course prior to the one in the main study. One student was a member of the medical profession. The other four were nurses. Their positions in the service were as follows:-

Community Mental Health Worker

Community Mental Health Nurse/Research

Senior Clinical Nurse

Senior Psychiatric Liaison Nurse

Senior Registrar Psychiatry

From the responses received to the Pilot questionnaire (Appendix E), some changes were made to the questionnaire circulated in the main survey (Appendix F);

1.   A space was provided after each question for comment

2.   A further question relating to systemic practice was introduced

3.   A question which related to 'concept of family' was enlarged to include same sex couples

4.	A final question to gain information as to what the students considered to have been the most important element of their learning process on the ENB A28 (See Appendix F).

Effort was made to contact every other student with the exception of the pilot group who had completed the programme since its validation by the E.N.B. During the intervening years, some had moved out of London, either to other parts of the country or overseas and left no available forwarding address. Other addresses held centrally were unreliable. In all, probably 30 were correctly delivered, of which 20 were completed and returned.

Findings were analysed using descriptive statistics. The qualitative comments were summarised and integrated into particular themes.

Appendix B

Findings (Retrospective Study)

Student Profile

Professional Background

15 Nurses
1 SW
1 MD
3 OTs

- 15 Nurses
- 3 Occupational Therapists (OT)
- 1 Medical Doctor (MD)
- 1 Social Worker (SW)
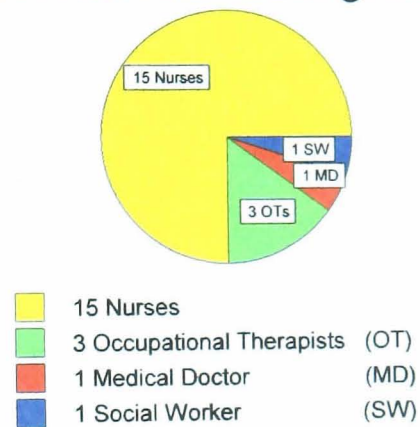
Total 20 Students

Ages of students

- None under 25
- 11 aged 36-45
- 6 aged 26-35
- 3 aged over 45
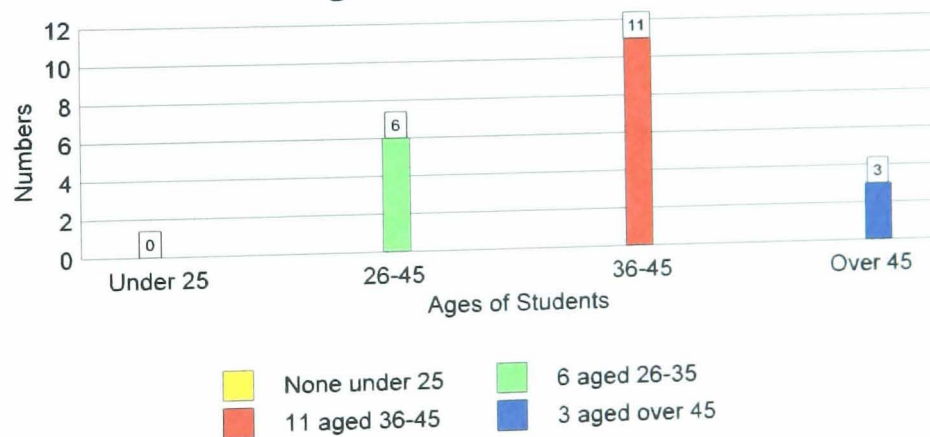
Total 20 Students

Gender of students

Numbers

14
12
10
8
6
4
2
0

| Males (6) | Females (13) | Unknown (1) |

Gender of Students

☐ 6 males ☐ 13 females ☐ 1 unknown

Total 20 Students

Ethnic Origins

White

Afro-Caribbean

Chinese

Black African

Irish

☐ 12 White Anglo Saxons
☐ 5 Irish
☐ 1 Black African
☐ 1 Chinese
☐ 1 Afro Caribbean

Total 20 Students

Year completing the course

7
6
5
4
3
2
1
0

| in 1993 | in 1994 | in 1995 | in 1996 | Unknown |

☐ 3 in 1993 ☐ 4 in 1994 ☐ 4 in 1995 ☐ 2 in 1996 ☐ 7 unknown

Total 20 Students
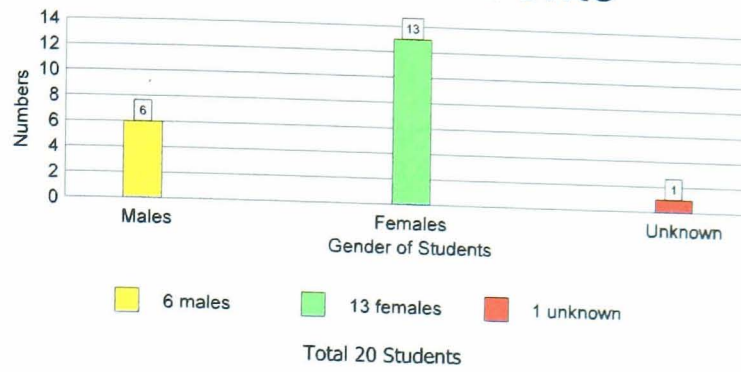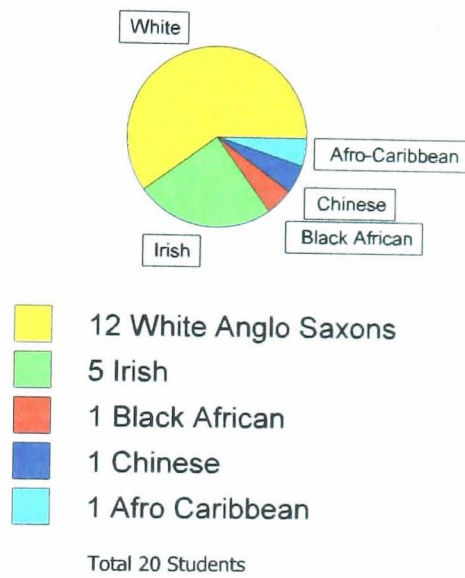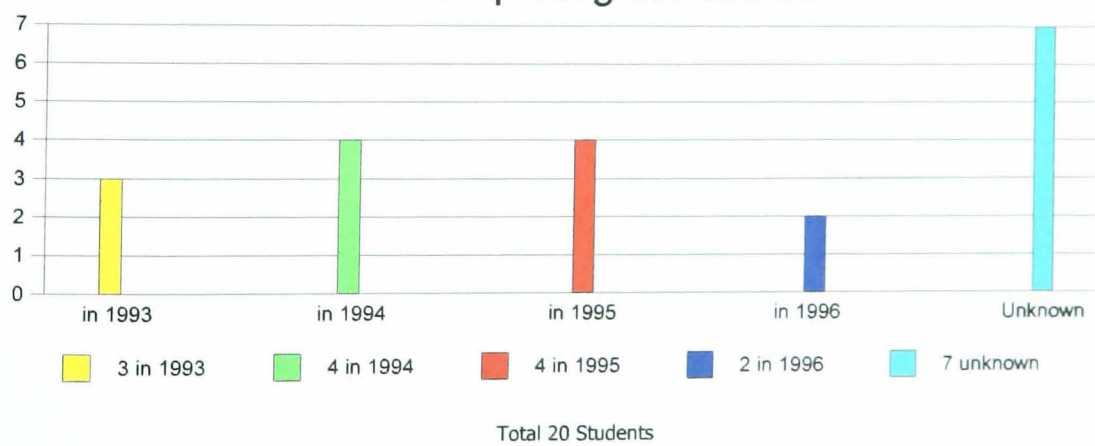
Present professional role

Legend:
- 3 Community Psychiatric Nurses [CPN]
- 1 Consultant Psychiatrist
- 1 Ward Manager
- 1 Clinical Nurse Specialist [CNS]
- 2 Charge Nurses
- 1 Approved Social Worker [ASW]
- 2 Team Leaders
- 4 Senior Nurses
- 3 Occupational Therapists [OT]
- 1 Head of Nursing Service
- 1 Lecturer in Nursing
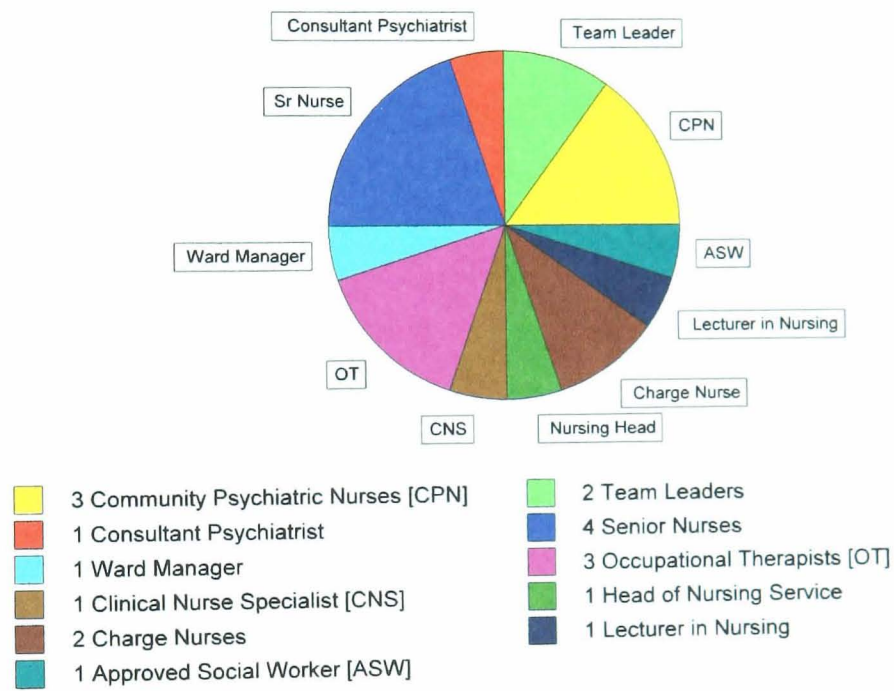
Findings

The questions aimed to gain information relating to the overall effect which the teaching on the ENB A28 had exerted on clinical practice and whether or not the findings confirmed those in the main study. The questionnaire was analysed question by question. The findings are presented according to the responses to each question.

Question 1.   Did you receive any preparation to work with families during your professional training?

The responses to this question indicated that there had been a wide interpretation of 'professional training' varying from the basic, for example the RMN, to those which included all post registration training. This possible confusion had not become apparent during the pilot study. Following discussion with my supervisor, it was decided to delete this question and responses from the findings.

Question 2.   Did you consider that the ENB A28 gave you confidence to work with families?

Professionals' lack of confidence to work with families was one of the reasons that the A28 was established. The responses to question 2 in this survey showed that the educational experience on ENB A28 resulted in 12 out of the 20 rating their confidence level as considerable while 5 rated theirs as moderate and only 1 as limited.

Question 3.   If you were given confidence to work with families, what do you think has contributed most to your preparation?

Of the respondents, 18 attributed their increased confidence to the same elements on the teaching programme as students in the main study: understanding the theoretical framework, particularly systemic thinking; supervision, both live and peer group; the practice of working with families. Additionally, 3 respondents included role play and video presentations as important while 4 others considered the skilled teaching on the ENB A28 which, in one instance, included the good ratio of students to tutors and support of individual course supervisors as crucial.

Question 4A. Do you consider that the ENB A28 gave you confidence to work systemically?

There was a clear distinction made by some of the respondents between what aspects of the course facilitated 'family' practice in general and a 'systemic' way of working as important. Three stressed the importance of now being able to consider the management of the patients/clients for when they were responsible in a new light, each within a family/social system; a focus on family rather than individual.

Question 4B. Can you say what has enabled you to work in this way?

The majority once more stressed the importance of theoretical understanding, watching skilled practitioners working with families and the role of supervision and support of their supervisor.

Question 4C. If you are not able to work in a systemic way, what is the reason?

Of the respondents, 3 complained of their difficulties in maintaining a systemic approach due to 'isolation' in their place of work, although 15 of the 20 respondents reported that they continued to think systemically whether or not they continued to work directly with families. Of the remaining 2, one had plans to set up a 'group' to reactive her ideas, while the other reported that due to a change in her job, she had not yet been able to introduce a systemic approach.

Findings will be considered jointly for the two next questions:

Question 5. On completion of the course, how long did you remain in your present post?

and

Question 6. Was any future decision to make a career move influenced by your experience on the ENB A28?

In response to these questions on issues relating to their employment 11 out of 19 respondents remained in their present post for a minimum of a year or longer. No future career move was influenced by their experience on the ENB A28. Eight of the remaining group were either partly or mostly influenced by the ENB A28 to make a career move but 4 did not do so for over a year. Two who were most influenced by

the ENB A28 to seek alternative employment did so within three months of completing the course.

Question 7. Did you receive support from your line manager to introduce a family system approach to your clinical practice?

There was a sharp contrast in the experience of the respondents to this question. A medical consultant did not consider this question relevant in her position. Of the other 19, 10 had good to excellent support whereas 9 had either limited support or none at all. Those who experienced difficulties in gaining management support to introduce a family system approach also experienced difficulty in gaining managerial support overall.

Findings will be considered jointly for the two next questions:

Question 8. Did you receive support from colleagues in your clinical team to introduce family work in your practice?

and

Question 9. Did you influence colleagues in the clinical team to consider using a family approach in their practice?

There was a correlation between the levels of colleagues' support and managerial support. 9 of the 18 respondents graded the support of colleagues the same as that of the manager, so in those instances where the manager gave only limited support, the respondents' difficulties were compounded.

Findings will be considered jointly for the next two questions:

Question 10. Are you working directly with families in your present practice?

and

Question 11. Are you able to think systemically in your present practice?

Whether or not the respondents worked directly with families in their present positions, 15 out of 20 continued to think systemically. One of the remaining 5 was about to set up a small group to reactivate her ideas and a second commented that she had just changed her job and consequently had not yet had the opportunity to introduce a systemic approach.

Question 12. Did your views on what constitutes a 'family' change while you were taking the course ENB A28?

The majority of respondents experienced marginal to moderate change in their 'concept of family during the course.

Question 13. What influence has working with ethnic minority groups and same sex relationships had on your concept of what is meant by 'family'?

The greatest shift in thinking related to the influence that working with ethnic minority groups and same sex relationships had on their concept of what was meant by 'family'. Six respondents rated the influence at the highest possible. With 2 exceptions, the remaining responses were in the moderate category. In general, the responses were given a higher rating than the previous question although it related to the respondents' 'concept of family'.

Question 14. What do you consider to be the most important element of your learning on the ENB A28?

The responses to this question were predominantly related to the value the respondents placed on 'systemic thinking'. Four related this most directly to mental health care. One now considered illness as a systemic based problem, affecting not only the individual but the whole system. Another of the respondents considered that learning theories and social circumstances which may contribute to mental illness and the strategies which could be employed in helping people with mental health problems and their families was most important. Similarly, another respondent considered it important to have learnt how family relationships contribute to patients' re-admission to hospital and one other was now aware of the people including self who were connected and exerting an effect within the client's system.

Other respondents considered the value of systemic thinking in general terms such as the concept of circularity and how each part of a 'system' has a 'knock on' effect for the others in that system and vice versa. An expansion of their knowledge gained on the ENB A28 enabled respondents to think in this way and was a consistent theme throughout.

According to other respondents, their confidence to work with patient/client's broader 'system' was obtained by observing experts at work, live supervision and

case presentations. The theoretical aspects of their course gave them an awareness of gender, ethnicity and power issues including seeing the family as 'experts'.

Conclusions

A key reason for the establishment of the ENB A28 was to increase professionals' confidence to work with families and to use systemic principles in their practice.

The findings demonstrated that the majority of the students who completed questionnaires reported their confidence to work with families was now considerable. They also considered that the most important element of their learning on the ENB A28 was 'systemic thinking'.

In its application as distinct from 'thinking' some experienced difficulties due to lack of managerial support. As in the main study the role of managers proved crucial as to students' level of effectiveness.

Finally, the students considered live supervision, theory and practice as important to gaining confidence to practice, thinking systemically and an awareness of issues relating to gender and ethnicity.

These findings reinforced the value of the educational programme ENB A28, especially when a number of the respondents participated in the course six years earlier than the main study and yet it had maintained importance in their clinical practice.

It can be seen that the findings in the questionnaire closely mirrored the findings in the main study, in particular the importance of managerial support to ensure clinical effectiveness and the value of the educational model of theory, practice and live supervision in the learning process.

Appendix C — Letter of Invitation to Participate (Pilot questionnaire)

29 Durham Road
East Finchley
London
N2 9DP
0181-883 2971

Dear

EVALUATION OF ENB A28

Some time ago, you generously gave of your time to be interviewed in a Pilot Study as part of a research programme I was undertaking, which included an evaluation of the ENB A28. Your experience of the course which you related during the Pilot Study influenced the questions I asked students who took part in the main study. This one involved interviewing students twice during the course which ran 1997/1998, at the beginning and on its completion. I also interviewed each clinical manager who supported a student's application for the course.

The final stage in the evaluation process is to conduct a retrospective study of the influence which the course has had on the clinical practice and professional development of previous course participants.

May I ask for your help once again, by completing the enclosed pilot questionnaire and advising me of possible changes or modifications which need to be considered. I would also be interested to know how long it took you to complete the questionnaire and if you felt the length of time was reasonable.

With very best wishes,

Shirley Stanner

Appendix D — Covering Letter for the Questionnaire

Tel. 0181-883 2971

Shirley Stanner
29 Durham Road
East Finchley
London
N2 9DP

17 February 2000

Dear

WORKING WITH FAMILIES OF INDIVIDUALS
WITH A MAJOR MENTAL HEALTH PROBLEM

I wish to thank all those who completed the questionnaire which I sent requesting information regarding students' experience on the above. The information which you provided was most valuable and will make a significant contribution to the overall assessment of how mental health care professionals are prepared to work in this important area of the service.

It is not too late for anyone who failed to meet the deadline. Your contribution will still be very welcome.

With best wishes.

Yours sincerely,

Shirley Stanner

Appendix E — Pilot Questionnaire

WORKING WITH FAMILIES OF INDIVIDUALS WITH A MAJOR MENTAL ILLNESS ENB A28

A retrospective study of the students' experience on this educational programme and the influence it had subsequently on their Clinical Practice and Professional Development.

Please answer the question by circling the answer that you think most nearly applies to you.

To ensure confidentiality the respondent will remain anonymous.

Thank you for your co-operation.

PERSONAL DETAILS

A.   Qualifications and Dates

B.	**Age**	25 or under	26 - 35	36 - 45	Above 45
C.	**Gender**	Male	Female		
D.	**Ethnic Origin**	White	Black Caribbean	Black African	Black Other
		Indian	Pakistani	Bangladeshi	Chinese

Other (please state)_____

E.   **Present Position**

EVALUATION OF THE ENB A28

1. **Did you receive any preparation to work with families during your professional training?**

   Well Prepared   Moderately   Limited   None

2. **Do you consider that the ENB A28 gave you confidence to work with families?**

   Much   Moderate   Limited   None

3. **Do you consider that the ENB A28 enabled you to think systemically in your practice?**

   Not at All   With Limitations   Moderately   Completely

4. **On completion of the course, how long did you remain in the same post for?**

   3 Months   6 Months   1 Year   Longer

5. **If you changed posts, was it?**

   Within the Trust   Outside the Trust   Within the Team   Outside the Team

6. **Was any future decision to make a career move influenced by your experience on the ENB A28?**

   Entirely   Moderate   Vaguely   Not at all

7. **Was a subsequent career move made to increase your opportunity to work directly with families?**

   Not at all   Partly   Mostly   Entirely

8. **Did you receive support from your line manager to introduce a family system approach to your clinical practice?**

   Excellent   Good   Limited   None   Not Relevant

9. **Did you receive support from colleagues in your clinical team to introduce family work in your practice?**

   Excellent   Good   Limited   None

   Comment:

10. **Did you influence colleagues in the clinical team to consider using a family approach in their practice?**

    Not at all   Limited   Moderately   Considerable

11.	Are you working directly with families in your present practice?	Never	Infrequently	Frequently	Consistently
12.	Are you able to think systemically in your present practice?	Continually	Frequently	Infrequently	Never
13.	Did your views on what constitutes a 'family' change while you were taking the course ENB A28?	Not at All	Somewhat	Moderately	Completely
14.	Have your ideas on what constitutes a 'family' changed since taking the ENB A28?	Completely	Moderately	Somewhat	Not at all
15.	What influence has working with black and ethnic minority groups had on your concept of what is meant by 'family'?	Considerable	Moderately	Limited	None

COMMENTS:

WORKING WITH FAMILIES OF INDIVIDUALS WITH A MAJOR MENTAL ILLNESS ENB A28

A retrospective study of the students' experience on this educational programme and the influence it had subsequently on their Clinical Practice and Professional Development.
Please answer the question by circling the answer that you think most nearly applies to you.
To ensure confidentiality the respondent will remain anonymous.
Thank you for your co-operation.

PERSONAL DETAILS

A.   Qualifications and Dates

B. **Age**	25 or under	26 - 35	36 - 45	Above 45
C. **Gender**	Male	Female		
D. **Ethnic Origin**	White	Black Caribbean	Black African	Black Other
	Indian	Pakistani	Bangladeshi	Chinese
	Irish			

Other (please state)_____

E.   **Present Position**

EVALUATION OF THE ENB A28

1. Did you receive any preparation to work with families during your professional training?

   Well Prepared   Moderately   Limited   None

   Comment:

2. Did you consider that the ENB A28 gave you confidence to work with families?

   Considerable   Moderately   Limited   None

   Comment:

3. If you were given confidence to work with families, what do you think has contributed most to your preparation?

   Comment:

4A. Do you consider that the ENB A28 gave you confidence to work systemically?

   Not at All   With Limitations   Moderately   Completely

   Comment:

4B. Can you say what has enabled you to work in this way?

   Comment:

4C. If you are not able to work in a systemic way, what is the reason?

   Comment:

5. On completion of the course, how long did you remain in your present post?

   3 Months   6 Months   1 Year   Longer

   Comment:

6. Was any future decision to make a career move influenced by your experience on the ENB A28?

   Not at All   Partly   Mostly   Entirely

   Comment:

7. **Did you receive support from your line manager to introduce a family system approach to your clinical practice?** Excellent   Good   Limited   None   Not Relevant

Comment:

8. **Did you receive support from colleagues in your clinical team to introduce family work in your practice?** Excellent   Good   Limited   None

Comment:

9. **Did you influence colleagues in the clinical team to consider using a family approach in their practice?** None   Limited   Moderate   A Great Deal

Comment:

10. **Are you working directly with families in your present practice?** Never   Infrequently   Frequently   All the Time

Comment:

11. **Are you able to think systemically in your present practice?** Continually   Frequently   Infrequently   Never

Comment:

12. **Did your views on what constitutes a 'family' change while you were taking the course ENB A28?** Not at All   Somewhat   Moderately   Completely

Comment:

13. **What influence has working with ethnic minority groups and same sex relationships had on your concept of what is meant by 'family'?** Considerable   Moderately   Limited   None

Comment:

14. **What do you consider to be the most important element of your learning on the ENB A28?**

Comment:

Appendix G — Letter enclosing 'Consent for Interview form' (Pilot for main study)

29 Durham Road
East Finchley
London
N2 9DP
0181-883 2971

Dear

EVALUATION OF ENB A28

Thank you for the interest you showed when I met with you and other students on the ENB A28 to explain the purpose of this project.

I am now writing to confirm that you agree to take part in the Pilot Study which we discussed. Its aim will be to gather information relating to your experiences on this course. This information will facilitate the development of a questionnaire to be used in the major review.

I would like to reassure you that your evidence will be confidential and that you will be given the opportunity to give written consent which will contain a clause to this effect. The interview will be semi-structured and last for no more than 45 minutes.

Thank you for completing the enclosed form.

With very best wishes.

Shirley Stanner

Appendix H — Consent for Interview Form
(Pilot and Main Study)

I agree to be interviewed   YES/NO

I would like to be interviewed at . . . .

. . . .

Please indicate the most convenient time and day of the week for the interview:

. . . .

. . . .

Signed . . . .

Appendix I — Interview Schedule of Students in the Main Study

Research Questions

A — Students' First interview

1. Reasons for applying to take the course

2. Experience of family work during basic professional training

3. Concept of family

4. Families in present own/ward practice

5. Interest shown by clinical team in student's participation on the ENB A28 and support given

6. Early impressions of the course

7. Feelings engendered by course content

8. Supervision on the course

9. Issues relating to confidentiality

10. Expectations of the course

B — Students' Second interview

Responses to the questions asked in the first interview were re-visited to establish what if any changes in the students' concept of the course had changed.

Where there were changes, these were explored.

Further questions related to the students' learning experience and what they considered had been the most important elements to the process.

Ideas they might have on the application of new learning to their clinical practice.

Plans for the future

Appendix J — Managers' Interviews in the Main Study

1. Reasons why they had supported a member of their clinical team to take the ENB A28

2. Experience of working with colleagues who had previously taken the course

3. Their views on the value of such a course to clinical practice in general

4. Their own educational experience in training to work with families/ carers

5. Their plans relating to maximise the student's new skills

6. Did they consider this experience would be of value shared with other members of the team

7. Problems encountered by the study leave arrangements

8. Communications with the Family Project. Had they been sufficiently appraised of the content of the course and its aims.

Appendix K - Audiotape Consent Form
(Pilot and Main Study)

School of Health, Biological and Environmental Sciences

Royal Free Centre

MIDDLESEX UNIVERSITY

AUDIOTAPE CONSENT FORM

I Understand:

1. That an audiotape recording will be made of the sessions in which I take part and that this audio recording may be used by the researcher and supervisor to review the sessions.

2. That every effort will be made to ensure confidentiality.

   I now agree that excerpts from these recordings,or descriptions of them ,may be used by the researcher for the purpose of teaching or publication in professional journals. For such all identifying information will be erased.

   SIGNED:

   DATE:

I Undertake that:

1. Any audiotape made with the above person will remain the possession of, and in the control of, the researcher or the research supervisors (Vicky Franks and Pam Smith) who will protect the confidentiality and anonymity of those involved in the sessions.

2. The audiotapes,or descriptions of audiotapes,will be used for professional purposes only.

   SIGNED:

   DATE:

Appendix L — Inquiries re Homicides by Mentally Ill Persons

Independent Inquiries Reports

Report into the Care and Treatment of:

Christopher Clunis, North East Thames and South East Thames regional Health Authorities — February 1994.

Kenneth Gray, East London and City Health Authority — November 1995.

Peter Horrod, East Norfolk Health Authority – detained indefinitely under Mental Health Act, December 1995.

Kumbi Mabota, Redbridge and Waltham Forest Health Authority — September 1996.

Nilesh Gadher, Ealing, Hammersmith and Hounslow Health Authority — April 1996.

Martin Mursell, Camden and Islington Health Authority — March 1997.