

Running head: Staff understanding of young people's mental health difficulties

How do staff in an inpatient adolescent service talk about, and understand, young people's
mental health difficulties?

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This paper discusses how members of an adolescent inpatient multi-disciplinary team made sense of young people's mental health difficulties and the impact of diagnosis, through semi-structured interviews with six participants.

Introduction

As a framework for understanding mental health, use of the 'medical model', which focuses on treating disease symptoms and developing specific treatments (Clare, 1980), is increasingly facing criticism (Shah & Mountain, 2007). Lebowitz and Ahn (2014) explored the empathy of mental health professionals and found that across different diagnostic categories, the biological explanation yielded significantly less empathy than the psychosocial explanation. The latter may therefore result in symptoms being 'reframed' as understandable in the context of life events (Corrigan & Watson, 2004). Furthermore, increased recognition of psycho-social issues encountered by young people may aid staff's appreciation of the difficulties they face and improve staff empathy (Anderson & Standen, 2007).

Psychological formulations are a framework for making sense of a client's difficulties and understanding factors that led to, and maintain, mental distress (Kinderman, 2005), supporting communication and agreed objectives amongst team members (Kinderman, 2005). Deriving meaning from contextual awareness is essential for consistency in working and allows for tailored interventions for clients (Delaney, 2006). Accordingly, in response to the recent revision of the DSM and ICD diagnostic criteria, the British Psychological Society (2013) refer to psychiatric diagnoses having 'significant conceptual and empirical limitations' (p.1). Specifically, the BPS oppose 'the increasing medicalisation of distress and behaviour in both adults and children' and argue for a move away from a 'disease model' towards the conceptualisation of distress in the (interacting) context of psychological, social and biological factors.

Consequently, the ways in which professionals conceptualise and understand mental health difficulties has implications for the empathy shown to service users and the nature of their therapeutic relationships. As such, this study explored staff perceptions of diagnostic categories and implications for the ways in which they care for young people.

Method

Since the aim of this study was to gain an insight into how staff understand young people's mental health, semi-structured interviews were used. The study was advertised within the inpatient service and six female clinical staff¹ (three nursing, one medical, two therapy) were recruited.

Data collection

A topic guide was formulated with the co-authors, which included the following questions: 'Please tell me about some of the presenting difficulties the young people experience in the service you work in'; 'How do you understand the difficulties and needs of the young people you work with?'; 'What helps/informs your decision making regarding the care and treatment of the young people you work with?'

Data analysis

All recordings were transcribed and analysed using Thematic Analysis (Braun & Clarke, 2006). This approach was deemed suitable because, epistemologically, the aim was to gain views/thoughts of participants. The transcribed data was reviewed and codes were assigned to identify emergent themes within and across transcripts. To establish reliability, authors discussed the categorisation of themes until consensus was reached and participants were offered feedback regarding the themes identified and invited to share their views.

The lead author was mindful of her own epistemological position of viewing concepts as being socially constructed and therefore attempted to keep the analysis as transparent as

¹ Pseudonyms are used throughout this article

possible, whilst noting any possible preconceptions. Co-authors and participants checked the themes identified from the data to mitigate against any additional themes being missed.

Results

Five main themes were identified in the data:

Theme 1: Diagnoses as helpful entities

When asked about the presenting difficulties of the young people they work with, all participants provided a list of diagnostic categories. Participants perceived diagnoses as, “useful for sort of giving you...an initial idea of what’s going on” (Sarah), providing a ‘snapshot’ of a young person’s presentation. They were viewed as “a very, quick, short hand way of describing what we are talking about” (Lena). Diagnosis was viewed as a reference framework, providing an “indicator” (Mary) of a young person’s difficulty. Indeed, “some children and parents feel they want a diagnosis” as this may help in a wider, systemic “appreciation” of their presentation (Anna). Participants who acknowledged the usefulness of diagnosis also spoke of how they then used a formulation to understand the origin and impact on the young person (theme 3).

Diagnosis was seen as important in guiding intervention. Mary made reference to using “clinical knowledge... [and]...diagnostic reasoning in terms of what you do and how you treat someone.” Lena similarly reported that:

“Diagnosis...serves a purpose...linking that with the available evidence, say NICE guidelines... which tend to be disorder specific so it helps us from that point of view and in terms of communicating with other professionals.”

The necessity of diagnosis for allocation of appropriate resources was highlighted. “Diagnosis [has] an impact on funding for placements” (Caitlin) and without this, young people may not be able to access the support they require upon discharge. Specifically, Sophie said, “having a diagnosis will allow patients to access certain services or say, for example, when we go back to school, they might get enhanced support or their family might

get more support from social services.” Thus, many participants recognised that diagnosis may be required in “ensuring an adequate, needs based, care plan at the point of discharge” (Lena).

Theme 2: Diagnosis can label someone too strictly into a box

Participants expressed concern about behaviour being viewed as a ‘mental disorder’ in young people due to their developmental stage (Caitlin). They argued that young people were in a process of “growing and developing, finding their own personality” (Anna) and, as such, perceived the young people as having the capacity to “change” as they mature and develop (Mary), thus no longer meeting diagnostic criteria. Some participants specifically referred to the permanency of a diagnostic label and being “mindful really of the implications that labelling somebody will have on them for the rest of their lives” (Caitlin). As one participant stated: “the way that society portrays [mental health] is quite negative” (Anna). Another highlighted the contrasts in longevity of diagnosis in physical versus mental health: “it's not like just going to the doctors and having the flu...you shake that off after a while and it's forgotten about” (Caitlin).

Variation in the presentation of young people with the same diagnosis was acknowledged by most participants: “even though, you know, they've got the same diagnosis, they could present totally differently” (Sophie). Participants also considered complex cases, “you can't find in the diagnostic criteria a single disorder that might explain it...if you look at the diagnosis, it might not give you any idea of the complexity of the patient” (Lena).

Theme 3: Formulation: Building up a picture

All participants acknowledged the importance of ‘formulation’, reporting that “building up a picture” of a young person was an important aspect of their assessment and treatment (Caitlin). Inclusion of a young person’s “family background...their current home situation...how they're getting on at school [and] their physical health” (Sophie) was cited as being “helpful” information for a framework for understanding a young person, and “getting a story basically of what's happened” (Mary).

Participants reported that “gathering... information and sharing...information and thinking about the person from lots of different points of views” (Anna) enabled them to consider “more about the person, instead of just which box they have been popped into” (Mary). Additionally, Lena believed that without this ‘formulation’, “not just us, but with outside professionals, would struggle to understand just from a two word label, what actually is the level of difficulty”.

Participants felt that this formulaic understanding allowed the team to choose appropriate interventions:

“the treatment plan is then linked particularly with these factors... especially the maintaining factors” (Lena).

“Formulation is a way to come... up [with] different strategies and methods of moving forward, combining lots of different professionals ...helping that young person... get more back to the norm that they're used to” (Caitlin).

Sophie reported that not only did a formulation guide the team, but also alleviated the emotional impact of working with this client group: “how best to sort of manage [a young person]... it helps staff sort of make sense of, because it can be quite anxiety provoking for the staff”. Additionally, building a picture of a young person was considered useful in instances where the team were “struggling with a young person and how [they thought] about them” (Anna).

Theme 4: They’re just teenagers

Theme 4 refers to participants’ wish to ‘normalise’ some of the behaviours of young people by acknowledging their developmental stage. Anna acknowledged: “they’re teenagers and sometimes teenagers are teenagers and misbehave and are a bit mischievous and cheeky and it’s not necessarily a symptom of something else developing. It’s just being a teenager” which was echoed by other participants. Empathy and normalising seemed crucial to their therapeutic alliance (theme 5), as well as understanding the young person’s presentation (theme 3). For example, Mary stated:

We've all been young people haven't we ... as a teenager, we all go through ups and downs and you know, you can really empathise with people.

In acknowledging that the young people were teenagers, participants sought to avoid labelling their presentations as a 'mental disorder' (theme 2) and aimed to normalise their distress and behaviour. Participants acknowledged that they too may have experienced difficulties during adolescence, and as such, this aided in building a therapeutic alliance with the young person.

Theme 5: The therapeutic relationship is key

Participants recognised that the core of their work was the establishment of a therapeutic alliance, and to "get [to] know to the young people themselves" (Sarah). Some regarded the therapeutic relationship an intervention in itself: "a lot the time young people come in here and their trust in adults has been damaged and we've got to rebuild that" (Mary). Anna reported that an integral part of her role was to "provide structure and consistency because sometimes they haven't always had that in their lives".

The therapeutic alliance allowed participants to "find out about the individual" (Caitlin), to establish "what they enjoy and what works for them" (Sarah). Their work with young people was "very dependent on the individual" (Sarah). Participants recognised the importance of "listening to [the young person] and [ensuring] that their voice is sort of heard" (Sophie) in order to "understand what they want" (Lena).

All participants regarded the involvement of young people in their care as paramount and discussed how a therapeutic alliance afforded exploration of a young person's views. They aimed to adopt a "collaborative" (Mary) approach in which decisions were made with the young person. Specifically, this involved "finding out what they want, what their dreams are and making sure they're in meetings" (Sophie) and "ask[ing] the young person about their hopes" (Caitlin). Decision making was viewed as a joint venture between professionals and the young person: "if it was me, what, you know, what would I want, how would I want someone to help me or how would I want to be treated" (Sophie). All participants referred to

the young people as individuals, and recognised that an approach developed to suit all would not be appropriate or “person centred” (Caitlin).

Indeed, for most participants diagnosis did not impact significantly upon their daily work with the young person:

It's not disregarding mental health, but just putting it to one side for a little bit and taking the person as a person for a little bit, (Caitlin).

Discussion

This study offers a perspective on the wider debate and critique of the categorisation of symptoms through diagnosis. While participants acknowledged the usefulness of diagnostic labels in providing a common language by which to communicate the difficulties of clients, they adopted a cautious approach and questioned its utility in working with young people. Jellinek and McDermott (2004) suggested that the ‘medical’ model provides a narrow focus on biological factors as the sole explanation for mental health difficulties. The current study echoes these findings as participants expressed that diagnosis was not sufficient in understanding a young person’s difficulties.

Interestingly, the results of this study offers a further perspective on Corrigan and Watson (2004) and Lam, Salkovskis, and Warwick’s (2005) suggestion that biological explanations may imply that individuals experiencing mental distress are ‘less human’. Within this study, participants distanced themselves from biological explanations and diagnosis and actively sought to view the young person as an individual. This has implications for the training of all mental health professionals as an acknowledgement of this person-centred approach appeared crucial to the development of their therapeutic alliance.

The present study is limited by sample size, but it is clear that participants valued formulations for understanding, care planning and relationship building. Formulations not only enabled professionals to make sense of client’s difficulties, but also diminished negative attitudes accompanying diagnoses by allowing staff to view the person as an individual. Here, participants distanced themselves from biological explanations and categorisation;

actively seeking to view the young person as a teenager and individual. Central in the findings was recognition that the therapeutic alliance was crucial in enabling them to better understand the young people, beyond their diagnoses. It is clear that staff value contributing to formulations to develop understanding, provide context to difficulties and develop tailored support plans. It would be very useful to continue investigation in this area, through large-scale more heterogeneous populations.

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