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Anti-psychotic medication decision making during pregnancy: a co-produced research study

Vanessa Pinfold, Ceri Dare, Sarah Hamilton, Harminder Kaur, Ruth Lambley, Vicky Nicholls, Irene Petersen, Paulina Szymczynska, Charlotte Walker and Fiona Stevenson

Abstract
Purpose – The purpose of this paper is to understand how women with a diagnosis of schizophrenia or bipolar disorder approach medication decision making in pregnancy.
Design/methodology/approach – The study was co-produced by university academics and charity-based researchers. Semi-structured interviews were conducted by three peer researchers who have used anti-psychotic medication and were of child bearing age. Participants were women with children under five, who had taken anti-psychotic medication in the 12 months before pregnancy. In total, 12 women were recruited through social media and snowball techniques. Data were analyzed following a three-stage process.
Findings – The accounts highlighted decisional uncertainty, with medication decisions situated among multiple sources of influence from self and others. Women retained strong feelings of personal ownership for their decisions, whilst also seeking out clinical opinion and accepting they had constrained choices. Two styles of decision making emerged: shared and independent. Shared decision making involved open discussion, active permission seeking, negotiation and coercion. Independent women-led decision making was not always congruent with medical opinion, increasing pressure on women and impacting pregnancy experiences. A common sense self-regulation model explaining management of health threats resonated with women’s accounts.
Practical implications – Women should be helped to manage decisional conflict and the emotional impact of decision making including long term feelings of guilt. Women experienced interactions with clinicians as lacking opportunities for enhanced support except in specialist perinatal services. This is an area that should be considered in staff training, supervision, appraisal and organization review.
Originality/value – This paper uses data collected in a co-produced research study including peer researchers.
Keywords Pregnancy, Psychosis, Medication, Peer research, Co-production, Decision making, Decisional conflict
Paper type Research paper

Introduction
The UK Government is prioritizing maternal mental health (Department of Health, 2012a; Mental Health Taskforce, 2016), with the costs of perinatal mental ill-health estimated at £8.1bn for each annual birth cohort, or almost £10,000 per birth (Bauer et al., 2014). The influence of fathers on child mental health is also beginning to be recognized, including their active involvement in the perinatal period supporting mothers (Khan, 2017). This paper uses data from a qualitative interview study to explore how women managing schizophrenia or bipolar disorder make decisions about anti-psychotic medication use in pregnancy. The context is limited availability of information for women or clinicians to guide decision making, balancing risks to mother and baby (Stevenson et al., 2016). There are no anti-psychotic medications with UK licensing authorization specifically for women who are pregnant or breastfeeding (NICE, 2014). The challenges that mothers with mental health problems can experience, which include feelings of guilt, problems coping with health difficulties, fear over losing custody of children and stigma, can start in pregnancy (Diaz-Caneja and Johnson, 2004; Jones et al., 2014).
Many women managing mental health problems feel empowered and confident in their reproductive decision making, but others can feel overwhelmed without adequate support (Krumm and Becker, 2006). Understanding how women, their families and clinicians make decisions over medication use in pregnancy, and the support and information they need to do so, may help improve women’s experiences of services, pregnancy and motherhood (Dolman et al., 2013; Perera et al., 2014).

A shared ownership of decisions and responsibilities between service users and clinicians has been recommended, to build trust and encourage planning for parenting “success” not “failure” (Fox, 2012; Adams et al., 2007), and to help manage disagreements openly and constructively (Deegan and Drake, 2006). Shared decision making is dominant in policy guidance (Department of Health, 2012b; Mental Health Taskforce, 2016) but implementation in practice requires changes in approach at both individual and system levels. Achieving concordance through partnership working in communication about medications has been shown to be challenging across health care, where clinicians tend to dominate consultations (Stevenson et al., 2004). In mental health, the ever present power to detain a person against their will using the Mental Health Act can undermine partnership and collaborative working (Seale et al., 2006). Practitioners are obliged to follow guidance around “best interests” of the mother and to also take into account capacity to make decisions following the UK Mental Capacity Act. Recent qualitative work describing in detail meso- and macro-level influences that can undermine the implementation of shared decision-making tools (Brooks et al., 2017). The same project reported agreement between stakeholders that shared decision making necessitates collaboration, but found service users and carers did not generally experience this within anti-psychotic prescribing practices (Harris et al., 2017). Previous research observed shared decision making practices in 92 consultations concerning anti-psychotic medication and found varying degrees of pressure being applied in practice (Quirk et al., 2012).

Research on antidepressant use in pregnancy has reported how many women facing medication decisions experienced moderate to high levels of decisional conflict (Walton et al., 2014). Decisional conflicts arise when there is personal uncertainty over which course of action to take because of internal dilemmas generated by differing opinions, often in the context of limited information. Service users and clinicians can impact on each other’s decisional conflicts. Inadequate service user involvement within consultations over clinically significant decision making can generate personal uncertainty in patients (Thompson-Leduc et al., 2016). Leventhal et al.’s (2003, 2007) common sense model of self-regulation describes how people draw on their own experience and identity, their perception of the illness threat and their understanding of the cause of the illness to determine a course of illness management action. For women with a previous mental health diagnosis, self-regulation is therefore informed by past experiences of ill-health including relapse, personal identity formations in relation to mental health problems, motherhood and other aspects of social identities including family, their own understandings of the cause of mental health problems and the perceived efficacy of different management techniques including medication (Baines and Wittkowski, 2013). During or when planning pregnancy, self-regulation is also influenced by culturally informed expectations on women to take responsibility for the health of a foetus through risk averse behavior including what they consume and activity levels (Lupton, 2012).

This paper presents a co-produced analysis of women’s accounts of anti-psychotic medication decision making during pregnancy. The focus is on how decisions are made and the role of others in the process.

Methods

The study was developed by a team of four women in the role of peer researchers, drawing on their experiences of mental health service use (CD, HK, CW, RL) university researchers (FS, IP), and members of a research charity (VP, SH, PS, VN). The former group were recruited as members of a lived experience advisory panel for a project which used primary care electronic health records to examine risks and benefits of anti-psychotic medication (Petersen et al., 2016). Co-production in research recognizes the different expertise of individual team members in terms
of data collection, project management, training and supervision, qualitative analysis and paper writing, but also requires different approaches are undertaken to value and include available expertise, sharing power, building productive relationships (INVOLVE, 2018). Peer researchers were recruited specifically for their expertise from both mental health research and as women of child bearing age taking anti-psychotic medication. For data collection, a methodology that has been described as peer research (Revolving Doors Agency, 2016) was employed, designed to enable peer researchers to illicit accounts through qualitative interviews with participants by drawing on their own experiences and reflecting upon them again within the data analysis phase. Collaborative research methods require extensive reflexive work (Finlay, 2005). The idea of co-producing accounts is common to qualitative research (Talmy, 2011), but is not always discussed and considered critically in the presentation of interview findings (Kvale, 2006).

The study was reviewed and received ethical approval from UCL Research Ethics Committee September 2013 (4930/001).

Recruiting research participants

Participants were recruited using service user and survivor networks via social media and snowballing techniques. The peer researchers within the team were active in promoting the study. However, where someone personally knew a participant, other team members carried out the interview.

When potential participants expressed an interest the project coordinator discussed the project with them over the phone, recording any preferences and requirements to plan interviews around their needs including accommodating childcare. Participants were offered a £10 thank you voucher for giving up their time to take part. In total, 12 women with children under five, and who had taken anti-psychotic medication prior to pregnancy, were recruited. This was an exploratory study in a novel area and the richness of the data obtained was judged sufficient to provide a range of accounts from women with differing experiences in a hard to reach group.

Data collection

Interviews were carried out by researchers working in pairs; the lead was always a peer researcher. After each interview the project coordinator was present to collate paperwork including consent forms and voucher receipts. The 12 interviews were semi-structured and lasted between 24 and 140 min; the mean was 57 min.

The interviews sought to understand women’s experiences of making decisions about anti-psychotic medication during pregnancy. Peer researchers drew on their own experiences, in a limited but deliberate way, to build rapport in the interview. They explained why they were doing the study at the beginning of the session and occasionally acknowledged their own experiences if appropriate whilst women provided accounts. Field notes were used by peer researchers to record reflections, including their use of personal disclosures.

Analysis

All interviews were fully transcribed and co-analyzed using a three-stage analysis process (see Figure 1). First, familiarization with the data involved seven members of the team each reading two to three transcripts and meeting to jointly agree a coding framework which was applied to the data using NVIVO-10 (VN). In Stage 2, a workshop was held to discuss one data theme: influences on decision making. Prior to the workshop, each peer researcher was allocated three transcripts to re-read and summarize using a diagram (see Figure 2) to show each woman’s decision making influences based upon the Stage 1 coding framework. Each of the 12 diagrams were displayed on the wall at the workshop, and were discussed. This process was used to complement Stage 1 analysis and facilitated ongoing active engagement of the entire team in the analysis process. Throughout Stage 2, the peer researchers actively reflected on their own experiences, including of decision making, and how this shaped their interpretation of the data. The final stage was a further workshop (VP, CW, CD, HR, RL, VN) to agree on our interpretations of how decisions were being made, consider gaps in the data, and acknowledge uncertainties in our understanding based on available accounts.
The paper uses pseudonyms to attribute quotations in order to preserve anonymity of participants. The results build upon the thematic analysis which we reported elsewhere (Stevenson et al., 2016). It draws specifically on the interpretations of peer researchers seeking to situate the women’s accounts of decision making alongside their own experiences and other published literature on shared decision making, decisional conflict and common sense models of self-regulation. None of this was straightforward; the research process involved decisional conflicts as well, with choices made collaboratively at first and through delegated authority within the writing process nearer the end.

**Results**

A summary of characteristics of the women interviewed is provided in Table I; one participant declined to complete a participant profile form.

All the interviewees described having to create new medication management strategies when they considered pregnancy or became pregnant. The decisions made varied both between participants and during the course of an individual pregnancy (see Table II). Two participants took no medication throughout pregnancy, others changed medication or reduced doses.

**Medication decision-making dilemmas**

Participants were asked to reflect back, with hindsight, on the choice they had made. The women’s accounts revealed that, even when they felt they had made the right choice, these decisions were difficult. The women, their family and clinicians, were faced with a series of dilemmas. The consequences of health risks and the use of medication were viewed as substantial. Medication decisions here were potentially life changing, whichever course was taken. The conflicting pressures to stay personally well and to protect the baby’s health provided women with a “huge decision” of uncertain outcome. Several women relapsed after giving birth, this included those who took medication and those that did not (see Table II):

> We did make the right decision I think […] I’ve been blessed that I have a healthy baby but in some respects I don’t know whether I would have taken the punt so much if I knew I was going to be so ill you know. (Iris)
Figure 2 Stage 2 analysis map – influences on medication decision making: themes from post-birth interviews

Table 1 Characteristics of women interviewed

<table>
<thead>
<tr>
<th>Variable</th>
<th>Description</th>
<th>Count (percentage)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>Range 28–46 years</td>
<td>Mean 37.5</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>White British 8 (72.7%)</td>
<td>White other 2 (18.2%)</td>
</tr>
<tr>
<td></td>
<td>Arab 1 (9.1%)</td>
<td></td>
</tr>
<tr>
<td>Region of residence in England</td>
<td>London 7 (63.6%)</td>
<td>Yorkshire and North East 2 (18.2%)</td>
</tr>
<tr>
<td></td>
<td>North West 1 (9.1%)</td>
<td>Eastern 2 (18.2%)</td>
</tr>
<tr>
<td>No of children</td>
<td>Range 1–3</td>
<td>Mean 1.6</td>
</tr>
<tr>
<td>Diagnosis</td>
<td>Schizophrenia/schizoaffective disorder 3 (27.3%)</td>
<td>Bipolar disorder 8 (72.7%)</td>
</tr>
<tr>
<td></td>
<td>General practitioner 3 (27.3%)</td>
<td>Secondary care services 6 (54.5%)</td>
</tr>
<tr>
<td></td>
<td>Data not supplied 2 (18.2%)</td>
<td></td>
</tr>
</tbody>
</table>

Note: \( n = 11 \)
<table>
<thead>
<tr>
<th>Name</th>
<th>Pregnancy planning</th>
<th>Meds pre</th>
<th>Tri 1</th>
<th>Tri 2</th>
<th>Tri 3</th>
<th>Relapse</th>
<th>Reflection on decision</th>
<th>Description</th>
<th>Summary of presented account</th>
</tr>
</thead>
<tbody>
<tr>
<td>Helen</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Unplanned</td>
<td>Came off medication</td>
<td>Independent decision making. Input from partner, GP, specialist services. Some evidence of negotiated strategies toward end of pregnancy.</td>
</tr>
<tr>
<td>Emma</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Planned</td>
<td>Felt it was right decision</td>
<td>Shared decision making described – open discussion. Actively sought medical opinion and followed it. Partner congruent.</td>
</tr>
<tr>
<td>Jane</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Planned</td>
<td>Felt it was right decision</td>
<td>Shared decision making described – open discussion. Agreement in advance in consultation with team.</td>
</tr>
<tr>
<td>Lisa</td>
<td>Came off</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Planned</td>
<td>Felt it was right decision</td>
<td>Independent decision making described. Discordant view from services. Partner congruent.</td>
</tr>
<tr>
<td>Iris</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Planned</td>
<td>Felt it was right decision</td>
<td>Independent decision making described, Explained decision to services which was congruent with their advice. Partner congruent.</td>
</tr>
<tr>
<td>Lily</td>
<td>No</td>
<td>No</td>
<td>Yes briefly</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Planned</td>
<td>Felt it was right decision</td>
<td>Independent decision making except when coerced to take medication under section.</td>
</tr>
<tr>
<td>Charlie</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Planned</td>
<td>Concerned about decision</td>
<td>Independent decision making described. Did not see psychiatrist for first half of pregnancy. Partner congruent.</td>
</tr>
<tr>
<td>Grace</td>
<td>Yes</td>
<td>No</td>
<td>SSRI</td>
<td>SSRI</td>
<td>No</td>
<td>Yes</td>
<td>Planned</td>
<td>Felt it was right decision</td>
<td>Shared decision making described – negotiation in order to agree which medication and dose to take. Partner congruent.</td>
</tr>
<tr>
<td>Claire</td>
<td>Yes/No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Planned</td>
<td>Felt it was right decision</td>
<td>Shared decision making described – negotiation began before pregnancy to change medication. Partner congruent.</td>
</tr>
<tr>
<td>Barka</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Unplanned</td>
<td>Felt it was right decision</td>
<td>Current pregnancy. Shared decision making described – negotiation. Family discordant view.</td>
</tr>
<tr>
<td>Agatha</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Planned</td>
<td>Felt it was right decision</td>
<td>Shared decision making described with psychiatrist – negotiation began before pregnancy to change medication. Partner not involved in decision.</td>
</tr>
<tr>
<td>Elizabeth</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Unplanned</td>
<td>Felt made wrong decision</td>
<td>Shared decision making described with team. Lack of support during pregnancy from services.</td>
</tr>
</tbody>
</table>
I was nervous about it you know, and I felt that I was making a big decision [to stay on medication], you
know, and it was something that was a huge decision to make. (Iris)

The consequences of decisions taken included not only risks to health, but also threats to identity
and expectations of being a good mother. In parallel, and interwoven within this process, the
women were also managing emerging new identities, as mothers with a mental health problem;
some for the first time. The overriding goal was to stay well to be a “good mum”:

And I find it hard to sort of believe that taking a couple of little tablets makes such a huge difference to
the way that I function, but my thinking now is I clearly need them and I want to just stay well and be a
good mum. (Emma)

One impact of decision making was sense of guilt, discussed by women with reference to having
a mental health condition, becoming a mother with a mental health problem, taking or not taking
medication and other identity-related issues. Guilt was expressed as a feeling held throughout
pregnancy, as well as afterwards. This was particularly acute when what was at stake had a
lifelong impact such as children being taken into care:

You’ve got the guilt of being like, like having mental health, where you feel really bad as a mother
anyway, which is quite hard to deal with, and then you’ve got the guilt of like not knowing whether to
carry on [taking medication]. (Helen)

Yeah, I mean sometimes I feel guilty for refusing my medication. And my partner, he finds
it quite difficult to comprehend the complexities of what I keep ranting on about, which
is all this [losing custody of my children]. And he says, you know you didn’t take your
medication. (Elizabeth)

There was also guilt associated with the risk of becoming unwell and not being able to
care for the baby and other family members. Medication decision making was an oscillating
struggle, fed by feelings of both certainty and uncertainty over the way forward to
manage the two intertwined health threats – relapse of mother’s mental health and risk of
medication to the unborn foetus. Grace described “feeling a failure” for taking medication
demonstrating the significant emotional impact that these dilemmas had, and consequences
for sense of identity:

I did have times of feeling guilty that I was taking medication while I was pregnant, you
know that I felt I’d failed for having gone ahead and taken medication because that’s,
you know, again something that goes along for me with depression is that feeling of failure or having
let down, let myself down. And that book was very helpful in terms of actually making
me remember that it was about making sure that I was well, as well as making sure that the baby was
well. (Gracie)

This layering of guilt, dilemmas over taking medication or not and continued management of a
mental health condition during pregnancy created pressures which accumulated around the
women and provided complicated decision making accounts.

Decision-making process: autonomy and social influence

The women demonstrated personal ownership of their decisions, even when they felt conflicted
about them. The women presented decisions as down to them, regardless of the involvement of
others in the decision-making process. Key sources of external influence were the views
of family and friends, information in books, published medical papers and the internet, and the
opinion of clinicians:

It’s all on you, the whole [pause] and that can make, that’s what can cause you to become really ill, the
pressure of that, the responsibility on your shoulders. (Helen)

I just said to him [partner] I’m going to carry on taking the medication really and I think my partner at the
time once said, “why are you doing that?” and I just said, “to remain well.” (Charlie)

I’d already kind of, before getting pregnant, made the decision that I, you know, if that happens, that I
would take the mood stabilisers this time round. (Emma)

The individual responsibility the women felt over staying well during pregnancy, led to some
compromises on medication taking. Claire and Jane reflected on their medication journey,
noting discord between in principle preferences and in practice behavior, in both cases linked to relapse experience:

[if] my circumstances were different, then I would try, I would definitely try, just for the principle of it, to come off my medication because I kind of feel like it’s not fair that something that happened to me when I was 21 should influence the rest of my life. (Claire)

I mean it was quite a straightforward decision for me to make [to stay on the medication], but if I […] If I was trying to become pregnant and had, maybe only had one year or two years of mental illness beforehand, I think it might have been a bit different and I might have taken the risk that things would be OK. (Jane)

Individual ownership of medication decision making was also demonstrated by women in their acceptance, if discomfort, of changing levels of control in their lives. We heard about both feeling a loss of control and strategies for staying in control:

And I think that’s a bit, you know, I think that’s, like when you’re pregnant, there’s a loss of control, vulnerability. Not only are you caring about yourself but you know most normal mothers, we’re going to, the first thing we’re going to think of is the baby. You know what I mean, I knew I was worried about getting ill then I thought, oh no if I get, and I remembered what it was like to be so ill, I thought I never want to go down that road again. But my first thought was the baby, has something happened to the baby. (Helen)

I just feel more in control I guess, if I know what I’m taking and why I’m taking it and also why I might not want to take something. I like working on that basis because I know then that I’m not, I’m able to take a decision knowing that there’s another point on the journey […] I didn’t really want to go there with a whole new, getting used to a whole new medication at a point where everything else in my life was sort of changing as well, I kind of wanted to know that OK I’m going to take sodium valproate once the baby’s born and I know that will probably do what it needs to do for me. So yeah, that’s the basis […] just trying to kind of forge a path that was right. (Grace)

Medication decision making, regardless of the involvement of others, was a difficult experience and could be isolating. We heard how women coped with the pressure by ignoring their pregnancy or hiding related behaviors such as medication taking:

To be honest I didn’t really feel pregnant throughout the nine months, I was trying to avoid thinking about it because of everything I’d been through. I was just keeping myself busy. (Barika)

Taking any medication is discouraged during pregnancy and was experienced as stigmatizing and something to hide in social situations:

And I did feel, I didn’t want to tell anyone because I’d never met these people, you know, I’ve got bipolar, that’s why I take medication, that’s why I won’t be breastfeeding, that was quite awkward sometimes I think, definitely, it was quite isolating. (Charlie)

Autonomy, and individual responsibility, did not mean other people and sources of information had no influence. We found two perspectives, personal ownership over decisions, and the role of other people in the decisions taken, ongoing during pregnancy and embedded in the process of decision making. The women sought, or received without asking, opinions from clinicians such as GPs, psychiatrists and midwives about medication taking in pregnancy and took on board the opinions of family and friends. These viewpoints influenced the decisions taken by each woman. They also had to rely on others to help them enact their chosen decision, necessitating negotiation and discussion to achieve an acceptable plan:

They were very supportive because there was a long, there was quite a prelude to this about what to do about my medication. Before I conceived. So there was input from the consultant. Because it took six months, the withdrawal process, from some of my medication. So there was quite a lot of negotiation. (Agatha)

Women’s accounts also showed an internal conflict between trusting their own instincts and knowledge gained through their previous experiences of relapse and recovery, and trusting and being influenced by their clinicians, particularly, if the presenting clinician was not someone with whom they had a long standing relationship. In most accounts, women respected and sought out clinical opinion, finding it helpful. However, looking back at the decision-making process during the interviews, several participants were unhappy with the
support and advice given by clinicians, and as a result regretted not acting (or being allowed to act) on their own instincts:

It’s not that I want to relinquish the responsibility that I have to take for my own health, not at all. But I am happy to be a patient, if I can trust the caregivers. But time and time again, during this experience, my caregivers have let me down in a very bad way. (Lily)

So for me they should have, when they were saying I were going to relapse, when I says yeah I am probably, I can tell you what it will be, they should have trusted me as a mum and my own experiences and then worked on that support. Not gone on a […] not supported me and then treat me in a really horrible way because I’d gone with a different decision to theirs [by coming off medication]. (Lisa)

In addition to clinical input, family opinions over medication were an important factor, particularly where non-congruent views were held. One woman found it hard to stay on medication during pregnancy knowing her family did not support her use of anti-psychotic medication at all. Another had to manage family concerns, impacting on pregnancy experiences:

I went to, abroad, I went to Dubai and my sister paid for me to see like private doctors over there because I was really upset about my medication because everyone was saying different things to me, oh you know you don’t need it, you just need to get married, you just need to do that, you just need to listen to the Koran. (Barika)

My parents were very kind of reluctant that I should stay on medication while I was pregnant. They really thought that it was a bad idea and thought that there was going to be something wrong with the baby if I did that. (Jane)

In contrast, congruent family opinions were far more helpful and empowering to women, supporting the process including uncertainty:

Yeah, I talked to my husband about it, I mean he’s very supportive, I don’t think he kind of […] he was happy to support me with my choice basically. (Emma)

**Decision-making strategies**

The women interviewed reported being influenced by multiple factors including: past pregnancies; mental health experiences and relapse; personal views about medication; information gathered online, from leaflets, journals or books and from clinicians; views of family and friends; and expectations over the level of support they would receive from mental health, primary care and maternity services (see Figure 2). In light of the interaction between personal autonomy and social influence on shaping decision making, our analysis revealed two decision making styles: shared and independent.

Shared decisions were based on seeking support or guidance from clinicians and others to make an informed choice. It was not one strategy, but had several key features: open discussion; active permission seeking; negotiation; and coercion. Independent decisions were described in relation to women making decisions predominately on their own and asking others to endorse their chosen strategy. A summary of the strategies adopted by each woman is provided in Table II. Independent decisions were described in relation to making decisions independently and asking others to endorse the chosen strategy. These two strategies were not disconnected states, they contain common features including women’s personal ownership of decisions and the influence of others. Both approaches involved decisional conflict and uncertainty.

Whether a shared or independent approach was described seemed strongly influenced by the women’s experience of working with their clinical team. Accounts of shared decisions were characterized by active involvement of both the women and their clinical team, and in many cases their wider family. Where continuity of care was reported, and established relationships were built upon trust, the accounts were more likely to describe a supportive process. Open discussion was found in accounts where alignment of views between the women and clinician were strong, including acknowledgment of uncertainty:

So we’d, prior to me getting pregnant, looked in depth at sort of what I should do, so I’d already made the decision [to stay on a specific medication]. (Emma)
There wasn’t an awful lot of information given to me, it was just, I was just told, well this is your best option really on the balance of things, considering your past history […] I knew that it was still a risk in case the doctors had got it wrong really. I was kind of glad that I wasn’t on a newer medication and it wasn’t that experimental. So I kind of felt reassured by them but you always have a doubt in your mind, how precise their knowledge is. (Jane)

Shared decision making also involved active negotiation, particularly to bring the clinical team onside with personal preferences. Negotiation was found in accounts where medication changes were required both in order to become pregnant and manage the risk to mother and baby during pregnancy:

I feel very fortunate that the psychiatrist was prepared to negotiate on [which medication to take] […] you know, I would take research papers along and say you know what do you think about this and how about that? (Grace)

The crucial thing, I did have a mission, I have to be honest, because I started negotiating with the psychiatrist before my husband had agreed to it [having a baby]. (Agatha)

However, where women described a shared decision-making approach, this did not necessarily preclude tensions between the woman’s position and that of others. The women described the ongoing pressures they felt from family and clinicians in the process, including the inherent threat from clinicians that their personal autonomy can be restricted in the case of relapse through the use of pressure or coercion. There was constrained decision making visible in accounts:

So I wasn’t too worried about it and the psychiatrist said a few times that, well if you became severely ill, we’d have to treat you with much higher doses of medication. (Jane)

In these accounts, the women reported working with clinicians to seek information and reach a decision that both felt comfortable with. It involved permission seeking, including to have a baby, and testing for opinion alignment or non-congruence. Active permission seeking sought to test and align views thus providing reassurance. This was particularly important for managing fear of relapse:

I just felt for me, practically, I wasn’t going to get through the pregnancy without having some kind of stabilising influence. (Claire)

Women wanted clinician support in this process, and actively sought it out. Where medication was involved, they needed clinicians to prescribe it. Examples included seeking referral to a specialist perinatal service, changing clinical team when they were unable to reach agreement with their doctor, and paying attention to their own presentation to be as credible as possible.

Reaching agreement on the decision with clinicians was, in most cases, helpful in achieving effective planning and support throughout the pregnancy and after childbirth. Close monitoring throughout the pregnancy provided the possibility to change an initial decision, as it did for Grace:

And because my health had been previously quite good, or had been good, the psychiatrist was happy for me to come off the medication during the process of trying for a baby with the recognition on both sides that if – both his side, as was then, and my side – that if things changed, if I became unwell, then we would re-visit the situation. […] So we agreed to do a close monitoring, and effectively I kind of weathered the low for as long as I could but then it sort of got a bit worse, to the point where I had to take a little bit of time off work, at which point I said, OK, hands up, I need something. (Grace)

Independent decisions, in contrast, were those made by the women without, or prior to, clinician input. They spoke of “trusting themselves,” drawing on their past experience of mental health problems and medication use:

I think if I had have fallen pregnant with my ex-partner because I’d have not been off meds a long time, I probably would have gone back on thinking that was the best and wouldn’t have had trust in my own capabilities at that time, to continue self-maintaining. I would have probably allowed the professionals to take over because I was only just building up confidence in myself. But I think when I had [name of baby], I was in a place where I trusted myself enough to continue my own self-care and was working on it. I trusted the people that were around me, my family, my other half, you know, they’re there as my safeguard. (Lisa)

By the time I saw the psychiatrist, my mind was made up and I was just going to continue doing it. (Charlie)
I made a decision before I was pregnant to stay on my medication […]. (Iris)

While these decisions were made independently, clearly being women-led decisions, the accounts showed that some of the women again made an effort to achieve clinician support for these decisions after making them. Examples were found of both clinician congruence and non-congruence with these women-led decisions. There was also evidence of women being open to changing their mind demonstrating the ongoing nature of decision making throughout pregnancy:

If she’d have said I’d rather you didn’t take it then I would have stopped it, but she was just very wishy washy. (Charlie)

Where women did not manage to secure the support of their clinician for their decision, this increased the stress and difficulty involved. Lisa resisted professional opinion to take medication and found it a challenging position to hold; she felt scrutinized and judged by clinicians. Lisa held her ground with the help of a supportive partner but she faced extensive opposition from services, challenging her readiness to parent:

I found that because I didn’t go on meds, they made me do God knows how many different positive parenting classes to prove that I could be a mum, because every time they were saying you’re more likely to relapse, they were suggesting that you know you may need, when you’ve had baby, to have this, and I was continually saying no. So I found that because I chose to invoke my right to stay off medication […] it was seen I was a bad parent and I wasn’t responsible. (Lisa)

Lily hid her decision to come off medication by pretending to take it even after discharge from hospital following a mental health relapse. This illustrates how isolated a woman can be in relation to decision making, even from their family, impacting on sense of identity and compromising personal integrity:

I came clean about not taking meds, [my husband] was in a state of utter disbelief initially but is getting over it now. The mechanics of me taking it from him but not ingesting it baffles him. It feels as if a huge boulder has rolled off my shoulders because dishonesty and deception don’t come naturally to me. (Lily)

It is also possible that women on reflection do not feel they understood the advice they were being given by their clinical team. These are complicated decisions. Neither shared or independent decision making can guarantee a successful outcome for mother or baby:

I needed someone to sit me down and say, explain things to me in a way I understood. But I was just getting passed from pillar to post, no one was sitting down and explaining to me, talking to me, saying this medication’s not going to harm you, it’s going to help you stabilise, it’s going to give you an opportunity to stabilise and prove that you’re able to care for your child. (Elizabeth)

Discussion

Decision making involved several distinct elements presented as a series of dilemmas, with consequences including long term feelings of guilt. In the context of limited access to information or guidance for clinicians or women on anti-psychotic medication taking in pregnancy, women have to rely on common sense evidence (Stevenson et al., 2016). The process was both isolating and required collaboration. It involved multi-layering of decision making with uncertain consequences, creating an environment for conflict and doubt which was experienced by all involved. Decisional conflict is common for many decisions during pregnancy, and particularly those involving medication use (Walton et al., 2014). The accounts show women’s best efforts to balance the need to make the best decision for them, their baby and family, with the need to bring their clinicians along with them.

The accounts differed in how far they described their decision as independent or shared, but in all cases, women assumed personal responsibility for decisions taken whilst acknowledging the social context that framed the process. Women did seek to maintain personal control over decisions whilst also recognizing the constrained choices they faced in the light of ongoing mental health needs. Shared decision making or an independent women-led approach are not separate entities but they connect through common features including the seeking out of clinician opinion. They are also subject to changes as women and clinicians refine their decisions in response to
circumstance including the mother’s deteriorating mental health. Independent decision making was present where women have clear, definite opinions with decisions made before clinician involvement. Women-led decisions require clinician support thus permission seeking was observed in accounts, but it was not always received. What our study also shows is the consequences of the response from the “observing others” in allowing women to fulfill their own self-regulating strategies. This included the emotional effects of social and cultural pressures, a reliance on support that may or may not be provided, and in some cases denial of the ability to pursue their chosen strategy through compelled or denied medication use.

Considering shared decision making, we identified different key elements; open discussion; active permission seeking; negotiation; and at times also underlying coercion. This is consistent with descriptions of the shared decision-making process in general, emphasizing two-way deliberation, information sharing, discussing options, seeking consensus and reaching a decision (Charles et al., 1997), and research specifically focused on medication shared decision making in mental health. The observation of psychiatric consultations concerning anti-psychotic medication found variable shared decision-making practices described as pressured, directed and open discussions, and clinical risk was a strong driver of directed and pressured decision making (Quirk et al., 2012). These descriptions show similar features to women’s accounts with coercion linked to risk management, though this was rare, negotiation and compromise including taking medication against their ideological principles, open discussion to review options, manage women’s concerns and acknowledge uncertainty, as well as permission seeking to start a family.

Further, our findings support those of previous research, that women with mental health problems report feeling guilty and worried about motherhood (Dolman et al., 2013; Jones et al., 2014; Perera et al., 2014). None of the women found decision making easy. Clinicians have an important role in helping women to manage the emotional impact of their decisions. Where the women felt judged as irresponsible or selfish women reported the effects on their own mental state and the clinical relationship. In contrast, having agreement for the decision – even with cautions attached – could provide reassurance. Women accessing specialist services, including perinatal units, provided the most positive accounts and had experienced shared decision making.

**Clinical implications**

The accounts all described the influence of clinical relationships on decision making, both mental health and general health care practitioners. In some cases, clinicians were an important source of information, but in a context where there is little solid evidence available on the effects of taking – or not taking – medication during pregnancy (Petersen et al., 2016), this was a relatively minor role compared with other medication decisions. However, mental health clinicians were always a powerful influence since they have the ability to reduce or constrain the autonomy of women’s self-regulation strategies through their role as medication prescribers as well as the Mental Health Act and Mental Capacity Act. What was crucial to the women was the health support that clinicians could provide during the decision-making process, and the need to keep that support during and after pregnancy regardless of decisional (non)congruence. The process of decision making and the level of agreement reached with clinicians should not affect women’s rights to access high standards of care.

These findings suggest that there is a need for improved training and supervision for all practitioners involved with women who are pregnant and managing a severe mental illness. This includes mental health clinicians and GPs, specifically around pregnancy as well as the wider general health community that pregnant women meet. Getting support right could have far-reaching benefits for women, their children and their wider families.

This support will also require better skills in shared decision making. Emerging research on shared decision making and severe mental illness recommends development of decision aids (Bentley et al., 2014), and how practices that take into account the treatment needs and support preferences of the individual are best supported by long term therapeutic relationships (Morant et al., 2015). A crucial part of share decision making is the role of patient – provider relationships (Eliacin et al., 2015), but these are often disrupted by a lack of continuity of care.
But implementing shared medication decision making is challenging, requiring system level changes as well as skill-based work on interpersonal factors such as professional and service user perceptions of each other (Brooks et al., 2017). This cannot be viewed as a barrier, shared decision making needs to progress in a resource poor and changing service context.

Limitations

This study has limitations. The sample was largely recruited through social media and thus the participating women were mostly people active in service user networks. Two women were recruited by NHS practitioners who alerted service users to the recruitment advert. It is a small, qualitative study and the sample of women involved are not representative and the sample is not particularly diverse. The accounts used in this study are retrospective and are therefore influenced by the outcomes of the pregnancy and other subsequent events. We would recommend a larger study involving practitioners, family including partners and women leading to the development of training materials.

A strength of the study was the methodology that involved co-production (Pinfold et al., 2015), relying on collaboration (Billborough et al., 2014) and distributed decision making (Gillard et al., 2012). This was beneficial for study design and data collection drawing upon the skills and experiences of different team members. It required considerable reflexivity at different stages to ensure the choices made were open and transparent, and this was imperfect. Co-production was also a deliberate strategy for data analysis in this paper, although the write up stage was more challenging to co-produce and thus here too we looked for a pragmatic “common sense” approach. There are parallels between the models chosen to understand our data and research approach. We identify dilemmas and constrained choices in both. Co-production in research is always challenging, and specifically so in a large multi-disciplinary team after a study has ended and the core team members disperse.

Peer researchers were asked to reflect on emerging themes that had particular personal resonance in relation to their own experiences of mental health care and the narratives of the 12 women interviewed, and provide possible explanations. First, peer researchers identified the importance of trust and developing therapeutic relationships to support decision making. Where the women had established relationships with clinicians, shared decision making was more likely to be adopted. Knowledge of the clinician whose support was required to help manage the pregnancy experience, and in some cases choice in the gender of that person, was observed as things that mattered. Second, peer researchers noted the context in which constrained choices and diminished autonomy in decision making was accepted because personal choices can be overridden by the mental health system. There was acceptance that although personally responsible for their decisions they were not fully in control; there was always a risk of relapse leading to a new medication management strategy and sectioning under the Mental Health Act. The peer researchers felt this was a key explanation in decision making in the women’s accounts, consistent with their own experiences. In co-production methodologies such peer insights are not followed uncritically, they rely upon detailed reflexivity and analysis. But they offer an important line of investigation to explore within data.

Self-regulation and common sense models

Leventhal’s et al. (2003) common sense model of self-regulation has five domains of illness representation: identity, timeline, consequences, cause and control. This model of explaining management of health threats resonates with women’s accounts, which balance external sources of influence such as family viewpoints, medical opinion and available information with experiential evidence linked to personal and identity factors including past illness experience, relationship with clinicians, attitudes to medication taking and trust in their own judgments. We note that the common sense model of self-regulation provides a useful way to understand the tensions between autonomy and social or cultural influence, and between the many factors, including previous experience, identity and perception of risk, that influence women’s medication decision making. Decisions about pregnancy in particular involve a high level of personal responsibility, as seen in the existing literature (Lupton, 2012), and decisions around mental health medication use are
characterized by a context in which autonomy may be externally constrained. These decisions are also particularly significant for their life changing consequences, not only to the health of the woman but to her ability to be a mother and to her whole family. With limited evidenced-based research, women have to use the experiential evidence available to them.

In light of this conclusion, there is an imperative to better support the process of decision making to support pregnant women living with a mental health problem such as schizophrenia or bipolar. This cannot proceed without also setting the common sense model of self-regulation in a wider context to create shared understandings of mental health problems both at a system and individual level. Training and enhanced supervision to increase practitioner confidence in shared decision making and other relevant models is needed covering entry level positions through to ongoing professional development of consultants. Having more psychiatrists with a special interest and training in perinatal care would also be an advantage. This will not remove the uncertainties and dilemmas that women experience. However, by supporting the practical and emotional aspects of decision-making processes and putting in place an improved care pathway for women with a history of mental ill-health during and after pregnancy, current variations in experiences would begin to be addressed.

References


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Cognitive analytic team formulation: learning and challenges for multidisciplinary inpatient staff

Rose Stratton and Ranil Tan

Abstract

**Purpose** – The purpose of this paper is to understand staff experiences of cognitive analytic team formulation, within an inpatient unit for women with a diagnosis of personality disorder.

**Design/methodology/approach** – In total, 16 staff completed an online questionnaire, rating their views on how helpful formulation sessions had been in regards to ten domains. Following this, six staff participated in semi-structured interviews exploring their experiences of the process and impact of cognitive analytic team formulation. Transcripts were analysed using thematic analysis.

**Findings** – Responses from questionnaires indicated the general process of team formulation was helpful across each domain. Interviews highlighted benefits such as an increased capacity to think and work relationally. This was impacted upon by staff’s confidence in using the model and the practicalities of attending sessions.

**Practical implications** – Team formulation has been described as the facilitation of a group of professionals to create a shared understanding of service-users’ difficulties. Team formulation continues to demonstrate benefits for staff working within complex mental health. The challenges of this are considered, however overall, a cognitive analytic framework seems to offer staff the opportunity to integrate learning from a service-user’s history, and current relational difficulties, in a way that develops reflective capacity and informs intervention.

**Originality/value** – Limited research has explored the theoretical models underpinning team formulation, and the impact for staff learning and practice. The current study develops previous work by specifically focussing on the contribution of cognitive analytic theory to team formulation.

**Keywords** Thematic analysis, Personality disorder, Team formulation, Inpatient, Cognitive analytic therapy

**Paper type** Research paper

Introduction

Formulation is a key aspect of many psychological therapies. It is defined as a process of collaborative sense-making, underpinned by psychological theory (Division of Clinical Psychology, 2011). Team based formulation, in a variety of formats, is a development which has been explored more recently. It is important to note that practice appears to have outstripped research, and therefore the research base consists mostly of service evaluations.

Team formulation has been described as the “process of facilitating a group of professionals to construct a shared understanding of a service-user’s difficulties” (Johnstone and Dallos, 2014, p. 5). Christofides et al. (2012) describe several different methods of team formulation including verbally discussing service-users, sharing specific reports and formulations, informal conversations, as well as more formal meetings designed for the staff team. Discussions around psychological formulation are particularly relevant in the evolving context of a medical model of mental health, whereby service-users may experience stigma and feelings of worthlessness and shame related to their diagnosis (Johnstone, 2014). Service-users have reported finding the medical language un-relatable, and feeling more validated and understood when able to tell their story (Gary, 2018).
Research into formulation itself has been marred with difficulties around the accuracy and reliability of formulations (Chadwick et al., 2003), however it seems that team formulation may ameliorate some of these difficulties, as groups appear to bring together a more available data set, and provide some level of balance against interpretative errors (Cole et al., 2015). It is further proposed that team formulation is useful in shifting multidisciplinary team (MDT) cultures towards a more psychosocial perspective (Division of Clinical Psychology, 2011), increasing awareness around trauma (Johnstone and Dallos, 2014), providing a forum for more open discussion of alternative conceptualisations of mental health (Onyett, 2007) and increasing confidence in the helpfulness of interventions (Berry et al., 2009).

It is suggested that team formulation may in turn benefit service-users by enhancing the care they receive (Cole et al., 2015). Improved ward environments and reductions in feelings of criticism have been explored thus far (Berry et al., 2016). However, due to the differences in implementation, in accordance with the setting, therapeutic model and logistical restraints of services, it has been difficult to examine effectiveness in detail. Much of the research body has focussed on staff experiences of team formulation. Some service evaluations have found common benefits of team formulation such as improved team functioning (Craven-Staines et al., 2010), increased staff knowledge and understanding of service-users (Summers, 2006; Wainwright and Bergin, 2010; Milson and Philips, 2015; Unadkat et al., 2015), increased compassion and empathy for service-users (Harrison et al., 2018) and more psychologically informed care plans (Cole et al., 2015). Some challenges and barriers, such as time constraints (Craven-Staines et al., 2010) and staff availability (Wainwright and Bergin, 2010) which negatively impact on staff experiences have also been uncovered. Harrison et al.’s (2018) analysis of barriers also revealed staff found it difficult to contribute when they felt their opinions did not matter; the perceived usefulness of the sessions suffered if the staff did not have an in-depth knowledge of the service-user being discussed; and low attendance often meant the meetings were perceived as being less useful than they could have been. On the whole, research appears to support the continued use of team formulation, with identified areas for improvement and refinement.

Although there have been many evaluations of staff experiences of team formulation, very little research has been conducted regarding the impact of the model underpinning the formulation. Cognitive Analytic Therapy (CAT) was originally developed as a time-limited psychotherapy to use individually with service-users, drawing on object relations, cognitive and social development theory and the work of Bakhtin (Ryle and Kerr, 2002). CAT is fundamentally relational in the way it makes sense of people’s experiences, and as such the therapy involves developing a reformulation of the ways in which early experiences have influenced relationship patterns with self and other, and how these may maintain current difficulties (Ryle and Kerr, 2002). The model is organised around a central idea of reciprocal roles (RRs) which are dyadic, internalised patterns of relating to oneself and others (Ryle, 2001; Ryle and Kerr, 2002). These can help individuals to navigate their social worlds. Difficult or traumatic early experiences are thought to give rise to a set of RRs that may continue to cause the individual problems in later life and may be linked to poor mental health (Ryle and Fawkes, 2007). For example, a RR of attacking (other) to attacked (self) may have arisen due to early experiences of interpersonal violence and abuse. This may become a template for how someone expects relationships to be with others (I am either attacked or have to attack others), and/or a way of relating to the self (I have to hurt myself). Reciprocal Role Procedures (RRPs) is the term given to the many patterns or ways in which individuals move between or within RRs (Ryle and Kerr, 2002).

Due to the emphasis on the importance of relationships and promoting change through corrective relational experiences, CAT has been utilised beyond the bounds of individual therapy. It provides a non-judgemental and accessible model to make sense of powerful or difficult behaviours and feelings (Carradice, 2004). Caruso et al. (2013) studied the impact of a CAT framework on mental health professionals working with service-users who they experience as challenging. They found the structured way in which CAT training helped mental health professionals to think about relational problems, led to a lower level of burnout related to overwhelming emotional responses, and a higher level of effectiveness and confidence in clinical work.
Aim of study

The present study aimed to explore staff experiences of team formulation in the context of the current literature, and to develop this further by specifically considering what CAT-informed team formulation contributed to staff learning and practice.

Service context and outline of team formulation

The study was carried out in a tier 4, inpatient unit for women with a diagnosis of personality disorder. Given its relational framework and the evidence for its use within personality disorder (Ryle, 1997; Pollock, 2001; Clarke et al., 2013), CAT is the overarching therapeutic model within the service. Each service-user (where possible) engages in a collaboratively derived CAT formulation within the first three months of admission. These formulations then form the basis of team formulation sessions (which are offered to all staff, on a weekly basis, for one hour). The ethos of the whole service is one of providing a safe environment to have service-users’ stories heard and understood, and therefore issues around team confidentiality and consent are discussed at assessment and continued throughout a service-user’s admission. Formulations and histories are only shared with professionals who are working directly with the service-user.

Each week a different service-user is the focus of team formulation meetings, and all attending staff members are given a copy of a one page history, CAT formulation and exit sheet. The one page history provides an overview of key life experiences, family relationships and identifies core learning about self and other. The CAT formulation is a diagrammatic representation of the service-user’s target RRPs (i.e. relational patterns that service-users identify as problematic and are the focus of the admission). The formulation is often referred to as a “map”. The map is a closed sequence, outlining how service-users move between problematic RRPs that keep them “stuck” in difficult relationships with self and other and unhelpful ways of coping and surviving. Therefore, exit sheets detail the potential “exits” from these closed sequences, and provide direction for staff and service-users. They are updated throughout a service-user’s admission, as they begin to identify and learn new ways of relating. Sessions focus on current difficulties the service-user has been having, tensions in the staff-service-user relationship and how these can be understood in the context of the formulation.

The aim of these sessions is to provide an opportunity to develop a shared understanding of service-users’ formulations, so as to inform team working practices within an overarching CAT framework. Sessions are facilitated by the second author (Ranil Tan (RT)).

All staff are provided with a bespoke 2 day “Introduction to CAT” training in addition to these sessions (Clinkscales et al., 2018), and therefore a subsequent aim is to draw out the knowledge gained in this training, and provide a sustained forum for continued relational thinking and practice.

Method

Design and participants

The study was carried out over two phases. Staff were included in both phases on the basis they had attended at least one team formulation in the last year, in order to have sufficient experience to answer the questions. In phase one, 37 staff in the service were asked to complete a questionnaire to ascertain feedback on their general experience of team formulation (see Appendix). In total, 16 staff (42 per cent of the staff team) completed the questionnaire. In all, 13 of the 37 members of staff sent the questionnaire were not eligible to participate, as they had not attended a session in the last year; these were nurses working predominantly night shifts or in management. All 16 respondents were eligible. In the second phase, qualitative interviews were conducted to gain more in-depth feedback of staff’s understanding and experience of using a cognitive analytic framework within sessions. Six staff were interviewed. All staff had taken part in the in-house two-day CAT training, and one staff member had undertaken a further six-month “CAT Skills for Case Management” course. Staff demographic details are shown in Tables I and II.
### Table I: Phase one staff demographics

<table>
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**Note:** $n = 16$

### Table II: Phase two staff demographics

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<td>25+ sessions</td>
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**Note:** $n = 6$

**Procedure**

In phase one, all staff members working in the service, were sent an electronic link via e-mail, to an anonymous evaluation questionnaire. The questionnaire clarified whether or not staff had attended any team formulation sessions in the last year. There were also ten multiple choice questions adapted from a questionnaire by Johnstone and Hollingworth (2014) which focused on the experience of team formulation, regardless of the underlying model used. Staff were asked to select a response from 1 (strongly disagree) to 5 (strongly agree) on a range of statements.
including: “I have found team formulation useful in developing a shared understanding of service-user’s problems, strengths and difficulties”, and “I have found team formulation useful in dealing with core issues relating to the service-user, not just crisis management”.

In phase two, staff self-selected to take part in an interview (via an e-mail invitation, sent to the whole team). Staff attended a 30 minute interview with first author (Rose Stratton (RS)), on site, as part of their shift. They were provided with information sheets and informed consent was taken, including consent to audiotaping. The interview was semi-structured in format, consisting of four main questions, focussed on the understanding and use of central aspects of CAT including formulation, exits and the use of the self. The interview questions were developed in supervision between the two authors and were designed to build on the results of phase one, by looking at how the therapeutic model influenced staff experience across each domain. All interviews were audiotaped, transcribed, anonymised and the original tapes destroyed in accordance with the service’s policy on information governance.

**Analysis**

In phase one, descriptive statistics were applied to the results of the questionnaire. Thematic analysis (Braun and Clarke, 2006) was used to analyse the data from phase two. All transcripts were returned to staff to check for accuracy. All transcripts were repeatedly read line-by-line. Initial coding was conducted by the first author (RS). Initial codes (meanings, commonalities and differences across interviews) and potential themes were proposed and discussed in supervision with the second author (RT), and a reflective log was kept alongside this. Superordinate themes and subthemes were developed and agreed upon by consensus and returned to staff for respondent validation.

**Results**

The mean percentages from phase one showed the majority of staff agreed or strongly agreed with each of the statements provided. In total, 7 per cent of staff disagreed with the statement “I have found team formulation helpful in minimising disagreements and conflict about service-users’ care within the MDT”; this was the only statement with which any staff disagreed. The full results can be seen in Figure 1.

Thematic analysis in phase two indicated two superordinate themes; “pausing to think and feel” and “challenges to keeping CAT alive”. Within each of these, several subthemes were identified. Three of the six staff members interviewed provided feedback on the themes, and all

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**Figure 1** Phase one questionnaire responses

![Phase one questionnaire responses](image)
agreed that these were representative of their views expressed at interview. All themes are shown in Figure 2, and described below with illustrative quotes (where (P) denotes participant number).

**Pausing to think and feel**

Sessions provided time for staff to stop and pay attention to their own and service-users’ thoughts and feelings, which in essence developed their capacity for reflective practice:

 [...] giving me insight into maybe what I’m seeing, what I’m feeling, what I’m experiencing, what they may be suggesting they are thinking or feeling or experiencing (P3).

This awareness appeared to enable staff not only to learn to “sit with” and notice their own emotions, but to apply this thoughtful noticing to the management of their emotions:

 [...] teaches you like, to feel what you’re feeling, and like it’s okay to feel that and, just like, sit with it but think, how can I attend to this feeling appropriately? (P5).

By building this reflective capacity, and learning how to attend to their emotional reactions, staff appeared to feel more able to reflect on learning from the sessions, and to integrate their experience of the service-user into a more coherent understanding:

 I can think back to the session, or even when I’m in the session, I can think actually that [procedure] is happening there and this [procedure] is happening now (P5).

The ability to pause, think and feel seemed to underpin all the following themes, as building this reflective capacity enabled staff to better understand service-users’ stories, understand RRs, make links, notice patterns, use the formulation and to find ways to respond therapeutically.

**Understanding a service-user’s story.** Connecting and holding it in mind. This theme was touched on by all staff, and as part of this the one page history summaries were highlighted as a useful tool. Their utility appeared to be as an aid to remembering; enabling busy staff to try to hold the historical context in mind:

 [...] even if you know the service-user quite well, it’s good to refresh your memory every time (P2).

**Figure 2** Diagrammatic representation of superordinate and sub themes
They also appeared to assist staff in connecting with the difficulties and struggles that service-users have faced on an emotional level, to enable them to retain empathy:

When you go into the case formulation you read the history [...] and [...] I’ve just thought [...] her entire life has been chaotic, it’s no wonder we’re just seeing chaos here (P3).

Understanding RRs. Self and other. Staff identified developing an awareness and understanding of their RRs, and those of other people, including service-users, and their colleagues:

There’s been times when other staff members have done something or said something and I haven’t agreed with them but [...] I’ve been able to use the motions of CAT [...] to understand why they’re acting like that, and then when I’m thinking about how someone else is acting, I can then reflect on how I’m acting and like take something from that as well (P6).

[...] it’s helped me to um to sort of recognise the reciprocal roles that I’m much more likely to get into and sort of recognise myself in them as well at different times (P1).

Making links, noticing patterns, using the map

This theme highlighted an ability to draw from service-users’ histories, to understand problematic procedures and to use the map as a tool to support them in noticing links between past experiences and current difficulties:

[...] this is what they only know [...] so it will help you to understand oh okay she is like pushing me away because what she is used to is being pushed away (P6).

I think the maps are useful [...] just looking at what patterns we can expect, what reciprocal roles we can look at that we might be getting into without really knowing about it (P4).

Finding a way out: Exits and professional responses. This theme described the ways in which staff were able to incorporate new knowledge into their interactions, and their ability to find therapeutic exits from unhelpful procedures, both in direct and indirect interventions:

[...] bearing in mind like their maximum level of functioning, because we don’t want to stretch them because we end up doing more damage [...] so this will also guide us, like okay we can go, we can stretch this far [...] but just remembering as well where they come from, what are their triggers erm how much they suffered (P6).

I suppose [...] just noticing how people are talking about particular women especially in times of crisis [...] I’ve been able to [...] support a different way of reframing and thinking about things (P1).

Challenges to keeping CAT alive

Amongst the opportunities for development, staff also highlighted some challenges to the use of their learning on a day to day basis:

I think at the minute [...] you go to formulation, it stays with you for a while [...] and then it kind of just seems to get forgotten about a little bit [...] (P4).

The barriers appeared to fall broadly under two categories; attendance and confidence.

Attendance. Staff identified difficulties with working a shift pattern, and not being able to attend weekly sessions frequently:

Some of the people that really need to go to case formulation um you know regularly you know like support workers and nurses who are working with the women face to face don’t often get the opportunity (P1).

Confidence. Staff described issues both with having confidence to speak and utilise sessions effectively, as well as the confidence to use this learning outside of the sessions (e.g. how it informs interventions):

I feel comfortable to be open and honest about what I feel and think, but I think a lot of people probably hold back and that could possibly erm [...] lessen the effectiveness of the sessions I suppose (P2).

I think my problem I have with CAT, maybe it’s my lack of understanding [...] of the interventions of CAT and how we move it forward (P3).
Discussion

The aim of the current study was to understand staff experiences of cognitive analytic team formulation, within an inpatient unit for women with a diagnosis of personality disorder.

The results appear to support previous literature, in that team formulation can assist staff to build a shared understanding of service-users’ difficulties by drawing on a range of information and a coherent theoretical framework (Johnstone and Dallos, 2014; Johnstone and Hollingworth, 2014). It further supports the idea that team formulation can help staff to reduce their frustration, develop a more compassionate and psychologically informed understanding of a service-user’s difficulties, and help them to believe they can be of help to a service-user in their care (Summers, 2006; Wainwright and Bergin, 2010; Craven-Staines et al., 2010; Harrison et al., 2018).

Phase one results indicated the majority of staff agreed or strongly agreed with the statements about team formulation across ten specified domains. Items regarding developing a shared understanding about service-users’ difficulties and relationship to the service, map onto the key themes from phase two: understanding the service-user’s story and understanding RRs. Phase two provides a richer narrative about how this is achieved. For example, staff reported acquiring a deeper understanding by connecting with service-users’ histories and using their own responses and emotions to gain “feedback” about the therapeutic relationship.

Similarities between high scoring responses and themes drawn from phase two are supportive of the validity of these results, as is the agreement of three interview participants that themes are representative of their discussed experiences. However, questionnaire results should be interpreted with caution, as they may be subject to response biases. Staff may have responded in accordance with what they assumed the authors wanted them to say (Orne, 1962) and this may account for the lack of negative responses in phase one. It is important to note that both authors work within the team (with the second author being the facilitator of team formulation), and therefore this could have impacted responses (Nichols and Maner, 2008). Staff may have felt pressured to respond positively, in order to maintain professionalism (Van de Mortel, 2008). Attempts were made to mitigate against this, by anonymising responses to the questionnaire and using a platform that did not alert either author when a response had been returned.

The qualitative results fall broadly into two superordinate themes; pausing to think and feel and challenges to keeping CAT alive. Within the first theme, staff members described a developing capacity to reflect on their work and the use of CAT as a way of structuring their thinking and approach, primarily through its relational framework. One key aspect of the CAT model is the ability to be able to “tune in” to your emotional experience and use this in a way that helps you to avoid enacting problematic RRP’s in a service-user’s life (Ryle and Kerr, 2002). Staff highlighted that team formulation had taught them to “feel what you are feeling” (P5), and this could be seen as an important part in supporting staff to better make sense of their emotional reactions, and those of service-users, in order to form a more coherent and holistic impression of interactions and relationships. Caruso et al. (2013) suggest using a relational framework helps to reduce burnout related to overwhelming emotional responses, as staff are encouraged to view their feelings as part of the process of clinical work, as opposed to attempting to “manage” these understandable reactions by creating distance or cutting off from them. Furthermore, staff noted an increased understanding of their own relational patterns and an ability to recognise themselves in unhelpful relationships with others. This awareness, combined with the ability to hold on to their empathic stance, would be a good basis for providing more corrective relational experiences that are key for service-users developing a more diverse and healthier range of RRP’s (Ryle and Kerr, 2002).

Understanding the service-user’s story and understanding RRs were sub-themes, whereby the integration of this knowledge seemed to allow staff to make links, notice patterns and use the formulation (map). The one page history summary was highlighted by all staff as a useful tool in this, and staff noticed this served a dual function, both to aid memory, but also to assist them to connect with a service user’s life experiences. This lends further support for previous findings where space within a team formulation to reflect on a service-user’s history enabled staff to feel more compassion and empathy (Harrison et al., 2018; Berry et al., 2009). Such practice would
therefore be important when considering what’s required to build more compassionate
environments (Francis, 2010).

The study supports the findings of Berry et al. (2009) in so much as staff reported team
formulation enabled them to feel as though the team could be of help to service-users they
support (81 per cent of phase one staff either agreed or strongly agreed with the statement
“I have found team formulation useful in encouraging me to believe that I and the team can be of
help to service-users”). Having a belief that your practice can effect change is vital in helping staff
have a sense of efficacy and purpose (Johnstone and Hollingworth, 2014).

The above themes culminate in supporting staff to think more clearly about exits from problematic
RRPs for service-users, and identifying non-collusive professional responses. Staff spoke about
formulations, alongside their increased understanding of the relational content, supporting them
to think about how they guide the service-user in their interventions. They were able to reflect on
the idea of “maximum level of functioning” (P6) whilst acknowledging the possibility that staff can
do unintentional harm without this relational understanding of service-users’ difficulties. They also
reflected on the importance of informal conversations, and being able to support the team using
the shared language of CAT, to reflect and reframe responses to service-users in terms of their
formulation. Sharing the formulation in this way appears to promote ownership and support the
team to develop a shared understanding and approach (Cole et al., 2015). However, as
discussed below, some staff felt the learning could be used more widely, especially in care
planning, and that there was a tendency for the session to “stay with you for a while” and then be
forgotten (P4). It may be important to position supervision as one of a number of different forums
for maintaining relational thinking within a service.

Similarly to Harrison et al. (2018) the analysis also highlighted barriers to utilising team formulation.
Low attendance was perceived as impacting the usefulness of the sessions, and attendance was
generally highlighted as a barrier to effective application of learning. This suggests a need to
carefully consider the implementation of any team approach to formulation to attempt to ensure
staff attendance. Harrison et al. (2018) also found a pattern of staff lacking the confidence or
knowledge to speak up in sessions. This is also noted within the current study, as staff reported that
sometimes people were afraid or unable to speak up in sessions. This may be related to
disagreements about care outside of team formulation sessions impacting on confidence to speak,
as “minimising disagreements and conflicts” was the only domain with which any phase one
participant disagreed. It may be important therefore to give consideration to the relational patterns
that may be at play within the staff team; being able to notice and safely work through this may
support less confident members and help create safer forums for learning.

The current study demonstrates CAT informed team formulation as an acceptable model of
supervision for staff within this sample. The work could be extended to gain more detailed
feedback on the impact of team formulation over time on staff’s reflective capacity, use of CAT
and working practices. This could be achieved by adapting the phase one questionnaire in light of
the qualitative feedback, and implementing this as a regular review tool within the service.
In contrast to the majority of previous research (e.g. Christofides et al., 2012), formulations in this
service were developed with service-users prior to being shared with the team. Further research
could explore the value of this approach, in terms of service-user experience and their overall
care. The phase one sample is a small proportion of the overall staff team (42 per cent), however
is considered to be representative of the gender, ethnicity and professional background mix of
the wider team. Staff selection may have been limited by the fact that interviews were conducted
on site and as part of the shift pattern. Future work may benefit from accessing a broader range of
staff (in terms of number of staff, gender and profession) so as to minimise response biases from
a self-selected sample.

In conclusion, team formulation continues to demonstrate benefits for staff working within
complex mental health. In line with previous research the challenges to this work involve the
practicalities of bringing teams together (i.e. staff attendance), group dynamics (e.g. confidence in
contributing to the session) and issues related to how learning from supervision is maintained.
However, overall, a cognitive analytic framework seems to offer staff the opportunity to integrate
the learning from a service-user’s history, and current relational difficulties, in a way that develops
reflective capacity and informs subsequent intervention.
References


Chadwick, P., Williams, C. and Mackenzie, J. (2003), 10.1007/s10597-012-9579-x


Appendix

You are being invited to participate in a service evaluation, specifically focusing on the Cognitive Analytic Therapy (CAT)-informed Team Formulation sessions that run weekly (Wednesday 11am) at X. Part 1 of the evaluation is a simple questionnaire, which will take approximately 5-10 minutes to complete. Your participation is entirely voluntary, and you can withdraw at any time by simply exiting or discontinuing the questionnaire. You do not have to answer any questions which you do not want to. To help protect your confidentiality, no personally identifiable information is required and all responses will remain anonymous.

1. Have you attended the Team Formulation sessions at X?
   - Yes [ ]
   - No [ ]

2. Please identify any barriers or difficulties in attending.

If you answered “Yes” to question 1, please complete the following 5 questions. The questions are rated on a scale between 1 (strongly disagree) and 5 (strongly agree), please select the most appropriate response for you.

1. I have found Team Formulation useful in developing a shared understanding of service-users problems, strengths and difficulties.
   - Strongly Disagree [ ]
   - Disagree [ ]
   - Neither Agree nor Disagree [ ]
   - Agree [ ]
   - Strongly Agree [ ]

2. I have found Team Formulation useful in increasing my understanding about how and why service-users relate to the service and staff members in particular ways.
   - Strongly Disagree [ ]
   - Disagree [ ]
   - Neither Agree nor Disagree [ ]
   - Agree [ ]
   - Strongly Agree [ ]

3. I have found Team Formulation useful in reducing the frustration I feel when working with service-users.
   - Strongly Disagree [ ]
   - Disagree [ ]
   - Neither Agree nor Disagree [ ]
   - Agree [ ]
   - Strongly Agree [ ]

4. I have found Team Formulation useful in increasing my confidence in working with women who have complex needs.
   - Strongly Disagree [ ]
   - Disagree [ ]
   - Neither Agree nor Disagree [ ]
   - Agree [ ]
   - Strongly Agree [ ]

5. I have found Team Formulation useful in encouraging me to believe that I and the team can be of help to service-users.
   - Strongly Disagree [ ]
   - Disagree [ ]
   - Neither Agree nor Disagree [ ]
   - Agree [ ]
   - Strongly Agree [ ]
6. I have found Team Formulation useful in minimising disagreements and conflict about service-users care within the MDT.
   - [ ] Strongly Disagree
   - [ ] Disagree
   - [ ] Neither Agree nor Disagree
   - [ ] Agree
   - [ ] Strongly Agree

7. I have found Team Formulation useful in drawing on the knowledge and skills of those from different professional backgrounds when working with service-users.
   - [ ] Strongly Disagree
   - [ ] Disagree
   - [ ] Neither Agree nor Disagree
   - [ ] Agree
   - [ ] Strongly Agree

8. I have found Team Formulation useful in dealing with core issues relating to service-users not just crisis management.
   - [ ] Strongly Disagree
   - [ ] Disagree
   - [ ] Neither Agree nor Disagree
   - [ ] Agree
   - [ ] Strongly Agree

9. I have found Team Formulation useful in challenging unfounded beliefs/assumptions about service-users.
   - [ ] Strongly Disagree
   - [ ] Disagree
   - [ ] Neither Agree nor Disagree
   - [ ] Agree
   - [ ] Strongly Agree

10. I have found Team Formulation useful in improving the satisfaction you get from working with service-users.
   - [ ] Strongly Disagree
   - [ ] Disagree
   - [ ] Neither Agree nor Disagree
   - [ ] Agree
   - [ ] Strongly Agree

Source: Adapted from Johnstone and Hollingworth (2014)

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Human givens rewind trauma treatment: description and conceptualisation

Shona Adams and Steven Allan

Abstract

Purpose – Human Givens (HG) Rewind technique is a graded trauma-focused exposure treatment for post-traumatic stress disorder and trauma. The purpose of this paper is threefold: first, to describe the technique; second, to provide an outline of its potential benefits; and third, to present some preliminary evidence.

Design/methodology/approach – This paper provides an overview of HG therapy and describes the stages of HG Rewind trauma treatment and its potential benefits. Similarities and differences between Rewind and other Cognitive Behavioural Therapy techniques are explored. Possible underlying mechanisms are discussed.

Findings – Preliminary evidence suggests that Rewind could be a promising trauma treatment technique and that HG therapy might be cost effective. The findings highlight the need for further research and a randomised controlled trial (RCT) on Rewind is warranted.

Practical implications – During the rewind technique, the trauma does not need to be discussed in detail, making treatment potentially more accessible for shame-based traumas. Multiple traumas may be treated in one session, making it possible for treatment to potentially be completed in fewer sessions.

Social implications – This UK-based treatment may be cost effective and make treatment more accessible for people who do not want to discuss details of their trauma.

Originality/value – This is the first description of HG Rewind in the peer-reviewed literature. Alternative explanations for mechanisms underlying this trauma treatment are also presented.

Keywords Human givens, PTSD, Trauma, CBT, Exposure, Rewind

Paper type Conceptual paper

1. Introduction

Exposure treatments for post-traumatic stress disorder (PTSD) have the strongest evidence base compared to other treatments (Cusack et al., 2016). Human Givens (HG) Rewind technique is a graded exposure treatment for PTSD and trauma but is not well known by either clinicians or researchers. Furthermore, the HG Rewind technique has not yet been described in any peer-reviewed journals and consequently there has been no discussion about the theoretical underpinning of this technique.

In the early cognitive behaviour therapy (CBT) literature a graded form of exposure called systematic desensitisation was found to be an effective treatment for PTSD (Brom et al., 1989) and was later developed into prolonged exposure (PE; Foa, 1992). There are now a variety of other exposure-based treatments such as narrative exposure therapy (Robjant and Fazel, 2010), cognitive processing therapy (CPT; Resick and Schnicke, 1993) and virtual reality exposure therapy (e.g. Rothbaum et al., 2001). Similar to some of these techniques, Rewind incorporates graded exposure in the protocol and utilises imaginal exposure. However, it remains distinct from other exposure techniques in that the protocol includes graduations of exposure based on decreased psychological distancing (i.e. observing oneself observing the trauma, then observing the trauma and finally feeling the trauma). As patients do not need to talk about the trauma(s) in detail this may make treatment potentially more accessible for shame-based traumas and multiple traumas could be treated in one session (Adams, 2017).
A distinction has been made between trauma-focused treatments for PTSD which focus predominantly on the past trauma, such as trauma-focused CBT (TF-CBT) and eye movement desensitisation and reprocessing (EMDR) and present-focused treatments that focus on current maladaptive behaviours and thought patterns arising from the trauma but do not focus on the past trauma (Belsher et al., 2017; Classen et al., 2011; McDonagh et al., 2005). While a review of 25 PTSD randomised controlled trials (RCTs) found no significant differences in drop-out rates between exposure and other trauma-focused treatment protocols (Hembree et al., 2003), present-focused therapy had lower drop-out rates (14.3 per cent) than trauma-focused treatments (31.3 per cent) for PTSD in five RCTs where they were directly compared (Frost et al., 2014). Moreover drop-out rates for TF-CBT in RCTs, which ranged between 0–54 per cent (Schottenbauer et al., 2008), tended to be lower than those in naturalistic clinical settings (Garcia et al., 2011; Najavits, 2015; Watts et al., 2014). For example, of 115 clinic patients in a university-based PTSD clinic delivering PE only 42 per cent started treatment and 28 per cent completed treatment (Zayfert et al., 2005). Also, only 11.4 per cent of a sample of 796 veterans with PTSD started CPT or PE treatment and 7.9 per cent completed treatment (Mott et al., 2014). Thus, while trauma-focused treatments are recommended for PTSD by the UK National Institute for Clinical Excellence (NICE, 2013), non-engagement and drop-out rates for TF-CBT in clinical settings and lower drop-out rates for present-focused treatments indicate that improvements to existing approaches and alternate treatments should still be explored.

Thus, the aims of this current paper are to briefly outline HG therapy and to describe the Rewind technique. Similarities between Rewind and other CBT techniques and the potential benefits of Rewind for patients, therapists and services are discussed. Finally, preliminary evidence for the efficacy of Rewind is presented, and potential underlying mechanisms of Rewind are briefly outlined.

2. Description of HG therapy, theory and the Rewind technique

Rewind is one of the HG (or HG therapy) treatment techniques for trauma that was developed in the UK Griffin and Tyrrell (2004). HG therapy is a brief solution-focused therapy that includes anxiety management strategies, goal setting, graded exposure and informally challenging negative thoughts. It also uses imagery, imagery rescripting, an understanding of the trance state, metaphors and the therapeutic use of language. Key theoretical principles include the role of REM state, the use of imagination, the importance of meeting our innate emotional needs and the use of our resources to achieve this, the role and regulation of emotional arousal, and the assumption that the fight flight response (FFR) is fundamentally adaptive (rather than being problem-focused). For a more detailed description of basic HG techniques see Yates and Atkinson (2011). HG’s application of methods are different to those of first generation CBT (e.g. not requiring written thought diaries or an agenda for each session, and the emphasis in treatment on reducing emotional arousal).

According to HG theory, when people have unmet emotional needs the FFR is activated to motivate them to take action to meet their needs. Emotional needs, otherwise known as “human givens”, include: safety and security, autonomy (sense of control), appropriate attention, intimacy (emotional connection in close relationships), community (connection to the wider community), status (sense of being valued, accepted and belonging), achievement and competence (sense of own abilities and competencies), privacy (enough time and space to reflect on, learn from and consolidate our experiences) and meaning and purpose (being stretched, being helpful or being connected to ideas or beliefs greater than themselves). A questionnaire called the Emotional Needs Audit has been developed to measure unmet emotional needs (Tsaroucha, Kingston, Corp, Stewart and Walton, 2012).

According to HG theory, if a person believes that they are in severe danger (unmet emotional need) their FFR is activated. Cognitive distortions (such as predicting the future, negative bias, catastrophising, personalising, mind reading and black and white thinking) that enable one to respond quickly to danger may also increase thoughts of perceived threat when there is no danger (Adams, 2017, Addendum). Misperception of danger can also be achieved through misused imagination by visualising or vividly imagining something bad happening thereby
activating the FFR. The high levels of cortisol that regulate the FFR also inhibit synaptic connections in the prefrontal cortex and the hippocampus (Le Doux, 2002). This can make it difficult to contextualise the trauma memory using the hippocampus to access logical information from the prefrontal cortex when the immediate danger has passed. When the trauma memory is not sufficiently processed and contextualised, a pattern match is created whereby memories or sensory reminders of the trauma again trigger a strong FFR from the amygdala when there is no present danger (the ability to pattern match is fundamental and enables humans to categorise objects and make assumptions about them, and to have language to describe and communicate with others). Thus, an “Activating agent” (or trigger) can be a Pattern match to a past trauma, which in turn creates an Emotional response (FFR, including cognitive distortions that enable us to respond very quickly in danger) and finally Thoughts about what actions to take and to make sense of our experiences. This is referred to as the APET model. Thoughts alone can also be the “activating agents” that create a pattern match to the thoughts that were experienced during the trauma, as can memories or sensory experiences and physical sensations that were experienced during the trauma. HG theory suggests that the ability to pattern match is adaptive in that one danger is rarely identical to the next and our brain needs the ability to generalise in order to be safe in future. In HG theory the above processes are not limited to PTSD, but may be involved in sub-threshold traumas that do not meet the criteria for PTSD.

This paper focuses on just one of the trauma-focused HG techniques called Rewind. Rewind is an HG technique that evolved from the Visual Kinaesthetic Dissociation (VKD) technique in Neuro Linguistic Programing (NLP) used in the treatment of anxiety (Bandler and Grinder, 1979). Both NLP and HG therapy are strongly influenced by the work of Milton Erickson, who also laid foundations for brief therapy, solution focussed therapy, hypnosis, strategic family therapy and family systems therapy (Gorton, 2005). While Rewind is very similar to VKD, Griffin and Tyrrell (2001) manualised the VKD technique, emphasised those aspects that they felt were important and provided a theoretical framework with both physiological and psychological components. HG Rewind bears similarities to David Muss’ version of Rewind that was independently developed from VKD in the UK as a PTSD treatment technique (Adams and Allan, 2018; Muss, 1991, 2002, 2017; Utuza et al., 2012). However HG Rewind differs from the Muss’ Rewind protocol in that it includes strategies to reduce emotional arousal. An initial increase in arousal is required during HG Rewind for the trauma memory to be activated, however according to HG theory it is important to keep arousal levels relatively low during exposure to allow the brain to process the trauma and prevent unnecessary distress for the patient.

2.1 HG Rewind treatment protocol: seven stages and one optional stage

2.1.1 Activating the trauma memory. Following a brief introduction to the technique, the therapist agrees with the patient the event(s) that will be rewound. They then create an imaginary film with the patient that includes all the traumas that need to be treated. This can include distressing subsequent symptoms such as panic attacks, suicidal thoughts, flashbacks and nightmares, all of which can be sub-threshold traumas in their own right. Each traumatic event will include starting at a point when everything was relatively safe before the trauma occurred and end when the trauma was over or the symptoms had subsided. The patient can provide a phrase (like “the bad thing that happened”, or “kitchen” if the event took place in a kitchen) that represents the trauma memory, and details of a trauma therefore do not need to be discussed with the therapist. More than one trauma can be included on the imaginary film.

The therapist ensures that the trauma memory has been activated by observing evidence of some physiological arousal in the patient, such as tensing of the jaw muscles, swallowing, skin flushing and fidgeting. The trauma template is often activated when discussing the process without going into the details of the trauma and hence arousal levels still remain relatively low. If the trauma memory was not activated at this time, the therapists will initiate the relaxation stage and when the patient has started relaxing they will then gently guide them to access some of their negative emotions associated with the trauma. When there is some evidence of physiological arousal, the therapist will continue with the relaxation. If the trauma memory has not been
activated the treatment is unlikely to be effective. The actual presentation of physiological arousal varies with each patient and their individual presentation, and all HG therapists are taught to identify this.

2.1.2 Relaxation. The therapist then helps the patient relax. There are several ways to achieve deep relaxation. The “utilisation principle” (use what works for a patient) is used to tailor the relaxation technique to the patient’s individual needs. Less focus is placed on the specific relaxation techniques themselves and more on ensuring that the patient relaxes or is deeply focussed. Arousal levels can be kept low by creating an imaginary grounding place in the patient’s imagination where they are happy and contented. The therapist can bring the patient back to this place between exposures to help keep arousal levels low. There is some flexibility in the order of the first two stages and the therapist is guided by what is appropriate for the patient. The therapist moves onto the third stage once the patient is very relaxed. The relaxation provides a means of emotional stabilisation during exposure.

2.1.3 Double distancing. This is the first part of the graded imaginal exposure. While the patient is in a grounding place in their imagination, they are guided to imagine watching themselves watching the film repeatedly until they feel calm and peaceful watching themselves. Observing themselves in their imagination watching their trauma on the film is called double distancing and helps keep arousal levels low. This stage allows the patient to observe that they will not be too anxious during subsequent exposure and to learn how to reduce the arousal between exposures.

2.1.4 Single distancing. In the next stage of the imaginal graded exposure the patient imagines watching the film of their trauma. The patient watches the film very quickly backwards from when they were safe, through the trauma memory, to before the trauma started. This is where the name of the Rewind technique originates. The film is watched backwards and forwards very quickly until the patient is calm and peaceful, or bored, when watching the film. The patient is directed to relax in the “grounding place” in their imagination between exposures to help keep their arousal low.

2.1.5 Association. The final stage of the imaginal exposure is when the patient is guided to allow the screen to fade away, and instead of watching the film they imagine being pulled backwards through the memory very quickly, starting from the end when they are safe and finishing before the trauma began.

2.1.6 Rehearsal (optional). The rehearsal stage is used when one of the patient’s goals is to help them develop competence in handling a situation in the future. The therapist prompts the patient to remember a time in the past when they dealt well with that kind of situation, or to vividly imagine how someone else might deal well with it. They then use this information to imagine or mentally rehearse themselves undertaking that activity in the desired way.

2.1.7 Ending. The patient is generally not aware of the ending stage, but as a therapist it is important to re-orient the person to the present. As the patient has been deeply relaxed, the therapist changes their tone and speed of voice to help the patient become more alert. The therapist can then check with the patient to see if the treatment has been successful by asking them to think of the trauma memories and report if they experience the memory differently.

3. Similarities and differences between Rewind and other CBT protocols

Although HG Rewind protocol differs considerably from other CBT exposure techniques, similar underlying mechanisms may be involved.

3.1 Psycho-education

Similar to other TF-CBT protocols (e.g. Ehlers and Clark, 2000), a brief rationale of the technique is often given before the treatment commences. However explaining a rationale for how Rewind might facilitate memory processing is not mandatory in the HG Rewind protocol. The rationales presented may differ in content between HG Rewind and CBT because the underlying theory is slightly different.
3.2 Imaginal exposure

TF-CBT includes imaginal exposure protocols such as “reliving” (Ehlers and Clark, 2000) where the patient describes the trauma verbally in detail to the therapist. A detailed account of the trauma memory can also be expressed in writing (e.g. Resick and Schnicke, 1993; Robjant and Fazel, 2010). However, in HG Rewind there is no need for the patient to verbalise any details of the trauma but rather they replay the memory of the trauma in their imagination. Given the details are in their imagination, they are encouraged to include sensory aspects of the trauma memory such as sounds, smells and sensations, all of which can be part of traumatic recall. Thus, imaginal exposure in HG Rewind may differ from other verbal or written CBT exposure protocols because it is not limited by language. Being primarily a non-verbal technique, it is possible for the exposure to occur more quickly because it is not constrained in speed by the use of language.

3.3 Repeated exposure

In TF-CBT exposure treatments, exposure to the trauma can be repeated multiple times, sometimes even as homework (e.g. Foa et al., 2007), until the anxiety has subsided. In HG Rewind, the imaginal recall of the trauma memory can be repeated forwards and backwards until the anxiety has subsided within the one treatment session.

3.4 Graduated exposure and distancing

Keane and Kaloupek (1996) acknowledged that graduated exposure to trauma-related cues is a typical part of trauma-focused exposure in PTSD treatments (e.g. see Foa, 1992). In HG Rewind, graduated exposure to the traumatic event(s) is built into the protocol. However, unlike many other TF-CBT protocols it is the level of emotional distancing during the exposure that is graduated. Distancing involves viewing an image from the perspective of a detached or distant observer (Koenigsberg et al., 2010) and has been found to be an effective method of emotional regulation (Ochsner and Gross, 2008). In the HG protocol the exposure begins with double dissociation in which the patients observe themselves watching a video of their trauma. This is followed by the single dissociation stage in which patients are only one step removed from the experience and observe their trauma through an imaginary video. The final stage involves full association to all of the sensory experiences of the trauma. Distancing is used in other CBT protocols. Ehlers and Clark (2000) described a distancing technique in which the patient is encouraged to imagine seeing the trauma from a different perspective. Sloan et al. (2012) and Sloan et al. (2013) ask the patient to write about their most distressing traumatic event from a distanced perspective without reading the account to the therapist. Thus, distancing the patient from the event during exposure is also used in other forms of CBT imaginal exposure for PTSD but is not conducted in a graduated manner.

3.5 Contextualise memory

One of the differences between a trauma memory and a processed memory is that a trauma memory is fragmented and a processed memory is contextualised. Some TF-CBT techniques actively aim to contextualise the trauma memory through the cognitive reprocessing or reappraisal (e.g. Ehlers and Clark, 2000). HG Rewind may achieve contextualisation of the trauma memories non-verbally through the imaginal exposure, with the recall of the trauma memory starting before the trauma and ending when the traumatic event is over. Recalling the trauma memory during relatively low emotional arousal may aid the contextualisation of the trauma memory.

3.6 Dual processing

Rewind also uses dual processing to help reduce arousal during the exposure to the trauma memories. In the HG protocol the therapist directs the patient to think of the memories backwards. By thinking of the memory backwards the patient is required to think of what a memory would look like backwards in the present while experiencing the trauma memory from the past. One can only think about one thing at a time (Levitin, 2014) and multi-tasking involves quick switches of attention. It is possible that dual processing (or such quick switches of attention) also occurs in trauma-focussed CBT when a person is experiencing their fear while at
the same time as looking at the evidence or considering what they now know. Thus, there would be slightly less attention on the trauma memory during exposure which might reduce arousal. This could be seen as similar to the eye movements in EMDR, where a person’s attention is split while recalling the memory (Lee et al., 2006; Pagani et al., 2017).

3.7 Grounding place

HG Rewind also uses grounding techniques by having the patient vividly imagine themself in a safe and contented place prior to the exposure to reduce their arousal prior to exposure. The patient is guided to return to that place in their mind’s eye in between exposures to keep their arousal lower during the imaginal exposure. The vivid use of all senses when focussing on the “safe” place is similar to mindfulness-type techniques. Patients typically enjoy this part of the treatment protocol. Using grounding techniques to reduce arousal and distress, as well as to manage flashbacks, are a common part of CBT trauma-focussed treatment (e.g. Keane and Kaloupek, 1996) and creating a “safe place” in the patient’s imagination while developing a compassionate mind is included in the Compassionate Mind Training (Gilbert and Procter, 2006). While grounding techniques are used in trauma-focussed CBT, they are not used to help keep arousal levels lower during imaginal exposure.

3.8 Relaxation

NICE (2005) does not recommend relaxation on its own as a treatment for PTSD, but states that treatment needs to be trauma-focussed. Before commencing exposure therapy, patients in TF-CBT protocols may be trained in coping strategies such as controlled breathing and relaxation to help them cope afterwards with any anxiety that was induced during the exposure (e.g. Foa et al., 2007; Lyons and Keane, 1989). Thus, rather than relaxation being an integral part of the trauma memory exposure, the emphasis is more on keeping the arousal levels low after treatment for the comfort of the patient and not leaving the patient in a vulnerable emotional state after treatment. In HG Rewind, trauma-focussed exposure is combined with relaxation.

4. Rewind as a third generation CBT technique

Although the role that distancing, contextualising, dual processing, a grounding place or relaxation has in processing trauma memories requires further research, HG Rewind uses many known CBT techniques but with a slightly different emphasis. Third generation CBT therapies have been described as being a transformation of the previous generations of CBT, having their own theoretical underpinnings and with the hope of improving outcomes (Hayes, 2004). As with other third generation therapies such as Mindfulness (Ludwig and Kabat-Zinn, 2008) and Acceptance and Commitment Therapy (Hayes, 2012), HG therapy has its own theoretical underpinning but also uses cognitive and behavioural techniques and as such may be considered a third generation CBT therapy. Nonetheless, as a technique that is distinct from other treatments, there may be some advantages of HG Rewind compared to other CBT trauma therapies that may warrant further investigation.

5. Potential advantages of HG rewind

In contrast to other NICE recommended treatments for trauma (NICE, 2013), during the imaginal exposure in the HG Rewind protocol the traumas are recalled through visualising, rather than verbalising or writing down the details of the trauma. This has two possible advantages. First, the trauma does not need to be spoken about in detail, which could have benefits for both patients and therapists. In addition, because it takes less time to visualise a trauma than to verbally describe it in detail it is possible to compete exposure to multiple traumas in one session.

5.1 Benefits for patients: potential increased accessibility of treatment and reduced drop-out rates for shame-based trauma

It is estimated that as many as 30–60 per cent who have been exposed to trauma either do not seek help, or refuse CBT approaches, or drop out of treatment, or are not significantly helped by
treatment (e.g. Bradley et al., 2005; Schottenbauer et al., 2008). Adams (2017) reported preliminary evidence suggesting that patients may be more likely to access treatment if they know that they do not need to discuss the details of their trauma. It has been proposed that embarrassment or distrust in some cultures and in some refugee populations may lead to people not reporting rape or sexual abuse (e.g. Tankink and Richters, 2007; ter Heide et al., 2011). Pre-treatment attrition rates have been found to be to be as high as 41.2 per cent for refugees (Paunovic and Öst, 2001), indicating that a large proportion of those with potential shame-based traumas may not access treatment. For those who are highly avoidant of the trauma memories, or for whom the trauma is a source of great embarrassment or shame, the option of not having to talk about the trauma in detail may make treatment more acceptable.

As noted earlier, differences in drop-out rates have been reported for present-focused treatment compared to trauma-focused treatments. In addition, a large variance in drop-out rates for CPT was reported, with only 45 per cent of African-Americans completing CPT compared to 73 per cent of the Caucasians (Lester et al., 2010), which indicates the possibility of cultural variations in drop-out rates. It was thought that high levels of anxiety induced by exposure to the trauma memory could lead to treatment dropout (Kilpatrick and Best, 1984; Pitman et al., 1991) but levels of anxiety have not been associated with drop-out rates (Foa et al., 2002). However none of the reviews of drop-out rates in PTSD treatment (e.g. Bradley et al., 2005; Cusack et al., 2016; Schottenbauer et al., 2008; Watts et al., 2014) focused on shame or separately considered shame-based traumas.

5.2 Benefits for therapists: Potential reduction in secondary traumatic stress

When a therapist does not have to listen to the detail of the trauma they may be less likely to experience secondary traumatic stress otherwise known as vicarious trauma, compassion fatigue or burnout (Baird and Kracen, 2006). In the most recent version of the Diagnostic and Statistical Manual of Mental Disorders (5th ed.) (APA, 2013), repeated or extreme indirect exposure to aversive detail of the event(s) in the course of professional duties is acknowledged as a qualifying event for PTSD. There are no studies reporting the prevalence of secondary traumatic stress in HG therapists. Estimates of the prevalence of secondary traumatic stress in therapists working with traumatised populations has varied from 6 to 26 per cent (Bride et al., 2009; Craig and Sprang, 2010; Ewer et al., 2014; NCTSN, 2014). The degree of exposure to traumatic material in therapy has been linked to compassion fatigue and burnout (Craig and Sprang, 2010), and secondary traumatic stress (e.g. Baird and Kracen, 2006; Ewer et al., 2014). However, other research has suggested that secondary traumatic stress has stronger associations with work related conditions and personal trauma history than with exposure to trauma stories (Devilly et al., 2009; Sodeke-Gregson et al., 2013). It is therefore unclear the extent to which exposure to traumatic stories is associated with secondary traumatic stress and further research on therapists using Rewind might shed light on this area.

5.3 Benefits for services: potential cost effectiveness

The process of visualising or remembering an event is faster than describing details of the trauma verbally. As a result, a single trauma can have many exposures in one session rather than requiring several sessions for the exposure. Multiple traumas can also be addressed in one session. The implications of this are that treatment can potentially be completed in fewer treatment sessions. This is considered briefly in the next section.

6. Preliminary evidence: number of sessions required and efficacy

Several studies on the effectiveness of HG therapy have reported on the number of sessions required for treatment. In a sample of 34 war veterans, the mean number of treatment sessions was 3.1 sessions, with a range of 1 – 8 sessions (Bishop and O’Callaghan, 2010). Mean scores on the Impact of Events-extended version (IES-E; Tehrani et al., 2002) reduced from 76.23 (SD = 13.13) to 28.88 (SD = 14.91). There was a large effect size (g = 3.32)
using Hedge’s $g$ to correct for the small sample size. In a large cohort treated with HG therapy ($n = 5,885$) the mean number of treatment sessions was $4.7$ (SD = $3.74$), although it was unclear from this study how many people were treated for trauma using Rewind (Andrews et al., 2013). In this study, mean scores on the Clinical Outcomes in Routine Evaluation (CORE-10; Connell and Barkham, 2007) reduced from $20.13$ (SD = $7.23$) to $11.35$ (SD = $7.70$), with a large effect size ($d = 1.18$) calculated using a pooled SD. This included those who did not complete treatment. Similarly, in the pilot study ($n = 124$), Andrews et al. (2011) found the mean number of treatment sessions to be $3.49$ (SD = $1.73$) and CORE-10 scores reduced from $19.41$ (SD = $7.13$) to $10.19$ (SD = $7.65$), with a large effect size ($d = 1.25$) calculated using a pooled SD. Finally, in a primary care study for treatment of depression, the mean number of HG treatment sessions was $2$ sessions compared to the control group of $4$ sessions of treatment-as-usual (Tsaroucha, Kingston, Stewart, Walton and Corp, 2012), with no significant difference between groups on the Clinical Outcomes in Routine Evaluation–Outcome Measure (CORE–OM; Connell et al., 2007) and the Satisfaction with Life Scale (Diener et al., 1985) at screening, and four months, eight months and one year after screening. Again, it was unclear in this study how many participants were treated with Rewind. A randomized controlled trial for both trauma and for depression is needed to determine if HG therapy can be completed in fewer treatment sessions than other recognised therapies.

To date there have only been two published studies that have reported on a single HG Rewind session. Murphy (2007) conducted a qualitative study on all those treated with Rewind at a trauma clinic in Northern Ireland ($n = 47$). Of these $47$ people, $27$ ($57$ per cent) had a single Rewind treatment session and $10$ of these were treated for multiple traumas in that single session. All participants had a diagnosis of PTSD prior to treatment. There was a large reduction in PTSD symptoms and none of the participants met the diagnostic criteria for PTSD after treatment. In a UK trauma clinic, Guy and Guy (2009) evaluated the efficacy of a single Rewind treatment session on a cohort of patients ($n = 97$) diagnosed with PTSD. Mean IES-E scores reduced from the severe range ($M = 61.64$, SD = $25.01$) to the normal range ($M = 21.05$, SD = $18.00$), with a large effect size ($d = 1.86$) calculated using a pooled SD. This study did not report on the number of traumas treated. These two studies were promising but neither included a control group so no firm conclusions can be drawn about Rewind from these studies.

7. Possible mechanisms underlying HG Rewind

Currently little is known about the mechanisms underlying the processing of memories in HG Rewind. Similar to Ehlers and Clark (2000) who commented that “at this stage, it is unclear why reliving [a TF-CBT technique] works”, we do not know exactly how Rewind works. Several potential mechanisms for Rewind treatment have been proposed: memory reconsolidation (Gray, 2010; Griffin and Tyrrell, 2004), the competing demands of dual processing and the orienting response and REM sleep (Griffin, 2005), low arousal and reduced cortisol levels enabling the hippocampus to contextualise and process the trauma memory as well as enabling the prefrontal cortex to inhibit the amygdala (Griffin and Tyrrell, 2004), psychological “distancing” using the observing self to observe the films (Dietrich, 2000; Griffin, 2005; Okhai, 2005) and extinction (Gray, 2010). It is beyond the scope of this present paper to address the current state of neurophysiological evidence from the cellular to the potential circuits involved, as well as experimental evidence for each of these proposed mechanisms. However, the following papers provide more information about these mechanisms; memory reconsolidation and extinction (Lee et al., 2017; Sartor et al., 2011), competing demands of dual focus of attention (Lee et al., 2006, 2017), orienting response and REM sleep (Pagani et al., 2017), and memory reconsolidation, sleep and the connectivity between the prefrontal cortex and the amygdala (Feng et al., 2018; Murkar and De Koninck, 2018). Thus, Rewind provides another opportunity to consider the mechanisms involved in processing trauma memories.

It might be surprising that a trauma memory can be processed without discussing details of the trauma. However, research on behavioural activation for depression has reported that cognitions can change without any formal discussion or addressing the cognitions at all (Veale, 2008). Grey et al. (2002) also noted that when a trauma memory changed, some appraisals of the...
memory also changed, which they called “spontaneous cognitive restructuring”. They proposed that this occurred because the appraisals were based on different information. More evidence is needed to link this process to underlying neurological mechanisms.

8. Limitations and future research

At the time of writing, most of the HG literature is not published in peer-reviewed journals and so it would be useful to conduct a systematic literature review that included the “grey literature” in order to identify and evaluate any additional evidence. Also there is limited published research on the effectiveness of HG Rewind and at present no RCTs have been conducted. An RCT is needed to directly compare the efficacy and cost of Rewind with other trauma techniques. It should include adequate follow-up as there is limited follow-up in existing studies. Given the possible cost-benefits of Rewind due to reduced number of treatment sessions, another RCT could investigate whether incorporating Rewind early in another course of treatment such as TF-CBT could reduce the average number of treatment sessions needed.

There is a suggestion that HG Rewind may provide potential benefits for shame-based traumas but, as yet, there is no firm supporting evidence. Population-specific studies could investigate whether Rewind may make treatment more accessible for people with shame-based traumas. In addition, qualitative studies could explore their treatment preferences. Furthermore, it is unclear whether the requirement to talk about a trauma may affect treatment for other populations. For example, in groups such as war veterans with high treatment drop-out rates in naturalistic settings (Najavits, 2015), a study could initially investigate whether HG Rewind might result in lower drop-out rates in this population.

Although HG Rewind has a distinct underlying theoretical perspective, the explanations for possible mechanisms require further research. It is currently unclear whether Rewind and other trauma techniques work through memory reconsolidation or memory extinction processes, or perhaps under differing therapeutic conditions either mechanism could be activated. There is also further scope for translational work linking Rewind and other trauma treatments to possible mechanisms involved in distancing, reduced arousal, dual processing or REM sleep. In addition, smaller case studies could investigate components of Rewind and CBT techniques to determine which are most efficacious in reducing specific trauma symptoms. The Rewind technique could also lend itself to neuroimaging studies that investigate brain structures involved in trauma memory processing.

9. Conclusions

HG Rewind is a graduated trauma-focused technique that combines reduced arousal with imaginal exposure. Reduced arousal, dissociation, the orienting response and memory reconsolidation have been proposed as possible mechanisms underlying this treatment. HG Rewind has its own distinctive theoretical underpinnings but uses CBT techniques and therefore could be considered a third generation CBT technique. HG Rewind differs from other trauma techniques in that details of the trauma do not need to be discussed and multiple traumas could be treated in one session with an emphasis on reducing arousal levels and not discussing the trauma in detail. Clearly more research is needed to compare HG Rewind with other treatments.

This research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors. There is no conflict of interest. Please note that since submitting this article for publication the HG Rewind protocol has been slightly refined. Please see https://hgi.org.uk/useful-information/treatment-dealing-ptsd-trauma-phobias/rewind-technique for the refined version.

References

Adams, S. (2017), Human Givens Rewind Treatment for PTSD and Sub-threshold Trauma, University of Leicester, Leicester, available at: http://hdl.handle.net/2381/39978


Further reading


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Can training improve staff skills with complex trauma?

Paula Robinson, Emma Griffith and Chris Gillmore

Abstract

Purpose – Studies show that experiences of repeated or complex trauma are very common in patients with severe mental health problems. Unfortunately, many professionals do not routinely ask about abuse, due to concerns about how to ask and respond. There is also a need for frontline staff to be trained in trauma-informed care. The purpose of this paper is to identify the needs of inpatient staff and developed a tailor-made training package.

Design/methodology/approach – A training programme was developed from focus-group discussion and delivered to the team. Questionnaires were administered pre-, post-training and at three-month follow-up, to assess changes in knowledge, confidence and worries in the assessment and treatment of complex trauma.

Findings – There was an increase in self-reported staff confidence (p = 0.001) and knowledge (p = 0.028) about working with complex trauma and their worries decreased (p = 0.026) between pre- and post-training.

Practical implications – In order to sustain the benefits of training for longer, recommendations were made to the service for on-going training, supervision and evaluation.

Originality/value – Given the recent interest in complex trauma within the literature (Diagnostic and Statistical Manual of Mental Disorders – Fifth Version (DSM-V); International Statistical Classification of Diseases – 11th Version (ICD-11)), the piloting and development of complex trauma training packages is timely. To the author’s knowledge, this is the first published account of complex trauma training for inpatient staff. This paper offers clinical and research implications to services who may want to develop as trauma-informed services within the NHS.

Keywords Staff training, Complex trauma, Service improvement, Programme evaluation, Complex PTSD

Complex trauma or complex posttraumatic stress disorder (CPTSD) was proposed by Herman (1992) to describe a syndrome of prolonged and repeated trauma. It came into being when some forms of trauma were found to be much more pervasive and complex (Herman, 1992). Childhood abuse that occurs over an extended time period is one such example (Courtois, 2004). Complex trauma suggests clusters of symptoms relating to affect regulation, consciousness, self-perception, perception of the perpetrator, relations with others and systems of meaning (Cloitre et al., 2011; Herman, 1992; Resick et al., 2012).

While there is growing attention to the concept of complex trauma, mixed views precluded the development of a diagnosis in DSM-V (American Psychiatric Association, 2013). On one hand, experts in the field argue for the inclusion of a distinct subtype of PTSD that more adequately captures the above cluster of symptoms, with such recognition seen as being the precursor needed for the development of research (Herman, 2012). On the other hand, the dearth of new research into the validity of complex trauma since DSM-IV has led to conclusions that there was insufficient evidence for complex trauma to be included as a subtype in DSM-V (Resick et al., 2012). In comparison, ICD-11 (World Health Organization, 2015) includes complex trauma as a separate diagnosis, due to an emphasis on different diagnostic criteria and as a less conservative approach has been taken than DSM-V’s requirement for a large burden of scientific proof (Friedman, 2014).
The association between complex trauma and other diagnoses

Studies have previously reported an association between complex trauma and borderline personality disorder (BPD) (Ford, 1999; McLean and Gallop, 2003; Yen et al., 2002; Zanarini et al., 2002), although a more recent study by van Dijke et al. (2012) found only a 26 per cent overlap between CPTSD and BPD. The overlap between complex trauma and BPD is in terms of symptoms, such as impaired interpersonal functioning, impaired sense of self, dissociative experiences, anger, impulsivity and self-harm; and theorised causal links to trauma exposure (Resick et al., 2012). Similarly, there is considerable research demonstrating that child abuse and neglect are significant causal factors in psychosis (Read et al., 2008). A review of studies by Read et al. (2008) highlights a dose-response effect, whereby the greater the frequency and/or severity of childhood abuse, the more likely an individual is to develop psychosis. Read et al. (2008) discuss the implications of this in terms of clinical practice and recommend that all mental health professionals take trauma histories with all patients. It is worth noting that traumatic experiences may not be present in the history of all people with diagnoses of BPD or psychosis.

The need to ask about abusive experiences

The UK Department of Health published a briefing paper on Implementing National Policy on Violence and Abuse (NHS Confederation, 2008) that acknowledges the links between violence, abuse and mental health diagnoses. It makes recommendations for staff in the National Health Service (NHS) to be trained in routinely and consistently asking all patients about abuse at first contact and subsequent assessments. Despite this, many professionals fail to ask about abuse (Read et al., 2007; Read et al., 2008). Barriers to asking can include concerns about distressing clients; fear of vicarious traumatisation; fear of inducing “false memories”; more immediate service concerns; the client having a diagnosis of psychosis and the clinician having a strong belief in biogenetic causal factors; and lack of training in how to ask and respond (Read et al., 2007, 2008). Given the high prevalence rates of abuse histories amongst mental health service users, failure to ask may leave a significant proportion of patients at risk, as CSA is suggested to be a better indicator of suicidality than depression (Hepworth and McGowan, 2012).

The phase-based treatment approach

While NICE (2005) guidelines exist for the management of Type I (single event) PTSD in the UK, research shows these guidelines to be inadequate in addressing the range of dimensions that Type 2 or complex trauma involves. It has instead been suggested that a phase-based approach be used (Courtois and Ford, 2013; Herman, 1992), with an initial period of stabilisation advocated and termed the phase one of treatment. Aspects of it can be delivered by any clinical staff member, such as enabling a client to attend to their safety and to develop grounding skills to cope with flashbacks and dissociative experiences (Courtois, 2004). Following stabilisation, treatment can progress to the second phase of remembering the past; and then the third phase of recovery within the context of therapy with a trained psychologist.

Training programs such as the Auckland Training Programme have been developed based around the three-phase approach (Cavanagh et al., 2004), although there are currently limited published evaluations of their treatment effects. Increasingly, the need to develop guidelines on trauma competencies for the education and training of psychologists has been noted in the literature, with publications from the International Society for Traumatic Stress Studies (ISTSS; Cloitre et al., 2012) and the American Psychological Association (APA, 2015). Similarly, the Board of the UK Psychological Trauma Society (UKPTS) have recently reviewed the available published evidence to inform clinical and service planning guidelines. It is worth noting an alternative view has been put forward by de Jongh et al. (2016), who argue that there is no rigorous evidence to support a phase-based approach as being necessary for positive treatment outcomes. In light of this, the ISTSS (2018) have written a position paper to consider the debate around the evidence for treatment of complex trauma.
Recently, there has been increased interest in the development of trauma-informed services in the UK (Sweeney et al., 2016; Sweeney et al., 2018). Sweeney et al. (2016; 2018) have examined the principles of trauma-informed approaches (TIA), originally developed within the USA, and have reviewed their application for the UK. They highlight the benefit of TIA to both staff and service-users and consider the barriers to implementation in the UK public sector, including funding, resources, time pressures, changing systems, staff turnover, a lack of training/supervision and a strong biomedical dominance. Currently, there is limited primary research into the design and delivery of complex trauma training to core frontline health care professionals. Some promising research suggests training can enable staff to gain confidence and knowledge to effectively assess and treat trauma within an early intervention for psychosis team (Walters et al., 2016) and a forensic women’s service for self-harm (Robertson et al., 2013). Similar training programmes may be beneficial for staff working with trauma within an inpatient setting.

Inpatient staff training

The improvement of adult inpatient care in the NHS through delivering and evaluating training was initially highlighted as a policy priority (DoH, 1999, 2002) and continues to be on the agenda, with particular attention paid to registered nursing staff and healthcare assistants (HCAs) (NICE, 2014). According to the Cavendish Review (2013), healthcare assistants make up around a third of the frontline caring workforce in hospitals in the UK, and research suggests that they now spend more time than nurses at the bedside. The report found that many HCAs report to feel undervalued and overlooked with no consistent training offered, and as a result there can be often high staff turnover in hospital settings. Methodological and practical concerns of organising staff training within inpatient settings exist (Bee et al., 2005; Milne and Roberts, 2002). Organisational challenges such as staff shortages and a lack of commitment by management can be frequent barriers to training implementation and need to be considered (Bee et al., 2005).

Aims and hypotheses

The aim of the current project was to: first, identify the requirements of inpatient staff in working with complex trauma, by meeting with the ward manager to perform a context analysis of the service and by holding focus groups with staff to ascertain their collective training needs. Second, the project sought to provide bespoke training to meet these identified needs and evaluated the outcome.

It was hypothesised that training would: significantly improve the knowledge and confidence of staff to ask about trauma histories and to be able to provide some brief stabilisation interventions (phase one) to distressed individuals on an inpatient ward; and significantly reduce worries or concerns about working with complex trauma.

Method

Design

The project was approved by (edited out for blind review). The project utilised a cross-sectional and mixed methods design, with a three-month follow-up. Qualitative data were generated from conducting focus groups with staff prior to developing the training; while quantitative data were collected at pre-training, post-training and follow up time points.

Participants

All clinical staff from an NHS inpatient ward were invited to participate. Information sheets were provided and written consent completed. Seven members of staff attended the two initial focus groups to discuss the training. Pre-training questionnaires were completed by 23 members of staff, either at the end of the focus groups or prior to training. In total, 15 staff members attended the training, including ward and clinical team managers; nurses; student nurses; and HCAs. Of the
15 who attended training, two did not complete pre-training questionnaires. Therefore, there were 13 staff members who completed both pre- and post-training questionnaires and seven of these staff completed a further questionnaire at three-month follow-up.

Measures

Qualitative focus group questions. A structured interview schedule was utilised to elicit participants’ responses to set questions. The questions asked about the participants’ current understanding and knowledge about complex trauma; and their worries about asking about trauma.

Quantitative questionnaire. No standardised measure currently exists to assess staff training in working with complex trauma. A self-report measure with face validity had previously been designed, piloted and published by colleagues (Walters et al., 2016). This was adapted with permission to produce a 17-item questionnaire. Four items were designed to assess confidence; five to assess current knowledge; and seven to assess worries. Each item is rated on a five-point Likert scale, ranging from “Strongly Agree” (5 points) to “Strongly disagree” (1 point). Total subscale scores could therefore range from 4 to 20 for confidence; 5 to 25 for knowledge; and 7 to 35 for worries. A higher score indicates a greater amount of confidence, knowledge or worries.

Procedure

The procedure was guided by the NHS Institute recommended model for service improvement (PDSA; Langley et al., 2009). This model includes a cyclical process of “Planning” for change, “Doing” or implementing changes, “Studying” the effects of such changes and “Acting” on the outcomes of evaluation:

- Plan: the ward managers and clinical staff were key stakeholders in this process. The planning highlighted ways to minimise obstacles and optimise opportunities. Shift patterns were taken into account by organising two focus groups on different days and the ward manager organised the rota three months prior to the training day, to ensure as many permanent members of staff as possible were available to attend one of the two training slots. In addition, posters were utilised to advertise the focus groups and increase staff awareness of the training.

- Do: two focus groups were held in the month before training, whereby a convenience sample of staff members were invited to discuss and identify their collective training needs for working with complex trauma. The focus group discussion primarily guided the format of the subsequent training and, to a lesser extent, the content. The discussions were audio-recorded, transcribed and analysed thematically. The subsequent training materials were developed from an existing training programme (C. Gilmore, personal communication, January 2015) for delivery to similar teams within the Trust. Themes identified from the literature and the focus group were used to tailor the training to meet the needs of the team. Two training sessions were offered to staff that incorporated PowerPoint, group discussion and experiential skills learning.

- Study: a questionnaire was administered prior to the training session, to measure the confidence, knowledge and worries of staff in assessing complex trauma and managing the distress on the ward. Post-training questionnaires were administered immediately after the training, to assess changes in these three constructs. The team was given three months to implement the material and skills from training. A follow-up questionnaire was then administered to assess longer term change in working with complex trauma.

- Act: this project acted as an initial stage of change for service improvement on an inpatient ward and this will be described in the recommendations later.

Analysis

Qualitative data analyses. The qualitative analysis of the focus groups was conducted according to Braun and Clarke’s (2006) suggested methodology for six phases of thematic analysis in psychology.
The researcher took a realist epistemological stance to the analysis, as it was felt that the focus groups would represent a true account of the reality of the participants. An inter-rater reliability check was completed to demonstrate trustworthiness and confirmability, as qualitative research is often criticised for lacking scientific rigour (Noble and Smith, 2015). A 50 per cent sample of transcribed text was separately analysed by a researcher unrelated to the project. The progressive maps were discussed and the two final thematic maps were compared. Where a difference was identified, the rationale for this was debated until mutual agreement between the two analysts including minor refinement of theme and sub-theme levels. A final thematic map was therefore produced.

Quantitative data analyses. Data were entered into an SPSS statistics software version 20 (IBM). The data were inspected visually and checked for outliers. It met the required assumptions for normality and sphericity, therefore, parametric tests could be conducted on the data. Three repeated measures ANOVA’s were performed to analyse confidence, knowledge and worries. Planned pairwise comparisons were conducted for pre- and post-training data (T1-T2); pre-training and follow-up data (T1-T3); and post-training and follow-up data (T2-T3).

Results

Qualitative focus group

In response to aim one, thematic analysis yielded several key themes which shaped the training programme. Four main themes evolved, with a number of subthemes clustered around each main theme:

1. understanding the heterogeneity of client experiences;
2. negative past experiences;
3. challenges to working with trauma; and
4. training needs and preferences.

Understanding the heterogeneity of client experiences. Staff members demonstrated different levels of understanding of complex trauma experiences for patients. The heterogeneity of client trauma experiences was discussed, in terms of there being a number of different causes to trauma. There was some reported confusion around single event trauma (Type I) and complex (Type II) trauma experiences:

- Car accidents – that causes PTSD, doesn’t it?
- Death in the family […].
- And physical abuse or sexual abuse.

Staff described how they thought people can respond differently to the same potentially traumatising circumstances:

- Well, I was thinking that trauma is different for different people, isn’t it? Because what might be just nothing to me might be quite devastating for somebody else. So it’s defining trauma really that I found quite difficult when I was filling the form out. Because there’s – different people classify it differently, don’t they?

There was some uncertainty in understanding whether an individual could have both a diagnosis of BPD and trauma:

- It says in her notes that she has been abused. Can someone have two diagnoses?

The training therefore covered information about what complex trauma is, how it is different to PTSD, and the association between complex trauma and diagnoses such as BPD and psychosis, to aid understanding of client’s and staff’s experiences on the ward.

Negative past experiences. The difficult client experiences that tend to be associated with complex trauma also have considerable impact on the resources of a staff team. Ideas about team splitting and boundaries emerged, and the resulting effects on staff morale. In particular,
past experiences of feeling powerless and disconnected when working with Personality Disorders as a staff team resonated with a number of staff members:

In the past we’ve had, you know, with personality disorders […] that there is a lot of team splitting. And that’s difficult.

I didn’t get involved in it. But there were certain members of staff on the ward who were […] over-involved, I feel. So I kept my distance from it really. It affected staff morale for a time.

It happens more than once, and these chosen ones, they just laid their own boundaries.

If you told people or asked people to back off they said “no, we’re not”. And there’s that splitting of the ranks.

From these themes, it was identified that previous negative experiences may be influencing staff morale and therefore the care they are able to provide to client’s who demonstrate more challenging behaviours. It seemed important to include in the training that BPD can be more compassionately understood as a complex trauma reaction (although not everybody with a diagnosis will have experienced trauma). The importance of staff self-care was also included in the training, although this was not the focus of the training package.

Challenges to working with trauma. A number of perceived barriers seem to get in the way of the staff team being able to work as confidently and competently as they would like with clients with complex trauma experiences. Asking about traumatic experiences seemed a particular worry, with emphasis placed on the words used and the impact of these words on the patients:

I don’t know what to say to some people when they are distressed.

I worry I will make it worse, use the wrong words.

These worries in turn lead to an avoidance of talking about trauma, with a sense of responsibility for any distress caused being shouldered by the staff:

I try not to talk about it unless they want to.

They might hang onto my words.

Because sometimes you shouldn’t ask. It will make things worse and – like, the patient escalates.

A lack of confidence in their own abilities and awareness about the role of the ward in stabilising distressed individuals was also apparent from the discussions:

Can we do that?

We haven’t really had any training in that […] us health care assistants.

As well as the training covering the role of inpatient staff in providing stabilisation to clients as part of the three-phase approach, time was also dedicated to discussing how to ask about trauma. This included examples of the language that could be used by staff.

Training needs and preferences. The staff preferences for the content and method of delivery of training were mixed, and at times, conflicting in their ideas. This confusion about their collective training needs may have reflected the confusion staff felt about understanding and working with complex trauma:

I also want to know, like, can they get better?

Have a broad overview, but then more detail.

Like, some things to read, but also that we want to talk about it.

More directive questioning elicited preferences for informal and discussion-based training that was supplemented by written material and skills-based training:

Some skills I can take away.

I quite like talking around a table. But maybe have some, headings or, you know– I think PowerPoint – it just gets lost.

From this discussion, the format of the training was devised. The training was set-up around a table to aid discussions, in view of a projector screen. PowerPoint was used with frequent
discussions to explore the ideas and to draw on the current experiences and resources of staff. The training provided skills through experiential exercises. Hand-outs and worksheets summarising the phase-one skills were given out to staff to aid practise. The below list summarises the content of the training workshop that was delivered.

Overview of training workshop:

- Overview of training, introduction and case study.
- Discussion about traumatic experiences, clarifying what people currently understand. Psychoeducation about the spectrum of trauma diagnosis and also key features of complex trauma identified from the current literature.
- Information about the prevalence of childhood abuse and National statistics. Also local data from a survey of services within the Trust with regards to the current picture of working with patients with traumatic expertise.
- Group discussion about how traumatic experiences present. Information about the similarities, differences and overlap between psychosis, complex trauma and Borderline/Emotionally Unstable Personality Disorder.
- Psychoeducation about the phased-based approach to recovery from trauma and discussion about how all clinical staff members are able to help provide the safety and stabilisation phase of the pathway. Re-visiting case study to demonstrate the principles.
- Discussion about asking about abuse, the principles of asking, using a “funnel” approach to questions, and possible issues to cover in a psycho-social history assessment. Small group discussion about how clinicians tend to ask the questions and sharing of good practice.
- Introduction to skills and techniques that can help achieve a sense of safety and stabilisation for patients on the ward. Experiential practice of grounding skills, soothing smells, safe place imagery and safe object.
- Discussion about self-care. Implications for clinical practice and taking ideas forward as a trauma-informed service.

Quantitative results

To evaluate the outcome of the training for aim two, questionnaire completions rates and demographics are presented in Table I and data analysis for all measures at pre-, post- and three-month follow-up evaluation is presented in Table II.

A repeated measures ANOVA determined that mean confidence differed statistically between time points ($F_{(2, 12)} = 18.0, p < 0.001$). A priori comparisons using the Bonferroni correction revealed that staff training elicited an increase in confidence from pre-training to post-training (10.6 to 16.0) that was significant ($p = 0.001$). However, this was not maintained between post-training and follow-up (16.0 to 13.7; $p = 0.128$).

A significant difference in knowledge was found across time ($F_{(2, 12)} = 8.0, p < 0.05$). A priori comparisons using the Bonferroni correction revealed that staff training elicited an increase in

<table>
<thead>
<tr>
<th>Table I Demographics and questionnaire completion rates</th>
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<tr>
<td>Demographics</td>
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<tr>
<td>Gender</td>
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<tr>
<td>Male</td>
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<tr>
<td>Female</td>
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<tr>
<td>Designation</td>
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<tr>
<td>Senior Manager</td>
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<tr>
<td>Manager</td>
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<td>Registered Nurse</td>
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<tr>
<td>Student Nurse</td>
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<td>Healthcare Assistant</td>
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knowledge from pre-training to post-training (14.4 to 16.7) that was significantly different ($p = 0.028$). Overall, staff knowledge increased from pre-training to follow-up (14.4 to 18.1), which was statistically significant ($p = 0.042$). However, the increase observed between post-training and follow-up (16.7 to 18.10 was not significant ($p = 0.66$). Therefore, the significant change in knowledge occurred between pre-and post-training.

A significant difference was also found for worry across time $F_{(2,12)} = 11.4$, $p < 0.05$. A priori comparisons using the Bonferroni correction revealed that staff training elicited a decrease in worry from pre-training to post-training (26.3 to 19.7) that was significant ($p = 0.026$). However, this change was not maintained between post-training and follow-up (19.7 to 21.0; $p = 0.964$).

### Discussion

This project used a mixed-methods design to firstly ascertain the training needs of clinical staff from an inpatient ward in working with complex trauma, through discussion with the ward manager and staff. Second, the project aimed to impact on the confidence and skills of inpatient staff working with individuals with complex trauma, by providing training to the clinical staff team and to evaluate the outcomes of this training. This discussion is embedded within the NHS Institute model for service improvement – “Plan, Do, Study, Act” (PDSA; Langley et al., 2009).

#### Impact of focus groups

In line with the first aim, the training needs of staff were elicited by dedicating time to planning with the key stakeholders and this constituted the “Plan” stage of the NHS Institute model (Langley et al., 2009). This planning enabled service needs and barriers to be identified and circumvented, such as being mindful of safe staffing levels and taking account of rota patterns for optimal attendance. Equally, staff needs and barriers could be identified through holding the focus groups, and training developed accordingly. The resulting tailor-made training programme appeared to address these needs and barriers, by promoting discussion and providing materials to facilitate understanding and skills. As such, it represented the “Doing” stage of service improvement (Langley et al., 2009).

The literature highlights the importance of inpatient staff asking about and responding to abuse disclosures; whilst also acknowledging the barriers to asking, such as concerns about distressing clients and a lack of training in how to ask and respond (Read et al., 2007, 2008). Consistent with the literature, several barriers to assessing for and treating trauma were identified by the team. In particular, within the theme of “the challenges of working with trauma”, worries about distressing clients by using the wrong words was elucidated. The theme “understanding the heterogeneity of client experiences” illustrates the confusion of staff in knowing the differences between PTSD and complex trauma; and whether someone can have more than one diagnosis. This seems to mirror the controversy within the literature about the construct of complex trauma and the implications for diagnostic criteria in DSM-V (Herman, 2012; Resick et al., 2012) and ICD-11 (Friedman, 2014) and advocates the need for training.

#### Impact of training

In considering the second aim, the preliminary questionnaire data appears to suggest that staff confidence and knowledge about working with complex trauma increased following the training session and worries about working with complex trauma decreased. This formed the “Evaluate”

### Table II Descriptive statistics and ANOVAs for study variables

<table>
<thead>
<tr>
<th>Variable</th>
<th>Pre-training (n = 21)</th>
<th>Post-training (n = 13)</th>
<th>Follow-up (n = 7)</th>
<th>ANOVA</th>
<th>Pre-post (n = 13)</th>
<th>Pre-follow (n = 7)</th>
<th>Post-follow (n = 7)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
<td>M</td>
<td>SD</td>
<td>M</td>
<td>SD</td>
<td>F</td>
</tr>
<tr>
<td>Confidence</td>
<td>11.43</td>
<td>2.40</td>
<td>15.46</td>
<td>2.57</td>
<td>13.71</td>
<td>2.93</td>
<td>18.0**</td>
</tr>
<tr>
<td>Knowledge</td>
<td>16.76</td>
<td>3.33</td>
<td>17.38</td>
<td>1.76</td>
<td>18.14</td>
<td>1.68</td>
<td>14.2*</td>
</tr>
<tr>
<td>Worries</td>
<td>24.62</td>
<td>4.12</td>
<td>21.62</td>
<td>7.06</td>
<td>21.00</td>
<td>6.45</td>
<td>11.4*</td>
</tr>
</tbody>
</table>

Notes: $N$, number; $M$, mean; $M$ diff, mean difference for pairwise comparisons. *$p < 0.05$, **$p < 0.001$
stage of the model (Langley et al., 2009) and adds to the findings of the Auckland training programme (Cavanagh et al., 2004) to provide additional support for the utility of training.

In total, 46 per cent of staff who attended the training and completed post-training questionnaires were HCAs. The Cavendish Review suggests that approximately one-third of the frontline caring workforce are made up of HCAs, who are unqualified members of staff who assistant nurses on the ward. While some HCAs can be very experienced at their jobs, more often than not it is this staff group who are offered little supervision and training opportunities and may therefore tend to report lower levels of knowledge and greater levels of worry in working with complex presentations. It is likely this current training may have been the only training they have received and therefore such training may go some way to help them to consider trauma and its treatment, to increase knowledge and confidence and decrease worry.

Whilst an overall increase in confidence and knowledge and a decrease in worry was found at three-month follow-up, the substantive and statistically significant change occurred between pre- and post-training. Staff were encouraged to consider how they could use the ideas from the training in their daily roles, but this seems unlikely to have been sufficient to sustain changes to follow-up. That being said, the observed trends for an increase in knowledge and confidence; and a decrease in worry were in the right direction between post-training and follow-up time-points; and did not recede to pre-training levels. Overall, this is consistent with the challenges of sustaining change following training to follow-up time periods that has previously been noted (Bradshaw et al., 2007; Milne et al., 2002; de Silva, 2014).

**Trauma-informed service implications**

This project forms the initial “Act” stage of service improvement, with continued cycles implicated (Langley et al., 2009). A number of learning points can be drawn from this process and the recommendations made to the specific service, for the consideration and application to other developing trauma-informed services. Whole team training is recommended to promote a consistent approach towards trauma. Within this, separate sessions based on experience levels may be warranted (Bradshaw et al., 2007). Recruiting both managerial and clinical “change champions” to generate “buy-in” to new practises through top-down and bottom-up methods is considered most effective (de Silva, 2014). It has been suggested that this is particularly useful when seeking to appeal to doctors (de Silva, 2014). Psychiatrists have been found to be particularly unlikely to receive training in abuse issues despite being key members of the multi-disciplinary team and frequently responsible for initial assessments (Cavanagh et al., 2004).

Greater consideration of the barriers to training implementation may be addressed using a relapse-prevention design (Milne et al., 2002), to identify likely struggles and use group problem-solving to negotiate this. The training could further be supported by offering a regular supervision slot or trauma-focused case discussion, as it has been suggested that this can help to maintain the changes achieved through training to follow-up (Bradshaw et al., 2007).

**Study limitations and research implications**

The greatest attrition (50 per cent) was noted for HCAs from post-training to follow-up time points. Although this was not looked at in-depth, the Ward Manager reported a number of HCAs as being signed off work due to sickness or had left their post at the time the follow-up questionnaire was completed. This is unsurprising, given the Cavendish Review highlighted that many HCAs report to feel undervalued and unsupported, and as a result there is often high staff turnover in hospital settings. Formally collecting more information on the reasons why participants could not be followed-up would be useful. By negotiating such barriers, the number of participant responses at follow-up may increase and in turn would increase the number of participants who could be included in the statistical analyses at all three-time points. The present study is likely to be under-powered and therefore caution is needed in interpreting the results. If barriers to follow-up are taken into account, coupled with the recruitment of a larger sample size, then subsequent versions of the research would be sufficiently powered to add confidence to the interpretation of the results. The training materials were drawn from evidence-based practice and were developed for the service. While this may have been more effective than a standardised training package, the lack of validation may limit
external validity. The questionnaire was developed to assess the key components of training as highlighted from the literature and previously piloted in the Trust. However, they have not been assessed for criterion validity and therefore some caution must be taken when drawing conclusions about the efficacy of improvement when employing a non-validated measure. A future version of the measure may like to further consider content validity through expert consensus; construct validity through comparisons with similar established measures; and test-retest reliability through administration at two different time points. In addition, the follow-up period may have not given participants sufficient time to deploy their new knowledge and skills, for sustained statistical and reliable change to be observed three months later. However, a longer follow-up time period may have increased the likelihood of attrition due to staff turnover and sickness. This could render the response rate too low for meaningful analysis. Future research studies way want to consider how to balance this trade-off, to ensure adequate time for training implementation against the possibility of participant attrition. In addition, future studies may like to additionally consider using a more direct measure of clinical impact such as changes to staff behaviour, to ascertain whether changes in confidence, knowledge and worries translate into improvements of clinical care. As this area of work is developmental, the findings of the current study are useful in directing future larger scale studies.

**Conclusion**

This project sought to identify the needs of inpatient staff and developed a tailor-made training package to address these needs and barriers. Self-reported staff confidence and knowledge about working with complex trauma increased following the training, and worries about working with complex trauma decreased. In order to sustain the benefits of training for longer, a number of recommendations were made to the service. Making the provision for on-going training and supervision will form a crucial part of future service development as a trauma-informed service. The continued evaluation of tailor-made training is indicated as part of this development.

**References**


Further reading


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Towards a unified model of human development

Rex Haigh and Nick Benefield

Abstract
Purpose – The purpose of this paper is to collaborate across disciplines to agree a better map of human development.
Design/methodology/approach – This paper used an iterative process of consultation with professionals and specialists in relevant disciplines, and service users, continually refining the diagram and text until a “good enough” consensus was reached to produce a diagrammatic form and explanatory text.
Findings – The process revealed a strong commitment across many disciplines to find a common contextual framework within which specialist understandings could be accommodated. The consultation process and iterative development of the diagram and text was marked by widespread interest and many detailed discussions. The substance of this paper is the result of that process.
Research limitations/implications – The model places research in different specialist fields onto a single “map of the territory”. It can encourage collaboration across disciplines when they are studying similar areas from different perspectives. It indicates the value of collaborative rather than competitive research enterprises.
Practical implications – Too often, professionals involved in fields concerning human development become focussed within narrow frameworks of specialisation. The model supports better understanding of how different elements relating to developmental life interrelate. This can facilitate the basis upon which a wide range of training, education and research programmes can be formulated.
Social implications – The model proposes greater use of a “whole-person/whole-life” perspective, which should allow greater integration between disparate approaches, and less experience of fragmentation. For a wide range of public sector activities, the quality of relational activity should be central to effective organisational and human outcomes. Without a unifying context, the understanding required to support relational work is weak: this model addresses that deficit.
Originality/value – This work is entirely original. It should be of value to all those interested in working in holistic ways; to policy makers wishing to avoid duplication, waste and ineffective interventions; and to researchers interested in working across disciplinary boundaries. Most importantly, it is for staff involved in health, justice, social care and education services at all levels. Their effectiveness relies on relational, as well as procedural working, and this model will support confidence in the primacy of these activities.
Keywords Human development, Biopsychosocial, Biomedical, Psychosocial, Integrative care, Community, Fragmentation, Policy development, Multidisciplinary, Cross-sector, Relational practice, Complexity, Whole-systems, Formulation
Paper type Conceptual paper

Introduction

In optimal circumstances, we would hope for each person’s life to be safe enough, reliable enough, and generally “good enough”. When human development is disrupted, the consequences can reach into every area of an individual’s personal and social world, resulting in alienated and unstable lives, and repercussions throughout their communities. The causes of this disruption may cover the whole range of physical, environmental, psychological, social and economic factors: from an unlucky genetic inheritance to a difficult birth, child abuse, inadequate parenting, failed attachment, multiple bereavements, repeated trauma or emotional deprivation. For each individual, the impact of these adversities will vary, and they may not be obvious to the individual or others. Further causal factors include poverty: material poverty and inequality, as well as the poverty of expectation that leaves individuals feeling powerless to have any impact on
the world in which they live, or to find fulfillment and meaning in their lives (Marmot et al., 2010; Social Exclusion Unit, 2004; Wilkinson and Pickett, 2009). The disruptions themselves can be single, multiple or continuous and can feed back and reinforce each other (National Scientific Council on the Developing Child, 2012).

Differences in class and educational advantage can provide some individuals with resilience – or a range of protective factors – which may afford them sufficiently strong constitutions to withstand the impact of these environmental failures, and emerge from their early experience to live what appear to be thriving and healthy lives (Rutter, 1987).

However, a significant number experience a situation where they are excluded from mainstream society and rejected by those who might be able to help them. They are then likely to experience lives of recurrent frustration, without sufficient happiness and contentment that most would consider a just life outcome in the twenty-first century. These individuals, and often their families, may have little conscious psychological sense of their place amongst others, or where they fit into their community and society. School, working lives and almost any pro-social relationships are difficult or impossible to establish and sustain. They experience the world as a hostile, unhelpful, threatening or undermining environment. As result they live in a marginalised underclass with high levels of substance misuse, self-harm, criminality, and suffering severe, enduring and disabling mental distress. People in this situation often use a wide range of statutory services to little long-term benefit (Social Exclusion Unit, 2004).

We are proposing that the life course narrative from birth to death must be understood as a complex system, similar to a weather system, rather than a single causal chain of events and consequences (Butz, 2018). A simplistic, single problem approach is insufficient, solutions therefore requires a more whole-person and whole-life framework. Fragmentation of understanding comes about when politicians, professionals or the public try to make complex problems manageable by simple means, even costly ones, in order to be seen to have “done something about it”. Whilst understandable, the natural consequence is to fragment the experience for individuals, undermining opportunities for joined up recovery or rehabilitation. It threatens a person’s sense of coherence, hope and security. This fragmentation is explored in more detail below.

The process of development

The work originated in the National Personality Disorder Programme (National Personality Disorder Programme, 2010; National Institute for Mental Health in England, 2003), where it was clear that a single approach was not tenable, and the pilot programme needed to embrace the complexity of working with different therapeutic approaches, different disciplines and their cultures and across different sectors. A 2009 product was the “Tube Map” which sought to provide an accessible image of birth to death, reflecting the complex pathways and events (NPDP, 2011). This informal illustration gave a generic understanding of these complexities, and indicated the need for a more accurate reflection of our current knowledge. The initial intention was focussed on health, social care and criminal justice, but the model we have developed since, and is presented here, has a broader scope and is aimed at a wider audience to include all areas where public policy might have an interest in human development.

After creating a basic working model from well-established knowledge frameworks, a process of consultation and iterative improvement was started. This took place over a three-year period, and involved a series of discussions at conferences, specialist events and discussions with a number of experts in related fields. This included group and individual psychotherapists, psychologists, psychiatrists, GPs, geneticists, social workers, nurses, occupational therapists, prison officers and other criminal justice staff, current and ex-service users and those with lived experience, policy makers, commissioners, mathematicians, philosophers, criminologists, politicians and ethicists.

As part of the process, the model has been through many revisions and the diagram itself over twenty iterations. Over 350 individuals and groups have contributed to this process. Themes were identified and clustered, then mapped onto successive iterations of the diagram; many discussions were held to test and refine the exact words and terminologies used.
A map of the landscape

The model provides a representation of human development, to include all the major factors that influence it, in both positive and negative ways. The intention is to provide a consistent framework for better collaboration across the fields involved, by allowing visualisation of the whole system, to encourage inclusion of all relevant factors and to produce a richer and more complex analysis.

It is a diagrammatic representation based on a range of established theories to explain behaviour and to identify life events and expected life outcomes. These are laid out as a graphic model that aims to incorporate the main areas of current thinking behind the concept of “human development”. The intention is that, given sufficient consultation, the model will be a “good enough” one to be useful in planning, practice and training across all relevant fields – predominantly health, social care, education and criminal justice. It should establish a baseline understanding within which we can locate the conceptual rationale for service interventions in public services, based on rational theories of causation and need, using established evidence, research and innovative investigation.

We have been at pains to prevent it becoming deterministic, to steer between clarity and complexity in an area where subtlety of language often makes it difficult to find the right words or phrases. Complexity and chaos theories are better at linking the different parts of the model than linear dynamic causality (signified by the multiple curved arrows). Complexity theory because it accommodates the multiple and interlocking feedback processes that lead to continually changing emergent outcomes that cannot be pre-determined or satisfactorily analysed with techniques such as multivariate statistics (Johnson and Johnson, 2009; Capra, 1997, 2005). Chaos theory is also helpful, for including concepts such as sensitivity to initial conditions and weather-type dynamics, leading to very limited and short-term areas of predictability (Williams, 1997; Butz, 2018) rather than any overarching perspectives which “trump” all others (Lyotard, 1984). This has clear parallels to how small differences in elements of experience can lead to very different developmental trajectories for humans. This is also in keeping with approaches that give priority to holistic, ecological views of life sciences, and modern mathematical ones, rather than mechanistic ones based on Newtonian physical sciences (Capra, 1997).

A unifying model

An understanding of individual development and change involves a birth to death perspective. In the development of individual and social life, we are calling the whole terrain the “Relational Field” and depicting it as the coloured background to the diagram. It involves both conscious and unconscious processing to different degrees in different areas. It establishes the centrality of the interface between each individual and their world both internal and external (Figure 1).

The three main areas before “outcome” are presented as discrete areas: pre-birth, emotional development and life experience, all contain numerous elements. “Pre-birth” covers genetic heritability, parental health and antenatal and birth factors. “Emotional developmental” stages assert the importance of a maturing and stable sense of identity, and contribute directly to the development of cognitive capability. “Life experiences” cover the range of individual and social relational experiences that provide the external support for emotional development and stability.

Adverse factors have direct effects on physical, cognitive and emotional development. This by omission (such as deprivation or poverty) or commission (such as trauma or abuse): they are shown in the “adversities” area in the diagram. This is supported by a large literature relating to each of these subject areas. Key references, which are not at all exhaustive, include the following: Winnicott (1965), Bowlby (2008), Rosenthal et al. (1981), Barker and Osmond (1986), Felitti et al. (1998), Edwards et al. (2003), Streissguth et al. (2004), Shonkoff (2007), Rutter et al. (2007), Chan and Koo (2010), Liebling (2011), Fok et al. (2012), Haigh (2013) and Pinderhughes et al. (2015).

The other main “biopsychosocial” factors, which can be positive or negative, are grouped in another area, of “modifiers”. The relationship between these three fields of modifying influences involves a complex interrelationship involving constant process of feedback, progression and regression. Sociocultural inheritance and expectations will have a variable impact on emotional development. Aspects of emotional development will continue to be strengthened or undermined by the quality and timing of life experiences and the opportunity for experiential provision and learning,
“Life Outcome” is a moving target (therefore itself also subject to and providing dynamic feedback in the system) and is depicted as another area containing a list of qualities, all of which are dimensional in nature, spanning negative to positive outcomes, with most people existing somewhere between the extreme points. The positive words in the upper section are chosen so that outcomes are aligned to indicate the optimal expected results of a satisfactory combination of pre-birth factors, emotional development and life experience. The “overall” paired words below can be considered as levels of individual capacity and capability and, in the societal sense, show how the individual responds across the four domains of health, education, employment and pro-social life.

“Post Life” recognises the significance of individuals’ spiritual or religious life with its expectations of remembrance and legacy, how they may influence the way their life is led, and their acceptance or rejection of life experience. The model also acknowledges the interconnected ways in which bereavement and legacy can have significant effects on the life courses of others in the wider relational community.

Application
The model gives a way to think of the relationships required to give a whole-person, whole-life perspective in the field of human relations. This could counteract the risk of fragmentation in knowledge, policy and practice.

Knowledge and research fragmentation
Many models of human development have been developed, researched, contested, used, modified – and discarded – over a long period of time. The process is likely to continue, and at times each model vies with others to own the “truth”. The discourse can be at the level of academic fields, institutions, theoretical approaches within a field, practice application or influential product champions.
Academic fields that all have a claim to parts of the jigsaw currently includes:

- **social sciences** (sociology, anthropology, critical theory, diversity and feminism, phenomenology and hermeneutics, criminology, disability studies, human geography, economics);
- **education and pedagogy**;
- **psychologies** (social, developmental and experimental);
- **psychotherapy** (psychoanalysis, group analysis, systemic and integrative);
- **medical sciences** (genetics, pharmacology, biochemistry, physiology and clinical studies);
- **the neurosciences** (neurobiology/-anatomy/-physiology and neuroimaging); and
- **humanities** (philosophy, spirituality and linguistics).

Relevant contemporary research is undertaken in all these fields, and there is a large literature base. However, the depth of understanding is much greater within the boundaries of each area of study than in the relationships between them. Overall, the current state of our knowledge is variable and there are overarching themes that remain conceptually and scientifically incomplete.

Professional and ideological rivalries also hamper a more integrated understanding of the “whole picture”. For example, in psychotherapy, psychoanalysis is often dismissed as old-fashioned and no longer relevant (Salkovskis and Wolpert, 2012), while the growth of cognitive behaviour therapy has caused similar antagonism in the opposite direction (Shedler, 2010; Dalal, 2018). Psychiatry has been criticised for its diagnostic systems and the influence of the pharmacological industry (Moncrieff, 2008). Nature vs nurture arguments are sometimes polarised, with specialist fields competing to grow and survive by bidding for the resources to undertake their work.

This all leads to little impetus to work across fields to “join up” the rich but disparate knowledge base about human development, particularly when so much of the relationship between the different parts is of an abstract or ill-defined nature. To change this would require specialist areas of theory and practice to locate themselves in the wider developmental context: whole-person and whole-life. This would allow determination of the key collaborations necessary to make specific policy or service interventions more connected, relevant and effective. We suggest that it is possible to provide a broad consensus on human development, and its course over time, as a basis for greater common understanding of how we are, how we progress or change, and how a complex rather than simplistic explanation is vital.

This absence of collaboration can be consider across many fields; an example of successful collaboration being implemented across very different fields is Gawande’s work on surgical safety being based on aviation industry practice (Gawande, 2010).

**Policy and commissioning fragmentation**

In parallel, the delivery of services has become increasingly based on service specifications and dependent on contract monitoring and performance (Appleby et al., 2010). Above all else, the quality of relationship between all professionals, with different roles and responsibilities, needs to be one to support the work. This would be based on the recognition and acceptance of complexity and uncertainty, and the commitment to the biopsychosocial principles which underpin the model.

The current context for delivery of public services creates a pressure to simplify interventions based on economic efficiency and contractual precision. The need to identify effective interventions, and implement them at scale, can tend towards a more mechanised and industrialised model of delivery (Cooper and Lousada, 2005; Haigh, 2014). The specifications often tend to favour services with sharply defined inclusion and exclusion criteria. The policy is in danger of being led towards the false efficiency promised by the quantification and costing of all services as discrete elements, without considering the relationships, overlaps and coordination between them. This can leave people with the more complex problems, who are most in need, without access to satisfactory treatment.
This implies that policies on which commissioning is based need to be rooted in a broader biopsychosocial framework, with recognition of the way different elements of the system affect each other. Policies need to be considered within the context of other related policy initiatives. Otherwise parts of the overall structure will be missing or working against each other, causing inefficiencies, ineffectiveness and wastage at best – or morbidity and mortality at worst. This absence of coordinated policy is reflected at central government level by the separation of the departments and organisations responsible for health, social care, housing, justice, education and public health: they are often dealing with the same problems – of disrupted human development – in inefficiently different or competing ways. This also results in gaps or conflicts between competing service provisions.

In the matter of wider public policy making, we often provide policy interventions that are out of synchrony with our generally accepted views of how human behaviour is understood and can be influenced or changed. In general, society sees a move to simplification as more likely to provide a solution than managing the “messiness” of a whole-person/whole-life framework. It is often an unsatisfactory and short-term solution, from the perspective of those receiving services.

Public policy may simply fail for belief that change cannot be achieved. Alternatively, this failure might happen because it is not based on a sufficiently robust model of understanding how humans develop – and how their behaviour may be driven, or changed, by factors not addressed by single policy initiatives themselves.

Clinical fragmentation

In order to comply with legal, procedural or managerial requirements, many professionals in social and health care, as well as other areas of public service, have now become specialised to such an extent that it is difficult to work with their clients, patients or service users in holistic or integrative ways (England and Lester, 2005). This is a process which inevitably leads to less consideration of relationships, between individuals, between providers and between elements of service; it results in a focus on quantifiable and measurable “part-person outcomes” (Clark, 2011).

In much of medicine, the requirement for precise diagnosis of illness leads to specialisation that treats only a small proportion of a person’s health. This risks excluding the relationship between different conditions and the way they interact with each other, and with the whole-person’s experience of illness. In specialised biomedical psychiatry, this can split the factors generating and maintaining illness into physical ones (which are frequently only treated with medication), and psychosocial ones (which are given less consideration, or none) (Double, 2002). Although good psychiatry is always taught with a stress on holistic or biopsychosocial formulation, increasing specialisation of services often renders this impossible in practice.

In physical medicine, diagnosis often offers a clear summary of causation and required treatment (e.g. bacterial pneumonia or ischaemic heart disease). In mental health, the diagnostic process cannot do this as causation and treatment are more multifactorial and complex. Furthermore, causation is more often disputed in biopsychosocial conditions than in physical health conditions (Middleton, 2015). Diagnosis alone, in psychosocial conditions, is unhelpful (Johnstone, 2014; Tyrer et al., 2011). Formulation offers a more comprehensive narrative, within which symptoms, behaviour and presentation can be better understood, and treatment may require a range of coordinated interventions.

In psychology, and to some extent psychotherapy, an impetus to develop tightly defined and researched treatments leads to a wide range of different therapies, with proven evidence-based effectiveness, but little or no consideration of the wider social, economic or political factors relevant for those in need of care. This approach also leads to a belief that the technology and practical delivery of a therapy is more important than the non-specific relational factors (such as the interpersonal relationship between therapist and client – the “therapeutic alliance”) or the process of engaging those who most need it (Thomas and Bracken, 2004). This branding of therapies also leads to commodification and competition between them, where they are considered in much the same way as different but similar medications. Appropriate therapy needs to be decided on the basis of careful formulation, not simple diagnosis and it should be
delivered flexibly according to individuals’ needs: the therapy needs to fit the person, and not the other way round. This is not possible when therapies are competing against each other for attention and resources (Haigh, 2014).

Despite the differences and divisions between various professionals, those using services have the most immediate view of their own needs – what helps and what does not, and when. For people with problems that leave them feeling distressed and troubled in many areas of their lives, and often isolated and fragmented in themselves, the commonest calls are for a sound professional relationship (“somebody I can trust”); services that offer continuity (“so I’m not handed on from one to another every time I go”); not to be rejected (or “disrespected”); and to be listened to (“without being told what to do, or how I should be feeling”). A fragmented approach, which is unlikely to deliver the quality of professional relationship needed, will lead to a sense of “me as an illness” rather than “me as a person” (Haigh, 2005). Alternatively, focus on helpful factors in across different modalities and approaches points to the centrality of relationships; the qualitative evaluation of the English personality disorder pilot projects demonstrates this (Wilson and Haigh, 2011).

Conclusion
The development processes involved and the dynamic interaction between the many different factors in human life require us to consider the complexity of their effects on each other. Singular, partial and compartmentalised explanations reduce this complexity to simplistic, often linear explanations that fragment our understanding of the person as a whole unique individual. Such narrow narratives are incomplete and of limited value to effective intervention. They also foster the denial of the importance the interrelatedness and interdependence of each to the other, and the impact of relational life on each individual’s capacity to progress and achieve a “good enough” life. In short, we concretise and fix the fluid nature of living and its myriad expressions in order to resolve the tension between our expectation to know, decide and act. Uncertainty and not knowing are not easy to reconcile in a world expecting deterministic action.

No individual’s development can be predicted, although research in many disciplines means that judgements on probability are becoming more robust. In the context of public policy, research and professional practice, the importance of the relational field and its significance to decision making at the individual (micro) and at the wider community/social (macro) levels requires understanding and actions rooted in the wider complexity, if they are to result in more effective and sustainable change.

The unifying model outlined here remains work in progress. The growth in knowledge from research across many fields will continue to inform, and therefore enrich, the detailed processes involved. For example, in recent decades the growth in our knowledge in respect of neuroscience and genetics alone has altered our understanding of the interactions between nurture and nature. This is not to tilt the overall understanding one way or another, but to confirm the complexity of epigenetics and the many areas in which we as yet no little or nothing of certainty. We anticipate this will remain the position for many years to come and seek only to maintain the overarching need to place all new learning into a larger framework which is simultaneously both individual and global.

In proposing this framework, we are working to strengthen “relational practice” in many human sciences and professional fields, by proposing this “whole-person whole-life” perspective. Consistency, reliability and therefore trust, engagement and successful outcomes, are directly driven by the quality of relating and of human interaction.

References


Social Exclusion Unit (2004), Mental Health and Social Exclusion, Office of the Deputy Prime Minister, London.


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Mental health, social inclusion and the development of vocational services in the NHS – what can be learnt?

Mark Bertram

Abstract

Purpose – The purpose of this paper is to describe the learning from a historical NHS vocational service development that focused on: mental health, employment and social inclusion – in an inner city area – involving service users, staff and commissioners.

Design/methodology/approach – It is a descriptive case study. A range of historical documents was content analysed and described through a first-person narrative: service user consultations, service specifications, audit records, outcome frameworks, internal service evaluations and published literature.

Findings – When vocational NHS service developments are grounded in what service users say helps them (person-centred, networked and co-ordinated approaches) the evidence indicates people can achieve their vocational goals.

Research limitations/implications – The range of documents described is factual, although the learning insights from some of the service developments are based on personal judgements. The author was the responsible manager – personal bias is high. There is not enough robust evidence to warrant generalisation.

Practical implications – When employment and social inclusion are prioritised, as core business in NHS, outcomes and health impact can increase. Greater detail is needed from healthcare policy makers – focusing on who exactly should undertake this work and what the key commissioning social inclusion performance indicators are.

Originality/value – The bulk of literature on employment support focuses on promoting evidence from one model: individual placement and support. Evidence here indicates a broader range of activity (education, training and volunteering) can have value and health impact.

Keywords Employment, Mental health, Social inclusion and employment

Paper type Case study

Introduction

Literature that describes the development and role of vocational services in secondary mental healthcare systems is largely non-existent. These services remain – at best, random and patchy – despite there being research evidence that participation in work, education or training can improve and sustain peoples well-being.

This paper describes a historical NHS service development, from the perspective of a manager. In my experience, vocational services are always very different. Their type, size and aims are determined by the personalities, priorities and beliefs of local management teams, and what commissioners will support. Here, I tell a story by describing what we did during (2006–2012) as a large inner city NHS mental health trust – in partnership with commissioners, service users and staff. Key aspects of learning from facilitating and evaluating an integrated range of vocational services are highlighted – as a whole system – that achieved a wide range of social inclusion outcomes.
The debates, facts and policy positions around employment, social inclusion and mental health are well-rehearsed. In short, unemployment rates are too high, too many people remain socially excluded and individual placement and support (IPS) has been shown to be significantly more effective than vocational training models for some service users, but not as a panacea for all. In our experience, the rapid job placement component of IPS is problematic because service users tell us they have to feel ready and/or able to cope with job role demands (Office National Statistics, 2017; Bond and Drake, 2014; Modini et al., 2016, McDonald and Bertram, 2018). The policy response from successive governments boils down to the same question: what more can be done? For example, UK policy intention is:

More people will have a good quality of life – greater ability to manage their own lives, stronger social relationships, a greater sense of purpose, improved chances in education, better employment rates and a suitable and stable place to live. (Department of Health, 2011, p. 6)

It is clear that more needs to be done in mental health care to raise the profile of work, as a health outcome priority with healthcare professionals (Department for Work and Pensions and Department of Health, 2017). This leads to another key question: how is this going to be achieved? Critiques of the care programme approach (CPA) highlight that the CPA model is generally not effective – in terms of helping people achieve their vocational goals, increasing community inclusion or enhancing life experience (Rinaldi and Watkeys, 2014).

Recent policy guidance – Mental Health Task Force (2016) – highlights that employment and social inclusion should be a core priority for mental health services, but lacks detail on how this is to be implemented. Department for Work and Pensions and Department of Health (2017) go a bit further by recommending that Public Health England run a health professionals’ survey to help understand their attitudes, knowledge and views on embedding work as a health outcome and Royal Colleges and other health professional organisations co-design a new consensus statement, for prioritising work and health. There is also the intention to deliver e-learning on the most common drivers and causes of work-related illness and how healthcare professionals can best help.

However, apart from seed funding to offer more IPS National Health service England, there are no clear community inclusion indicators, or policy detail on what an effective vocational service should look like. Specifically, would it integrate into clinical settings, or stand alone? Who should actually provide it – clinicians, employment specialists, the voluntary or private sector, the NHS – or everyone joined up? Incredibly, even though we have known for decades that the unemployment rates of people in contact with mental health settings are too high, there are still more questions than agreed solutions, as to how to resolve this (Bertram and Howard, 2006). Crucially, what do service users say they want, to help them achieve work and social inclusion?

Where did we start?

The foundations for our vocational service developments were grounded in the most valuable form of evidence – insights from the experience of local mental health service users. Extensive consultations, some user led, identified the range of help that approximately 300 people (mainly on CPA) wanted, and the key issues they faced with regard to social inclusion (Bourne et al., 2007; Bertram, 2008; Josefsberg and Bertram, 2012).

Table I highlights some Borough wide consultation themes that were derived from verbatim quotes by service users.

One of the main concerns expressed about social inclusion was that people causally linked their difficult experiences of trying to survive in modern society, to the mental distress that brought them into contact with mental health services in the first place. Factors such as poverty, discrimination, isolation, trauma, violence and abuse featured frequently. Understandable feelings of powerlessness, pessimism and anger emerged because of their social status and
precarious lived realities. As a solution, service users often said they wanted a better deal in the
world: developing relationships, having enough money to live on and accessing effective
support to achieve personal vocational goals was critically important.

**Evidence gathering and policy levers**

In addition, we undertook an extensive audit of CPA care plans \( n = 278 \) to get a proxy baseline
on how many people were employed and what the extent of occupational care planning was.
The results were stark: 96 per cent of people engaged with community teams were unemployed
while evidence of occupational care planning was running at 8 per cent.

These facts were timely, dovetailing with the Government’s action plan on social exclusion (2006).
Several NHS Trusts put out bold social inclusion strategies. These chimed with what people said
helped in a recovery process (Faulkner and Layzell, 2000). For example:

> The principle guiding our work at all levels of the organisation must move away from a primary focus on
> the reduction of symptoms towards one of enabling people to do the things they want to do and lead
> the lives they wish to lead. The yardstick of success must be the extent to which the treatment and
> support we provide enables them to rebuild valued and satisfying lives and to gain/maintain the
> homes, friends, families, relationships, jobs, social and spiritual opportunities, leisure and cultural
> activities that give their lives meaning (Perkins and Rinaldi, 2007).

Collectively, this evidence, combined with the policy drive for mental health service
transformation, was telling us a lot more needed doing, to increase the priority of the social
inclusion agenda. A range of vocational initiatives existed in our Borough, such as a Clubhouse
and some work training projects, but a strategic plan, stakeholder coordination and enough
capacity did not exist.

**What did we do next?**

Small amounts of headway were being made in terms of user engagement, but we still had a
fundamental problem – there were no clear referral pathways, or vocational assessments being
undertaken in any community services.

A small occupational therapy (OT) pilot in a community sector team was set up. Two OTs and a
welfare benefits adviser were given time to become vocational leads. They undertook vocational
assessments and supported people to achieve their vocational goals. The outcome was: 22 of
the 55 people engaging went on to engage in a range of social inclusion activity within six weeks,
while 11 needed on-going support to continue with their choices. The remainder did not attend,
or dropped out for various reasons (Bourne et al., 2007).

With the support of our local service director, we started to grow a range of innovative
initiatives. We had a small Borough vocational service housed in a borrowed office in a

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### Table I Consultation themes

<table>
<thead>
<tr>
<th>Theme</th>
<th>User perspective</th>
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<tbody>
<tr>
<td>Effective support needs to be person centred</td>
<td>Being listened to, feeling understood and encouraged – having a human heart – is what helps</td>
</tr>
<tr>
<td>Create meaningful opportunities</td>
<td>Replace the fear with real possibilities</td>
</tr>
<tr>
<td>Access to accurate and local information</td>
<td>We need a one-stop shop to know where to start our journeys</td>
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<tr>
<td>Different people ask for different types of help at different times</td>
<td>We should be able to say what we want, not be told what is available and that is it</td>
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<tr>
<td>Increases in confidence, skills and well-being happen through a range of activity – not just employment</td>
<td>Education, volunteering and training are valued</td>
</tr>
<tr>
<td>Welfare benefits – advice is needed</td>
<td>The benefits trap is still here</td>
</tr>
<tr>
<td>Stigma still needs addressing</td>
<td>The principle causes of low self-esteem are connected to stigma that we suffer from in a direct or indirect way</td>
</tr>
<tr>
<td>Helping people achieve vocational goals needs to be a priority for health and social services</td>
<td>Work should be an integral part of any care plan – not just an afterthought</td>
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social services day centre. This was providing a user-run information point, a small IPS employment service (one worker) provided by the voluntary sector, an income-generating work training project and dedicated volunteering service. We were also linked up with a Time Bank (volunteering exchange of time credits). Collectively, we were engaging with 170 people. It was time to approach commissioners with our outcome evidence. Positive negotiations with our service director and the PCT led to significant developments during 2008–2009.

**Vocational service evolution**

Through a service specification, we co-designed a strategy and a continuum of employment and social inclusion support. The model focused on integrating and expanding existing social inclusion work streams, e.g. a co-ordinated Borough wide approach utilising the skills and strengths of vocational staff and service users. We created a pathway that offered choice, support and a central Borough information point. Its access was opened up – linked to a range of multi-disciplinary professionals, agencies, community teams, residential settings, wards, mainstream services and people could self-refer.

The key functions were:
- vocational assessments + individual action plans;
- person-centred support: helping people achieve their goals;
- matching peoples choices, strengths and needs with employment, education, volunteering, supported employment, sports and leisure opportunities;
- education of employers; and
- partnership working with mainstream community agencies such as job centres and local colleges.

The Key performance indicators were:
- supported employment;
- mainstream employment;
- mainstream education and training;
- volunteering opportunities; and
- sport, arts and leisure opportunities.

Strategically, to give this transformation priority, an employment project board was formed consisting of senior members of the PCT, Local Authority, NHS Trust, voluntary sector and all vocational service providers. We looked at the local picture and set up, co-ordinated and drove forward improvements including: increasing access, referrals and the range of options, improving the user voice to influence provision and co-designing systems for performance management. A network coordinator was appointed and capacity grew at pace:
- the IPS voluntary sector employment service grew to three posts;
- the OT pilot was extended across all three sectors with three posts;
- our paid work training project grew to two posts;
- the user-run information and support service expanded to two posts;
- construction of a volunteering service (two posts charity funded);
- a dedicated vocational resource centre housing these projects with space for training, community events and an I.T. suite for service users opened in 2009;
- the largest Time bank in London was integrated into the centre – two posts; and
- the NHS patient record system was changed to include an employment field allowing clinical staff to update on employment status.
As a whole system, this meant people could access a wide range of options. A continuum of support – in a centre – for social inclusion, tailored to individual choices and needs.

In the conclusion of the service specification, I stated:

Outcome predications are never an exact science for new services and are always complex, fluid and determined by a range of inter-dependent factors, such as how these services will work in relationship and the individual needs of service users. However, given the pilots and our experience and evidence, to date, I am certain that the investment in this provision will amount to several hundred people benefiting from the support they will need to achieve a wide range of social inclusion outcomes. It also represents the possibility of a culture shift for mental health services e.g. from a primary emphasis on the reduction of symptoms, toward supporting people to engage in socially inclusive activities that enhance well-being. (PCT service specification)

Outcome evidence

This is exactly what happened. During 2009–2010 over 470 people engaged in this NHS vocational service: 41 gained open employment (off benefits), 87 went into volunteering, 89 went into mainstream education and 80 went into supported employment, training, sports or leisure activities. Locally, these vocational outcome ratios reached an all-time record high. Very few were admitted and many more were being discharged from secondary care – no longer needing to depend on these services. Our evidence indicated that different people benefited from different activities at different times, to learn grow and sustain health and well-being. There was not a panacea, but through working together closely in a networked, co-ordinated and person-centred way, the sum of the component parts achieved more together, e.g. some people engaged with several projects simultaneously, we did whatever it took.

In order to delve deeper and understand further what had worked with service users, we undertook an internal service evaluation to explore in-depth what helped seven people achieve their vocational goals: three people achieved employment, three became volunteers and one went into education (Bertram and McDonald, 2015). We also knew from service users there was a strong impact emerging across a range of dimensions, e.g. health, personal, vocational and social inclusion inputs, outputs and outcomes (Table II).

These improvements were self-reported by service users. A significant leaning point was that the more person centred the interventions were the better the outcomes and health impact. For example, our user-run information and support service were achieving an outcome ratio exceeding 70 per cent.

In this context, person-centred means: facilitating a range of inter-personal and environmental conditions that help people find their own self-defined way forward. It also means that

| Table II | Impact and outcomes |
| --- | --- | --- |
| **Health** | **Personal** | **Vocational and social inclusion** |
| Discharged from hospital and CMHT’s | Increased sense of control | Paid employment |
| Avoiding hospital admissions | Increased confidence | Work experience |
| Avoiding crises | Increased hope and optimism | Actively job seeking |
| Stopping or reducing prescription medication | Increased resilience | Saving money |
| Stopping illegal drug use | Feeling happier | Volunteering |
| Stopping or reducing alcohol use | Feeling comfortable with self | Training |
| Improved physical health | Feeling valued | Acquiring new skills |
| Improved self-management abilities | Feeling independent | Improved social relationships |
| Healthy eating | Feeling better | Improved family relationships |
| Improved sleep | Feeling alive | Improved accommodation |
| Improved mood | Feeling stronger | Helping other people (peer support) |
| Improved sense of well-being | Being able to accept compliments | New routines |
| No self-harm | Improved personal hygiene |  |
where the person has an opportunity to feel safe and autonomous enough – to work with their own experience, build a mutually trusting supportive relationship for as long as necessary, freely choose and undertake activity, and feel validated and in control of what is happening throughout.

User involvement

We took user involvement to a highly participatory level, where service users were managing and facilitating an information and support service integrated into secondary care. This is rare. To gain further insight into why this project was so effective, the manager described how they worked. This is a small extract from a report for commissioners – called: “Can’t see the wood for the trees”:

When we are assisting users in the Vocation Matters project it feels quite often as if they meet with us and in front of them they are holding up a mirror of their own lives. In this imaginary mirror they are in a very dense wooded area without any light, just themselves looking small and vulnerable. Every tree in this mirror represents a difficulty in their lives. Many of us will have walked though heavily wooded forests and even on the sunniest of days they can be dark, cool unwelcoming places where you could easily get lost. This is more often than not the view of their lives that they bring to the initial meeting. Over a period of time we work together to try and clear the trees a little to get some light shining through. The more problems that are dealt with the happier and more empowered the individual often feels- this is not an exact science and as in everyone’s life things do not always run smoothly, but in general individuals do want to do more for themselves.

By discarding an assessment form we build up a working relationship that empowers individuals to do things for themselves. We therefore do not put people in boxes, we work in a natural way, allowing the conversation to flow freely. Often we do not need to ask the same questions for everyone, and it is often appropriate to allow the service user to be asking most of the questions and taking the lead. Whilst the main aim is to assist with vocational needs, including welfare issues, we often find that amongst the vocational barriers such as lack of qualifications, experience and confidence there are numerous other needs which might need addressing before they can progress. These are the sort of problem areas often found in a relatively poor inner city area e.g. alcohol and drugs, housing issues, relationship breakdown, family concerns, physical health needs, debt, immigration status, torture and abuse. The list goes on and on. If we can assist individuals with some of these needs by finding help lines, information on the internet- organisations and advice we will do, and depending upon the individual in question we pass the responsibility for dealing with these issues to the service user.

If we need to be more proactive we do take a more hands on approach until the individual feels capable of addressing these needs themselves. Both parties are then more able to focus on vocational need, but always with an eye on these other areas of concern. One thing to note is that of all the obstacles (trees) preventing real change in their lives there are only one, maybe two (if adverse side effects of medication are counted) directly related to their mental health.

We find because individuals are being listened to, they feel as if they are working in a partnership rather than being a passive recipient with little or no choice. They are then more likely to go away and do research, visit places that they would not have done before. Some individuals just need in-depth information relating to vocation to move forward with minimal support. Everyone is different and progress towards their goals can be rapid, or it can be laborious, but most who receive information and support from the project do make significant gains. By the end of the process we see, and more importantly the service user sees a more confident person in the mirror, with fewer obstacles around them and some direction in their lives. The mental health system as a whole needs to use approaches which are truly collaborative and empowering for service users, if they want them to be valued members of society (Williams, 2010).

This user perspective (written by the manager of the user-run vocation matters service) on how to facilitate social inclusion is simple, clear and insightful. Here person-centred means: discarding assessments, box ticking and spectator modes of working. Instead it means listening deeply and maximising trust through relationship building – recognising that through these authentic types of relationships people can find their own way forward, to progress. Service evaluations revealed that these validating conditions created feelings of partnership,
self-determination and confidence growth. When this orientation was combined with a goal achievement process and a safe space, many people turned their lives around by learning, growing and achieving their own goals.

How did it work?

Staff and service users contributed – over time – to create the centre. This space was comfortable, clean, welcoming and warm. All of the locks were removed from doors, signage was kept to a minimum, and the usual glass fronted reception space had its glass and locked door removed. Our income generation meant that we could buy good furniture (four staff offices, five consulting rooms and a large group room). A digital projector, sound system and a large plasma screen to display information were installed. This worked well for groups and development meetings. All of the decorating was done by our decorating project (saving the NHS £6,000). The paid cleaners were from our work training project (saving £5,000 per annum) and the receptionists were all service users. Artists donated and put up artworks and many plants were brought in and looked after. Staff and service users both stated they liked being in the centre, and there was a sense of belonging and a friendly feeling.

The vocational centre stood alone, opposite a primary school in a red brick Council building. It did not look like a mental health setting. Service users consistently stated that they wanted support for vocational development to be away from clinical settings, particularly away from where some were receiving depot injections.

Staff team

None of the staff facilitating the five projects had any clinical backgrounds, although at one point, three were training in counselling and psychotherapy. Their main emphasis was on the development of trusting relationships – real connections were being nurtured, so that people reported a sense of trust and feeling cared for in a way that made it possible to work through emotions and commit – in time – to a path of personal and vocational development. The staff team were close knit, shared with each other closely and were open and honest. Several had been through high levels of distress and had a range of experiences using a range of mental health services.

Income generation

As well as increasing the person-centred nature of provision, we were also mindful of finances – how much we cost and how much we needed to continue and expand. We worked on a pilot project to address the employment needs of people in our forensic services and secured £476,000 to do this work. Our work training project continued to expand, and for the first time secured a commercial contract for £368,000 to clean our local authorities libraries and day centres. We innovated by using public sector procurement money to fund posts and increase social value. The service users in our information and support project secured £178,000 to offer an education grant to service users, so they could get professional college courses paid for. This scale of income generation helped secure our service.

Descent

Ironically, at the exact time when we had created effective solutions for everyone concerned: outcomes and income generation peaking and health impact increasing – austerity struck. Our local authority was hit with a 56 per cent budget cut and NHS budgets started to meltdown. To the extent that the service director resigned because, according to him, the writing was on the wall. Perfect storms were coalescing and never mind salami slicing, a bloodbath was to follow. Think the unthinkable we were told by commissioners. It all felt apocalyptic. Fortunately, this scenario of doom did not happen. The Trust drew on reserves and a new form of collaborative working across all sectors was designed.
The grim economics did transcend and trump our evidence bases though. It was no longer possible to undertake expansion, or pilot service developments – funding any new innovations were out of the question. Clinical priorities were being examined and questioned – should the NHS be doing vocational work – should not the voluntary sector be doing this stuff? This uncertainty hung over us for many years and still does. Fortunately, some very senior decision makers understood the value and impact of what we did, but some did not and some still do not. The sustainable future of our vocational service in the NHS still remains very uncertain.

**What was it like to oversee this – my perspective?**

I experienced the full range of emotion during these developments. Excitement, joy and deep satisfaction and in descent: anxiety, uncertainty and profound sadness – with moments of despair, frustration and complete cynicism. I probably internalised too much responsibility, for everything.

The knowledge and skill set I had to learn quickly – I think, was unusual. This was because of the sheer range of people and organisations involved, to drive and make this work. In short, interpreting and bridging many different worlds, language sets and levels of power. It was vital to communicate the mission and potentials effectively, to make things happen. Creating clarity and trust were central.

My philosophy throughout was: do not lose your nerve; do not let brick walls get you down; do not give up – bounce back and push where it moves. I tried to achieve a balance between accepting uncertainty, mistakes and cultivating hope that the inherent goodness will shine through. I continue to be a passionate student in that respect.

**Looking back – what made it work?**

Co-design and co-production. We gathered a substantial range of insightful evidence from service users – enough to create an authentic blueprint, to guide our service development and specifications for commissioners. Nowadays, this process would be called genuine co-design and co-production.

Creating good conditions. The right organisational conditions emerged because there were the right policy levers and the right people committing (managers, commissioners, staff and service users). It was important to have clear evidence to justify prioritising social inclusion, as a central element in mental health service transformation. Paperwork was kept to a minimum, regular and trustworthy communication meant everyone was on the same page, and there were enough financial resources. Unlike some NHS service development – which can be likened to pushing treacle uphill – this one flowed and happened relatively quickly. In a subjective sense, it just felt right and good.

Knowing an effective vocational service. We were able in partnership with commissioners and service users to develop a range of performance management frameworks. Extensive service evaluations also lead to the development of input, output and outcome frameworks that captured personal, vocational, social inclusion and health impact. The outcome ratios were high and service users were saying this type of vocational service was effective in helping them make positive life changes. In short, we developed a robust evidence base and published in the literature.

**Future challenges**

Policy clarity, levers and resource

The number and range of Government policy exhortations to do more about employment and social inclusion in secondary care mental health services can only be described as vast and repetitive. However, there are no strong and clear policy levers in this area. NHS policies still do not spell out exactly who should be doing this important inclusion work, or what the key performance indicators are. Given the extent of cuts – funding needs to be prioritised for this area, or it is likely that vocational services in the NHS could disappear.
**Good enough facilitators**

Employment and community inclusion, as a process, involves a complex set of dynamic interactions between the individual, their goals and the community context. It raises the question: what is the skill set and experience needed to facilitate effectively? There is no agreement in the literature – several professions and sectors will continue to jostle and lay claim that they can “do it”. Critical is the ability to believe that with the right conditions service users can find their own way forward, as experts. Currently, this orientation is almost antithetical to professional health care trainings.

**Addressing life struggles**

In my experience, the difficulties that bring people into contact with mental health services are multifaceted, but have common themes – problems with living and being invalidated personally and/or socially. The challenge is to recognise and address the material, psychological and social consequences of these life struggles. If these areas are not addressed, then the demand on services will continue to increase because the lived sources of distress remain.

**A shift in care and treatment priorities**

Can we say that the primary emphasis on symptom management has shifted, to the extent that person-centred approaches, occupational care planning, high levels of user involvement and social inclusion are now top priorities in the clinical world? No. What will it take to make that happen? How are mental health services across the UK ever to be holistically person centred?

**Cost efficiencies**

People gaining employment clearly has cost benefits and savings. An economic model that is workable needs to be designed to calculate these financials accurately.

**People shaming-welfare benefits**

The perpetually changing, complex and shaming welfare benefits system continues to make deep cuts that lead to increased poverty and terrible misery for service users. This makes it increasingly difficult for people to survive – never mind thrive and undertake employment and/or social inclusion journey.

**Conclusion**

A key future challenge for secondary mental health services in the NHS is to ensure – that as the cuts continue to bite – we do not let economics transcend the value and impact of the evidence base surrounding social inclusion, by rationalising that it is not core NHS business, or a priority. We need to retain a focus on what service users tell us they want – particularly around achieving personal vocational goals. The alternative is: more expensive monitoring, static caseloads of people and growing admissions (Plate 1).

In contrast, social inclusion can create hope, a sense of purpose and well-being – often leading to healthier and more satisfying life experiences. A service user clearly articulated to us how mental health services, policy makers and commissioners could approach this:

> Social inclusion is not about disability, symptoms or “treatment management”. It is about an individual’s activity of daily living, and how they relate to the outside world. It is about bringing the world into a life. The mental health system focusses purely on symptomology, which is in its very nature negative. The whole person needs to be looked at, and the symptoms need to be “put on a backburner”. The more socially included an individual feels in a societal way and in a personal way, the more likely they are to grow, find greater independence, and be self-sufficient (anon).
References


Further reading


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