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**Non-engagement in psychosis: A narrative analysis of service-users'
experiences of relationships with mental health services**

&

Clinical Research Portfolio

VOLUME I

(VOLUME II Bound Separately)

David John Grinter

March 2012

Academic Unit for Mental Health & Wellbeing

Submitted in part fulfilment of the requirement for the Degree of Doctor in Clinical Psychology

Faculty of Medicine Graduate School

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"If you are deemed insane, then all actions that would otherwise prove you are not do, in actuality, fall into the framework of an insane person's actions. Your sound protests constitute *denial*. Your valid fears are deemed *paranoia*. Your survival instincts are labelled *defensive mechanisms*. It's a no-win situation. It's a death penalty really. Once you're here, you're not getting out." - *Rachel Solando*

"You have that power. I don't. And that makes me vulnerable. Being vulnerable makes me scared" - *Peter Breene*

From "Shutter Island" by Dennis Lehane

"All things are subject to interpretation whichever interpretation prevails at a given time is a function of power and not truth." - *Friedrich Nietzsche*

"Do I contradict myself? Very well, then I contradict myself, I am large, I contain multitudes." - *Walt Whitman*

Chapter 1: Systematic Review

A systematic review of assessment of integration and sealing over following psychosis

David Grinter*

Academic Unit for Mental Health & Wellbeing

Keywords:

Integration, Sealing Over, Psychosis, Recovery Style

***Correspondence to:**

David Grinter
Academic Unit for Mental Health & Wellbeing
Academic Centre
Gartnavel Royal Hospital
1055 Great Western Road
Glasgow
G12 0XH

Abstract

Introduction

The terms *integration* and *sealing over* are used to describe psychological adjustment of individuals following episodes of psychosis. It is believed that these two concepts exist at opposing ends of a theoretical continuum. Integration and sealing over are considered to be imported in both clinical and research domains. Two psychometric assessments (ISOS and RSQ) exist which purport to reliably and validly measure integration and sealing over. This review focuses on how reliable these assessment measures are and to what extent the concepts of integration and sealing over are valid, as assessed by these. It also attempts to summarise the correlates of integration and sealing over.

Methods

Search terms were applied to electronic databases for all years up to October 2010. Reference checks of the selected articles were undertaken to gather further articles.

Results

Fifteen relevant articles were included. The ISOS was found to have good inter-rater reliability but no validity measures have been reported. The RSQ lacked reported factorial validity and reliability measurements varied from good to poor. Reported correlation between measurements varied in strength from strong to medium. Integration and sealing over were associated with a variety of correlates.

Discussion

ISOS and RSQ do not necessarily assess the same phenomenon. RSQ displayed instability and factorial validity remains unconfirmed. Lack of theoretical coherence in research and further assessment of RSQ and ISOS is required.

Introduction

Integration and sealing over coping styles have increasingly become the focus of research in recovery from acute psychosis over the past decade. Coping style refers to the way in which an individual adapts emotionally, socially and functionally following an episode of psychosis and how they come to make sense of these experiences. It was in the 1970's that these concepts first began to be the focus of empirical investigation. McGlashan (1975, 1976, 1977) defined and operationalised integration and sealing over in a clinical context (Levy, McGlashan & Carpenter, 1975; McGlashan, Levy & Carpenter, 1975; McGlashan, Docherty & Siris, 1976; McGlashan, Wadeson, Carpenter & Levy, 1977; McGlashan & Levy, 1977). Recovery from, and reaction to, psychotic experiences had been previously defined by Mayer-Gross (1920). The descriptions of reactions to psychosis postulated by Mayer-Gross were considered to be analogous to integration and sealing over (McGlashan et al., 1975) and this early work provided a theoretical platform for further empirical exploration.

Sealing over was considered to be related to denial but had not been appropriately defined in the literature to date (McGlashan et al., 1975). *Integration* had been variously described as a synthetic ego function (Hartmann, 1964), a differentiation of ego boundaries (McPherson, Buckley & Draffan, 1971) and the general intactness of the personality (Mosher, Reifman & Menn, 1973). Despite these descriptions being available, there were no empirically derived definitions of integration and sealing over that had been unequivocally accepted.

Research at NIMH

McGlashan and colleagues endeavoured to operationalise and accurately describe integration and sealing over. Qualitative studies initially concentrated on observations of individuals in an inpatient setting (the National Institute of Mental Health clinical research unit) as well as the clinical case notes that staff recorded regarding the individuals (Levy, McGlashan & Carpenter, 1975; McGlashan, Levy & Carpenter, 1975; McGlashan, Docherty & Siris, 1976; McGlashan, Wadeson, Carpenter & Levy, 1977; McGlashan & Levy, 1977).

The defining features of integration and sealing over were grouped into two categories; *experience of psychosis*, and individual's *social relatedness* (McGlashan et al., 1976). The key features of experience of psychosis included impact of illness, responsibility for psychotic experiences, meaning of psychosis and information that can be derived from these experiences. Social relatedness consisted of attitudes to mental illness, attitudes to help and boundary surveillance (the individual's concern with retaining control of inner impulses but also their respect of other's boundaries). Sealing over was defined as:

"...a process by which psychotic experiences and symptoms are isolated from non-psychotic mental events and then made unavailable by both conscious suppression and repression" (Levy, McGlashan & Carpenter, 1975; pp: 310).

Successful sealing over is characterised by disinclination towards discussing feelings and thoughts that are experienced when acutely psychotic. They proposed that individuals who seal over can often appear to lack awareness of details of their psychosis and do not locate the psychosis within a personal context; there is no continuation between life prior to psychosis and the psychotic experience. There is also a lack of curiosity regarding the psychosis and those who seal over do not seek to gain information from the experiences. Finally, there is a strong desire to return to pre-morbid functioning and a belief that the experience can be safely forgotten.

In contrast, integration was defined as "the patient's awareness of the continuity in their mental activity and personality from before the psychotic experience, during psychosis and through recovery" (McGlashan et al., 1977; p. 861). Individuals take responsibility for the source of their psychotic experiences and are curious regarding these experiences. Individuals who adopt an integrative style of coping also attempt to acquire new information from these experiences to help them achieve an enhanced understanding of themselves.

Integration and sealing over can have an influence on interpersonal dynamics between service-users and staff and also within staff teams. This can have implications for service user treatment and recovery (McGlashan & Levy, 1977). Inter-personal problems can arise when staff

are confronted with their own anxieties, which are then mimicked in the behaviour of service-users. When staff seal over their own experience in this way it may encourage individuals to also adopt a sealing over coping style. Other implications for recovery included problems with “mutual projection”. Individuals may attribute the cause of their psychotic problems to the actions of staff (or other external objects). These attributions may result in changes in an individual’s behaviour, something which is likely to be challenging for staff. Such changes have the potential to trigger staff attributions as to the cause of the individual’s difficulties. Due to the difficulties experienced by staff the perceived causes of service user behaviour will invariably be negative and thus will have negative connotations for the way in which staff and patients interact with one another (McGlashan & Levy, 1977).

The two recovery styles were conceived of as existing on a continuum of recovery styles, each occupying a polar extreme (McGlashan et al., 1977). Integration or sealing over were perceived to have trait-like qualities; an individual adopted one style of recovery and that this was to a greater extent fixed within that individual (McGlashan et al., 1977). Despite the assertion that recovery style was unchanging within an individual there was one caveat; the individual could have periods where they adopted aspects of the alternative recovery style (McGlashan et al, 1976). It was argued that this paradox could exist because, although sealing over and integration are opposing constructs, they are not considered to be mutually exclusive processes of recovery. Nonetheless, these two assertions are clearly contradictory and represent an unresolved issue within the literature.

The Integration/Sealing Over Scale (ISOS; McGlashan et al., 1977) utilised a semi-structured clinical interview, based around 13 items that were derived from previous qualitative research, to derive a clinician rating of recovery style. Integration and sealing over are located at the polar extremes of a 6-point Likert scale; each point representing a different style. It was acknowledged that the assignment of recovery style type to an individual was influenced by the individual’s relatedness to the observer (McGlashan et al., 1977) but it was argued that the use of multiple, independent observers would potentially reduce chances of bias (McGlashan, 1987).

Integration and sealing over were conceptualised within a dynamic, systemic and narrative framework and thus interpersonal dynamics were an integral aspect of the rating process.

Re-emergence of Interest in Integration and Sealing Over

Research focussed on integration and sealing over diminished following the 1970's but curiosity was reignited in the late 1990's. The constructs as defined by McGlashan continued to be adopted by more recent investigators (Drayton, Birchwood & Trower, 1998; Tait, Birchwood & Trower, 2003). Research shifted from attempting to defining sealing over and integration and instead focused on the prognostic value and clinical correlates of the constructs, as well as understanding their aetiology. The change in empirical focus is reflected in change in research methodology from predominantly qualitative investigation towards quantitative, hypothesis testing approaches.

The constructs developed by McGlashan were operationalised in to the Recovery Style Questionnaire (RSQ; Drayton, Birchwood & Trower, 1998) to provide a self-reported measure of an individual's own recovery style. This scale consisted of 39 items which were constructed as personal statements, such as "There was a gradual build-up to me becoming ill" and "Others are to blame for my illness", and these are allocated a score according to a predefined 3-point Likert scale. The 39 statements were derived from 13 concepts as defined in McGlashan et al. (1977). A total score for the RSQ could be generated, with each of the concepts contributing equal value to this score. The process of developing the RSQ included several individuals' input via focus a group in addition to contributions from mental health staff (Drayton et al., 1998). A by-product of the introduction of the RSQ in more recent research has been a coincidental reconstitution of the definitions of integration and sealing over, from a narrative, systemic and dynamic perspective to a social-cognitive influenced interpretation.

There are now, therefore, two different conceptualisations of the recovery styles, and two different methods of assessment. Questions are ultimately raised regarding the veracity the two different conceptualisations and by association the assessment tools via which they are measured. The relationship between the different interpretations of integration and sealing

over (and the ISOS and RSQ) needs clarification. Are the two interpretations actually analogous, or are there fundamental differences, that indicate that integration and sealing over have not yet accurately been described as phenomena? Do the measurement constructs accurately reflect the behavioural construct? The integrity of research to date relies upon both integration and sealing over being tightly conceptualised, but also reliably and validly assessed. To this end the available assessment measures should be evaluated.

Methodology

Objectives

This systematic review aimed to answer the following questions in context of psychosis:

1. How reliable are the assessments of integration and sealing over?
2. How valid are the constructs of integration and sealing over, as assessed by current measures?
3. What are the correlates of integration and sealing over?

Data Sources

This review was conducted and reported according to recommendations of the Meta-analysis of Observational Studies in Epidemiology (MOOSE) group (Stroup, Berlin, Morton, Olkin, et al., 2000). The computerised bibliographical databases Ovid MEDLINE (1950-October 2010), PsycINFO (1967-October 2010) EMBASE (1980-October 2010), ISI Web of Knowledge (All Years) were searched using combinations of the following terms *sealing over*, *integration*, *recovery style* combined with either *schizophrenia*, or *psychosis*. The reference sections of the selected articles were checked in order to include any relevant articles that may have been missed by the initial search.

Inclusion & Exclusion Criteria

Studies were included only if a standardized diagnostic system was specified for classifying mental health problems (e.g. DSM-IV, ICD-10). Studies that were published in a language other than English, which were review articles, which were not published in a peer-reviewed publication (e.g. conference abstracts, book chapters, dissertations) or which were studies of non-human participants were excluded from the review. Studies using scales not specifically designed for measuring recovery style were excluded.

Appraisal of Methodological Quality

The methodological quality of the cohort studies was assessed using guidance from the Scottish Intercollegiate Guidelines Network (SIGN) 'SIGN 50: A Guideline Developers Handbook' (Scottish Intercollegiate Guidelines Network, 2008). Aspects of the Consolidated Standards of Reporting Trials (CONSORT) guidelines were also included in the checklist for assessing the methodological quality of the studies. The checklist included criteria assessing primary and secondary questions, sample, quality of analysis and assessment of reliability and validity of measures.

Reliability of Quality Rating

The studies were ranked by the reviewer according to the specified criteria. The top and bottom ranked papers were selected along with the paper at the top of quartile third quartile and the bottom of the second quartile. These studies were independently rated by two reviewers according to agreed criteria. When reviewers' conclusions over the quality of a study differed, the study was reviewed jointly and discussed.

Results

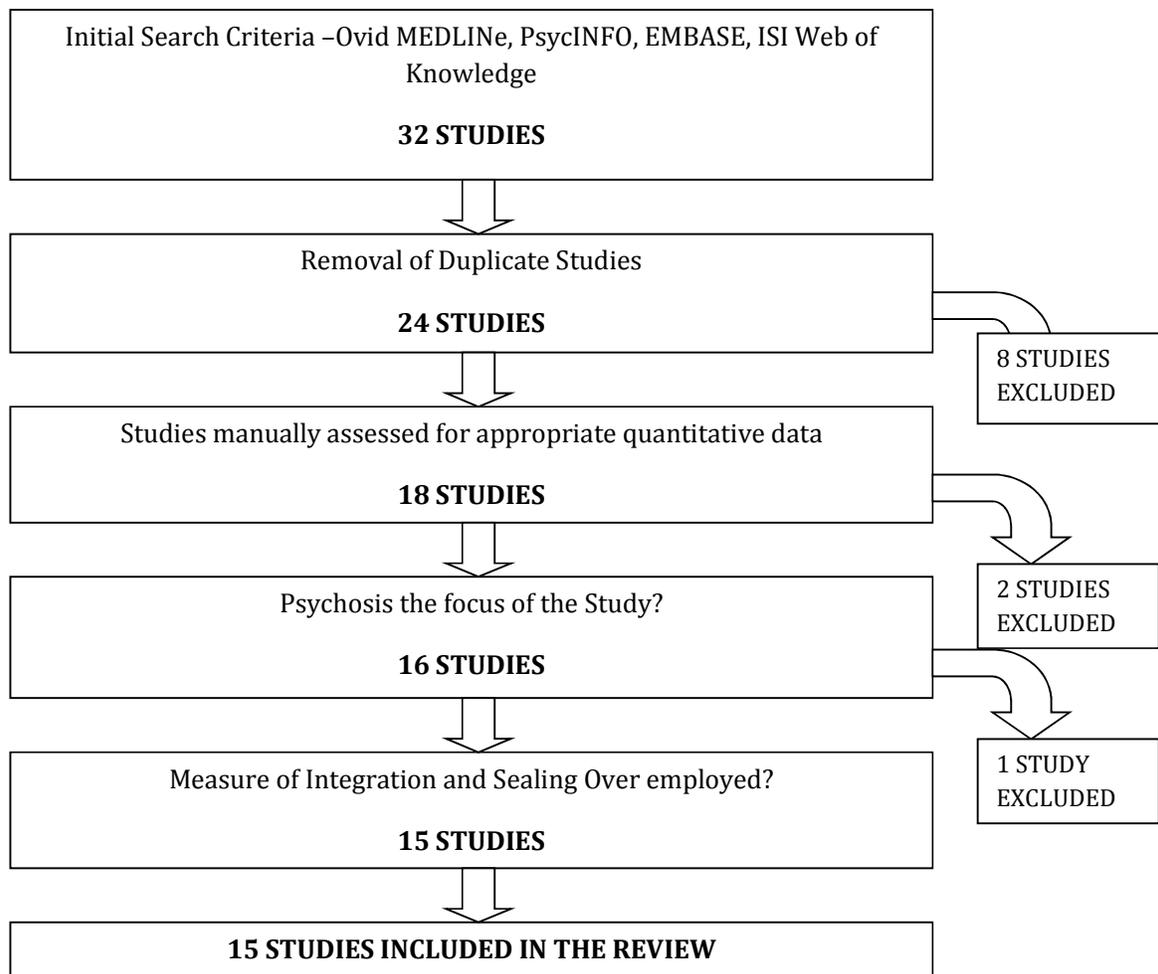
Outcome of Search Process

The computerised search yielded 32 papers (once duplicates were eliminated), of which 24 were retained as being relevant to the research questions on the basis of their titles and

abstracts. There were 9 articles that did not meet the inclusion criteria. No further papers were identified from hand searches or from the references lists of papers included from the electronic search. Therefore a total of 15 studies were reviewed.

Six studies were excluded as they did not provide any usable data that could be analysed (McInnis, Sellwood & Jones, 2006; Roe & Kravetz, 2003; McGlashan & Levy, 1977; McGlashan, Docherty & Siris, 1976; McGlashan, Levy, & Carpenter, 1975; Levy, McGlashan & Carpenter, 1975). The further two studies were excluded as they focused on diagnoses other than psychosis/schizophrenia (Lindbom-Jakobson & Lindgren, 2001; Ursano, Wheatley, Sledge, Rahae & Carlson, 1986). A final study was excluded as it did not use a measure of integration/sealing over (Bell & Zito, 2005).

Flowchart of Study Selection



Demographic Information

A total of 15 studies were included in the analysis. The total number of participants included in the studies was 1148 (sample size range 24-231). The median age of the participants across all groups was 32.3 years of age (range of 18-71). The group was primarily male, 67.8% (n=655) although one study (McGlashan, 1987) did not provide any information regarding the characteristics of the sample.

A total of two studies recruited first episode of psychosis samples (Thompson, McGorry & Harrigan, 2004; Jackson, McGorry, Henry, Edwards, et al., 2001), eight studies utilised samples of individuals in the recovery phase of psychosis (Mulligan & Lavender, 2010; Stainsby et al., 2010; Jackson & Jones, 2006; Tait et al., 2004 & 2003; Drayton et al., 1998; D'Angelo & Wolowitz, 1986), five studies used inpatient samples (Modestin, Caveng, Wehrli & Malti, 2009; Startu, Wilding & Startup, 2006; Modestin, Soult & Malti, 2004; McGlashan, 1987; McGlashan et al., 1977), one study used a forensic population (Fitzgerald, 2010).

Two of the studies reported duration of untreated psychosis (DUP; Thompson et al., 2004; Jackson et al., 2001). Thompson reported the median DUP as 54 days, however Jackson reported the mean DUP of 321 days. A further four studies (Stainsby et al., 2010; Bernard et al., 2006; Tait et al., 2004 & 2003) included data on the amount of time that had lapsed since first episode of psychosis with the range 30.91 to 196 months. The duration of hospitalisation for a first episode of psychosis population has a mean of 40.15 days (S.D = 37.25, range not reported). Three other studies (Modestin et al., 2009; Startup et al., 2006; Modestin et al., 2004) included data on hospital admissions for non-first episode samples. The mean number of admissions per individual was 4.6 (S.D = 4.73, range not reported) and mean duration of hospital admission was 18 months (S.D 11 months, range not reported).

Operationalisation of Integration and Sealing Over

Integration/ Sealing Over Scale (ISOS)

A total of nine studies used the Integration/Sealing Over Scale (McGlashan, Wadeson, Carpenter & Levy, 1977; D'Angelo & Wolowitz, 1986; McGlashan, 1987; Drayton, Birchwood &

Trower, 1998; Jackson, McGorry, Henry et al., 2001; Thompson, McGorry & Harrigan, 2004; Modestin, Soult & Malti, 2004; Startup, Wilding & Startup, 2006; Modestin, Caveng, Wehrli & Malti, 2009). The ISOS was developed as a six-point Likert scale with the end points sealing-over and integration being distinct recovery styles (the lowest score indicating integration). There are 13 dimensions on which integration and sealing over are assessed on the ISOS. A global evaluation is based on the summation of the dimensions of the scale. The rating of the ISOS is derived from the clinical judgement of two raters.

No inter-rater reliability or validity measures were reported in McGlashan et al. (1977). Inter-rater reliability was reported to be $r = 0.80$ (McGlashan, 1987; Modestin et al., 2009), and between $r = 0.88$ and 0.91 (D'Angelo & Wolowitz, 1986). Cronbach's alpha for internal reliability has been reported as $\alpha = 0.86$ (Modestin et al., 2004) and $\alpha = 0.93$, however, it is not reported how this was assessed (Modestin et al., 2009). Cronbach's alpha was not calculated in Startup et al. (2006)

Recovery Style Questionnaire (RSQ)

Eight studies used the Recovery Style Questionnaire (Drayton, Birchwood & Trower, 1998; Tait, Birchwood & Trower, 2003; Tait, Birchwood & Trower, 2004; Bernard, Jackson & Jones, 2006; Modestin, Caveng, Wehrli & Malti, 2009; Fitzgerald, 2010; Stainsby, Sapochnik, Bledin & Mason, 2010; Muligan & Lavender, 2010). The RSQ is a 39-item self-report measure that was specifically designed as an alternative to the ISOS. The 39 items are reported to contain 13 subscales, and each subscale can be assigned a score. Overall recovery style is evaluated via a single score, which is derived from the summation of the 13 subscales.

Factorial validity of the RSQ

There are 13 subscales (3 questions each) that reflect the categories developed by McGlashan et al. (1977). None of the studies identified in this review have empirically evaluated the factor structure of the RSQ. The factorial validity of the RSQ therefore remains unconfirmed. No exploratory factor analysis has been undertaken.

Reliability

One month test-retest reliability correlation coefficient for the RSQ has been reported at being $\alpha = 0.81$ (Drayton et al. 1998). The internal reliability of the measures was reported to be $\alpha = 0.73$ (Drayton et al. 1998), at $\alpha = 0.78$ (Modestin et al. 2009) and $\alpha = 0.73$ to $\alpha = 0.76$ by Stainsby et al (2010). However, Mulligan and Lavender (2010) reported the Cronbach alpha to be much lower at 0.52.

RSQ Measurement

The RSQ initially showed bi-modal distribution, with peaks indicating sealing over and integration, reported to be similar to the ISOS (Drayton et al., 1998). According to Drayton and colleagues there is a strong correlation between the measures with regard to test-retest reliability ($r = 0.81$; $p < 0.002$) and internal reliability ($\alpha = 0.73$). In the second study reported by Drayton et al. (1998) the correlation between the measures was found to be $r = 0.92$ ($p < 0.002$).

However, in a later study the correlation was $r = 0.50$ (Modestin et al. 2009). In the alternative scoring method (Tait et al., 2003) the RSQ was used to categorise individuals into four categories; integration, mixed-picture predominately integration, mixed picture predominately sealing over and sealing over (Tait et al. 2003). There were no studies in this review that published data validating this alternative method. A lack of information regarding how the RSQ was scored prevents further replication in other studies but could also indicate that the original research or assessment scoring criteria were at fault.

Correlates of Integration and Sealing Over

Engagement

The total sample size for studies that consider treatment engagement factors was 295 individuals. Integration/sealing over, as measured by the RSQ, have been reported by Tait et al. (2003) to predict engagement over time (ES not reported; $p < 0.001$), measured by Service Engagement Scale (SES; $\alpha = 0.91$). Integrators were more likely, than those who seal over, to receive in psychological therapy (ES not reported; $p = 0.066$; Modestin et al., 2004). Individuals

who had participated in Cognitively Orientated Psychotherapy for Early Psychosis (COPE) were more likely to adopt an integrative recovery style at the end of therapy, than those who do not partake in any therapy (ES not reported: $p= 0.008$; Jackson et al., 2001). Individuals who drop out of psychotherapy are more likely to be sealing over (ES not reported: $p<0.01$), they have poorer engagement with therapists ($r= 0.79$; $p<0.01$) and the working alliance, in terms of task agreement was not as good as between integrators and therapists (ES not reported, $p=0.04$, Startup et al., 2006), However, on other measures of working alliance there were no significant differences between those who seal over and those who integrate.

Stability of Sealing Over/Integration over Time

A total sample size of 74 individuals was used to assess the stability of integration and sealing over. The stability of RS over time was not certain. RS was relatively reportedly stable across time in McGlashan et al.'s study (ES not reported, significance not reported: 1977). Other studies have found that RS is not fixed but can fluctuate. Thompson and colleagues (Thompson et al. 2003) found that 44.4% of participants changed their recovery style over 12 months. The majority of individuals (20.1%) switched over 12 months to an integrative style (from either a sealing over or mixed style of recovery).

Tait et al. (2003) found that RS had a "distinct capacity for change" (p.126) with a predominant shift from integration to sealing over (ES not reported, $p=0.011$).

Insight

A total of four studies explored the relationship between insight and integration and sealing over (Drayton et al., 1998; Tait et al., 2003 & 2004; Fitzgerald, 2010). The total sample size for these studies was 136 people. The relationship between RS and insight is not consistently reported. Fitzgerald (2010) found that in individuals being treated in secure mental health settings recovery style did correlate with insight (ES not reported, $p<0.006$), although Tait et al. (ES and p not reported, 2003) and Drayton, Birchwood and Trower (1998) did not find this relationship (insight was measured with the Birchwood Insight Scale).

Perceptions of Illness

A total sample of size of 50 people was used to assess perceptions of illness. Integration, as measured by the RSQ, was associated with greater perceptions of illness coherence ($r = -0.35$; $p = 0.015$; Stainsby et al., 2010), as measured by the Illness Perception Questionnaire (IPQ). Using the same measure, Integration was also associated with lesser symptom severity and perception of treatment as being more effective ($r = .36$; $p = 0.012$; Stainsby et al., 2010).

Attachment/Parental Bonding

Assessment of attachment variables was undertaken in by three studies (Drayton et al., 1998; Tait et al., 2004; Mulligan & Lavender, 2010), with a sample size of 159. There are conflicting outcomes regarding the correlation between parental bonding and recovery style. Mulligan & Lavender (2010) found no correlations between measures of parental bonding (Parental Bonding Instrument, PBI and Attachment Style Questionnaire, ASQ)) and integration and sealing over, the exception being a moderate, negative correlation on the relationships as secondary to achievement subscale (ASQ; $r = -0.41$; $p < 0.01$); those who seal over have a greater tendency towards valuing achievement over interpersonal relationships. The relationships as secondary subscale was reported to have acceptable reliability in this study ($\alpha = 0.74$), however, the subscale has also been documented as having questionable reliability ($\alpha = 0.68$, Blair, 2007).

By contrast, Tait et al. (2004) found that sealing over individuals rated both parents as being significantly less caring and more abusive on the PBI (ES not reported: $p < .001$). No differences were found between groups regarding perceived parental protection. Those individuals who adopted a sealing over style of recovery were less likely to feel comfortable with closeness in their personal relationships and less likely to feel they can depend on others (ES not reported: $p < .001$. RAAS; Revised Adult Attachment Scale). The sealing over individuals also experienced greater fear with regard to interpersonal rejection (ES not reported: $p < .001$. RAAS). Drayton et al. (1998) reported that those who seal over perceived both mother (ES not reported: $p < 0.02$) and father (ES not reported: $p < 0.002$) to be less caring than the integrators did.

Associations with Clinical Picture

A total sample of 421 individuals was used in assessing mental ill health symptoms. Sealing over recovery style, as assessed by the RSQ, is associated with insecurity (ES not reported: $p < 0.01$; Tait et al., 2004), negative views of self (ES not reported: $p < 0.001$; Tait et al., 2004. ES not reported: $p < 0.05$; Drayton et al., 1998) and significantly greater symptoms of depression (Calgary Depression Scale for Schizophrenia) than an integration recovery style (ES not reported: $p < 0.003$; Drayton et al., 1998). Both the ISO and the RSQ correlated moderately with the Calgary Depression Scale; (ISOS $r = 0.51$, RSQ $r = 0.47$).

Modestin and colleagues (2004 and 2009) found that the integration and sealing over were correlated ($r = 0.36$: $p = 0.0014$ & $r = 0.54$: $p < 0.001$ respectively) with negative symptoms of schizophrenia (Positive and Negative Syndrome Scale, PANSS; Kay, Fiazbein & Opler, 1987).

There were significant differences between recovery style and course of psychotic illness. Integration was associated with short duration of illness and episodic illnesses with full remission, where as sealing over was associated with persistent residual symptomatology (ES not report: $p = 0.022$; Modestin et al., 2004).

Thompson et al. (2003) found that individuals who sealed over reported significantly more symptoms (as rated by clinicians; Scale for Assessment Negative Symptoms and Brief Psychiatric Rating Scale) than those with an integrative or “mixed” coping style (ES not reported: $p = 0.003$ & ES not reported: $p < 0.001$ respectively).

Improvement in psychotic symptoms between 3 and 6 months recovery is correlated with increased tendency towards sealing over ($r = -0.34$: $p = 0.03$, Tait et al., 2003).

Outcome

A total sample size of 331 was used for assessing outcome variables. Integration is correlated ($r = .49$) with better “overall outcome” than sealing over (McGlashan, 1987; overall outcome is defined in McGlashan, 1984). Overall outcome is considered in terms of; number and closeness of social contacts ($r = 0.35$: $p < 0.001$ & $r = 0.41$: $p < 0.001$ respectively), percentage of

follow-up time spent symptomatic (sealing over weakly associated with greater persistence in symptoms, $r=0.31$: $p<0.001$) and percentage of follow-up time spent in employment ($r=0.40$: $p>0.001$). Similarly, quality of life outcomes were worse in sealing over individuals than in “mixed” or integrated individuals (ES not reported: $p<0.001$; Thompson et al., 2003).

Integrative recovery style was found to have positive correlations with QoL ($r=-0.34$: $p=0.017$) and life skills ($r=-0.32$: $p=0.022$), at baseline, as measured by the Manchester Short Assessment of Quality of Life (MANSA, $\alpha=0.79$; Stainsby et al., 2010). However, no associations were found between integration and sealing over and perceptions of mental health problems and treatment outcomes at two year follow-up. Therefore, although integration and sealing over do influence quality of life, they do not mediate the relationship between perception of problems and outcomes (Stainsby et al., 2010).

Psychological Defensiveness

A single study (D’Angelo & Wolowitz, 1986) considered psychological defensiveness with a total sample size of 53 being used. Both recovery styles are associated with similar levels global defensiveness (Defense Mechanism Inventory, DMI; Gleser and Ihilevich, 1969) and social functioning (Community Adaptation Schedule, CAS; Roen & Burnes, 1968). However, in contrast to integration, sealing over is significantly associated with more primitive, Reversal type defences, including denial, negation and repression ($r=.79$, $p<0.001$), as opposed to more sophisticated forms of defence (D’Angelo & Horowitz, 1986).

Methodological Critique

Overview

Across the studies the reporting of independent evaluations of validity and reliability of assessment measures was inconsistent. Convenience sampling was utilised in all of the studies. Convenient samples are not necessarily representative of the wider population and thus any results or conclusions can, at best, only tentatively be applied to said populations. Three studies focused upon a first episode of psychosis sample (Mulligan & Lavender, 2010; Thompson et al.,

2004; and Jackson et al., 2001), four studies use inpatient samples (Modestin et al., 2009; Modestin et al., 2004; Startup et al., 2006; McGlashan, 1987; McGlashan et al., 1977) the remainder use samples from recovering, community-based populations.

There was a lack of reporting of statistical power in the studies, with only two articles including this information (Mulligan and Lavender, 2010; Fitzgerald, 2010). All studies used parametric statistics to evaluate the data despite both the RSQ and the ISOS providing bi-modal distribution of data rather than normal distribution. The use parametric statistics when non-parametric statistics should be utilised is only discussed in one study (Mulligan & Lavender, 2010). In this instance parametric statistics were applied “...to allow comparison with other studies and to ensure consistency of power across the study...” (pp. 273).

Consideration of Construct Validity

A factor analysis of the 13 sub-scales of the RSQ has never been published, and whole of the RSQ validated on a single sample of 56 individuals (Drayton et al., 1998). The participants were rated as either integrating or sealing over, implying that the sample was highly selective, and not representative of population from which it was selected. The method of scoring the RSQ has not been empirically assessed in the literature. A single, summed score is used to ascertain RS, but the justification for implementing this structure is not documented in the literature.

In later studies (Tait et al., 2003 & 2004) the RSQ is reported to distinguish four different recovery styles, not just sealing over and integrating. No empirical justification for this change in the properties of the RSQ has been published. The sensitivity of the RSQ regarding these categories has not, to date, been empirically validated.

The ISOS, although developed in a different style to the RSQ, has not been constructed via empirical methodology. The constructs that underpin integration and sealing over have not been subject to validation anywhere in the literature.

Discussion

Research Questions and Outcomes

There are two published assessment measures of integration and sealing over, the ISOS and RSQ, which are routinely used in research and clinical practice. The internal reliability of the RSQ was reported to be poor (Mulligan & Lavender, 2010) to acceptable (Drayton et al., 1998), where as the internal reliability of the ISOS was good (Modestin, et al., 2004) to excellent (Modestin et al., 2009). Inter-rater reliability of the ISOS was unequivocally strong (D'Angelo & Wolowitz, 1986; McGlashan, 1987; Modestin et al., 2009). The correlation between the measurements fluctuates between medium (Modestin et al., 2009) and strong (Drayton et al., 1998) implying that the RSQ and the ISOS do not necessarily assess the same phenomena.

There were fluctuations in both reliability and validity for the RSQ within and across studies indicating instability in the RSQ. No factorial validity assessment of the RSQ has been undertaken and remains unconfirmed. The development and the subsequent validation of the RSQ was completed with an inadequate number of individuals (Clark-Carter 2004), and was not reported to have been repeat tested (Drayton et al, 1998). The RSQ was closely based upon the constructs of ISOS. Convergent validity has been measured by Drayton et al. (1998) and Modestin et al. (2009) but has been found to be inconsistent.

Research regarding integration and sealing over has been wide in scope and this is reflected in the variety of study outcomes reported. There is still debate regarding the relationship between attachment style to caregivers and integration and sealing over (Mulligan & Lavender, 2010; Tait et al., 2004). Individuals who adopt a sealing over recovery style tend towards having poorer quality of life outcomes than those who integrate. Integration is associated with a better functional recovery trajectory (Stainsby et al., 2010; Thompson et al., 2003). Over time recovery styles tend to change, with a greater proportion of individuals changing from integration to sealing over (Thompson et al., 2003; Tait et al., 2003). These last two findings taken together indicate that long-term functional outcomes for individuals recovering from psychosis may not necessarily be as great as would be hoped by service user and clinician alike.

Limitations of Studies

Across all of the studies the reporting of the results was incomplete. Frequently the effect size was not reported alongside the significance values which hindered the interpretation of the results. The implication of these omissions of data is that the conclusions and applications of the results may not be an accurate interpretation of the actual findings and as a result validity of the results could be compromised. This is not a failing exclusive to this area of research but has been noted as a failing in research reporting in general (Gigerenzer, Krauss & Vitouch, 2004).

There is a lack of coherence within the published research with little continuity between studies. Different populations are selected for sampling and sampling procedure is always convenience which prevents a depth of knowledge in any particular area from developing.

Of the papers included in this review only a single study (Mulligan & Lavender, 2010) referred to the bi-modal distribution of data that both the ISOS and RSQ produce. In all of the studies parametric statistical assessments are implemented despite the fact that the distribution of data violates the rules for using parametric analyses.

Limitations of the Review

The search terms used were based on diagnostic categories (e.g. schizophrenia) and non-medical alternatives were not considered (e.g. voice hearing). Use of these alternatives alongside the adopted terms may have generated a larger data set for the review. The use of articles that were published in English and no other languages also potentially limited the data set.

Clinical Implications

The failure of an individual to successfully adopt and implement either sealing over or integration is an outcome that has not, so far, been considered in the empirical literature. There is an assumption that an individual will adopt a recovery style and that they will be successful in doing so. Whereas sealing over and integration have been observed and defined extensively,

there is an absence of information regarding failed recovery; change in recovery style over time (Thompson et al., 2003) does not imply failure to adopt the initial coping style.

McGlashan and Levy (1977) discussed the implications that sealing over could have on interpersonal relationships between staff and individuals and also amongst staff members. However, this potentially significant point is not referenced in any of the studies that use the ISOS as the primary measure of recovery style. There is risk that judgements made using the ISOS could be confounded by these interpersonal dynamics, which are often beyond the conscious awareness of the assessor; they may be oblivious to these influences. Within a research context these issues are somewhat reduced if multiple assessors are employed to provide inter-rater reliability. These issues do, however, remain pertinent when use of the ISOS is considered in clinical practice. The interpersonal dynamics between service user and staff is not explicitly addressed in any of the items of the ISOS, although these would be potentially difficult to operationalise. The RSQ does not consider the interpersonal context of integration and sealing over as it is a self-report measure.

Although the inter-personal aspect is not relevant to the RSQ this does not mean that it is immune from potential errors via presentation management. An individual who adopts a sealing over stance, could respond falsely to the RSQ in an attempt to prevent their mental health worker from being inquisitive regarding threatening experiences or in an effort to please or placate their care team. The responses to the RSQ could therefore indicate an integrative recovery style had been embraced by the individual when it would not be so with implications for ongoing clinical.

The language adopted by the RSQ is grounded within a bio-medical conceptualisation of psychosis and operates within the assumption that the individual interprets their experiences as being the result of “mental illness”. The use of this language is problematic when an individual does not share this conceptualisation but instead have idiosyncratic explanations of the cause of the problems. An individual could adopt an integrative stance regarding their experiences but in the same instant not acknowledge illness as the cause. This could, theoretically, result in inaccurate interpretation of responses to the RSQ. The same style of

language is also integrated into the ISOS, however, the influence that this has on assessment of integration and sealing over is largely negated as the basis of the scoring is not the individual's self-report.

Research Implications

There is a lack of theoretical coherence with which to guide research resulting in substantial variability in research questions and study populations. The outcome is a research field which lacks a consistent narrative and obvious empirical objectives. Continuity between studies and a concerted effort to answer questions that are established by pre-existing research would go some way to redressing these issues.

A key issue raised by Stainsby and colleagues (2010) is whether sealing over and integration are actually opposing poles of a uni-dimensional construct. This postulation has yet to be validated by empirical investigation and an alternative model has yet to be proposed. Further investigation exploring the feasibility of any alternative model needs to be undertaken.

There are residual issues regarding the available tools for assessing integration and sealing over. An exploratory factor analysis of the RSQ should be undertaken to clarify the underlying structure of the assessment tool and to provide factorial validity. There are potential problems regarding the stability of the RSQ due to the variations in reliability measurements across studies, this may relate to problems with the underlying structure of the RSQ and a factor analysis would provide clarity to this issue.

For the ISOS inter-rater reliability is regularly reported, however, it is not clear if these reliability scores relate to the total score (0-6) or the extent to which the individual items are attributed to a participant's behaviour by each clinician. Additionally, the face and content validity of the ISOS, appear to be strong; the observational studies by McGlashan (1975, 1976, 1977) are comprehensive. However, there has been no construct validation of the ISOS to date and this would be prudent as the validity of the constructs (integration and sealing over) in the ISOS underpins the entire field of research.

Conclusion

Integration and sealing over can be assessed by two different measures; ISOS and RSQ. There are potentially important clinical and empirical correlates of integration and sealing over, however, the research to date lacks a consistent direction. Consequently, understanding of the clinical relevance integration and sealing over is diminished somewhat. A more coherent research path should be trodden in order to improve understanding.

There are two major issues that should be confronted with a sense of urgency. The first is whether integration and sealing over are really diametric opposites of the same construct. The second concerns the assessment measures themselves and whether they can be considered to be reliable and valid measures of integration and sealing over when subjected to greater empirical scrutiny.

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Chapter 2: Major Research Project

Non-engagement in psychosis: A narrative analysis of service-users' experiences of relationships with mental health services

David Grinter*

Academic Unit for Mental Health & Wellbeing

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***Correspondence to:**

David Grinter
Academic Unit for Mental Health & Wellbeing
Academic Centre
Gartnavel Royal Hospital
1055 Great Western Road
Glasgow
G12 0XH

Lay Summary

Non-engagement is a common problem for health services. It is considered a particular problem for people with psychosis with a significant number not receiving input from services.

The relationships between service-users and clinicians have been identified as being important reducing non-engagement with services. Understanding of what causes non-engagement is not completely understood and one such area is the extent to which requirements of engagement with mental health services represent a threat to the individual's sense of freedom.

Reactance theory attempts to explain why individuals often do the opposite of what is asked of them, such as taking medication. Everyone values freedom, and when that is under threat they can attempt to address this by doing something different to what is expected. The dynamic and changeable nature of relationships is not reflected in reactance theory and exploration of stories service-users tell provides an opportunity to develop an understanding of the intricacies of these relationships. This study aimed to exploring individuals' experiences using qualitative research methods using narrative analysis to develop understanding. Eleven participants recovering from psychosis were interviewed. The stories appeared to be narrated by different voices; Defiant, Subordinate and Reflective-Conciliatory. These voices all exist within individuals and offer different perspectives on experiences.

Narratives surrounding recovery and engagement with services can appear complex, contradictory and fragmented. Understanding of the complexity of stories may be helpful for clinicians in having an awareness of the different understandings individuals may have of their experiences of recovery and with services.

Abstract

Introduction

Non-engagement with treatment is a familiar problem for health services and has been identified as a particularly important issue for those who experience psychosis. The therapeutic relationship between service-users and clinicians is considered to be crucial to good engagement. The extent to which requirements of engagement with treatments and mental health services represent a threat to the individual's autonomy is a potential factor in non-engagement. Reactance theory has attempted to explain this phenomenon. However, relationships are complex and reactance theory does not reflect this. The exploration of narratives is an opportunity to develop an understanding of the intricacies of these therapeutic relationships.

Methods

Interviews were conducted with 11 participants who were recovering from an episode of psychosis. Narrative Analysis of the transcripts was undertaken. During the process interpretation of the transcripts required the introduction of Dialogical Self Theory.

Results

Three self-positions were identified through which participant's narrated their experiences. Defiant, Subordinate and Reflective-Conciliatory positions were described.

Discussion

Narratives surrounding recovery and engagement with services can appear complex, contradictory and fragmented. They are narrated by different self-positions. This understanding of the complexity of narratives may be helpful in guiding clinicians in maintaining a wider awareness of the multidimensional nature of individuals' understandings of their experiences of recovery and relationships with services.

Introduction

Adherence, Engagement & Compliance

Non-engagement with treatment is a familiar problem for health services. Compliance, adherence and concordance are all terms which have been used to describe engagement, though the precise meaning of each is subtly different from the other. Compliance has been described as *'the extent to which a person's behaviour coincides with the medical advice given'* (Sackett & Haynes, 1976 cited in Nose, Barbui & Tansella, 2003, pp. 1149). Adherence has also been defined as *"the extent to which the patient's behaviour matches agreed recommendations from the prescriber"* and that *"there should be agreement between professional and patient about the prescriber's recommendation"* (NICE, 2009, pp.1). Finally, concordance refers to the anticipated outcome of the agreement between the clinician and service-user regarding treatment, with the parties working collaboratively to help achieve the goals (Pound, Britten, Morgan, Yardley, et al., 2005). These definitions reveal differences in how the nature of the relationship between "prescriber" and "patient" is conceptualised. In practice the terminology is used interchangeably but for ease of understanding the term *engagement* will be used throughout this document. Engagement encompasses more than just compliance with medication and is, instead, a multifaceted concept including attendance with appointments, help-seeking during a crisis, availability for appointments and adherence with treatment (Tait, Birchwood & Trower, 2004).

Overall rates of non-engagement in individuals with psychosis have been estimated at 24% (Nose, et al., 2003). Adherence to anti-psychotic medication amongst individuals with psychosis is consistently reported to be poor with up to 74% of individuals discontinuing oral medication within 18 months of commencing treatment (Lieberman, Stroup, McEvoy, et al., 2005). Median level of engagement with mental health services following hospitalisation have been estimated at 58% (Kreyenbuhl, Nossel & Dixon, 2009) and approximately 30% of service users will disengage completely from mental health services (O'Brien, Fahmy & Singh, 2009). The large degree of variance between the rates reported across studies may be due to type of assessment measures used or variability between samples. Rates of adherence to maintenance

medication in other health conditions generally report wide ranging levels of engagement (e.g. 20-60% in diabetes, Walker, Molitch, Kramer, Kahn et al., 2006). Even in clinical trials where participants are monitored more closely than in clinical practice, adherence rates can vary from 43-78% (Osterberg & Blaschke, 2005). There is sufficient evidence to indicate that a significant proportion of individuals who have been diagnosed with psychosis do not receive input from services, either by failing to engage in the first place or dropping out of care (O'Brien, Fahmy, Singh, 2009).

Psychosis and Therapeutic Engagement

Although issues of engagement transcend many mental health problems they appear to exert particular influence in individuals who experience psychotic symptoms, such as requirements for long-term treatment and more frequent out-patient appointments to reduce risk of relapse (Nose, Barbui & Tansella, 2003). Failure to engage with maintenance anti-psychotic therapy places individuals with psychosis at risk for exacerbation of psychotic symptoms, increased clinic and accident & emergency department (A&E) attendance, as well as re-admission to hospital (Fenton, Blyer & Heinssen, 1997). Service users who are not engaged with services are significantly more socially-impaired and have an increased risk of admission to hospital (Killapsy, Banerjeem King & Lloyd, 2000).

Service user and clinician perspectives of the therapeutic relationship, medications, insight and treatment choice are an important source of understanding engagement (Stanhope et al., 2009; Tranulis, Corin & Kirmayer, 2008; Lang, Davidson, Bailey & Levine, 1999). Service-users and clinicians regard a strong, positive therapeutic relationship as being integral to successful engagement (Boydell, Stasiulis, Volpe & Gladstone, 2010; Stanhope, Henwood & Padgett, 2009; Green, Pole, Janoff, Castleton, et al., 2008; Seale, Chaplin, Lelliot & Quirk, 2006; Priebe, Watts, Chase & Manatov, 2005). Being provided with good information, working collaboratively with supportive clinicians (Boydell et al., 2010; Green, et al., 2008; Kikkert, Schene, Koeter, Robson, et al., 2006; Forchuk, Jewell, Tweedell & Steinnagel, 2003), ensuring that

medication is not the sole focus and feeling that one was treated seriously are considered by service users to be pertinent to a successful therapeutic relationship (Stewart, Anthony & Chesson, 2010; Priebe, et al., 2005; Kilian, Lindenbach, Lobig, Uhle et al., 2003). The service-user needs to be treated as an individual and the relationship should be accepting and warm; not feeling comfortable with the clinician can lead to non-adherence (Green et al., 2008). Having continuity of care is important for establishing strong therapeutic relationships (Green, et al., 2008; Crawford, de Jonge, Freeman & Weaver, 2004). Clinicians do not necessarily place such importance on provision of information, carer involvement and ongoing support in maintaining engagement with medication (Kikkert et al, 2006), considering medication to be the most important aspect of treatment of psychosis (Seale et al., 2006).

Whilst psychiatrists agreed that honest relationships were important they would withhold information from service-users if they believed this to be in their best interests (Seale et al., 2006). A proportion of service-users would be willing to act against advice regarding medication if they considered it to conflict with their own opinions (Kilian et al., 2003). Medication side-effects were one of the primary causes of non-engagement with treatment attributed to service-users by psychiatrists (Seale et al., 2006). Clinicians recognised side-effects to be unpleasant for service-users but refrained from sharing this information, fearing motivation to comply would diminish (Kikkert et al., 2006). In parallel, there is also a distrust of the information about medication provided by clinicians is common amongst service-users (Pound, Britten, Morgan, Yardly et al., 2009). Concern about the side-effects of medication can result in experimentation with dosage in order to reduce these (Angermeyer, Loffler, Muller, Schulze & Priebe, 2001). Service-users did not disclose changes they made to their medication due to fear of coercion and "*an awareness of their powerless position*" (Pound et al., 2005, p.149). Service-users can also experience "imposed compliance" whereby friends, relatives and clinicians can exert pressure to stick with treatment despite the individual wishing not to (Usher, 2001). Involuntary hospitalisation and other mandatory treatment can be a barrier to future engagement (Compton, 2005) in many instances, however, service-users do not wish to be part of a joint decision making process preferring clinicians to assume responsibility (Stewart

et al., 2010). Both service users and clinicians regarded a trusting relationship as key to engagement (Green et al., 2008; Usher, 2001). Research to date has obviously not exhausted the factors that may have a potential role in explaining non-engagement. One such factor is the extent to which requirements of engagement with treatments and mental health services represent a threat to the individual's autonomy.

Reactance Theory

Reactance theory (Brehm, 1966, Brehm & Brehm, 1981) proposes that all humans have a desire for freedom. Freedom is defined as the number of behaviour alternatives an individual has available to them in any moment. Individuals must hold a concrete sense of freedom, it cannot be abstract, and have awareness of it in order for reactance to occur (Rains & Turner, 2007). When this freedom is threatened it stimulates the arousal of a motivational state that drives the restoration of autonomy. This motivational state is known as reactance. This reaction is common when individuals feel obliged to engage in particular or restricted behaviours. Threats to freedom can come from more powerful social agents via implied warnings but they can also come from those with lower social status by "*an irreversible act that eliminates materials necessary for freedom*" (Rains & Turner, 2007; pp.242).

The theory attempts to explain why individuals will often do the opposite of what they are instructed (e.g. refuse to take medication) and why attempts at persuasion can be futile. When reactance is aroused a number of potential responses can be evoked. A *boomerang effect* (Brehm, 1966) may occur in which the individual will, paradoxically, engage in restricted behaviours (Buller, Borland, & Burgoon, 1998) in an attempt to reassert the freedom that has been impeded. Evocation of reactance can encourage the individual to adopt unfavourable attitudes towards the behaviour that has been imposed (Rains & Turner, 2007) and potentially cause aggressive behaviours or attitudes towards the agency that imposed the restrictions (Baumeister, Catanese & Wallace, 2002). Reactance may make the lost freedom appear more desirable to the individual than it was initially (Brehm, Stires, Sensenig & Shabban, 1966) or

prompt the individual to partake in different freedoms in an attempt to reinstate autonomy (Quick & Stevenson, 2008; Wicklund, 1974). Alternatively, the individual may deny that a threat exists (Worchel, Andreoli, & Archer, 1976).

Very little research has been conducted regarding psychosis and reactance, possibly because assessments of reactance have been criticised as being unreliable (Shoham, Trost & Rohrbaugh, 2004), however, there is but one notable study regarding reactance and psychosis. Moore, Sellwood and Stirling (2000) found that insight and reactance were not related and that the most significant factor in predicting non-compliance was reactance. Whilst the level of reactance was correlated with perception of treatment as a threat to freedom, reactance was found only to correlate with past compliance not current behaviour. The authors hypothesised that these individuals had developed greater insight or had gained a greater subjective response to their medication in order to account for these findings.

Reactance is aroused in different contexts and requires a combination of factors to interact for this to occur. Increase in the magnitude of reactance is a direct function of the size of the perceived threat on freedom (Fogarty, 1997). Four factors influence the magnitude of reactance. Firstly, reactance will only be aroused when an individual believes there is any freedom with regard to a potential outcome (Brehm & Brehm, 1981). Secondly, if the individual has attractive options impeded or eliminated; the level of arousal is dependent of the importance the individual places in the alternatives (Brehm & Brehm, 1981). Level of reactance is related to the number of freedoms threatened. Finally, implied, as well as actual, threats can trigger reactance (Brehm & Brehm, 1981).

Reactance theory has attempted to explain why individuals do not always engage with treatment. Interpersonal relationships between service-users and clinicians can be complex. The dynamic and changeable nature of these relationships is not reflected in reactance theory, which suggests that individuals will attempt to reassert autonomy when confronted with threats. The nature of these threats cannot simply be defined by requests to accept some form of treatment or other but are likely to involve a more complex range of interpersonal cycles arising from and

through both the service user and the clinician. For example, Dozier, Cue and Barnett (1994) have shown that interactions between case managers and service users diagnosed with schizophrenia and bipolar disorder is related in the interaction of their respective attachment states of mind.

Another issue is the understandings gained of reactance through the use of self-report methods. Scott (1990) has described that there can be differences between explicit (public transcripts) and hidden behaviours (hidden transcripts) when freedoms are perceived to be threatened. Indeed, clinicians themselves admit to engaging in these forms of communication when addressing issues of medication compliance and avoiding issues of side-effects (Kikkert et al., 2006). This further illustrates the complex nature of these relationships and highlights the need to explore understandings of engagement as reflected in narrative. Narrative analysis is a qualitative method of empirical investigation which allows individuals to recount stories of their experiences, how they link these, and attempt to make meaning from them (Murray & Sargeant, 2011; Gray, 2001). The exploration of narratives is an opportunity to develop an understanding of the intricacies of these therapeutic relationships, from the perspectives of the service-users. Narratives are stories that an individual creates to give meaning to their experiences within the context of their lives (White & Epsom, 1987). They are constructed when the individual makes connections between time, place, affect and cognition and not only tell the story of who an individual is but who they are in relation to others. Narratives are constructed within a social, political and cultural context (White & Epsom, 1990) and they convey only one view of “reality” of any given situation or problem. By exploring these narratives we can gain an understanding of the way in which interpersonal relationships with service providers are experienced by service-users and whether this may shed light on the processes of engagement and the development of mutuality of tasks and goals (or the lack of). The ways in which service-users recount stories of these relationships, their experiences of services and of psychosis will be the focus of this study.

Methods

Participants

Participants were attending mental health services in NHS Lanarkshire (NHSL). Eligible participants were identified in collaboration with key-workers. Participation was voluntary. Participants were fully informed of the aims and procedures involved in the study and all gave written informed consent. Ethical approval was granted by the NHS West of Scotland Research Ethics Committee (Ref: 11/S0701/1).

Inclusion & Exclusion Criteria

All participants were recruited from Community Mental Health Teams and Psychiatric Inpatient Wards and met the diagnostic criteria (either DSM-IV or ICD-10) for Schizophrenia. The diagnosis was verified by the respective key-worker. Participants were aged 18 and over. Having experience of difficulties with engagement with mental health services was a necessary inclusion criterion; this was judged by the key-worker. Participants were judged by the key-worker as able to exercise capacity to consent and patients legally detained in hospital were also eligible for the study. Individuals were excluded from the study if the primary cause of their symptoms was considered to be the result of organic disorder or traumatic brain injury. Those individuals with an Intellectual Disability, inability to understand and speak English fluently and those who were acutely psychotic at the time of the interview were excluded from participation in the study.

Procedure

Each participant was interviewed once. All interviews were conducted in a room in a Community Health Centre, Psychology Department or attached to hospital ward. Interviews were digitally recorded and lasted between 40 and 75 minutes. The interviews were transcribed in entirety and subjected to analysis.

The Recruitment Process

Eight Community Mental Health Teams (CMHT) were contacted and three failed to respond to requests to recruit participants from their caseload despite repeated attempts to establish contact. All three Psychological Therapy Teams that were contacted responded to requests for participants. During meetings with the CMHTs who opted in to the research there were a number of interesting responses, documented in the lead researcher's logbook. Some clinicians expressed doubts over the usefulness of the research since they understood why service users did not engage already. In addition, there was some pessimism expressed suggesting that service-users who would be ideal for the study wouldn't attend interview due to problems such as lack of willingness to talk, poor concentration or lack of insight. These expressions lead to concerted efforts to engage Community Mental Health Teams in the research process through visits and presentations. Of the eight teams contacted two contributed to the study.

The Interview Schedule

The initial interview was composed of five questions, and a series of prompts, that aimed to gain an overview of the individual's experiences of mental health services, develop a timeline and orientate the individual to telling their story, exploring supports over time, developing an understanding of autobiographical memories and finally allowing for development of reflections. Having piloted the interview with two participants it became apparent that there would be a requirement to adapt the schedule due to a lack of autobiographical memories that were elicited. There were no changes to the wording of the questions in the schedule but a number of prompts were introduced to modify the schedule in an attempt to address the problems. Addition prompts included *"can you give me an example of that?"*, *"how did you feel about that?"*, *"how did you feel about this particular aspect of the relationship?"* and *"How do you, now, feel about these changes?"*

Transcripts

The transcripts were prepared using colloquialisms and local dialect. This was undertaken in an effort to retain authenticity and to preserve meaning that is conveyed by idiosyncratic use of language.

Analysis

There is no singular and accepted way of conducting Narrative Analysis (Murray & Sargeant, 2011; Phoenix, Smith & Sparkles, 2010). There are multiple ways in which researchers can regard and explore their narrative data (Elliot, 2005). It is an umbrella term for techniques that allow one to understand the way(s) in which an individual try to make sense of their world and how they attempt to make sense of their reality (Phoenix et al., 2010). Narrative analysis is as much about how things are said as it is about what is said by and individual. Two broad categories of analysis have been proposed; *story analysts* and *storytelling* (see Phoenix et al., 2010 for a detailed explanation). The method of analysis used in this study is consistent with a story analyst approach; stories are invited and collected before analysis is conducted. In keeping with Thornhill, Clare & May's (2004) method of analysis the stories were considered as a whole but distinct sections were also explored if this was deemed relevant. The approach to analysis evolved and changed as the study developed, with analysis generating a feedback loop that prompted new questions and introduced new ideas and perspectives through which to observe the data.

Once the transcripts were completed and anonymised they were each subjected to line-by-line analysis and coding of content. Following completion of this initial analysis, coding of sections was completed with a focus on content and tone. These data was then subjected to a third level of analysis involving connecting content and developing themes, with consideration given to the narrator positions and the structure and coherence of the narratives. It became apparent during the analytic stage that the stories appeared to be narrated from different perspectives throughout. This was most obviously characterised by apparent contradictions,

fluctuations in tone and the expression of seemingly conflicting ideas within the narratives. For example, in the case of Norman he initially spoke rather positively about his current relationships with the community mental health team and psychiatrist. However, as the interview progressed his regard for the psychiatrist changed considerably, with him stating that he *“never got on with a psychiatrist at any level at all.”* Similarly, Russell offered a number of different explanations for the cause of his problems throughout the interview. In one short period of time he inferred that the medication caused him to experience a psychotic episode before indicating that the source of his psychotic experiences was spiritual. These apparent contradictions were a source of some puzzlement and confusion during the analytical process and during supervision, alternative theoretical perspectives that were faithful to a narrative based understanding were considered. Dialogical Self Theory (DST; Hermans, 1996) offered a helpful framework for understanding the co-existence of different narration perspectives within and across individual transcripts.

Within DST, individuals are considered to be ‘communities of selves’ (Doan, 1996; as quoted in France & Uhlin, 2006) with each person having multiple self-representations which have differing and varied points of view. The different self-representations can conflict or complement each other; or they may ignore each other. Self-representations include both internal and external positions and are bound to particular contexts or people (Lysaker & Hermans, 2007). The dialogical self is not simply conversations within the mind but incorporates complex exchanges with the external world (Lysaker, Lancaster & Lysaker, 2003; Vygotsky, 1978). DST posits that an individual’s concept of the self is a result of a perpetual process of amalgamation of the various self-representations in to a sense of identity coherency (Lysaker, Lysaker, & Lysaker, 2001). There exists a hierarchy among the self-representations which is flexible, allowing different representations to exchange positions depending on context. Different self-representations will assume a dominant position with the others retreating to the background within these changing contexts (Hermans, 1996). With this theory as a starting point the narratives were further analysed with the aim of exploring different self-positions which exerted dominance at different points during the story.

Self-positions

In keeping with DST, attempts were made to identify different self-positions that made themselves available in the narrative; the dominant self-position may fluctuate as the narratives progressed. Different self-positions may arise during the course of a narrative to give differing accounts/perspectives of the same event. Stories are told by individuals in order to help them make sense of experiences and stories require a narrator. The narrator's perspectives are considered to be the self-positions (this is analogous to the narrative technique of identifying *positions* within stories; Murray & Sargeant, 2011). The stories generate ideas and create a context within which exploration of experiences occurs. Key events or topics are elicited by the story telling process and such changes in focus also alter the context of the story telling in a symbiotic manner. Self-positions are characterised by the tone and inflection of the narratives; changes to these denote switching of self-positions.

Tone

Identification of the dominant tone or tone is achieved by reading and re-reading the texts. This is done early on in the analytical process in order to develop a general understanding of the narratives and to try and characterise the stories being told. The subjective response of the researcher to the narratives forms part of the analysis as much as the participant's manner of telling the stories does.

Narratives

The identification of a narrative is attempted in order to characterize key aspects of narratives as a whole, either individually or collectively. In this analysis no attempt was made to identify a core narrative which would fit the whole account. To reflect the breadth and depth of topics that could constitute an account of engagement behaviour and relationships with mental health services multiple narratives were identified/described. Thornhill et al., (2004) tried to

summarise core narratives in a phrase or a few words; replication of this practice was attempted in this study.

Results

Participants

A total of 12 people agreed to take part in the study. One of these people subsequently opted out of participation prior to the interview taking place. In two instances the participant did not provide sufficient information in the interview for any analysis to be undertaken. The participants were predominantly male (n = 88.8%) with a median age of 45 years (range 30-56 years of age). Most of the participants' engagement difficulties were related to medication and non-attendance at appointments was a problem in a third of participants. Other engagement difficulties included being available for Community Psychiatric Nurse (CPN) domiciliary appointments, non-engagement with psychological therapy work and failure to accept agreed hospital admissions. Table 1 provides a summary of the demographic information.

Table 1. Participant Demographic Information

Participant	Gender	Age	Non-engagement	Venue
Russell	M	54	Medication	Psychology
Norman	M	32	Medication	CMHT
Andy	M	45	Medication / Hospital Admission	CMHT
Diane	F	30	CPN Visits / Appointments	CMHT
Michael	M	40	Medication	CMHT
Max	M	56	Appointments / Medication	Hospital
Bradley	M	46	Appointments / Medication	Hospital
Gillian	F	48	Psychological Therapy	Psychology
Luke	M	38	Medication	Hospital

Stories

Within the narratives a number of stories emerged, many of which were recounted by multiple participants. All of the participants gave accounts of their experiences of relationships with staff, within in-patient and out-patient settings, and tightly allied to this was the role of power within these relationships. Positive qualities and elements of these relationships were present, such as being listened to by the clinician and having non-problem focussed dialogue in appointments, alongside less favourable aspects, such as perceived lack of understanding and empathy and inconsistent care. There were explicit, and subtle, references to the level of power one had in relation to the clinicians. The relative lack of power was regularly highlighted by accounts of compulsory treatment, use of depo-injection medication and experiences of being on an inpatient ward.

Medication was a prevalent topic within the narratives. The benefits of taking medication were occasionally described by participants but these accounts were also balanced against experiences of feeling excessively medicated, perceptions of medications being used by staff as an easy option to cope with service user problems and of medication having no subjective effect on symptoms.

A further group of stories existed regarding the stigma of psychosis in society. The negative connotations of stigma, such as feeling worthless within and ostracised by society featured most prominently. In contrast to this there were positive accounts of stigma being the platform from which group projects and contributions to voluntary services were launched.

The final selection of stories revolved around considerations of the role of service-user both as an out-patient, an in-patient and within a wider societal context. These stories often explored relationships between the participant and other service-users. Again, there are both positive (e.g. finding support from fellow service users) and negative accounts (e.g. not being valued by others) regarding this topic.

None of these types of stories could be used to distinguish between individual participants. Each participant revealed multiple stories throughout their interviews and the relative dominance of these stories within each narrative varied between individuals.

Self-Positions

There were a variety of self-positions evident in the narratives of participants. Defiant, Subordinate and Reflective-Conciliatory positions were observed across narratives, although not all participants exhibited all of these different self-positions.

Defiant Self-Position

Voices: Offended, Insulted, Resentment

Tone: Aggressive, Energetic, Angry, Derogatory, Defiant

Content: Power, Relationships with Clinicians, Stigma, Medication, Role of Patient

One of the most common self-positions from which individuals narrated their lived-experiences is that of anger. These self-positions were situated in relation to a number of contexts and did not form a homogeneous group but, rather, shared similarities with each other. There was a universal comprehension of the power which mental health services held over patients. Predominantly power was represented by mental health sections or compulsory treatment orders but was also seen in the machinations and rules within inpatient wards. Compulsory admissions to psychiatric wards were acknowledged by the participants to curtail their freedoms and this was something that was difficult for individuals to accept. Often freedom was associated with the ability to move freely, or to have choices about where one could go. Max,

Luke and Michael all drew attention to the constraints of space within the hospital setting and the restrictions placed on the patients in leaving the ward.

Max: *"I didn't like being constrained".*

Interviewer: *"Okay. In what way were you constrained?"*

Max: *"Uh, freedom to come and go. Uh,...(6 second pause)...that didn't come 'til later. I had to fight to get that."*

Michael: *"The ward was very much to do with medication and constraint of space to, you could-, couldn't go out at certain times."*

Both Diane and Luke indicated that they did not believe their admissions to be valid and expressed some antagonism towards mental health services because of this:

Luke: *"I feel, feel it's wrong, it was unjustified."*

Diane: *"But some of the times that I've been in I could, do it at home. I really didn't need to be hospitalised."*

Bradley spoke about the side effects of the medication and the fact that he felt the nurses ignored his complaints of these. Anger occurred in response to being made to feel insignificant and the one's opinions were not afforded any value or worth by staff.

Although a positive account of relationships with staff was generally offered by Gillian the angry self-position took over her story when discussing a member of the inpatient ward staff.

Gillian: *"...why on earth would I seek the advice of a 17 year old lassie who's had no training...Are you daft?"*

The angry self-positions often assumed the dominant position when the narrative focused on perceived injustice such as not being listened to, being asked to work with some deemed unqualified or being asked to take medication that does not appear to be effective. The narrative could become derogatory in tone at times, with disparaging remarks made regarding treatment or an individual. Norman expressed his lack of faith in medication and its subjective lack of efficacy:

Norman: *"I mean, I felt some of the medication was, um, absolutely rubbish, you know?...I never felt it worked out great at any level at all."*

The use of medication as a means of exerting control was more commonly referenced, such as Russell's assertion that medication provided a "chemical lobotomy." Diane and Michael used the phrase "doped up" to describe the experiences of medication and that in Diane's case she was given no other options despite believing that she should have had the opportunity to speak about her problems. A perception that many clinicians concerned themselves primarily with medication during appointments was expressed frequently, as was a sense that one's problems were not adequately heard. These issues seemed to form the basis of fragile and

fractious relationships with clinicians. Max described his frustrations with one of his psychiatrists as:

Max: *"I felt this one was, uh, grounded and, uh, built up around medication. I felt, uh, medication was the be all and end all of existence."*

Stigma was a common theme amongst the participants. There was an awareness of negative perceptions that others have of mental health problems and how pervasive these beliefs are. There was anger towards society in general for continuing to hold such views but also towards individual's who pronounced such opinions.

Michael: *"...general society has got an improper view of mental [ill] health. It's the first images that comes is van Gogh cutting his off his ear and shooting himself because he had Bi-Polar."*

The tone with which Michael expressed the first point was sharp and tinged with resentment, as though this was an inappropriate and restricted way to consider mental ill health. The second point was very much defiant in tone and expressed a resistance to the idea Michael believed society to have of those with psychosis; that they cannot function. Andy did not hide his anger towards those who intended to ridicule him due to his mental health problems. This often led to confrontations and police involvement as Andy could become aggressive towards other members of the public:

Andy: *"I suppose I was angry at the time. I, more noo I try tae keep my temper. ...(4second pause)...I think it's easier noo that I have been diagnosed and everybody round about me knows that tae dae."*

...(3 second pause)... *But you still get the odd snipes now and again. You see the Joe Bloggs in the street saying 'he's a nut case.' It makes me angry...I don't think anybody should be judged"*

Feeling that one's problems were not given their due by clinicians was vexing for individuals and formed part of the narrative of relationships. These experiences implied that service users wanted to feel valued by the professionals responsible for their care, and that there should be a sense of equity in the relationships. Following an attempted suicide Diane couldn't understand why no-one had asked her why she had done it.

Diane: *"Instead of just giving me medication and putting me to bed and leaving me there. I just, I feel as if I should have been spoke to instead of just doped up."*

She reflected that things would not change if they remained unspoken and attempted to reason why staff took this approach; without finding a resolution. Similarly, Gillian talked of her experience of one psychiatrist whom she felt was dismissive of her and made Gillian feel as though she was an inconvenience. It was observed by Gillian that this particular individual was perhaps *"...in the wrong job."* Norman expressed frustrations with the services and increasingly criticised their practices and conduct towards him. Near the end of the interview he indicated that he had learned *"not necessarily to trust a psychiatrist at any level at all"* and that he *"never liked a psychiatrist at any level at all."*

Subordinate Self-Position

Voices: Sorrow, Passive, Bewildered

Tone: Meek, Mournful, Fearful, Acquiescent

Content: Power, Relationships, Diagnosis, Stigma, Medication

Diane's fear of being admitted to a ward made her unwilling to share certain information with her psychiatrist in the belief that they would place her under section. Diane reflected that she was willing to share this information with a psychologist because she *"...didn't think the psychologist had the authority to do anything."* The unwillingness to share information was echoed by Russell and Andy who also both feared being *"locked up."* Both men engaged with services but held back from fully engaging because of the potential threat of being admitted to hospital. The service-users acquiesce to the wishes of the clinicians enough to avoid any repercussions. In response to the use of power many participants described acquiescing to authority and being compliant with the rules. Bradley recounted an early admission to hospital and the staff had described him as *"no problem"* which he had construed as meaning he did not complain about aspects of life on the ward which bothered him:

Interviewer: *"Why didn't you complain about it?"*

Bradley: *"I don't know, I just didn't complain about it."*

Interviewer: *"What would have happened? What do you think would have happened if you had complained?"*

Bradley: *"They would be strict, they would be more strict with you."*

The above excerpt details Bradley's submissive relationship with ward staff. In response to a perceived, if unlikely, threat, Bradley proffered no resistance and did not exercise his rights as a service-user. In this instance subordination to authority and compliance with the ward orthodoxy was the preferred course of action. In keeping with the theme of the service-

user's role Gillian considered that one needed to learn to fulfil the role expected of them on the ward:

Gillian: "If you're a patient in there you better be patient, because when you think you're seeing the psychiatrist once a week, and you've been told you're seeing him at 11 o'clock and you've got up and you've had your breakfast and you've had your shower and you're ready at 10 o'clock and you still haven't been seen by 1 o'clock. And you go up and you're like that and it's always the same answer "Well he's seeing somebody the now"... obviously, some people have gone through a lot in the last week so they have a lot they need to talk to. So you do have to be patient because they are entitled to see the doctors just as much as you are"

Gillian chose not to object to the situation that has presented itself and went along with what is expected on the ward; in her words to be "*patient*". There was no defiance or confrontation, just a reluctant acceptance of the status quo prevailing. These notions of powerlessness and reluctant acceptance were echoed by Michael when offering his insight into the power structure within the ward:

Michael: "As a person in the hospital, you're just a small, a small piece of flotsam or a small boat on a big, on a big ocean amongst very tumultuous waves. And you just have to ride whatever, whatever is thrown at you, you just have to kind of accept. You have no form of redress or ...(7 second pause)...or standing within society within the ward or the hospital. The top dog is the psychiatrist and it works its way down, you know, all the way down to the patient. The patient isn't number one. The psychiatrists and the nurses are the people with the power. And, uh, you just have to accept that and hope for the best."

Although stigma was generally spoken of with anger and a sense of unjust, at times the language adopted by the individual's indicated that stigma had become internalised and they yielded to this negative view of themselves. Michael, conveyed his understanding of how he believed society perceived him:

Michael: *"...being ridiculed by society instead of being esteemed or functioning in a positive manner, that contributes to society. But, it's if just went crazy, of not worth, you know, to anybody....it's like having a murder in the family or something. I, it, there's nothing to be proud of..."*

Subordination to stigmatizing views of mental illness was reflected in Diane's use of derogatory terms to describe herself as she imagined other people perceived her. She used the term "looney" to refer to herself in the first person initially before reusing it to describe herself from the perspective of others:

Diane: *"They know I was a looney...a lot of people would say that I was a looney...people don't understand that it's an illness and just label you."*

A fear of being "locked up" was frequently expressed by various participants with Luke expressing disbelief that he could be "institutionalised" despite disagreeing with the doctors' assessment of his problems. When discussing being resident on a ward Luke's tone was flat and weary, this was reflected in the language he used to describe his predicament:

Luke: *"I'd say I was, uh, resigned....basically just complied with them, with the request, yeah. They were insisting. And, and I couldn't do anything...there was nothing much I could do about it so...I lay down and go."*

Luke had believed that his admission to hospital had been voluntary, however, he became convinced that it was compulsory. In response to discovering this he displayed no anger or resentment but just expressed resignation to the situation he found himself in. This was in contrast to a previously expressed resentment towards his psychiatrist for getting him to go in to hospital:

Interviewer: *"So it was compulsory when the doctor said "come in to hospital", it was a compulsory order?"*

Luke: *"I didn't realise anything at the time you know, you...I took more like an invitation but since then I've come to understand that, ay, it's compulsory and..."*

Interviewer: *"And how do you feel about that then?"*

Luke: *"Disappointed, um...(3 second pause)...but at the end of the day you're right enough."*

Diane and Michael used the phrase "doped up" to describe the experiences of medication and that in Diane's case she was given no other options despite believing that she should have had the opportunity to speak about her problems. This continued a theme for Diane regarding her perception of a lack of help from services, which she appeared to have resigned herself to re-experiencing with her current nurse:

Diane: *"I think she'll last about 5 weeks and she'll just trot on her merry way to somebody else. (mmm) That's just the way it's been with CPN's. (mmm) I just don't seem tae achieve any goals."*

Interviewer: "How do you feel, how do you feel about that?"

Diane: *"That's quite sad, because, uh, really the time spent there should have been some achievement or some-, something you could say 'aye, that was really helpful having that CPN' but there's absolutely nothing..."*

Russell had a definite idea of what he believed his freedom should entail and conveyed this to the staff. This freedom, to not take medication, came under overt and significant threat by the administration of a depo-injection. The behaviour (i.e. fighting back) that the arousal of reactance triggered is repressed due to the perceived consequences (i.e. being jailed). The tone was very much defiant to begin with; however, it alters to a more subordinate, subdued tone as Russell recounts his realisation of the consequences of any actions:

"I refused to take the medication 'cause I signed myself in. I said 'I don't need medication'... two days later, three of them jumped me in my room...they got a big needle, like that, and gave me a jab in the arse. And I felt like fighting them and getting out of there. But I said 'if I fight these people, if I fight back, you know, or struggle they're just gonnae lock me up for longer. Or they'll end up chucking me in the jail or something like that...I just don't like getting locked up, I like my freedom, you know?...that's where you don't want to express yourself because you feel as though they've got that threat over you...that they can lock you up."

Reflective Self-Position

Voices: Philanthropy, Acceptance, Empowered

Tone: Calm, Positive

Content: Power, Role of Patient, Relationships with Clinicians

In contrast to anger another common self-position to regularly featured was defined as a reflective-conciliatory position. This position often offered insights and opinions that would be in opposition to the angry position. These self-positions offered a more balanced understanding of an experience or conceded that previous statements may have not been valid. Relationships with services, specifically individuals within services, were prevalent topics. Both positive and negative aspects of these relationships were, to varying degrees, shared by all of the participants. Generalisations were made in many instances, but the story was funnelled down to experiences with specific individuals. Indeed, several participants clarified that isolated incidents or particular clinicians did not necessarily represent teams or professions as a whole. Gillian indicated that her experiences with an inpatient member of staff were not representative of her views of all nursing staff who she praised at great length especially CPN appointments in which she felt comfortable having a “*wee blether*” and not feeling that the focus of the meeting was entirely on her problems. Whilst discussing the NA she offered the following insight:

Gillian: *“She was too young. But, in saying that, how do I know that? Um, she may well have had family that had mental health problems all their lives. I don’t know that.”*

Similarly, Michael expressed concern that his regular psychiatrist had left the role and he was seeing a new psychiatrist at each subsequent appointment. He quickly concedes that “*...psychiatrists have got their own lives to lead...*” which offers a reflection that psychiatrists are

people outside of their professional role. The reflective position is sympathetic in nature and attempts to understand events from the perspective of the other person. Having built up a relationship with this psychiatrist over a number of years, Michael lamented that the appointments with other psychiatrists since then were “...*all just medication.*” He reflected that “...*it would be nice if somebody went through it [his case file] and then addressed me, you know, had a deeper understanding of who I am.*”

Max found his relationship with his General Practitioner (GP) to be more positive as he was able to share his ideas about how to resolve problems and the GP often agreed to implement these. The perception of being listened to and having one’s opinions valued by mental health staff was of particular significant and importance to many of the participants. In some instances medication was seen as being an option that clinicians could take instead of talking and listening to the service user. Norman spoke about the support he received and the relationship he had with his psychiatrist. In contrast to the anger he expressed towards psychiatry at different point in the interview he offer a more balanced account of the relationship without invective:

Norman: “...*[the psychiatrist] was pretty alright but it’s the same script to go through, it’s information they go through and they ask you if you have bettered or gained more happiness from what you wrote down the last time or given them as information and sometimes it’s quite good and that but it depends what way they’re trying to ask you to go you know?*”

The theme of power was also considered by the reflective-conciliatory self-positions. Within the ward, power was evident in the use of medication (Michael: “*We were, just to control us we were doped up to the eyeballs*”) or by the implementation of 24 hour observations such as experienced by Gillian and Andy. Although there was an acknowledgement to the necessity of these in some instances the participants found them to be oppressive and invasive and took

away their freedom to do what they wanted; such as to have a cigarette when one wished. Michael recalled his first admission to a mental health ward and how he perceived the staff there to have all the authority and power and that the patients had little themselves. The tone was calm and level, with Michael recalling the events in a factual manner almost without emotion.

Michael: *"You know, they, they have, they have total control over, of like, the patients, you know...it can be frightening. And people have different reactions, some people lash out, some scream, others, uh, turn inwards, you know?...Well they controlled your access out of the, out of the ward. The doors are locked and then...(pause)...you can only go to certain areas. Other, other doors within the ward are locked. So, you know, you, they could corral all the patients in one room. The cameras could keep them in there, or lock certain doors so that the access wasn't available, as, as punishment..."*

A story from that first stay in hospital which encapsulated an awareness of authority at the hospital and a covert way of subverting it was recounted:

Michael: *"...it just meant that for half an hour or 45 minutes we had the eyes of the establishment, or the powers that controlled us in the hospital, taken off us and we were allowed to go for a walk along a country lane."*

Interviewer: *"And how did that feel?"*

Michael: *"Liberating. Yeah...(pause)...Yeah, a positive experience."*

Taken together these excerpts detail Michael's attempts to create options for himself within a system which he perceived himself to have very few. The act of leaving the ward without permission provided him with a sense of freedom which he felt was omitted from his life on the ward. There was no anger expressed during this story nor was there a sense of subordination, rather there was a reflective, matter-of-fact account of the event, which had a positive impact on the individual. The act may have only created a temporary sense of free will but it was a significant event for Michael and remained hidden from the ward staff.

For Michael and Andy, the experience of psychosis and the associated stigma led them to become involved in service user groups. They channelled the negative experiences into something constructive and positive. Stigma of mental ill health remains a problem in the 21st Century and causes consternation and worry for a significant proportion of service users.

Andy: "I think now that I'm involved with the health service, and that, and a new client comes in I like tae give them the support that I never got, or what, whatever I've learnt... I've got a lot tae give back tae the services. I feel as if...(3 second pause)...if I were tae help somebody, you see, with in the services, I feel like that's my way of gaeing back 'cause they've helped me all these years, my way of saying thanks."

Reactance in Narratives

Reactance behaviours were referenced across the different self-positions. The nature of these behaviours varied slightly between the positions with those mentioned within the Defiant position being overt and protestant in nature. These types of behaviours are often confrontational in nature and can be a challenging for staff.

Andy: "But I don't, I don't, it's no, I feel if I can go in any place like that [Hospital], I'm not getting back out. Does that make sense? I just, I just feel I'm going tae get locked up and I'm no goin' tae see the world again...There was a couple of times there, I was almost in. I decided I was going, I was going in tae hospital. And see whenever the worker was coming tae get me? I jumped on a bus, I knew they were coming fae me, I jumped on a bus and away I go... I says "I'm no goin' in tae hospital.""

Norman: "I don't agree with the diagnosis of schizophrenia psychosis or anything like that. I think they're going to have to prove that an awful lot more than what they have tried to. Um, I've never complained of any condition at any level at all to a doctor or that. Um, they've come up with different conditions themselves."

"They [the ward staff] just prescribed medication, I said I wasn't taking it, you know. I mean, I maybe took it the first night I said that, that's absolutely terrible that, that doesn't fix you. I mean that could have screwed me up permanently as a medication you know?"

Russell: ""...they don't lock up Mediums for hearing voices", I say "I'll speak as long yous don't lock me up", you know what I mean? 'Cause naebody like being locked up, you know? Even going, coming in to hospital is like going in to prison to me."

Reactance within a Subordinate context predominantly consisted of restraint of behaviours due to perceived adverse consequences. The motivation to reassert one's freedom is expressed by the individual but the behaviour that would achieve this is consciously inhibited. The individuals display an awareness of potential consequences and make a judgement to not act upon their desire. A reactant state can therefore occur in tandem with explicit engagement with treatment/services.

Max: "I think that my GP noticed this, there were things I could to the GP about, I wouldn't normally talk to any other doctor about."

Diane: "Um, I've kept back a lot of suicide attempts, I've kept back a lot of things that are happening in my life. Um, for fear that he's just going tae me, put me in tae hospital."

Russell's account (described in the Subordinate self-position section above) , of being given a depo-injection whilst in the hospital illustrates a restraint of reactance behaviour. He prevented himself from fighting against the ward through concern of greater, negative consequences and thus inhibited his own reactance. Other subordinate-type reactant behaviours are not typified by overt defiance, but rather tend to be hidden from services/clinicians. The potential consequences of asserting one's own autonomy are again considered by the individual but attempts to circumvent these are incorporated into the behaviours.

Norman: "I've seen plenty patients down at [the hospital] getting their tablets and putting them in their pockets and then down the sinks with it and get rid of it."

Andy: "Because I wasnae telling them the whole story. I was just trying tae deal with it in my own way."

The Reflective/Conciliatory accounts of reactant behaviours were more covert and subtle in nature compared to the other self-positions. They pose less of a direct threat to engagement with services, but can be potentially challenging for clinicians to deal with. Such behaviours were recounted by Norman:

Norman: "I was offered different types of medication at the start and I said will it work and they said we think it will and I listened to other folk, you know other folk with the same conditions and they told us that this is what I take and I've had this before and I've had that before and they told us you know this one's not that good, this one you won't like, this one is a better one to me but um, I maybe just went with whatever the psychiatrist went with but I was suggested by somebody else Risperadol... I said that I would take that one and they said you can if you want you know we'll give you it through your psychiatrist."

Michaels account of leaving the ward with fellow patients without being supervised by ward staff and having time alone also depicts a reactant behaviour which is not directly threatening as it was unknown to the staff, but would have been challenging to deal with under different circumstances.

Discussion

Stories of relationships with services, both positive and negative aspects, power, medication and stigma featured prominently within narratives and across self-positions. Consistent with Kikkert et al. (2006) participants drew attention to aspects of relationships that they found to be helpful, such as being listened to and not having relationships based around power and medication. Aspects of relationships and services that had been unhelpful were more frequently explored by the participants. The narrative analytical approach allowed for individuals to explore topics that they felt were pertinent and significant to them and thus these topics were spontaneously elicited. The role of power within relationships and systemically within mental health services was both explicitly discussed but also permeated other topics in a more subtle manner. Participants also chose to talk about their medications, sharing their beliefs about its effectiveness and also providing commentary on the way it was given by mental health clinicians.

The narratives that were explored in this study revealed a number of self-positions from which individuals told stories of their life experiences. The self-positions observed within the narratives were labelled as Defiant, Subordinate and Reflective-Conciliatory. These self-positions provided a stance from which individuals storied their experiences. The narratives were not incoherent as had previously been described in studies of DST and psychosis (Lysaker, Lysaker & Lysaker, 2001). Rather, these narratives were understandable but constituted a complex matrix of interweaving themes and experiences in which the individual attempted to construct meaning and understanding. Different self-positions switched between relative ranks in the hierarchy in order to dominate the story telling at different points in the narrative. These changes in self-position were not acknowledged or remarked upon by the participants, despite their sometime contradictory nature. Different self-positions existed within each individual and often provided differing perspectives of, and insights in to, an experience. None of the individuals could be defined by any of the individual self-positions, which cannot be disaggregated from each other. Rather the relative dominance of the positions differed between participants and fluctuated within participants throughout the course of the interview. The defiant and reflective-conciliatory self-positions generally exerted greater dominance over the narratives than the subordinate position. However, the use of subordinate language borrowed from services or associated with stigma, was pervasive throughout the narratives affording the subordinate position a more subtle influence on the stories.

Implications for Clinical Practice

Non-adherence is a problem for mental health services, but rather than being an issue for the service-user in isolation it should instead be considered a limitation in the way in which healthcare is delivered (NICE, 2009). DST proposes a potential way of conceptualising and understanding the wider interpersonal and systemic reasons for non-engagement with services and treatment. Service-users do not necessarily behave in a regular, predictable and consistent fashion. Self-positions will be adopted in response to the historical, interpersonal and

environmental context in which the individual finds themselves. Variations within these domains will ultimately affect how the individual responds to clinicians and treatment options.

Service-users reported having difficulties with the constraints of an in-patient setting, anti-psychotic medication and diagnostic labelling. In response to these difficulties some service-users rejected clinician advice or refused treatment. They also expressed concerns about stigma associated with psychosis. These responses could be understood as acts of defiance or reactance which overtly challenge clinicians' power and authority. In contrast, other service users were compliant with treatment and to the instructions and recommendations of clinicians. These responses could be characterised as submissive and subordinating and were characterised by their own distinctive tone and self position.

Routine clinical practice tends to conceptualise engagement, adherence and compliance in terms of levels of insight and awareness of illness (Tranulis et al., 2008; David, 1990). Arising from this a number of interventions including adherence therapy and psycho-education (NICE, 2009) have emerged. Recent NICE guidance and meta-analytic data have shown that adherence and psychoeducation are not effective in improving critical outcomes for people with schizophrenia including symptoms, relapse and staying with a service.

The findings of this study suggest that an understanding of service engagement and adherence, conceptualised within an insight framework, will be limited. Rather, engagement and adherence need to be understood in the context of the dynamics of therapeutic relationships which may, and can, involve differential levels of power, rank and position, and also include coercion into treatment. In this study, the narratives of service users revealed a complex and dynamic pattern of responding that involved reactance, defiance and disengagement on the one hand and submissiveness, subordination and compliance on the other. Subordination and defiance can be understood as evolutionary based strategies for managing threat and power in relationships (Gilbert, 2000; Scott, 1990). Coping strategies such as defiance/reactance are important with regards to developing and maintaining therapeutic relationships. Clinicians'

knowledge and competence of these strategies is relevant to their practice as they are required to identify, formulate and adapt their treatment style to accommodate these factors.

Implications for Research

Narrative inquiry does not aim to draw conclusions of certainty (Elliot, 2005) and as such many questions have been posed by the current study for which future investigations should attempt to provide answers to. A re-conceptualisation reactance theory, within a dialogical framework has been proposed, and tentative evidence for this has been provided. Validation of, or further elaboration upon, this idea is necessary before definite conclusions can be asserted.

The therapeutic relationships, which exist between service-users and clinicians have previously been explored in the research literature; however, the application of dialogical theory to these contexts has so far not been the focus of empirical endeavour. DST appears to provide a frame through which to understand how service-users and clinicians come to make sense and meaning from their worlds and the inherent difficulties that they both experience within their relationships with each other.

Limitations

The study focused on a sample of individuals with psychosis who had experienced difficulties in engaging with mental health services and treatment regimens but were currently engaged with services. As a result individuals who were currently not engaged were not able to be included. It is impossible to determine if this “hidden” population had different experiences with services or exhibited similar behaviours as a result of reactance. Although data saturation was achieved, the sample size was small and recruitment was from a narrow range of services within NHS Lanarkshire. All participants were over 30 and had multiple episodes of psychosis

and hospitalisation. Experiences of first-episode and younger service-users may have be different from long-term service-users.

Clinician narratives were not included in this study and these would potentially offer complimentary or juxtapose insights into therapeutic relationships and provide a wider context in which to explore both relationships and reactance further. Relationships are dialogical in nature, and this study only explores one side of this interaction.

Conclusion

Narratives surrounding recovery and engagement with services can appear complex, contradictory and fragmented and some authors have suggests that narratives of recovery can therefore be incoherent (Lysaker, Lysaker & Lysaker, 2001). However, understandings derived from Dialogical Self Theory (Hermans ,1996) allow for the co-existence of multiple self positions within individuals which may be fully disaggregated and differentiated or partially interacting and overlapping. In this study, narratives of Defiance, Subordination and Reflective-Conciliatory illustrating different self positions were observed. These self-positions could be understood in the context of experiences of power and as exerted by services and as perceived by participants. This understanding of the complexity of narratives may be helpful in guiding clinicians in maintaining a wider awareness of the multidimensional nature of individuals' understandings of their experiences of recovery and relationships with services. As such, clinicians can engage service users in exploring different stories of recovery, their interpersonal context and clinicians own implication and presence in these stories.

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Chapter 3: Advanced Clinical Practice 1: Reflective Critical

Account

Consultation: A Reality Check

David Grinter*

Academic Unit for Mental Health & Wellbeing

***Correspondence to:**

David Grinter
Academic Unit for Mental Health & Wellbeing
Academic Centre
Gartnavel Royal Hospital
1055 Great Western Road
Glasgow
G12 0XH

Abstract:

Reflective learning is integral to the role of a Clinical Psychologist despite the lack of a universal definition. An adapted version of Pedlar et al.'s (2001) Model of reflection is presented and is the mechanism for reflective practice throughout. Consultation is deemed one of six National Occupational Standards by the British Psychological Society (BPS; 2002). The process of reflection is detailed in relation to the author's experiences of providing consultation to inpatient staff on an older adult dementia specialist ward. Additional, post-reflection analyses and key learning points are discussed.

Chapter 4: Advanced Clinical Practice 2: Reflective Critical Account

Training Mental Health Professionals in Formulation

David Grinter*

Academic Unit for Mental Health & Wellbeing

***Correspondence to:**

David Grinter
Academic Unit for Mental Health & Wellbeing
Academic Centre
Gartnavel Royal Hospital
1055 Great Western Road
Glasgow
G12 0XH

Abstract:

Formulation is a core skill for any psychotherapist and is becoming increasingly used by mental health professionals. Reflective learning is integral to the role of a Clinical Psychologist despite the lack of a universal definition. An adapted version of Pedlar et al.'s (2001) Model of reflection is presented and is the mechanism for reflective practice throughout. Training of others is part of the National Occupational Standards by the British Psychological Society (BPS; 2002). The process of reflection is detailed in relation to the author's experiences of providing training on formulation to a Community Mental Health Team.

Appendices

Appendix A. Participant Information Sheet



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Stories of Engagement with Mental Health Services: A Narrative Analysis of Service Users Perspectives

Participant Information Sheet (Version 3, 28/02/2011)

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. We advise that you take at least 24 hours to decide whether to take part in the study.

What is the research about?

The aim of this research is to develop an understanding of how people who have experienced psychosis describe their experiences of this and of their experiences of Mental Health Services. This type of research will be helpful for developing health care professionals' knowledge of service users' experiences and ultimately lead to developments in patient-professional relationships and enhancement in care provision.

Who is being asked to take part?

I am asking people who have experienced a psychosis in the past to take part in this study. By psychosis we mean unusual experiences such as hearing voices no one else can hear, or perhaps having some beliefs that others may consider unusual.

Why have I been asked to take part?

The clinician responsible for your care has discussed the project with you and you have consented to have your details passed on to me. You have been offered, or received help, for a psychosis in the past and I am interested in talking you about your experiences.

Do I have to take part?

No. Taking part is entirely up to you. If you do not wish to take part it will not affect any treatment that you currently receive, or may receive in the future. Also, if you do decide to take

part, you are free to change your mind and withdraw from the study at any time without it affecting your care either now or in the future.

What will happen next if I want to take part?

If you decide to take part in the study after reading this information sheet and after you have your questions answered by the researcher, the researcher will confirm that you wish to take part and arrange to meet with you again. During your meeting with the researcher, they will re-iterate the information from the first session and provide a chance to ask further questions. The interview will then start and will last approximately 45 minutes. The interview will be recorded on a digital recorder as part of the research process. The recording is confidential and will be stored securely and would only be listened to by professional staff involved in the study, after which they would be destroyed. They can also be made available for you to listen to if you wish (some people find this helpful).

Results will be provided to you by post if you wish to receive this information.

Are there any risks or benefits to taking part?

Some individuals value the opportunity to discuss their experiences with individuals who are not involved in their treatment. In the interview you will have the opportunity to talk about mental health difficulties and your experiences of services. These topics can sometimes be upsetting to talk about. You do not need to talk about that feels uncomfortable. If you feel upset you are free to stop the interview and this will not impact in any way on your care.

Will my taking part be kept confidential?

Yes. The information you provide me with will be treated confidentially. All recordings and transcriptions will be stored on a password-protected computer. Your name and any information that could identify you will not appear in any reports.

If you share information that makes me concerned for your safety or the safety of other people, I may be required to tell others involved in your care (e.g. your key-worker or psychiatrist). I will always notify you beforehand if I am going to do this, and explain why.

If, during the course of the interview it becomes apparent that your safety or that of others is at risk I would be required to discuss this with your key-worker. This would be discussed with you beforehand.

Your GP will be informed of your participation in this study.

What will happen to the results of the study?

Once the study is completed we will produce a report that will describe the findings of the study. You will not be identified in any report or publication. The report will not include any personal details of the people who took part; it will only describe what happened to the groups of people who received different types of treatment.

Who is organising and funding the research?

The University of Glasgow and NHS Lanarkshire will organise the research. The research will be funded by the University of Glasgow and NHS Education for Scotland.

Who has reviewed the study?

The study has been reviewed by the University of Glasgow to ensure that it meets standards of scientific conduct. It has also been reviewed by the Research & Development Department at NHS Lanarkshire and the West of Scotland NHS Ethics Committee to ensure that it meets standards of ethical conduct.

What if I want to make a complaint?

If you want to complain about any aspect of this study, please contact Prof. Andrew Gumley, Department of Mental Health and Wellbeing, Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow, G12 0XH. You can also contact

You can also use NHS Lanarkshires official complaint department by contacting Mr Graeme Walsh, Patient Services Manager, Strathclyde Hospital, Airbles Road, Motherwell , ML1 3BW. Tel: 01698 245 004

If you have any further questions or want further advice regarding the study from an independent person please contact Professor Tom McMillan at The Department of Mental Health and Wellbeing, Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow, G12 0XH.

Thank you.

Appendix C. Consent Form



CONSENT FORM (Version 2: 28/02/2011)

**Title of Study: Stories of Engagement with Mental Health Services: A
Narrative Analysis of Service Users Perspectives**

*Contact Address: Department of Psychological Medicine
Academic Centre
Gartnavel Royal Hospital
1055 Great Western Road
Glasgow
G12 0XH*

Please Initial Box

1. I confirm that I have read and understood the information sheet about the study dated 28/02/2011 (Version 3).
2. I confirm that I have had an opportunity to consider the information, ask questions about the study, and have had these answered satisfactorily.
3. I understand that my participation in the study is voluntary and that I am free to withdraw from the study at any time, without giving any reason, and without my medical care or legal rights being affected.
4. I am aware that the content of the interviews will not be discussed with anyone involved in my care however I confirm that there are limits to confidentiality and these have been discussed with me. I consent that the researcher may contact professionals involved in my care should my safety, or the safety of other be at risk.
5. I understand that the nature of the research requires the digital recording of the interview and give my consent to this.
6. I give consent for a summary of my engagement history to be obtained from my health workers by the researcher.
7. I give consent for my GP to be informed about my participation in this study.
8. I give consent for quotes from my interview to be used in publications related to the research. These quotes will be anonymised.

9. I give consent for the research team to contact the doctor involved in my care to confirm my diagnosis.

10. I agree to participate in the above study.

Name of Participant Date Signature

Name of Person taking consent Date Signature

When completed, original to be kept in case notes. Copies for participant and researcher file.

Appendix D. Interview Schedule

Narrative Interview for Exploring Reactance (Version 2).

Introduction – As we spoke about when we first met, I was hoping to ask you some questions about your experiences with mental health services. Remember that this interview will not be shared with anyone involved in your care, as we discussed last time.

I am aware that there may be some things that are distressing for you to discuss. You do not need to discuss the most distressing things but it would be good to discuss experiences that are important to you. Do you have any questions for me before we begin?

Aim of 1st Question is to gain an general overview of the person's experiences of mental health services.

Question 1. I'd like to start by getting a bit an overview of how things are at the moment. Perhaps you can tell me the kind of problems you get help for, who you currently see, what kind of help you receive and how long you've been seen by the service?

Have you had many changes in key worker?

Have there been many changes in your treatment?

How would you describe your relationship(s) with services?

How well do you feel you have gotten on with services?

How have services gotten on with you?

Do you feel that services have understood you?

The aim of the 2nd question is to establish a timeline, orientate participant to telling their story and exploring availability of supports (including informal and family) over time.

Question 2. That's a really helpful overview, I wonder if you can tell me how you came to be in contact with mental health services?

When was that?

Who did you see?

Who was around at the time?

What other supports did you have?

How did you feel about that?

How did you understand the problems you were having?

What did others make of the problems you were having?

Question 3 is the heart of the interview, important to identify (if possible) specific events so it's useful to ask peripheral questions trigger autobiographical memory (not semantic memory).

Question 3. You may have mentioned some of this already, but can you tell me about particularly important experiences of mental health experiences? Of course these can events that can be positive, negative or a bit of both.

Probing specific events:

Can you tell me what happened?

How did you react? How did others react?

How did you feel when this happened?

Were there particular relationships that are/were important to you at this time?

Can you tell me about that relationship?

How did you feel about this relationship?

What about relationships with professionals?

Was there any particular professional?

What was it about this relationship that was particularly important?

Can you give me an example of...? (if statement of relationship is not given enough detail/clarity)

What was helpful or unhelpful about that?

How did you feel about this particular aspect of the relationship?

Questions 4 and 5 are closing phase of interview moving away from specific autobiographical memories.

Questions 4. How have your experiences changed over time?

What has been helpful?

What has been difficult?

Do you have an example of this to mind?

How have you changed over time?

How do you, now, feel about these changes?

How have services changed over time?

Question 5. What do you think that you have learned from your experiences?

What do you feel I should take away about your experiences?

What could services can learn from your experiences?

Appendix E. Major Research Project Proposal

Psychological Reactance, Insight and Service Engagement Problems:

Service User Perspectives

Protocol Version 6

Introduction

Insight

Insight has been an integral part of research in psychosis. It is linked to a variety of outcomes and considered to be a core feature of the disorder. There is no consensus amongst professionals and researchers as to what the defining characteristics are, or even what the definition of the concept is. Amador observes that there is a “...bewildering sea of terms that have been applied to the observed unawareness of illness...” (Amador & Kroengold, 2004, pp 4). It is generally accepted that insight is not a dichotomous categorical phenomenon such as described by Aubrey Lewis (1934) but rather it is a multidimensional and graduated construct. A number of researchers have adopted a multi-dimensional model of insight (McLeod, Coertze & Moore, 2009, Mintz et al., 2003). Of the dimensions, awareness of having a mental disorder, is the one that is most consistently included in insight scales (Mintz, Dobson & Romney, 2003) and this can be considered a core feature of insight.

Studies have shown that between 50% and 80% of all patients diagnosed with schizophrenia do not believe that they have a disorder (Amador & Gorman, 1998). Insight has been consistently shown to predict treatment adherence (Kemp & David 1996; McEvoy, Freter, Everett et al., 1989), and levels of psychopathology in psychosis (Buchy, Torres, Liddle & Woodward, 2009; Mintz, et al., 2003).

Insight can have an effect on quality of life outcomes in paradoxical ways. Poor insight has been associated with poor outcomes in social functioning, clinical outcomes and treatment

adherence. Good insight has been linked with lowered self-esteem, higher levels of dysphoria and decreased quality of life. These incongruent findings may be explained by the meaning(s) that a person attaches to schizophrenia (Roe & Kravetz 2003). For example, high internalized societal stigma towards schizophrenia in tandem with greater insight has been associated with increased levels of hopelessness and lower self-esteem, whilst high insight and low stigma is associated with better social functioning and greater hope (Lysaker, Roe & Yanos, 2007, Lysaker and Luria, 2005). These findings have lead researchers to question if good insight should necessarily be desired (Lysaker and Luria, 2005).

The Social Context of Insight

According to Burns (2007) the concept of madness is socially constructed and is a product of evolution. Separating the “sane” from the “mad” allows the sane to exert dominance and increase their chances of successfully passing on their genes. It is a form of controlling competition, reducing threats and reaffirming one’s own dominance and position. The “us” and “them” distinction has been noted by other authors (Bentall, 2003) and contributes to the social unacceptability and stigma associated with mental ill health. Scott (1990) has commented that in societies and in relationships where a dominant ideology is held, other ideas are suppressed. Psychosis is one of the only psychiatric problems that has supporters for a purely biological cause (Fulford, 2005), and this idea can often be at the expense of social and psychological explanations (Kirmayer, Corin & Jarvis, 2004). Foucault (1997, in White et al., 2000) observed that insight can have the character of a symptom for many mental health professionals. This conceptualisation of insight as a symptom places the “problem” within the person, and affords no acknowledgement of the individual’s social context and how this may influence their understanding and interpretation of their psychosis. The traditional use of insight “...conceals the extent to which self-beliefs emerge refracted through the appraisals of others and derive ultimately from a shared store of cultural representations” (White et al., 2000, pp 501).

Cultural factors, such as understanding of mental health problems and religious beliefs, have been found to influence symptomatology, help-seeking and the course of schizophrenia and on insight (Saravanan, Jacob, Prince, Bhugra and David, 2004). Those born outside the UK and from ethnic minority backgrounds are rated as having poorer insight compared to other patients (White et al., 2000; Kirmayer et al., 2004). Stigma and social attitudes have been found to have a negative effect on reported levels of insight (Johnson & Orrell, 1995, Williams, 2008). This may be linked to the findings that societal attitudes towards mental illness tend to be harsh and fearful (Thornicroft, Rose, Kassam, & Sartorius, 2007, Thornicroft & Kassam, 2008). As a result of this prejudice people with psychosis may deny their symptoms in order to retain relationships and social status (Kirmayer, et al., 2004). This behaviour is similar to a phenomenon described McGlashen as “sealing over” (McGlashen et al., 1977).

Sealing Over

In the recovery from psychosis, “sealing over” is characterized as minimizing the significance of symptoms, displaying a lack of interest or curiosity regarding the experience of psychosis and playing down the impact of the psychosis. It is considered an avoidant coping styles as individuals will usually display “reticence towards exploring possible underlying emotional difficulties” (Gumley, Schwannauer, MacBeth & Read, 2008) and is associated with poorer quality of life and worse psychological pathology following a psychotic episode (Thompson, McGorry & Harrigan, 2003).

Treatment engagement can, in part, be predicted by recovery style, with “sealing over” being associated with poorer engagement (Tait, Birchwood & Trower, 2003). Although “sealing over” has often been conceptualised as an epiphenomenon of lack of insight, the relationship is not clearly understood. Tait et al (2003) found that insight and symptom severity did not explain service engagement issues as well as recovery style did. Insight and treatment compliance are often tightly associated in research but this study indicates that the link may be better explained in terms of other interpersonal concepts. Roe & Kravetz (2003), hypothesize that sealing over

(in the context of other factors) may offer an alternative explanation for non-engagement in clients with severe mental illness as opposed to the current model of insight, and that this may best be uncovered using the personal narratives of those who have endured mental illness.

Tait, Birchwood and Trower (2004) and Staring, Van der Gaag, Van den Berg, Duivenvoorden and Mulder (2009) suggest that “sealing over” is associated with low personal resilience in adapting to psychosis, feelings of insecurity and concerns pertaining to interpersonal rejection. Individuals who utilise avoidant coping strategies may be more disposed to misinterpreting others’ behaviour as being rejecting or critical. The stigma that is associated with a diagnosis of schizophrenia may lead to an individual adopting an avoidant style of coping as it may ensure preservation of the sense of self identity. The need to protect themselves from being controlled by others may also lead to sealing over, serving to keep those who may wish to control (mental health professionals) at a distance. The desire to exert one’s freedom and rights is integral to the concept of reactance.

Reactance Theory

The initial premise in reactance theory (Brehm, 1966, Brehm & Brehm, 1981) is that all humans have a desire for freedom. When this freedom is threatened this leads to a reaction of opposition against the entity that is curtailing this autonomy. Reactance is directed towards restoring the behaviour that is under threat through oppositional behaviour. Very little research has been conducted regarding psychosis and reactance, possibly because rating scales for reactance have been criticised as being unreliable (Shoham, Trost & Rohrbaugh, 2004). Moore, Sellwood and Stirling (2000) proposed that highly reactant patients (i.e. those who endorsed a greater number of items on the Hong Psychological Reactance Scale, Hong & Page, 1989) may perceive clinician advice as a threat to their freedom, and that they may attempt to assert their autonomy via non-compliant behaviour. This study is the only study that has explicitly looked at the theoretical relationship between levels of reactance, insight and treatment compliance in individuals with psychosis. There was an interaction between perceiving treatment as a threat

to freedom and level of reactance. Non-compliant individuals did not exhibit significantly different levels of insight than compliant individuals. Past compliance was correlated with reactance, current compliance was not. Logistic regression indicated that reactance, not insight, was the most significant contributing factor to non-compliance with medication.

Interestingly, it was found that some individuals who were currently compliant with medication but who were also highly reactant. This paradoxical outcome was explained in terms of anecdotal observations and not research evidence. The authors hypothesised that these individuals had developed greater insight or had gained a greater subjective response to their medication. However, compliance was quantified via self-report, which is a measure which could be easily manipulated by the participant. As Scott (1990) has described, there can be differences between explicit and hidden behaviours when freedoms are perceived to be threatened. It is possible that in Moore et al.'s study, levels of compliance were reported to be decent by the participant (explicit behaviour) while in reality the compliance rates were much less i.e. reactance or hidden behaviour. There are parallels between reactance and "sealing over"

Sealing Over and Reactance

Tait et al. (2004) have suggested that those who adopt an avoidant coping style retain a need to protect themselves from being controlled by others, and sealing over offers this protection. Reactance is elicited in individuals when they feel that they need to protect or reassert their freedom. It evokes behaviours that the individual believes will reinstate their perceived freedoms. Moore et al. (2000) supposed that these behaviours would manifest as avoidance, disengagement and noncompliance with treatment; these behaviours are commonly observed in individuals who "seal over".

The current research on "sealing over" clearly implicates factors other than insight in having an influence treatment adherence in individuals diagnosed with a psychosis, this finding was also true of the reactance study. These studies highlight the possibility that the concept of

insight may not be complete or accurate, and that other constructs need to be given consideration in research and clinical practice. These findings grant an opportunity to investigate other inter- and intra-personal constructs which may mediate the apparent relationship between insight and treatment compliance.

Insight has traditionally been constructed in terms of bio-medical implies an absolute truth with regard to illness and can lead to tautological reasoning and situations for clients (if they acknowledge that they have psychosis they will be labelled as such. If they reject the diagnosis it they lack insight and that this is proof of their illness). Other social constructs have often been overlooked (Kirmayer, Corin & Jarvis, 2004), but Roe and Kravetz (2003) have suggested that insight may be more beneficially conceptualised in terms of an individual's personal narrative. Narratives do not assume an absolute truth, contending that different truths exist regarding a given situation. Narrative accounts of insight will allow individuals to explain their experiences of engagement freely in the absence of preconceived notions of illness and insight. These will be helpful to help clinicians in understanding non-engagement and will provide a basis for resolving these problems.

Aims & Questions

The study aims to characterise the narratives of individuals with psychosis who have experienced difficulties engaging with mental health services. Specifically, we wish to explore how these individuals narrate their experiences of relationships with service providers.

We also wish to explore how individuals construct their reactions to services with particular respect to how these reactions are reflected in the organisation and structure of their narratives. Expressions of reactance and “sealing over” with in the narratives will be of particular interest.

Plan of Investigation

Participants

This study requires the participation of those individuals who have experienced difficulties with engagement with mental health services either in the past or the present. Recruitment from this population may be difficult and to maximise successes participants will be recruited from a wide range of mental health services within NHS Lanarkshire Health Board. Outpatient Psychiatry, Community Mental Health Teams, Psychology/Psychotherapy Services and Patient Groups (e.g. Schizophrenia Fellowship) will be approached for recruitment.

Inclusion and Exclusion Criteria

All participants should be aged 18 or over and should meet the diagnostic criteria (either DSM-IV or ICD-10) for a psychotic disorder, such as Schizophrenia, Bi-polar depression etc. The diagnosis will need to be verified by the staff involved in their care provision. Participants will be excluded if they; are under 18 years of age, have an organic disorder or traumatic brain injury, have an Intellectual Disability, do not speak English as a first language or if they are acutely psychotic at the time of the interview.

Justification of Sample Size

Turpin et al. (1997) have suggested a sample size of between eight and twenty participants is desirable for a good qualitative research for the Doctorate in Clinical Psychology. This sample size should allow for theoretical saturation to be achieved. Theoretical saturation occurs when all of the main variations of the phenomenon have been identified and incorporated into the emerging theory (Guest, Bunce & Johnson, 2006).

Procedure

The participant's care co-ordinator will ascertain the participant's interest in participating and provide them with a study information sheet. The researcher will meet with the participant and the care co-ordinator to provide additional explanation of the study and obtain informed consent. The further interview session will be arranged during this meeting.

The interview will be conducted by one researcher and may last up to one hour. The interview will be semi-structured, with open ended questions based on the aims of the study but also guided by the participant's account and the researcher's reflections on these. To help orientate the participant and to elicit a narrative account general introductory questions will be utilised. The participant will be asked to discuss their experience and understanding of psychosis and their experiences of mental health services. They will be encouraged to reflect on how their beliefs have changed and how their experiences have impacted on them. The structure will be flexible and evolve with the emerging themes as discourse unfolds. The researcher will remain mindful of their beliefs and assumptions and attempt to prevent them unduly influencing the narrative of the participant.

Settings and Equipment

The interviews will be conducted on NHS Lanarkshire premises that are familiar to the participants, such as CMHT offices or GP surgeries. All interviews will be recorded on a digital recorder, anonymised and transferred to a secure, encrypted laptop. Participants will receive a copy of the transcript from their own interview.

Data Analysis

Narrative analysis design will be used to analyse interview transcripts of the participants. There is no singular and correct way to conduct Narrative analysis and this study will follow a methodology based around the concepts in Thornhill, Clare & May (2004) and Vanheule & Hauser (2008). Narratives will initially be considered in their entirety with an

emphasis on considering the genre or type of story that is being told. Reactance/defiance, submission/subordinate and acceptance/negation genres will be considered during analysis, although these may not be exclusive genres and may be paired in a variety of combinations.

Reactance narratives could be identified by; 1) the protagonist (I) giving an account of injustice, imbalance of power in relationships with, or perceived threat, from MH services and 2) describing actions that may constitute reactive behaviours meant to redress this threat and imposition on freedoms (i.e. disengagement).

The more incongruent narratives (e.g. reactance/submission) may show greater complexity and disorganisation and will reflect loss of coherence with regard to understanding and explanation of episodes of psychosis, treatment and engagement. These narratives may also reflect both explicit and hidden narratives that individuals can construct in relation to threat and domination (Scott, 1990).

Gricean Maxims (Grice, 1989) will be utilised to ensure that interview transcripts have internal consistency and that the interviews themselves were truthful and collaborative. The transcripts will be read with the four maxims (quality, quantity, relation, manner) as a guide to ensure consistency and collaboration.

Health & Safety Issues

All interviews will be conducted on NHS Lanarkshire premises where standard safety procedures will apply. No domiciliary visits will be conducted. The care co-ordinator will be consulted to ensure that the research will in not in any way affect the participant's treatment. The limits of confidentiality, which are standard across NHS Lanarkshire, will be explained to all participants. Local procedures for dealing with disclosure issues will be followed if the participant discloses information which may be construed as presenting risk to the safety of others and themselves.

Ethical Issues

Ethical approval for the study will be sought from the NHS West of Scotland Research Ethics Committee. Participants will be given a copy of an information sheet that will outline the details of involvement and informed consent will be sought. Confidentiality needs to be ensured with identifying information being anonymised and participants assured that the interviews are not shared with any individual not involved in the research project. The interview may lead to discussion regarding their experiences of client-practitioner relationships in the context of their care. They may worry that this will have a bearing on their current or possible future care or treatment. This will be included in the confidentiality agreement. Due to the high likelihood of emotive topics being discussed, care will be taken to ensure that participants do not experience high levels of distress. Participants will be encouraged to notify the researcher if they become increasingly distressed and the interviews can be suspended if need be. Should a participant present with psychotic symptoms during the course of the interview the concerns of the interviewer shall be raised with the participant and self-referral to their General Practitioner or another professional involved in their care will be advised. The interview will not be used in the analysis if this occurs.

Financial Issues

For transcription purposes an Olympus VN-6800PC 1GB digital dictation recorder will be required as will an Olympus AS-2400 Transcription Kit. The requirement of materials for administrative purposes will be; paper (£7.40), envelopes (£6.50), postage (£17.50), photocopying (£10).

Time Scale

July 2010: Proposal passed by University of Glasgow.

August 2010: Ethical review. Begin recruitment.

October 2010 – February 2011: R&D and Ethics.

April 2011 – May 2011: Recruitment, interviews and analysis

June 2011: Analysis and write up.

June 2011-July 2011 – Write up and submission

September 2011: Viva.

Practical Implications

Thus far very few studies have looked at reactance in the context of insight and treatment adherence in psychosis. This study will be one of the first to address this void in research.

The concept of insight, and its practical use in clinical settings, has always been structured around medical and positivist ideas. However, the research on “sealing over” and the work of Roe and Kravetz (2003) has indicated that this concept may be in need of updating or re-evaluated. The narrative accounts with its emphasis on the meaning and understanding individuals attach to their experiences may afford a greater personal perspective on these concepts.

By obtaining a greater understanding of individuals’ personal experiences the problems of service engagement and treatment compliance may be more adequately and appropriately addressed. The findings of this study may help pave the way for the implementations of future programmes to improve engagement/compliance.

This study also has practical applications in terms of influencing the direction of future research as it is intended to produce hypotheses and methodological considerations to be explored in future research.

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