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**SOCIAL CONSTRUCTIONS OF PSYCHLOPS (PSYCHOLOGICAL OUTCOME
PROFILES) IN THE CONTEXT OF CBT FOR PSYCHOSIS**

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**Outcome Measurement, Recovery and Psychosis:
A Literature Review**

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Abstract

This paper presents key issues associated with the use of routine outcome measurement in psychological therapy for people diagnosed with psychotic disorders. It introduces the concept of outcome measurement by reviewing its development and extent of use alongside policy. Idiographic and nomothetic approaches are discussed, exploring the frequency (pre-post versus sessional) and impact of outcome measurement. The measurement of change after therapy for psychosis is addressed and concepts related to recovery are considered. Two representatives of nomothetic and user-generated approaches are described. Future directions for research are then discussed.

This paper suggests that the suitability of conventional outcome measures with people experiencing severe mental distress, particularly psychosis, is an issue warranting greater attention. It also recognises the role of power related dynamics and discourses and argues for increased attention to be given to the way in which therapists and service users negotiate power in relation to outcome measurement.

INTRODUCTION

The focus of this study is on the use of routine outcome measurement in psychological therapy for people diagnosed with psychotic disorders. The frame of reference is how different measurement traditions and techniques fit with a recovery model in psychosis. This study is particularly interested in a Foucauldian framework, taking into account the political and historical position of change measurement. It explores two measurement traditions: nomothetic and user-generated, using representatives of each to illustrate pertinent issues.

HISTORY OF OUTCOME MEASUREMENT

How has the use of outcome measurement developed?

Considerable attention has been devoted to the measurement of outcomes in psychological care over the last forty years and the concept of measuring outcomes has become an integral part of mental health culture. Outcome is invariably linked to process and has been defined as the 'immediate or long-term changes that occur as a result of therapy' (Hill & Lambert, 2005 p.103).

Early attempts to measure change in patient status following psychological intervention date back to the 1930s and 40s (Singer & Young, 1941). In the 1950s, approaches to measurement tended to favour unvalidated projective tests or multi-item

questionnaires (Fiske, 1957). In the 1960s, it was deemed important, albeit retrospectively, to gain an experiential perspective on the events of therapy (Meyer, Borgatta & Fanshel, 1964; Orlinsky & Howard, 1966, 1967). In the mid 1990s the focus shifted to the quality and outcome of care, with emphasis placed on data generated *during* treatment. Johnson and Sahaha (1996, 1997) were among the first researchers to document the impact of specifically designed outcome and process tools on the quality and outcome of psychotherapy. This signified a move towards seeking a more 'objective' study of the subjective experiences of service user and therapists and a 'search for scientific rigour' (Lambert, 2004).

In recent years there has been a move towards using empirically supported treatment and assessment methods, with clinicians being encouraged to adopt evidence-based practices (Garland, Kruse & Aarons, 2003). The establishment of an outcome-informed approach to clinical practice has inevitably led to more pressure being put on clinicians to collect outcome data on their clients (Miller, Duncan & Hubble, 2005).

What are we measuring?

There is some disagreement about what is actually reflected by outcome. It is argued that the notion of 'outcome' is to some extent dependent on what the information is needed for and employed to do. Before you can measure an outcome, it is necessary to know what you intend to measure (McCartney & Brown, 1999). This perhaps is not as

clear as it seems, particularly with the 'marketisation' of the NHS, resulting in the acquisition of data for managerial as well as clinical purposes. The notion of outcome is also influenced by subject position. For example, according to Lakeman (2004), a psychiatrist might view outcome in terms of a reduction in symptoms, a therapist may anticipate their client being able to resolve their problems, whereas an essential outcome for service users may be to feel safe, respected and cared for, or to be empowered (Trivedi & Wykes, 2002).

There have been attempts to review the practices involved in assessing outcome (Lambert, 1996) but what these reviews found was a lack of consensus on how change is measured making meaningful integration of findings difficult. Hill and Lambert (1996) assert that 'there is no accepted standard for evaluating and reporting patient change' (p. 117). Others agree that there appears to be a lack of agreement over what constitutes adequate outcome measurement (Mellor-Clark, Barkham, Connell & Evans, 1999).

Purpose of measurement

Many standardised instruments and client-based measures have been developed for the purpose of measuring clinical symptoms, service user needs and health related quality of life. Assessment of outcome has been considered useful in helping clinicians make decisions about treatment options, monitor progress in terms of symptom reduction and evaluate the impact of therapy (Gillbody, House & Sheldon,

2003). Data from outcome measurement is also proposed to be useful for service development, resource allocation and programme planning (Coombs & Meehan 2003). Some have even argued that evaluation is an ethical obligation (Clement, 1999).

Whilst the routine collection of outcome data is becoming more established (Gilbody, House & Sheldon, 2002) the way that the data are utilised in clinical practice is not well understood. Indeed, some reluctance stems from uncertainty about whether the data will be used politically e.g. to assess the affordability of care (Corrie & Callanan, 2002).

Changes in political context

National Health Service policy and guideline publications have re-evaluated the emphasis given to the measurement of outcomes in psychological therapy (DH, 2004). This is, in part, attributable to a 'Review of Strategic Policy on NHS Psychotherapy Services in England' (DH, 1996) whereby the quality of national service provision came under scrutiny. The recommendations called for more practice-based evidence in the application of outcome measurement data.

In 2002, the Department of Health produced a document proposing that services should use 'routine systematic attempts to assess the outcomes of psychological interventions using standardised instruments' (principle 9.5). In 2004, it recommended that services 'incorporate measures of outcome into [your] psychological therapy

services as a matter of routine' (p.31). In 2005, the National Institute for Mental Health in England announced the findings of a two year programme to introduce routine outcome measurement across NHS mental health services. They stated that successful implementation was dependent upon the positive engagement of both practitioners and service users. In 2008/9, the NHS operating framework stipulated that patient-reported outcomes should be a mandatory requirement for audit (DH, 2008/9).

Extent of use of outcome measures

In the United Kingdom (UK), the formal evaluation of client progress is viewed as a central component of clinical practice within the NHS (Bewick, Trusler, Mullin, Grant & Mothersole, 2006). Less is known about UK private sector use. The proportion of UK clinicians engaging in routine outcome measurement at all probably varies greatly by service, locality and treatment modality though there is little detailed empirical evidence to confirm or refute this. Whilst some form of outcome assessment is used in most clinical mental health encounters, the routine use of standardised outcome measures is not universal (Slade et al., 2006). There is evidence that some clinicians prefer informal assessment over standardised evaluation (Ogles, Lambert & Fields, 2002).

Mellor-Clark, Barkham, Connell and Evans (1999) reported high rates of UK measurement use. All providers, in a survey of 220 NHS services, were reported to have used an outcome measure during assessment or at first contact. Fifty-nine per cent also measured post-treatment outcomes. Hatfield and Ogles (2004) investigated

psychologists' use of outcome measures in clinical practice in the US, reporting that only 37% actually used measures. Eagar, Trauer and Mellsop (2005) found that in Australia (where routine measurement of outcome is mandatory) 95% of adults received at least one measure at some point, although this figure fell to 58% when looking at those who received a combination of pre- and post-intervention measures.

Attitudes to outcome measurement

Whilst there are many benefits to measuring outcomes, the implementation of such measurement can sometimes be challenging due to clinician and service user ambivalence. However, it is suggested that the more you engage people in the process of outcome measurement, the more likely the data you acquire will be meaningful (Garland et al., 2003) Despite this, research into the attitudes and behaviours of clinicians who use outcome assessments in practice is limited. Hatfield and Ogles (2004), in a study from the United States (US), ascertained what information clinicians found most useful from outcome measures. Tracking patient progress and determining whether treatment needed to be altered were rated highly and were the main incentives for use. These authors also sought to determine the reasons why clinicians chose not to use outcome measures. The most prominent reasons related to practicalities such as extra paperwork, additional burden on the client and the amount of time it consumed. Secondary reasons included cynicism as to whether outcome measurement actually benefited practice, concerns about confidentiality, interference in clinician autonomy and concern of misuse by others.

One problem is that therapists' concerns about measures may contribute to them being used inconsistently or incompletely e.g. administering a pre-CORE-OM but no post-CORE-OM. The reactions of clinicians and the impact on them of completing outcome measures are poorly understood (Meehan, McCombes, & Hatzipetrou, 2006). Rao, Hendry and Watson (2010) examined strategies for outcome measurement and highlighted some of the challenges to practice. Practical issues relating to applicability and complex clinical presentations were raised, as well as concerns about intrusion to the therapeutic process. Concern around the adequacy of outcome measures is another reason cited by clinicians for their reluctance to use them in routine practice. The authors noted that clinicians also had anxieties about performance monitoring.

Impact on therapeutic relationship

Intrusion to therapy is a concern that is raised by a number of authors (Phelps, Eisman & Kohout, 1998). Negative change can occur in therapy as a result of empathic failures or ruptures in the therapeutic alliance (Lambert, Bergin & Collins, 1977) and there are concerns from some clinicians that introducing an outcome instrument during therapy may affect the alliance, particularly if clients have suspicions about the use of a measure. The therapeutic alliance could equally be affected from the therapist's perspective if they do not buy into the outcome measure or think it may affect how they are perceived. It is proposed that within psychotherapeutic approaches, therapeutic alliance is responsible for up to 30% of all treatment outcomes (Bambling & King, 2001).

Therefore fear of interfering with this alliance may leave some clinicians unhappy with using measures, and even more so if used in every session.

On the other hand, it can be argued that the use of an outcome measure could bolster the therapeutic alliance. Miller and Hubble (2004) suggest that using an outcome measure can be seen as a very open and explicit way in which the therapist is showing that they take client feedback seriously and are wanting to improve their capacity to help. Providing feedback to clients about their scores can also be reinforcing.

Measurement and therapeutic orientation

It is reported that the theoretical orientation of clinicians can impact on the use of routine outcome measurement. For example, those using a CBT approach may view the evaluation of symptoms as an integral part of their clinical work, whereas those working psychodynamically may view the application of outcome measures as detrimental to the experience or process of therapy. Those who view the role of the measure as a means of informing their clinical practice are more likely to engage with it than those who view it as an unrelated activity (Corrie & Callanan, 2001).

Impact on service user experience

Elcombe and Westbrook's (1996) study was one of only two papers identified that directly asked service users about how they actually felt about filling in outcome measures. Seventy per cent of their sample reported a positive experience to

completing questionnaires. However, many revealed that the information that they felt had been provided with thought and care was not referred to again by the psychologist, leaving them with feelings of not being valued. There also appeared to be some confusion about the purpose of these measures, with a large number of clients thinking that they were providing the psychologist with a preliminary insight into their feelings rather than giving a baseline measure of their symptoms.

The second study identified that sought service user opinion was Miller and Shepherd (2008). These authors suggested that client experience and understanding of the purpose of outcome data collection might be influenced by the way the measure is administered. It has been suggested that some service users may have difficulty assessing their own condition or understanding self-rating procedures (Bilsker & Goldner, 2002). It is also argued anecdotally that if the client knows what they have written will be viewed by the clinician then they may give a more positive response to please them. Alternatively, if therapy is ending against their wishes they may express their dissatisfaction through the use of the measure.

TYPES OF MEASURES

Idiographic versus nomothetic measures

Two main approaches are used to measure psychological and social states: nomothetic and idiographic. Nomothetic instruments use the same questions for all participants and in doing so ensure that everyone has a score that represents a varied

level of dimension. This results in general dimensions of difference that apply to a whole population. Idiographic instruments allow the description to be personal to the individual thus investigating unique aspects of the person (Ashworth et al., 2007). The terminology in outcome literature is confusing with different terms used to describe the same thing. For example, 'traditional', 'conventional', 'pre-determined' and 'fixed-term' are generally used in reference to nomothetic instruments. 'Individualised' and 'patient- /client- /user-generated /-based /-reported /-centred' are used to refer to idiographic measures.

There are strengths and weaknesses to both idiographic and nomothetic measurement. The term 'idiographic measure' has been used to include a range of projective measures with standardised prompts, such as the Thematic Apperception Test (Morgan & Murray, 1935) and the Rorschach test (Rorschach, 1927). These were thought to provide a solution to the restrictions of nomothetic instruments by inviting a free projective opportunity to the participant. However, the group of idiographic outcome or change measures considered here are those known as 'user-generated measures' or 'personal questionnaires'. These invite the individual to define their own areas of concern and then score it, seemingly ensuring that the content is that which is important to the client. However, their individualised content means it is not possible to compare scores against population norms

Nomothetic measures incorporate dimensions that are relevant to wider populations thereby enabling the use of normative comparisons. Nomothetic instruments can be particularly useful for broad spectrum assessment, although

incorporating such a broad spectrum may mean that specific areas of distress are omitted. If issues which are particularly problematic are not covered then individuals could see their distressing experiences being under-scored. The likelihood of this happening increases as nomothetic instruments are made shorter. This may also lead to some service users scoring below cut-off points when such low scores do not reflect the severity of their distress.

Client based measures and the Personal Questionnaire (PQ)

An early bridge between projective idiographic tests and nomothetic tests was the Personal Questionnaire (PQ) (Shapiro, 1961). This measure asked patients to generate items summarising their problems as they saw them in their own words. The PQ focused on statements of 'illness', 'recovery' and 'improvement' with scoring based on the ranking of cards. The complexities involved in administering this measure meant that it did not become popular. Since then, several attempts have been made to simplify the PQ, e.g. Phillips (1970a); Phillips (1970b); Mulhall (1976); Singh & Bilsbury (1989); Elliot, Shapiro & Mack (1989) and most recently Morley (2002).

In order to understand the quality of healthcare, it was increasingly recognised and incorporated into Department of Health (DH) policy that service user perspectives should be sought (Hermann et al, 2004) and the service user's voice and involvement increased (DH Research Governance Framework, 2005). This recognition also led to an increase in the development of patient-reported outcome measures (PROMS). The

political drive for PROMS initially focused more on physical than mental health but aimed to provide a reliable, valid, acceptable and feasible way of gaining the perspectives of service users on illness and health care interventions (Marshall, Haywood & Fitzpatrick, 2006).

The use of individualised outcome measures is increasingly being considered as essential to evidence-based rehabilitation because the outcomes measured are, it is hoped, most relevant to the service user (Greenhalgh, Long, & Flynn, 2005). Lakeman (2004) argued trenchantly that traditional outcome measures were dehumanising and probably counterproductive saying that they 'strip the person's experience of all meaning and reduce it to predetermined categories' (p.212). He argued for alternatives to the most traditional nomothetic instruments.

Two measures were used in this study. These were a widely used nomothetic outcome measure and a user-generated measure. Both measures were employed to provide an experience of a contrast to the participants. It is important to understand their history and therefore consider them in this literature review as it will affect our understanding of their use in the study and therapy services in general.

FREQUENCY OF MEASUREMENT

Pre-post vs sessional

Despite the push for practice to be more evidence-based, Lakeman (2004) argues that there is little evidence that measuring outcomes actually leads to improvement in outcome. He asserts that the information outcome measures provide is not particularly meaningful to clinical practice and therefore they themselves are unlikely to lead to any improvements in customer health. He argues that any effect is attributable to the relationship between a therapist and their client and this dynamic is difficult to quantify. Lambert (2004) argues the reverse saying that the introduction of session by session monitoring in rationalist therapies like CBT and some humanistic/integrative ways of working, benefits the client engaging in that rationalist agenda.

C. Evans (personal communication, June 17, 2010) claimed that advocates of The Improving Access to Psychological Therapies Program have argued passionately for session by session data, partly because nothing less than 90% of outcomes measured would convince politicians to continue funding therapies. This notion is supported by the Improving Access to Psychological Therapies (IAPT): Outcomes Toolkit 2008/9 (DH, 2008) which 'requires psychological therapies services in the UK to engage with outcome measure frameworks in order to demonstrate the patient benefits in domains including 'improved health and well being, social inclusion and employment, improved choice and improved patient experience' (p.9). Following on from this, IAPT advocates the use of a range of outcome measures in every session.

IMPACT OF OUTCOME MEASURES

It is argued that evidence linking the effectiveness or quality of mental health services with the implementation of outcome assessment protocols is limited (Burnam, 1996). However, the extensive work of Lambert (2001, 2002) and of Miller & Duncan (2000, 2004) has shown apparent empirical benefits to some therapies in terms of reduced duration of therapies and better outcomes. For example, experimental investigations into the effects of feedback indicated that deterioration rates could be reduced and success rates increased if feedback on progress was provided to therapists (Lambert et al, 2001, 2002; Miller, Duncan, Sorrell & Brown, 2004). However, to date these outcomes have been reflected by the measures that have provided the feedback into the therapies and as yet there is no evidence that such feedback within therapies produces outcome improvements on independent measures and at follow-up.

PSYCHOSIS & MEASUREMENT IN PSYCHOSIS

Outcome measurement and the recovery model

There is an increasing focus on 'recovery' in mental health services, both in terms of the process and what it symbolises. A range of incompatible meanings are used when referring to recovery and Slade, Amering and Oades (2008) emphasise the need for conceptual clarity. They consider two meanings: 'clinical recovery' within an illness framework which is related to sustained remission, removal of symptomatology and functional improvement; and 'personal recovery', emphasising recovery as 'a

deeply personal unique process of changing one's attitudes, values, feelings, goals, skills and roles' (Anthony, 1993 p. 527).

Beresford (2002) claims that 'mental health policy, provision and practice are now predominately based on notions of 'cure' 'care' and 'recovery' tied to a medical model' (p.583). Bentall (2009) argues that the medical model is the dominant philosophical model underpinning the field of mental health. Dominant psychiatric ideology has political and professional authority and so many people are invested in it, including pharmaceutical companies in the literal sense of profit-generation, that it has immense social power and credibility (Hornstein, 2009; Moncrieff, 2008). The medical model has been challenged since the mid 1980's by the service user/survivor movement (May, 2000; Harper, 2004) but it is argued that the mental health system is still based essentially on the idea of 'mental illness' and people being 'mentally ill' (Bentall, 2003).

Adhering to a conceptual framework such as this means that mental distress is medicalised and individualised with emphasis placed on bio-chemical and genetic explanations. This interpretation is based on a deficit model whereby mental distress becomes pathologised. An inadequacy is presumed whereby thoughts, emotions, perceptions and behaviours are conceptualised as wrong and defective (Beresford, 2002). Within this framework the social context is not as valued (Duggan, Cooper & Foster, 2002). Coleman (1999) argued that it is the desire to understand mental distress

from a medical frame of reference that has led to outcomes 'sanitizing a non-recovery process rather than measuring a recovery process' (p. 23).

From an outcomes perspective, people with severe and persistent mental illness have been considered a difficult population to monitor in terms of the care offered to them (Rowan & O'Hanlon, 1999). There has been an active debate about which outcome measures should be used with this population (Greenwood et al., 2010). It is suggested that routine standardised outcome measurement is a crude and narrow lens to witness recovery and that outcome measures that capture individuality are more consistent with the principles of a recovery model (Roth & Fonagy, 1996).

It is proposed that conventional predetermined outcome tools reinforce the traditional institutional way of thinking and are therefore inconsistent with a recovery approach to mental health (Browne, 2006). These measures also fail to capture important issues for service user such as empowerment and social inclusion (Trivedi & Wykes, 2002; Chadwick, Lees & Birchwood, 2000). It could also be argued that traditional measures fail to capture negative effects of treatment such as loss of episodic memories following electro-convulsive therapy (ECT) (Rose et al., 2003) or debilitating medication 'side effects'.

Whilst more attention has been given to the concept of recovery within the development of mental health service policy and delivery (Davidson et al., 2008), the evidence for what helps and what hinders the recovery of people with mental illness

remains limited (Mancini, Hardiman & Lawson, 2005). O'Connor and Delaney (2007) raise the issue of whether recovery and evidence-based practice are compatible. If the goals of recovery are determined by the person and then individually paced, then where does evidence-based prescriptive treatment fit in? Browne (2006) questions whether it is feasible to select outcomes that actually capture the recovery process. On the other hand, however, a number of service user developed measures have been appearing in recent years, such as Wellness Recovery Action Plan (WRAP) (Copeland, 2004) and Recovery Star (Mental Health Providers Forum, 2008).

Lakeman (2004) argued that if the measures used to determine outcomes have a biased approach to mental health then one risks alienating the client from the recovery process. Lakeman suggests that observations should not necessarily be considered objective, evidence-based or meaningful just because they are quantifiable. Whilst measures may be evidence-based they may still miss meaningful information and the objectivity in any research could be debated.

It is therefore proposed that for us to embrace outcome measurement for people experiencing severe mental distress, we need to measure things that are relevant to the philosophy of recovery and the new culture associated with this. Evidence-based treatments that concentrate primarily on symptoms are only one contributor to personal recovery (Schrank & Slade, 2007) and there may be a need for outcome measures that include constructs that are more compatible with personal views of recovery.

Measuring change in psychosis

These deliberations illustrate how unhelpful it is to have an outcome measurement system that exclusively focuses on symptoms and functioning (Davidson et al., 2009). Services that focus solely on symptom reduction and crisis management, face neglecting psychological or social interventions and self-help (Healthcare Commission, 2006). They also run the danger of ignoring the link between social context and mental well-being (Drukker, Gunther & van Os, 2007). However, the case is not straightforward. For example, whilst people with psychosis may experience impairments in health status and quality of life which are unrelated to the severity of their symptoms (e.g. stigma and exclusion), they may also benefit from treatments which alleviate symptoms and associated distress (Ruggeri & Tansella, 2007).

A number of different definitions of what constitutes recovery in psychosis exist and an adequate definition is considered by many to be elusive (Mausbach, Moore, Bowie, Cardenas & Patterson, 2009). There is a difference between those who put emphasis on symptoms and functioning and those who view recovery as a process incorporating empowerment, hope and respect. In this respect, a person who has successfully recovered socially and psychologically, in terms of returning to work and managing ongoing symptoms, may therefore view clinical recovery as irrelevant to their quality of life (May, 2007).

Greenwood et al., (2010) reported that the primary outcomes in measures used in cognitive behavioural therapy (CBT) for psychosis are psychotic symptom reduction

and improved function. They imply that the reason these measures are less concerned with issues related to distress or fulfilment is because the measures are derived from pharmacological studies. This notion is supported by recent meta analyses whereby symptom reduction and global function were reported by all randomised controlled trials (RCTs) as primary outcomes (e.g. Wykes, Steel, Everitt & Tarrier, 2008).

Defining and monitoring recovery in such limited terms has implications for the type of language that is afforded to service user. It could also lead to individual experience being pathologised and objectified by the use of traditional clinical language. This was exemplified by Rosenhan's (1973) seminal experiment which involved researchers who got themselves admitted to psychiatric hospitals, but thereafter behaved completely normally, but found normal behaviour labelled as part of assumed pathology. This phenomenon can compound feelings of anxiety and powerlessness (Surrey, Holttum & Wilson, unpublished thesis).

This has fuelled debate for ways to value the subjective experience of psychosis giving more emphasis to the meanings people attach to their experiences (May, 2000). Shared decision making is advocated for service user in mental health services and it is recommended that people with psychotic illness be included in therapeutic decision making (National Institute for Clinical Excellence, 2002). Furthermore, there is evidence that individuals with psychosis want a more active role in treatment decisions (Hamann et al., 2008). A focus on individual experience is considered by Bentall (1990) to be a

helpful framework from which to understand psychosis, and is regarded both empirically and practically more helpful than traditional diagnostic categories.

There are a number of challenges involved in measuring recovery in severe mental illness. These include using measures with norms which provide interpretive meaning and instruments which are sensitive enough to detect the subtleties of change associated with a population who are expected (by some) to demonstrate little improvement. This appears to be a key issue, for although symptom reduction may be minimal, significant change could be demonstrated in the way people understand or manage their symptoms. One of the questions therefore is whether outcome measures can adequately capture the various processes integral to recovery in psychosis?

THE MEASURES USED IN THIS STUDY

CORE-OM (Clinical Outcomes in Routine Evaluation-Outcome Measure) development

The number of instruments available to assess the effectiveness of psychological therapy is considerable. Froyd, Lambert and Froyd (1996) published a review of psychotherapy outcome measurement and from the 334 papers reviewed, reported the use of 1430 different outcome measures. Mellor-Clark et al., (1999) surveyed 220 NHS services and discovered that over 57 different measures were being used. In 1996 the UK Department of Health (DH) published a strategic review of psychotherapy services. It stated that 'important links between clinical practice and research are established and

maintained by using outcome measures' (p.62). This review emphasised the need for effectiveness data (from routine clinical settings) and efficacy data (from randomised controlled treatment trials) to be compared. Comparisons proved difficult, however, when as illustrated by Froyd et al., (1996) and Mellor-Clark et al., (1999) such a diverse and inconsistent array of measures were being used. As a means of resolving this predicament, the rationale for a 'core' outcome measure was proposed (Barkham et al., 1998), leading to the development of a wider core system (Mellor-Clark et al., 1999), leading finally to the design of the CORE-OM (Clinical Outcomes in Routine Evaluation-Outcome Measure) (Evans, et al., 2000).

Description

The CORE-OM is a nomothetic, generic outcome measure that can be used in both primary and secondary care. It is a 34 item self-report measure focusing on the last week and covers four domains: problems, functioning, well-being and risk (Barkham et al, 1998). It is a change measure for all psychological therapies required for use either at beginning and end of therapy or more frequently. It was designed to reflect what users, therapists and commissioners might regard as a minimal "common core" of questions for a change measure. Whilst the introduction of the CORE-OM addressed some of the pre-mentioned concerns, a number of studies have demonstrated that service users frequently express issues of concern on idiographic measures that are not identified in nomothetic instruments (Hunter et al., 2004).

PSYCHLOPS

Development

Ashworth et al., (2004) believed that many instruments in common use misrepresented service user views by reducing them to 'mere scores' that were not sensitive to the emotional complexities presented by people. PSYCHLOPS (Psychological Outcome Profiles) (Ashworth et al., 2005a) was therefore designed in accordance with the notion of evaluating health care based on the client's personal experience, the earliest example of which was the Personal Questionnaire (PQ) (Shapiro, 1961) mentioned previously.

All research to date featuring PSYCHLOPS has focused on primary care. The research comprises a study exploring the experiences of therapists using the measure alongside the CORE-OM (Clinical Outcomes Routine Evaluation – Outcome Measure) (Ashworth et al., 2005a), a study of the psychometric properties of the instrument (Ashworth et al., 2005b), a narrative-based classification of clients' problems as described on the instrument (Robinson et al., 2006), a comparison of psychological issues (i.e. the clients' presenting problems) and scores from PSYCHLOPS and the CORE-OM (Ashworth et al., 2007); and a study measuring outcomes following cognitive behaviour therapy (CBT) in primary care comparing PSYCHLOPS and HADS (Hospital Anxiety Depression Scale) (Zigmond & Snaith, 1983) (Ashworth, Evans & Clement, 2008). PSYCHLOPS has not yet been explored in secondary care where it may have particular applicability.

Description

PSYCHLOPS is an idiographic client-centred outcome measure which seeks the client's own view by asking what the most important problem is to them as an individual. It provides a way for issues of importance to the service user, which may not be adequately captured by nomothetic instruments, to be identified. PSYCHLOPS was originally designed as a pre- and post-therapy/ intervention measure but a mid-point measure has also recently been developed (Ashworth, personal communication, June 30, 2010). Whilst PSYCHLOPS has never been used sessionally a mid-point version was introduced based on the notion that therapy is dynamic and any static instrument, however good, can only capture one 'snapshot' of the process. Through the process of having therapy other important problems may have emerged due to the client's life experience. The mid point version therefore provides a way of monitoring this.

PARTICULAR POTENTIAL OF PSYCHLOPS FOR USE IN PSYCHOSIS

It has been suggested that people diagnosed with psychosis who enter into mental health services may begin to lose their identity through the power of medical and psychiatric discourses (Foucault, 1971; 1976). Feenan (1997) has argued that service users are expected to bring their own individual experience into line with the reality endorsed by the medical profession. It is further argued that service users are obliged to adopt the rules, language and structure of this system (De Barbaro, et al., 2008). Surrey et al., (unpublished thesis) showed how service users could not even experience brief periods of happiness without it being interpreted as a 'warning sign' and sign of

pathology. Furthermore, Masteron and Owen (2008) argue that the power of conventional assessment measures can lead to this information being prioritised over clinicians' judgement and decision making. They suggest that if a critical perspective is taken on power structures and working practices then the recovery discourse is at risk of a backlash from the professional groups whose power is threatened.

Although the medical terminology in outcome measures is often carefully written so as to be understood by a lay person, the imposition of such language could still be viewed as stigmatising and alienating to the service user. It is suggested that the power contained within psychiatric language could lead to the service user unwillingly assuming the role and identity of a 'mentally ill' patient (Harper, 1999; 2002) through the power of the medical discourse. It could be suggested that conventional measurement instruments similarly encourage a reduction in the expression of personal experience through the language presented, albeit in a less marked way. When combined with the disturbing impact of psychotic experience and the need for relief from distress, as well as existing social disadvantage, any compliance with medical discourses could contribute to the negation of personal experience, thoughts and feelings and result in a level of de-individualisation.

De Barbaro et al., (2008) looked at the effect of hospitalisation on a patient's identity. They found that the patient's use of language changed in terms of content (e.g. language became more medicalised and intellectual) and form (e.g. dialogic statements decreased whilst monologic statements increased). They also demonstrated a

significant increase in sense of stigmatisation. It could be argued that conventional outcome measures could feed into this by limiting the expression of personal experience.

According to Magliano et al., (2009) client-generated instruments may be useful in psychiatric services with those experiencing severe mental distress. In part, this may be because of the complexity of experience. The severity of symptoms in people with psychotic illness may, for example, be unrelated to impairments in quality of life or health status. Here, client-centred outcome measures could have an important role as they can address more than symptoms. As clinical consultations and practice are typically focused on symptomatology, the success or failure of treatment is predominately judged on this criterion which may not be the most valid.

FUTURE DIRECTIONS

This review suggests that the suitability of conventional outcome measures with people experiencing severe mental distress, particularly psychosis, is an issue which warrants greater attention. The recovery movement encourages people to seek empowerment by taking an active role in managing their difficulties and evaluation of change is one example of this. If it is accepted that conventional outcome measures limit the expression of personal experience, then it could be argued that empowerment is being compromised. One solution could be the implementation of more service user generated measures.

PSYCHLOPS is a service user centred measure which is particularly congruent with more recent notions of recovery and which may offer an opening for greater expression of issues about which people experiencing psychosis are concerned. The applicability of PSYCHLOPS to this population, however, has not yet been explored.

The literature suggests that outcome measurement operates within a wider system that is susceptible to power related dynamics and discourses. It could therefore be argued that further attention needs to be given to the way in which therapists and service users negotiate power in relation to outcome measurement, taking a critical perspective on power structures and working practices.

The following paper aimed to address these concerns by evaluating service-user and therapist discourses of PSYCHLOPS in the context of CBT for psychosis. Two main research aims were identified 1) Exploring the process and experience of using PSYCHLOPS by considering the types of discourses drawn upon by service users and therapists when talking about the use of outcome measures (specifically PSYCHLOPS and the CORE-OM) and 2) Considering the consequences, in terms of subject positions, and where power is located, of the construction of discourses for the following discursive objects: PSYCHLOPS, recovery and psychosis.

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**PSYCHLOPS and Psychosis:
A Foucauldian Discourse Analysis**

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Abstract

PSYCHLOPS (Psychological Outcome Profiles) (Ashworth et al., 2005a) is a client centred outcome measure which had prior to this study only been researched in the context of primary care mental health. However, PSYCHLOPS appears congruent with the 'recovery model' popular in services serving people diagnosed with psychosis as it explicitly values individual experience by giving people the opportunity to express their difficulties in their own words. To explore this apparent congruence, a Foucauldian discourse analysis explored the discourses drawn upon by service users (n=4) and therapists (n=4) when talking about the use of outcome measures with individuals receiving CBT for psychosis.

This study used a qualitative design. Data were collected by administering PSYCHLOPS and the CORE-OM at three time points for each service user during time-limited therapy followed by a post- or during-treatment interview with each service user and their therapist separately. The discourses about PSYCHLOPS were juxtaposed with those about the CORE-OM, a nomothetic outcome measure which the services employing the therapists expected to be used at beginning and end of therapies. Dominant discourses to emerge included power, empowerment, 'being heard', engagement, chaos and containment. The results suggest that PSYCHLOPS can offer a user-centred approach congruent with a recovery framework, but which may also be subject to powerful surrounding discourses. More research is needed but the results underline the complexity of change measurement and importance of congruence between outcome measures and the models the therapists and clients bring to the therapy.

Psychosis and recovery

In the recovery literature, a prominent aim of clinicians working with psychosis is often the desire to support clients in achieving a more fulfilled life. This raises a dilemma for clinicians trying to measure outcomes using nomothetic instruments which appear to have associations with the medical model. The application of client-generated outcome measures to ideas about psychosis and recovery may therefore be particularly congruent with more recent notions of recovery, especially those which are defined by service users (May, 2000).

Most outcome measures for psychosis are derived from pharmacological studies focusing on symptom change rather than distress or fulfilment (Greenwood et al., 2010). This is in spite of many difficulties associated with psychosis often consisting of more than just clinical consequences. For example, whilst difficulties may include auditory hallucinations and delusional thinking, the condition also often involves a complex relationship to poverty and social isolation (Turkington, Kingdon, & Weiden, 2002). Distressing perceptions may also be accompanied by a reduced ability to cope with usual day-to-day activities and routines. It could be argued that the problems associated with all of these factors may not be adequately captured by conventional nomothetic outcome measures. There is, therefore, a need for outcome or change measures which address a wider range of phenomena and are more congruent with the recovery model.

Power and control in mental health

Service user literature has criticised outcome measures for not capturing empowerment issues (e.g. Trivedi & Wykes, 2003). Some service users have devised their own measures, such as the Recovery Star (Mental Health Providers Forum, 2008), capturing a range of areas important to service users. It is unclear how much importance service users place on open-ended questionnaires as opposed to those exploring pre-defined areas. It may be more important that any pre-defined areas cover issues that other service users have highlighted rather than the measure offering completely open-ended questions. Nevertheless, at the time of writing, there is relatively little use of service user devised measures, and this is only one aspect of the way in which power is located predominantly with clinicians.

Trivedi and Wykes (2002) reported that in response to education about medication, service users valued empowerment as an outcome over traditional outcomes such as medication compliance and insight. This is significant considering that it could also be suggested that the measurement of change in severe mental distress is limited by attempts to objectify experience using language that serves the medical system more than the service user (Garland, Kruse & Aarons, 2003).

The potential power inequality between therapists and service users appears to be an issue that clinicians often neglect to recognise (Horsfall, Cleary, Walter & Malins, 2007). Health professionals may be unaware of the impact of administering outcome measures on their client in terms of choice of measure and freedom to contest their

parameters. PSYCHLOPS (Psychological Outcome Profiles) (Ashworth et al., 2005a) is a client-centred measure which could be seen to offer a potential solution to these dilemmas as it seeks the client's own view by asking what the most important problem is to them as an individual.

The PSYCHLOPS measure

PSYCHLOPS is a client-centred psychometric instrument used as an outcome measure. It is a one-page questionnaire that is self-administered. It asks the service user to identify up to two problems of greatest personal priority, to describe them within free-text boxes, then to rate their impact using Likert scales. The questionnaire also has two other items relating to level of functioning as a result of the problem described, and an overall rating of well-being. The instrument is then used to monitor change in these individually meaningful problem areas. It has been reported to be a sensitive indicator of change (Ashworth et al., 2004) and has been used in therapy in primary care as a before-and-after intervention measure (Ashworth et al., 2005b; Robinson, Ashworth, Shepherd & Evans, 2006). A during-therapy version has also recently been developed. During the development of the measure, Depression Alliance, a voluntary organisation offering support for people with depression, was consulted to gain a user perspective. They suggested that the title written on the actual questionnaire be changed from PSYCHLOPS to 'A questionnaire about you and how you are feeling', a suggestion that was adopted. PSYCHLOPS offers a way for issues of importance to the service user

which may not be adequately captured by more conventional instruments to be identified and any change to be measured.

The developers of PSYCHLOPS recognised that many instruments currently in use, including Quality of Life (QoL) measures, were heavily based on clinician and researcher opinion in terms of the types of domains included and questions asked. They felt that these conventional measures lacked the perspective of service users. Before producing PSYCHLOPS, its authors searched the literature for any simplified, short patient-generated quality of life measures and discovered the MYMOP – (Measure Yourself Medical Outcome Profile) (Paterson, 1996), a one page questionnaire measuring the aspects and effects of physical illness deemed by the patient to be most important to them. PSYCHLOPS was developed from this design.

Lambert et al., (2001, 2002) and Miller, Duncan, Sorrell and Brown (2005) propose that sessional feedback can be beneficial in terms of reducing duration and providing better outcomes. Whilst PSYCHLOPS is not used sessionally, it may enable therapists and users to become more interested in outcomes by fostering collaboration in two ways. Firstly, over the issues the client's words throw up and secondly by doing this in a way potentially more appealing to clients and therapists than nomothetic outcome measures because it provides an opportunity to discuss issues most relevant to the client.

PSYCHLOPS and psychosis

The idiographic nature of PSYCHLOPS may be of value in capturing the unique difficulties experienced by people experiencing psychosis and in reflecting the individual person's concerns. According to service user literature, a key element of recovery would seem to be about people taking control of their lives and at the very least having more control over what happens to them in the mental health system (Wallcraft, Read & Sweeney, 2003). Giving service users a voice to express their difficulties in their own words, by using an instrument that explicitly values their individual experience, is arguably a way of facilitating service users having greater control in a therapy context, although of course it is not the only way. It may, however, offer an opening for greater expression of a number of issues about which people experiencing psychosis are concerned.

Furthermore, taking a discursive perspective enables one to link the notion of 'recovery' with subject positions, highlighting the presence of contrasting ideas. For example, psychiatric frameworks may be seen to privilege discourses pertaining to the reduced applicability of diagnostic criteria following treatment, or amelioration of particular symptoms, whereas a survivor perspective may be seen to privilege discourses constructing recovery as the regaining of control over one's life and the ability to function in society despite ongoing difficulties (Dillon & May, 2002).

Previous research on PSYCHLOPS

PSYCHLOPS was designed for use in primary care mental health and all research to date has focused on this context. Prior to the current study, the use of PSYCHLOPS in other clinical settings, particularly those involving people with severe and enduring mental health difficulties, had not been explored. Existing research which has particular relevance to this study involves comparisons with the CORE-OM (Clinical Outcomes in Routine Evaluation-Outcome Measure) (Evans, et al., 2000). Key findings include that the qualitative information from PSYCHLOPS became part of the therapeutic process and was thought to complement the quantitative information from the CORE-OM (Ashworth et al., 2005b) and that service users mentioned issues on PSYCHLOPS which were not clearly featured on CORE-OM (Ashworth et al., 2007).

Rationale for using PSYCHLOPS with psychosis

Foucault asserts that where there is knowledge there is power, believing this paradigm to be exercised through discourse (Foucault, 1971, 1972). 'Expert' knowledge is something which psychiatric discourses privilege and is synonymous with power. An example of this is the development of sane and insane 'positions' which have led to the acceptance of categories of abnormality (e.g. DSM-IV). The diagnoses of psychosis and more particularly schizophrenia, the validity of which have been questioned (Bentall, 2006) could be seen as a method of social control (Foucault, 1961).

In keeping with Foucault's (1961, 1971, 1972) expositions of the way that psychiatric and medical discourses and institutions maintain power relations that are oppressive to those positioned as patients, it is suggested that certain discourses associated with over-use of a medical model of mental distress potentially take social power away from service users. This could be by defining problems, goals and progress in terms of too narrow a focus on symptoms and defensive risk management with insufficient emphasis on strengths and individually meaningful goals (Surrey, Holttum & Wilson, unpublished thesis), or on positive risk management (DH, 2008). Surrey et al., and also Harper (1999, 2005) have demonstrated that medical and psychiatric discourses tend to position service users as unable to make their own judgements.

None of the previous research on PSYCHLOPS addresses the way in which therapists and service users negotiate power and therefore the current study could potentially raise awareness of how subject positions are negotiated (Davies & Harre, 1990). If PSYCHLOPS does aid service users in making a more active contribution to assessing progress in therapy by having their own voice, then the current study could also highlight these processes.

Research questions

This study was an evaluation of service user and therapist discourses of PSYCHLOPS in the context of CBT for psychosis. The study was specifically about the application of PSYCHLOPS to this client group. It was not a study of the use of outcome

measures in general but was designed to explore how therapists and clients construct and reflect on their experiences of using outcome measures. It uses the Foucauldian framework to highlight issues of power and legitimisation as these contribute to the construction of this and every social system.

The services in which the therapists work and the clients are seen are already required to use a nomothetic self-report measure, the CORE-OM, at the beginning and end of therapy so this provided a referential experience against which the addition of PSYCHLOPS for this study could be explored. Though the CORE-OM is routinely used only at the beginning and end of therapy within this study it was used, like PSYCHLOPS at beginning, after six weeks and at the end of therapy ensuring that both were, at least in part, in a new focus.

The research questions were as follows:

Process /Experience of using PSYCHLOPS

What discourses are drawn upon by service users and therapists when talking about the use of outcome measures with individuals receiving CBT for psychosis?

What are the consequences, in terms of subject positions, and where power is located, of the construction of discourses for the following discursive objects:

- a) PSYCHLOPS
- b) Recovery
- c) Psychosis

Methodology

Discourse analytic approaches

Discourse analysis has been defined as 'an examination of language use – the assumptions that structure ways of talking and thinking about the topic of interest and the social functions that the discourse serves' (Powers & Knapp, 1990. p.40). Wetherell and Potter (1988) suggest that discourse is orientated towards particular functions, giving language both a constitutive and constructive role. Two main approaches dominate the literature; Discursive Psychology and Foucauldian Discourse Analysis (Burr, 2003).

Discursive Psychology is predominately concerned with the way in which language is used to negotiate and manage social interactions to achieve interpersonal objectives (Willig, 2008). Foucauldian Discourse Analysis is more interested in the position of discourses in relation to wider social processes of legitimisation and power. It

maintains that the discourses used to construct individuals and objects are embedded in power relations, supported by institutional practices. It is difficult to completely separate the two approaches but, as this study chose to focus predominately on power issues, a Foucauldian approach was adopted as the main framework.

Epistemological position

Discourse analysis is located within a social constructionist epistemological framework which adheres to a number of implicit assumptions. These include challenging taken-for-granted ideas; suggesting that 'knowledge' and 'truth' are sustained by social processes and should therefore be viewed as historically, socially and culturally specific; and that descriptions and explanations are never neutral as they represent forms of social action which serve to maintain certain patterns and functions (Gergen, 1985).

Researcher's perspective

Foucault (1972) recommends that we gain an awareness of how we came to see ourselves in the way we do. This felt particularly salient given that I was conducting research encompassing knowledge and power. It was important for me to try and develop a reflexive awareness of the status of my own claims of knowledge, questioning what discourses are used in their construction.

Design

As noted above, this was a qualitative design comprising data collected by administering PSYCHLOPS and the CORE-OM at three time points for each service user during time-limited therapy. Then a post-or-during-treatment interview with each service user and their therapist separately. Participants were asked to complete a 'before therapy' PSYCHLOPS questionnaire at the start of therapy, a 'during therapy' questionnaire at six weeks and, at 12 weeks, either another 'during therapy' questionnaire or, in the unlikely event that treatment was completed by then, an 'after therapy' questionnaire.

Therapists were given guidelines on how to administer PSYCHLOPS but were all given the opportunity to integrate the measures in a way that felt consistent with their clinical practice. Three of the therapists chose to administer PSYCHLOPS collaboratively with their client in the session (e.g. reading the questions and thinking about the responses together) whilst one therapist chose to give PSYCHLOPS to their client to complete outside of the session and bring back.

The CORE-OM was also given to service users at the same three time points (rather than only pre- and post-intervention as routinely required within the service). It was proposed that experience of the other outcome measure would be valuable as a reference point in the interviews for this study in looking at the discourses concerning completing questionnaires. The questionnaire scores and data were not used in any analyses as this study was concerned with social constructions rather than outcome

data. The CORE-OM (Evans et al., 2002) is a 34 item self-report measure focusing on the last week. It is the one of the approved change measures required for use either at beginning and end of therapy or more frequently for all psychological therapies in these Trusts. It is an interesting contrast point to PSYCHLOPS as, although users were heavily involved in its design, it was designed more around the views of therapists of many different modalities, of what could be a sensible minimal “common core” of questions for a change measure. It was not designed for work with psychosis and no published papers on its use specifically in therapies for psychoses were found.

Participants

Inclusion and exclusion criteria

Service users with a diagnosis of ‘psychosis’ who had embarked on CBT within the mental health trusts for which ethical approval had been granted were eligible for inclusion in the study. These service users were identified by the therapists working with them. The therapists included individuals working in a secondary care mental health team using CBT. As the National Institute for Clinical Excellence (NICE) recommends cognitive behavioural therapy (CBT) for psychosis, I chose to work only with therapists/ service users who had chosen CBT as their main therapeutic modality. Exclusion criteria also included anyone under the age of 18 and/or with active suicidal ideation.

Participant characteristics

Four therapists and four service users were included in the study. Therapists consisted of two males and two females and were aged between 26 and 45. The ethnicity of therapists was white British. Three were clinical psychologists and one was a BABCP (British Association for Behavioural and Cognitive Psychotherapies) accredited CBT therapist. The amount of time since qualification ranged from two years to 19 years. The service users consisted of one female and three males and were also aged between 26 and 45. Ethnicity included two white and two black British. The duration that participants had been receiving support from mental health services ranged from six months to 15 years. Two individuals were given diagnoses of schizophrenia, one had a diagnosis of schizoaffective disorder and one was diagnosed with psychotic depression. Service users' duration in CBT at the time of interview ranged from 12 to 18 weeks.

	Gender	Age Group	Ethnicity	Profession	No. years qualified	Type of team
John ¹	Male	26-35	White British	Clinical psychologist	3 years	Psychological therapies
Beth	Female	26-35	White British	Clinical psychologist	2 years	Psychological therapies
Mark	Male	46-55	White British	CBT therapist	5 years	Psychological therapies
Laura	Female	36-45	White British	Clinical psychologist	19 years	Community rehabilitation support

¹ pseudo names have been given to all therapists

Table 2
Service user Characteristics

	Gender	Age Group	Ethnicity	Diagnosis	Time in services	Time in CBT at interview	No of PSYCHLOPS completed
Paul ¹	Male	36-45	Black British	Schizophrenia	15 years	14 weeks	3
Harry	Male	46-55	White British	Schizoaffective disorder	8 years	12 weeks	2
Kim	Female	26-35	Black British	Psychotic depression	6 months	16 weeks	3
Nick	Male	26-35	White British	Schizophrenia	10 years	18 weeks	3

¹ pseudo names have been given to all service users

Interview

The semi-structured interview questions (Appendix G) were developed with the aim of eliciting narratives about the experience of using PSYCHLOPS. They were piloted with two clinical psychology trainees. Topic areas included how PSYCHLOPS was introduced, process of using PSYCHLOPS/ CORE-OM, relationship between PSYCHLOPS/ CORE-OM and therapy sessions, and progress of therapy.

Procedure

Within South London & Maudsley and Oxleas NHS Trusts, fourteen adult community mental health teams, whose client group included psychosis, were identified. Therapists from these teams were approached by email and phone. The researcher attended eight team meetings to introduce the project and answer any questions.

Information packs were hand delivered to any therapist who practised CBT and expressed an interest in participating in the research (Appendices E & F).

Therapists were asked to identify service users meeting the inclusion criteria with whom they were about to commence therapy. They were asked to introduce the study at their own discretion. If the service user was agreeable to taking part then the information from the pack was given to them and they were asked to think about it for a week before making a decision. Once consent had been established, the therapist administered the first set of measures and contacted the researcher to inform them this had taken place. The researcher then agreed to contact the therapist in 10 weeks' time to arrange a time to interview them and their client at a time agreeable for them at around 12 weeks once the final set of questionnaires had been administered. A one-to-one semi-structured individual interview was then undertaken and audio taped with each participant. Each interview lasted between 40 minutes to an hour. All interviews were held within two weeks of the final set of measures being administered.

For clinical psychology doctoral level projects using discourse analysis, five hours of material is the recommended minimum amount (Turpin et al., 1997). It was therefore ensured that the amount of data collected for this project met these requirements.

Quality assurance

Reflexivity: The researcher's thoughts and assumptions were questioned and challenged throughout the research process through discussions with supervisors and the use of a reflexive diary. This helped me to reflect on my relationship to the research and status of my accounts. *Audit:* One supervisor completed an audit of coding to check for other readings. A discussion of the differences led to some developments both in the coding and in the arguments for these.

Ethical considerations

Ethical approval was secured from Lewisham Local Research Ethics Committee. Research and Development approval was obtained from South London and Maudsley (SLaM) and Oxleas NHS Trusts. Written consent was obtained from all participants prior to the study commencing.

Analysis of data

The researcher engaged with the data starting with the process of transcribing interviews. Transcripts were read a number of times and notes made on the overall impression of the data. Coding was then generated through the development of 'intuitive hunches'. The objective was to engage with a process of reading and re-reading through which parts of text that were related to the research questions were identified, rather than a 'discovery' of the 'true discourses' (Willig, 2008).

The focus was on PSYCHLOPS as the primary discursive object and all material related to it was identified, with themes or ideas written in the margins of the transcript in line with the aims of the study. Attention was then given to how PSYCHLOPS was constructed in relation to psychosis and recovery and how these discourses positioned individuals. All relevant extracts were methodologically examined in concordance with the six stages described by Willig (2008) comprising an analysis of Discursive constructions, Discourses, Action Orientation, Positionings, Practice and Subjectivity. Particular attention was given to the types of discourses that emerged throughout these stages (e.g. the different ways in which PSYCHLOPS was constructed in the texts), the ideological dilemmas that were elicited (e.g. with competing discourses) and the way in which subject positions were constructed (e.g. how the self and others were positioned) (Edley, 2001). In line with the epistemological framework of there being no one 'truth', this analysis is just one possible interpretation of the research. However, it was subjected to supervisor review to check for alternative readings, and any differences of view were discussed and in some cases led to modified interpretations.

Results

PSYCHLOPS: the road to service user empowerment?

Throughout the interviews PSYCHLOPS was constructed through discourses similar to those found in the recovery literature.

'it fits in with that kind of ethos of person centred work and recovery, the person's own experience, the person's own definition of what's difficult for them, what's at the centre and I think that's particularly pertinent often in psychosis 'cause often the language, the meanings you attribute to things that the person's experiencing are so important and often their history of services can be can be very problematic in that their understanding and their beliefs about what's happening are very different from what psychiatrists and psychologists are saying about it, and sometimes I think that's what's difficult about preset questions, the language may actually be language that they have found difficult in the past so giving them the reins if you like is really helpful' (Laura – therapist, lines 202-214).

Here, person-centred language is positioned as a crucial element of service user experience. The type of language that is afforded to service users has the potential to either empower, by enabling individualised expression or disempower, by obstructing freedom of expression through the service user having to adhere to discourses with which they might not connect. PSYCHLOPS is constructed as enabling service users to break free from the constraints of past, unhelpful professional discourses which have been placed upon them. Contrastingly, however, Nick said:

'With these mental health problems, you've got to tell people how you're feeling, people have got to know and they can only go by what you're saying' (Nick – service user, lines 18-20)

Whilst appearing to construct the service user voice as central, this extract could be seen to construct therapy and therapists in a position of power by stressing how imperative it is to tell health professionals how you are feeling for fear of them adopting their own ideas. It could equally reflect service user power, i.e. therapists can only go on what you are saying.

Referring to what was written on the PSYCHLOPS questionnaire, Paul seems to be saying it is about his power:

'that was not her words, my words' (Paul – service user, line 125)

Having the opportunity to use his own words in the context of representing his personal journey appeared to be something that Paul valued. The fact that he is stating this could suggest that normally it would not be his words that were used in an outcome measure. Therefore he is constructing PSYCHLOPS as a measure that is open to capturing HIS words.

'I liked the PSYCHLOPS, I thought it is a really good idea to give the person free-hand to describe their difficulties and then get them to ascribe values to the impact and so on. I think that's a really nice way to do it rather than leading them into specific areas and asking about them, letting them dictate what the main theme is, is really helpful' (Laura – therapist, lines 43-47)

PSYCHLOPS is presented by a professional as an instrument which has the potential to readdress the inequality of power, something which gives service users the power to 'dictate' what they want rather than receiving something which is dictated to them. PSYCHLOPS legitimises the position of service users as 'experts' concerning their own experience.

PSYCHLOPS as an aid to collaborative working and reducing power differentials

In the interviews PSYCHLOPS was constructed as an instrument which supports collaborative working.

'I think what really fits about PSYCHLOPS is it's explicitly about collaboration and it's explicitly about getting the client's perspective' (Beth – therapist, lines 63-65)

But collaboration itself seemed to raise concern about therapist power:

'certainly with psychological measures per se, I wouldn't want to influence either way what they were doing, but I can see with this 'my mental health' [client's own problem-description] it's just such a general statement of what she's struggling with. Whereas normally if I'm doing problems and goals and things like that I try to help them be a little more specific. Again as a CBT therapist it's being socratic, it's not trying to influence them' (Mark – therapist, lines 80-83)

This illustrates an ideological dilemma whereby the therapist wants to be able to help or guide the client to use the measure in the most effective way, positioning himself as having power to guide the client, and the client as unable to formulate her own problem with sufficient precision, but at the same time does not want to exercise his power, positioning himself as allowing the client to exercise her own authority by making the decision about how to describe her problem. Interestingly this therapist referred to the administration of PSYCHLOPS as a;

'piece of self-directed activity' (Mark- therapist, line 68)

and so constructs PSYCHLOPS as activity aligned to CBT, and CBT as a therapy that incorporates client self-direction. In her interview, his client said that she welcomed being able to take the measure away to complete in her own time as it gave her space to process her thoughts. It transpired that whilst 'my mental health' was written as her first problem, she refined her second problem to;

'my self-confidence and self-esteem' (Kim – service user, line 51)

Adding that PSYCHLOPS;

'helped me to prioritise what really troubles me the most... it really made me think about is this really a problem or not?' (Kim – service user, lines 68-69)

PSYCHLOPS is constructed as an instrument that has the potential to encourage service users to explore their own ideas helping Kim to make sense of her difficulties.

This was not only reflected by service user discourses but also by therapists:

'it kind of led into a very focused discussion. I think it maybe led us right directly to the problem. Certainly for him it seemed to help him express the centrality of that problem, actually writing it down and scoring it' (Laura - therapist, lines 24-27)

PSYCHLOPS is presented as having an impact beyond that expected from an outcome measure. It is seen as having the potential to influence the process of therapy by supporting clearer communication between the service user and therapist. In addition, compared with administering the CORE-OM, completing PSYCHLOPS appeared to be constructed as a more collaborative activity:

'we did the PSYCHLOPS more collaboratively whereas the CORE I just kind of left him to it. He didn't seem to mind doing the CORE, he just went about his business ticking the boxes and gave it back' (John – therapist, lines 179-182)

With the CORE-OM, the service user is spoken about in a more detached way with the therapist making assumptions about how the client found the process. The CORE-OM is also referred to as 'doing business' and 'ticking boxes' and therefore is constructed as part of the organisation or as routine. The comment 'went about his

business' suggests a client socialised into clinic routines of ticking boxes on questionnaires and 'he didn't seem to mind' further bolsters this idea that it was a routine and expected operation. This could perhaps be seen to position the service user as someone who is expected routinely to fill in questionnaires and not to mind.

PSYCHLOPS as insufficiently powerful against the biomedical system

As a client-centred outcome measure it might be assumed that PSYCHLOPS would not be affiliated with biomedical discourses in the same way as many of the more traditional nomothetic measures. However, it was sometimes constructed by therapists and service users as unable to withstand the biomedical discourse.

'the referral kind of loosely stipulated that he was paranoid and so he came to this conclusion that his main problem was that he believed he was being persecuted by strangers and family members' (John – therapist, lines 61-64)

Here John constructs his client's problem in terms of diagnostic discourses of paranoia and views this discourse as having sufficient legitimacy and power to determine the client's goals on a client-centred measure. John seems to be saying that his client formed his decision about his main problem based on what was written in his referral. John goes on to say;

'I was a little surprised at how straightforward it seemed to be in terms of specifying that as the main problem using that language in a way that we could both go, "This is the main problem" (John – therapist, lines 70-72)

This implies a 'shared' discourse of paranoia. John, appears to not to challenge this. Taking this position means that the 'problem' is just accepted, and not thought about in depth. This in turn reinforces the expectation of the client that he or she will only be heard by presenting himself in this way, and by presenting themselves differently clients might fear that they will not be heard.

Construction of the CORE-OM as part of an oppressive system

The literature suggests that some service users, particularly those with severe and enduring distress, are afforded limited power or control in mental health services and therefore have an oppressive experience of the mental health system (Newnes, Holmes & Dunn, 1999). The following extract demonstrates the role that outcome measures and therapists may play in this:

'I suppose it just raises in my mind then, for some people, what does ticking all these boxes actually mean? What am I part of? Why am I being asked to do this? Where's the information going? Who's going to look at it? How long is it going to be kept for?' (Mark - therapist, lines 189-193)

Here the therapist refers to administration of the CORE-OM, questioning its purpose and meaning, and his role and responsibility in this process which he constructs as having wide-reaching implications. Speaking more broadly about outcome measurement, Mark suggests that whilst some service users *'love doing them'* (line 172) others may question what *'ticking boxes and being scored'* (line 177) means and yet comments that therapists still give outcome measures without knowing the answers to these questions. By positioning the system as dictating his use of the CORE-OM and not giving him explanations, the therapist is positioning himself as lacking the power to ask questions about it. The CORE-OM is the instrument of an oppressive system in which, somewhat sinisterly, he does not know what he is 'part of'. Mysterious people might look at the questionnaires but he knows nothing about them. Beth goes even further:

'I get the CORE filled in because we're expected to, and if I don't buy into it then I think there's something slightly unethical about doing it, cause if you're not using the information afterwards then why are you getting someone to fill it in?, and ultimately the CORE is about the service, it's about the Trust that I work in... for me it feels sometimes like the motive behind it is at a broader organisational level and it's not about that individual's life ' (Beth – therapist, lines 158-166)

In this extract Beth positions herself as lacking power to say no to using the CORE-OM, but as having power to choose not to use the CORE-OM scores in therapy even though she dutifully collects them. However, Beth constructs this as placing her in

an ethical dilemma, and the CORE-OM again as the instrument of a powerful system that does this to her. It could be that Beth is resisting any form of exploration of the impact and effectiveness of the CORE-OM or that she feels alienated from the managerial system per se and so experiences the CORE-OM as 'bad' because this came from the managerial system.

Measures as containing or uncontainment and psychosis as chaos

Containment is a term used in psychodynamic/psychoanalytic theory to infer a boundary which engenders safety and security (Winnicott, 1965). Containment appeared to be a discourse which was privileged by both service users and therapists. The following extract refers to PSYCHLOPS:

'if it asked about something and it touched upon a subject then you're likely to go beyond the premise of what the question was and go into something else which the survey would not cover, so it wouldn't make sense' (Harry – service user, lines 186-189)

PSYCHLOPS is a measure that offers service users much greater opportunity for expression, whereas the CORE-OM with its predetermined questions and answers provides limitations. Harry positions himself as someone who needs containing and therefore demonstrates an ambiguity in relation to PSYCHLOPS. Whilst enough 'space' is desired to enable sufficient expression of the complexity of his difficulties, there is the worry that this unconstraint might lead to something that 'wouldn't make sense'. It would

appear that having some form of containment provided by a structured framework of predetermined questions versus being offered the opportunity to have one's own say in free text is an ideological 'dilemma' for service users. Two opposing discourses are implied, one being the desire for therapist power to keep things within certain limits, and the other the desire for service user power to express themselves freely.

Harry's parallel discourse around the CORE-OM suggested at one point he felt more contained by the CORE-OM than PSYCHLOPS. He constructed PSYCHLOPS as being so sensitive that it could be 'affected' and unbalanced by his experiences:

'you could put something in there [PSYCHLOPS] that could totally unbalance the questionnaire' (Harry – service user, line 185)

Harry's experiences are constructed as being so powerful they can influence this measure. This discourse, however, appeared to shift the more Harry talked about PSYCHLOPS, revealing that at different points PSYCHLOPS was constructed as containing and uncontainable for the same person.

PSYCHLOPS was also constructed as containing for therapists as well as clients. Here again, psychosis is constructed as a form of chaos with power to disrupt things:

'We had already started to identify a bit more of a focus, 'cause I think that also, particularly with this client group, it can sometimes feel quite difficult to give structure and focus to the sessions. People can feel and present in quite a chaotic way if there's a lot of distress around, you can often find you're dealing with the distress initially and that can kind of throw things off track a bit, so I think having the PSYCHLOPS was helpful' (Beth – therapist, lines 42-48)

PSYCHLOPS is positioned as something which gives order to sessions, protecting the therapist from becoming overwhelmed by the distress and chaos of the client's experience (of psychosis). PSYCHLOPS appears to 'formalise' discussions by giving structure. Interestingly, the CORE-OM was not spoken about in the same way by therapists. The therapists in this study did not seem to have the same level of conversation about the CORE-OM once it had been completed:

'often in therapy you kind of specify a goal anyway and this way it [PSYCHLOPS] just sort of formalises it and gives you a bit of structure around how to go about it. It's a more consistent way of measuring it, before, middle and end, cause you know it's easy to lose track and actually it's a nice tidy way of recording that initial specified goal' (John – therapist, lines 52-57)

PSYCHLOPS appears to legitimise the decision to focus on just one or two issues making therapy feel more manageable. It raises the question of whether

therapists tend not to have conversations around what is put on outcome measures because what they are measuring is too broad or narrow. In a way PSYCHLOPS is portrayed as legitimising those discussions within a more formalised, structured framework.

Being ill: Medication and health

Interestingly, medication was a subject referred to by service users but not by therapists:

'sometimes coming up with words when you're on medication, your focus is not there, and when you've got multiple choice one of them brightens up, it clicks, you know you go, yeah that's the one, but when you've got an open option you really have to think' (Harry – service user, lines 167-170).

Throughout his interview, Harry constructed medication as something which was necessary to keep him 'well' but that also caused him many difficulties. This paradox also transferred to the notion of outcome measurement, with medication constructed as a discursive object so powerful it could significantly reduce the ability of service users to engage fully in a measure explicitly designed to aid empowerment. Completing the CORE-OM is positioned as an easier exercise when medication is affecting 'your focus'. In this respect, the CORE-OM is constructed as an instrument that does not need as much thinking about as PSYCHLOPS. This could either be seen as something which

meets the needs of service users at this difficult stage in their illness or something which legitimises the control resulting from psychiatric processes.

Balancing strength with weakness

Both professional and service user discourses constructed psychosis as an illness with many different aspects. They suggest that conversations about psychosis can be seen to privilege deficits with not enough emphasis given to positive attributes that shape a person's recovery:

'the other thing I find really important working with these clients is always being mindful about trying to balance this idea around difficulties with strengths and it would be really interesting to see a measure that thinks a bit about ways of coping' (Beth – therapist, lines 280-288)

Beth draws upon the discourse of outcome measures being largely problem-focused in nature and so introduces the idea of balancing distress with something more positive. This raises the interesting question of why outcome is predominately determined by an emphasis on deficit rather than attainment. Beth suggests that a balance could be reached if PSYCHLOPS included;

'one thing that you felt good about in the last week' (line 288)

She develops this notion further by suggesting that shifting the emphasis from deficits to strengths could also have implications for the therapeutic relationship. The idea here is that balance in a measure might be needed to form a more balanced collaborative relationship:

'I would reckon if you asked service users about this it might have quite a profound effect on them. If you asked about what they're pleased about or what they feel good about, that would probably open up a whole different conversation'
(Beth – therapist, lines 291-294)

Here, Beth illustrates the benefits of outcome measures adopting a recovery discourse. Having a measure which values strengths as well as difficulties means that you are addressing the 'whole person' rather than just one element.

Engagement and psychosis: the role of the outcome measure

Engagement is an essential element of any therapeutic contact and has particular resonance with this client group because the symptoms associated with psychosis may affect their ability to interact or understand information. Discourses around engagement and therapeutic alliance had greater prominence in the narratives of therapists than service users. These discourses centred on explanations for administering measures and choosing the right time to introduce them:

'I'd be quite careful myself about doing it too early. I guess just to have a bit of time with the person so that they get to know you in a personal way before a piece of paper comes along' (Laura - therapist, lines 161-163)

The notion of needing to be careful implies that there is something which needs to be treated with care. This could be understood to refer to the client, their experience or the therapeutic relationship. The comment about administering a measure too early assumes that there is a 'right' and 'wrong' time. This could apply to the stage of engagement (i.e. the client not knowing the therapist in a 'personal way') or the service users' stage of illness. This positions both the service user and the therapeutic relationship as something which could be damaged by the introduction of 'a piece of paper' and in doing so constructs outcome measures as objects with significant power.

This discourse could also be seen to reflect the anxieties of the therapist as they are faced with the dilemma of having to balance organisational requirements advocating the collection of data at specific time points rather than when their own clinical judgement deemed it appropriate.

'particularly for this client group, you've got to be administering things that aren't seriously at odds with the way you do things' (Beth – therapist, lines 190-192)

Here, Beth also positions outcome measures as discursive objects which have the potential to be damaging. The notion of being 'at odds' implies that these measures

have the potential to 'unbalance'. It could be inferred that if the therapist is not happy with a measure, then the client will also be unhappy with it. This constructs this client group as being so sensitive that they will be affected by a therapist giving them a questionnaire despite having doubts about its value. It could also be seen as justifying an anti-questionnaire position by positioning the clients as fragile.

PSYCHLOPS and psychosis

Mental health discourses of recovery consider the type of language available to service users vital in them being able to express their experience in a meaningful way. The following extract highlights how this may relate to PSYCHLOPS:

'it talks about how affected, how much it's affected you. If you're thinking about psychosis I would probably say distress is a crucial component to this client group... for instance, someone might put the trouble "not being able to go out", how affected have you been in the last week? Not that affected. That might be because in that week they haven't had to go out, but they might be extremely distressed by that so therefore you're missing some really important information'
(Beth – therapist, lines 266-270)

This extract illustrates how language can be misinterpreted and positions PSYCHLOPS as a measure whose potential utility could be 'affected' by the language chosen. In some ways this notion fits with a survivor discourse illustrating the need for exploration rather than just accepting what is written. Evidently, this notion is not

exclusive to psychosis but is recognised here as having particular relevance to this client group:

'I sometimes find, for example, measures like the CORE do not necessarily capture all aspects of someone's experience, and obviously PSYCHLOPS doesn't try to do that' (Beth – therapist, lines 45-47)

Here the CORE-OM is constructed as a measure which does not permit full expression of service user experience but assumes that it does. PSYCHLOPS in comparison is positioned as an instrument whose authors realised the futility of trying to capture such diversity in predetermined categories. PSYCHLOPS is therefore positioned as a measure which meets the needs of this client group by not pretending to represent something which is unattainable i.e. all experiences.

'First of all I didn't think there was enough room to put all the problems and then I realised there was enough room because the only problems you really need to think of are the ones that are troubling you now, not all your problems, because the ones on the surface are interconnected to the other problems you have so if you get the surface problems sorted, the second, third and fourth get sorted out themselves' (Paul – service user, lines 374-381)

From a service user perspective, PSYCHLOPS is constructed as a measure which aids self discovery, enabling the service user to see how his problems are

positioned. This process leads to a prioritisation of his difficulties, helping him to re-evaluate which issues are most salient.

PSYCHLOPS as a measure with integrity

Discourses around honesty were privileged in discussions about PSYCHLOPS but interestingly less so in discussions about the CORE-OM.

'to be honest, it's much easier to do the PSYCHLOPS than the CORE. I feel much more tentative about giving the CORE, partly because you just don't know how people are going to respond to it and it feels quite invasive in many ways, whereas the PSYCHLOPS feels much less invasive' (John– therapist, lines 99-104)

PSYCHLOPS appears to be constructed as allowing you to be more true to who you are. In order to speak against the establishment, perhaps one has to take the legitimising position of self-righteousness. To use a strong word like 'invasive' which may not be how clients view the CORE-OM, suggests a rhetoric occurring that giving service users the CORE-OM is a dreadful thing to do, when possibly 'they do not seem to mind'. This quote could equally be read as a reflection of invasion and unpredictability.

'I've got to be honest when I received the actual measure [PSYCHLOPS] it fitted so well with what I was trying to do anyway' (Beth – therapist, lines 2-4)

An implied compulsion is expressed by Beth opening with 'I've got to be honest'. She seems to be slightly embarrassed by liking it so much and fears that she is losing a bit of professional location in being so direct.

Discussion

Within this study a number of discourses were drawn upon by service users and therapists when talking about the use of outcome measures with service users experiencing psychosis. A dominant discourse that emerged was the use of language and 'being heard'. The findings suggest that PSYCHLOPS gave service users a voice to express themselves in words that reflected their individual experience.

Previous literature suggests that service users who have spent significant time in psychiatric care may have become familiar with medical language and may have adopted dominant terms used by healthcare professionals as a way of having their experiences legitimised (De Barbaro et al., 2008). PSYCHLOPS, by virtue of eliciting the service user's own words, offers the potential for alternative discourses and more client-centred ways of thinking about their problems.

The findings of this study highlight the therapists' role in the process of service users 'being heard'. They imply that the way in which therapists approach outcome measurement can influence the power dynamic and that discourses can operate to obscure the power relations that exist in mental health settings.

Discourses around power and empowerment highlighted the consequence of therapists positioning themselves as helping a client to express themselves through PSYCHLOPS. In doing this, therapists could be perceived as exercising their own authority over that of the client. This raises the question of whether we are being naive in assuming that PSYCHLOPS is more client-centred than other measures. By adhering to wider discourses that exist in the contexts within which they work, therapists may be labouring under a misapprehension that they are not implicated in biomedical rhetoric. PSYCHLOPS was designed to move away from some of the discourses that are seen to disempower service users, but it may be that motivations underlying the use of outcome measures need to be addressed. For example, if PSYCHLOPS is being used to get someone to quickly define one or two problems so that work can be done in a specified number of sessions (i.e. NICE) then who is it actually working for?

Engagement was a discourse implicated in discussions about recovery from psychotic distress. With recommendations of 16 individual sessions of CBT for psychosis (NICE), CBT therapists have only limited time in which to work. They may therefore be uncertain where to put the completion of measures, particularly measures with open ended questions like those in PSYCHLOPS, within their 16 weeks.

Therapists working with more severe distress tend to offer longer therapeutic contracts as the process of engagement is often challenging, but this can result in similar issues about timings and administration. No studies were found that address the whole issue of how such measures impact on therapy. It was surprising, given the ostensibly client-centred nature of PSYCHLOPS, there were not more references to recovery discourses in this study.

Therapists referred to ideas of chaos and containment imputing chaos to the psychotic state of the client and raising their concerns as therapists about how to help 'contain' this and about how PSYCHLOPS might impact on this. This concern was also raised by some of the clients. Service users constructed PSYCHLOPS as being both containing and uncontainment at different points. At times service users felt more contained by the CORE-OM than PSYCHLOPS because it provided limits and did not require as much thinking. These findings support previous research whereby therapists felt PSYCHLOPS to be more challenging than the CORE-OM because service users had to think about and classify their problems on their own (Ashworth et al., 2005a).

Limitations of the study

The sample was recruited from two mental health Trusts, the number of participants met the criteria for this type of project the sample size was small and it is possible that only enthusiastic therapists and service users participated, all factors affecting the representativeness of the data.

This study was a reading of words in the context of an interview held in mental health premises which might evoke feelings about the mental health system. As such, my analysis does not seek to say anything about the people as they might actually be, only about how the words they used on that specific occasion may be seen as reflecting extant discourses and could be seen as placing themselves or others in certain social positions. In an interview on another occasion, or even with a different researcher on this occasion, they may say things that are interpretable in a completely different way. A further limitation could be the effect of my own assumptions on the interpretation of the data. I was aware, for example, that my belief in the recovery model may have led me to be slightly more biased against the medical model.

As a trainee clinical psychologist, I too am part of the establishment being discussed. Smail (1993) suggests that power is located within systems rather than in the individual and so I wonder how much power I was unwittingly wielding in my interactions with service users in interviews and how this may have influenced their responses.

Future work

Even though this analysis was subjected to supervisor examination offering the potential for alternative readings of the data, further research could be done to examine the claims of these findings. Other possibilities could involve PSYCHLOPS being administered in every session to explore whether this is feasible, exploring if when

PSYCHLOPS is used in services they get better completion rates than for nomothetic outcome measures, exploring whether clients do better in CBT if given PSYCHLOPS as opposed to another outcome measure, trying out PSYCHLOPS with other therapies (than CBT) for people with psychosis and exploring whether clinicians would be less positive if PSYCHLOPS was 'imposed' as other outcome measures have been.

Clinical and research implications

The therapists in this study had a positive experience of PSYCHLOPS when using it as part of their work delivering CBT to people with diagnoses of psychosis. Some therapists clearly preferred it to the CORE-OM and revealed great concerns about the imposition of the CORE-OM. Service users also experienced PSYCHLOPS positively but some found it more challenging than the CORE-OM. Given the increasing pressure on therapists to evaluate their work, and concerns about intrusions into the therapeutic alliance (Phelps, Eisman & Kohout, 1998), PSYCHLOPS may offer a user-centred approach which aligns itself with a recovery framework, but which may also be subject to powerful surrounding discourses.

There is a need for much more research and thought at practitioner level, service level (including service managers) at the purchaser/provider and higher political levels about how the imposition of measures and incongruence between measures and the thinking of the practitioners and clients, probably severely damages the information value in some measures as used currently.

There is a need to distinguish much more thoughtfully the repeated use of measures within a therapy from the cross-sectional aggregation of data, whether collected repeatedly or just in pre/post design, to summarise service effectiveness, data collected and the impact on the therapy of the measures offered. This is driven by the wish to shape individual therapies and is liable to be very different from the data from and impact of, measures given with the other aim. It is probably possible to have a way of using measures that does usefully serve both purposes but the complexity of therapists' and clients' constructions of the measures, particularly user-generated measures, may mean that data collected in one way should be compared with data collected in the other with great caution.

Given the concerns that clients and therapists expressed very clearly we should be wary of assuming that user-generated measures are easy to complete and should look at ways, perhaps particularly with people with psychotic disorders, in which the presentation of the measure can be optimized. In this light, completion of measures is clearly not a passive process, on the contrary, measurement of psychological states and traits, particularly within therapies with clients who have psychotic experiences, is a very complex iterative process in which the client considers what the effect of the completion of the measure in a particular way will be on them, on the therapist, on the therapy. This is highly likely to become a recursive and iterative non-linear process if measurement is repeated sessionally within therapy and has the potential for chaos as well as positive and negative feedback loops. The assumption that measurement is

largely passive, reliable, valid and predictive of eventual outcome is largely implicit in the models of Lambert and Miller and Duncan. Hence, session by session measurement is constructed as a benign information channel capable of providing a negative feedback loop, 'power steering' for the therapy.

As this study suggests, measurement is not that simple and it is particularly important that we do not assume that outcomes can be judged simply on the measures that have become active parts of the therapy. We should also not assume that such concerns do not affect nomothetic measures just because they have been less to the fore in the discussions in this study. Collaborative research with service users, or user led research into some of these effects will help strengthen the user/client voice in exploring this area.

Conclusion

PSYCHLOPS was constructed in the interviews as a measure with the potential to enable alternative discourses to emerge which are conducive to recovery. There was some evidence that service users also constructed it as offering more client-centred ways of thinking about problems, but also at times, a more traditional measure was constructed as more containing. While much more research is needed, this study shows clearly that therapists have concerns about the imposition of nomothetic outcome measures and that clients and therapists recognise the use of both nomothetic and user-generated change measures in therapy as a complex psychological arena.

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Critical Appraisal

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Overview

This study aimed to explore how a sample of service users and therapists constructed the use of PSYCHLOPS with people receiving CBT for psychosis. The construction of discourses for PSYCHLOPS, recovery and psychosis were examined in particular.

This section provides a critical reflection on the process of conducting this research from its conception to its dissemination. It describes how the idea developed and gives a rationale for the epistemological framework chosen. It goes on to outline the processes involved in data collection, explores ethical considerations and issues of quality assurance. Dissemination is discussed along with study implications and limitations. It concludes with an account of the researcher's personal reflections of undertaking this study.

Developing the idea

An email was sent to Salomons trainees outlining research possibilities involving a new mental health outcome measure called PSYCHLOPS with scope to develop your own research ideas. The team behind PSYCHLOPS included a GP with an interest in mental health, a consultant clinical psychologist, a psychiatrist/psychotherapist, and a sociologist. The idea of a new client-centred outcome measure interested me, as did conducting research with a supportive team. I therefore contacted the team's psychologist to initiate discussions.

Initial conversations revealed that all of the research about PSYCHLOPS to date had been conducted within primary care. At the time I was working in secondary care in a community mental health support and recovery team and psychosis was an area that interested me. A number of meetings took place to help me to develop my ideas about how I might be able to combine a study about PSYCHLOPS with my interest in psychosis.

During the brainstorming stage I wondered how PSYCHLOPS would translate to secondary care. I spoke to psychologists at my placement to get their thoughts. The feedback I received was that it could potentially be valuable to use a measure like PSYCHLOPS with this client group. I then progressed to thinking about the focus of the research. What kind of questions would I be asking? Would they be pragmatic, personal, political, theoretical or philosophical? Conversations with the PSYCHLOPS team made me realise that I needed to separate these levels and focus on one position as choosing more than one could lead to confusion. I also needed to establish what could be achievable for a project of this size.

My initial ideas included: Does PSYCHLOPS help make things more transparent in the therapeutic process? Does PSYCHLOPS help us to understand how clients conceptualise their difficulties? It is helpful for clients to be asked to conceptualise their problems on their own without the help of the therapist? What do clinicians think about that process? I was also interested in the introduction of Improving Access to

Psychological Therapies (IAPT) initiatives and the potential introduction of administering measures in every session. This notion appealed to me as there appeared to be a dearth of literature investigating the relationship between outcome measures, the therapeutic alliance and power differentials. With the help of my supervisors I was able to start refining these ideas leading to the development of my research questions.

Epistemology

Narrative analysis

A narrative approach was initially chosen during the proposal stage. It was anticipated that the way in which service users and therapists narrated their experiences, and the stories that emerged, would provide an insight into the facilitation of the recovery process and the possible role of PSYCHLOPS. Once I began writing Section A and started giving more thought to the processes involved in outcome measurement and the wider context, however, I questioned whether narrative analysis was the most appropriate approach. Whilst linguistic and cultural resources are taken into account in narrative analysis it soon became apparent following the first interview that a narrative approach would not provide a sufficient analysis of issues of power. Therefore a social constructionist approach was considered.

Social constructionism

A social constructionist approach seemed appropriate for this study as I was keen to explore the constructive power of language. A constructionist framework takes a

critical stance towards 'taken-for-granted' knowledge, assumes historical and cultural specificity, sees knowledge as sustained by social processes and knowledge interacting with social action (Gergen, 1985). A mainly Foucauldian discourse analysis was subsequently identified as an appropriate method to use.

Using a discourse analysis approach

Discourse analysis is dominated by two main approaches, discursive psychology and Foucauldian discourse analysis. In discursive psychology, attention is given to what people actively do with their language, and to what end they use their own talk (Willig, 2008). This form of analysis focuses on 'action-orientation' with an emphasis on how talk is situated and is used to construct reality within a social context (Hepburn & Potter, 2003). This approach represents the 'micro' level of interaction in discursive practices (Harper, 2006).

Foucauldian Discourse Analysis, based on the work of Foucault, is influenced by post-structural writers such as Derrida (Burman & Parker, 1993) drawing upon the principles of feminism, Marxism, psychoanalysis and critical psychology (Parker, 2003). This approach is more interested in the position of discourses in relation to wider social processes of legitimisation and power, thus representing the 'macro' level of interaction in discursive resources (Harper, 2006). From this position it is argued that a focus on the 'action-orientation' of language may lead to an avoidance of the implications of power and politics (Parker, 1997). Foucauldian discourse analysis adheres to the

premise that individuals and objects are constructed by language and these discourses are embedded in power relations supported by institutional practices. It seeks to challenge dominant, taken-for-granted discourses by recognising the constraints of these repertoires to particular individuals (Harre & Van Langenhove, 1999) and the way they in turn position individuals within the social context in which they are used, that is, prescribe or limit the social possibilities for certain groups of people. The distinction between the two approaches can become blurred at times, but given this study's emphasis on issues of power, a Foucauldian approach was the dominant framework.

The data collection process

This study aimed to explore the use of PSYCHLOPS with people with a diagnosis incorporating psychosis, and in particular the discourses used by service users and therapists. The National Institute for Clinical Excellence (NICE) recommends cognitive behavioural therapy (CBT) for psychosis and so I chose to work only with therapists/ service users who had chosen CBT as their main therapeutic modality. Given that I was using Foucauldian discourse analysis and attaining 'truth' was not the goal of this analysis (Potter & Wetherell, 1987), it was less important to find individuals who were representative of all service users experiencing psychosis and of all therapists using CBT, and more important to explore the language and subject positions involved in the therapy process. Convenience sampling was therefore applied as discourse analysis is focused less on language users and more on language use (Wood & Kroger, 2000).

I had been given ethical approval to contact adult mental health teams in two mental health Trusts. I began by firstly contacting five therapists who I knew personally. I arranged visits in order to explain the study requirements and hand deliver folders containing the study information. Service user recruitment proved more difficult than I had anticipated. Five months after I first approached these therapists no service users had been recruited. This was primarily because therapists had not taken on any new clients or new clients were considered too ill to participate in a study or had declined to take part.

At this stage I used my contacts to obtain names of other therapists working with people with psychosis. I emailed them to ask whether I could visit or arrange a time to speak on the phone. This resulted in me attending eight team meetings where I presented the study and led to four therapists finding four clients willing to participate.

Once a therapist had identified a service user meeting the inclusion criteria, it was left to their clinical judgement to decide on an appropriate time to introduce the study. Once the service user had been given sufficient time to consider whether to participate and agreed to do so, the therapist would inform me and return the consent forms. I did not have contact with the service user until 12 weeks later when I arranged the interview. Before contacting them I spoke to their therapist to ensure that it was still appropriate to do so.

The interviews were semi-structured and intended to elicit conversations about the experiences of using PSYCHLOPS. In my ethics proposal I had suggested that between 3-4 therapists would be involved with 1-2 service users each, based on the therapists who had already agreed to participate. Due to the difficulties described previously, and the fact that I had chosen a different analytic approach from narrative analysis, I searched the literature for guidance on required sample size. Guidelines published by Turpin et al. (1997) recommended a minimum of five hours' data for clinical psychology doctorate projects using discourse analysis and other projects also appeared to use similar numbers.

A Foucauldian discourse analysis approach was chosen which predominantly focuses upon knowledge, power and legitimacy and not on the complexities of speech such as pauses, rising and falling tones. Therefore, when transcribing the interviews it was not necessary to include characteristics of speech such as pauses or intonation.

Ethical considerations

Ethical approval was obtained from Lewisham Local Research Ethics Committee. Research and Development approval was obtained from South London and Maudsley (SLaM) and Oxleas NHS Mental Health Trusts. The study adhered to the BPS Code of Ethics and Conduct (British Psychological Society, 2006).

At the start of interview, participants were reminded that they could take a break or stop the interview at any time. At the end of the interview participants were asked if

they wanted time to debrief where they could reflect and talk about their experience of participating in the project. None of the participants took up this offer and so they were reminded that they could contact me or speak to their therapist following the interview if they wished to discuss any aspect of their participation at a later date.

Informed consent

Verbal consent was obtained from all participants and was followed up by written consent prior to my involvement. Therapists gave me their consent at the point of agreeing to take part but the responsibility for obtaining the service users' consent fell to the therapists involved. Whilst no concerns were raised regarding capacity for giving informed consent, the following issues were addressed. I had to rely on therapists to pass the study information on, although I had also written an information sheet for service users. On reflection, I wondered how understandable this information was for people experiencing severe mental distress. I had raised these concerns with members of Salomons Advisory Group of Experts (SAGE) who had experience as mental health 'service users' or informal 'carers' and received feedback that what I had prepared was satisfactory. Regardless of how user-friendly the language may have been, however, I was concerned that some people might have found those types of forms intimidating and therefore would instead make their decision on what they were told verbally which meant I was reliant on therapists giving an accurate account of the study. I also worried that perhaps some service users may have felt obliged to take part if they were asked by their therapist, although this did not appear to be the case based on the conversations I had with service user participants.

Confidentiality

Participants were assured that no identifiable information would be kept alongside interview data or be presented in the final written report. Interviews were anonymised at the point of transcription and password protected. All transcriptions were completed by the researcher. Participants were informed that the data would be securely stored for ten years before it was destroyed.

Quality assurance

My thoughts and assumptions were questioned and challenged throughout the research process through discussions with supervisors and the use of a reflexive diary. It was necessary for me to reflect on my role as researcher whereby 'truth' is often claimed through the supposed objectivity of the traditional scientific paradigm. I therefore embraced the notion of objectivity being an impossibility as there is no 'truth' and any conclusions to be drawn are based on just one perspective, tempered by my supervisors' examination of my analysis and by potentially offering alternative readings of the data.

Personal reflexivity

One of the issues that I considered was my relationship to the research and the way in which my position may have been influencing the study. I was aware that as a

clinical psychology trainee employed by the NHS, I may have shared similarities in the language used with both therapists and service users. I tried not to take this for granted and to maintain a respectful curiosity (Cecchin, 1987).

Throughout the analysis I constantly asked myself 'why am I reading the text in this way at this point?' and 'how could I read this differently?' (Willig, 2001). There are so many aspects inherent in discourse analysis (e.g. rhetorical devices, Edwards & Potter, 1992; positioning theory, Davies & Harre, 1990), I found it was possible to grasp one concept but then become confused again after reading another. The tension that this generated and subsequent discussions with supervisors eventually helped me to clarify the analysis process. In discussions with my academic supervisor it was suggested that sometimes I seemed overly positive about the value of PSYCHLOPS and ready to take staff participant positive statements about it at face value. I acknowledge that I might have had a wish to claim evidence for its utility, which I had to resist because this would have constituted a realist research aim rather than in keeping with identifying how it was socially constructed. Conversely, by portraying positive statements about PSYCHLOPS and negative statements about CORE-OM by staff participants as constructions rather than realist data I realised I was inviting the reader to doubt these claimed positives and negatives. This too could be seen as a rhetorical device. Yet a different kind of study would be required to investigate the comparative utility of each measure.

Ecological validity

A strength of this study was its inclusion of 'real-life' scenarios. Therapists administer outcome measures routinely as part of their practice and the CORE-OM was a measure which would have been used regardless of this research.

Grounding in examples

This study used extracts from the interviews throughout the report in order to illustrate constructions, subject positions and ideological dilemmas. This enables the reader to see on what basis the conclusions have been drawn. The inclusion of transcripts in the appendices also helps the reader to see how interpretations were developed.

Providing credibility checks

Throughout the study I kept a reflexive diary of the progression of the research and any thoughts I may have had. This helped me to reflect upon any assumptions or particular values I may have held that might have entered into the process. I also met regularly with my supervisors. Our discussions, which included thinking about possible alternative readings of the data, increased the credibility of the analysis.

Respondent validation

In qualitative research the validity of findings can be enhanced through seeking the views of participants (Gilbert & Mulkay, 1984). However in discourse analysis seeking feedback from interviewees is not always considered appropriate. Harper (1994) claims that respondents can often take a defensive position because of the 'critical interpretations' associated with discourse analysis. This process can also generate so many different readings that clarity of focus is lost.

Coherence and resonating with readers

In writing up this research I attempted to ensure that my interpretations were presented in a structured way by using headings which described the dominant discourses. Extracts illustrating the use of discourses were also provided to aid coherence. My supervisors read drafts of my analysis and their feedback was used as a barometer of how much this would resonate with readers. Including raw data in the appendices also enables readers to make their own interpretations.

Dissemination

All participants who had said they would like feedback were sent a brief written summary (Appendix L). Only one service user said he did not want to receive any information. A summary was also sent to Lewisham Ethics Local Research Committee and the Research and Development departments of South London and Maudsley (SLaM) and Oxleas NHS Trusts. The study will be submitted to the Journal of

Counselling and Psychotherapy Research and therefore Section B adhered to the format of this journal as much as the guidelines for this submission would allow (Appendix M). Participants were invited to respond to my summary of the study but at the time of submission no responses had been received.

Inviting participants to respond to the findings felt inconsistent for this methodological approach as it is argued that it can lead to a proliferation of readings (Marks, 1993) but I felt I had an ethical obligation to do so. This presents a dilemma for there is the possibility that participants may not agree with my interpretations. There is also the possibility that it might be upsetting for service users.

Study implications

Although there still seemed to be issues about the power of medical model discourses around psychosis and therapy with psychosis, there also seemed some indication that the application of PSYCHLOPS in CBT with psychosis might help to prompt and support alternative discourses giving people greater control in the therapy context. PSYCHLOPS ostensibly gives service users an opportunity to express their problems and goals in their own words, and where this seemed to happen it appeared consistent with greater self-direction. This not only has implications for helping people to make better sense of their difficulties but also potentially for supporting clearer communication between the therapist and their client. However it also seemed to have

the possibility to bolster medical-model discourses, e.g. 'paranoia' as the main problem, and this is probably something that needs to be held in mind when it is used.

It could be argued that PSYCHLOPS offers a way for psychologists to retain the position of scientist-practitioner without compromising the therapeutic relationship, and for service users to participate in being curious about their own development. A common problem with administering questionnaires for the purposes of clinical audit is that they are rarely applied in a consistent manner, especially when it comes to post-therapy questionnaires (Bewick, Trusler, Mullin, Grant & Mothersole, 2006). On the one hand this could be because therapists value their own and their clients' evaluation of therapy over a questionnaire that may not capture key elements, and on the other, it could be seen as a reluctance for therapy to be open to scrutiny. Set against this, there is a specific issue with psychosis and severe and enduring mental distress, in terms of measuring what is most appropriate to service users, which may not be about symptom severity but about symptom management and meaningful life activities. It does appear that PSYCHLOPS could offer the opportunity, within a broad recovery-orientated service, for such issues to be collaboratively monitored. A particular strength of the current study is that it highlights the way that medical-model discourses crept into therapist and service user language despite general service aims towards more recovery-orientated working. It may be necessary to work more actively to question such discourses and highlight alternative strengths-based and person-centred discourses.

Study limitations

It is noted that discourse analysis is a process considered difficult to describe in written form (Potter & Hepburn, 2005). Although I hope this would have been addressed by supervision and the use of Willig's (2008) step-by-step guide, even this left a large margin for my own interpretation of the approach. This relative lack of clear guidance in the literature about how to 'do' Foucauldian discourse analysis means that there may have been 'implicit' processes followed by more 'expert' discourse analysts which may not have been explicit to a novice such as myself and which may therefore have impacted on the quality of my work .

A further limitation is the generalisability of discursive findings to other contexts, although there may be a degree of transferability to people in similar social contexts (Hepburn, 2003). It is important to note that samples in discourse analysis research are not intended to be representative of the wider population. Rather, in-depth analysis is facilitated in the context of a small sample. It is also possible that had a different researcher been conducting the study they would have interpreted the data differently. However, the possibility of alternative readings was facilitated by exposure to two supervisors who frequently questioned my assumptions about what the data indicated.

Reflections

Reflections on the findings

The level of positive constructions of PSYCHLOPS by therapists supported my initial bias towards PSYCHLOPS being a measure that would be of benefit to psychosis. However, I was surprised that given the ostensibly client-centred nature of PSYCHLOPS there were not more references to recovery discourses. It could be argued that the study raises awareness of how subject positions can be negotiated by highlighting issues of power between therapists and their clients and it was helpful for me to see how PSYCHLOPS and the CORE-OM, were implicated in this.

Throughout this study, I realised that I had been viewing empowerment as something that could be given to someone as a result of giving an outcome measure. It has been argued that empowerment is not an object you bestow upon people but is instead manifested through relationships (Cromby & Harper, 2009). This made me reconsider whether the actual measure itself should be positioned as responsible for empowering people. Instead it made me realise that it is the responsibility of the therapists and how they manage this interaction to do so, or at least to act in a way that is more conducive to service users claiming social power.

My role could be seen to position me and the participants in a particular way and therefore there is a possibility that some of them might strongly disagree with some of my interpretations as happened with Stevens and Harper (2007), whereby some of their

participants wrote to the journal which published their study contesting their characterisations of them. An important point to keep in mind, however, is that, as with the pre-mentioned authors, none of my interpretations are intended to be a characterisation of actual participants, but rather to characterise specific pieces of talk that I elicited in an interview held at a specific moment in time and within a specific social context.

Reflections on approaching this research from a social constructionist stance

The thought of approaching this research from a social constructionist perspective was appealing and I relished the opportunity to challenge my 'taken-for-granted' ways of understanding the world (Burr, 2003). However, maintaining a critical stance at all times throughout the analysis and write up was more difficult than anticipated. On occasion I would find myself falling back into the pattern of assuming a true reality. This is where the use of a reflexive diary and conversations with supervisors proved invaluable. This helped my awareness by offering new alternatives and perspectives that I may not have thought of at that stage.

Discourse analysis is considered one of the most complex qualitative approaches to learn (Harper, O'Connor, Self & Stevens, 2008). In my attempt to try and understand this approach I read a wide variety of literature but was often left feeling more confused than when I started. I was surprised to find that there are relatively few accounts of how to actually conduct discourse analysis, something on which Figuera and Lopez (1991)

have commented. Whilst a number of introductory texts have since been written with the aim of addressing this absence (e.g. Wood & Kroger, 2000; Hepburn & Potter, 2003; Willig, 2001, 2008) they attempt to cover such an array of situations that they tend to be fairly general in nature. It is understandable that detailing the process of discourse analysis may lead to concern about the epistemology being compromised but, for novices, not having a clear procedure to follow is inevitably anxiety provoking. One of the main reasons why I followed Willig's (2008) description of Foucauldian discourse analysis was that it seemed the best example of a structured procedure.

Another reason why I found Foucault's conception of discourse particularly challenging is because it is suggested that one 'cannot remain simply *within* the text' but instead needs to move 'both *in and out* of the text' (Hook, 2001 p.543). I sometimes found it difficult to reflect on my own critical stance and 'taken-for-granted' assumptions whilst at the same time retaining an awareness of 'extra-textual' factors such as institutional practices and conditions of possibility.

Discourse analysis uses a very distinct, form of language (e.g. legitimatising, constructing, positioning) and in doing so offers a new way of seeing text and listening to talk. Carrying out the analysis whilst adhering to this language was another area of steep learning. Terre Blanche and Durrheim (2002) note how this distinct way of talking can often start to permeate the researcher's speech outside of the analysis and this was something I certainly experienced.

Reflections on the research process

Overall the process of conducting this research was challenging. This was predominately due to having to juggle the competing demands of the clinical training course and finding enough time to commit to this project amongst other academic and clinical pressures. Time constraints had particular implications for the type of analysis I had chosen. I found Foucauldian discourse analysis difficult to fully comprehend and having to take frequent breaks away from it meant that my developing understanding, at times, felt compromised and the whole process somewhat disjointed. I feel that I could have benefited from having a considerable amount of time away from other demands to fully immerse myself in the material.

I was overly optimistic about the recruitment process and had not anticipated how difficult this would be. As a result, many of my study days allocated for writing up the research were instead spent hanging around community mental health teams in the hope that, if therapists became familiar with seeing me around, they may be more inclined to take part. This certainly seemed to be the case in one Trust where my visibility definitely made a difference in terms of recruitment.

Using semi-structured interview questions, which in some ways felt quite freeing, also led to some anxiety about whether the material generated would be sufficiently rich. I was concerned that having less structure might mean that the participants might have been swayed into other areas of discussion which, whilst might have been

important to participants, might not have been directly relevant to the research questions. This was certainly the case with two of the service users who spoke at length about their experiences of mental health, life events, family history, medication etc. By attempting to guide the participants back to the topic at hand I worried that I was implicitly influencing how that topic was discussed.

I experienced a similar dilemma with another service user who was less communicative than some of the other participants. Again, I worried about my level of direction and the impact that this had on issues of 'bias' and 'neutrality' (Speer, 2002). Whilst 'objectivity' is considered to be a particular form of subjectivity (Burman, 2010) at these times I questioned the position I had adopted as I felt that I had shifted from the encouraging facilitator to a 'journalist' (Harper, O'Connor, Self & Stevens, 2008) asking explicit questions.

As a means of connecting with the data, I chose to transcribe the interviews myself. As well as connecting with the data, the process of transcribing also enabled me to distance myself sufficiently from the actual interviews in order to reflect on the language. I found by adopting this process that I noticed a number of discursive features whilst not consciously looking for them. This provided a good starting point to begin to develop categories and codes.

Discourse analysis is described as needing a much slower pace of analysis than some other qualitative approaches (Potter, 1998). It was not until I began this process

that I realised just how arduous and time consuming it was. In the initial stages of analysis I followed Willig's (2008) six steps rigorously in order to become sensitised to looking for positioning and constructions. In doing this I realised that many of the steps had considerable overlap and therefore once I learned how each step linked with the other it was easier to move through them in a less laborious way. In the early stages I found that the amount of data I was generating was too huge for the limits of this study. I therefore I had to be strict and ensure that I kept to the focus of the study but it was very disheartening to have to discard work that had taken up considerable time.

In terms of writing the report I was aware that I had used the words 'service user' 'client' and 'patient' interchangeably. I considered using one term throughout but in different contexts one title appeared to fit better than another and therefore it seemed appropriate to use the different names.

Overall, the process of conducting this research was both challenging and rewarding. Although I found Foucauldian discourse analysis very confusing at times, it was ultimately a stimulating and satisfying methodology to have chosen. I received fantastic support from supervisors and fellow trainees and it was this support which helped me to manage the multitude of demands and pressures associated with the study.

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