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Doctoral Thesis

The importance of practitioner and client accounts of context in mental health

Heather Spankie
Trainee Clinical Psychologist

Doctorate in Clinical Psychology
Division of Health Research, Lancaster University

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Section	Text	Appendices (title pages, abstracts, tables, figures and references)	Total
Thesis Abstract	331	-	331
Literature Review	7942	8223	16165
Research Paper	7987	14675	22662
Critical Appraisal	4000	802	4802
Ethics Section	4400	1770	6170
Total	24660	25470	50130

Thesis Abstract

With no accepted definition, conceptualisations of ‘context’ can range from considering relationships or material circumstances to the impact of wider socio-political factors and an individual’s place in society. Substantial evidence of the potential harms of contextual difficulties across all of these levels exists, whether difficulties in relationships, the impact of living in poverty or belonging to a group which society stigmatises. This thesis aimed to explore personal accounts of the importance of context, including individual experiences with contextual difficulties and the experiences of professionals hoping to understand and intervene with such difficulties.

The example of stigma towards people who inject heroin is the subject of the literature review, aiming to synthesise qualitative research of individuals’ accounts of stigma experiences. This meta-ethnography produced four themes: 1) The impact of stigma: Outcast, escape and concealment; 2) I’m an addict – not a junkie: Inter-group stigma; 3) Multiple identities: Layering stigma or positive alternatives? and 4) Perpetuating stigma: From institutions to internalisation. These findings contribute a richer understanding of the complex, individual experiences of stigma and provide an example of how contextual influences can range from stigma experienced from family to the importance of institutional and societal level stigma.

In acknowledgement of the impact of contextual difficulties on mental health, the research paper explored how context is understood and addressed in clinical practice by psychologists. A thematic analysis of interviews with eight clinical psychologists produced four themes: 1: The need to justify working with context; 2: The need to work with context beyond the therapy room; 3: “My context is their context”: Influences on the ability to work with context; and 4: Sources of validation for working with context. The findings revealed a

desire to work with context and examples of successes but also the potential for significant barriers.

Finally, the critical appraisal discusses implications of the dominance of the medical model as a barrier to both research and practice involving context, suggestions for clinical psychology training and a reflective account of completing the thesis.

Declaration

This thesis presents research submitted in July 2016 as partial fulfilment of the requirements for the degree of Doctorate in Clinical Psychology at Lancaster University. The work in this thesis is the author's own, except where due reference is made. This research has not been submitted for any other academic award.

Name: Heather Spankie

Signature:

Date:

Acknowledgments

Firstly I would like to thank the participants for making this research possible and for the passion and honesty that they expressed. They not only contributed valuable accounts to inform he research but also inspired my own future clinical practice. I would like to thank my supervisors, Dr Pete Greasley and Dr Jane Simpson, for their invaluable support and guidance throughout and for enabling me to pursue a topic that I am passionate about. I am also thankful for my friends and family for their unending encouragement, support (and tolerance!) throughout this process.

Contents

Section One: Literature Review

Section Two: Research Paper

Section Three: Critical Appraisal

Section Four: Ethics Proposal

Section One: Literature Review

The experience of stigma for intravenous drug users of heroin: A metasynthesis

Heather Spankie
Trainee Clinical Psychologist

Doctorate in Clinical Psychology
Division of Health Research, Lancaster University

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All correspondence should be sent to:

Heather Spankie
Doctorate in Clinical Psychology
Furness College
Lancaster University
Lancaster, Lancashire
LA1 4YG
Email: h.spankie@lancaster.ac.uk

Abstract

Aims: Stigma is an established barrier to treatment access for people who use drugs as well as having other harmful consequences. The complexities of stigma have received less research attention compared to understanding barriers and knowledge is particularly lacking regarding people who use drugs compared to other marginalised groups. People who inject drugs and those who use heroin are at increased risk of both increased stigma and the consequences of restricted service access. Therefore, this review aims to examine the stigma experiences of injecting drug users of heroin.

Method: A systematic review of qualitative evidence generated 16 papers for inclusion in the synthesis, using a method of meta-ethnography.

Findings: The synthesis produced four themes: 1) The impact of stigma: Outcast, escape and concealment; 2) I'm an addict – not a junkie: Inter-group stigma; 3) Multiple identities: Layering stigma or positive alternatives? and 4) Perpetuating stigma: From institutions to internalisation.

Conclusions: Findings progress the understanding of stigma as a complex individual experience. Responses to stigma include varied forms of escape and the existence of inter-group stigma. Beyond individuals, the significance of institutional stigma, policy, service design and language use in perpetuating and leading to the internalisation of stigma is supported.

Keywords

IDU, stigma, discrimination, stereotypes, harm reduction, addiction

Stigma for people who use drugs poses a significant barrier to treatment access. This has been found, through both quantitative and qualitative investigations, to include health and social care and drug addiction treatment and is suggested to be due to avoidance of stigma, fears of receiving discriminatory treatment or concealment of drug use (Ahern, Stuber & Galea, 2007; Copeland, 1997; Kurtz, Surratt, Kiley & Inciardi, 2005; Link, Struening, Rahav, Phelan & Nuttbrock, 1997; Lloyd, 2010; Reist, 2010). Moreover, Injecting Drug Users (IDUs) and heroin users experience higher levels of stigma than other drug users (Crawford, Rudolph, Jones & Fuller, 2012; McElrath & McEvoy, 2001), potentially due to being perceived as more dangerous (Capitanio & Herek, 1999; Crandall, 1991). This stigma may result in lower rates of service access including estimates that only 5% of IDUs worldwide access needle and syringe programmes (Degenhardt et al., 2010). Moreover, the effects of stigma are particularly pertinent for IDUs due to associated risks of illness and mortality from infection (including HIV) and death by overdose (Degenhardt & Hall, 2012; Mathers et al., 2013; United Nations Office on Drugs and Crime [UNODC], 2015). Therefore, IDUs are a group at increased risk of poor health outcomes as a result of stigma.

Empirical research, particularly relating to individuals using Methadone Maintenance Therapy (MMT) (the provision of methadone to treat opioid dependence), has indicated the considerable barrier stigma poses to service access. Reviews, including international data, confirm stigma is a barrier to MMT access and also that it limits service delivery and development (Bell, Dru, Fischer, Levit & Sarfraz, 2002; Joseph, Stancliff & Langrod, 2000). Most research has not aimed to explore stigma for IDUs exclusively but rather includes IDUs as an at risk group for HIV, where barriers can limit diagnosis and treatment, or as a group who may be more impacted by HIV related stigma, as suggested by Capitano and Herek (1999) in their exploration of public attitudes in the USA.

Beyond barriers to services, the impact of stigma has received less attention, particularly for drug users compared to other marginalized groups. This may be due to more acceptance of stigma towards drug users, potentially informed by beliefs that stigma may discourage drug use, or that drug use is due to personal choice and moral failure and therefore less deserving of help (Adlaf, Hamilton, Wu & Noh, 2009; Crisp, Gelder, Goddard & Meltzer, 2005; Tindal, Cook & Foster, 2010). However, available evidence for the impact of stigma on drug users includes both qualitative and quantitative research suggesting poorer physical and mental health (Ahern, Stuber & Galea, 2007; Kulesza, Larimer & Rao, 2013; Link, Struening, Rahav, Phelan & Nuttbrock, 1997), social isolation and reduced social functioning (Conner, Rosen, Wexler & Brown, 2010; Link et al., 1997), higher rates of trauma and self-harm (Shora, Stone & Fletcher, 2009) and delayed recovery and reintegration (Buchanan & Young, 2000) are experienced. In recognition of these harms, the need to address stigma among drug users has been highlighted (Dearing, Stuewig & Tangney, 2005; Kulesza et al., 2013; Luoma et al., 2007). It is possible that, due to experiencing higher levels of stigma, IDUs face greater risks of these negative consequences.

Despite mainly focusing on other groups, stigma theory and research has been applied to drug users with Goffman's work frequently cited. Goffman (1963) defines stigma as a discrediting attribute associated with difference. The attribute, such as injecting drug use, is different in a way that is seen to oppose social beliefs which excludes those with it from acceptance by society. A discredited identity is created through internalisation of stigma whereby stigmatised individuals come to perceive an attribute of themselves as spoiled. Those who are not stigmatised, "normals", are seen as agents of stigma by delivering discrimination to those with spoiled identities. Research into discrimination against drug users includes professionals, delivering this through differential or poorer treatment or denial of treatment. This has been evidenced both from self-reports of IDUs' (e.g. Brener, von

Hippel, von Hippel, Resnick & Treloar, 2010; Hopwood, Treloar & Bryant, 2006) and professionals. For example, Peckover and Chidlaw (2007) interviewed nurses and concluded that, due to prejudice and concerns regarding risk, many were not prepared to work with substance using clients.

Developments of the concept of stigma are also relevant to drug users. For example, Link and Phelan (2001) suggest "stigma exists when elements of labelling, stereotyping, separation, status loss, and discrimination occur together in a power situation that allows them" (p.377). In these situations the stigmatising group or individual has power over the circumstances of the stigmatised, delivering discrimination e.g. controlling access to resources. Link and Phelan describe a process beginning with labelling an individual as different (e.g. "IDU"), with this difference linked to negative stereotypes that exclude and "other" with the creation of "them" and "us" categories. Evidence of stereotypes of drug users includes stereotypes of lacking control and of problems being self-inflicted and unworthy of help and of being violent, dangerous, deviant, criminal, immoral and unwilling to change. These stereotypes have been demonstrated among both professionals and the general public, with a systematic review of qualitative and quantitative research by Lloyd (2013) finding that stigmatising attitudes were common and a significant barrier to recovery. Moreover, a review of research into the attitudes of healthcare professionals by van Boekel, Brouwers, van Weeghel and Garretsen (2013) concluded that, despite these negative attitudes being common, research is lacking regarding the consequences of such attitudes.

The complexities of stigma have required further definition including the distinction between "enacted" and "anticipated"/"perceived" stigma, both of which can have negative impacts (Link & Phelan, 2001; Scambler, 1998). Enacted stigma describes actual experiences of stigma and anticipated stigma the expectation of discrimination (Jacoby, 1994). Stigma can also manifest as internalised, felt or self-stigma: the incorporation of stigma as part of a person's self-concept (Jacoby, 1994; Scambler & Hopkins, 1986). These are significant considerations as stigma can have negative consequences in the absence of discriminatory treatment as, although the discrediting attribute may be able to be concealed from others, it cannot be hidden from the individual (Goffman, 1963). Studies vary in the aspects of stigma they investigate which has been criticised as underestimating the impact of stigma on drug users (Ahern, Stuber & Galea, 2007)

In addition to seeking to advance understanding of complex dimensions of stigma experiences for IDUs, a further gap in knowledge relates to a lack of acknowledgment of context and institutional stigma due to a focus on individual experiences (Scambler, 2006; Scambler, Heijnders & Van Brakel, 2006; Tindal, Cook & Foster, 2010). Institutional stigma can be understood as the "rules, policies and procedures of private and public entities in positions of power" (Livingston & Boyd, 2010, p. 2151) and is important to consider due to its role in providing conditions that lead to the internalisation of stigma (Campbell & Deacon, 2006). Although research has explored stigma from professionals, less attention has been given to the institutional stigma that may arise within policy. For example, Cooper, Moore, Gruskin and Krieger (2005), based on the findings of their grounded theory analysis of IDUs' experiences of enforcement policies, have theorized that provision with the aims of Harm Reduction (HR) rather than abstinence or enforcement may be less stigmatising by the creation of a distance from the moral judgements of drug use.

There is also a lack of knowledge regarding responses to stigma, particularly among drug users; such responses can include "emotional responses, psychological attributes and behavioral strategies (…) that may lessen or exacerbate the effects of stigma" (Ahern, Stuber & Galea, 2007, p.189). As responses may have negative consequences, it would be valuable to advance understanding. Additionally, gaining further knowledge of the experiences, processes and wider impact of stigma could not only inform understanding of barriers and strategies to reduce them but also ways to reduce the negative impact of stigma and improve outcomes.

Consequently, this systematic review will synthesise available empirical research to provide a deeper level of understanding regarding individuals' experience of stigma and drug use. A focus on qualitative research is used as this is well positioned to explore individual experiences and complexity. A meta-ethnography will be useful to synthesise research findings to develop new insights and a rich understanding of the complexities of stigma experiences, and to accommodate the interpretations of authors and incorporate this explanatory context.

Studies vary significantly in the type of drug use explored and in order to make a synthesis feasible, a degree of homogeneity was required. IDUs of heroin are the chosen focus of this review due to potentially facing the highest degrees of stigma (Crawford et al., 2012; McElrath & McEvoy, 2001) and will be referred to as "IDUs" throughout. Both former IDUs and current participants in treatment are included due to evidence that stigma continues despite drug cessation (Link et al., 1997) and that accessing treatment is stigmatising (Jones, Simonson & Singleton, 2010).

The review addresses the research question: "what are the experiences of stigma for IDUs?".

Method

Search Strategy

A systematic search for relevant studies was conducted in November 2015 with titles, key words and abstracts searched using terms: stigmatiz* OR stigmatis* OR stigma OR label* OR discriminat* OR stereotyp* OR shame OR prejudice AND alcohol* OR drug OR substance OR addict* OR inject* OR syringe* OR needle* OR intravenous OR IDU.

PsycINFO, SCIE, Embase, Web of Science and Academic Search Complete databases were searched with no restriction on publication date. Figure 1 shows 3,263 results were generated. The large number of results is not representative of research in the area with the majority of results irrelevant due to inclusion of the search term “drug” e.g. pharmaceutical studies. The relevance of papers was screened by reading the title and abstract or the whole text if relevance was unclear. The reference sections of eligible studies were searched to identify additional papers.

Study Selection and Quality Appraisal

Studies were included if they used qualitative analysis, included first-hand accounts of IDU related stigma and were published in English language in a peer-reviewed journal. Studies were excluded if participant views included individuals other than IDUs (e.g. professionals), other types of drug use or other stigmatised groups. If studies did include such participants but the interpretations relating to IDUs could be clearly identified then they were included in the review. As previously discussed, stigma is well established as a barrier therefore studies were excluded if this was the only relevant finding (e.g. Bobrova et al., 2006; Lally, Montstream-Quas, Tanaka, Tedeschi & Morrow, 2008; MacNeil & Pauly, 2011). Studies needed to have included a more in-depth exploration of the experiences of IDUs which provided findings that could contribute to a richer understanding of stigma experiences. Studies were not required to have a research question explicitly aiming to study stigma and papers were included if stigma emerged as a finding e.g. from investigations of service experiences or influences on drug use/risk behaviour. After applying inclusion/exclusion criteria, 16 papers were identified.

Table 1 provides details of the selected studies which were published between 2008 and 2015. Samples were from: UK and Ireland (6), USA (4), Canada (3), Vietnam (2) and

Puerto Rico (1). Sample sizes ranged from 10–215. Eleven studies used one-to-one interviews, one used focus groups and one used both. Three used secondary data, one using data from previous studies by the authors, one using data from a city case study and one a secondary analysis of a related study. Seven of the studies outlined unspecified qualitative analysis methods generating themes, four used grounded theory, two content analysis, one adaptive coding, one phenomenological analysis and one specified thematic analysis.

The Critical Appraisals Skills Programme (CASP) (Public Health Resource Unit, 2006), which consists of a series of questions designed to enable the evaluation of qualitative research, was used to consider strengths and weaknesses of the selected papers. Scores of either zero, one or two were assigned for each question to allow an indication of overall quality, with a maximum score of 20. A score of zero was given when little or no information was provided, one for moderate information and two for fully addressing the question (Duggleby et al., 2010). Conducting the appraisal revealed that most studies scored poorly on descriptions of analysis and method and lacked an acknowledgment of the influence of researchers on the study, such as reflexivity regarding analysis. Strengths included good ethical practice within the research. CASP scores are reported in Table 1.

Many papers were limited by small sample sizes or convenience sampling, potentially excluding certain groups of IDUs. Most recruited participants who were engaged with services, potentially missing individuals who do not access them or drop out which is particularly relevant considering the issue of stigma as a barrier to services. Participants tended to want to abstain from drugs which could exclude a population of drug users who may not aim to abstain. Restrictions from researching within office hours were noted as potentially excluding certain IDUs including homeless IDUs, those involved in “night time economy” (such as sex work), individuals with mental health problems and those in custody

(Radcliffe & Stevens, 2008). Considerations of why IDUs might not have participated were scarce despite the acknowledgement of stigma.

Synthesis

The aim of the meta-synthesis was to reach an interpretative analysis rather than provide a descriptive account to summarise all aspects of all papers. The synthesis was based on a method of meta-ethnography proposed by Noblit and Hare (1988) which outlines a process of translating results from different papers to produce new interpretations and insights. This involved initial reading and re-reading of each paper followed by the recording of relevant concepts, themes or theme components (first order constructs) in a table. Supporting quotes and relevant findings (second order constructs) for themes were then collected and added to the table, including the insights and interpretations of the authors'. Through a process of comparison of recurring concepts, both within and between studies, findings were translated to develop third order constructs: concepts which encompass multiple studies. These captured themes from across the studies, incorporating similarities and differences and giving an interpretation of how studies were related. An example of this process for one theme is provided in Appendix A.

Results

The meta-synthesis generated four themes: 1) The impact of stigma: Outcast, escape and concealment; 2) I'm an addict – not a junkie: Inter-group stigma; 3) Multiple identities: Layering stigma or positive alternatives? and 4) Perpetuating stigma: From institutions to internalisation.

Theme 1: The impact of stigma: Outcast, escape and concealment

This theme shows responses to the detrimental consequences of stigma. By feeling rejected, isolated and driven to avoid the harms of stigma, IDUs attempted to conceal their

IDU identity and escape stigmatising experiences. This can be harmful and create a barrier to involvement with both services and society. The impact of relative vulnerability and disadvantage appears to influence the responses to stigma.

Direct experiences of stigma, including discrimination, were reported from a range of individuals: from friends, family, employers, professionals and generally from the public/community. This included both enacted and anticipated stigma which persisted despite ceasing drug use, entering or completing treatment. The stereotypes that were reported included being untrustworthy, particularly through stealing, lying and using deception to get medication, stereotypes of danger, 'deviance' and poor moral character, primarily relating to presumed sex work and criminality, and perceptions of relapse to IDU and associated behaviour as inevitable, of always being an addict (1; 2; 4; 5; 9; 10; 11; 12; 13; 14; 15): "They see you as a dangerous person (…) You're capable of doing anything. You're capable of holding a knife to their throat for the sake of a tenner" (8): "Basically, once you have a habit… you're a lost cause to society" (4). Participants also described instances of prejudice including being looked down on/thought less of" (15), experiencing a lack of caring/warmth (3), feeling rejected (8), being treated coldly or rudely (3; 10), being patronised (1), being the subject of gossip and rumour (15), displaying judgmental attitudes (9; 10; 13) and scorn (8).

The impact of this stigma described throughout the papers was wide ranging including fear, anxiety, hurt, anger, frustration, distress, sadness, loneliness, shame, embarrassment, low self-esteem and self-worth, defeat and a sense of being taken advantage of and feeling vulnerable. One way to respond to escape such feelings involved returning to drug use to cope:

> What I feel right now is as if I didn’t have anybody, alone (…) I stay with my addiction (…) I have to hold on to this [drug use] and keep doing it. I don’t have anybody else to help me (…) my best friend right now is the drugs (7).

Experiencing rejection was significant to such drug use, increasing harmful and risky behaviour such as sharing needles, and self-destructive behaviour, as captured by one participant:

> Thoughts of hurting yourself come to mind (…) when these rejections come, we escape further into drug abuse (…) when my mother rejected me; I stayed on the street for over a week using drugs, I was self-destructive. Because being rejected (…) would make me feel so horrible (…) You go out there to destroy yourself (6).

A further impact of stigma commonly reported was social isolation which could be both inflicted by being ostracized by non-IDUs or as a result of escaping stigma. Social rejection, avoidance and exclusion were reported from families and communities (2; 3; 7; 9; 15). Being stigmatised and rejected, whether perceived or enacted, reduced IDUs’ social circles, e.g. “no one wants to be around a junkie” (7): “I’m a social reject, because heroin is a social reject drug.” (16). IDUs could also avoid social contact to escape stigmatising experiences and socialising with other IDUs could provide escape (7; 8; 12). Distancing from other IDUs may be important for recovery by avoiding “risky relationships”, being back in the “the lion’s den” (12) of relapse and by helping to develop alternate identities. However, with limited options for alternative relationships, IDUs could see returning to peers, and relapse, as inevitable (15).

Another common form of escape from stigmatising experiences related to what Goffman (1968) referred to as ‘passing’, that is, the concealment of a stigmatised attribute in order to pass as “normal”. Passing included avoiding being seen at services, leading some participants to attempt to detox alone (12). Others avoided being seen by accessing pharmacies during quiet periods or waiting until they were empty (14; 15). Concealment was used to avoid disclosures, activities or appearances that could reveal drug use, such as by posing as “normal” pharmacy customers by pretending to buy items (6; 10). However, concealment could increase risks, such as injecting in more dangerous but more concealable areas, missing potential interactions of drugs with other prescriptions by not disclosing IDU and preventing access to support (7; 11; 16).

The responses of IDUs may be influenced by both the vulnerability or disadvantage that they experienced. Findings supporting such factors included the disadvantage of limited choice due to the availability of services, support and social networks and varied power to change circumstances, such as leaving an area. For example, impaired mobility could limit the ability to access alternative services (10) or being homeless could result in an appearance more attributable to an addict, making “passing” more difficult (13).

With the negative consequences of stigma further established, the papers were also able to expand understanding to consider responses to these consequences. Such responses can risk further harm and the choices available to IDUs may vary dependent on relative advantage/disadvantage experienced.

Theme 2: “I’m an addict – not a junkie”: Inter-group stigma

Evident in many studies was the existence and use of stigma hierarchies to make inter-group comparisons. As a response to stigma, IDUs rejected addict/IDU identities by employing inter-group stigma to assign this identity to those judged as lower in the hierarchy. Becoming agents of stigma allows identification as responsible members of society, of the “dominant moral community” (12) and not part of the rejected group.

A general hierarchy of drug use was supported with heroin and injecting seen as the most stigmatised compared to other drug use. It was judged as less socially acceptable, lacking control and linked to prostitution (3; 4; 6; 10; 11; 16). An awareness of hierarchies was shown through descriptions of being “looked down on” or thought less of, e.g.: “They look at you like you’re a drug addict (…) like they can treat you any way they want (…) you’re lower than I am if you use drugs.” (2).

Participants appeared to endorse these judgments (4; 8; 11; 13), however, they distanced themselves by extending the hierarchy, applying stigma to other “worse” or “bad” users, such as differentiation between “addict” and “junkie”: “I class myself [as] an addict’ I hate the word junkie… I believe that a junkie is a person that goes out and mugs people and things like that, that’s a junkie” (16). The hierarchy was extended with distinctions of responsible versus irresponsible behaviour, normality, functioning and being in control (4; 8; 11; 13). For example, one participant explained how they classified themselves:

> You see I am not a drug user, you know, I don’t smoke crack cocaine, I don’t take Valium and all that, all right I take heroin but, you know, I don’t do it in front of anyone, it is something that is very private. I am not a social user, you know, I used to get up every morning for the kids, you know what I mean, get them washed, dressed, ready for school, bed, take them to school, pick them up (12).

There were further distinctions to distance from stereotypes regarding the function of drug use, with attempts to align with use to maintain functioning rather than pleasure, including associations with medical use (12).

The judgments underpinning the hierarchy mirrored stereotypes held about IDUs in general. This shows the internalisation of such stereotypes and the efforts to relieve this stigma by seeking judgements to allow the attribution of stereotypes to others who are lesser or worse in some way. Homeless IDUs could be seen as “the bottom of the pile” by conforming most to stereotypes such as being perceived as showing irresponsibility through needle sharing and unsafe disposal (13).

Theme 3: Multiple identities: Layering stigma or positive alternatives?

This theme explores the possibility of IDUs holding multiple, interacting identities. Positive alternatives could aid recovery and reduce the impact of stigma but IDUs could also experience identities that added to or interacted with IDU stigma, creating further difficulty. This supports the importance of looking beyond IDU in isolation and considering the wider context and varied aspects of IDUs’ lives which may include current or potential roles.

Having other identities that were also stigmatised, “layered stigma”, most frequently included participants being stigmatised for having HIV or Hepatitis C or for engagement in sex work (2; 11; 15; 16). Eight forms of stigma were reported among one group of participants, including age, mental health, poverty and race (10). Pregnant women faced additional stigmatising experiences regarding perceived failings as women and mothers, fearing their children may be taken into care (4; 8; 9). One participant described her treatment by a health visitor, experiencing intrusive questions and judgmental attitudes:

> Yes, my baby has a milk disorder and my health visitor, she made another appointment with me. I got treated like a piece of shit basically. [She asked me] Have you got a bond with your son? What [is] your partner in prison for? Do you still use [illegal drugs]; I didn’t need to tell them that and thought [that] I did (8).

Layering of stigma could involve additional discriminatory treatment which, towards parents, included unnecessary involvement of child protection services based on the stereotypes held by both professionals and family members regarding their ability to parent. The stereotypes and treatment persisted despite no longer using drugs, for example:

> DCF [Department of Children and Families: USA] was called just because I was on methadone. Methadone's a medication, so why should you call DCF because I'm taking a medication? I had no dirty urines my whole entire pregnancy, I was clean the whole entire time… I have a stable living, house so why is DCF being called on me for taking a medication? (2)

Layering of stigmas created increased difficulties and barriers to services which might not have been additive but magnified. For example, the association of HIV and IDU as causing transmission could amplify guilt or shame and stigma: "When I was addicted, the community hatred was [rated as] 5. When I got HIV, the hatred was 12 times more." (12).

Considering other roles or identities that could be held by IDUs was also relevant to the extent stigma was internalised or whether ambivalence about change was experienced, both indicated as important to recovery (9; 12). The availability of alternate identities had the potential to reduce stigma and support recovery from drug use and accessing treatment was viewed as making available "alternate categories of self" (11). However, treatment could also be associated with IDU identities and stigma which could lead to disengagement (11). The simultaneous possibility of alternative identities and recovery, contrasted with the risks of stigma from treatment, created ambivalence among some participants. Ambivalence might also be created by a conflicting pull towards positive aspects of IDU identity, such as "outlaw appeal" (4).

Whether considering potential difficulties, such as layered stigma or ambivalence, or promoting positive alternatives, the complexity and significance of varied roles and identities, including but not limited to IDU, are apparent.

Theme 4: Perpetuating stigma: From institutions to internalisation

This theme details how stigma is cascaded from the institutional level. This is seen through evidence of stigma within policy, service design and delivery then influencing stigmatising interactions with professionals and ultimately contributing to the internalisation of stigma among IDUs. Policy and language use was also seen to mirror societal stereotypes and in turn perpetuate them, as evidenced by the stigma reported in communities.

Stigma at the level of services was experienced not only directly through staff attitudes and behaviour but also from the way services were delivered which communicated and thus perpetuated stereotypes of criminality, untrustworthiness, lower status, undeservedness, deviance and immorality. The service delivery in question included surveillance, lesser and differential treatment, segregation, exposure to stigma and punishment. These will be discussed in turn.

Surveillance included being watched closely, treated with suspicion and undergoing supervised methadone consumption which was a common requirement (1; 5; 11; 12). Although primarily MMT services were reported, suspicion and surveillance were evident in other settings, such as hospitals where: “Because of us being a drug user, they won’t let us move. They won’t let us get off the ward or they won’t let us go for a cigarette or anything like that. You feel as if they can’t trust us and we are going to get up to all sorts.” (10).

Reports of differential treatment in comparison to ‘normal’ pharmacy customers included being made to wait or being seen in separate areas (1; 5; 9; 11). Segregation could allow privacy to some extent by avoiding exposure to stigmatising interactions with the public and was preferred by some participants. However, attempts to provide privacy did not ensure concealment. For example, one participant described: “There’s a wee [small] private area, but people [other customers] know what’s going on back there” (5). Segregation could also be experienced as stigmatising and “ostracising” (1) such as experiences with separate entrances:

> which to me means that that separates us from the regular customers right off the hop, so that gives you the sense of “you’re not worthy; we have to hide you coming in. ” The entrance is completely different from the other one, and there’s notices up saying, “You can’t hang around or police will arrest you. ” … then when you ask why we’re separated, it’s like “Well, not all of you are honest, and some of you are thieves” (1).

Such treatment could be enforced by discriminatory rules including having to enter pharmacies alone and being made to wait until “normal” customers had been served. One participant described the impact of such rules:

> They [pharmacy staff] (…) serve all other normal people first, and make us all wait round the corner, like we are scum (…) they treat you (. . .) like you are just not really human, like you are less than human (10).

Some services imposed rules via contracts, emphasising power differentials with requirements for IDUs and not professionals (5; 9). Breaking rules carried punitive consequences, as did returning “dirty” urinalysis results, and participants were aware of the power of staff to issue reward or punishment. Examples of punishment reported by (5) include discharge, suspension of methadone, and increased surveillance, testing and contact with services and examples of rewards included unsupervised/take home prescriptions.

Examples of the powerful influence of the language used in policy included the dichotomy between “clean” and “dirty” which often emerged (2; 5; 6; 8; 15; 16). This has origins in “dirty” urinalysis results, expanded to equate “clean” to being not only drug but methadone free (16). Moreover, a dichotomy was suggested to equate good and bad behaviour and associated reward and punishment. This served to further reinforce stereotypes of deviance and danger through keeping the dirty separate from the clean, for example: “Stablized people go on Wednesday. That’s me. One dirty urine, and they could put me back to Thursday” (6). Such language use carries judgments of impurity, disease and contamination, summarised by (11) as portraying “social dirt; a source of both contamination and danger to other members of society”. The use of associated language by participants showed the extent the stigma conveyed via this language use was adopted among both participants describing themselves and their accounts of varied agents of stigma. Examples included lepers/leprosy (3; 5; 7), “less than human”/”dog” (5; 14), “garbage” (3) “scum” (2; 9; 10); “piece of shit” (8; 9). In addition to the clean/dirty dichotomy, policy language, such as “high harm causing” and “social evil”, communicated judgements of morality (12). The internalisation of this was shown by participants referring to morality and punishment including some viewing receipt of stigmatising treatment as punishment (14; 15).

The role of different policy orientations, frequently Harm Reduction (HR) versus enforcement and/or abstinence, and their role in propagating stigma were discussed (6; 7; 14). Enforcement orientated policy was highlighted as exacerbating blame and stigma (7) and is the dominant policy orientation reported in the papers. Potentially in a parallel, perpetuating process, similar stereotypes, such as criminality, are evident in the media which permeate into drug policy (9). Policy then informs service design, expressed through mechanisms of reward and punishment while in turn IDUs are treated with suspicion and as under surveillance from professionals and the public. Policy perspectives also attribute difficulties to individual failure or weakness rather than social problems (12) potentially influenced by stereotypes regarding the nature of IDU. These stereotypes are then internalised by IDUs themselves, as evidenced in inter-stigma hierarchies.

Treatment was accused of viewing clients as passive recipients, perpetuated by a lack of involvement (6). Locating problems in individuals with passive involvement fits with a medical model, the dominance of which can be seen through service and treatment provision (IDUs receiving prescriptions with an emphasis on individual failings and associated responsibility). Despite this, many participants experienced being seen as addicts and not accepted as medical patients which could be less stigmatising (12). There was often frustration at the differing attitudes and treatment of addiction versus medical conditions (3; 12). It appears that, despite existing within a medical model, stigma can exclude IDUs from being considered as valid medical patients. The view of IDUs as addict rather than patient were reflected in wider society, with explanations of reduced stigma after HIV was disclosed as due to perceptions of addiction as chosen and controllable versus HIV positive individuals being considered “ill and in need of care” (12).

Discussion

The findings of the meta-synthesis offer advancements in the understanding of further complex and understudied aspects of stigma for IDUs. This includes responses, the existence of hierarchies and inter-group stigma and the role of language use and institutional stigma in internalisation processes and perpetuation of stigma. Additional findings regarding the significance of layered stigma, alternative roles, vulnerability and disadvantage highlight the importance of understanding complex and individual experiences of stigma. The contribution of the review to knowledge in these areas and stigma theory will be discussed with implications for interventions to reduce stigma, limitations and future research options considered.

Responses to Stigma

Knowledge is advanced regarding responses to stigma. In addition to contributing to an understanding of responses of avoidance, concealment and passing, the use of inter-group stigma was highlighted. Inter-group stigma has been described as “downward comparisons”

(Crocker & Major, 1989) that allow stigmatising behaviour to be attributed to “others” who are “lesser” or “worse”. It is a strategy to reduce felt stigma by distancing from the stigmatised group, an attempt to raise self-esteem, cope with stigma or access power by feeling a sense of belonging to the in-group (Preble & Casey, 2001; Tajfel & Turner, 2004), achieved by stereotyping according to the in-group values. Findings support the application of inter-stigma based on a hierarchy. The evidence of stigma hierarchies in general is consistent with findings that heroin and injecting are the most stigmatised forms of drug use. Further understanding is offered regarding the expansion of hierarchies among IDUs to make distinctions between those lower on the hierarchy based on stereotypes, enabling inter-group stigma.

The characteristics that informed hierarchies in the review appear to reflect stereotypes regarding functionality, irresponsibility and deviance and include similar findings to other studies of IDUs, such as lacking control, not participating in daily living and drug use consuming identities (Boeri, 2004; Rødner, 2005). Using ethnographic and interview data, Boeri developed a typology of heroin use, including “controlled occasional users” and “junkies”, finding that dimensions of control over drug use and alternative social roles were salient. The attributes that are stigmatised between IDUs may relate to the degree stigma is visible (Goffman, 1963), potentially explaining why homeless IDUs could be most stigmatised. The use of inter-stigma, including hierarchies, has also been found among other stigmatised groups, such as people with disabilities (for review and discussion, see Deal, 2003; Reeve, 2008).

Context

There was a focus in some papers on explorations of individual experiences rather than considering context and institutional stigma, confirming criticisms of this gap in research. Findings supporting the importance of seeking contextual understanding of IDUs' circumstances include the relevance of disadvantages/vulnerabilities, social support and additional/alternative identities.

The importance of looking beyond IDU in isolation was evidenced by findings regarding multiple identities that IDUs can hold. These can offer positive alternatives which supports the pursuit of interventions facilitating identity change. However, ambivalence about intervention was suggested to be due to difficulty letting go of or changing identity. This is an important consideration as it expands understanding of barriers to service access beyond simple avoidance of stigma. It is possible that holding multiple identities may mean remaining "entangled" with IDU despite perusing alternatives (Martin, 2011) and IDU may be integral to a sense of self, potentially carrying positives such as the "outlaw appeal". Hughes (2007) discusses the concept of tangled identity as more complex than an individual and their drug use as it includes wider inter-relational contexts and, therefore, developing a non-addict identity requires more than just identity work. She argues that a focus on individual's resolving their identity is a consequence of viewing addiction as a problem located within individuals.

Multiple identities can involve layered stigma as these identities may also be stigmatised. The findings of the review relating to layered stigma include similar stigmatised identities to other studies, such as HIV and Hepatitis C, gender, mental illness, sex work, sexuality, homelessness, race, poverty and criminality (Capitanio & Herek, 1999; Dean & Rud, 1984; Habib & Adorjany, 2003; Hartwell, 2004; Mosack, Abbott, Singer, Weeks & Rohena, 2005; Reidpath & Chan, 2005; Room, Babor & Rehm, 2005). It is suggested that layered stigma can be explained by the intersection of stigma with disadvantages and other forms of oppression, such as racism and classism, to "create new forms of discrimination" (Smye, Browne, Varcoe & Josewski, 2011). Intersectionality is a perspective exploring how different social identities or categories intersect to create layered stigma, social inequality and oppression (Crenshaw, 1999; Samuels & Ross-Sheriff, 2008). This approach acknowledges the complexity and uniqueness of stigma experiences, including context and society's treatment of individuals. Papers discussing such issues stressed the complexity of these factors, warning against attempts to understand IDU in isolation.

Considering social networks is significant as social support was found to be important for both coping with stigma and supporting treatment for drug use. This is consistent with other findings, such as Gourlay, Ricciardelli and Ridge (2005) who found participants with "non-addict" or "functional" self-concepts had more resources and social support in contrast to "conflicted" users who had negative self-concepts, limited resources and few social contacts. However, the review findings present a complex picture regarding whether social contact with other IDUs is helpful or harmful. The importance of developing relationships with non-IDUs has been recommended elsewhere to facilitate identity change and avoid the risk of relapse (e.g. McIntosh & McKeganey, 2000; Warburton, Turnbull & Hough, 2005). However, the review findings suggest IDUs may have limited opportunities to do this due to social isolation and the pull towards other IDUs either to satisfy social needs or escape stigma. Belonging to the same group may provide escape by feeling a sense of normality and "as good as anyone else" (Goffman, 1963, p.172). However, this still risks exposure to stigma whether through association with IDUs, activation of internal-stigma or exposure to inter-group stigma. This suggests a complex and conflicting picture which has implications for group intervention/treatment which could be used to support positive relationships between IDUs while also addressing inter-stigma, potentially practicing coping strategies and empowerment (Gunn & Canada, 2015).

The use of psychological formulation could support the exploration and acknowledgment of contextual factors. Understanding IDU as a response to difficulty, including stigma experiences, rather than a choice for pleasure could reduce stigma. This could include exploring internalisation and meaning of stigma and its role in perpetuating drug use, vicious cycles (e.g. unemployment) and coping strategies and risk behaviours. The review findings suggest that medical understandings of addiction may reduce stigma. However, medical labels are still stigmatised, such as HIV, with moral and medical views able to coexist, including addiction being seen as both a disease and a moral weakness (Lloyd, 2010). Also, complex routes into addiction should not be ignored or IDUs made to feel they have no choice or control (Lloyd, 2010) which could be the case with medicalised understandings. A psychological formulation could provide further reduction of stigma and benefits of empowerment and choice of intervention, including acknowledging social causes, rather than being limited to individual responsibility for abstinence and/or reduction of harmful behaviours with the view of addiction as a medical condition out of people's control.

Institutional Stigma

Findings are able to advance understanding of institutional stigma, and the power of language as a vehicle to perpetuate stigma. This was seen to cascade from media and policy to influence the stigma experienced from services and the community, ultimately resulting in internalised stigma among IDUs. Despite highlighting the need to change language, particularly the "clean"/"dirty" dichotomy, suggestions for alternatives were lacking. Some available suggestions include renaming MMT clinics as "addiction recovery centres" (White, 2010, p.46) and reframing IDUs as customers/consumers (Fraser & Valentine, 2008; Reisinger et al., 2009).

The perpetuation of stigma was also evident in the stereotypes underlying policy and service design, such as stereotypes of deviance influencing policies of social control. Criticisms within the papers regarding social control in MMT, described as "[possibly] the most regulated and controlled intervention that operates under the guise of treatment" (Harris & McElrath, 2012), are a concern shared elsewhere (for discussions see Bourgois, 2000; Joseph, Stancliff, & Langrod, 2000). Justification for social control may come from concepts in wider policy regarding morality and stereotypes of deviance, with stigma considered a reaction from those in power to "'isolate', 'treat', 'correct', or 'punish' individuals engaged in such behaviour" (Schur, 1971, p.24). This includes enforcement oriented policy which was highlighted as the dominant policy orientation despite evidence that it does not deter use and has negative consequences and opposite outcomes. Consequences include an offending history being stigmatising in itself (Clear, Rose, & Ryder, 2001; Hartwell, 2004) and establishing and/or confirming stereotypes of criminality, deviance and immorality. Evidence of the harms of such policy include findings from the World Health Organisation (WHO) world mental health surveys (Degenhardt et al., 2008) and UNODC (2015) world drug report.

Harm Reduction (HR) was suggested as a less stigmatising alternative which is supported by the WHO (Degenhardt et al., 2008). HR is a term which "defines policies, programmes, services and actions that work to reduce the health, social and economic harms to individuals, communities and society that are associated with the use of drugs" (Newcombe, 1992) with a commitment to public health and human rights (Harm Reduction International, 2016). There is a focus on "reducing the negative consequences of substance use for individuals, communities and societies (…) rather than focusing on decreasing or eliminating substance use" (Pauly, Goldstone, McCall, Gold & Payne, 2007, p.6). Moral judgements and stigma towards IDU may be reduced by focusing beyond abstinence and individual concepts of 'recovery' can be accommodated, taking account of varied causes and impacts of problems, varied resources and individual priorities (Pauly et al., 2007), including acknowledging the potential benefits of drug use (Riley at al., 1996). Recommendations to advance HR include political action, engagement and collaboration (Smye, Browne, Varcoe & Josewski, 2011).

To reduce institutional stigma may require addressing both structural-physical settings (buildings, locations and procedures) and psycho-environments (staff attitudes and restrictive policies influenced by stigma) (Simmonds & Coomber, 2009), both found to be relevant in the review. Barriers to service and policy change should be acknowledged. The social, political and economic context that services sit within is not immune from institutional stigma and has been acknowledged as a barrier (Ezard, 2001; Keane, 2003; Rhodes, 2002). Examples include stereotypes regarding the causes of addiction and political interests influencing policy priorities and funding (Balian, 1998). Therefore, any recommendations should consider service contexts which may have barriers of limited resources or competing ideologies regarding treatment and recovery. Recommendations for policy change also exist alongside stereotypes and beliefs that could present barriers. This includes the argument that stigma can be a helpful deterrent, a tool to discourage unhealthy behaviour (e.g. Satel, 2007).

Contribution to Stigma Theory

The findings of this review support the application of stigma theory to IDUs by adding to evidence of the widespread existence of stigma and its impact, including mental health, risk and barriers to service access. The responses to stigma that were reported, such as strategies of passing and concealment, and findings relevant to processes of labelling and othering are also applicable to existing work, for example Goffman (1963) and Link and Phelan (2001). Evidence of enacted, anticipated and internalised stigma further supports the assertion that complexities of stigma exist which require investigation to avoid underestimating the impact of stigma (Ahern, Stuber & Galea, 2007).

Although findings can contribute to overarching theory on stigma by offering similar results to other stigmatised groups, there may be differences due to particular stereotypes (e.g. criminalisation) or the nature of stigma experienced by IDUs. For example, Mankoff (1971) differentiates "ascribed" deviance that someone is born with, from the more stigmatised "achieved" deviance involving purposeful actions, breaking the rules of society, such as IDU. The level of stigma may be relevant and drug addiction is more stigmatised than mental and physical illness (Corrigan, Kuwabara & O'Shaughnessy, 2009; Schomerus et al., 2011). Also, stigmatised attributes may differ in whether they are protected and whether discrimination is illegal, for example substance use disorders are included in the Americans with Disabilities Act (1990) but not in the UK's Equality Act (2010).

Limitations

The review was limited by access to papers which are published and using English language only. This could potentially miss relevant findings, such as those from charities and community groups, which could be particularly relevant for IDUs, and a broader range of cultures.

Many of the papers did not exclusively study stigma for IDUs. This was sometimes due to the research focus on HIV meaning other at risk groups were included in the same study. Also, papers often included varied forms of drug use. Findings were only included if it could be discerned that they related to IDUs, however, with varied quality of reporting this was sometimes difficult and might have led to the exclusion of some findings and limited interpretation of results due to not being able to differentiate from non-IDU participants. However, there was enough data to conduct a synthesis and, given the risk to IDUs of experiencing greater stigma and more significant consequences of barriers to service access, it is important to pursue evidence to inform these issues.

Future Research

IDUs who might have been excluded from research should be engaged, including a consideration that stigma can also be a barrier to research participation (Beyrer, Malinowska-Sempruch, Kamarulzaman & Strathdee, 2010). It would be useful to gather experiences from IDUs at a range of stages in treatment/service access, including those who cannot or do not want to use services.

Further understanding of processes such as identity change, ambivalence, internalisation and inter-stigma is required. Further exploration of stigma at all levels, particularly institutional stigma which has received less focus, contextual and individual factors, including multiple identities, is also valuable. Advantages, strengths and protective factors should also be studied, including the importance of social support and the potential tensions regarding accessing support from other IDUs.

Findings appear consistent across the different countries and cultures included in the review. This is despite stigma being considered a social construction. It is possible similar stigma has developed across cultures. Alternatively, research may be lacking into more diverse cultures, with the possibility some societies do not stigmatise or experience problems with IDU, therefore not attracting research attention. Conversely, research was not available from cultures which may discriminate more strongly, such as detention, forced labour and violence in China (Human Rights Watch, 2010).

Research evidence could support arguments for policy change, including the cost-effectiveness of HR strategies and outcome measures such as health and risk (for examples, see Emmanuelli & Desenclos, 2005 and Wood, Tyndall, Montaner & Kerr, 2006). Hwang (2007) has argued for the importance of using evidence to inform policy-making related to substance use. Such arguments may be more successful with quantitative data, however qualitative research remains important to understand the experiences, processes and complexities of stigma, retaining the position that this is a complex and individual experience.

Conclusion

This review emphasises the widespread existence and impact of stigma for IDUs, extending understanding beyond barriers to services. Knowledge is advanced to include the complexities of stigma experiences and responses, including inter and layered stigma, and the relevance of contextual influences. Recommendations to reduce stigma include supporting alternative identities and addressing social support both within and beyond IDU communities. The importance of expanding focus and addressing issues of institutional stigma within service design, policy and language use is supported and HR appears a promising approach to combat stigma, allow complex intersectional understanding, including context, address root causes and provide varied, individual intervention or support. Further research is needed to advance understanding of the complexities of stigma, to develop the treatment and support available for IDUs and to work to reduce stigma.

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Figure 1

Flow Diagram of Screened and Included Papers

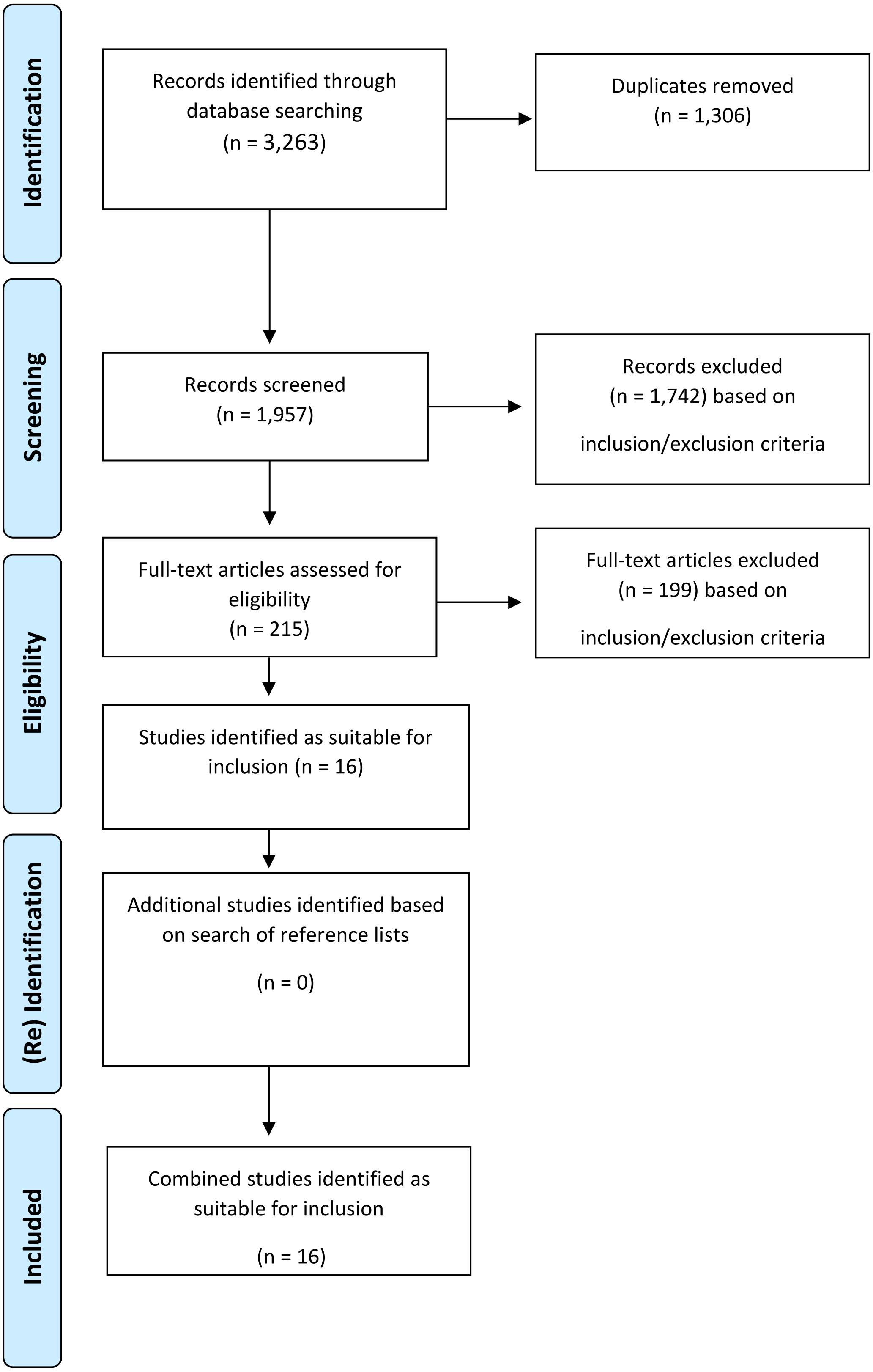

Table 1

Details of Papers Included in the Review

Paper	Research question/aim	Methodology (data collection = one-to-one interviews unless otherwise stated)	Participants	Setting	CASP rating
(1) Anstice, Strike & Brands (2009)	To analyse MMT clients' experiences of supervised methadone consumption, examining the positive, negative, and stigmatizing aspects and explore how stigma is conferred, managed, and ameliorated.	Grounded theory	64 MMT clients. 42 male, 22 female. 16 under 21, 20 age 30 to 39, 23 age 40 to 49, 5 age 50 plus	Four low threshold methadone programs. Ontario, Canada.	11
(2) Earnshaw, Smith & Copenhaver (2013)	To characterise drug addiction stigma from multiple sources; to describe the sources of stigma, types of stigma and the ways stigma was experienced.	Secondary analysis of qualitative interview data originally	12 MMT clients. 8 male, 4 female. Age from 22 to 52.	Inner-city MMT site.	9
(3) Guarino, Moore, Marsch & Florio (2012)	To examines substance use patterns among immigrants from Russia or the Former Soviet Union including contextual factors that may create vulnerability, as well as specific substance use behaviours that may place them at risk for HIV/HCV.	Constructivist Grounded theory	Ten IDU immigrants living in New York City. 5 male, 5 female. Age from 19 to 45.	Six drug treatment providers. New York, USA.	11
(4) Gunn and Canada (2015)	To explore the peer group experiences of women with histories of addiction through the lens of multiple, intersecting stigmas.	Constructivist Grounded theory	30 women participating in a residential drug treatment centre. Age 19 to 56. 70% hard users, 30% were the soft users.	Residential substance use treatment facility in Midwestern USA.	10
(5) Harris & McElrath (2012)	To explore how MMT clients experience social control, the nature of institutional stigma and the reinforcement of spoiled identities.	Interview data was pooled from four qualitative studies by the authors: "we identified emerging themes"	215 participants from across four studies. Study A (heroin use and IDU). 54 participants Study B (IDU). 90	Two studies conducted in Northern Ireland and two in the Republic of Ireland	11

Paper	Research question/aim	Methodology (data collection = one-to-one interviews unless otherwise stated)	Participants	Setting	CASP rating
			participants Study C (problem drug use). 35 participants Study D (drug misuse). 36 participants		
(6) Jackson, Parker, Dykeman, Gahagan, & Karabanow (2010)	To explore the influence of social relationships, at the interpersonal and community level, on safer and unsafe drug use practices among IDUs.	Grounded theory	38 IDUs. 23 male, 15 female. Age from 18 to 59.	Needle exchange programs. Nova Scotia, Canada.	9
(7) Jiménez, Puig, Sala, Ramos, Castro, Morales, Santiago & Zorrilla (2011)	To explore felt stigma among socially marginalised groups and the impact on risk behaviour.	Content analysis Four focus groups of 8–10 participants.	34 participants "at risk of becoming infected with HIV". 17 male IDUs, 17 female sex workers (also drug users but not exclusively IDUs). Most male participants were aged from 30 to 49.	Research Community Initiative Centre. San Juan, Puerto Rico.	11
(8) McPhee, Brown & Martin (2013)	To explore how IDUs on MMT experience stigma as drug addicts, and as service users in health care and pharmacy settings. Additionally, to explore micro and macro institutional factors and the impact of definitions of recovery as "drug free".	Thematic analysis	14 IDUs in MMT. Eight male, six females. Age from 18 to 55.	Three MMT centres. Scotland, UK.	9
(9) Neal, Tompkins & Sheard (2008)	To fill knowledge gaps of problems faced by IDUs when securing general health care and non-substance-misuse specific support.	Data was analysed using "Framework"	75 current IDUs. 52 male, 23 were female. Age from 19 to 48.	Three needle exchange programmes. West Yorkshire, UK.	10
(10) O. Conner & Rosen (2008)	To explore the potential additive effect of stigma on individuals who are experiencing multiple stigmas simultaneously by examining stigma experiences and the impact on delayed entry into treatment.	Content analysis	24 older adults in MMT. 10 male, 14 female. Mostly aged between 50 to 60.	MMT clinic in Midwestern USA.	10

Paper	Research question/aim	Methodology (data collection = one-to-one interviews unless otherwise stated)	Participants	Setting	CASP rating
(11) Radcliffe & Stevens (2008)	To explore how drug users who dropped out of treatment describe the stigmatisation of drug users and drug services, particularly the stigmatised identity of the junkie.	"Adaptive coding"	53 drug users who dropped out of treatment. 39 male, 14 female. Age from 19 to 50.	12 randomly sampled drug treatment services in three Drug Action Team areas. England, UK.	9
(12) Rudolph, Davis, Quan, Ha, Minh, Gregowski, Salter, Celentano & Go (2012)	To explore perceptions and experiences of layered stigma of IDU and being HIV-positive in both a community and family context, considering the connection to decisions to disclose HIV status.	Unspecified analytic method: "interviews with participants revealed some universal themes"	25 HIV-positive male IDUs. Age from 27 to 47.	Recruited as part of a large RCT. Thai Nguyen, Vietnam.	9
(13) Simmonds & Coomber (2009)	To consider the way that social stigma impacts both on and within IDU populations and the consequences for prevention and harm reduction.	Data taken from a city case study, part of a national needs assessment of Safer Injecting Services facilities. Unspecified analytic method: "the theme [stigma] was emergent from the qualitative process itself"	91 participants made up of varied drug use, including four steroid injectors, and professionals. 67 male, 24 female. Mean age, 32.	Safer Injecting Services. England, UK.	7
(14) Smye, Browne, Varcoe & Josewski (2011)	To explore Harm Reduction and MMT using an intersectional lens to provide a more complex understanding particularly of how they are experienced differently by people dependent on how they are positioned (e.g., living in poverty and homeless and/or near homeless). To elucidate the need for approaches that reflect an understanding of and commitment to addressing the historical, socio-cultural and political forces that shape responses to mental health, addictions and harm reduction.	Interviews (18 participants) and focus groups (21 participants) Interpretative thematic analysis.	39 aboriginal MMT clients. 19 male, 21 female. (professionals were also interviewed)	Five community-based mental health, addiction and primary health care agencies. British Columbia, Canada.	10
(15) Tomori, Go, Tuan, Huong, Binh, Zelaya, Celentano, Dat & Quan (2014)	To investigate the challenges and facilitators of re-entry into community and family life among men released from "06 centres" (drug treatment centres that IDUs are sent to for compulsory detoxification, vocational training, and labour for up to four years).	"analysed for key themes"	43 IDUs released within the past 2 years from "06 centres".	Outpatient HIV clinics, self-help groups and peer referrals. Hanoi, Vietnam.	6

Paper	Research question/aim	Methodology (data collection = one-to-one interviews unless otherwise stated)	Participants	Setting	CASP rating
(16) Whitaker, Ryan & Cox (2011)	To unpack, analyse, and identify the multiple layers of stigma experienced by IDU sex workers in Dublin society.	"Recurring themes were identified and interpreted."	35 IDU sex workers. 4 male, 31 female.	Specialist agencies; drug treatment and homeless services, and services providing health treatment for sex workers. Scotland, UK.	13

Appendix 1-A

Example Synthesis Data for the Theme "Perpetuating stigma: From institutions to internalisation"

First Order Constructs	Second Order Constructs	Third Order Constructs	Relevant Papers
Family/Friends/ Healthcare Workers	Participants found stigma more frustrating if they saw addiction as disease because they felt they were not understood/ prejudice was shown by a lack of caring/ doctors who do not support MMT are more prejudiced/ discrimination from healthcare workers included being treated differently once drug use was known, mostly by denying pain meds/treatment being treated rudely/coldly participants pointed out the irony of addiction Vs medical condition and differing attitudes/ "Once you start talking about your drug, you your experiences with drugs and alcohol, they tend to look down on you."/ "But now that I'm a changed individual, I'm trying, I'm workin' hard to keep myself clean, it seems like you guys [people in general] would give me the benefit of the doubt. You know, not always thinking about 'Damn, this, that, and the third' … or 'he used [drugs]' cuz, you know, if you're still thinking like that then, you know what, you're not even open minded to me changin. You don't even think I can change."/ "DCF was called just because I was on methadone. Methadone's a medication, so why should you call DCF because I'm taking a medication? I had no dirty urines my whole entire pregnancy, I was clean the whole entire time, I have no… I have a stable living house so why is DCF being called on me for taking a medication? That's the, that's the…I don't understand. It's like… that's the part that kills me. I just don't get it I guess."/	Perpetuating stigma: From institutions to internalisation	Earnshaw & Smith & Copenhaver (2013)
Stigma from family, friends, staff and treatment	examples were given of drug stigma from staff at rehab facilities, drug counsellors and in society/ "you need to show a lot more compassion."/ "You kinda felt almost like a herded-in cow or something . . . and we ain't in a barnyard. They made everyone feel so yucky about themselves. You know cause they had cops here guarding the place and looking at you like you did something wrong or terrible. But you didn't' really do anything wrong. . . . They were very, very untrusting. And even if you didn't do anything, they would look at you like you did."/ "I went to people [drug counselors] that just downed their noses at you. I didn't wake up one day and say 'Hey, I'm gonna be a junkie.'"/ "You know, we [opiate addicts on methadone treatment] are the scum of the earth to them people that write them books, and we are somebody! And the average one of us are intelligent people. You know, if they was to stop and try to learn, you know, sit down and try to talk to us instead of judging us, we would all be better off." "I've lost all faith in doctors to be honest with you. As soon as you get there they don't want to know what's wrong with you, they just want to know who is your insurance company. I'm afraid to tell people I'm even on this [methadone] program. I'm (Renee) and then I'm not (Renee) anymore, instead I am the woman on methadone. You know, then I'm one of those. You see, I can pick up on that easily."/ "My father was like [thought] I was the scum you know, and it's not a disease, it's just you wanna party that's all it is, you just wanna party, you like getting high."		O. Conner & Rosen (2008)
The layering of HIV-related stigma	Shame and stigma could be caused if HIV was acquired through drug use and HIV- stigmatization was considered by participants as a punishment for their behaviour		Go, Tuan, Huong, Binh, Zelaya, Celentano, Dat,

First Order Constructs	Second Order Constructs	Third Order Constructs	Relevant Papers
			Quan (2014)
Fears of Exposure and Feeling Judged/	participants experienced enacted stigma and feeling judged by staff/ “And when my brother passed away, that time Dr. [name] turned around and said to me, “Do you know what? It should have been you instead of your brother. You’re nothing but a dirty fucking junkie. You are a drug pusher.” And I snapped, and I jumped up, and I grabbed him by the head and bounced his head off the table. And then all the GAs [general assistants] came running in and grabbed me, and then I got fucked down to [name] Street, I did, over it and that’s how I ended up in [name] Street. It was over assaulting Dr. [name].”/ A lack of worth was “reflected in the insensitive manner in which some health professionals conveyed the news to clients that they were HIV or HCV positive, and also by the lack of a continuum of care and treatment.”/		Whitaker, Ryan and Cox (2011)
Stigmatizing Language (Dirty and Clean)	“Language is an important vehicle through which stigma is perpetuated and reproduced e.g. dirty or clean urine, language was then internalized by the drug users when referring to their own urine and themselves”/ clean included taking no methadone/ participants did not know they had internalised language and how this continued the stigmatising cycle/ “Institutional stigma is perpetuated through the use of language, which in turn is internalized by those who are stigmatized, and the stigmatizing cycle continues.”/ “Eight years ago, when I was 21, I finished it and stayed clean for two years. Then I had three slips over the time, and then went back on it at 23, on methadone. . . . I feel I have cleaned up a lot since Christmas. I’ve been very clean. I have been trying, I had to get clean so that I could get away from my partner, that is the only way I could get away from him, ’cos he was very abusive”/ “I got clean and got off everything, no methadone, nothing.”		
Stigma and Discrimination	The attitude of providers was a barrier to care and included perceived and enacted stigma experience “The experience of ‘being taken advantage of’ because of being an “addict” in addition to the rules and regulations associated with MMT engendered a sense of vulnerability, and, to a belief by some participants, that they were being punished for their drug use” Participants experiences mistrust/ “And it’s easy to kick a wounded dog, I mean, you know, I mean that’s what happens down here, [service providers] don’t mean to do it, they don’t get up in the morning with a plan to go ‘I’m going to go kick ten junkies today,’ they don’t do it, it’s just as the day builds, as the day builds they just desensitize, year after year they get desensitized to needs and then they just start dealing with what the immediate needs are”/ “Within the system there is some prejudice people in there and I try not to get too mad with them when I find out that they’re prejudice, they don’t like Natives and they don’t like drug addicts.” “Even though now that I’m clean, I’m in recovery, my mom and dad rarely even talk to me. Every time they see me, they have in the back of their mind, ‘Is he clean?’, ‘Is he gonna steal from us again?’, ‘Is he a changed individual?’. It seems like my mother and father wouldn’t give me the benefit of the doubt.”		Smye, Browne, Varcoe and Josewski (2011)
Stigma from needle exchanges: what IDUs had to say/	stigma was reported from pharmacists and support staff/ this may be more of a community pharmacy issue as dedicated drugs agencies may be more non-judgemental/ “.you know they think you’re a thief and you know you can see sometimes when people notice and like people working in chemists . . . you know it was like a look of shock as if to say . . . they keep an eye on you, you know, embarrassing.”/ “I’d say that there’s people in the outreach that are basically a lot more understanding and helpful. It seems more of a chore for the people in the chemist.”/ “they don’t smile at you or nothing, know what I mean,. . . if you’re in there with other people and that, customers, you don’t know what they’re going to say and you feel uncomfortable.”/ “once they’ve seen your face a few times, they’re more relaxed and you can have a general chat about the day and it’s not a problem.”/ Stigma may reduce over time/		Simmonds & Coomber (2009)
Stigma: from the community/	Stigma was experienced from pharmacy customers/ There was a lack of privacy, a risk of being labelled as criminal and moved on/		

First Order Constructs	Second Order Constructs	Third Order Constructs	Relevant Papers
	Attempts to cope included waiting until the pharmacy was empty/ Participants own sense of stigma resulted from “their feelings of ‘wrong-doing’ or ‘deviance’, and from the verbal and non-verbal judgements of other customers and staff”.		
The general sense of stigma and fear of recognition	“A substantial theme was the general sense of stigma, shame or embarrassment at being an injecting drug user and in accessing SIS, fear of recognition” “The IDUs interviewed testified to feeling stigmatised by professionals and the public alike, resulting in their involvement in risky behaviour.”/ “you should be able to go get them [clean needles] without people knowing because some people are malicious and they like, will try and get you kicked out of your property or something.”		
Addict Identity as Master Status/	“MMT clients were treated as addicts regardless of their stage of recovery. The saliency of this identity was manifested through (a) rules and regulations that equated addicts with deviants and criminals, (b) contractual power differentials, (c) labels that incorporated a clean/dirty dichotomy, and (d) clients’ lack of input into treatment decisions.”/		Harris and McElrath (2012)
The addict as criminal/	Stereotypes of deviance/crime were evident / Participants were aware they were supervised/closely watched, assumed to be deviant/ This was reflected in regulations e.g. not being allowed to enter with friends/adult relatives/ “One time I was buying toothpaste—toothpaste, like. She [counter staff] thought I was trying to steal it. Why would I steal toothpaste? And if somebody was stealing toothpaste, why would they steal it from the chemist where they get their methadone? I know it’s hard on the chemist too. Maybe they get ripped off [robbed] sometimes. But see being treated like that? Everyone needs to go through that to see what it’s like.”/ “They would literally watch you and follow you to the door, like you’ve just been caught shoplifting. That’s how you would feel, which I think is just damn right rude. Now they’ve been told and told and told from [consultant psychiatrist], apparently, to stop.”/		
Contractual power differentials/	“Loads of pharmacists in town told meth [methadone] clients that they can’t bring friends [with them into the pharmacy]. You can’t bring friends unless they are buying something. What about other people picking up prescriptions for drugs? How come they bring friends?/ “continuation of MMT depended in part on how clients behaved”/ contracts listed various client behaviors that could result in penalties. E.g. being punctual, giving notice to change appointments/ the behaviors outlined in these contracts related to the client only/ “contractual language suggests an emphasis on controlling client behavior through rules that reinforce addict and deviant identities./ There was the possibility of discharge or withholding of methadone for missed appointments, lateness, behaviour etc./ I think they [pharmacy staff] just need to treat people better from the start. They look at us like dogs, [as if we are] robbing and all. You see that paper [list of rules; contract] they give us when we start? We’re not supposed to even look around the room. Interviewer (I): What room? The whole pharmacy? R: Yeah, we’re just supposed to look straight ahead, not look around at all. And we have to sit there.”/ “You see, we sign this contract, and we’re not supposed to go in with other people. One time in [town], there were four of us who got there together. He [the pharmacist] said to me, “You’re last in, you go out [and wait until the others have left the pharmacy].” I had my baby with me and it was raining, and then there was loads of us standing outside in the rain, and me with the baby. Now he [pharmacist] did apologize when he saw the baby.” “It doesn’t take a genius to know why you’re in there. You had to sit in a chair. She had to call my name before I could go to the counter. You’d swear I had leprosy. And you couldn’t go in if someone else was in there getting their methadone. There was like a screen, and you could see the top of their head [someone else taking the methadone]. I’d wait outside ’til they finished”.		
“Clean/dirty” dichotomy/	“Stablized people go on Wednesday. That’s me. One dirty urine, and they could put me back to Thursday.”/ “[Addiction service] is far better. Just the way they get on [do things; provide the service]. They’re not all having a go at you ’cause you’re giving dirty samples and all. They don’t stand over you and watch you go to the toilet like in [other addiction service]. They let you go in privacy and stuff like./ The words clean and dirty equate with good and bad behavior/		

First Order Constructs	Second Order Constructs	Third Order Constructs	Relevant Papers
	"Individuals are "clean" when in recovery, or when they have abstained from using heroin even for a brief time." MMT clients who are clean are often rewarded by treatment, e.g. unsupervised or take home methadone/ unclean clients had more regular surveillance e.g. supervised consumption, daily collections of methadone, frequent meetings with drug workers, urinalysis testing for other substance/ "the dichotomy and the associated system of reward and punishment serve to reinforce the distinction between good and bad behavior, and amplify the addict identity."/ They "dichotomize recovery and reinforced spoiled identities. In turn, the dichotomy restricted opportunities for developing client identities that incorporated incremental steps of the self in recovery." The dirty were kept separate; believed to have the "power to influence the relapse of the clean."/ "As a mechanism of social control, urinalysis represents a powerful and intrusive form of surveillance. heavily regulated under the assumption that addicts are deviant"		
Undeserving Customers/	Underserving customers: was reflected by limited privacy, lengthy wait times, and poor facilities./ "Clients' perceptions of the gaze [of the public] were heightened because they were placed well down the list of preferred pharmacy customers."/ "The public wait was described as "embarrassing" or "agonizing""/ "Sometimes I have to wait half an hour to get my meth. She has to serve everyone first, even people who come in after me. I'm waiting there, and people looking at me like I've got two heads. She's getting paid for helping us, but you feel like you have to kiss her toes"/		
Limited privacy in pharmacy settings/	"You can ask to go in there [separate and private room], but you have to make a point of it. I ask [for privacy], as there's members of my old work and others [present] . . . there's always people standing here, and I get really embarrassed. Private? It's not really that private. They walk out with the cup [of methadone] like. And plenty of time there's some people in there—especially at lunch hour. Walks out with the cup, and says, "C'mon [client]." And I go into the room—not really a room; that's where they take the photos. And everyone knows what's in the cup."/ Lack of privacy was a concern to clients because they perceived this setting to be characterized by a stigmatizing public gaze/ attempts to minimise stigma included attending early in the morning, waiting until customers left, buying something to look like a normal customer./ "I would be nervous going in there. There's a few reasons. Your ordinary people come and get their prescriptions. Could be your mom's mate, someone down the lane, someone in the UDA [Ulster Defence Association, a loyalist paramilitary group in the North of Ireland]." "It might be packed with people. Maybe your next door neighbor. You got to get a cup of water and your methadone, and drink it. There's a wee [small] private area, but people [other customers] know what's going on back there."		
Poor facilities	Participants perceived that treatment staff thought they were undeserving of clean toilets. "Rather, the assumption was that "dirty" toilets are appropriate for "dirty" people."/ Methadone provision "was characterized by social control and institutional stigma, which served to reinforce spoiled identities, expose "undeserving customers" to the public gaze, and create barriers to reintegration."/ "social control is multifaceted and layered within and across the contexts in which MMT is provided. The layers of social control expand from the official registers to the settings of clinics and pharmacies, and extend further to regulations and surveillance within these settings."/ "These layers of social control are tied closely with institutional stigma. The label of addict emerged as a salient identity among MMT clients, and was imposed by service providers."/ "spoiled identities equated addicts with criminals (…) Frequent exposure to institutional stigma across various settings served to reinforce spoiled identities of MMT clients./ "MMT provision is characterized by highly regulated social control mechanisms and institutional stigma that (a) reduce the likelihood of developing trusting relationships between providers and clients, (b) reinforce spoiled identities of clients, and (c) view clients as passive recipients of treatment."		
Stigma and the	"the treatment regime itself became stigmatising."/		Radcliffe &

First Order Constructs	Second Order Constructs	Third Order Constructs	Relevant Papers
treatment regime	segregation in pharmacies and supervised consumption of medication was a humiliation/ different treatment was noted when changing from a drug abuse to pain management category: "no longer being subject to the strictures of collecting his prescription at particular times of day, standing in particular places at the pharmacy counter, or taking the medication in front of the pharmacist"/ this shows the moral significance of drug use as a medical problem versus addiction and also how stigma is interpersonally enacted/ "prescriptions marked respondents out as separate from and outside normal life were emphasised in the barrier that daily pick-ups of prescriptions presented for working, for travel both within and outside the UK" Participants had "frustrations about how substitute prescribing made leading a 'normal' life – including working – difficult, and while methadone regimes presented logistical problems, use of heroin was described by several respondents as being compatible with normality."/ "and the way they treat you in the chemist. 'you go over there in the corner and only come between one and two o'clock' or something like that 'and you come at certain hours so you don't frighten my customers'"/ "I'm treated different and it just shows you the way that they do treat people'."/ "it seems like you're trapped when you get on your script because like work-wise you've got to worry about making the chemist everyday. Making your appointments to get tested and everything"/ "you had to go through all this palaver to get on to the programme at that time and I just didn't have the time; I was working lots of hours. It was easier really to go up to London three times a week [to buy heroin]"/ "Discursively, the policy focus on ''high-harm causing users'' continues to support the labelling of a certain group of drug users as social dirt; a source of both contamination and danger to other members of society. The use of HHCUs in policy documents is reflected in the use of the term 'junkie' by popular newspapers and by drug users themselves as well as by other residents of areas that are affected by socio-economic deprivation and crime (Neild, 2007). The term continues to denote a binary opposition between people who embody purity and productivity, and others who embody pollution and deviant consumption"/ Participants'' "failure to consume appropriately is seen as resulting from individual weakness, and not from social problems"/ The medicalising of drug treatment can have a de-stigmatising effect		Stevens (2008)
Absence of layered stigma in the family after disclosure	Absence of layered stigma in the family after disclosure/ "Interestingly, several HIV-positive IDUs who had initially faced separation and a loss of status from family members because of their drug use experienced a reduction in stigma from family members when they disclosed their HIV status. may be due to a perception that as compared to HIV-negative IDUs who can control their behavior, HIV-positive individuals are seen as ill and in need of care"		Rudolph, Davis, Quan, Ha, Minh, Gregowski, Salter, Celentano and Go (2012)
Perceptions of treatment	Discomfort and stigma were experienced when using a public chemist and when providing "dirty" urine/ participants described "experiences of shame and stigma, even if they complied with treatment, by having to consume methadone in public. There was a gradual erosion of self-worth and increasing opportunities for stigma in pharmacies and in treatment and health care settings meant that the participants struggled to maintain consistent feelings of self-worth."/ "people know what you're in for, I find it embarrassing (…) everybody in the shops knows what you're getting – seeing them bring your methadone down to you, so they know what you're getting anyway"/ "I just think from the pharmacy, they could have a bit more consideration for folk like me, we're not a piece of shit, and we're human beings at the end of the day"/ "their outlook changes straight away once they find out you're a heroin user. They look at you a different way from when they first looked at you when you went in. I've spoken to hundreds of boys about it and they've all said the same"/ "Yes, my baby has a milk disorder and my health visitor, she made another appointment with me[y] I got treated like a piece of s*** basically. (She asked me) Have you got a bond with your son? What your partner in prison for? Do you still use (illegal drugs); I didn't need to tell them that and thought I did. You definitely get judged"		McPhee, Brown and Martin (2013)
Positive and Negative Accounts of	"how services were provided mattered more than context (i.e., on-site dispensary versus community pharmacy)."/ "restricted service hours placed limitations on clients' daily lives and were viewed by some as intrusive."/ Good relationships were valued. "Clients appreciated efforts to accommodate them, for instance, by arranging for their methadone		Anstice, Strike & Brands (2009)

First Order Constructs	Second Order Constructs	Third Order Constructs	Relevant Papers
Supervised Methadone Consumption: Clients' Perspectives/ Convenient Access/ Relationships with Pharmacists and Dispensing Staff/	to be dispensed at a local pharmacy instead of at the on site dispensary. However, these accommodations were understood as privileges extended to good clients"/ "I've been very lucky. I've had a few times where I missed the hours or I've woken up and it's been 7 o'clock right on, and I jump in the car and drive like a maniac to the pharmacy, and luckily someone will be there, or I've been in a position where my prescription's been there, but I just missed them, and I've even called the pharmacist from home and he's sent someone down, so I've been very lucky. In my opinion it's because I'm always nice to the people at the pharmacy."/ "Negative accounts of interactions with pharmacists and dispensing staff tended to focus on feelings of discrimination. Clients complained that they were patronized, treated with suspicion, and made to wait unnecessarily"/ "[The pharmacy owner] is wonderful, but if he's not there, including his wife, you'll sit there for an hour, and they'll pretend they don't even see you. (2.13)Well I was at [pharmacy 1] for a while, and there they treated you like no matter who came in, if there was another person there they would immediately go to that person, and the methadone people had to wait until there was nobody in the store, which was pretty bad, but I don't find that at [pharmacy 2]. [Pharmacy2] is actually quite nice."/ "Like today, [worker name] does it a lot when she's on dispensing hours, and I can understand she has to go to the bathroom, and she wants to have a cigarette or a coffee, but I think that she should be there for the client during the dispensing hours. Today, I had to finally come and ask for her, and then I got the "I'll be right there [client name]," like "You can wait," even though I'd already been waiting 10 minutes, and 10 minutes is a long time to wait. I don't mind waiting a few minutes, but she should be there, because those are the dispensing hours."/		
Dispensing Space/	"Clients valued dispensing environments that were not stigmatizing to use."/ "Some participants were concerned about being seen using MMT services"/ using a community pharmacy could be preferable because if they were seen entering a pharmacy they would not be distinguishable from other pharmacy customers"/ "participants valued discreet service and privacy because it minimized (though did not eliminate) the embarrassment of drinking their methadone in public"/ "Even when dispensing services were discreet, clients were very aware that taking methadone at the pharmacy could distinguish them from other customers. However, privacy and discretion were not always afforded MMT clients, and some were embarrassed by this"/ "On the other hand, being explicitly separated out or hidden from the view of other pharmacy customers also conferred stigma. One client commented that this was "ostracizing"; others felt it demonstrated that they were viewed as shameful and untrustworthy"/ "I don't run into people up there and the stigma if I'm going into a pharmacy versus a methadone clinic. If someone sees you it's not so labeling I guess."/ "It's hard to explain, but the way the counter's set up, they have their usual place where people come and pick up their prescriptions, and there's a waiting area there, and then there's the counter, and then there's the little corner down here where they usually take the methadone people, so they can drink it without the people that are waiting there sitting there watching. . . . Sometimes I think about it and try to think what the other people are thinking. I would think that other people wouldn't even know what it is."/ "Everybody stares at you as if you're different . . . everybody's looking at you. You've got to sign this piece of paper and get your drink. How many people walk in a pharmacy and drink something and walk out? I mean, something funny's going on, and everybody stares at you. (2.15) . . . because we go to the pharmacy and we have to drink out of a brown bottle in front of everybody, and it's very embarrassing. I usually do it when the place is packed, or if I'm with somebody, they say "What is that?" People look at you like you couldn't even wait till you got home? You know, it's embarrassing."/ "[H]e has a separate entrance for us, which to me means that that separates us from the regular customers right off the hop, so that gives you the sense of "you're not worthy; we have to hide you coming in." The entrance is completely different from the other one, and there's notices up saying, "You can't hang around or police will arrest you." You know, no loitering and stuff, and then when you ask why we're separated, it's like "Well, not all of you are honest, and some of you are thieves, and this way there's no temptation for people to steal from me, because there's nothing to steal," and that goes with separating."/		

First Order Constructs	Second Order Constructs	Third Order Constructs	Relevant Papers
	“They kind of try and stick you away in the corner, because that’s where everybody picks up their medication, and you tell them what you’re there for, and they pull you back to this little corner, and they give it to you like they want to hide you away from the rest of the clientele.”/ “While some dispensing contexts may help clients manage a stigmatized identity, others confer or make visible this identity”/ Some situations could help by passing as normal customers and others could risk being visible as MMT clients/ “Requiring MMT clients to wait while others are served discriminates between MMT clients and other pharmacy clients. It suggests that MMT clients are assigned a lower status, compared with other pharmacy customers, and has the potential to make their stigmatized status visible to others (Daker-White, 1997).”/		
General practice/	discrimination included doctors being unwilling to register them, “generally because drug users had a reputation for trying to deceive medics about their prescription needs.”/ “Both male and female injectors often complained that they had encountered hostile and judgemental attitudes at doctors’ surgeries. This included GPs and receptionists being rude to, looking down on, speaking harshly to, and not engaging with them. Indeed, participants reported being put off returning to services where GPs had told them that their health problems were their own fault, had threatened to stop their medication, or had refused to see them.” “I never really bother with the doctors. I can’t go to the doctors and say, ‘Look I am a junkie [drug user]. Can I have some tablets?’ It is embarrassing”/ “They talk to me like I am a piece of shit ... I can’t stand the place, but I am scared if I go to another surgery they will give me nothing. Then what am I going to do? I am going to be in the shit.”/ “They [pharmacy staff] will make you wait around the corner and serve all other normal people first, and make us all wait round the corner, like we are scum. So I just didn’t like it. And it is not just me that said it. A load of people say they treat you ... like you are just not really human, like you are less than human.”/		Neal, Tompkins & Sheard (2008)
Pharmacy services/	participants experienced negative staff and public attitudes in pharmacies. “These included staff ignoring or looking down at them; accusing or suspecting them of shoplifting; specifying strict rules about behaviour (such as not allowing them to enter the shop with others); being ‘abrupt’, ‘nasty’ and ‘grumpy’; and making them wait unspecified amounts of time”/ “The doctor actually said to me, ‘You have inflicted it on yourself and you shouldn’t really be here, because you are wasting not only our time, but [the time of] whatever family you have got.”/		
Hospitals/	“They [nurses] treat us like crap really. And also like letting us off the wards and things like that. Because of us being a drug user, they won’t let us move. They won’t let us get off the ward or they won’t let us go for a cigarette or anything like that. You feel as if they can’t trust us and we are going to get up to all sorts.”/ “participants complained that they had been made to feel that they were not worthy of receiving help from the hospital and that they were wasting valuable resources”/ “hospital staff had treated them poorly and/or differently from other patients. For example, they stated that they had been sent home prematurely, not given information about what would happen to them whilst in hospital, and not given appropriate aftercare on discharge.”/ “Heroin injectors tended to emphasise the lack of adequate substitute medication received while an inpatient. Others complained that they had not been allowed visitors or had been very closely monitored to ensure that they were not causing trouble or consuming drugs on hospital premises”/		
Housing and homelessness services/	Participants “routinely complained that those who worked in housing departments were not prepared to help them”/ “housing staff did not believe what they said and were generally hostile or negative towards them. Other problems identified included lengthy waits in unwelcoming housing department waiting rooms (a particular problem for injectors who were withdrawing or trying to avoid other drug users).”/		
Social services	participants “complained that social services were heavy-handed and monitored them excessively, or that social workers were unhelpful, did not understand their problems, and could not be trusted.”/		
Stigma and social relationships	“Within the current Canadian political context, there is a move to shift drug policies away from harm reduction toward a more enforcement-based approach. This shift will likely only exacerbate the current discourse of blame and stigma directed at injection drug users. In addition, it may serve to increase the interdependency among IDUs, and social and economic exclusion from non-		Jackson, Parker, Dykeman, Gahagan, &

First Order Constructs	Second Order Constructs	Third Order Constructs	Relevant Papers
	IDUs.” “If I want to stay anywhere I have to say I’m clean”		Karabanow (2010)
Social Contexts Structuring Opioid Use within the FSU Immigrant Community	“old-school Russians, they’ll look at drug addicts as garbage... like people with leprosy, you don’t want to go near them.”		Guarino, Moore, Marsch & Florio (2012)
Concepts Related to the Word Stigma: Rejection. Devaluation Prejudice and Disdain	“It’s like a label that they put on you; that’s when you feel rejected” and “. . . as if you were some sort of leper.”		Jiménez, Puig, Sala, Ramos, Castro, Morales, Santiago, Zorrilla (2011)

Adapted from Britten et al. (2002)

Appendix 1-B

Publication Guidance for Authors Submitting to Drugs: education, prevention and policy

Instructions for Authors

Drugs: education, prevention and policy publishes multi-disciplinary research papers, reviews and commentaries on policy, treatment, prevention and harm reduction issues regarding both the use and misuse of alcohol, tobacco and other drugs. The policy of the journal is to encourage submissions which reflect different cultural, historical and theoretical approaches to the understanding of the drug and alcohol field and the development of policy and practice. The journal provides a forum for communication and debate between researchers, policy makers and practitioners concerned with social, health and judicial policy responses to legal and illicit drug use. The Editor welcomes contributions based on original research, policy discussion, social responses to substance use or misuse, co-evaluations of policy and practice, literature reviews, and finally those papers which examine historical and cultural aspects of substance use.

Manuscripts: We accept a number of different types of manuscript including reviews, research papers, policy analyses and policy commentaries. Manuscripts should be between 3000-5000 words. However, we will consider longer length papers up to 8000 words, particularly for historical and qualitative analyses. We also accept shorter manuscripts in the form of editorials and short reports between 1500 and 2000 words. We are happy to advise on submissions. If you would like to discuss your submission, please contact Dr Torsten Kolind (tk.crf@psy.au.dk), Dr Karen Duke (k.duke@mdx.ac.uk) or Dr Rachel Herring (r.herring@mdx.ac.uk).

Papers should be typed, double spaced (including the references), with margins of at least 2.5 cm (1 inch). All pages must be numbered.

All submissions should be made online at *Drugs: education, prevention and policy's* Manuscript Central site. New users should first create an account. Once a user is logged onto the site submissions should be made via the Author Centre.

Authors should prepare and upload two versions of their manuscript. One should be a complete text, while in the second all document information identifying the author should be removed from files to allow them to be sent anonymously to referees. When uploading files authors will then be able to define the non-anonymous version as “File not for review”.

The first page should include the title of the paper, name(s) of the author(s), and for each author a full institutional address, and an abbreviated title (for running headlines within the article). At the bottom of the page give the full name and address (including telephone and email address) of the author to whom all correspondence (including proofs) should be sent. The second page should repeat the title and contain an abstract of not more than 200 words. The third page should repeat the title as a heading to the main body of the text. Within the text section headings and subheadings should be typed on a separate line without numbering, indentation or bold or italic typeface.

Authors are themselves responsible for obtaining permission to reproduce copyright material from other sources.

Abstracts: The abstract for an empirical research study should be structured into: aims, methods, findings, conclusions. Abstracts for other submissions (e.g., policy commentaries, historical analyses etc.) need not follow this structure. Abstracts should be no more than 200 words.

Key words: Please include a minimum of three key words, which you can select from our list on Manuscript Central. If the key words from the list do not adequately match the content of your manuscript, then you can provide your own key words.

Reviewers: All submissions will be sent anonymously to independent reviewers. Authors have the opportunity to suggest the names and contact details of several potential reviewers. Please note that the editor retains the sole right to decide whether or not the suggested reviewers are used. You may also suggest an Editor to whom you think your paper could be assigned.

Acknowledgement of funding and conflict of interest: Authors are requested to acknowledge sources of funding for research projects and to declare any conflict of interest. Acknowledgements should be placed after the text and before the reference section.

References: All publications cited in the text should be listed following the text; similarly all references listed must be mentioned in the text. Style, statistical reporting, and reference citations should conform to the American Psychological Association's guidelines, from the APA Publication Manual, fifth edition.

Within the text references should be indicated by the author's name and year of publication in parentheses, e.g., (Tones, 1996) or (Wilson & Styles, 1990), or if there are more than two authors (Power et al., 1996). Where several references are quoted consecutively within the text the order should be alphabetical. If more than one paper from the same author(s) and year are listed, the date should be followed by (a), (b), etc., e.g., (Plant, 1990a).

To conform with APA style, references should be alphabetised at the end of the manuscript text, in the following formats:

Kozlowski, L. T., Henningfield, J. E., & Brigham, J. (2001). Cigarettes, nicotine, and health. Thousand Oaks, CA: Sage Publications.

Weinstein, N. (2001). Smokers' recognition of their vulnerability to harm. In P. Slovic (Ed.), Smoking: Risk, perception, & policy (pp. 81-96). Thousand Oaks, CA: Sage Publications.

Perkins, K. A., Donny, E., & Caggiula, A. R. (1999). Sex differences in nicotine effects and self-administration: review of human and animal evidence. Nicotine & Tobacco Research, 1, 301-315.

Further examples are available in the APA style manual, fifth edition, or online at: www.apastyle.org/elecref.html

Endnotes: Please note that endnotes are preferred to footnotes.

Illustrations: All illustrations (including photographs, graphs and diagrams) should be referred to as Figures and their position indicated in the text (e.g. Fig. 3). Each should be submitted separately to the main text document and numbered with Figure number (Arabic numerals). The captions of all figures should be submitted when prompted in Manuscript Central at the upload stage, should include keys to symbols, and should make interpretation possible without reference to the text.

Figures should ideally be professionally drawn and designed with the format of the journal (210x297 mm) in mind and should be capable of reduction.

Tables: Tables should be submitted separately, numbered in Arabic numerals, and their position indicated in the text (e.g. Table 1). Each table should have a short, self-explanatory title. Vertical rules should not be used to separate columns. Units should appear in parentheses in the column heading but not in the body of the table. Any explanatory notes should be given as a footnote at the bottom of the table.

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Section Two: Research Paper

Clinical psychologists' experiences of exploring and addressing 'context' in formulation and intervention

Heather Spankie
Trainee Clinical Psychologist

Doctorate in Clinical Psychology
Division of Health Research, Lancaster University

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All correspondence should be sent to:

Heather Spankie
Doctorate in Clinical Psychology
Furness College
Lancaster University
Lancaster, Lancashire
LA1 4YG
Email: h.spankie@lancaster.ac.uk

Abstract

Contextual factors relating to an individual's material and social circumstances are crucial influences on mental health. Despite evidence of the importance of contextual influences, the dominance of the medical model in mental health can exclude context from understanding and intervention in favour of locating problems, and solutions, within individual pathology. The present study aimed to explore the practice and experiences of working with context among eight UK based clinical psychologists in recognition of potential barriers to exploring and intervening with contextual causes of distress. Semi-structured interviews were analysed using thematic analysis, producing four themes: 1: The need to justify working with context; 2: The need to work with context beyond the therapy room; 3: "My context is their context": Influences on the ability to work with context; and 4: Sources of validation for working with context. The hopes, difficulties and successes of working with context arising from these themes are discussed in addition to clinical and research recommendations and a consideration of limitations.

Keywords

Clinical psychology, context, professional, barrier, formulation, intervention, prevention, inequality, social change

The Importance of Context

The wider context of people's lives is rightly acknowledged as significant to wellbeing and mental health. Accordingly, the World Health Organisation (WHO) (2009) have called for 'context' to be addressed based on its extensive review of varied individual and community outcomes relating to mental health. This context includes immediate material circumstances such as an individual experiencing poverty and unemployment which are associated with increased mental ill health (Fryers, Melzer, Jenkins & Brugha, 2004; WHO, 2009). Wider societal, cultural and political contexts are also important, as demonstrated by Wilkinson and Pickett (2012) who established in their review of evidence from 50 countries that higher levels of social inequality damage physical and mental health outcomes. They highlight the importance not just of harms from material poverty but also relative poverty and inequalities. Moreover, the WHO (2009) concludes: "levels of mental distress among communities need to be understood less in terms of individual pathology and more as a response to relative deprivation and social injustice, which erode the emotional, spiritual and intellectual resources essential to psychological wellbeing." (p.5). Further, past events and influences are also relevant to understating an individual's current and future context. For example, there is evidence of collective or transgenerational trauma such as the impact on subsequent generations of relatives of holocaust survivors and the impact of belonging to a social group that has been persecuted in the past (Danieli, 1998).

Despite this support for the relevance of context to mental health, the extent this is acknowledged may be hampered by the dominance of the medical model where symptoms of mental illness are considered to be caused by diagnosable disorders with largely physiological causes. The application of a disease model to mental health has been criticised, including the failure of diagnoses to adequately acknowledge contextual influences (e.g.

Bentall, 2009; Boyle, 2002) yet this remains the dominant approach (Boyle, 2006; Harper, 2016).

Context and Clinical Psychology

Context is a subject which is pertinent to numerous disciplines including an extensive literature among medical sociology (for example, see Pilgrim & Rogers, 2015). Within clinical psychology context is being increasingly recognised, particularly in relation to the advancement of psychological formulation which is "a hypothesis about a person's difficulties, which draws from psychological theory' (Johnstone & Dallos, 2006, p.4). Formulation has been promoted as an alternative to diagnosis and can allow contextual influences to be considered. It is viewed as a key skill of clinical psychologists and has particularly been advocated in the UK where the professional body, the British Psychological Society (BPS), issued a position statement from its Division of Clinical Psychology (DCP) challenging the use of diagnosis driven by the medical model and made the case for the use of formulation (DCP, 2013). It has also produced guidance on the use of formulation which stresses the importance of understanding context, including social and cultural influences and inequality (DCP, 2011). Thorough formulations provide the opportunity to locate problems within context rather than individuals, helping avoid ineffective interventions and the pathologising of individuals, reducing shame and blame (DCP, 2011; Gambrill, 2014; Smail, 1995).

Although both evidence and guidelines supporting the importance of addressing context exist, the extent this has been applied to practice has been questioned. Boyle (2014), for example, criticises a portrayal of adverse contexts as consequence (rather than cause) of mental illness, for example stress-vulnerability models may include contextual difficulties but with an understanding that they only have adverse impacts when combined with a predisposition located back within the individual. It has been suggested that the influence of an individualising approach, adopted from the dominance of the medical model, potentially excludes contextual thinking from practice, and Simpson and Thomas (2014) describe a tradition within mental health of analysing the individual and an associated preference for individual therapy as the solution. Similarly, The BPS (2011) highlighted concerns that such thinking locates problems within individuals at the expense of considering "undeniable social causation" (p.2).

The avoidance of context within clinical psychology has been explored by Boyle (2014) and includes the motivation to seek acceptance from psychiatry through an adherence to the medical model, driven by concerns that exploring context is 'unscientific' and outside of the remit of psychology. Psychologists may also be limited by working within systems where policy, service design and funding is dominated by the medical model. The difficulty of resisting and acting against these pressures has been acknowledged, that "paymasters choose their pipers' tunes" (Smail, 2010, p.458). It has been suggested that, in response to service cuts, the limited resources and pressure to work 'productively' and increasingly individually, clinical psychology is "pushed even more toward its customary focus upon the individual, as the supposed locus and cure of all personal and social problems" (Midlands Psychology Group [MPG], 2014, p.235).

Intervention and Contextual Difficulties

By seeing the problem and therefore the 'cure' within individuals, psychological intervention can be seen to endorse the medical model. Harper (2016) has highlighted concerns about psychology's focus on individual therapy; that it is unfeasible to provide to all that need it, and also unethical to provide reactive intervention to harms already caused by contextual issues - rather than seeking prevention. He cites Tarrier (2002) in considering therapy as "a sticking plaster over the wound of (…) inequality" (p.292). Alternative approaches include community psychology which strives to understand the relationships between individuals, communities and wider society, seeking to act at the community rather than individual level (Dalton, Elias & Wandersman, 2001). Similarly, critical psychology endeavours to address such difficulties for disadvantaged groups through action towards social justice, targeting social change rather than the individual needing to adjust (Fox, Prilleltensky & Austin, 2009). Alternatives can also be informed by disability studies, an approach developed outside of psychology but with relevance to theories on mental health (Simpson & Thomas, 2014). The social model of disability offers a perspective acknowledging the importance of context, viewing problems as located in social, economic, cultural and environmental barriers that create difficulty for individuals (Oliver, 2004).

Acknowledging the limitations of individual therapy does not mean rejecting its benefits. Suggestions for intervention involving contextual causes of distress include David Smail's "social-materialist approach" (Smail, 2005) where therapy is believed to make a difference, but not by providing a 'cure' (MPG, 2006). Smail (2001) outlines three elements of therapy that can be helpful: comfort (that someone is not alone), clarification (that feelings are understandable), and encouragement; supporting the use of available power and resources, potentially seeking solidarity with others to change contexts.

Support in the form of therapists advocating and taking action regarding contextual difficulties is supported by Seager (2013), drawing on attachment theory. He argues the therapeutic alliance is an attachment relationship through which the expression of warmth and caring is in itself therapeutic. The act of giving practical help with contextual problems can be an important expression of care and therefore a valid intervention.

Defining 'Context'

Aspects of people's lives considered as context are wide ranging and a clear definition is absent, potentially impacting on the understanding and application of guidelines to practice. However the social model of health (Dahlgreen & Whitehead, 1991) may be helpful in accounting for both proximal and distal influences. Layers of influence on individual health are described with individual differences at the centre followed by lifestyle factors, social and community networks, living and working conditions and socio-economic, cultural and environmental conditions. Context may be defined at any of these levels and it has been identified that broader contexts of community, social inequality and human rights have been largely absent from practice among clinical psychologists (DCP, 2011).

This paper will define context as both present and historical influences including individual circumstantial and life event related factors (including housing, employment, health, poverty etc.), immediate and wider community relationships and wider socio-economic, cultural, environmental and political factors (including inequality, discrimination and power).

Implementing Guidelines

Although potential barriers to working with context have been discussed, to the best of the author's knowledge, there has been no empirical research exploring either clinical practice or the views and experiences of psychologists. Research is also lacking regarding the extent professional guidance for clinical psychologists is implemented. However, efforts to explore the implementation of guidelines relating to mental health among other professions may provide some insights. Reviews of studies with mixed methodologies recruiting varied mental health professionals have found training and supervision are important to enable professionals to implement guidelines and that there is a need for services to support such provision, as well as protecting time and caseload availability and providing good leadership (e.g. Berry & Haddock, 2008; Menear & Briand, 2014; Morriss, 2008; Shafran et al., 2009; Tarrier, Barrowclough, Haddock & McGovern, 1999). Clinical psychologists may have similar experiences regarding the implementation of guidance relating to context, however, they may also face additional barriers.

In contrast to much of the guidance discussed in these reviews, guidelines relating to context are less compatible with a medical model, make less clear recommendations, lack incentives to be implemented and apply to a single profession representing a relatively small proportion of the workforce. If the reviews found that it was difficult to secure implementation for guidelines which did have compatibility with a medical focus, incentives and service wide applicability then it is likely that achieving support for recommendations relevant to a single profession more distant from the medical model will be more difficult.

Professional guidance may even contradict wider guidelines and service priorities, for example, in the UK, National Institute for Health and Clinical Excellence (NICE) guidelines are a priority within NHS services. They focus on individual therapy and have been criticised as medically biased (e.g. Barker & Buchanan-Barker, 2003), potentially placing them at odds with working with context. This not only suggests clinical psychologists may face additional barriers implementing guidance relating to context but raises the question of how individuals experience having their professional guidance at odds with service priorities.

As the majority of the research into guideline implementation has been quantitative, it would be useful to contribute qualitative data. Qualitative research is also useful to gather insights into the experiences of clinical psychologists working with context as this has yet to be studied and an in-depth exploration would allow salient issues to emerge.

Summary

Although professional recommendations support clinical psychologists working with context, what is understood by this and how it relates to clinical practice remains to be explored. Qualitative research, enabling an exploration of experiences and opinions, is needed to explore what is understood by context, in light of the absence of clear definitions, and how this is addressed in practice, exploring what barriers may exist and what psychologists hope to achieve.

Research Aim

This research aims to investigate what clinical psychologists understand by 'context' and how this is explored and approached in practice.

Method

Participants

Participants were recruited through social media and an advertisement in a BPS publication. Inclusion criteria required participants to be qualified clinical psychologists who had practised within the last year. Eight participants took part; six female and two male. Career length varied from newly qualified to approaching retirement. The majority of participants worked in England in a variety of service settings. Details are provided in Table 1.

Design

Qualitative methodology and specifically thematic analysis was adopted due to this being a broadly applicable qualitative method allowing extraction of a rich data set, well suited to the study aims of gathering experiences of practice (Braun & Clarke, 2006). This was chosen over alternatives, such as interpretative phenomenological analysis, because analysis was not directed towards developing understanding of a phenomenon but to gain an overview of experiences. Data was collected using one-to-one semi-structured interviews ranging from 53 to 84 minutes with a mean duration of 70 minutes.

Procedure

Ethical approval was granted by the lead researcher's host institution's Research Ethics Committee. Permission was sought from the BPS to circulate advertisements (Appendix A). Recruitment information was also hosted online by the host institution and disseminated on social media. Those interested in taking part were invited to contact the researcher by phone or email to gain further information and/or arrange interviews. Face-to-face interviews were offered where convenient and selected by half of the participants, ensuring confidential spaces were available. Telephone interviews were completed by one participant and Skype interviews with three participants. Participant information sheets (Appendix B) and consent forms (Appendix C) were emailed prior to interviews. Before commencing interviews, confidentiality and consent were explained and the consent form signed or returned in a prepaid envelope in the case of Skype/telephone interviews. The option to stop or break at any time was explained and the participant information sheet was referred to and discussed if necessary. A Dictaphone was used to record interviews.

The interview schedule (Appendix D) had open questions and prompts, allowing flexibility in questioning so that interviews could develop to facilitate discussion and themes which arose as significant to the participant. Questions began with an exploration of participants' definitions of context and awareness and agreement with guidelines, expanding to questions relating to the extent context was used in practice, accommodating examples, aspirations and barriers. The debrief sheet (Appendix E) was provided on completion of the interview. Recordings were transcribed verbatim by the researcher and anonymised with participants assigned as CP1 to 8.

Data Analysis

The six phase guide of Braun and Clarke (2006) was primarily used to guide analysis, consisting of familiarity with data, generation of initial codes, theme development and review, definition/naming of themes and presentation of themes. This began with transcribing and listening to recordings in full with repeated reading of the transcripts to gain familiarity with the data. Annotations were made with initial ideas and comments then coding was performed manually. Codes were then combined into four themes with research supervisors contributing to the development of these themes. Audit trails were recorded to evidence decisions and the emergence of themes from data, including assumptions informing the analysis. On-going reflexive analysis throughout data collection and analysis was used to monitor and consider the potential influence of the researcher, in addition to discussions with supervisors. An example of the development of a theme is provided (Table A1).

The thematic analysis was conducted using an inductive approach with limited availability of existing research or theory to presuppose what definitions of context are held, what working with context involves and what barriers are encountered in practice. Coming from a critical realist perspective, a contextualist method was followed (Braun & Clarke, 2006) in an exploration of both the experiences and realities of participants and the influences of social context on this experience.

Reflexivity Statement

I have developed views regarding the importance of addressing contextual difficulties through prior experience working as an advocate and adviser and believe that it is appropriate for clinical psychologists to take an active role, both through engagement with wider contextual influences and providing practical help. The potential desire to achieve findings in support of this role was considered and monitored through on-going reflexive analysis.

Monitoring of the influences of my own beliefs, values and experiences was in place throughout the development of the interview schedule, data collection and analysis, interpretations, recommendations and evaluation of relevant literature. This was particularly pertinent during data analysis as it emerged that participants' views, and the resulting themes, appeared very much in line with my opinions. In recognition of this, interpretations were revisited and alternatives considered, aided by the use of supervision.

Ethical Concerns

This study was considered unlikely to cause distress but signs of distress were monitored. The limits to confidentiality in regard to risk were explained, for example, if it was perceived by the researcher that there was a risk of harm to the participant or another person. In addition, confidentiality could have been broken if there were concerns that a participant's practice could put clients at risk. There was a reminder that, if discussing clinical work, details of clients should be kept confidential. This was also outlined in the participant information sheet with the opportunity to discuss further if needed.

Results

The thematic analysis produced four themes: 1) The need to justify working with context; 2) The need to work with context beyond the therapy room; 3) "My context is their context": Influences on the ability to work with context and 4) Sources of validation for working with context.

Theme 1: The need to justify working with context

Participants were unanimous in their agreement about the importance of understanding and addressing contextual influences on difficulties and distress. However, they were aware of disapproval regarding perceived inappropriateness of working with context and pressures to maintain an individual focus. This theme outlines the justifications participants gave which includes arguments for the fundamental importance of working with context, spanning from understanding engagement with services to assessment, formulation and intervention. Other arguments explained the necessity for action that it was agreed could be considered outside of a clinical psychologist's role but nonetheless needed, such as providing practical help.

The fundamental importance of understanding context was expressed through frustrations with the pathologisation of individuals, as summarised by CP4: "what you [client] are doing is coping astoundingly well with an incredibly difficult um situation, actually your coping strategies are not particular high risk and therefore why are we pathologising you?". Varied examples were given of contextual difficulties being the primary source of distress and difficulty for clients, with poverty a common example, including poor housing, issues with welfare benefits and unemployment.

The importance of contextual understandings of engagement, concerning both service access and engagement with intervention, was also argued. More often purely practical barriers were described that could ultimately exclude people from services and included limited finances and access to transport and commitments such as work and childcare. Participants described a lack of acknowledgment of such factors and how they could be: "reflected back as commitment (…) they need to be more committed, they need to save their money to come, they need to get childcare to come, and it's very little appreciation of someone's situation" (CP3). In this way services tended to consider engagement an individual responsibility, ignoring contextual barriers, which could result in discharging clients. This was frustrating to participants, viewed as punitive by some and even discriminatory (CP3). Exclusion from services included cases where contextual difficulties were acknowledged but labelled as too great, as CP7 explained: "if somebody's got too many stressors (…) they may actually be excluded at the point they are referred, say, “but they can't engage in a recovery orientated therapy””.

Regarding intervention, although expressing certainty about the importance of context, participants were less definite about how to intervene with contextual difficulties. Interventions varied to the extent they were aligned with individual therapy and could be considered a part of the intervention, alongside it or separate. While individual intervention to address the impact of contextual difficulties was one option, there was also criticism that this could align with the pathologisation of individuals, as captured by CP6:

> I don’t think whacking some prescriptions at somebody is going to do a great deal for that [stressful and unhappy circumstances] and probably nor is CBT (…) I don’t think the problem is your thoughts; the problem is we have a society which doesn’t take care of people.

Individual intervention was used to both reduce distress and assist clients to address contextual difficulty. Participants justified this focus with successful examples including the use of Cognitive Analytic Therapy, solution focused therapy and family therapy. Some participants described the work of David Smail with techniques of power mapping (a method of representing different levels of context and the resources and powers acting within them; Hagan & Smail, 1997), and a focus on comfort, clarification and encouragement. Others discussed relevant intervention such as normalisation, acknowledgement and understanding, empowerment, assertiveness and communication skills, accessing support and networking. CP7 argued the importance of the latter as clients may struggle to make changes alone due to being “beaten down and disempowered and exhausted and harmed by the world that we live in”. Acknowledging clients’ isolation and difficulty connecting with others who could collaborate to make changes, CP7 aimed to “work more directly with people to, to sort of reduce those obstacles to being able to connect and get together with other people so that they can do something together.".

Practical help with contextual problems was the most contentious form of intervention. Participants initially varied in the extent they considered this an intervention at all, but on reflection during the course of the interview acknowledged its legitimacy. Examples varied from providing information and signposting to contacting services and advocating on clients' behalf to directly giving money to clients. Participants were most comfortable with the appropriateness of signposting and providing information, with efforts to remain boundaried and not provide advice but rather to present options and sources of advice if desired. Directly assisting and advocating on behalf of clients appeared more uncertain and required justification.

"Crisis managing and firefighting" (CP6), e.g. clients not having money or food, was a form of practical help. Some participants considered taking action appropriate to their role, with the view that: "it's a mental health professional's role (…) I see myself as that as much as a clinical psychologist" (CP3). Others considered risks and harm to their clients could not be ignored, therefore making it appropriate to act, as CP6 described: "the very least I can do is tell a bailiff he has no right to evict my patient, you know, what kind of professional would I be if I didn't do that?". Participants did not attempt to justify being in the best position to provide practical help, agreeing that other professionals were more appropriately placed. However, these professionals were often unavailable leading to a belief psychologists should take action.

Maslow's hierarchy of needs (1954) was used to justify working with context, arguing that meeting primary needs (such as safety), that are the main sources of distress, is more valuable and needed before attempting to address 'higher' needs (e.g. interpersonal and self-esteem needs). This is despite the latter being considered more within clinical psychology's remit and expectations of individual therapy. However, if primary needs are not met, attempts to address higher needs can be reduced to "talking about whatever":

> this is going to have more of an impact on this person's mental health than any session of talking about whatever (…) if that person's got their benefits then they're not going to be harming themselves whereas (…) when they're filling in their form for benefits which is incredibly stressful that's when they were cutting themselves (...) So that has a direct impact and I think it's an appropriate use of clinical time. (CP7).

However, difficulty justifying work with context to colleagues and superiors was described, including lacking 'evidence' sought within the medical model, as described by CP7:

> it's not manualised and it's not the stuff of RCTs and all of that (…) you can't evidence it, you can't argue for it. But in terms of day to day value and what, I think what people experience as helpful or unhelpful that seems to me more useful.

Justification strategies included highlighting risk or care planning needs and describing work in ways that fit expectations such as describing work as:

> graded exposure or narrative work or whatever (…) you have to kind of fudge it sometimes people expect you to do very specific things (…) if you deviate from that they don't really get it (…) there are a thousand ways to kind of persuade people that what you are doing is valid even though you know it is but you have to describe it in a way which they can make sense of (…) [using] words that they can't really argue with (CP6).

This suggests that participants' own justifications for their work may not translate into arguments that can be presented to other professionals.

This theme demonstrates the desire to understand and address contextual difficulties, including the need to provide practical help, setting aside intervention regarding "higher needs" for urgent issues. However, working within services with an individual focus and expectations regarding the role of clinical psychology meant that working with context required justification.

Theme 2: The need to work with context beyond the therapy room

In acknowledgement of contextual causes of distress, participants discussed efforts that were required beyond their work with individuals to change their contexts. Such efforts are captured within this theme and include prevention, community work and engagement with policy and media. Despite valuing such action, it emerged that participants varied in whether they wished or felt able to engage but that efforts to influence their own service context felt more accessible, such as disseminating contextual understanding among colleagues.

Wider intervention that participants valued included community work and development of networks and support. Community work was appreciated for providing the desired step away from an individual focus, seen as: "proper psychology. Somebody is kind of out there really kind of helping people within their circumstances." (CP2). Perceived opportunities for such work included social enterprises, identified as allowing freedom and creativity and an alternative to restrictions in NHS settings. By providing networking opportunities, social media was considered useful to reduce power imbalances, cultivate co-production and networking and empower clients, including "challenging stuff together." (CP7). Preventative work was also valued, as emphasised by CP6:

> It's not good enough to know what we know from public health and epidemiology and to just sit around waiting for people to come into our doors traumatised 20 years

> later (…) that's a bloody disgrace (…) we know the causes of distress in many ways and we know them both through data and through common sense (…) [but we've] lost the value of common sense.

The value of "speaking up" to increase awareness of the importance of context and how to intervene and prevent difficulty was described, from the level of immediate service contexts to informing the public to engagement with media and policy, including "thinking about the impact of policy on actual human lives" (CP6). Participants hoped for more visibility of the profession in addressing context, requiring: "bigger voices and more of them and we need to stop saying "well, it depends" and take a bloody position" (CP4). Media involvement included awareness of the impact of policy, such as austerity, and providing contextual understanding of events, as emphasised by CP2:

> if some big incident has happened, well, where is the psychology reflection on this? (…) don't just write an academic paper on this, what's your view? (…) We need to be a bit more out there (…) a bit braver.".

Wider action was valued but not all participants desired to engage themselves whether due to time and energy, or perceived risks. Risks included being perceived as troublemakers or of being reprimanded, based on uncertainty regarding "bringing the profession into disrepute" and being instructed not to engage with politics or media, as exampled by the experiences of CP1: "we were told that a psychologist had to be registered with the HCPC, you weren't allowed to be that political (…) that was a really powerful message that you felt that actually you were going to get struck off".

However, participants described efforts to influence their immediate contexts including joint working and communication with team members and services they liaised with. This involved contributing formulations, or less formal discussions, that acknowledged context, shifting understanding away from individual pathology.

In summary, participants recognised a need to work outside of traditional individual therapy to address contextual causes of distress. However, such work was met with more uncertainty, challenge and risk than efforts to work with context within existing roles, maintaining a focus on individual therapy.

Theme 3: "My context is their context": Influences on the ability to work with context

This theme explores various aspects of participants' own contexts that emerged as relevant to the extent they worked with context. This included personal, service and wider professional contexts such as the position of clinical psychology within a dominant medical model. Prevalent restrictions included limited resources, service pressures and a perceived lack of knowledge and skills which could create pressure to return to an individual focus.

On the individual level, participants could be drawn away from intervening with context due to uncertainty of how to help. This included a "skills and knowledge vacuum" (CP7), lacking signposting information or, frequently, lacking understanding of welfare benefits. Participants described lacking time to find information, but having it could increase confidence, as described by CP1:

> sometimes it can be easier not to think about it or really talk about it with people because what do I do with the information that comes up? (...) once I knew about it [signposting] it sort of made me feel confident that (…) that is ok if someone brings this up.

Participants' training and experience were also relevant with some feeling they lacked models to adequately accommodate context and that predominant models had more of an individual focus. CP3 described their training as:

> [predominantly about] situating a, the problem in the individual (…) I don't think we've got a convincing model that is used regularly that encourages us, us to take context into account (…) a trap that I fall into quite often, and I think other psychologists fall into, is that we consider those contextual factors but then you're always looking for the underlying internal factor that makes those things difficult (CP3).

Other participants reported finding certain models useful, or developing confidence in formulating without the use of models.

Barriers to working with context within services included increased restriction on roles, higher caseloads and priority to reduce waiting lists and prove outcomes in a competitive market, linked with service priority for "bums on seats" (CP1) individual therapy and a move:

> further towards protocol driven therapies (…) very streamlined psychology (…) I don't know if there's room for context in that really because I, for me that's very individual focused and, um very much about what we need to do with that person to get them to change and get their scores up on whatever outcome measures we're using and I think that's a challenge to context (CP3).

The current economic climate, austerity policies and service cuts were attributed to the lack of resources participants described as a barrier, summarised by CP5: "resource issues are central to making a proper evaluation of context. If you've got too many patients to see and too few people to see them, context is going to be over looked".

Participants were aware of the relevance of different service contexts. Inpatient settings were regarded as better resourced, including the availability of support, expertise from other professionals and more routine exploration of contextual difficulties, e.g. through discharge planning. All participants felt under pressure but it was suggested that primary care settings had less flexibility and more focus on providing manualised therapy. Medically driven services or teams were described as a source of conflict and "exhausting" (CP8). Some described difficulty getting context acknowledged and that colleagues could "shut off".

Barriers to participants' practice were reflected in considerations of difficulties faced as a profession. This included concerns of being political and uncertainty regarding role boundaries with other professions. CP7 summarised the risks that cascade from the professional level:

> [clinical psychology being] seen as too political (…) leaning too far towards sociology and social work rather than psychology, that it's not being empirical, it's not being objective (…) there's a sort of conflict because psychology kind of made its mark by coming away from the subjective and looking at, you know, the individuals (…) that's always going to be a stumbling block for psychology because it doesn't want to lose its scientific basis and if it, if it does embrace context more actively then it, it runs the risk of that (CP7).

Clinical psychology's potentially vulnerable position as a new profession was seen through competing with other disciplines, played out within services, as observed by CP5: "each discipline has to prove their worth (…) to justify their employment (…) there's a whole lot of empire building.". This was also connected to an unwillingness to risk loss of salaries and status and of "professional elitism" (CP3). The attitude that: "there's someone else who can do that, and our, what we do is kind of up here and we do therapy and that's really special and we're not getting involved in any of the ground level dirty work" (CP3) was seen as a particular barrier to practical help.

This theme outlines the pressure from services following a medical model, exacerbated by service cuts combined with a lack of certainty and risk stemming both from individual experiences and the position of clinical psychology as a profession.

Theme 4: Sources of validation for working with context

As participants were aware working with context could be considered inappropriate and involve personal risks, receiving validation, legitimacy and support was important to enable them to pursue such work. Varied sources of validation could come from both within and outside of services and from the profession as a whole. What participants described had parallels with the networking and solidarity suggested as important for clients to address their own contextual difficulties.

Within services, the degree participants felt supported by supervisors and managers was discussed, with CP1 feeling "shut down" when trying to include context in formulations despite their supervisor also being a clinical psychologist but holding a more medical view. Validation was achieved from supportive, encouraging and interested supervisors, managers and team members, such as the reinforcement of the value of CP4's work where the intervention consisted entirely of helping a client obtain a bus pass:

> my boss said (…) "that was a really useful piece of work (…) why do you feel you've got to do something that looks like CBT? If she's [client] making contact with, you know, immediate tangible positive reinforcement then things are going to be substantially better for her. Stop, stop trying to do CBT!".

Validation could come from the service structure such as exploration of context emphasised in policy, role remits or service priorities, allowing the flexibility to work with context and the possibility of wider action counting as Continuing Professional Development

(CPD). Training was also considered significant toward legitimatising the importance of context and informing how to include it in practice. CP3 hoped training would support:

> thinking more clearly about where you can consider context when you're formulating and where that might be relevant in, in an intervention (…) [encouraged] to expand our role when it's appropriate and to have more conversations about that (…) thinking about meeting their basic needs first, and it being ok for us to do some of that (CP3)

Other sources of validation and encouragement included contact with role models and like-minded individuals through work experiences or attending groups. However, job pressures restricted this and most participants described successfully using social media to connect with similar voices, a "psychology tribe" (CP6), giving inspiration, ideas for practice, confidence, reciprocal support, identity and helping development.

Participants discussed the impact of the status and position taken by clinical psychology as a profession on their practice. There was a desire to see stronger positions from the BPS to legitimise working with context and the importance of strong messages matching opinion with practice, showing working with context is appropriate. CP3 spoke passionately about what was required from the BPS:

> we can't be giving an opinion about welfare reforms (…) but then refusing on an individual basis to support people to fill in benefits forms (…) would it be better to focus on the grass roots and thinking about what we can do to support individuals with that rather than making a stand as a profession but refusing to get our hands dirty? (...) we've got do both and I think we've got to stand up as a profession but also we've got to be prepared to help people on a practical level with those contextual difficulties (CP3)

The progress made by the profession, and specifically the BPS, in being more vocal about context was acknowledged. However, the extent this influenced practice and how much of an audience existed was questioned, suggesting linking with other professionals would help.

Discussion

This paper highlights the perceived importance of and desire to address context among UK based clinical psychologists. All participants endorsed wider definitions of context but this did not necessarily relate to practice. Multiple barriers were suggested that could risk a focus returning to individual pathology including service remit and resource restrictions and knowledge/skills deficits, similar to findings regarding barriers to the implementation of guidance among other professionals. Validation emerged as important with participants aware of perceptions that working with context could be considered inappropriate, particularly regarding practical help or wider action such as policy and media engagement. Participants shared hopes for wider action from their profession but did not all pursue this with efforts more focused on influencing their service context. These findings will be discussed in reference to other literature with limitations and future research considered.

Although having limited awareness of guidance relating to context, participants endorsed definitions corresponding with the social model of health (Dahlgreen & Whitehead, 1991). More immediate circumstances, e.g. lacking food, were linked with Maslow's hierarchy of needs (1954), referenced by some participants, with meeting such needs justified for addressing both primary causes of distress and barriers to engagement. Participants' discussions of wider issues, such as stigma, can be understood more within the framework of the social model of disability (Oliver, 2004) where having a particular attribute can be neutral in itself but when this attribute interacts with social and material influences distress is created. (MPG, 2006). Although, due to service restrictions, assessment and formulation of wider contextual difficulties was limited, it appeared that these difficulties were more amenable to intervention than more immediate contexts such as finances. This may be due to intervention for the latter facing more barriers and the former being more compatible with individual intervention.

Pressure to focus on individual therapy more aligned with the medical model was a common barrier. Participants' accounts were in accordance with Boyle's (2011) explanations of "professional avoidance". These include working with context being deemed inappropriate and the avoidance of feeling powerless to change contextual problems in contrast to feeling able and confident in providing individual therapy. These issues appeared to intensify in combination with financial pressures on services where individual therapy, able to draw on an evidence base, outcomes and find favour within a medical model, was emphasised within a competitive market. Intervention options were also limited by time pressures, increased workloads and pressure to reduce waiting lists. These barriers are similar to those reported for other mental health professionals in the reviews previously discussed.

Clinical psychologists may face further/enhanced difficulties in implementing guidelines relating to working with context compared to other professionals by conflicting with dominant medical influences. Participants experienced conflict from valuing work with context in a job which prioritises an individual focus and a mismatch between individuals and their job roles is a risk factor for burnout (Leiter & Maslach, 2000). The high demands and limited resources described are also risk factors, such as indicated by Bakker, Demerouti and Euwema (2005) in their analysis of the interactions between job demands and resources. Further, a "poorly cohesive" work group increases risk (Lasalvia et al., 2009) as indicated by participants describing restricted opportunities to communicate and general difficulties working with teams predominated by the medical model. Christofides, Johnstone and Musa (2012) explored clinical psychologists’ use of formulation with teams and similarly found perceptions of conflicting perspectives, difficulty being heard and reported service pressures reduced teams’ capacity to engage in psychological thinking.

Burnout is not only a concern but may present a further barrier to working with context through avoidance of distress, as may a perceived lack of competence. Thériault and Gazzola (2005) used grounded theory to explore feelings of competence among therapists and associated discomfort and distress. They describe feelings of inadequacy (arising from initial questioning of knowledge, skills and training), with more distress and difficulty linked with insecurity (reduced confidence in job roles and faith in the process of therapy) and ultimately incompetence (where doubts are attributed to the self). Participants described both instances of inadequacy, such as the “skills and knowledge vacuum”, and issues with the restrictions of their roles and faith in therapy as being influenced by the medical model.

To counter pressure to focus on individual pathology, participants provided justifications for working with context. Further justification may be afforded by knowledge of models and interventions providing a rationale such as attachment theory (Seager, 2013) or Smail’s (2005) social-materialist approach which could also reduce the “skills and knowledge vacuum”. There is also justification available for psychologists taking an advocacy role, including the suggestion of a scientist-practitioner-advocate model (Fassinger & O’Brien, 2000; Mallinckrodt, Miles & Levy, 2014).

Participants agreed with concerns that other professionals were better suited to provide practical help and would signpost and refer clients. However, they lacked signposting information and, due to resource issues, often other professionals were unavailable. As the only professionals available to help, participants could then struggle with a lack of training regarding contextual issues. With evidence of the impact of practical issues on both distress and engagement, concerns of inappropriateness and financial costs regarding clinical psychologists' time being spent on such issues, it seems logical (and cost effective) to employ welfare workers within mental health services. Greasley and Small (2005) report the outcomes of a welfare advice service within GP surgeries which was successful in addressing the impact of socioeconomic and environmental influences on health and an account of a mental health service offering psychosocial services as well as individual therapy is available from White (2008), involving "matched- rather than stepped care" (p.847).

Competition with other professionals was recognised by participants. Competition against professionals taking a more medical approach increased difficulties disseminating psychological thinking and inter-professional competition was seen to fuel an allegiance with the medical model within clinical psychology to gain acceptance. Formulations accommodating context were emphasised as important but competition was not discussed in terms of its potential influence on the promotion of formulation as a unique selling point of clinical psychology to justify roles. The importance of formulations was used to justify working with context and it is possible this justification may be dismissed if considered an attempt to compete for funding for posts. Similar rejection could occur if working with context is claimed as an ability restricted to clinical psychology. It has been noted that formulations can provide "the start of versions of holistic formulations: they are a window into a complex open system. But psychologists do not have expertise in all aspects of that system" (Pilgrim, 2015, p.297). The role of diverse professional groups needs to be acknowledged in order to access the benefits of collaboration.

Although a desire to move away from individual pathology to addressing context was shared, a focus on individuals was maintained overall as participants' were limited in their ability to engage in action beyond individual therapy. Support for wider engagement is not limited to within the profession (e.g. Friedli, 2014; Smail, 2010; Ussher, 1991). For example, the WHO (2009), have called for a commitment to public mental health, including seeking social justice, and policy change, emphasising the social production of mental health over individual pathology. This supports the need for clinical psychologists to “speak out”, potentially drawing on recommendations form the recent briefing paper from Psychologists Against Austerity (2016).

Speaking out appeared more achievable within immediate service contexts with participants describing efforts to instil contextual understanding. This included sharing formulations and more informal and indirect efforts to advance understanding, similar to findings from Christofides et al. (2012) that psychologists tended to “chip in”. Christofides et al. suggested that more formal identification and documentation of formulation may be helpful. Similarly, acknowledging work with context could also be beneficial with the availability of an accessible definition of context a potential first step towards facilitating discussions and exploration of practice.

Validation and support were key for participants to feel able to work with context. The potential lack of role models and examples of practice to provide validation has been acknowledged (Harper, 2014). There is also evidence of the importance of supportive and meaningful contact from peers, colleagues, clients and supervisors such as the exploration of therapist development by Rønnestad and Skovholt (2003). The BPS could provide validation with clear messages about the importance of context and legitimacy of psychologists taking action and by making efforts to counter restrictions on roles and resources. They could also have a role in promoting training on contextual difficulties, including teaching on politics, economics and reform (Acker & Suesse, 2014), both within the clinical psychology doctorate courses (Harper, 2014) and beyond. This would develop awareness of contextual issues and how to address context as part of an 'appropriate' intervention.

Limitations and Future Research

It is possible participants had a particular interest in context and different views and practices may not be represented in the analysis. The study is limited to UK perspectives within the NHS which may involve different factors impacting on work with context. However, the findings present a starting point that could be generalised to mental health professionals attempting to work in a way that may oppose service priorities. Participants may also have been motivated to demonstrate good practice due to the status of the researcher as a trainee clinical psychologist (Hewitt, 2007). However, participants did appear forthcoming with their frustrations and perceived limitations. Having a single researcher meant data coding and development of themes did not have the advantage of multiple perspectives and corroboration throughout to reduce the potential for bias. However, supervisors were available to provide input into coding and theme development.

Future research should further explore how context fits with practice, including service access and engagement, assessment, formulation and intervention. Research involving audit could be helpful to assess the extent context is included in practice and how, including the use of questionnaires and quantitative analysis. Experiences appeared to differ based on service settings, including the extent the medical model dominated, and it would be useful to investigate any relevance further, including comparative studies. Similarly, explorations of experiences of other applied psychologists and mental health professionals would also be useful because evidence of a more widespread desire to work with context, and the efforts needed to support this, could help advance collaborative work. Research developing models to include context in formulation and intervention would be advantageous, as would the development of best practice which may be particularly lacking regarding wider intervention. This could help provide confidence and justification to support work with context. To assist in future research, discussion and practice, the development of an accessible, shared definition of context is important.

Conclusion

There are various barriers which may limit the application of guidance highlighting the need to work with context. These barriers may be enhanced due to the distance of such guidance from the medical model. Some barriers are similar to those faced by other professionals, including resource issues and lacking knowledge, skills and support, however clinical psychologists may face difficulties due to being a small professional group whose guidelines may oppose service priorities focused on individuals. Context can be included in individual therapy, however, wider action is required and should include preventative as well as reactive efforts. Roles of scientist-practitioner-advocate (Fassinger & O'Brien, 2000) or "community clinical psychologists" (Smail, 2010) can enable work at individual, community and political levels simultaneously. It is important for 'more appropriate' professionals to work with context, however, while this is not available clinical psychologists have a role in removing both distress and barriers to engagement. The importance of working with context is not limited to clinical psychology and it is imperative to work collaboratively with other disciplines and other professionals who could influence the contextual difficulties that have such a profound impact on the health and wellbeing of service users.

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Table 1

Participant Characteristics

Participant	Stage of career	Sex	Service setting
CP1	Qualified less than 2 years	Female	Physical health services, within a team
CP2	Approaching retirement	Female	Clinical health psychology, lone working
CP3	Qualified less than 2 years	Female	Adult acute inpatient unit
CP4	Qualified less than 2 years	Male	Secondary care adult mental health
CP5	Qualified more than 10 years	Male	Medium secure forensic setting
CP6	Qualified less than 2 years	Female	Older adult team
CP7	Qualified more than 10 years	Female	Adult mental health
CP8	Qualified more than 10 years	Female	Secondary care adult mental health

Appendix 2-A

Participant Recruitment Advert and Poster

Advert Version 1

Are you interested in how clinical psychology considers the context of clients' lives in practice? Qualified CPs required for qualitative research project.

Advert Version 2

PARTICIPANTS NEEDED:

Hi everyone, I am a DClinPsy trainee undertaking research investigating how clinical psychology considers the wider context of clients' lives and how this relates to clinical practice. I am looking for qualified clinical psychologists to take part in a qualitative study to explore their thoughts and experiences on this topic.

Details can be found in the poster below. Please don't hesitate to get in touch with any queries or for further information (Email: h.spankie@lancaster.ac.uk, Tel: 07508375665).

Please feel free to share for others who may be interested.

Advert Version 3

Participants needed for research exploring how clinical psychology considers the wider context of clients' lives and how this relates to clinical practice.

The importance of the wider context of clients' lives has been well evidenced and is recognised in guidance for clinical psychologists. This research aims to explore how this fits within current practice.

Qualified clinical psychologists are sought to take part in a qualitative study involving face to face, telephone or Skype interviews lasting between 30 to 60 minutes. All data will be anonymised.

To receive a participant information sheet, request more information or arrange to take part, please contact the researcher at h.spankie@lancaster.ac.uk or 07508375665.

Clinical psychologists' experiences of exploring and addressing 'context' in formulation and intervention

My name is Heather Spankie and I am conducting this research as a student on the Doctorate in Clinical Psychology programme at Lancaster University, Lancaster, United Kingdom.

What is the study about?

The importance of the wider context of clients' lives has been well evidenced and is recognised in guidance for clinical psychologists. The purpose of this research is to explore how this fits within current practice.

Qualified clinical psychologists are sought to take part in a qualitative study aiming to find out about experiences and opinions regarding the exploration of 'context' in formulations and/or relevance to interventions. I hope to find out what is understood by 'context' and explore its relevance to clinical practice.

Participants must have been practicing within the last 12 months in order to comment on current practice.

What does the study involve?

If you decide you would like to take part, you would be asked to attend one interview which will last around 30 minutes to one hour which would be digitally recorded and later transcribed. As this study is nationwide, face to face interviews will be offered if possible in the North West of England and otherwise conducted by telephone or Skype.

To receive a participant information sheet, request more information or arrange to take part, please contact the researcher at h.spankie@lancaster.ac.uk or 07508375665.

Thank you for taking the time to read this information.

Appendix 2-B

Participant Information Sheet

Participant Information Sheet

Clinical psychologists' experiences of exploring and addressing 'context' in formulation and intervention

My name is Heather Spankie and I am conducting this research as a student on the Doctorate in Clinical Psychology programme at Lancaster University, Lancaster, United Kingdom.

What is the study about?

The purpose of this study is to find out about experiences and opinions of clinical psychologists regarding the exploration of 'context' in formulations and/or relevance to interventions. I hope to find out what is understood by "context" and explore its relevance to clinical practice.

Why have I been approached?

You have been approached because you are a qualified clinical psychologist. You do not have to be currently working in a specialist health role but must have practiced as a clinical psychologist within the last 12 months in order to comment on current practice.

Do I have to take part?

No. It's completely up to you to decide whether or not you take part. You are welcome to find out more and ask any questions with no obligation to take part. You can also withdraw from the study at any time without giving a reason. After data has been anonymised and analysed it may not be possible to withdraw but every effort will be made to extract the data up to the point of publication. If you do want to take part you will be asked to sign a consent form to give your permission to be part of the research.

What will I be asked to do if I take part?

If you decide you would like to take part, you would be asked to attend one interview which will last about 30 minutes to one hour which would be digitally recorded and later transcribed. As this study is nationwide, face to face interviews will be offered if possible in the North West of England and otherwise conducted by telephone or Skype. Face to face interviews can be held at Lancaster University or arranged at a convenient location to you if possible. If this was to be your place of work you may need the agreement of your line manager.

Will my data be confidential?

All personal information you provide will be strictly confidential. The data collected for this study will be anonymised and stored securely. Only the researchers conducting this study will have access to this data:

- Audio recordings will be destroyed and/or deleted on completion of the study.
- The files on the computer will be encrypted (that is no-one other than the researcher will be able to access them) and the computer itself password protected.
- The typed version of your interview will be made anonymous by removing any identifying information including your name, the names of other people if mentioned, and places of work. Anonymised direct quotations from your interview may be used in the reports or publications from the study, so your name will not be attached to them.
- Electronic, encrypted copies of anonymised transcripts will be kept by Lancaster University for 10 years in accordance with the Data Protection Act (1998).

There are some limits to confidentiality: if what is said in the interview makes me think that you or someone else is at significant risk of harm, I will have to break confidentiality and speak to a supervisor about this. If possible, I will tell you if I have to do this. If there were concerns over practice causing harm to clients I may also need to discuss this.

Please note that we cannot guarantee Skype as an entirely secure system beyond Skype's own terms and conditions. We can assure that the process that follows will ensure any recordings from the Skype interview are kept securely.

Only I, as the main researcher, will know the identity of the people who take part in the research and that information will be strictly confidential.

Confidentiality during interviews. Participants should be aware of the need to maintain the confidentiality of their clients, past and present and of colleagues. As the content of interviews may touch on clinical practice with individuals, participants should be mindful of discussing this in a way which would not reveal any identifying information about clients. Transcripts will be anonymised by the researcher to ensure anonymity of both participants and any other individuals or services.

What will happen to the results?

The results will be summarised and reported in a research project and will also be submitted for publication in an academic or professional journal.

Are there any risks?

There are no risks anticipated with participating in this study. However, if you become distressed during the interview the interview can be stopped at any time. If there is anyone you would like me to contact in the event of becoming distressed, please inform me of this. If you experience any distress following participation you may find it helpful to contact one of the support resources listed at the end of this information sheet.

Are there any benefits to taking part?

Although you may find participating interesting, there are no direct benefits in taking part. However, participants may value taking part in research making a contribution to clinical psychology practice.

Who has reviewed the project?

This study has been reviewed by the Faculty of Health and Medicine Research Ethics Committee, and approved by the University Research Ethics Committee at Lancaster University.

Where can I obtain further information about the study if I need it?

If you have any questions about the study, please contact me using the details below.
Heather Spankie
Trainee Clinical Psychologist
Tel: 07508375665
Email: h.spankie@lancaster.ac.uk
Division of Health Research
Faculty of Health & Medicine
Furness Building – C20
Lancaster University
Bailrigg
Lancaster
LA1 4YT

Complaints

If you wish to make a complaint or raise concerns about any aspect of this study and do not want to speak to the researcher, you can contact:
Dr Jane Simpson
Research Director
Tel: (01524) 592858
Email: j.simpson2@lancaster.ac.uk
Division of Health Research
Faculty of Health & Medicine
Furness Building – C20
Lancaster University
Bailrigg
Lancaster
LA1 4YT

If you wish to speak to someone outside of the Clinical Psychology Doctorate Programme, you may also contact:
Professor Roger Pickup
Associate Dean for Research
Tel: (01524) 593746
Email: r.pickup@lancaster.ac.uk
Division of Biomedical and Life Sciences
Faculty of Health and Medicine
Lancaster University

Lancaster
LA1 4YD

Thank you for taking the time to read this information sheet.

Resources in the event of distress

Should you feel distressed either as a result of taking part, or in the future, the following resources may be of assistance.

- You may find it useful to speak to your GP.
- Mind
  0300 123 3393 (weekdays 9am - 6pm)
  info@mind.org.uk
- Samaritans
  08457 909090 (24/7)
  jo@samaritans.org

Appendix 2-C

Consent Form

Study Title: Clinical psychologists' experiences of exploring and addressing 'context' in formulation and intervention.

We are asking if you would like to take part in a research project exploring the experiences of clinical psychologists regarding their use of context in their clinical work.

Before you consent to participating in the study we ask that you read the participant information sheet and mark each box below with your initials if you agree. If you have any questions or queries before signing the consent form please speak to the principal investigator, Heather Spankie.

1. I confirm that I have read the information sheet and fully understand what is expected of me within this study. ☐
2. I confirm that I have had the opportunity to ask any questions about the study and to have them answered. ☐
3. I understand that my interview will be audio recorded and then made into an anonymised written transcript. ☐
4. I understand that audio recordings will be kept until the research project has been examined. ☐
5. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected. ☐
6. I understand that once my data has been anonymised and incorporated into themes it might not be possible for it to be withdrawn, though every attempt will be made to extract my data, up to the point of publication. ☐
7. I understand that the information from my interview will be pooled with other participants' responses, anonymised and may be published. ☐
8. I consent to information and quotations from my interview being used in reports, conferences and training events. ☐
9. I understand that any information I give will remain strictly confidential and anonymous unless it is thought that there is a risk of harm to myself or others, in which case the principal investigator will/may need to share this information with her research supervisor. ☐
10. I consent to Lancaster University keeping written transcriptions of the interview for 10 years after the study has finished in accordance with the Date Protection Act (1998). ☐
11. I understand that I can request to pause or terminate the research interview at any time. ☐
12. I understand that data will be discussed and shared with research supervisors. ☐
13. I confirm that I received information about the study at least 24 hours before taking part. ☐
14. I consent to take part in the above study. ☐

Please initial the box after each statement

Name of Participant____________________ **Signature**______________________ **Date** ____________

Name of Researcher __________________**Signature** ____________________**Date** __________

Appendix 2-D

Interview Schedule

Interview schedule

Introductions and background information

- Introduce self and project
- Explain confidentiality
- Describe process (around 60 minute interview that will be recorded then transcribed)
- Review participant information sheet and answer any questions
- Sign consent form
- Confirm that the interview can be paused or terminated at any time

Introduction

Recent BPS guidance has brought the importance of context into focus with recommendations that the context of clients' lives should be kept in mind. I'm interested in finding out about your opinion on this, what you understand by context and how this might relate to your clinical practice. I am focusing on the area of clinical health psychology as context may be more relevant in such settings for example as clients may also access other services.

TOPIC 1: UNDERSTANDING OF CONTEXT AND GUIDANCE:

- **First off, could you please explain what context means to you? (And how might be relevant to clients issues?)PROMPTS:** What aspects of a person's life circumstances/situation would you consider as part of their context?
- **To what extent were you aware of BPS guidance relating to context?**
- **What is your opinion of the guidance? To what extent do you feel this guidance relates/applies to your clinical work? Are you able to address context to the extent that you would like? What (could) help/hinder adherence to these guidelines?**

TOPIC 2: RELEVANCE AND APPLICATION TO CLIENTS:

- **How does context fit within your clinical work?**

PROMPTS: (FORMULATION)

- To what extent have you included context in formulations/thinking about cases?

- What aspects of context do you consider/explore with clients? How do you do this?

- Do you do this routinely or under certain circumstances?

- To what extent do you explore contextual difficulties as potential <u>causes or contributors</u> to distress?

- To what extent do you explore contextual difficulties as a <u>consequence</u> of distress/difficulty?

- To what extent do you explore thinking about context in shared formulations with clients?

- Do you consider contextual difficulties as contributing to engagement with therapy? (Either psychological or practical demands of the situation.) If so, do you address this? How?

(INTERVENTION)

- To what extent and how is context addressed in intervention?
in addressing barriers to engagement?
in addressing causes/exacerbations of distress?

- Have you ever felt unable to work with a client due to their contextual difficulties? What did you do and what informed this decision?

TOPIC 3: THE ROLE FOR CLINICAL PSYCHOLOGISTS

- **What is your view of a role for clinical psychologists to address contextual issues?**

PROMPTS: (INDIVIDUAL CLIENTS)

- Have you ever worked with a client with a contextual difficulty that you recognised but felt unable to address? What did you do and what informed this decision? What was the impact of doing this (positive or negative)?

- Have you supported a client to address a contextual issue by (e.g.) a) giving advice b) building skills e.g. confidence, self-advocacy etc. or setting therapy goals c) assisting them to search for services and self-refer? What did you do and what informed this decision? What was the impact of doing this (positive or negative)?

- Have you ever acted on a client's behalf to (e.g.) a) make a referral b) research services c) seek advice d) correspond with services e.g. DWP, housing, employer etc? What did you do and what informed this decision? What was the impact of doing this (positive or negative)?

- Have you ever worked with a client with a contextual difficulty that you addressed but felt that this was stepping out of a clinical psychology role? E.g. help to access services, making a referral etc. What did you do and what informed this decision? What was the impact of doing this (positive or negative)?

- Whose role would it be instead?

(SOCIAL ACTION)

- To what extent do you feel there is a role for clinical psychologists to engage with social action?
- What (could) help/hinder this?

Appendix 2-E

Debrief Sheet

Participant debrief sheet

Clinical psychologists' experiences of exploring and addressing 'context' in formulation and intervention.

Thank you for participating in this study.

The information you have provided will be anonymised and used to help generate themes describing what is understood by context among clinical psychologists and how context relates to clinical practice.

Contact details

If you have any questions or wish to withdraw your data from the study, please contact me:
Heather Spankie
Tel: 07508375665
Email: h.spankie@lancaster.ac.uk

Resources in the event of distress

If you experience any distress following participation you may find it helpful to contact one of these support resources.

- You may find it useful to speak to your GP.
- Mind
  0300 123 3393 (weekdays 9am - 6pm)
  info@mind.org.uk
- Samaritans
  08457 909090 (24/7)
  jo@samaritans.org

Complaints

If you wish to make a complaint or raise concerns about any aspect of this study and do not want to speak to the researcher, you can contact:
Dr Jane Simpson
Research Director
Tel: (01524) 592858
Email: j.simpson2@lancaster.ac.uk
Division of Health Research
Faculty of Health & Medicine

Furness Building – C20
Lancaster University
Bailrigg
Lancaster
LA1 4YT

If you wish to speak to someone outside of the Clinical Psychology Doctorate Programme, you may also contact:
Professor Roger Pickup
Associate Dean for Research
Tel: (01524) 593746
Email: r.pickup@lancaster.ac.uk
Division of Biomedical and Life Sciences
Faculty of Health and Medicine
Lancaster University
Lancaster
LA1 4YD

Thank you once again for taking the time to contribute to this study.

Appendix 2-F

Publication Guidance for Authors for the Journal of Social and Political Psychology

Author Guidelines

Submissions can reflect different epistemological, methodological, theoretical, and cultural perspectives. Work using the dominant hypothetico-deductive method of scientific inquiry and quantitative methodology is as welcome as work adopting alternative approaches (i.e., inductive or abductive methods of science, qualitative and mixed methods research). Submissions should contribute to innovation, questioning of assumptions, and controversy and debate. They should give creative impetuses for academic scholarship and, where appropriate, for applications in education, policymaking, professional practice, or advocacy and social action.

JSPP operates a rigorous and transparent peer-review process that focuses on a broad range of criteria. The overarching purpose of the peer-review process is to help achieve the highest possible quality for JSPP's manuscripts. Its aims are (1) to ensure that the research is technically sound; and (2) to offer guidance to support authors in making their manuscript as strong as possible, in line with JSPP's profile. JSPP uses a broad range of review criteria, some of which are less prominently considered in other journals. Depending on the type of article (see below), this may include:

- Societal importance and noteworthiness of the problem or topic
- Thoroughness of foundation, as documented in a comprehensive, fair, and critical review of the theoretical and empirical literature that situates the research meaningfully in relevant contexts
- Consistency of research goals and objectives, rationale and purpose, and research questions
- Suitability and creativity of the methodological approach in light of the research questions
- Quality and rigour of research design, sampling, data generation or measurement, and analysis
- Consistency of inferences and interpretation, insightfulness of discussion, adequacy of conclusions
- Degree of contribution to the literature, including potential to open up new avenues
- Interest and accessibility to a broad audience
- Sensitivity to ethical issues, including potential political and societal consequences of the research
- Clarity of presentation, including quality of writing and parsimony of tables and figures

Further information on quality criteria for quantitative, qualitative, and mixed methods research can be found in, for example, Dellinger and Leech (2007), Elliot, Fischer, and Rennie (1999), and Teddlie and Tashakkori (2009).

Because JSPP is published online only, there are no space limitations that sometimes lead to the rejection of high-quality papers in other (print) journals. However, manuscript length has to be commensurate with the degree of contribution; wordiness and redundancy should be avoided.

Submission Preparation and Management Guidelines

Follow these guidelines when preparing your manuscript for submission.

Show all / Hide all

⊟ Author Names

Provide all authors' full names in the form "[First name] [Middle names] [Surname]". Omit all titles/degrees (e.g. Dr., Prof. etc.). Mark the corresponding author with an asterisk (*). Only one author can be named as corresponding author, e.g.:

Barbara Jennifer Smith*

Category: Submission Preparation Guidelines

⊟ Author Affiliations

Provide your affiliation using the following pattern: "Department, Institution, City, Country", e.g.

Department of Psychology, University of Oslo, Oslo, Norway

Category: Submission Preparation Guidelines

⊟ Running Head

Provide a running head for each manuscript. The running head is a short title (no more than 50 characters) that appears in a paper's header.

Category: Submission Preparation Guidelines

⊟ Headings

Organize your manuscript by headings into an unambiguous hierarchy with at least two headings at each level. Use MS Word standard styles (Heading 1, Heading 2, Heading 3) to indicate heading level. Alternatively you may use the decimal system of headings (e.g., 1.3.1, 1.3.2).

Note: The decimal system will be replaced during production by appropriate layout styles.

Category: Submission Preparation Guidelines

⊟ Abstract

Each abstract should comprise a single paragraph without a heading (the abstract heading will be automatically generated during the layout procedure). Avoid introductory words such as "Abstract:" as well.

As an abstract has to be a stand-alone entity (because it is often published separately from an article), do not refer in it to tables or figures. References to the literature are also uncommon. Therefore, use them only if they are absolutely necessary (in this case, it is required to provide as detailed reference information as you would use in the reference list).

Papers in a language other than English require both an English-language and an original-language abstract.

Category: Submission Preparation Guidelines

⊞ Figures - Submission of Figures

⊟ Font Type

To avoid compatibility problems, use common Microsoft Word fonts (e.g., Times New Roman, Arial, Courier).

Do not include special characters as miniature images. Instead, use designated Word fonts (e.g., Symbol) or the Word Symbol Feature under "Insert > Symbol".

Category: Submission Preparation Guidelines

⊟ Formatting Styles

Use only Microsoft Word standard styles for formatting article elements such as headings, paragraphs, words, characters, sections, and tables (e.g., „Normal", „Heading 1", „Emphasis", "Bold"). Refrain from defining custom styles.

Category: Submission Preparation Guidelines

⊟ Text - grammar and spelling

Take care that the grammar and spelling of your manuscript is accurate as language errors distract the reader and impede clear and efficient communication. Ask a colleague to proofread your paper to detect mistakes and contradictions.

For articles written in English authors may use consistently either British or American English.

Category: Submission Preparation Guidelines

⊟ Appendices

All appendices have to be appropriately labeled (e.g., use headings such as "Appendix 1", "Appendix 2" etc.). Identify all appendix tables and figures as appendix elements by giving them labels that combine capital letters with Arabic numerals (e.g. Table A1).

Category: Submission Preparation Guidelines

⊞ Ensuring a Blind Review

⊞ **How can I upload a supplementary file?**

⊞ **How can I upload a revision of my article?**

Capitalization Guidelines

Capitalization should be consistent within and between journal articles. There are rules for capitalization of headings, subheadings, table titles and footnotes, figure captions, and words in the body of your text and in the reference list.

Show all / Hide all

⊟ Capitalization - in titles (including table titles, and headings)

In titles (including table titles, headings, and subheadings), capitalize

- all major words. Major words are nouns, adjectives, verbs (including linking verbs), adverbs and pronouns.
- all words that have four or more letters, even if they are not major words.
- both elements in a hyphenated compound (e.g., Teacher-Rated).
- the first word after a colon (:) or dash (—).

Example:

School Anxiety: Teacher-Rated Stress Factors in Bulgarian School Children

Use lower-case letters for nonmajor words (conjunctions, articles, and short prepositions). To table and figure footnotes apply the capitalization rules for references (see below).

Category: Capitalization

⊟ Capitalization - in the reference list

In the reference list, capitalize

- only the first word of book and article titles (exception: retain the capitalization that is used by a journal in its title).
- proper nouns (and words used as those).
- the first word after a colon or dash.
- the first constituent of a hyphenated compound at the beginning of a title or subtitle, or after a colon or dash (e.g. Teacher-rated).

Example:

Richards, M. (2005). School anxiety: Teacher-rated stress factors in Bulgarian school children. *SchoolPSYCHOLOGY Journal*, *7*(1), 81-97.

Category: Capitalization

⊟ Capitalization - in the text body

In the text body, capitalize

- nouns followed by numerals in a numbered series (e.g. Table 4 shows that on Day 3 in Experiment 6...).
- Titles of books and articles mentioned in the text (e.g. In his book, *The Psychology of Everyday Things* the author clarifies that...).
- Titles of tests (e.g. Advanced Memory Test (AMT)).

Category: Capitalization

For more detailed information regarding capitalization visit:

http://blog.apastyle.org/apastyle/2012/03/title-case-and-sentence-case-capitalization-in-apa-style.html

In-Text Citation and Reference List Guidelines

Each reference cited in the text (in-text citation) must be contained in the reference list and vice versa. Make sure that the spelling of author names and the publication year are identical in both entries.

Take care that the reference list is accurate, valid, and complete.

Show all / Hide all

⊟ In-Text Citations - general rules

APA Style requires authors to use an author-date citation system. Insert the surname of the author and the publication year in the text in the form below:

Name of the author is part of the narrative (nonparenthetical format):

> Jackson (2012) found out that humor prolongs life.

Name is not part of the narrative (parenthetical format):

> Humor prolongs life as a recent study concluded (Jackson, 2012).

When including multiple citations inside the same set of parentheses, alphabetize the studies (same order as in the reference list) and separate them by semicolons:

> Humor prolongs life as several recent studies concluded (Adler, 2011; Jackson, 2012; Miller, 2010).

If your reference list contains two or more publications authored by the same person(s) in the same order and the same year, use lowercase suffixes immediately after the year to distinguish them, e.g.:

> Jackson & Miller (2012a, 2012b) found out that humor prolongs life.

Use the suffixes also in the respective reference entries. Order those types of entries alphabetically by title (excluding nonmajor words).

Category: In-Text Citations and References

⊟ In-Text Citations - 1-2 authors

Authors are named throughout the manuscript:

Jackson and Miller (2012) found out that humor prolongs life. [nonparenthetical]

Humor prolongs life as a recent study concluded (Jackson & Miller, 2012). [parenthetical]

Please note that in nonparenthetical format, the word “and” precedes the last author, while in parenthetical format, an ampersand (&) is used.

Category: In-Text Citations and References

⊟ In-Text Citations - 3-5 authors

All author names are listed at the first occurrence in text. Afterwards, the list is shortened to et al.:

Jackson, Miller, and Stevens (2012) found out that humor prolongs life. [1st citation, nonparenthetical]

Jackson et al. (2012) found out that humor prolongs life. [subsequent citations, nonparenthetical]

Humor prolongs life as a recent study concluded (Jackson, Miller, & Stevens, 2012). [1st citation, parenthetical]

Humor prolongs life as a recent study concluded (Jackson et al., 2012). [subsequent citations, parenthetical]

Please note that in nonparenthetical format, the word “and” precedes the last author, while in parenthetical format, an ampersand (&) is used. A comma precedes "and"/"&" if an author list contains three or more names. Use a comma to set off the year in in-text citations in parenthetical format.

If two or more reference entries with the same publication year can be shortened to the same form, precede et al. with the number of names necessary to distinguish the ambiguous references. E.g., Jackson, Miller, Stevens, Veith, and Parker, 2012 and Jackson, Miller, Veith, Parker, and Armstrong, 2012 would both shorten to Jackson et al., 2012. To avoid ambiguity, cite:

Jackson, Miller, Stevens, et al. (2012) found out that humor prolongs life.

Jackson, Miller, Veith, et al. (2012) found out that humor prolongs life.

Please note that in this case, et al. is preceded by a comma. Also, as "et al." indicates plural, it can only stand for more than one name. If only one name is left to abbreviate, shortening is not possible, and all names have to be spelled out throughout the text.

Category: In-Text Citations and References

⊟ In-Text Citations - 6 and more authors

et al. is used right from the beginning:

Jackson et al. (2012) found out that humor prolongs life. [nonparenthetical]

Humor prolongs life as a recent study concluded. (Jackson et al., 2012) [parenthetical]

If two or more reference entries with the same publication year can be shortened to the same form, precede et al. with the number of names necessary to distinguish the ambiguous references. E.g., Jackson, Miller, Stevens, Veith, and Parker, 2012 and Jackson, Miller, Veith, Parker, and Armstrong, 2012 would both shorten to Jackson et al., 2012. To avoid ambiguity, cite:

Jackson, Miller, Stevens, et al. (2012) found out that humor prolongs life.

Jackson, Miller, Veith, et al. (2012) found out that humor prolongs life.

Please note that in this case, et al. is preceded by a comma. Also, as "et al." indicates plural, it can only stand for more than one name. If only one name is left to abbreviate, shortening is not possible, and all names have to be spelled out throughout the text.

Category: In-Text Citations and References

⊞ In-Text Citations - no author

⊟ In-Text Citations - citing page numbers

When providing page numbers – which is required for word-by-word citations, but also encouraged for paraphrased citations – insert them behind the year, set off by a comma. Do not use a colon for setting off the page numbers.

Humor prolongs life as a recent study concluded (Jackson & Miller, 2012, pp. 120-121).

If you are referring to a single page, precede the page number with p. (instead of pp.):

Humor prolongs life as a recent study concluded (Jackson & Miller, 2012, p. 120).

Category: In-Text Citations and References

⊟ Reference List - Author Names, Titles

Author Names
Display all authors' names in an inverted format. Provide surnames as well as first and middle name initials for up to seven authors. Add an ampersand before the last author. Note: When referencing a book chapter, invert the chapter author's name but not the editor's name.

Jackson, A. J., Miller, J. T., Stevens, G. K., Veith, S. L., Dexter, W. S., Hu, M.-L., & Gregory, K. A. (2012).

If a work has more than seven authors, list the first six authors' names, insert a comma followed by three ellipsis points, then add the last author's name:

Jackson, A. J., Miller, J. T., Stevens, G. K., Veith, S. L., Dexter, W. S., Hu, M.-L., … Gregory, K. A. (2012).

In case the author is not known, move the title of the work to the author position, followed by a period, e.g.:

Europe's seniors. (2012).

Titles

Italicize the names of periodicals (journals, newsletters, magazines), as well as the titles of books, reports, and other separate, nonperiodical literature.

Include additional information (e.g., report number, edition) in parentheses immediately after the title without setting it off with a period. Do not italicize the additional information:

Collins, Bill (2012). *Annual report on school psychology* (Report No. 12-2012). New York: American Association of School Psychologists.

Category: In-Text Citations and References

⊟ Reference List - Books

For referencing books, use the template below:

Author, A. A., Author, B. B., & Author, C. C. (year). *Title of book* (xx ed., Vol. xx). Location: Publisher.

Jackson, A. J., Miller, J. T., Stevens G. K., & Veith, S. L. (2012). *Psychology in universities*(2nd ed., Vol. 1). Thousand Oaks, CA: SAGE.

Jackson, A. J., Miller, J. T., Stevens G. K., & Veith, S. L. (2012). *Psychology in universities*(2nd ed., Vol. 1). Heidelberg, Germany: Springer.

If a book was published in the U.S., provide the state abbreviation, if it was published outside the U.S., provide the country. For edited books, add "(Ed.)" and a period behind the editor's name, respectively "(Eds.)" for more than one editor:

Jackson, A. J., Miller, J. T., Stevens G. K., & Veith, S. L. (Eds.). (2012). *Psychology in universities* (2nd ed., Vol. 1). Heidelberg, Germany: Springer.

When author (respectively editor) and publisher are identical, do not repeat the name; rather, add the word "Author" (respectively "Editor") instead of the publisher name, e.g.:

Leibniz Institute for Psychology Information. (2012). *The official PsychOpen handbook*. Trier, Germany: Author.

Category: In-Text Citations and References

⊟ Reference List - Book Chapters

For referencing book chapters, use the following template:

Author, A. A., Author, B. B., & Author, C. C. (year). Title of chapter. In A. Editor, B. Editor, & C. Editor (Eds.), *Title of book* (xx ed., Vol. xx, pp. xxx-xxx). Location: Publisher.

Jackson, A. J., Miller, J. T., & Stevens, G. K. (2012). School anxiety: Teacher-rated stress factors in Bulgarian school children. In M. Brunner, S. Page, & S. Gilbert (Eds.), *Psychology in schools*. London, United Kingdom: School Press.

If a book has a single editor, use (Ed.) instead of (Eds.). Place additional information (e.g., edition number, volume, or page range) in parentheses immediately following the title:

Jackson, A. J., Miller, J. T., & Stevens, G. K. (2012). School anxiety: Teacher-rated stress factors in Bulgarian school children. In M. Brunner (Ed.), *Psychology in schools* (2nd ed., Vol. 2, pp. 12-37). London, United Kingdom: School Press.

Provide a DOI if one is assigned. If a DOI is available, omit the publishing information, e.g.:

Jackson, A. J., Miller, J. T., & Stevens, G. K. (2012). School anxiety: Teacher-rated stress factors in Bulgarian school children. In M. Brunner (Ed.), *Psychology in schools* (2nd ed., Vol. 2, pp. 12-37). doi:10.1000/182

For electronic books without a DOI add the exact landing page URL (xxxx) for the book from the publisher homepage. Use the format: Retrieved from xxxx

Jackson, A. J., Miller, J. T., & Stevens, G. K. (2012). School anxiety: Teacher-rated stress factors in Bulgarian school children. In M. Brunner, S. Page, & S. Gilbert (Eds.), *Psychology in schools* (pp. 12-37). Retrieved from www.schoolpress.org/books/showitem.asp

Category: In-Text Citations and References

⊟ Reference List - Journal Articles

For referencing journal articles, use the template below:

Author, A. A., Author, B. B., & Author, C. C. (year). Title of article. *Title of Journal, volume number*, pp-pp.

Jackson, A. J., Miller, J. T., & Stevens, G. K. (2012). School anxiety: Teacher-rated stress factors in Bulgarian school children. *Journal of Psychology in Schools, 53*, 12-37.

Provide a DOI if one is assigned:

Jackson, A. J., Miller, J. T., & Stevens, G. K. (2012). School anxiety: Teacher-rated stress factors in Bulgarian school children. *Journal of Psychology in Schools, 53*, 12-37. doi:10.1000/186

In cases where no DOI is available, include the journal homepage URL (xxxx) for the periodical. Use the format: Retrieved from xxxx

Jackson, A. J., Miller, J. T., & Stevens, G. K. (2012). School anxiety: Teacher-rated stress factors in Bulgarian school children. *Journal of Psychology in Schools, 53*, 12-37. Retrieved from www.psischool.org

If a journal is paginated separately by issue (i.e., each issue begins with Page 1), provide the issue number in parentheses immediately after the volume number, without italicizing it, e.g.:

Journal of Psychology in Schools, 53(4), 12-37.

Category: In-Text Citations and References

⊟ Reference List - Magazine Articles

For magazine articles, use the following template:

Author, A. A., Author, B. B., & Author, C. C. (year, month). Title of article. *Title of Magazine, volume number*(Issue number), pp-pp.

Miller, T. M. (2012, September). Is college a lucrative investment? *College Magazine, 58*(9), 64-78.

For an online magazine article provide the home page URL (xxxx) of the magazine by using the format: Retrieved from xxxx

Category: In-Text Citations and References

⊞ Reference List - Newspaper Articles

⊞ Reference List - Technical and Research Reports

⊞ Reference List - Proceedings

⊞ Reference List - Doctoral Dissertations and Master's Theses

Numbers and Statistical Symbols Guidelines

Show all / Hide all

⊞ Decimal Fractions

⊞ Statistical Symbols

Tables Guidelines

Particular attention should be given to tables while preparing your manuscript for publication.

Show all / Hide all

⊟ Tables

Table Title

Provide a concise and explanatory title for each table. Table titles should contain a table number and should be placed above the table. Capitalize all major words (nouns, adjectives, verbs, adverbs, pronouns), all words that have four or more letters, both elements in a hyphenated compound (e.g., Teacher-Rated), and words after a colon (:) or dash (—).

Example:

Table 3. Factor Loadings of the School Anxiety Inventory — Teacher-Rated Results From Study 1

Table Structure

To avoid any disorganization of content during the partially automatized copyediting procedure, provide a separate cell for each content item (instead of setting off content elements by using tabs or returns within the same cell). The table content should be placed into a single Microsoft Word table. Do not split it into separate tables.

Column Heads

The column heads should be as brief as possible – ideally they do not have more characters than the widest entry.

Decimal Values

Whenever possible, use the same number of decimal places for decimal values (if possible, round to two decimal places).

Table Referencing

Reference every table in the text, e.g., "see Table 1" or "as shown in Table 2".

Table Borders and Shading

Only use horizontal borders at the top and the bottom of the whole table as well as the bottom of the header row. Eliminate all vertical borders. Do not use any shading.

Category: Tables Guidelines

⊞ **Tables - Footnotes**

Figures Guidelines

Show all / Hide all

⊟ **Figures**

Table A1

Example of Theme Development for the Theme "The need to work with context beyond the therapy room"

Theme components	Initial codes	Participant quotes
The need to speak out	CP needs to be more visible and raise awareness	"I think for psychologists, as with many other professionals, we might be seen to be a bit um, not sitting in an ivory tower but being a bit removed from things and I thought that was a really open thing to do and a really being out there and being part of the context of society and not saying that psychology was, um this little thing that's done somewhere but actually that psychology is something that's part of everybody's life isn't it. It's about psychology is everything really isn't it? How you think, and feel, and behave, and so I think that I, think we, I would say much more explicit talk about it" CP2 "we should be visible we should actually be going it's actually very powerful at the moment for a psychologist to be out there holding a banner or wearing a T-Shirt that says psychologist against austerity because people go "oh what the fuck?!" That's interesting and then they want to come up and engage and then they want to find out things and that's, that's, you know there's a huge amount of stuff for instance that we can be doing with that and it's, you know why I think things, things like PAA are so wonderful and so important. But also there's tremendous value in, in a psychologist popping up wearing a, you know, wearing their day, their work clothes and saying "ok, you know actually there's a huge amount of evidence to suggest that maybe something that looks a bit more like a policy intervention might be good um, you know, how do we do this at a public health level?" CP4 "they had done this sort of walk in the summer where they had walked 100 miles [walk the talk] I thought that was really interesting because even though I think that was about austerity wasn't it and how it's affecting people, raising awareness and consciousness, and I thought that was really interesting thing to do" CP2 "there are definitely things we can be doing as psychologists you kind of not about an individual person necessarily but kind of like the walk the talk thing, of speaking up about the um, speaking up and kind of highlighting the impact of all these um, contextual factors on peoples mental health um, and I guess indirectly that is an intervention for people but not, not an individual patient" CP1
	CP need bigger voices and opinions	"we need bigger voices and more of them and we need to stop saying well it depends and take a bloody position because there's nothing so frustrating as someone with 3 degrees, um, without the, kind of moral fibre to have an opinion they can stick by, you know, it doesn't make you a bad person to have an opinion because in the, in the real world people don't think in grey, they think in soundbites and then I think we have a real difficulty as a profession in saying "this is my thinking, this is what I believe, this is my opinion", you know, it doesn't make you rigid or narrow or whatever it means you have the ability to communicate with lay people." CP6 "I am an older, very well educated, comfortably off, painfully middle class, privately educated white male, who has all the benefits that come with being a privately educated white male, which largely comes down to confidence because, you know we think we rule the fucking world because actually people who look very much like me do tend to be in positions of power. So it's a probably a lot less anxiety provoking for me to be able to say "Excuse me! Can we, can we talk about something else here?" than it is for a lot of other people that I'm very, very, very aware of that and I suppose it comes back to that idea of well, you know as someone who in societal terms is ridiculously empowered. It's, I think it's, it's vital that I, I try to find ways to, to say "What am I doing with this power? And in what possible way, um, you know? I don't deserve this, how can I, how can I try to use the luck I have to shine the spotlight on all sorts of different things?" I'm probably not explaining that very well. But I'm I'm lucky because it doesn't, you know from, from the age of 5 or 6, you know I was sort of being encouraged to go into rooms and, you know overcome my fears and, you know talk about these things so yeah it, it maybe comes a bit more naturally to me so I'm very, very aware that, you know to cut along version of this short, you know what I'm saying is, you know my privileged background is very, very, very helpful here." CP4
	The ability/responsibility to use power and privilege	"having the kind of voice that, you know knows how to make itself heard… having the confidence to, to be a bit of a pain in the arse, you know within maybe, you know training particularly or within team meetings and say "hey what, what about what about this?" CP4

Theme components	Initial codes	Participant quotes
	Personal power/privilege Professional power	“I have multi minority status myself I can get away, I can get away with saying a lot, um, I think some of the things I say in lectures and on my and in my kind of writing other people wouldn’t be able to get away with, um, if they were white for example of if they were church of England, but because I’m a minority you get so much more liberty which is a real shame, actually, um, but if that’s the way it is well, you know, I’ll use that liberty to say what I think is right and true but it it’s still a shame.” CP6 “there is credibility that comes with our titles, and our education. But using that to actually make something better for all of us” CP6
Media engagement	Informing the public	“I think the role of clinical psychology in explaining and communicating to members of the public through the media is quite important … I think clinical psychology can inform the public about the 'sort of root cause analysis, the factors involved in these um episodes and quite often they’re not as obvious as they look. and again that’s a good thing for context to be considered in. The, the first you know, impression of causal factors is not always the most accurate one so psychology can go in and say well, you know "We've looked at this and, and um these are the um explanations to consider and to use the Occam razor the most likely one is this". so we can inform the reading public and listening public and the watching public about good empirical scientific practice and also not to just take at face value what looks the obvious answer there might be other explanations to consider” CP5
	Psychological reflection on events	“if some big incident has happened well where is the psychology reflection on this? Well where’s your, you know don’t just write an academic paper on this? What’s your view? What do the public not know about to know if psychology should be in the middle of all this? And so I think there is a movement towards that I just, I just get the feeling as a profession were a bit slow. We need to be a bit more out there. Um, a bit braver.” CP2 “I think there’s a role for us to respond to you know, big events and try and communicate them more effectively to the people who are reading about them. Things like major gun crime” CP5
	Challenging/educating	“I think there’s a role for psychology in actually talking about immigration, and integration, and fear, and what fear does, because fear breaks down societies it, it erodes communities, and it makes us tribal, and we stick with who and what we know because they will keep us safe and, you know, this is all textbook and, you know, the, the other is dangerous but a lot of people don’t think like that outside of psychology and we need to be shouting this from the rooftops.” CP6
	Blogs and writing	“I blog, um about social inequality um, I write a bit as well” CP6
	Social media Networks, collaboration and coalitions Coproduction and increasing equality Increase engagement, out of therapy room Reduce power differentials Inspiration and support	“it's an incredibly powerful, easy place to make some of the connections that you, you know, I suppose what we were doing in that project I was describing was trying to create networks and trying to build networks and weave connections and trust and those sort of things, so you've got more horizontal sorts of um relationships so that you can build things together rather than kind of hierarchies and all the rest of it. And I think something like social media means that you can, you can do that in quite a, quite an amazing sort of a way I mean where it, where it will go, who knows.” CP7 “it's people who are kind of having conversations, trying to understand each other’s point of view, looking for ways in which they can collaborate and support each other, that's, that's where things will grow and where there's more potential for equality” CP7 “that's the other thing I really like the, the social media stuff for because you can see out there in social media that people are beginning to sort of get together and form these sort of coalitions, challenging stuff together rather than just being, struggling away on their own on something.” CP7 “social media being very, very useful because if were prepared to go out there and engage, then we are putting ourselves straight away in a different context we, we are talking ourselves out of the, the traditional clinical psychology context if you like or the traditional therapeutic context or, you know, the traditional team context, and were putting ourselves out there” CP4 “I love it because it’s so democratic and, you know, I chat to people who use services, and who provide them, and people who do both and the power differential really kind of diminishes um and you can relate in a very human way and sometimes with the best will in the

Theme components	Initial codes	Participant quotes
		world it's hard to relate in a human way when you come is a Dr X clinical psychologist even though you don't use the word doctor, you know what I mean? it's so hard sometimes um, so I think social media is kind of the brave new world actually and it's a, it's a real shame more of us don't embrace it, because it can be an absolute joy." CP6 "having got more involved with Twitter and sort of a lot of psychologists on there kind of speaking out which, um I think it's been a really important part of my development as a psychologist and helping me think not as individualistically about intervention or formulation or whatever, um, yeah, um and quite I guess inspiring kind of gave you ideas about not you what you could be doing" CP1 "also having colleagues and friends who think in similar ways is really useful um and interestingly, I, I never kind of found people like that during training actually but I found those people via Twitter so I feel like my kind of psychology tribe the people who I, I identify with and who I think have similar values and ethics to me and who actually practice them rather than having them academically are people I've found via social media and that's been um terrific because that 'gives you a kind of that gives you an identity as well" CP6
Political/policy engagement	Introducing David Smail's into community, voluntary, statutory organisations and government	"if you think about that idea of sort of comfort, clarity, encouragement we can be doing that with vol orgs, we can be doing that with community organisations, we can be doing it with other statutory organisations, we can be doing it at a wider governmental level, we can be doing it, you know ,we can be engaging with politicians and saying "Absolutely, you know I completely understand the pressures you are under and why, you know you are in this bind. Let's look at, you know, let's look at that, lets look at what other things might be going on, let's look at how we might be able to work together." so always, always, always, you know understanding, comfort and understanding, why people are in a certain context themselves, clarity around how that context has come about and encouragement to do what they might want to do to change things." CP4
Community and preventative work	Community psychology Preventative work	"community psychology and um, and I think that's in I think that's, that's really incredible you has been incredible you're sort of and I feel that's sort of really proper psychology somebody is kind of out there really kind of helping people within their circumstances." CP2 "We need to get out of our offices and out of our ivory towers and go and do preventative work. It's not good enough to know, what we know from public health and epidemiology and to just sit around waiting for people to come into our doors traumatised 20 years later. So we know what impact abuse and neglect and violence have and we know um, which parts of the country for example; have particular problems um, so we should be doing, you know, we should be doing perinatal we work, should be doing kind of work with kids um looking at kind of sexual violence and how to keep themselves safe, we should be helping people avoid, you know, domestic violence, we should be working much more closely, um, with the children of people who have drug and alcohol problems, you know, early on in life it's not good enough for the kid to become the carer and to become stressed age 14, you know, that's, that's a bloody disgrace it, it's, it's, ur it is neglectful on our part to that child um, so we know the causes of distress in many ways and we know them both through data and through common sense, you know, but I think we've often lost, lost the value of common sense um, so, no we, we shouldn't be waiting for someone, um to walk in through our door age 30 when actually if you look at their, at their kind of life story the signs were there 20 years earlier. It has to be much more preventative" CP6 "Also prevention and I think that's where the policy stuff and all the stuff that like Jamie Hacker-Hughes is doing, you know, he's, well I don't know if he is meeting with the secretary of state, but he's, he's trying to influence things I think at a um governmental level and, you know, and I know other people, the big cheeses, are. So doing that kind of work and highlighting the impact of lots of different contextual issues in relation to mental health, doing that so that it gets on an agenda that way and so that it can feed into a preventative agenda, public health agenda um and I think I, I can see a role for psychologists at all levels" CP7 "outside of the NHS for one thing so it's, so it's sort of, more, there's more freedom attached to it um so it's kind of more, it feels like it, you know, you can be more creative around it everything without um the, the powers that be kind of not going along with it." CP7

Theme components	Initial codes	Participant quotes
	Social enterprises	
Barriers and risks	Confidence/power	"I think I'm feeling a bit stuck about the what next and the kind of actually how to, yeah, what to do because it's a lot of the people who you hear about are the kind of more powerful senior psychologists. Not all but it's kind of how do you with my little kind of newly qualified voice actually contribute to that? And I think Twitter is a good place because it's, it's easier to be more confident behind a computer keyboard" CP1
	Using anxiety to innovate, risks but benefits of debate	"we are a new discipline, still, in the general scheme of things we've not really existed for all that long we've certainly not existed in the way that we look now for very long at all. Um we have, I think been a little bit frightened about our role in the NHS and continue to be so and I think we worry terribly about, you know, what will happen to clinical psychology posts? But if we can move forward in acceptance of that and in acceptance of, well actually yeah, you know we, we, we are expensive professionals and, you know we have to be realistic about this. But if we can say "Where, where else might we be able to bring value for money?" I think that's actually really exciting I think that, you know, we're coming right up against that fear of, you know ultimately lets, lets just call that fear "oh god I could get sacked!", um or "oh god, you know my post could disappear!" fine, you know, ok if, if, if we allow, if we allow ourselves to be in touch with that and say "Yeah we need to take these risks", but think, think how powerful a social clinical psychology could be, think how powerful it would be to, to have our voices heard, to have these debates, you know to, to be driving these debates, and to be involved in these debates, and have all, and by have our voices heard I mean; all the different kind of voices that ultimately say "yes that this is about people and this is about what we understand about what drives peoples distress." and to do that while using all our research skills and to be getting involved in bigger and bigger research projects and to be able to say "well how can how can we get involved with, you know wider public health things? How can we work nationally, internationally to do this? " that's really fucking exciting and to me that was kind of what I wanted to be doing or at least slightly involved with and, you know if, if even on the most minor, minor level during my career I'm involved with something that starts to look a little bit like clinical psychology going down that direction, I'll feel really, really happy about it. Um, so again perhaps one of the other things that, that we have to do is, is to recognise that desire that we've got to make things right and to, to do things in a certain way in, you know and say, "You know evidence based practice isn't just about looking at the evidence base we've got and looking working within it." it's about saying, "You know, yeah we we've got some great evidence but god there's so much more we could be doing, you know let's get out there, lets engage, let's do this research, lets work with other people and find ways forward" CP4
	Risks of consequences Powerful messages Trouble maker Being struck off Bringing the profession into disrepute Uncertainty Being marginalised	"a worry about, um kind of being seen as a trouble maker by employers or by whoever, I know I remember it was really on in my, um in my training course in first year we were told that a psychologist had to be registered with the HCPC you weren't allowed to be that political, and that really stuck in my mind, like, really? is that, what if were not what are, what are we what are we doing every, um, even by not being political you are being political, um in a way, and I just that, so I, I get, I get and I know that's not all training courses and it wasn't that every member of staff that worked on my course was, that that was a really powerful message that you felt that actually you were going to get struck off by the HCPC if you were political and um to a kind of, um already anxious terrified first year that has clearly stuck if I remember it four years later. Um, so um, yeah I think that for me was a really big barrier kind of, and well that's not anything we should be doing at all um, and whereas I think im slightly wiser now to know that that's a load of rubbish but, um but those messages can be really powerful when it's, when you, when it's maybe sort of senior psychologists, and ones that are training you, and um, so I think I have a feeling like it's a legitimate role of a psychologist, um whether that's from training courses, BPS, whatever, your employer, but I think yeah, kind of yeah, this is something you should be doing or at least if you want to do it, it's not something were going to tell you off for doing." CP1 "I think people do get a bit anxious about boundaries um, and um, and because we're HCP registered which I think people it makes people more nervous than if the BPS had been, you know because there's an organisation outside of our own professional organisation that I think were a bit more unfamiliar with so I think people maybe are a bit more concerned about being reported or something or doing something wrong so I think that's sort of that, that probably, you know would be hinders people a little bit. Um, what you can do in a private capacity and what when that becomes public." CP2 "the fear of getting into trouble, the fear of overstepping the mark, the fear of putting ourselves out there, and being slapped down and yet,

Theme components	Initial codes	Participant quotes
		you know, well what's, what's that fear about? you know what, what, what, what am I, what am I trying avoid there? You, you know I'm trying to avoid the discomfort that might go with doing something that I, I actually quite want to do, so well ok, you know, that's, that's for me to to, to, to work with and, and, you know in whatever way I, I can and, you know, I think certainly, I know, I know what I would say to myself in a therapeutic context about, you know well, "Where do your fundamental values lie? how might you do this?" CP4 "I think if you are a clinician who takes into account context in an active way then I think you're sort of tolerated, or not tolerated, um, you know, you, again there's a risk involved I think. You run the risk of sort of being marginalised or being kind of um identified as being in a certain camp or being too political or this or that so, so it's like you're, in terms of having a voice and having a kind of um being included and stuff like that I think that there are, there are risks I think for clinicians. And you've kind of got to make that personal choice it's about, about whether you want to take that risk and, you know, you might make choices and at certain times it's, you know, the costs are, you know, they might be significant but they're worth it and there might be other points in your life or your career or the day when it doesn't feel worth it at all" CP7 "one of the trainees said "I had a blog when I began training and I was told by the course to take it down" and I was enraged I said "well, if even our training bodies oppress us and limit our voices you know, it's no surprise as a profession we are often voiceless" CP6 "because we also have these overriding things that we must not bring our profession into disrepute haven't we (…) you know you mustn't behave in public in any way whatsoever that would bring the profession into disrepute and that would include getting drunk, that would include if you, I think there have been cases of somebody having a road accident when drunk and they've been, not struck off but they've like have been reprimanded professionally and you think what's that got to do with anybody actually that's got nothing to do with, it's maybe not a very nice thing to do to be drunk driving and very dangerous but it's got nothing to do with your psychology and you think are any other professionals brought under those kind of rules, you know so it's that kind if feeling still, I think psychologists are a little bit nervous about that. probably not all psychologist but in think some psychologists that might hinder um, that yeah being much more involved in that context really yeah." CP2 "I absolutely appreciate the, the barriers that might exist, you know where people might say, you know "I don't have the time" or yes but I'm scared of what might happen if I become politically active. I am anxious about what might happen if I am seen by someone somewhere to be crossing a line in terms of, of, of political engagement, but I'm also confident that I would have the skills to, to deal with that appropriately as it came up and also that, you know I am fairly sure that I know where those lines are" CP4 "I think there is a role for us but, I don't know, I'm not sure I would want to take on that role with the government particularly um. But definitely, you know, we can promote. I think wherever we go and whatever we do we can promote it um on a very personal level and just do what we can to reach out to the people that are within our, our reach I think." CP8
Working with immediate context/teams	Accessibility of working with direct service context/ influencing psychological thinking Promoting formulation and joint working Benefits Inform care/treatment/intervention/staff understanding	"I think that some people are more able to put themselves out there and engage with the government and promote things that way um and I think that's really valuable but I don't think I could do, I don't think I could do that. I don't think that's for me, I think that for me, I feel that the best I can do is to work within the context that I already work in a way and to help people at that level" CP8 "there's always something psychologists can do. So where, you know if you can't do direct therapy then work with the care coordinator or work with someone's nurse about, about, to offer psychologically informed care" CP3 "on a much smaller level in teams maybe feeling like, not all of the time because, not wanting to alienate colleagues… but, maybe it is kind of acknowledging some contextual factors for a patient in an MDT meeting or something like that just to kind of actually, this is important. Um, so I guess, yeah, I guess it's not sitting on what were maybe thinking but actually saying it out loud in whatever way and, in whatever place that is" CP1 "I think working in the context of a medical model is really exhaust, is quite exhausting at times and I think that in itself is um, feels like enough somehow to do but I think that wherever I go if I have contact with external services like, you know, a residential home or like a, I don't know, a day centre or whatever, wherever I might go I think that because of where I'm coming from I would hope that I would be communicating in that way wherever I, and trying to encourage people to think more broadly um because it's just part of, such an integral part of what I do, I can't see that I wouldn't do it wherever I went." CP8

Theme components	Initial codes	Participant quotes
		"when we have CPAs or case conferences and (…) when we have ward rounds um I'm continually trying to remind people of the background to what's going on, the context, the setting, the all of these things which might impact on how the person's presenting. So I mean it's, it's really 5 days a week urm that these issues are um present. And they, they can lead to disagreement." CP5 "I try to link in with colleagues like occupational therapy as much as I can, um if I'm working in a care home for example um I will try and do some work with the staff team if I can or make recommendations um to then be thinking you know, more systemically" CP6 "the community mental health team might feel stuck with somebody and not sure how to move them on and when they bring the case and we talk about it we can see that part of the reason they're stuck is because they're stuck in another aspect of their life. So they're stuck with us in a way and we can't move them forward within mental health services because within the context of their lives they're stuck in some way. So, an example might be say somebody who is 40, 50 years of age and still living with mum and dad um quite dependent on mum and dad and quite dependent on services and that kind of stuckness around separating from services is reflected their stuckness of, you know, not being able to separate from their family of origin. Um so I think, so it does come up but I'm not sure that social work or the community mental health team would bring it with that in mind but it might be by us having the conversation with them we would bring it up and bring it into their mind, if that makes sense? Um so I'm not sure that we're approached necessarily directly about context but I think in the process of their conversations that we have it will always come up in some way, shape or form." CP8 "give an opinion really about that about, what I felt they needed or to enlist the OT as well to help with that Um and a lot of that is about looking about how someone has coped before coming into hospital and if, where they were before was disastrous for them then we can't put them back there is my opinion and that isn't always an opinion that's shared but and I suppose that's part of the formulation more often thinking about what was it about that place that they were living before? and, um how can we ensure that they don't go back to somewhere that's going to be difficult in the same way for them?" 3 "saying, what is the context in which, in which this person's coping um, and if they haven't got support, and so that might alert other members of the team to thinking well were aware about the lack of support instead of perhaps being impatient with somebody isn't following a particular treatment regime or something um, um, so I think that sharing of information can be incredibly important about that context" CP2 "that prevents teams feeling, this phrase is something used that, I'm not comfortable with it they might say this patient is playing people off against each other and I think I'm not sure that happens actually I don't like that idea of manipulation. I think sometimes patients just tell that person what they want them to hear or what they feel they need to know and it might be slightly different from something they tell another member of that team. it's about communication" CP2 "they're [formulations] challenged, its difficult to get them heard, um, it's difficult to get them to move away from the medical model and that's nursing staff and other disciplines as well, to consider that, this, this is this could be a symptom but it might be something else. you know, so I, I don't want to just sort of throw confusion in the mix but I just want people to consider alternative hypotheses as opposed to oh this must be a symptom therefore we must titrate the chemicals more powerfully and we must limit the leave and we must do all these other intervention, you know, so I just want people to consider the options before they do something which is compromising the person's quality of life and sometimes threatening their lives with chemicals" CP5
		"they [teams] appreciate that wider context and not just what's in front of them um, um, they, they in fact they've often said they see it as a kind of story that they would like reading that letter because they see as like a story, you know it's kind of, of someone's, of what's going on with someone" CP2 "people are hungry for any psychological formulation to be absolutely honest" CP3 "mostly other agencies they're keen to hear from us and what we think um and quite often they're surprised that were going the extra 10 yards to share an opinion or formulation." CP5
	Valued by other professionals	"I have had some very hotly contested formulations urm where I think the context has been missed and the decision made have been wrong and they have sent people's progress back and made my work more difficult." CP5

Theme components	Initial codes	Participant quotes
	Challenges/ Strategies	"I suppose my kind of attempt to change my colleagues thinking is you know, about sort of sharing that formulation but I often wonder if I, I often wonder how much they really take on board you know, do they just think oh actually that just the, the, the you know the way the psychologist thinks" CP6 "I just sort of remember a bit of an eye roll about kind of, you know, this kind of liberal psychologist not, not living in the real world. That, that was my perception of the eye roll (...) , I think what I was talking about, was kind of talking about the bigger issues and feeling like that's not always heard by teams or not welcomed." CP1 "it's difficult sharing those types of things with staff because a lot of the time those contextual factors feel outside of their control" CP3 "often my opinion that someone need supported accommodation doesn't go down very well, because for example with that person they could go back to live with their mum and then the bed would be freed up but my formulation for that person that I have created, in a collaborative way with them, focuses a lot on those external stressors really and on what her situation means to her at the moment." CP3 "I think confidentiality certainly with teams is a little bit more of an issue (…) psychologists are naturally a bit tentative abut that kind of thing um, what does someone need to know um, so I think the con, the confidentiality makes me more cautious about a team" CP2 "I'm a scientist practitioner so I try to um provide evidence for my formulation um and I try to use metaphor and very clear straight forward language to explain what I'm saying. um and I, I think that's probably different from some of our team members who get locked into a particular model and who you know try to show people by using you know big flash words and who kind of become so focused on aspects of a person that they're not, not looking at the rest of the context. So simple, clear communication uh the broken record technique you know uh repeating a, a message in a slightly different format. um and, and a few people pick me up on those things well yes I'm saying the same thing because I don't get the feeling of being heard I'm saying it again because I want it to be heard, my take on how this individual is in this current circumstance." CP5 "sometimes it can be as simples as saying "Ok so the psychiatric formulation of this person is that, they have a longstanding psychotic condition and they are currently unable to look after themselves because of this condition and um we don't really have much choice. because we think, you know for their own safety and possibly the safety of other people they, they really need to be, to be on a on some kind of compulsory treatment or whatever." Um and coming in sometimes and unpicking that a little bit and saying "Yeah oh ok absolutely I, I take on board the risk and, you know these are very, very valid concerns." but when we're talking about this, this longstanding psychosis um what, what began with that? And what, what, what are this person's fears? And what is it about their, you know? What, what do we know about their upbringing that might point to why they might be unable to keep themselves safe or why they might be responding quite badly to being told by um a very powerful team of people? Well we've decided this is what you're going to do and um, you know these are the medications you're going to take, you know are we, are we wondering what it is in, you know their very ,very formative experiences that might make them respond quite badly to a figure in authority saying; do this". So, you know that, that kind of work with teams I have found incredibly valuable and incredibly rewarding, and my experiences have always, always been that teams are really, really willing to listen to this if we, you know, but again, a, a, as long as we don't diminish what they're saying, you know and were also saying "Yes absolutely though, you know particularly in terms of where, where the consultant psychiatrists are concerned; you're the dude who's carrying the risk here. You're the, you're the professional who is ultimately responsible for this person's care. And, how do we work with you on this?" as opposed to coming in and saying "Yeah look at me with my psychology with my, with my biopsychosocial formulation." You know these, these are, these are smart, these are smart highly educated professionals and I think, you know we, we, were not the only people thinking like this and that that's something I'm keenly aware of." CP4 "I think we could probably do a bit more of again working, working in teams, you know it comes back to the team formulation idea but, sort of saying "Look are we are we addressing this person's life in a holistic way?" or "Are we hoping that all these discrete things will suddenly magically gel?" and, you know "They're, they're, they're gonna have this wonderful, wonderful moment of insight". so um so yeah I think I think, you know examples like that, you know coming back to, to working with teams and saying "Ok, you know here's a diagnosis but, you know where, where does that fit into to, to the social environment? You know what, what, what else could we, could we, maybe, could we be looking at?" CP4 "work with teams I have found incredibly valuable and incredibly rewarding, and my experiences have always, always been that teams are

Theme components	Initial codes	Participant quotes
		really, really willing to listen to this if we, you know, but again, a, a, as long as we don't diminish what they're saying, you know and were also saying "Yes absolutely though, you know particularly in terms of where, where the consultant psychiatrists are concerned; you're the dude who's carrying the risk here. You're the, you're the professional who is ultimately responsible for this person's care. And, how do we work with you on this?" as opposed to coming in and saying "Yeah look at me with my psychology with my, with my biopsychosocial formulation." You know these, these are, these are smart, these are smart highly educated professionals and I think, you know we, we, were not the only people thinking like this and that that's something I'm keenly aware of." CP4 "we might have then talked about politics a bit or, or, the impact of political um, context on them, um, but, I guess I've been conscious of not, not pushing it as my agenda on either teams" CP1

Section Three: Critical Appraisal

Reflections on: The importance of addressing the impact of contextual difficulties on mental health

Heather Spankie
Trainee Clinical Psychologist

Doctorate in Clinical Psychology
Division of Health Research, Lancaster University

Word Count: 4000

All correspondence should be sent to:

Heather Spankie
Doctorate in Clinical Psychology
Furness College
Lancaster University
Lancaster, Lancashire
LA1 4YG
Email: h.spankie@lancaster.ac.uk

This paper provides a reflective discussion of limitations and recommendations from the doctoral research project “Clinical psychologists’ experiences of exploring and addressing ‘context’ in formulation and intervention”. This qualitative exploration of UK clinical psychologists’ experiences, using semi-structured interviews to collect data for a thematic analysis, produced four themes: 1): The need to justify working with context; 2): The need to work with context beyond the therapy room; 3): “My context is their context”: Influences on the ability to work with context; and 4): Sources of validation for working with context. These themes captured participants’ belief in the importance of understanding and intervening with their clients’ contextual difficulties and their experiences of attempting to work in line with these beliefs within a dominant medical model. As well as accounts of successfully working with context, participants also described barriers, such as lacking skills and knowledge, facing criticism and professional risk and working with limited resources in opposition to an individualistic biomedical focus.

The empirical paper is accompanied by a systematic literature review exploring an example of contextual difficulty: “The experience of stigma for intravenous drug users of heroin: A metasynthesis”, providing insights into the difficulties faced by drug users who experience stigma. Considering the subject of stigma provides an example of a contextual difficulty which is part of the wider context of the society within which an individual is located. The harmful impact of belonging to a stigmatised group is substantial, yet considerations of contextual difficulties at this level may be absent from practice among clinical psychologists (Division of Clinical Psychology [DCP], 2011).

A limitation and difficulty apparent while conducting both projects has been the limited availability of literature to draw on, with empirical research particularly lacking. Although significant bodies of work exist supporting the impact of context on mental health and other outcomes, such as Wilkinson and Pickett (2012) and the WHO (2009) report

“Mental health, resilience and inequalities”, more direct empirical investigations were lacking. It was particularly difficult to find a topic related to context with enough evidence to conduct a literature review, highlighting the extent that research associated with a focus on context over individual pathology is absent. Where research was available this was primarily quantitative and had already been the subject of reviews (e.g. a review of unemployment and suicide by Milner, Page & Lamontagne, 2014), often focusing on physical and mental health outcomes. As context is such a vast topic with a wide ranging impact, it was also difficult to find a contextual difficulty which had been researched among a relatively homogeneous group in enough depth to make a review feasible. Research was also lacking in regard to explorations of clinical practice, whether in terms of outcomes or practitioner experiences.

Awareness of this issue has heightened my motivation to provide empirical findings to contribute to an evidence base regarding both the importance of addressing contextual difficulties and the role of clinical psychology. I believe being able to draw on evidence provides an important source of validation and justification for working with context. The importance of this is supported by participants’ descriptions of a lack of knowledge as a barrier and the need to justify working with context. I believe this thesis provides a starting point for further research by highlighting the perceived need for and desire to work with context and preliminary suggestions of good practice and barriers.

My experience led me to consider why research is lacking. Through considering this, various issues arose which have parallels to some of the difficulties suggested to limit working with context, including the dominance of medical perspectives (e.g. Boyle, 2014). This parallel could suggest that research reflects what is done in practice, i.e. a traditional focus on the individual, and/or that practice is influenced by the individual focus within research. I will discuss potential barriers to addressing context, considering further suggestions for future research and implications for clinical psychology training.

The Wider Socio-political Context

The lack of focus on context in both psychological research and practice may represent beliefs in society about the causes of difficulties, with a focus on individual responsibility over an acknowledgement of contextual influences. It has been suggested that in societies where wealth is unequally distributed, such as the UK (Wilkinson & Pickett, 2012), the greater difference between income groups leads those in power to ‘other’ lower income groups which can increase the likelihood that people are blamed for their position, ignoring contextual causes (Orford, 2014). It may be that people in higher income groups find it more comfortable to see society as fair, where people’s circumstances reflect what they deserve, rather than facing potentially uncomfortable truths about the unfairness and harm that exists (Lerner, 1980). Another societal influence in Western cultures is the dominance of capitalism and neoliberal ideology (a focus on free trade, privatisation, deregulation and globalisation) which also sees individuals as entities disconnected from context (Bauman, 2008). It is suggested that society is viewed as serving the economy, a purpose to be pursued regardless of the social, material and emotional impact, and those who disrupt or do not contribute productively are viewed as needing to be managed or repaired (East Midlands Critical and Community Psychology Group, 2014).

The role of mental health services in social control has been suggested (e.g. Vassilev & Pilgrim, 2007) with coercive control, such as involuntary detention, particularly criticised (e.g. Szasz, 2007). Elements of control are also involved within ‘voluntary’ relationships, where services are sought but doing so is influenced by messages in society (De Swaan, 1990). Improving Access to Psychological Therapies (IAPT) is an example of mental health services being driven by efforts to modify behaviour to address employability that the public access voluntarily. The Midlands Psychology Group (2007) have criticised such programmes as encouraging a de-contextualised and individualised view of distress with associated individual blame. In addition, the cultural belief that individuals have the ability and control to overcome problems has been highlighted within mental health (Epstein, 2010).

If contextual difficulties, including relative poverty, were to be addressed this would in effect require a restructuring of society and redistribution of both wealth and power. This may not seem feasible but also may not be acknowledged or supported as Orford (2014) suggests there is less support for policies which could address inequality and redistribute wealth and more support for policies which further concentrate wealth. The likelihood of policy makers to admit the damage of their policy, such as austerity in the UK, and further to then remedy it, can be questioned. If it is to be presumed motivation to do this is lacking, then it can also be considered that research that could identify any such damage and/or suggest alternatives will not receive support to be conducted or be well received.

These socio-political influences focusing on individual responsibility and placing the source, and remedy, of problems within individuals is compatible with a medical model of mental health. These influences may not only be relevant to those with power to influence the direction of research and service policy but also to clinical psychology. As a profession considered to be populated primarily by privileged groups it is possible that holding this position in society may influence beliefs. Further research exploring the use of context could assess the existence of presumptions regarding individual responsibility, possibly evidenced through an allegiance with the medical model. Such allegiance may be suggested through subtle attitudes and practice, such as individual therapy and the pathologisation of individuals being prioritised over exploring and addressing context.

Research and the Medical Model

Lacking an audience, politically and socially, for a focus on contextual issues over individual responsibility may have implications for the support, funding and publication of associated research. A further issue faced by such research is that it is less amenable to producing the type of evidence currently favoured, that is, evidence aligned with the medical model. The medical model dominates as diagnosis is a firmly established, common narrative throughout the NHS, government departments e.g. welfare (Gill, Mullin & Simpson, 2013) and guidelines and outcome measures such as Payment by Results (Todd & Weatherhead, 2013) and IAPT (Stiles, Barkham, Twigg, Mellor-Clark & Cooper, 2006). Its dominance in research stems from the application to mental health of methodologies originally designed to investigate physical health and medical interventions. This has seen randomised control trials established in evidence hierarchies as the "gold standard", appropriate for pharmacological studies but criticised within mental health. Criticisms include being unrepresentative of the realities of clinical practice and the variety and complexity of clients compared to research participants (Barkham, Clarke, Harris, Hobson & Richardson, 2007; Chan & Altman, 2005; Rolf, Cutcliffe & Ellis, 2005; Stratton, 2007).

The medical model's dominance may be maintained through associated benefits of pursuing such research. Publication in medical journals may be sought as they can be considered "higher impact" and the use of diagnoses may fit more easily to statistical grouping and generalisation (Gill et al., 2013). The priority afforded to IAPT could increase pressure to conform to the use of IAPT outcome measures to pilot interventions and to align with manualisation (Wood, 2010).

Alternative research, such as qualitative studies, could be viewed as having limited value by individuals who influence what research is commissioned, supported and disseminated. Difficulties go beyond negative perceptions of qualitative research as using a weaker and 'less scientific' methodology, further down the hierarchy, but also a lack of understanding among commissioners about what it is and how it can be used (Morse, 2006). Qualitative research may struggle to fit a "sound bite" society (Morse, 2006) with findings requiring more laboured explanations than the more direct provision of figures. Quantifiable outcomes from manualised therapies could be considered more easily in terms of units of a specified treatment to be commissioned for a specified disorder, perpetuating a focus on individual therapy at the expense of contextual factors in both research and practice.

More subtle examples of the dominance of medical thinking have been suggested within efforts to draw focus onto context. Examples include the concept of ‘empowerment’, often mentioned by participants in the empirical paper, which has been critiqued along with similar concepts such as will power (Smail, 2001a). Criticisms include the risk of translating such concepts “into a language of individualistic psychology” (Harper, 2014, p.27) such as exploring a ‘sense of’ empowerment rather than ‘real’ empowerment which enables people to take action. The concern is that this distracts from contextual causes of difficulty and limits on power and returns to the pathologisation and treatment of individuals. As summarised by Harper; “we need to remain vigilant that we don’t just put new wine into old bottles and continue to think about things in individualistic and intrapsychic ways” (p.27). This suggests the need to take account of potentially varied underlying assumptions of concepts such as empowerment. As with context as a whole, a range of definitions may exist with varied degrees of allegiance to medical thinking. Research which appears to explore context may be limited by applying concepts back to individuals and away from addressing contextual difficulties. Therefore, future research efforts should consider this and aim to provide definitions.

Alternative Research

Although not specified by participants in the empirical paper as part of wider action they desired, the promotion of alternative research, and challenges to the dominant paradigm, is a form of “speaking out” about context and making efforts to influence policy. Successful examples include the Association for Family Therapy effectively lobbying to include family therapy in National Institute for Health and Clinical Excellence (NICE) guidelines (Stratton, 2007). The British Psychological Society (BPS) has been engaging in NICE consultations, with the majority of their recommendations accepted, and encourage members to use consultation to input psychological evidence in policy making (BPS, 2011; 2013a, 2013b).

It would be useful to explore varied forms of research regarding both context and clinical practice in future. In addition to qualitative research in general existing as an alternative to the focus on quantitative methodology within the medical model, other suggestions have been made to advance alternatives. For example, quantitative data can be employed without the use of diagnosis, such as the suggested use of formulation and statistical grouping of experience (for a discussion see Gill et al., 2013). A shift from a unidirectional model, where research evidence informs practice, to a bidirectional model, where practice also informs research, has also been promoted (Teachman et al., 2012). Practice Based Evidence involves measuring and recording practice to produce “outcome data gathered in routine clinical settings” (Todd & Weatherhead, 2013, p.195) and the development of Practice Research Networks (PRNs) has been suggested to capture and develop such evidence. PRNs involve groups of clinicians working together researching service delivery issues (Zarin, Pincus, West & McIntyre, 1997) and provide “the infrastructure to enable discrete services (…) to collaborate on audit and evaluation ventures [which] yields potentially large data bases” (Thomas, Stephenson & Loewenthal, 2007, p.3).

I am reminded of the system for gathering social policy research in my pre-training employment with Citizens Advice Bureau. By working closely with the public, issues of concern, such as zero hours contracts or pay day loans, could be reported and logged centrally. These issues could then be addressed with research and associated reports and campaigning. I have wondered if a similar system would be applicable to reporting contextual difficulties faced by clients of mental health services. This could not only highlight areas of concern and suggestions for research but potentially yield evidence. Additional benefits of the social policy research system were clear to me as providing a sense of validation for the difficulties faced and the injustice of them. Additionally, it appeared to help counter feelings of helplessness and powerlessness, for both clients and professionals. Such feelings have been suggested to draw psychologists away from focusing on context as such difficulties can seem unchangeable in comparison to individual therapy and create a source of distress (Boyle, 2014). Participants in the empirical paper did explain the importance of support and working with others to make change and a network to report contextual issues could also help provide this. This could include input from varied professions and service users themselves who could all benefit from the experience of comfort, clarification and encouragement (Smail, 2001b) that could be afforded by such a platform.

The Need for Collaboration

It is possible concerns regarding blurred roles with other professions and disciplines, such as sociology (Boyle, 2014), that apply to clinical practice may also hamper research involving context. As participants emphasised, they needed allies to help develop ideas and spread awareness of the importance of context, possible intervention and prevention efforts. As varied professionals work with contextual difficulties, both working and researching collaboratively seems essential. Developments towards collaborative research include the BPS membership of the Alliance for Useful Evidence and Savoy Partnership, supporting collaborative working to invest in research (BPS, 2013b).

Collaborative working may be hindered by a lack of awareness of other professions/disciplines and how to engage with collaborative working or also by competition.

This could involve direct competition for research funding or more generally competition to claim understanding of a topic. This has been noted within clinical psychology with literature exploring the history of the profession (e.g. Pilgrim & Treacher, 1992) describing various efforts to seek legitimacy. Although the development of psychological explanations was partly in response to biological reductionism, the pursuit of psychological factors alone would equally be psychologically reductionist. It is worth reflecting that "psychology has no monopoly on knowledge about human experience" (Pilgrim, 2010, p.11) and varied professionals, and service users, provide valuable perspectives and knowledge.

Reflecting on my experiences of pursuing a research project which I feel has crossed boundaries from clinical psychology to other disciplines suggests a further barrier to collaborative research. Awareness of the relevance of other fields and my limited knowledge of them has felt intimidating and exposing at times, stepping outside of relative comfort and competence regarding clinical psychology. I can appreciate that this discomfort and uncertainty has made making connections with other subjects feel somewhat risky, aware of the limits of my knowledge and the potential to be under scrutiny. I have considered whether researchers may experience similar feelings as a barrier to exploring relevance to other fields/professions. This appears similar to the avoidance of working with context due to relative confidence and competence in individual intervention (Boyle, 2014). I have been able to appreciate that it is not possible to have expert knowledge on all areas of clinical psychology, let alone other disciplines, and reflect on the benefits of disseminating research to as varied an audience as possible and being open to discussion, including criticism, from wider fields. Different ideologies may interact, or even clash, but being open to debate seems beneficial and helpful towards collaborative efforts. Drawing on theories of social causation and social reaction may help illuminate potential differences underlying attempts to work with context which may be more or less aligned with diagnosis. Following social causation theory, social influences may be considered in terms of the aetiology of diagnosis. Alternatively, with social reaction theory, consideration may be given to how mental illness is socially constructed and the role that stereotypes and labelling play within this.

Reflections on Clinical Psychology Training

By developing an awareness of the relevance of fields beyond clinical psychology, including sociology, community psychology, critical psychology, disability studies etc., I have reflected on the need to include such topics in clinical psychology training. I am aware of some variability in this regard as some courses provide a community psychology module, for example. I have also considered what I have learnt through my pre-training experience as an advice worker and advocate, seeing first-hand the impact of varied contextual difficulties, wondering how aware I would be without this experience and whether there is a space for outlining common contextual difficulties of service users in training, or perhaps if it is expected that awareness naturally develops through clinical experience. Although training in how to support benefits applications may be more contentious, basic knowledge of the benefits system, and other systems service users commonly interact with, seems appropriate to provide. Other pertinent examples include understanding the impact of zero hours contracts and job instability or the importance of understanding benefits entitlements to counter the assumptions of generosity, ease of entitlement and benefit fraud that, unfortunately, I have encountered from various professionals. I also wonder if certain realities, such as the poor quality of housing, is acknowledged or whether certain presumptions of basic standards within a wealthy, developed country are maintained. This could relate to the potential distance of psychologists as a privileged group from these realities and perhaps the discomfort from acknowledging them.

I believe that it is important to promote critical discussion. However, I can also see the need to seek a balance between engaging with critical thinking without rejecting ideas entirely. For example, I appreciate the need to be critical of the dominance of the medical model but not to the extent that the relevance of medical perspectives is ignored; to remember that 'bio' is an important part of the biopsychosocial model. I have felt at times that criticism of the medical model can edge on becoming too rigid and rejecting. Even leading critics of the use of diagnosis, such as Lucy Johnstone, accept the need to compromise: "It is impossible to work as a critical psychologist on, for example, an in-patient ward and not collude to some extent; if you object to every use of psychiatric labelling, your role will be impossible" (Johnstone, 2011, p.102). An inclusion of structured exploration and debate of critical ideas throughout training could help promote balanced considerations.

I have similarly encountered an apparent rejection of CBT and even individual intervention in general. Although I again value the critical engagement with intervention, such as the issue of pathologising individuals at the expense of addressing contextual difficulty and the need for preventative efforts, I do not reject the benefits of intervention for individuals. During discussions about the empirical paper I have been aware of the potential to appear that, by promoting context, I am rejecting the role of biology and/or medication and individual therapy. I have reflected on the potential consequences of this as generating objections and arguments for the importance of these interventions and the need to acknowledge biology which may distract from the important message regarding context. However, providing prolonged clarification and caveats could also distract from this message and certainly seems distant from achieving anything suitable for "sound bites". Social media was highlighted by participants as a useful tool to both collaborate and raise awareness which further highlights the need to provide succinct, impactful messages. I expect that the many requirements of clinical psychology training may mean there is limited time available and create a need to highlight critical ideas while struggling to account for balanced discussion.

Reflexivity

As part of the empirical paper, I explained in a reflexivity statement that influence of my pre-training experience working closely with contextual difficulties. I have acknowledged the influence of my beliefs throughout the research process and made additional efforts to ensure reflective practice was followed as it emerged that participants shared these beliefs. They agreed with broad definitions of context, of the importance of including context in formulations and of the need to intervene, both with individual service users and via taking wider action. I made use of supervision and revisited coding and theme development, making efforts to consider alternative interpretations to help ensure this apparent agreement was not biased. I also maintained an awareness that I am developing ideas and opinions regarding how I wish to work with context and ensured that my interview questions remained relevant to the research aims and did not stray towards satisfying my personal interest.

Reflexive analysis was also required due to my emotive reactions. This included distress regarding the difficult circumstances of service users described and frustration at the barriers experienced to working with context. I also experienced anxiety, triggered by considering the uncertainty and challenges that I may face in future clinical practice. As it became apparent that there was a shared passion regarding the subject between myself and participants, I also made efforts to remain impartial and not influence interviews with emotive responses. I focused on attempting to display active listening as I would in other circumstances. It is likely that participants volunteered to take part in the study because of an interest in context, therefore demonstrating similar views may not be unexpected. However, their awareness of the aims of the research may have influenced their responses, as social desirability could have been a factor (Hewitt, 2007).

Being aware of the potential influence of my motivation to work with context from the beginning, I was prepared to acknowledge the desire to achieve research findings to support this. I was prepared for the possibility of finding evidence that clinical psychologists did not value or work with context. In this case, I would have still valued this evidence as important to understanding why recommendations were not translating to practice. I have considered that this could have been more difficult if there was not the overarching agreement with my beliefs from such guidance to justify the research.

Conclusion

This appraisal has been useful to reflect on some of the challenges of conducting this research. Pursuing a project which both spans disciplines outside of my training and has a limited evidence base to draw from has been personally challenging. However, I have appreciated having the opportunity to pursue a topic about which I feel passionately, also acknowledging that this increases the importance of reflexive analysis. I appreciate that training courses differ in their focus and that an exploration of context may be variably supported. It has also helped me to consider where this research fits within the wider literature and societal context and conclude that, although further research into both context and clinical practice is required, this may be difficult to pursue. Collaboration may both generate support for research and help findings reach wider audiences.

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Section Four: Ethics Section

Heather Spankie
Trainee Clinical Psychologist

Doctorate in Clinical Psychology
Division of Health Research, Lancaster University

Word Count: 4400

All correspondence should be sent to:

Heather Spankie
Doctorate in Clinical Psychology
Furness College
Lancaster University
Lancaster, Lancashire
LA1 4YG
Email: h.spankie@lancaster.ac.uk

University Research Ethics Committee Application Form

Faculty of Health and Medicine Research Ethics Committee (FHMREC)

Lancaster University

Application for Ethical Approval for Research

Instructions

1. Apply to the committee by submitting
   - ✓ The University's Stage 1 Self-Assessment Form (standard form or student form) ***and*** the Project Information & Ethics questionnaire. These are available on the Research Support Office website: LU Ethics
   - ✓ The completed FHMREC application form
   - ✓ Your full research proposal (background, literature review, methodology/methods, ethical considerations)
   - ✓ All accompanying research materials such as, but not limited to,
     1) Advertising materials (posters, e-mails)
     2) Letters of invitation to participate
     3) Participant information sheets
     4) Consent forms
     5) Questionnaires, surveys, demographic sheets
     6) Interview schedules, interview question guides, focus group scripts
     7) Debriefing sheets, resource lists
2. Submit all the materials electronically as a **SINGLE** email attachment in PDF format. Instructions for creating such a document are available on the FHMREC website (http://www.lancs.ac.uk/shm/research/ethics/).
3. Submit one collated and signed paper copy of the full application materials. If the applicant is a student, the paper copy of the application form must be signed by the Academic Supervisor.
4. Committee meeting dates and application submission dates are listed on the research ethics committee website http://www.lancs.ac.uk/shm/research/ethics. Applications must be submitted by the deadline stated on the website, to:

   Diane Hopkins
   Faculty of Health & Medicine
   B03, Furness College
   Lancaster University, LA1 4YG
   d.hopkins@lancaster.ac.uk

5. Attend the committee meeting on the day that the application is considered.

1. Title of Project:
Clinical psychologists' experiences of exploring and addressing 'context' in formulation and intervention.

2. If this is a student project, please indicate what type of project by ticking the relevant box:

☐ PG Diploma ☐ Masters dissertation ☐ MRes ☐ MSc ☐ DClinPsy SRP

☐ PhD Thesis ☐ PhD Pall. Care/Pub. Hlth/Org. Hlth & Well Being ☐ MD ☐ **DClinPsy Thesis**

☐ Special Study Module (3rd year medical student)

3. Type of study

☐ **Involves direct involvement by human subjects**

☐ Involves existing documents/data only. Contact the Chair of FHMREC before continuing.

Applicant information

4. Name of applicant/researcher:

Heather Spankie

5. Appointment/position held by applicant and Division within FHM

Trainee Clinical Psychologist

6. Contact information for applicant:

E-mail: h.spankie@lancaster.ac.uk Telephone: 07896326044

Address: Division of Health Research, Faculty of Health & Medicine, Furness College, Lancaster University, Lancaster, LA1 4YG

7. Project supervisor(s), if different from applicant:

Name(s): Pete Greasley, Jane Simpson

E-mail(s): p.greasley@lancaster.ac.uk, j.simpson2@lancaster.ac.uk

8. Appointment held by supervisor(s) and institution(s) where based (if applicable):

Teaching Fellow, Lancaster University Clinical Psychology Training

Research Director

Lancaster University Clinical Psychology Training

9. Names and appointments of all members of the research team (including degree where applicable)

Pete Greasley, PhD

Jane Simpson, DClinPsy

The Project

NOTE: In addition to completing this form you must submit a detailed research protocol and all supporting materials.

10. Summary of research protocol in lay terms (maximum length 150 words).

It has been recommended that clinical psychologists routinely include an exploration of the context of clients' lives in clinical practice. This is in acknowledgment of the important role context has to play towards clients' wellbeing. However there is no clear definition of context, suggesting practice may vary. Investigating how context is understood and used in practice can involve both formulation (a hypothesis using psychological theory to provide a framework for understanding problems) and intervention. Potential barriers to exploring context exist including the potential influence of the dominant medical model e.g. conceptualising difficulties at the level of the individual can be opposed to considering the influence of contextual problems outside of the individual. This research aims to explore understandings of context and adherence to guidance, potentially identifying barriers and examples of good practice. Data will be collected via qualitative interviews with clinical psychologists in the UK and analysed using thematic analysis.

11. Anticipated project dates

Start date: Sept 2015 End date: June 2016

12. Please describe the sample of participants to be studied (including number, age, gender):

The aim is to recruit between 10 to 15 participants, with a minimum of 4 participants.

Inclusion criteria:

qualified clinical psychologists

practicing within the last 12 months in the UK

13. How will participants be recruited and from where? Be as specific as possible.

Participants will be recruited via an advertisement on the British psychological Society's website, Facebook and Twitter accounts and via an advertisement in the BPS The Psychologist magazine. The advertisement will include a brief description of the study with contact details for potential participants to find out more information and/or agree to take part. Depending on the format of the social media platform, a poster advertising the study will accompany the advert. An advert will also be distributed via other available social media platforms e.g. Lancaster University accounts. The adverts will be available for distribution on social media from these sources. These adverts will be in no way affiliated with the researcher's personal social media accounts or personal email.

Efforts will be made to interview everyone who is interested in participating as much as is possible within the constraints of the study including time restraints due to the time required to interview, transcribe, and analyse the data. If there are more potential participants than can be interviewed within these constraints then participants will be included in the order that they expressed a willingness to participate in the study.

14. What procedure is proposed for obtaining consent?

The participant information sheet will be emailed to all participants who volunteer to take part in the study or request further information. Participants will have a minimum of 24 hours between receiving this information and taking part in the study. For face to face interviews, when arriving, a consent form will be presented by the researcher, read through by the participant, discussed as necessary, and signed before beginning interviews. If interviewing by telephone or Skype the consent form will be emailed prior to the interview according to participant preference and discussed before beginning the interview. A paper copy of the consent form will be sent to participants with a stamped addressed envelope for the participant to return a signed copy to the researcher.

15. What discomfort (including psychological), inconvenience or danger could be caused by participation in the project? Please indicate plans to address these potential risks.

It is not anticipated that distress will be caused by the interview. However, the participant information sheet and consent form will outline the option to stop the interview at any time. Participant distress/discomfort will be monitored by the researcher throughout and breaks and/or termination of interview offered if felt necessary.

Participants will be de-briefed after interviews and reminded of the purpose of the study and their right to withdraw will be reiterated.

Participants are informed they can withdraw without giving a reason and that every effort will be made to withdraw their data up to the point of publication. They are advised it may be difficult to withdraw after data has been anonymised and analysed.

The participant information and debrief sheets provide contacts that may be helpful if distress is experienced.

16. What potential risks may exist for the researcher(s)? Please indicate plans to address such risks (for example, details of a lone worker plan).

As clinical psychologists are being interviewed, anticipated risks are low. However, the Lancaster Care NHS Trust lone working policy will be followed including that ongoing risk assessments are conducted and a colleague is aware of when the researcher is conducting interviews.

http://www.lancaster.ac.uk/shm/study/doctoral_study/dclinpsy/new/onlinehandbook/appendices/lcft_lone_working_policy.pdf

Contact between the researcher and participants will be via university email address and research mobile phone, not personal email or phone. Personal accounts will not be used as part of the recruitment/advertisement strategy on social media.

17. Whilst we do not generally expect direct benefits to participants as a result of this research, please state here any that result from completion of the study.

There are no direct benefits but participants may find it a positive experience to share their experiences and feel they are making a contribution to research.

18. Details of any incentives/payments (including out-of-pocket expenses) made to participants:

If interviewed at Lancaster University travel expenses will be reimbursed.

19. Briefly describe your data collection and analysis methods, and the rationale for their use

Potential participants can make contact by phone or email. The researcher will confirm that the participant is eligible by checking that they are a qualified clinical psychologist and have practiced within the last 12 months.

Once agreeing to take part, a convenient time and place for the interview will be arranged with the participant. They are invited to be interviewed face to face at Lancaster University or an alternative venue can be discussed. Alternatives will be discussed with participants based in the North West who may be within an accessible travel distance. If they request to be interviewed at their place of work it will be discussed that they will need to seek agreement from their line manager. If a face to face interview is not possible then telephone or Skype interviews will be arranged. The participant information sheet states that Skype cannot be guaranteed to be completely secure and participants will be reminded of this before commencing the interview. The researcher will contact the participant.

Data will be collected through semi-structured interviews. The sample interview schedule will be used as a guide only, and will have open questions and prompts to allow flexibility in questioning so that the interview can develop to facilitate discussion and themes which arise as significant to the participant.

The interviews will be digitally recorded and then transcribed by the researcher.

Thematic Analysis will be used to analyse the transcripts due to the usefulness of its flexibility in being a broadly applicable qualitative method with the ability to extract a rich data set.

Interviews will be confidential with the exception of disclosure of potential risk to the participant or others. If there is such a disclosure, the participant will be informed of the need to break confidentiality if possible. The researcher will then report to research and/or field supervisors.

Data will be anonymised with the use of pseudonyms.

20. Describe the involvement of users/service users in the design and conduct of your research. If you have not involved users/service users in developing your research protocol, please indicate this and provide a brief rationale/explanation.

Service users have not been consulted as participants will solely be clinical psychologists interviewed about their profession and not any topics relating to the use of services, expertise through experience etc.

21. What plan is in place for the storage of data (electronic, digital, paper, etc.)? Please ensure that your plans comply with the Data Protection Act 1998.

The researcher will be responsible for the storage of electronic and hard copies of data and documents throughout the study.

Participant contact details will be stored in an encrypted file on a password protected computer. These details will be deleted by the researcher after the thesis is assessed unless the participant requests to be contacted with a summary of the research).

Paper copies, e.g. of consent forms, will be kept securely in a locked drawer or filing cabinet, accessible to the researcher only, scanned as soon as possible, and then the originals destroyed by the researcher.

Transcripts and scanned documents will be stored as encrypted files on the secure university server in password protected files. If necessary, documents may be stored on a password protected computer in encrypted files.

On completion of the study, electronic copies of the anonymised transcripts and scanned documents will be encrypted then kept by Lancaster University according to the Data Protection Act (1998). The electronic documents will be stored for 10 years. Encrypted documents will be transferred securely by the researcher to the Research Coordinator who will arrange for their secure storage on the university server. The DclinPsy admin team will be responsible for the long term storage of data and deletion once the 10 year period has ended.

22. Will audio or video recording take place? ☐ no ☐**audio** ☐video

If yes, what arrangements have been made for audio/video data storage? At what point in the research will tapes/digital recordings/files be destroyed?

The researcher will be responsible for the storage, transcription, and deletion of recordings.

Audio recordings will be stored with passwords and encrypted. If the device cannot be encrypted the data will be transferred to a password protected computer as soon as possible and then deleted from the recorder. The recorder will be stored securely until the transfer of data is possible.

Recordings will be deleted once the thesis is assessed.

23. What are the plans for dissemination of findings from the research?

The findings will be reported in a thesis project as part of the Lancaster University DClinPsy programme.

Results of the research may be submitted for publication in an academic/professional journal.

Participants will be sent a brief summary of the results and the findings may be submitted to conferences/seminars etc. if relevant.

24. What particular ethical problems, not previously noted on this application, do you think there are in the proposed study? Are there any matters about which you wish to seek advice from the FHMREC?

Participants may disclose details about the conduct of themselves or other professionals. If this is considered a potential risk to clients this will be considered a risk issue. This issue is described in the participant information sheet as a potential exception to confidentiality. If this issue arose, the participant would be informed of the concern, if possible, and the research and/or field supervisors consulted.

If participants mention the names of other staff or other individuals in general this will be anonymised in transcripts.

In the participant information sheet, participants are reminded of the need to maintain the confidentiality of their clients. This reminder may be needed as they will be discussing supervision which may touch on their work with individual clients.

Signatures: Applicant: ……………………..……………………......................................

Date: ………………………………………………...

Project Supervisor* (if applicable): …………………………………..................

Date: ………………………………………………...

*I have reviewed this application, and discussed it with the applicant. I confirm that the project methodology is appropriate. I am happy for this application to proceed to ethical review.

Research Protocol

Clinical psychologists' experiences of exploring and addressing 'context' in formulation and intervention

Chief Investigator: Heather Spankie (Trainee Clinical Psychologist, Lancaster University)

Academic Supervisor: Dr Pete Greasley (Lancaster University)

Field Supervisor: Dr Jane Simpson (Lancaster University)

Introduction

It has been demonstrated that the wider context of people's lives can be significant to wellbeing and mental ill health and, accordingly, the BPS (British Psychological Society) Division of Clinical Psychology (DCP) (2010 & 2011), World Health Organisation (WHO) (2009) and Health and Care Professions Council (HCPC) (2012) have called for this 'context' to be addressed. Aspects of people's lives considered as context are wide ranging. The DCP (2010) make it a requirement of clinical psychology training that "societal and cultural factors" are acknowledged. The HCPC (2012) further call for social understanding informed by "community, critical and social constructivist perspectives" (p. 27), bringing a consideration of social inequality and power. They also discuss "sociological and circumstantial or life-event-related factors" (p. 26).

However, although there is agreement on the importance of addressing context, a clear definition is absent. This suggests that clinical psychologists and other mental health professionals could hold varied definitions of 'context' which could impact on the understanding and application of guidelines to clinical practice. For example, conceptualisations of context could be limited to an individual's immediate family and other professionals or services involved, whereas broader definitions could account for wider socioeconomic difficulties such as poor housing or social isolation. The DCP (2011) highlight that the even broader contexts of community, social inequality and human rights have been largely absent from practice. For example, there is well documented evidence of the impact of poverty on mental health but also evidence that, beyond this, relative poverty is detrimental (Wilkinson & Pickett, 2011).

There is a crucial role for context in both formulation and intervention. The DCP (2010) define formulation as "the summation and integration of the knowledge that is acquired… that may involve psychological, biological and systemic factors and procedures… draw on psychological theory and research to provide a framework for describing a client's problems or needs, how it developed and is being maintained" and in the (2011) guidance on the use of formulation stress the importance of such information. It is recommended that even if not included in a formulation shared with clients for the purposes of therapy, such information should always be held in mind. Including context in formulations not only provides valuable understanding of difficulties such as poverty and their contribution to mental health, in addition, potential challenges to engagement with therapy can be explored which could include the overwhelming demands of a situation or practical issues such as transportation to appointments.

With regard to intervention, there is also a role for psychologists to work towards resolving contextual problems. This role is well established in approaches such as community psychology which strives to understand the relationships between individuals, communities and wider society and seeks to act at the community rather than individual level to enhance quality of life (Dalton, Elias & Wandersman, 2001). This approach is underpinned by values of social justice, empowerment and inclusion. Similarly, critical psychology endeavours to address such difficulties through action towards social justice, targeting social change rather than seeing the individual as needing to adjust to difficult circumstances (Fox, Prilleltensky & Austin, 2009).

The social model of disability also offers a perspective acknowledging the importance of context. This view focuses on problems as located in social, economic, cultural and environmental barriers that create difficulty for a person, rather than the person themselves (Oliver, 2004). An “impairment” is considered as a feature of the individual’s mind or body but a “disability” exists as a disadvantage caused by society (Thomas, Gradwell & Markham, 1997). Clinical psychologists are likely to work with clients with a range of impairments but, as suggested, the extent that context and therefore also disability are considered could vary considerably.

Although these approaches are focused on systemic interventions, there are also options for intervention available for psychologists to address contextual difficulty in individual therapy. Drawing on attachment theory, Seager (2013) posits that the therapeutic alliance is an attachment relationship through which the expression of warmth and caring is in itself therapeutic. In this way, an exploration of an individual’s context could be used to convey genuine interest and caring which could form part of an intervention at the stage of formulation or throughout therapy. Seager further describes the act of giving practical help with contextual problems as an important expression of care and therefore a valid part of an intervention. This could also be required initially if contextual difficulties were preventing engagement with further therapy.

Other ways that contextual difficulties could be addressed in intervention include equipping people with the skills to problem-solve and self-advocate and to engender empowerment, potentially working alongside them to access services. Lewis, Ratts, Palandino and Toporek (2011) emphasise the skills and knowledge that both counsellors and psychologists have to facilitate change in a client’s environment which can be part of an intervention or part of wider social change; either with or on behalf of clients. They consider barriers to a client self-advocating which can contrast with the “institution power” held by professionals to effect change. Advocating for clients is also supported by the HCPC.

Despite the evidence available and guidelines produced, the extent to which clinical psychologists follow such guidance in practice has been questioned, with the influence of an individualising approach potentially excluding contextual thinking from practice. Simpson and Thomas (2014) describe a tradition of analysing the individual and an associated preference for individual therapy as the solution. The BPS have highlighted concerns that such thinking locates problems within the individual at the expense of considering “undeniable social causation” (DCP, 2011). They suggest that ethnic, cultural, and social factors, such as unemployment, poverty, class and power imbalances are often overlooked or downplayed.

Potential avoidance of context is explored by Boyle (2014) who describe avoidance as being demonstrated by either a focus on intra-psychic attributes over context or an acknowledgement of context which falls short by portraying adverse contexts as a consequence of mental illness and not a cause. For example, although stress vulnerability models include contextual difficulties, these are understood as only having adverse impacts when combined with a predisposition located back within the individual. Boyle suggests potential contributions to this avoidance which include concerns that an exploration of context is “unscientific” and outside of the remit of psychology which may risk an “identity crisis” for the profession. Another suggestion is that feelings of helplessness are being avoided as people may feel powerless to change contextual problems in contrast to feeling able and confident in providing individual therapy. The need to gain acceptance from psychiatry is also explored with an adherence to the medical model demonstrated by downplaying context in favour of internal pathology. The power of the medical model in itself may also be relevant as psychologists work within systems where legislation and funding is dominated by discourses of diagnosis and an individualising approach. Approaches such as community and critical psychology and the social model of disability offer an alternative viewpoint, rejecting locating problems, and therefore the target of intervention, within the individual.

It is possible a psychologist's theoretical orientation and position regarding these boundaries could impact on concerns held and barriers against addressing contextual problems. It has been argued that such intervention could be considered as harmful if it is seen as a boundary crossing or as constituting "saving" a person (Lewis et al., 2011), particularly if "dependency" is a concern. It could be felt that providing help with contextual difficulty is counterproductive to the aims of therapy by deskilling and reducing confidence and independence, instead increasing a need to rely on others for solutions and help. However, addressing concerns about "saving" clients, Lewis et al. (2011) argue that it is not saving but facilitating a client in "gaining more skill and power". The decision to explore, and act on, contextual issues could be informed by concerns and beliefs held. In this way, decisions about addressing context could present ethical and professional dilemmas.

A practical barrier to addressing wider contextual issues is the service context including available time, resources and service requirements such as targets. This may influence the focus of therapy towards delivering an evidence based intervention driven toward outcomes that may not account for efforts towards changing context. The available time to explore and address contextual problems may be limited and seem to fall outside of the intervention. Also, the service itself may vary in the extent information on sources of remedy for contextual problems is available and in the arrangements and ease of referral to other services.

In summary, although professional recommendations and literature support the exploration of context, the potential for psychologists to follow an individualising approach combined with beliefs and concerns about addressing context and service constraints may impact on the up take of such guidance in clinical practice. Research is needed to explore what is understood by context, in light of the absence of clear definitions, and how this is addressed in practice compared to guidelines, exploring what barriers may exist.

Research Aim and Objectives

The research aims to investigate what clinical psychologists understand by ‘context’ and how this is explored and approached in practice. This will gain an insight into whether the BPS and HCPC guidance is acknowledged in formulation and therapeutic intervention, additionally exploring successes and potential barriers to this approach.

Method

Participants

Participants will be qualified clinical psychologists who have practiced within the last 12 months.

An advertisement for the study (Appendix 1) will be circulated with different versions adapted to different medium. Advertising on social media will initially include the BPS Facebook and Twitter accounts. In addition, an advertisement will be hosted by Lancaster University for online distribution, including social media. An advertisement will also be placed in the BPS *The Psychologist* magazine. A poster advertising the study will also be made available (Appendix 2).

Eligibility criteria for participation requires qualified clinical psychologists who must have practiced within the last 12 months.

The study aims to recruit between 10 to 15 clinical psychologists. This is based on small sample sizes being ideal in qualitative research due to allowing rich depth of analysis of data (Maclean et al., 2010).

Design The proposed study follows a qualitative design using semi-structured interviews to collect data. The interview schedule will have open questions and prompts to allow flexibility in questioning so that the interview can develop to facilitate discussion and themes which arise as significant to the participant. Questions will explore understandings of context and how this relates to practice within formulation and intervention (see Appendix 3 for more details). Audit trails will be recorded to evidence decisions made and the emergence of themes from data, including assumptions informing the analysis. On-going reflexive analysis throughout data collection and analysis will monitor and consider the influence of the researcher.

Procedure The BPS will display information about the study and contact details on their Facebook and Twitter accounts and in an advert in *The Psychologist* magazine. The same information will be hosted online by Lancaster University. These adverts will be in no way affiliated with the researcher's personal social media accounts or personal email. The information will request any potential participants to make contact by phone or email for more information and/or to agree to take part. If agreeing to take part, a location and time of the interview convenient for the participant will be arranged. This could be face to face at Lancaster University or an alternative location. If face to face interviews are not possible, telephone or Skype interviews will be conducted. The participant information sheet (Appendix 4) will be emailed to potential participants once agreeing to take part or if they request further information. This will include a statement making people aware that it cannot be guaranteed that Skype connections will be completely secure. Information will be made available a minimum of 24 hours before taking part.

At the time of meeting for the interview, confidentiality and consent will be explained and a consent form provided to sign (Appendix 5). The format of the interview will be explained including the possibility to stop or take a break at any time if needed. This information is also included in the participant information sheet which will be referred to and discussed if needed before starting the interview.

Interviews will last approximately one hour with a degree of flexibility depending on the needs of each participant. A sample interview schedule (Appendix 3) will be used flexibly to guide the interview while allowing participants to discuss topics which are meaningful to them. A Dictaphone will be used to record the interview and transcribed as soon as possible after the interview. The transcription will be verbatim and anonymised. The recording will be deleted upon completion of the study. The transcription will be saved as an encrypted file stored on a password protected computer.

A debrief sheet (Appendix 6) will be provided at the end of the interview providing contact details for enquiries or requests to withdraw data and contacts in the case of any distress being experienced. If conducting telephone interviews the debrief will be emailed prior to the interview and then referred to.

Analysis Thematic Analysis will be used to analyse the data due to the usefulness of its flexibility in being a broadly applicable qualitative method and ability to extract a rich data set. The six phase guide of Braun and Clarke (2006) will be primarily used to guide the analysis. The research supervisor will be involved in corroborating emerging themes from the analysis using anonymised data.

Practical Issues The costs of printing, photocopying and postage will be met by Lancaster University. Travel and telephone expenses will also be met by the university. Interviews will be offered at Lancaster University or at a place convenient to the participant. If this is at a place of work this will not be on NHS premises as NHS ethical approval has not been sought. If participants are interviewed at Lancaster University travel expenses would be reimbursed.

Participant contact details will be stored in an encrypted file on a password protected computer. These details will be deleted by the researcher as soon as possible after the research project has been assessed. Paper copies, e.g. of consent forms, will be kept securely in a locked drawer or filing cabinet, scanned as soon as possible, and then the originals destroyed by the researcher. Transcripts and scanned documents will be stored electronically as encrypted files on the secure university server protected by passwords. If necessary, documents may be stored on a password protected computer in encrypted files.

On completion of the study, electronic copies of the anonymised transcripts and scanned documents will be encrypted then kept by Lancaster University according to the Data Protection Act (1998). The electronic documents will be stored for 10 years.

Audio recordings will be stored with passwords and encrypted. If the device cannot be encrypted the data will be transferred to a password protected computer as soon as possible and then deleted from the recorder. The recorder will be stored securely until the transfer of data is possible. Recordings will be deleted as soon as possible once the research project is assessed.

Ethical Issues

The study is unlikely to touch on sensitive issues for participants and is unlikely to cause distress. However, participants will be monitored throughout interviews for signs of distress. If they do appear to be distressed, the researcher will ask if a break is required. Before commencing the interview the participant information sheet will be reviewed including what to do if participants become distressed. Contact details for Mind and Samaritans will be provided. It is also suggested participants could contact their GP if distressed. The consent from will also explain participants may break to stop the interview at any time or withdraw at any time. The debrief sheet will be provided to take away which will reiterate this information and contact details.

The consent form will also cover the limits of confidentiality explained in the participant information sheet. Confidentiality may need to be broken if there is a risk of harm to themselves or others, including a risk to clients through malpractice. The participant information sheet also specifies that participants need to be aware of maintaining confidentiality if discussing their clients.

Participants will be de-briefed after interviews and reminded of the purpose of the study and their right to withdraw will be reiterated.

If there are any concerns and the potential need to break confidentiality, this will be discussed with the participant if possible. Both Field Supervisor and Research Supervisor can be approached to discuss any potential risk issues. Potential risk issues include general risk of harm to the participant themselves or others but also risk associated with any disclosures of professional conduct, of the participant or other staff, that indicates a potential risk to clients.

Timescale

June 2015 - Submit to ethics

October – December 2015 - Data collection. Draft method and introduction sections.

January – March 2016 – Analyse data. Draft abstract, results and discussion sections.

Complete draft by end of March.

April - May 2016 – Complete final version of research paper.

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Appendix 4-A

Correspondence Regarding Ethics Application Amendments

From: Hopkins, Diane
Sent: 13 July 2015 15:10
To: Spankie, Heather
Cc: Greasley, Pete; Simpson, Jane
Subject: FHM REC Review letter (ref: FHM REC141011 Heather Spankie)
Attachments: FHMREC14111 Heather Spankie Review Letter.pdf; Heather Spankie (FHMREC14111) vAFB comments.pdf

Dear Heather,

Please find attached the letter from the Chair of the FHMREC, Professor Roger Pickup, providing a review of your FHM Research Ethics Committee application.

In addition to this letter, I have attached your original application, in which some minor changes have been marked up (with ‘sticky notes’). Please address these as well as the issues raised in the letter in amending your application.

Please ensure that you re-submit the entire application document and all materials (including those which did not require any changes) as a single PDF with any changes highlighted. It is this document which will go forward to UREC for approval. You do not need to re-send a hard copy, nor resubmit your self-assessment.

Note that the documentation you submit must be the final version, with all participant materials complete in the format in which they will be used. Any changes at a later date must be submitted for review as part of an amendment application.

If you have any queries, please let me know.

Best wishes,

Diane

****

Dr Diane Hopkins
Research Support Officer
Room B14, Furness College
Tel: (01524) 592838
Research Support web page: Sharepoint

Ethical approval of research:
FHMREC deadline: 12 noon on Monday 24 August for the meeting on Thursday 10 September guidance and documentation: www.lancaster.ac.uk/shm/research/ethics/

Faculty of Health and Medicine Research Ethics Committee

Our ref: FHMREC14111

13 July 2015

Heather Spankie

Division of Health Research

Faculty of Health and Medicine

Lancaster University

Dear Heather,

Re: FHM Research Ethics Committee application for project titled: *‘Clinical psychologists' experiences of exploring and addressing 'context' in formulation and intervention’.*

Thank you for sending in the paperwork for your application. We appreciated reading about the project. We have a few minor concerns, and ask that you address the following in revising your application materials: • **General**

  - Please use the correct Faculty logo (included at the end of the email in which this letter was sent). • **Application section 10** o Define ‘formulation’.
  - Add details of your sample, the type of research you are conducting, and the type of data collection.

- **Application section 12** o State the minimum number of participants which will ensure your study is viable.
- **Application section 13** o Clarify that it is the page administrator who will be posting to the BPS page, and that this will not be linked to your personal Facebook page in any way.
  - Move information regarding data collection to section 19.

- **Application section 14** o Clarify that you will ensure the participants will have had a chance to read all the information prior to giving consent at the interview session, noting the timing between information being provided and consent being given.
- **Application section 19** o Make clear in this section that, since Skype interviews are not wholly secure, you will make this clear to participants, and will remind them of this at the start of the interview.
    - Clarify here that you will be carrying out the transcription.
- **Application section 21** o Data files should be stored on password-protected and encrypted server.

  Amend this section accordingly o We suggest that you wait until your project has been assessed before destroying any data files, and amend this section accordingly.
- **Application section 22** o We suggest that you wait until your project has been assessed before destroying the original recordings, and amend this section accordingly.
- **Application section 23** o Add that you will send a generalised anonymised summary of results to your participants.
    - Please note here if you intend to present your findings at any conferences.
- **Participant Information Sheet** o **Do I have to take part?** Note that not taking part will have no negative repercussions in relation to treatment
    - **Will my data be confidential?** Limits of confidentiality: amend '*speak to a member of staff about this'* to read '*speak to **my supervisors** about this.'*
    - **Confidentiality during interviews.** Reword this to make clear (and ensure) that it is you as the researcher who is taking responsibility for anonymising transcripts. It is not the participant's responsibility to 'edit' their input.
    - **What will I be asked to do if I take part?** Note also that Skype interviews are not wholly secure.
    - **Are there any risks?** Amend the suggestion to speak to the GP as a first port of call. We suggest instead the following statement: " *if distressed you may find it helpful to contact one of the support resources listed at the end of this information sheet."* Also add this to the debrief sheet.
- **Consent form** o Add an item noting that you will share and discuss data with your supervisor. o Clarify that you have given information at least 24 hours before coming for interview.

In addition to the above a number of minor changes and typos are noted on your application form, attached with this letter. Please address these, as well as the matters above.

Ensure consistency between the application form, the Research Protocol and the supporting materials in line with the changes requested above.

Please use Lancaster University letter-headed paper for all participant materials

We ask that you attend to these in writing by (re)submitting to the FHMREC via Diane Hopkins (d.hopkins@lancaster.ac.uk) the application document and materials with any changes highlighted. If your responses to the above are satisfactory then approval will be recommended on Chair's action. If you have questions, please feel free to contact me.

Yours sincerely,

R. W. Pickup

Prof Roger Pickup

Chair of the Faculty of Health and Medicine Research Ethics Committee

Lancaster University

Appendix 4-B

Correspondence Regarding Approval of Project

From: Hopkins, Diane
Sent: 24 August 2015 12:50
To: Spankie, Heather
Cc: Greasley, Pete; Simpson, Jane
Subject: ethics application

Dear Heather,

your application for ethical approval of your research project has now gone forward to the University's main Research Ethics Committee (UREC) with a recommendation that it is approved. Unless they have further questions, you will receive the approval letter in the next few weeks (subject to the availability of the Chair of UREC).

Please note that any changes to your project from this point on, including to your participant materials, must be submitted for review as part of an amendment application.

If you have any queries, please let me know.

Best wishes
Diane

****

Dr Diane Hopkins
Research Development Officer
Research Services
Room B14, Furness College
Tel: +44 (0) 1524 592838
FHM Research Support web page: Sharepoint

Ethical approval of research:
FHMREC deadline: 12 noon on Wednesday 23 September for the meeting on Thursday 8 October guidance and documentation: www.lancaster.ac.uk/shm/research/ethics/

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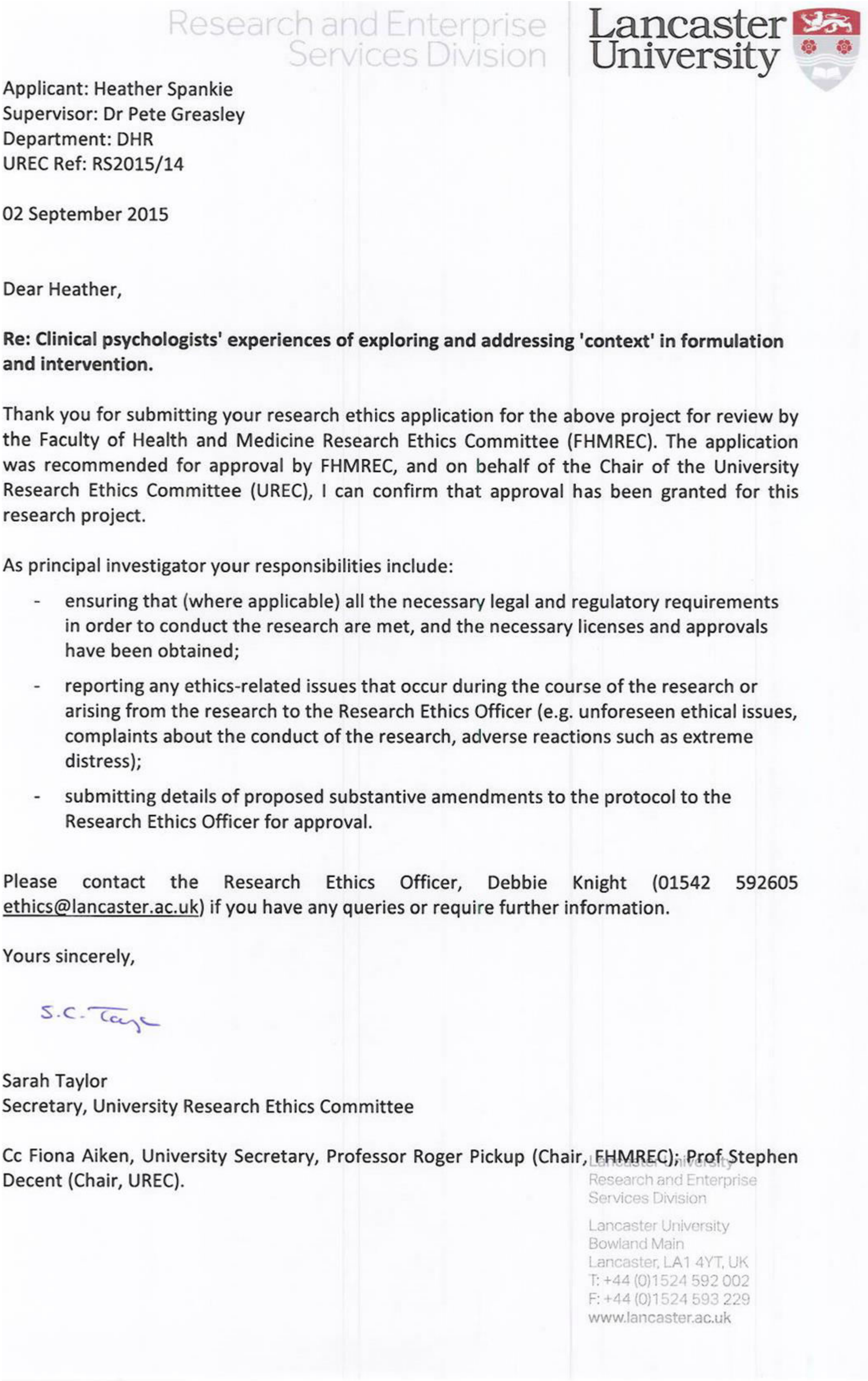

Research and Enterprise
Services Division
Lancaster University

Applicant: Heather Spankie
Supervisor: Dr Pete Greasley
Department: DHR
UREC Ref: RS2015/14

02 September 2015

Dear Heather,

Re: Clinical psychologists' experiences of exploring and addressing 'context' in formulation and intervention.

Thank you for submitting your research ethics application for the above project for review by the Faculty of Health and Medicine Research Ethics Committee (FHMREC). The application was recommended for approval by FHMREC, and on behalf of the Chair of the University Research Ethics Committee (UREC), I can confirm that approval has been granted for this research project.

As principal investigator your responsibilities include:

- ensuring that (where applicable) all the necessary legal and regulatory requirements in order to conduct the research are met, and the necessary licenses and approvals have been obtained;
- reporting any ethics-related issues that occur during the course of the research or arising from the research to the Research Ethics Officer (e.g. unforeseen ethical issues, complaints about the conduct of the research, adverse reactions such as extreme distress);
- submitting details of proposed substantive amendments to the protocol to the Research Ethics Officer for approval.

Please contact the Research Ethics Officer, Debbie Knight (01542 592605 ethics@lancaster.ac.uk) if you have any queries or require further information.

Yours sincerely,

S.C. Taylor

Sarah Taylor
Secretary, University Research Ethics Committee

Cc Fiona Aiken, University Secretary, Professor Roger Pickup (Chair, FHMREC); Prof Stephen Decent (Chair, UREC).

Lancaster University
Research and Enterprise
Services Division

Lancaster University
Bowland Main
Lancaster, LA1 4YT, UK
T: +44 (0)1524 592 002
F: +44 (0)1524 593 229
www.lancaster.ac.uk