

CLINICAL PSYCHOLOGISTS' CONSTRUCTIONS OF INSIGHT IN ADULT MENTAL HEALTH

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1 ABSTRACT

Insight is a term used in adult mental health to try to think about and understand how service users' understand their difficulties. There has been a growth in interest in its potential use in practice. This has led to the development of multiple theories and scales. Research in this area has yielded a vast array of results. Although to date, this enterprise has yielded inconsistent results. While the various insight theories implicate different factors in their models, there is convergence on three recurrent themes: acceptance of mental illness, agreement with treatment, and ability to label experiences as pathological.

However, insight in adult mental health is a term that is often used but rarely defined. This research took a social constructionist stance to explore the way insight is deployed by clinical psychologists in practice. It sought to explore the degree to which ideas about insight are used in practice. Conversely it also looked to explore if insight was not used what, if any, analogous psychological theories were deployed in their day-to-day work. The research actively explored a variety of contexts in which clinical psychologists might encounter "insight talk" and how they negotiate these contexts.

Nine clinical psychologists working in a variety of adult mental health services within one NHS trust were recruited. Semi-structured interviews were used to explore if, and how, insight is used. The transcripts were analysed using a mixed design of Discursive Psychology and Foucauldian Discourse Analysis.

The results suggest that insight and analogous terms are used at different levels of practice. In terms of service user contact (micro-politics) "insight talk" considered insight as psy-model, narrative insight, and formulation. In discussion with colleagues (meso-politics), psychologists constructed their colleagues "insight". At a system level (macro-politics) psychologists constructed systems as lacking insight and the promotion of a psychologically minded workforce.

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3 DEFINITIONS

Conditions of possibility: relates to the framework of ideas, institutions, social practices etc. that enable an entity or idea to exist e.g. DSM-V, and bio-psychiatry enable and legitimise the “existence” of theories of schizophrenia as a biologically based mental disorder.

Cultural capital: a set of social assets and skills that enable social mobility and/or access to circumscribed social contexts. (Bourdieu, 1990).

Discourse: a system of statements about the world which make certain social practices and ways of ordering knowledge seem reasonable and others problematic (Parker, 1992).

Discursive resources/practices: historically and culturally specific rules for organising different forms of knowledge.

Dramaturgical: Is a sociological analysis that attempts to map how people manage themselves, their actions and talk in social interactions (Goffman, 1959).

Governmentality: is a process implicated in the instruction, dissemination and enforcement of state sanctioned social behaviour at every level of society. (Foucault, 1978/2002).

Ideology: system(s) of ideas, values, and beliefs that interact with social practices to explain a political order, sustain power asymmetries, and maintain group identities (Chiapello & Fairclough & 2002).

Interpretative repertoires: collections of culturally familiar statements that are common sense ways of organising accountability and managing subject positions in social interaction (Wetherell, 1998).

Non-discursive practices: are 'institutions, political events, economic practices and processes' (Foucault, 1969 p.162).

Objectification: the act of understanding a person or institution with recourse to discipline specific tools and discourses and thus attempting to fix an identity/label to them as a result of applying these tools and discourse.

Pastoral power: the convergence of specific set of techniques design to govern or guide the behaviour of others. Extended discussion is contained on p. 64).

Power: is taken from Foucauldian theory and summarised by O'Farrell (p. 149-150, 2005)

- “power is not a thing but a relation”
- “power is not simply repressive but it is productive”
- “power is not simply a property of the State”
- “the exercise of power is strategic and war-like”
- “power operates at the most micro levels of social relations”

Power-knowledge relations: used in this research interchangeably with “power-knowledge constellations” which are ways in which knowledge(s) are collected and deployed in social interaction. It is supported by power relations and attempts to be self-sustaining.

Psy-encounter: relates to any service user – health professional interaction in a mental health context.

Psy-technologies: relates to any psychology specific tools and mechanisms deployed in social interactions e.g. formulation.

Regimes of truth: the ways that disciplines and institutional practices create, circulates and deploy knowledge(s) to privilege a specific version of reality (Foucault, 1982).

Subject positions: implied positions within a discourse that may be taken up or rejected by a person and are implicated in identity or experience (Burr, 2003).

Subjectivity: is related to selfhood or identity. However, while identity is a static construct, subjectivity is a dynamic and relational concept in which a contingent self is continually co-created and re-created in social interaction.

Subjectification: produce subjectivity and/or to make subject to by recourse to discursive and non-discursive practices in social action.

4 INTRODUCTION

Insight can be seen as an important construct in adult mental health. It is widely cited as a core feature of schizophrenia (Roe & Davidson, 2005) and has also been linked more broadly to “psychosis spectrum disorders” (O Connor, Wiffen, DiForti, Ferraro, Joseph et al., 2013). Clinically, the determination of service user insight can influence treatment decisions in terms of type and location of interventions offered (Klausen, Haugsgjerd & Lorem, 2013). Theoretically, there has been a growth in interest in the construct since the 1990s that has led to the development of several “insight” scales and a profusion of published material on the subject. Research and clinical practice has considered insight in relation to socio-demographic variables, past psychiatric illness, prognosis, compliance, severity, cognitive functioning, brain structures, psychosocial functioning and quality of life, and diagnostic category (Marková, 2005).

As a starting point “insight” in adult mental health will draw on the construct definition offered by David (1990), who proposed service user insight as:

1. acceptance of mental illness
2. compliance with prescribed treatment
3. ability to re-label unusual experiences as pathological

Researchers have proposed several other variations. For example, Amador and Kronegold (2004) suggest that a service user with insight should demonstrate awareness of:

1. having a mental disorder
2. its symptoms,
3. attribution of the symptoms to the mental disorder.
4. the social consequences in terms of the disorder, and thus
5. the need for treatment

While using different terminology, this definition essentially privileges similar ideas to David's (1990) generic construct i.e. concordance with clinician, compliance with treatment, and constitution of self and experience as pathological. This succinctly summarises the main themes that emerge from several major scales developed to measure insight in people presenting with psychosis (Appendix A). It also closely represents service users' understandings of insight applied in adult mental health (Dillon, 2011).

It could be argued that this definition positions power within clinician to define not only the nature of another's experience as pathological but also expects the person to accept this formulation uncritically. This ideology is problematic for the current healthcare landscape that champions patient choice and consumerism (Speed, 2011) and promotes a patient-centred approach (DH, 2005; 2006; 2013a).

However, insight, is a word that although widely recognised, is more readily used than defined (Tranulis, Corin & Kirmayer, 2008). While researchers might have the privilege of defining their constructs, in multi-disciplinary clinical contexts, like adult mental health, this lack of clarity may led to divergent therapeutic agendas, mixed messages to service users, team conflict etc. Furthermore, insight as constructed by David and co. makes several assumptions that could be contested and will be discussed in more detail throughout. However, principally it can be considered contestable in that they privilege a bio-medical view of distress.

This research is concerned with exploring if, and how, insight is talked about by clinical psychologists working in adult mental health services. It is interested in how they negotiate the ambiguous and possibly contestable nature of the term. It will consider what alternatives, if any, are used in this context. Importantly it will consider what this does in terms of subjectification. Subjectification is a complicated term taken from the French "*assujettir*" which means both to produce subjectivity and to make subject to (Henriques, Hollway, Urwin, Venn & Walkerdine, 1998a). Subjectivity is related to identity, but implies a dynamic and reflexive identity. Thus subjectification can be thought of as a process of making a variety of identities available in relation to the socio-historical and cultural

context (Henriques et al., 1998a). However, identity has been traditionally theorised as a reified entity; but the subjectivity proposed here is more akin to the decentred subject. That is, a subject that is relative and relational, and continually co-constructed in social action (Burr, 2004). The concept identity owes much to the enterprise of promoting the unitary rational subject evident in theorising of traditional personality and social psychology (Venn, 1998). It has been critiqued as an attempt to label an individual within a limited frame of reference (O'Farrell, 1996). Subject positions and subjectivity are preferred as both are more congruent with subjectification, which offers the potential for a contingent subject rather than a fixed identity. These terms will be returned to in the methodology section. In summary, this research will consider insight talk in relation to processes of subjectification.

This literature review will begin with a brief history of the term insight in adult mental health and outline some of the prevailing models that dominate current theorising and practice. Psychoanalytic, cognitive, neuropsychological and narrative theories of insight will be reviewed. A critical appraisal will attend to methodological, epistemological and ideological assumptions that support the dominant “regimes of truth” (Foucault, 1975). This will be followed by a discussion of potential implications of language in mental health. Specifically how language is deployed to construct the service user, the mental health assessment and models of madness. This section will finish with a brief summary and rationale for the research.

4.1 Literature Search

Theories about insight have been developed for over 120 years and have been influenced by diverse fields in psychology. For purposes of this study searches were restricted to topics directly referencing mental health concerns. Searches used the term “insight” with “psychosis”, “psych*”, “schizophrenia”, “schizo*”, “mental”, “health” + “illness” in both “subject” and “titles terms” domains. Separate searches used “insight” with “depression”, “construct*”, “cultur*”, + “personality disorder” and with the terms “capacity” and “psychiatry”. All searches were run on PSYCH INFO, PSYCH ARTICLES, and PUBMED.

4.2 A History Of Insight

4.2.1 Constructing History

History making can be considered story telling, which necessitates decision-making in terms of form, content and the construction of historical fact (Carr, 1961). This can create an illusion of historical inevitability (Foucault, 1975). However, the historian cannot detract from their socio-cultural and historical world-view in shaping the multi-layered and continuous decisions that shape the product of this work (Derrida, 1994). Therefore in this context, this history will not attempt to construct historical facts but will outline some of the early protagonists in the development of concept insight. It will posit some of the available discourses that made possible early conceptualisations of insight and how they relate to the modern mental health discourses. In history making, and in particular with historical enterprises in mental health, it is important to make a distinction between ontology and epistemology; noting that ontology can depend on epistemology (Berrios & Marková, 2004). Thus, ideas about the nature of madness, self-knowledge, the self, etc. make available both legitimate objects and tools of investigation and can have a determining influence on what we know and can know. That is our methods embody our theoretical assumptions and thus shape potential results (Danziger, 1985). What is interesting and congruent with a social constructionist approach is that different ideas about insight emerge from different cultural contexts. This history will briefly consider these ideas in relation to insight. It will then draw on Lewis' (1934) paper "The psychopathology of insight" which will be considered as a distillation of previous ideas and a template for contemporary theorising.

4.2.2 Etymology Of Insight

Insight as a concept does not exist uniformly across all languages and while north and west Germanic linguistic codes have the word, Latin based languages don't (Berrios & Marková, 2004). Insight as a construct in mental health practice and theory has evolved with ideas about reason, consciousness and self-knowledge, with the consequence that the meaning has become fused with these ideas.

In Germanic linguistic codes the word “*verstehen*” does not have a Latin correlate and thus is difficult to translate French, Italian etc. “*Verstehen*”¹ refers to understanding and introspection and can be considered in terms of the totality of one’s mental and existential state including non-conscious aspects (Danziger, 1980; Ghaemi, 2003). This holistic construct and formulation requires not just the knowledge of being ill but also an understanding of the processes involved in emotions and volitions (Berrios & Marková, 2004). Also, the more directly translatable Germanic “*einsicht*” similarly does not have a Latin variant. It simply means insight, in the sense of understanding someone or something. It is not surprising then that different linguistic constructions facilitate different theoretical and applied use of insight. A brief overview of the French, German and British ideas in the early years of alienist-practice² may help to illustrate this.

This necessarily requires simplification here as the debates were broad and vigorous in each context. Nevertheless, some generalisations may be useful. In France, in the mid-late 19th century the prevailing view was that people could have “insight” into being unwell, but not be able to control their (criminal) behaviours (e.g. Falnet and Monel). In Germany, neither Kraepelin or Bleuler considered insight to be important in terms of diagnosis or prognosis in mental health. In Britain, Maudsley believed the insane mind was incapable of making rational judgements (Berrios & Marková, 2004). These divergent views reflect elements of mental health discourse that are still played out today. Namely, the questions about the relationships between “madness” and rationality, “madness” and self-knowledge, criminal responsibility, and the degree to which insight is part of a disease process (and if so is insight a categorical or continuous construct)?

¹ The word predates Jaspers but he was the first theorist to systematically apply it in the mental health arena (Ghaemi, 2003).

² Premedical term for psy-professions (psychiatry and psychology)

4.2.3 **Constructing A History Of Insight**

As noted the history of the concept is inter-linked with notions of reason, consciousness and self-knowledge and historical construction of madness. Considering insight a categorical or continuous construct emerges from this connection (Marková & Berrios, 1995). Conceptualising insight as categorical can be thought of as an “all or nothing” concept. It is also linked to bio-medical ideas of mental health with the adoption of the sign-symptoms model from medicine³. This assumes that insight as a part of a disease process should be identifiable and measureable as a distinct entity. Alternatively, insight as a continuous construct moves away from this idea of insight as unitary construct and considers the possibility of different levels of insight for different symptoms.

Categorical formulations are evident in Jaspers (1913/1963) who noted “in psychosis there is no lasting or complete insight”. While this may have come from some form of clinical observation, it is also a reformulation of earlier conceptualisation of rationality and self-hood proposed by Locke and Hobbs who posited awareness of all our experiences, and consciousness and self-awareness and intrinsically tied to identity (Marková, 2005). Thus, madness in the form of the presence of delusions must reflect an absence of self-awareness (Berrios, 1994b). This idea is echoed by Kraepelin (1919) who reported that in psychosis “the faculty of judgment suffers without exception complete injury”. The totality of the loss draws on Descartes’ “*cognito ergo sum*” assumption that we are aware of all of our experiences and that awareness of ourselves is a core part of our identity (Payne & Rae-Barbera, 2010). The implications are of a categorical insight and insightlessness as pathological, thus the person afflicted is yoked to the professional order to properly describe reality for them. It is also noteworthy, that a categorical insight is both constituted by and a constituent of overarching discourse of the unitary rational subject. This is the idea that an indivisible rational self is at the centre of our understanding of ourselves and is the central tenet of Humanism (Henriques et al., 1998b).

³ The merits or otherwise of this model in mental health will be explored in section 1.4.3.

However, the idea of a categorical insight was debated with Krafft-Ebing (1893 cited Marková, 2005) and later Jaspers (1948, cited in Marková & Berrios, 1996) who considered insight as variable but ultimately progressive over the life cycle of the proposed illness. While Maudsley (1885) promoted the idea that madness affected all of the brain and thus rational thought, self-knowledge and awareness of illness were impossible for the “insane”. Although these ideas are somewhat incongruent, they both make assumptions about insight as part of a disease process, a disease that at its core impacts on the individual as a rational being. Here we see the emergence of the ideology of biological determinism.

In Lewis’ (1934) paper “The psychopathology of insight” we begin to see the consolidation of several core assumptions that permeate insight theorising to this day. Of particular note is the idea of insight as “the correct attitude to morbid change in oneself, and moreover, the realisation that the illness is mental” (p. 333). Lewis is in no doubt that the “correct attitude” is that unusual experiences are pathological and thus explicable through the definitions proposed by clinical psychiatry. This negates any personal narrative of a person’s distress outside of these definitions and renders them part of the disease process. Here we see the privileging of medical discourses of distress.

This formulation is echoed in Jasper’s (1948) “comprehending appropriation”. An idea that emerged from his struggles to theorise about and measure insight clinically. He orientated towards an assessment of the service users’ “objective knowledge”. By this he meant, the ability of the service user to understand and apply professional medical knowledge to themselves (Berrios & Marková, 2004). What is interesting is the uncritical assumption of objectivity embedded in this idea. In some ways, it is an early formulation of the social constructionist critique of diagnostic categories merely reflecting specifically defined ways of ordering information in the world rather than universal reified entities. However, it would be an act of extreme revisionism to assume that was his intention. For the purposes of this research it does raise two important ideas. Firstly, in privileging professional discourses, this formulation legitimises a description of experiences as pathological with specific reference to the knowledge and language of psychiatry. Secondly, it illustrates a facet of the idea of “Cultural

Capital” theorised by Bourdieu (1986). That is the ability to understand and deploy specific cultural idioms, ideologies and actions to facilitate access to, and the benefits from, a culture/group. This has implications for processes of subjectification. Thus in this context, is insight part of a disease process or the repetition of psy-professional discourses in order to make available or avoid various interactions with services?

The construction of insight as an expression of the “correct attitude” as defined by psy-professional discourses can be considered one of the central ideas embedded in current constructions of insight (David, 1990; Amador & Kronegold, 2004). In this vein what insight becomes is a privileging of clinician concordance over cultural concordance (Nordeck & van Heugton, 2014). Promoting clinician authority over patient subjectivity. Cultural concordance can be thought about in terms of respect for, and understanding of, culturally congruent ways of understanding unusual experiences⁴.

Of note, is the transformation of insight to an ontological reality and a site of assessment for clinicians – this creates the basis for the inclusion of insight in clinical assessment. For example, the widely used Mental State Exam (MSE) (Trzepacz & Baker, 1993) attempts to assess insight clinically and, interestingly, links insight to the patients’ attitude to the assessor (Martin, 1990). It can also be deemed an important attribute necessary for engagement in psychological therapies and somewhat circularly a goal of some talking therapies. Thus, by associating insight with both engagement and outcome, it can be important in determining “suitability” (i.e. access to services).

⁴ Jinn possession is a common explanation among some Islamic communities in the UK. Cultural concordance promotes a dialogue with religious workers and the community to more appropriately and sensitively develop collaborative ways of working to support these service users (Dein & Illaiee, 2013).

4.3 Theories Of Insight

Lewis (1934) recognised that “insight is not a word of plain and single meaning”. This is partly due to its use in a range of applied fields and to some extent the cross pollination between them. This section will explore psychoanalysis and the implications for insight and the de-centred subject. Cognitive approaches will be considered in terms of CBT and the development of The Beck Cognitive Insight Scale (BCIS). Neuropsychological theories will make reference to the assumptions embedded in research methodologies and linking insight to executive functioning. Lastly, narrative approaches will be discussed in terms of a move from dialectical to dialogical service user interactions and the implications for subjectivity.

4.3.1 Insight In Psychoanalysis

Psychoanalysis should not be thought of as one unified body of knowledge but rather collections of theories that share some similarities and many divergent ideas. Despite this I will attempt to outline some overarching and relevant themes in relation to insight. In order to do this, it is important to contextualise insight within psychoanalytic paradigm of the de-centred subject. This should be seen as a direct critique of Humanist idea of a unitary rational subject outlined previously. Freud (1933/1964) described psychoanalysis as the third revolutionary movement de-centring “the naïve self-love of man”. He proposed that Copernicus first re-positioned the earth from the centre of the universe. Darwin secondly re-positioned “man” as part of evolutionary chain and not the culmination of creation. Lastly, psychoanalysis’ description of the unconscious questioned the validity of a conscious ego as the source of thought. Lacan (1955/2006) was to take this point further and critique Decartes’ “*cognito ergo sum*” by suggesting “I think where I am not, therefore I am where I do not think” (Lacan, 2006, p. 517). This refers directly to psychoanalysis’ proposition that unconscious thoughts, drives, and defences are dynamically engaged with each other without our consciousness recognition. Therefore, operating outside of the realm of rationality and negating the idea of a rational subject. In this context, gaining insight of this process is an active, but ultimately never fully realisable, goal.

In psychoanalysis, then, insight can be thought of as self-knowledge by the transformation of what is unconscious into consciousness - "*Wo Es war, soll Ich werden*"⁵ (Freud, 1932). It is the recognition of the interaction of our conscious world, experiences and relationships with our unconscious drives, desires, and defences (Malan, 1999). Gaining self-knowledge should be thought of as a dynamic process that involves the analyst working with the transference and counter-transference in order to make interpretations for the analysand (Lemma, 2003). For example, in Kleinian analysis interpretations of the transference might give insight into one's defensive organisation, helping to re-integrate split off parts of the self and thus be part of the means but not the end of therapy. The clinician is also expected to have sufficient self-insight to separate their own processes from that of the client (Temperley, 1984).

Despite the idea that insight in psychotherapy is considered to be an important construct, there is limited empirical research on the topic (McAleavy & Castonguay, 2013). In part this may be due to methodological considerations. Insight in this field has proven a difficult construct to define and consequently various and often divergent measures and models have been used to attempt to capture it (Connolly Gibbons, Crits-Christoph, Barber & Schamberger, 2007). Furthermore, attempting not only to isolate but also capture the specific therapeutic operations that the clinician did to bring about insight has been equally problematic (Roback, 1971). This mirrors several other connected psychotherapy processes that are deemed important but empirically elusive e.g. transference and counter-transference.

The paucity of empirical evidence has not undermined insight's importance in psychoanalysis. For example, the symptom can be thought of as symbolic (Bell, 2003), and this has led to considering insight as a defence in mental health (Laing, 1960), hypothesising that the experience of extreme poverty, isolation, and abuse are potentially traumatic. This trauma can be re-lived through an adversarial experience of care involving a potentially incongruent diagnosis, coercion and hospitalisation (Duggins, 2010). The patient unconsciously rejects this reality to protect the ego through defences e.g. denial. Van Putten, Crumpton and Yale (1976) proposed that positive symptomology e.g.

⁵ "where id was, there shall ego be".

grandiosity, can be thought about in terms of a denial of the experience of coercive and medicated life on the ward. Similarly formulating lack of insight as a useful explanatory model in terms of negative symptoms of withdrawal or dissociation as a means to protect against engaging with their current predicament. Both formulations position considerable power in the clinician to both recognise if this process is happening and guide the person to what Freud somewhat optimistically termed an acceptable form of melancholia (Freud, 1933/1964).

Denial could be considered a key concept borrowed from psychoanalysis in the current mental health conceptualisation of insight (Marková, 2005). Despite its proposed clinical utility in psychoanalysis, denial's uncritical use can promote individualistic formulations of distress and can negate the value of service user input thus entrenching power asymmetry. Indeed David (1999) somewhat myopically notes that insight in psychoanalysis became "synonymous with the willingness of a person to agree with Freudian theory" (p. 211). Alternatively recruiting "denial" in a formulation can open the possibility to explore the symbolic and "latent" content of e.g. "grandiose delusions". This might open possibility for the system to formulate the impact of the potential powerlessness experienced by the service user, thus opportunities to extend and transform the subjectivity of service users and clinicians.

4.3.2 Insight And Cognitive Psychology

It appears that early formulations of insight were at least partially influenced by Gestalt theories in the early part of the twentieth century (Lewis, 1934; Marková, 2005). However, this review will focus on more recent developments of cognitive and behavioural psychology in mental health.

Behavioural techniques emerged as a response to the then dominant intra-psychic models in 1950s and many of its proponents were psychoanalytically trained therapists. Indeed, in the formative years of clinical psychology as a discipline behavioural approaches were favoured as an applied-scientist approach (Pilgrim & Treacher, 1992). More recently, cognitive and behavioural theories link to insight in mental health through the theorising of psychosis as a

collection of disorders of self-monitoring and self-regulation (Beck & Rector, 2005). Cognitively informed interventions (e.g. ACT, CBT, CFT, MBCT⁶) are used widely in services (Baer, 2005; Beck & Rector, 2000; Braehler, Harper & Gilbert 2013). Chief among them is CBT, which has been suggested to have clinical utility (Kuipers, 2005) and has the additional status of being a institutionally sanctioned treatment⁷ (NICE, 2009). However, cognitive models are built on the assumption that people become entrenched in dysfunctional thinking patterns and these can, and by implication should, be changed. This implies that a normative judgement (decided by the clinician) about the correct way to think about, and make attributions of, one's experiences in the world. Explicitly the model formulates that we are subject to irrational thinking, but implicitly infers "normal" thinkers are stable and accurate readers of their experiences and thus anything other than this is dysfunctional/pathological.

However, evidence from attribution theory (Ross, 1977) and from the study of heuristics (Tversky & Kahneman, 1973; Kahneman, 2011) suggests that people are consistently unreliable in this regard. In the case of insight in mental health the decision making process is further complicated by the requirement to agree with the world of view of clinician. This requires the service user to demonstrate an understanding of the ways of thinking, theorising and constructing the world of the clinician i.e. the aforementioned cultural capital (Bourdieu, 1986). This is likely to be a tall order for novice service users. Although, more experienced service users have been documented to demonstrate, what could be thought of as, cultural capital in order to influence restrictive systems towards their own ends (Goffman, 1961; Weider, 1974). This might suggest that mental health provision is implicated in what might be called governmentality (Foucault, 1978/2002). That is, implicated in the instruction, dissemination and enforcement of state sanctioned social behaviour. This shifts the emphasis institutionally from the therapeutic to pedagogic and individually from dialogic to

⁶ ACT = acceptance and commitment therapy, CBT = cognitive behaviour therapy, CFT = compassion focused therapy, MBT = mentalisation based therapy

⁷ "Treatment for schizophrenia usually involves a combination of antipsychotic medication and social support. CBT or another type of psychotherapy called family therapy are also often used." NHS choices – psychosis; treatment last accessed 10.2.2015

(<http://www.nhs.uk/Conditions/Psychosis/Pages/Treatment.aspx>)

didactic practice. However, Foucault was also interested in the transformational potential of subjectivity in response to powerful discourses e.g. in response to institutionalisation, patients resisted and created an alternative system (“underlife”) where different values and ways of being made possible different subjectivities than those espoused by “total institution(s)” (Goffman, 1961).

In some cases the application of CBT within mental health services can be used to support hegemonic constructions of distress. Rathod and Turkington (2005) reported that short-term CBT can improve insight in the domains of compliance with treatment and acceptance of experiences as part of “mental illness”. While, Zygmunt, Olfson, Boyer and Mechanic’s (2002) review suggested that CBT for medication compliance is significantly better than traditional psychoeducation approaches. One might question the practicality of using a talking therapy in this way. Issues regarding consent to engage in therapy are pertinent here. Also presumably, medication compliance must have been a goal of this type of intervention. However, given that compliance was also the issue (if only for the service), one might wonder about how collaborative the goal setting was and possibly even the entire intervention. Lastly, one might also question the ethics of deploying a talking therapy to get service users to re-label their experience as pathological and by proxy subjugate other possible narratives to explain their distress.

This is not to say that the distress is not a very real experience for people, but suggests that in this instance talking therapies can become part of the discursive and institutional practices that attempt to fix power relations in a very particular way. Deploying talking therapies in this way promotes uni-dimensional constructions of distress and a control agenda (Szasz, 1972). As agents of this agenda, therapies and therapists run the risk of being associated with a “funnel of betrayal” (Goffman, 1961) that equates deprivation of liberty and autonomy with a positive therapeutic outcome.

This type of application supports the charge of psychology as the magician's assistant in mental health provision (Cole, Diamond & Keenan, 2013). This refers to psychologists' use of individualising talking therapies that implicitly endorse depoliticised and decontextualized constructions of distress. In this way psychologists' orientation, models and methodologies are positioned as promoting and supporting the enterprise of bio-medicalism. A neo-Weberian analysis of psy-professions would consider the institutional practices used to support this position. "Social closure" has been suggested to be an important professional practice that promotes power asymmetries (Rogers & Pilgrim, 2010). Social closure is achieved by fostering the ideology of a speciality (e.g. clinical psychology) and monopolising the intervention technologies (CBT for compliance). It is worth stating the CBT for psychosis can, and has been, reported by service users to be a useful way for making sense of their distress (BPS, 2014). Service users have reported the value of the psychoeducation component and respectful relationship, while others have emphasised the coercive potential through this pedagogic component (Massari & Hallam, 2003).

However, the development of the model "cognitive insight" in psychosis has to some extent shifted the emphasis away from clinician concordance. Beck, Baruch, Balter, Steer and Warman (2004) propose a model of insight that considers self-reflectiveness and self-certainty (over-confidence) to be core components of insight. The BCIS (Appendix A) was deemed to correlate with awareness of mental disorder on the SUMD and to reliably differentiate inpatients with a psychotic diagnosis from those without this diagnosis label (Beck et al., 2004). This study illustrates some key trends that reappear in mainstream research of insight in mental health. Methodologically, they concede that no standardised measure was used to diagnose the participants. This sidesteps an important issue in terms of a key variable in study i.e. the diagnostic category itself. That mental health diagnostic categories have been consistently reported to be inconsistently applied, even by the same clinician, is not discussed (Bentall, 2010; Boyle, 2011). In doing so the researcher and reader can avoid this inconvenient idea and unproblematically assume that the diagnoses were valid and consistently applied on this occasion. There is another issue that arises from a potential selection bias. Duggins (2010) reports that non-compliant service users can be problematized as lacking insight within

mental health systems. The degree to which problematic or problematized patients were recruited to the study is unclear. Thus, is the reported sample reflective of a group of “psychotic” patients who have already been socialised to the model, language, and practice of psychiatry in this setting? Is their expression of “awareness of the disorder” as per the SUMD merely an artefact of cultural capital made available through processes of governmentality in this setting? Conversely, are service users actively deploying cultural capital to “dramaturgically” perform⁸ the available role (Goffman, 1959) without agreeing with the terms of the reference of the study?

In fact one might consider it to be ethically perilous to gain full consent from a participant that may be deemed to lack self-awareness in other key aspects of their life, and implicitly suggests theorists promote continuous over categorical model of insight. Describing consent in the context of questionable self-awareness necessitates a discussion of capacity. But despite capacity being a key feature of mental health care provision and enshrined in legal frameworks (Mental Health Act, 2007 and Mental Capacity Act, 2005), it is rarely mentioned in studies. The BCIS has also been suggested to be more useful than clinical insight in terms of predicting outcome in first episode psychosis (O'Connor, Wiffen, Diforti et al., 2013). This enterprise uncritically presents progress and recovery as intricately linked with the *modus operandi* of standard mental health care (i.e. professional contact and treatment compliance). This link has been questioned by considerable and robust presentations by service users (Dillon, 2011; May, 2000; Romme & Escher, 1993) and practitioners (Moncrief, 2008; Mosher, Vallone & Menn, 2005).

There is also a wealth of evidence that suggests that for some people contact with services is important. Of this cohort, BCIS has been suggested to usefully predict who might benefit from talking therapy (Perivoliotis, Grant, Peters et al., 2010). However, there is also evidence that talking therapies increases cognitive insight (Granholm, McQuaid & McClure, 2005). This type of circularity, can be connected to the aforementioned cultural capital i.e. that those who display evidence of socially desirable attributes e.g. cognitive insight, can gain

⁸ Is a sociological model developed to study how subjectivity is co-created and negotiated in social action (Goffman, 1959).

access to resources deemed useful to improve it. This has implications for how services screen for and allocate resources. In terms of insight, this type of theorising legitimises objectifying cognitive insight and associated processes of subjectification.

4.3.3 Insight In Neuropsychology

The neurological disorder anosagnosia has theoretical connections with cognitive models and has provided impetus to explore neural correlates of insight in psychosis. Anosagnosia can be defined as a deficit in awareness of disability arising from a specific brain injury in frontal, parietal and temporal regions of the brain (Lezak, Howieson, Bigler & Tranel, 2012). Early theorists made analogous observations between insight in neurology and madness and assumed that the neural correlates would inevitably be discovered (Marková, 2005).

Boyle (2002) notes that researchers have for over 100 years attempted and largely failed to find a comprehensive biological explanation for mental health conditions. On one level this fails to address the considerable problems that plague the validity and reliability of mental health constructs (Szasz, 1972; Read, 2013). Thus using a diagnosis of, for example, schizophrenia as a definitive, objective, and discrete variable in research is questionable. This endeavour also represents a type of biological reductionism that depoliticises distress – negating public and political responsibility to address inequality, trauma and abusive social structures and placing this solely in the domain of individual responsibility (Patel, 2003). Furthermore, it implies individual responsibility is diminished by the very biological and genetic composition that makes them vulnerable to disease processes. At the social and political level the recruitment of the discourses of biology and science in psy-professions' methodology adds credence to the cult of rigour, authority, and evidence-based practice.

However, it is important to acknowledge that biology must play a role in our experience of ourselves and the world (BPS, 2014; Insel, 2010). Yet this recognition and the attempt to evidence it, presents more dilemmas for the psy-professions. I will consider briefly the linking of awareness to the neuropsychological construct of executive functioning to elucidate this.

Insight, or self awareness, in psychosis has been linked to executive functioning (Raffard, Bayard, Gely-Nargeot, et al., 2009). As a higher order cognitive function, this is in turn linked to the prefrontal cortex (Lezak et al., 2012). The term “executive function” owes much to Andrew Jackson’s⁹ political reforms who like his contemporaries believed that a strong rational political executive could contain and manage lower order irrational and emotional classes (Bentall, 2003). This political ideology was mapped onto neurology and implied a top down control of our decisions and emotions. More recent evidence suggests that higher order functions are executed through the recruitment of multiple interacting systems (Thomas & Karmiloff-Smith, 2002), with some research suggesting that subcortical regions, e.g. amygdala, are central and at least equally culpable in higher order tasks (Bechara, Damasio & Damasio, 2007).

Despite the recognition of the brain (and indeed the whole body) as a complex interacting system (Head & Holmes, 1911) much of the research in neuroscience is underpinned by modularity (Fodor, 1983). This refers to the idea that the brain is comprised of specific domains (modules) that have specific functions. This potentially limits research in this field by using simplistic models (e.g. correlation and reverse inference) that attempt to locate function in discrete regions (Poldrack, 2008). Put simply, the tools and designs are not sophisticated enough to adequately model even basic cognitive tasks in the laboratory let alone complicated real world interactions (Logothetis, 2008). This statement in itself is a reformulation of the defence that biological psychiatry has presented in face of 100 years of failed research into biological aetiology of mental illness. That is, that there must be a neuro-biological model to account for schizophrenia, but the research methodologies are not, as yet, sophisticated enough to detect it (Boyle, 2002).

⁹ seventh President of the USA, 1829–1837 (Yoo, 2007).

To date the prefrontal, temporal and parietal cortices along with anterior and posterior cingulate, insula and cerebellum have been implicated in insight studies (Sapara, Ffytche, Birchwood et al., 2014). These results may represent parts of a yet to be fully described “insight” system or artefacts from the lack of conceptual clarity and inadequate methodology. It seems sensible to conclude that the search for an “insight centre” by biological psychiatry is likely to be misguided at best (David, 1999).

4.3.4 Narrative Constructions Of Insight

The models presented thus far privilege the conceptualisation of insight from the professional. However, there is growing movement that recognises the value for service users’ authoring their own experience (Romme & Escher, 1993; White & Epston, 1990) and of the legitimacy in promoting narratives that are sensitive to their socio-cultural and historical context (Johnson & Orrell, 1995). Being able to build a personal narrative that makes meaning out of mental illness can aid recovery (Dillon, 2011). Doing this using available familial, community and cultural scripts about wellbeing can also maintain recovery (Anthony, 1993). This democratises insight and questions the authority of psy-professionals’ ability to define another’s reality. It also represents a shift to the idea of insight as a dynamic, interactive, and socially constructed concept (Kirmayer & Corin, 2004). In effect, narrative insight opens the possibility of thinking about insight not as noun but a verb and the emergence of relational constructions of insight (Klausen, Haugsgjerd & Lorem, 2013). That is the transformation of insight from an object to an active subjective and relational experience of oneself.

Epistemologically, narrative insight calls for a movement from a dialectical approach to a dialogical approach in the encounter between the psy-professional and service user. In the dialectical method a thesis is presented, augmented by an anti-thesis and reformulated as the synthesis. This then becomes the authoritative account and the new thesis (Horkheimer & Adorno, 1944/2002). While interaction is implied the directional flow moves from one authoritative account to another and the interactional partner’s role is to present an anti-thesis – which may be taken up or rejected. The dialectical approach is

embedded in traditional insight models, and much professional practice, assuming a movement towards something i.e. ultimate decision on an individual's level of understanding about their diagnosis and need for treatment. Positioning the nature of insight as a value judgement linked to clinician concordance can also be seen as an authoritative and corrective account of another view of themselves and reality. Thus, psychiatric insight limits the legitimacy of alternative knowledge(s) and construction(s) of the self and distress i.e. hearing voices as auditory illusions and a consequences of schizophrenia.

In contrast the dialogical approach assumes multiple co-constructed meaning(s) of experience, reality and subjectivity. This has important ramifications in terms of the outcome of the therapeutic encounter and subjectivity itself. Firstly, there is a shift in emphasis to a collaborative practice, which calls for continual reflexivity in terms of the interactional process (Anderson, 2012). This calls for an interrogation of the clinician's pre-understanding(s) that might drive inferences made about the interaction (Wittgenstein, 1953/2001). Together this necessitates a "radical listening" not only to the patient but also to ourselves (Weingarten, 1997).

With this comes the potential of multiple, co-constructed, socio-cultural and historically defined mental health and wellbeing dialogues to negate the universalist assumptions of biological determinism. This does not mean adopting a radical relativist position, which can be considered equally problematic (Edwards, Ashmore & Potter, 1994). But it does prompt a recognition of the Procrustean nature of western mental health theories (Saravan, Jacobs, Prince, Bhugra & David 2004). In doing so it calls for an orientation to what is being constructed in the therapeutic interaction and how; but equally importantly what is being prevented from being constructed and how? For example, this creates the possibility of understanding voice hearing as distressing and understandable in the context of multiple traumas. In this case dialogic approaches enables both service user and clinician to be open to hearing and making available thick descriptions to compliment thin (bio-medical) descriptions (Geertz, 1973).

Traditionally constructed concepts of insight may not fit in culturally divergent populations' understanding of themselves and their community. Furthermore, they tend to be static and resistant to change in contrast to the radical contingency of concepts that change over time within communities. Dialogical approaches do not reject diagnostic categories but consider them to be one of many possible equally valued and personally elaborated narratives. This opens the possibility of psy-professionals using "insight discourses" as a means to explore meaning making and relational experiences that service users are negotiating and not simply a descriptive category.

Lysaker (2002) suggests that patients' experience of awareness of their illness is complex and evolves through multifaceted social interactions. It has also been suggested that insight narratives are multiple and fragmentary for service users and that they change over time (Klausen et al., 2009; Taylor, 2011). This presents an alternative to the dominant model that positions insight as aetiological and/or pathological. Roe and Kravetz (2003) suggest a model of narrative insight should include:

1. an illness narrative
2. themes conveyed in this narrative
3. consequences of the communication of those themes in terms of empathy, control over illness, and quality of life.

It is possible that some clinicians are less interested in theoretical cognitive short-comings and are more focused on functioning and recovery (Lorem, 2009). Narrative constructions of insight suggest a more nuanced view of insight is possible. Interestingly, narrative models hold onto the idea of "illness" and are uncritical of the mental health diagnostic regime which may be objectionable to people who ascribe to the survivor movement e.g. the Voice Hearing Network. Nevertheless it could be considered a "turn to discourse" (Parker, 1989) and presents an alternative to the dominant models of insight.

4.4 Language And Mental Health: Subjectivity And Subjugation.

It can be argued that any discussion of insight in mental health is necessarily a discussion of subjectivity (Hamilton & Roper, 2006). However, as previously outlined subjectivity as transformative process is associated with being subject to, a process of subjugation. Thus, the term subjectification has been used. We have been moving towards a “turn to discourse” and considering not only language but also the means by which language is deployed in professional theorising and practice. Heidegger (1971) suggested that “man acts as though he were the shaper and master of language, while in fact language remains the master of man” (p. 213). While it may not be true to say that Heidegger was a Marxist¹⁰, one can see parallels with Marx’s ideas on ideology and its implications for subjectification. For example in Marx’s (1867/1976) formulation of ideology “they do not know it, but they are doing it”, can be seen as a direct correlate. Althusser’s (1971) concept “interpellation” attempts to directly connect ideology and the subject. Interpellation is the process by which the subject (identity) is constituted by ideology that is embodied in social institutions and their practices. The privileging of ideology, language and non-discursive over the subject heavily influenced post-structural theories.

However, here we are considering the subject, as dynamically constitutive of and constituted by discursive and non-discursive practices; in effect by processes of subjectification (Wetherell, 1998). Thus making available a critical reading of the de-centred subject as not just the product of, but a producer in, social action, language, and ideology. Thus enabling an alternative reading of subjectivity in the social space i.e. Žižek’s (1989 p.25) interpretation of Sloterdijk’s (1983/1988) cynical reason as: “they know very well what they are doing, but still, they are doing it”. This makes possible radical social action by the subject strategically but contingently forging alliances to work within, transform, and challenge hegemony (Laclau & Mouffe, 1985).

¹⁰ In fact it has been widely reported that he was member of the Nazi party between 1933-1945, however the degree to which he was ardent proponent has been the subject to much speculation (Žižek, 2008).

This section will consider the deployment of discursive and non-discursive practices and processes of subjectification in terms of service users, the mental health assessment, notions of objectivity, models of madness and the psycho-encounter as a contested site.

4.4.1 Users Of Services

The labels used by, and applied to, the users of services have changed radically in recent years. The broadening of the franchise and expected roles of users of services is complex and comes from a number of, often competing, sources. In part it may reflect a change in the way that people who use services want to see themselves, the way that professionals want to see themselves and the changing political and economic ideologies that all contribute to shaping clinical practice. It is highly likely that these factors are among others that interact with multiple other factors including gender, race, ability, class, ethnicity etc. (Burnham, Alvis Palma & Whitehouse, 2008).

People can identify with or be identified as service users, patients, healthcare consumers and/or healthcare survivors. This offers a range of subject positions that can be taken up by people that may be incongruent. For example, in the current political and healthcare landscape at least two competing state sanctioned labels are promoted: consumer and patient. The former, the healthcare consumer is strongly connected to the choice agenda (Coulter & Collins, 2011; Speed, 2011) and the patient-centred approach (DH, 2005; 2006; 2013a). Both consumerism and choice assume the user of services has at least an equally powerful relationship with the provider in the market place. This increased power can be seen in the proliferation of service user forums in NHS trusts, the promotion of service user feedback as an outcome measure (DH, 2013b¹¹), and attempts to position service users at the heart of commissioning e.g. through the “patient reference group” (NHS, 2011). However, the degree to which users of mental health services who may be deemed “difficult” consider themselves consumers is likely to be limited. Patients are often problematized in

¹¹ The use of the term patient(s) outweighs service user(s) by 175:6 in this document entitled “Transforming Participation in Health and Care.”

terms of non-compliance and disagreement with diagnosis and treatment plans (Duggins, 2010) and *ipso facto* problematized in terms of insight.

It has been suggested that “difficult” service users are more susceptible to coercion in the mental health system (Harris, 2010). The right to determine one’s own treatment is imbued with the ideas of a unitary rational subject and the autonomous individual in the market place. Conversely constructions of mental illness within bio-medicalism can undermine subjective autonomy. For example, insight can be used as a powerful reversal of the consumer position and used as a gate-keeping mechanism. At one extreme, the positioning of service users as unable to know their “true” level of illness and need can lead to patriarchal models of care e.g. hospitalization and forced medication. On the other hand exclusion from services can be couched in the language of thresholds, suitability, and complexity. The professionals’ decision about insight can then become a powerful tool determining access to service but also the nature of the service offered (Klausen et al., 2013).

4.4.2 Mental Health Assessment

The assessment in mental health can be considered a primary site for the deployment of authorised language and potentially positions the assessor as the master of truth (Foucault, 1975). It can also be considered a template for all patient-professional encounters (psy-encounters) and one way in which subject positions are enabled and disabled e.g. patient-subject or survivor-subject. However, the approach taken in the psy-encounter can also be seen to create a professional-subject. Professional subject positions have become increasingly theorised, for example the professional as expert and/or collaborative (Madsen, 2007).

Professional discourses can be presented as new technologies and procedures for understanding. However, the suggestion of discontinuity often obscures the reformulation of a longstanding mechanism of power. At a macro level this can be seen, for example, in the association of the Enlightenment with the discovery and democratisation of liberty, individuality and rationality; a rampant expansion of the discourses and possibilities of subjectivity. Conversely, it could also be

seen as a period that heralded the invention of the disciplines (psychiatry, psychology, medicine, penology, and pedagogy) that has each strived to develop not only discourses but also institutional mechanisms to explain, define and confine subjectivity (Foucault, 1975). At a micro level the psy-encounter also presents as a new technology but it has also been suggested to be a reformulation of existing mechanisms of power and an expression of “pastoral power”¹² (Foucault, 1982). In this is the proposed transformation of the form but not the process previously deployed by clerics and now taken up by the disciplines. Power is considered here to be productive, polyvalent, and expressed in social interaction (Foucault, 1976).

With this in mind the professional approach taken up can have important implications for the outcome. Psy-encounters can be considered sites of contested meaning. Nevertheless as an institutional mechanism the psy-encounter can also be considered central to the procedures of discipline(s) i.e. the establishment of discourses and “regimes of truth” that are central to power-knowledge relations (O’Farrell, 1996) and thus processes of subjectification. Foucault’s “discipline” of course is more appropriately, though most likely less commercially appealing, translated as “docile-utility”¹³. Regimes of truth¹⁴ should not be considered attempts to formulate a relativistic construction of material reality, but instead attempts to question the way disciplines and institutional practices create, circulate and deploy knowledge(s) to privilege a specific version of reality (Foucault, 1982). Thus an examination of the relationship between power and knowledge (power-knowledge relations) is required. The psy-professions have a long history of attempting to create and monopolise technologies through psy-assessment tools (Danziger, 1997). The creation of not only a discourse of insight but also technologies used to objectify it can be seen as a continuation of this process and extends processes of subjectification both to the object of assessment and the subject deploying psy-technologies.

¹² For an extended discussion see p. 64.

¹³ Translators note in Sheridan, A. (1995) edition of Foucault’s *Discipline and punish: the birth of the prison*. Penguin edition (pp. ix – xx).

¹⁴ “régime du savoir” (Foucault, 1982)

4.4.3 Insight As Object In Subjectification

The psy-encounter “manifests the subjection of those who are perceived as objects and the objectification of those who are subjected” (Foucault, 1975 p. 184). Asymmetrical power relations are one way in which the conditions of possibility are created to make individuals into subjects, i.e. that they are controlled and/or dependent on the other and tied to the identity created in the encounter (Foucault, 1982). This implies a power that attempts, in part, to subjugate and make the individual subject to the process. In this way it is not the individual but facets of their subjectivity which become an object of the assessment.

One means of subjugation within this model is the creation of discourses of “objectivity”. This becomes manifest in clinical discussions, for example, arising from MSE (Trzepacz & Baker, 1993) where the professional is seen as an objective observer of reality and the patient as subjective. This has implications in terms of insight in mental health. Firstly it positions power in the professional to define the reality of the other as an objective truth. In so doing it leaves little room to contest authoritative accounts and limits the ability of the patient to engage in personally relevant and culturally concordant meaning making narratives. The use of “objective” in this way discredits the subjective experience of the patient.

One might legitimately ask who can witness another and to what degree does witnessing actually mean seeing? (Derrida, 1994). In this light, it is possible that what clinicians see is a reflection of the theories they have about the world (May, Angel & Ellenberger, 1956). In terms of insight this is of critical importance. The object of the insight assessment is informed by the theoretical orientation of the clinician and drives the type and nature of insight discourses created (Marková, 2005). Therefore, it may be more appropriate to consider professional objectivity as another form of subjectivity (Parker, 1989). A reflexive practitioner might interrogate the regimes of truth and power-knowledge constellations invoked in clinical practice (Hedges, 2010). However, despite calls for the abandonment of this type “objective-subjective” positioning in mental health (Berridge, 2002), the practice persists.

Another important implication of the discourses of objectivity relates to constructions of an illness profile. In traditional medicine the symptom is considered to be a subjective experience relayed to the doctor and then mapped onto signs of disease that can be objectively tested using professional instruments (e.g. insulin blood level test). In mental health the symptom has become inverted and this link with signs has been broken (Boyle, 2002). This distances the method of psychiatry considerably from traditional medicine, but psychiatry continues to draw on this framework and apply it to mental health. In the absence of professional instruments to test for signs, the professional becomes the instrument. As the instrument the professional objectively reports the symptoms as if they were signs. There are at least two important implications of this. First the service users' subjective experience (e.g. legitimacy to describe experience/symptoms) is discounted, thus creating the conditions of possibility for a devalued patient role that does not and cannot know themselves. Secondly, the professionals' assumptions about the internal world of another and their experiences, positions them uncritically as the arbiter of reality. In both cases insight assessment becomes a mechanism by which the patient can be both objectified and subjugated.

4.4.4 Models Of Madness

As noted, the validity of the assessment of insight can be determined by the validity of the model of illness (Tranulis, Corin & Kirmayer, 2008). Traditional mental health models privilege biological, individualistic and Eurocentric theorising (Patel, 2003). However, there is a growing recognition of the need to augment this with relational, environmental and cultural factors (Dillon, 2011; van Os, Kenis & Rutten, 2011; Read, 2013). Despite the increasingly diverse theorising in mental health an extension of the dominant bio-medical ideologies has also gathered momentum (Hyman, 2010). Thus, bio-medicalism represents the *lingua franca* in theorising and practice. However, this is not to say that language is innocent (Andersen, 1996) nor that epistemology is neutral (Deleuze & Guattari, 1980/2013). Therefore, the way that mental health discourses are created and circulated has direct implications for available regimes of truth in this context.

An example of this can be drawn from the use of bio-medical language in the constructions of mental health in pharmaco-research trials. It is perhaps not surprising but it can serve to illuminate how bio-medical discourses of distress are used to frame research questions and potentially reinforce hegemonic theorising and practice. The results of a PsycINFO search are reported in Appendix B. While this is a crude measure, it suggests a subtle but pervasive structural bias in the terms and reference of published (and by proxy publishable) research “evidence”. The table shows, no reported pharmaco-evidence was generated using the term “hearing voices” in comparison to the term “auditory hallucinations” and “schizophrenia”. The language of “hearing voices” is drawn from “survivor” discourses (Romme & Esher, 1993). Survivor and other anti-establishment narratives are selectively excluded from the generation of knowledge.

In practice, mental health discourses of (ab)normality have been linked to the ideas of rationality and safety/risk and thus the need to control. Psychotic disorders specifically have been categorised as disorder of rationality (Roe & Davidson, 2005). The idea of rationality was important in early mechanisms of control and the creation of the asylum. However, more subtle discourses of rationality have been connected to mechanisms of power expressed in perpetual surveillance and the self-supervising subject (Foucault, 1967a). Thus adherence to a social norm becomes enforced through a myriad of interconnected social forces; every social actor becomes an agent of self and other surveillance. Thus dissent from a social norm becomes an act of irrationality against oneself and the community and is often associated with risk to oneself but also the community. Nevertheless, the state retains a functional role in this regard, and positioned psy-professionals as active agents in this enterprise through successive legislation (Pilgrim & Treacher, 1992). The most recent incarnation of this is the Mental Health Act (2007)¹⁵.

¹⁵ Mental Health Act (2007) section 3 which can be enacted for your health, your safety or for the protection of other people. Under s3 you can be detained and treated for up to 6 months. Consent for treatment is not required, but can be transferred to a Second Opinion Appointed Doctor after three months.

The connection of madness with risk became a powerful rationale for the continuation of control based treatment models. However, one must consider the advent of neuroleptic medication as an important development in deinstitutionalisation and legitimising models of control in the community (Moncrief, 2008). This type of theoretical orientation places the service user in the patient-position, in need of continuous assessment and patriarchal care packages. Adhering to this model means submitting to discourses of the self as pathological, dangerous, and incapable of making informed decisions about ones own needs. Furthermore, insight discourses can negate the validity of service users' views and explanations of the distress. In this context, the rejection of the definition of madness by service users and by implication the rejection of the treatment can be challenging to the system. Not least to the professional positioned as a carer.

Psy-professions' evolution has been proposed to gain status and power through the ability to theorize and create models to control social deviance (Foucault, 1976). As such, positioning them as arbiters of difference as madness and functioning as state agents of social control (Szasz, 1972). Insight has been suggested to be a symptom of psychotic illness (Amador & David, 2004). Lack of insight has been of thought of as an important component of people with a diagnosis of schizophrenia (WHO, 1973). Despite not being directly accounted for in ICD-10 or DSM-V, insight remains an important construct enabling services to position service users in relation to the constructs contained in these nosological frameworks. As such insight can be considered an important mechanism for directing and dictating models of care.

4.4.5 Language And Contested Social Spaces

The psy-encounter can be considered a site of negotiate meaning (Antaki, Barnes & Leudar, 2005). However, it can also become a site where discourses and clinical practice promote institutional goals. Therefore, it is important to critically examine theory, research, and practices that sustain and entrench power in the healthcare sector (Patel, 2003). In his classic genealogy of madness, Foucault (1967a) recognised the shift from brute force expression of power to discourses that define “regimes of truth”. In this vein, explorations of how discourses are constructed, contested, and changed (Speed, 2011), can contribute to theorising and models of care. Thus, a critical exploration of constructions of madness that dominate current theory and practice is merited (Pilgrim, 2005).

Insight is a concept that appears to persist in mental health practice (Perkins & Moodley, 1993). A number of theoretical models arising from realist and qualitative research paradigms and several measures developed from these that have been widely used are reported in the research literature (Marková, 2005; Chakraborty & Basu, 2010). The results from this research have produced inconsistency, and often contradictory, findings (Tranulis, Lepage & Malla, 2008). This has led to claims that hegemonic discourses of insight are culturally biased (Johnson & Orrell, 1995) and simplistic, damaging and confused (Beck-Sanders, 1998).

However, some qualitative research has suggested that insight can be a more nuanced construct. It has been suggested that service users can develop rich and complex stories about themselves and their illness. Mizock, Russinova, & Chandrika-Millner (2014) have suggested that service users can accept they are unwell and reject diagnosis and professional constructions of their distress. Moreover, rather than being a fixed entity service users can think about insight as changeable, provisional and relational (Galasiński, 2010; Klausen et al., 2013).

It has been suggested that insight is not used clinically in current practice (BPS, 2014). However, recent research considered constructions of insight from service users perspective (Taylor, 2011) and by teams in review meetings (Goicoechea, 2013). It also been suggested that a greater understanding of clinician's constructions of insight may usefully inform practice in mental health services (Hamilton & Roper, 2006). A recent study reported clinical psychologists constructions of mental health in the NHS (Lofgren, Hewitt & das Nair, 2014). They reported the psychologists manage stake and accountability in terms of helpfulness through integrating biological and psych-social discourses on mental health. It is interesting that helpfulness and hegemonic formulation of distress was key idea in this research. What is useful and who decides this "regime of truth" is an important, but perhaps often overlooked, question?

Smail (2006) suggests that an orientation towards "outsight" rather "insight" might greatly advance our understanding of what is helpful and when, in adult mental health. This suggests that a demystification of the psy-professional technologies may lead to a genuine appraisal of what can be achieved in therapy. It calls for an orientation to the external social factors that impact on distress. This creates the potential of focusing on distal sources of distress as legitimate objects of intervention. This distinctly politicised formulation can include service level, community level, societal level, and/or ideological level interventions. Furthermore, it legitimises a critical analysis of the entire hegemonic field, which includes discursive and non-discursive practices (Laclau & Mouffe, 1985).

Psychologist's ability to adopt pragmatic and eclectic approaches to practice has been noted to emerge from a professional identity crisis in the 1960s and 1970s (Pilgrim & Treacher, 1992). Goldie (1977) proposed that the three positions that psy-professionals can take within services are compliant, eclectic, or radically opposed. Each has implications for processes of subjectification in terms of possible alignment with, appropriation of, and rejection of hegemonic ideologies. More recently it has been suggested mental health teams implicitly endorse a complex range of theories and practices in psy-encounters (Colombo, Bendelow, Fulford & Williams, 2003).

It also been suggested that practitioners deploy a variety of strategies to work around bio-medical constructions of distress, including extending diagnostic categories to include personal information, colluding with clients to provide acceptable diagnosis to access services and/or actively deconstructing diagnostic labels in sessions, and ignoring state sanctioned interventions in favour of individually tailored interventions (Strong, Gaete, Sametband, French & Eeson, 2012). Thus it appears that there may be multiple ways of working in and around dominant ideas in systems. Each has a range of transformative potentials and limitations at service user, team and ideological level.

4.5 Rationale

This literature review briefly reviewed the historical development of the concept insight in mental health. A review of the contributions of psychoanalysis, cognitive, neuropsychology and narrative constructions of insight has facilitated a look at the divergent theorising that has been developed on this topic. Multiple models and assessment processes have also been developed and this has led to a whole industry of research into insight in mental health. Nevertheless, the results of this largely quantitative research enterprise can be said to be at best inconsistent (Tranulis, Lepage & Malla, 2008). This is perhaps, in part, a consequence of a lack of conceptual clarity.

However, there appears to be convergence on a construction of insight linked closely to clinician concordance and adherence to bio-medical view of distress. Thus insight can be seen as part of power-knowledge constellations that privileges bio-medical constructions of distress. Bio-medicalism can be said to facing a number of challenges. One of which has emerged with the promotion of person-centred care approaches in the NHS, where there is a greater onus on collaborative care that is sensitive to service users' voice and concern in the psy-encounter. Another, is a growing concern with the reliability and validity of western bio-medicalism's nosology of mental health. Finally, the language used and knowledge(s) deployed problematise alternative constructions of distress (i.e. lack of insight).

Qualitative methods have been used to explore constructions of insight from service users (Taylor, 2011) and teams (Goicoechea, 2013). Team working presents considerable challenges where conflicting ideologies compete to establish “regime(s) of truth” to define practice. Psychologists have been noted to take up a variety of positions in teams both in support of and in resistance to hegemonic ideas. Thus, an exploration of clinical psychologists constructions of insight may add to the available research. This is particularly pertinent in light of policy agenda to promote and extend person-centred care (DH, 2013b) and the professional agenda to promote leadership roles for clinical psychology e.g. NWW¹⁶ (Lavender & Hope, 2007),

This research will endeavour to explore to what extent clinical psychologists use insight or related concepts in their work? To what extent does the hegemonic construction of insight permeate this clinical work? By focusing on contested sites in the psy-encounter it may be possible to explore how insight is constructed by clinical psychologists and how this shapes their practice.

4.6 Research Questions

1. How do clinical psychologists construct the notion of insight and how does it inform clinical practice?
2. What kind of subject positions these constructions makes available?

¹⁶ New Ways of Working

5 METHODOLOGY

The social constructionist position was applied to the design and analysis in this research will be outlined. This position enabled the researcher to elaborate an analytic process that incorporated elements of discursive psychology (Potter & Wetherell, 1987) and Foucauldian Discourse Analysis (Parker, 1992). I will outline why I have chosen this epistemology and method to address the research questions:

1. How do clinical psychologists construct the notion of insight and how does it inform clinical practice?
2. What kind of subject positions these constructions makes available?

This section will also outline procedural elements of the project, attending to ethics, recruitment and participants, process of data collection, analysis, and reflexivity. Finally, I will consider the question of evaluative criteria and how these might apply to this research.

5.1 Social Constructionism.

The question of “the social constructionist position” alluded to above provides a starting point from where we can begin to think about this position and its implications in this context. “The” is a reference to one position, but it must be recognised that there is no one position but a collection of possible positions. While there are some overarching themes, there are also multiple and idiosyncratic constellations of ideas that can be drawn on. Thus, in each application a new formulation is required to make public what theory is being drawn on, what knowledge claims are possible from this and what are the limits to these claims. “The” here refers to the constellation applied to this research context.

Social constructionism takes a critical stance on universal truths and rather than seeing these as fixed, considers them to be constituted by the activity and products of social exchange (Anderson, 2012). Therefore, social constructionism is concerned with the way ideas are generated and reproduced (Burr, 2003).

I have already outlined several different models that theorise insight. In so doing I have suggested that there is no one “insight” and that clinicians can deploy insight in different ways in practice. Thus, it is entirely consistent to propose insight as socially constructed and adopt this epistemology to explore how insight is deployed in mental health practice.

The version of social constructionism deployed in this research will attempt to align itself with Gergen’s (1985) four assumptions:

1. A critical stance to taken-for-granted knowledge
2. Understandings of the world are specific to a cultural and socio-historical context
3. Knowledge as constructed in social action rather than the product of objective observation
4. Knowledge as negotiated and sustained by privileging certain social practices and excluding others.

As such, this way of looking at knowledge generation does not privilege one truth over another, recognising that multiple equally valid versions are possible, but can describe how one truth can take up a privileged position over another. Thus social constructionism can be used to consider how power is generated in social actions to create regimes of truth in a reciprocal manner. This has been called “power-knowledge” relations (Foucault, 1975). As social constructionism proposes knowledge to be relative and bound by social action within a cultural and socio-historical context, one should also consider power in the same vein.

From this standpoint power, knowledge, truth etc. can all be considered intangible “objects”. Thus social constructionism focuses on discourse as a medium through which people make sense of their world in social action and where these types of intangible objects are deployed. Discourse can be considered a system of statements about the world which make certain social practices and ways of ordering knowledge seem reasonable and others problematic (Parker, 1992). Foucault (1969) used the analogy of a “table top” upon which we arrange knowledge about the world. The table permits us to order a limited number of pieces of information that can be (re)organised in a limited number of ways thus enabling constructions of reality based on this. The

analogy legitimises an analysis of not only the pieces of information and their arrangement¹⁷ but also the ideological edifice itself in the form of the “table top”. Ideology, has been both the object and subject of much philosophical theorising à la Marx, Adorn, Althusser, Sloterdijk, Žižek etc. and even a brief review of these debates is beyond what is required here. However, ideology in the current context will refer to a system(s) of ideas, values, and beliefs that interact with social practices to explain a political order, sustain power asymmetries, and maintain group identities (Chiapello & Fairclough & 2002). This interaction should not be seen as causal but mutually sustaining through a constellation of social practices and discourses.

Social constructionism is also interested in the ways that discourses inform identity. However, I have already outlined the rationale for favouring a dynamic and contingent subject and thus subjectivity is preferred. It is particularly suited to explore how the subject can be transformed and extended but also limited in social interaction i.e. subjectification (for example see Appendix C)

Social constructionism can be accused as relativism (Edwards, Ashmore & Potter, 1994). That is that knowledge, truth, morality are solely generated within a specific social and historical context and not universal. This can lead to a further charge of solipsism arising from the infinite possibility of meaning. However, the version of social constructionism applied here prefers contingency to relativism. In drawing on Deleuze and Guattari's (1980/2013) *être/et*¹⁸, I recognise the materiality of the lived experience talked about by people but also consider the description of, for example, “patient as lacking insight” to be drawing on specific social discourses (psy-professional as expert) and made available through social practice (the deduction of mental state based on the MSE) and so on.

¹⁷ For example CBT and psychoanalysis might both formulate anxiety with a service user, but by arranging different constellations of information (knowledge) they are enabling distinct types of social action (e.g. interventions based on behavioural experiments or working through inter-psychic conflict).

¹⁸ to be/and

Social constructionism's description of power asymmetries as intangible has been suggested to negate social action (Cornish & Gillespie, 2009). However, here one can consider the attempt to describe the hegemonic field and the strategic deployment of discursive resources and subject positions within this as creating the conditions of possibility for social action (Laclau & Mouffe, 1985). However, this in itself runs perilously close to a description of agency. Again, rather than formulate about agency, with its latent reliance on the concept of the unitary rational subject (Venn, 1998), I will propose a subject that is dynamically constitutive of and constituted by discourses and processes of subjectification. This will be elaborated further in the following section.

5.2 Discourse Analysis.

There are two main branches of discourse analysis that propose different constructions of, and emphasis on, subjectivity i.e. discursive psychology and Foucauldian Discourse Analysis (FDA). I will briefly outline both and orientate towards an integrated approach proposed by Wetherell (1998) that is deployed in this context.

5.2.1 Discursive Psychology

Potter and Wetherell (1987) established discourse as an object of research within psychology. They proposed speech/text as the site of social action where participants manage stake, accountability and interest. This methodological approach focuses on rhetorical devices and interpretative repertoires in speech/text to consider how subject positions are deployed. Stake is managed locally by rhetorical devices¹⁹ i.e. patterns of language use that position statements as natural, reasonable and unproblematic (Edwards & Potter, 1992). For example, "category entitlement" can be deployed to add legitimacy to an account based on drawing attention to specific group membership of the speaker ("as a doctor I think you have schizophrenia"). The "thinking" speaker references professional membership, which has the effect of transforming lay thinking to the status of professional medical opinion.

¹⁹ for list of rhetorical devices see Appendix D

Interpretative repertoires are collections of culturally familiar statements that are common sense ways of organising accountability and managing subject positions in social interaction (Wetherell, 1998). For example, service users' attempts to counter the power of professional opinion in psy-encounters by drawing on "emotional doctor" repertoire i.e. a doctor that is emotionally invested in their judgements, thus de-legitimises "doctor" as rational and objective (Taylor, 2011).

This attention on locally managed constructions of subject positions that are focused on the text has enabled discursive psychology to promote itself as rigorous and transparent. It also promotes the idea of the subject as constituting a version of reality through social action. However, this focus has also left it open to the criticism of failing to account for wider socio-political power relations (Wetherell, 1998). Thus it can be thought of as an adequate methodology to attend to discursive but not non-discursive practices.

5.2.2 Foucauldian Discourse Analysis

Conversely, FDA theorises the subject constituted by discourse and draws on Foucauldian idea that there is little point describing discourse without attending to non-discursive practice (Foucault, 1967b). Thus, FDA posits that both discursive and non-discursive practices construct subjectivities, social relations, and systems of knowledge (Fairclough, 1992). It can be thought of as a collection of methodologies rather than a clearly defined research tool. However, Arribas-Ayllon and Walkerdine (2008) suggested there to be three dimensions that are commonly applied under the banner of FDA:

1. genealogical and archaeological approach to current discourse
2. examination of power and its functioning
3. processes of subjectification that extend, transform and limit subjectivity

Foucault's writings are known for theorising power. Thompson (2003) suggests there are two main branches of this theorising:

1. technologies of domination: e.g. docile-utility (Foucault, 1975)
2. technologies of self: e.g. governmentality and pastoral power (Foucault, 1978/1982)

However, it is the latter of these and the implications for subjectification that Foucault suggested in later writing to be of greater theoretical and practical importance (Foucault, 1975; 1982).

FDA's overt movement away from the interactional context in order to comment on wider non-discursive practices has led to charges of failing to attend to micro issues, lacking rigour and imposing intellectual preoccupations onto practice (Schegloff, 1997).

5.2.3 Integrated Approach

In keeping with a social constructionist epistemology it seems appropriate to propose a flexible approach to bridge the paradox that people are at once "masters and slaves of language" (Barthes, 1982). Wetherell (1998) suggests an integrative approach is possible that promotes a dialogue between discursive psychology and FDA. Considering people as both products and producers of discourse (Billig, 1991), this research attempts to create a dialogue between micro and macro levels. That is an iterative movement between micro subject positions and macro power-knowledge constellations. In this way the subject can be theorised through the processes of strategic social interaction (Laclau & Mouffe, 1985), in which they are dynamically constituted and reconstituted through multiple overlapping and at times contradictory discursive practices (Davies & Harré, 1990).

This approach enables an exploration of psychologist's use of insight and related concepts in multiple ways in practice. It permits an analysis of how this talk is managed locally (as master/producers) but also how it is made possible (as slave/products).

This *bricolage* perhaps runs the risk of lacking the subtlety of discursive psychology and the freedom of FDA. Nevertheless, it is epistemologically congruent with the *être/et* position previously outlined. It also moves away from dogmatic methodology in favour of a sensitivity to the research question(s) which in turn creates the conditions of possibility to theorise processes of polyvalent subjectification. The specific application of this approach in this context will be outlined below (section 5.5 Analysis).

5.3 Procedure.

5.3.1 Ethical

The University of East London Research Ethics Committee and the XX Foundation Trust (XXFT) R&D Committee gave ethical approval for this project (Appendix E & F). No issues emerged from this process.

5.3.2 Recruitment

The researcher used a purposeful sampling method i.e. the sample was targeted to meet the needs of the research question. The information sheet (Appendix G) was sent to local area psychology leads to be distributed among their staff. One lead requested a presentation at a team meeting and this was facilitated. Inclusion criteria specified only HPC registered clinical psychologists who have worked in NHS run adult mental health services for more than one year would be recruited. There are no specific age, gender, ethnicity, or religious restrictions or targets for recruitment. There was a specific attempt to recruit participants who worked in a variety of settings across adult mental service provision in XXFT.

5.3.3 Participants

Nine participants were interviewed in total. This has been deemed an appropriate sample to reach theoretical saturation i.e. no more themes are likely to emerge from further data collection (Guest, Bunce & Johnson, 2006).

Of the nine participants, three were female; six male. They worked in a range of services including Assertive Outreach, CMHT, Secondary Care, Psychological Therapy Services, Acute Inpatient, Specialist Disorder Specific Services and Access Services. The psychologists had between one and over ten years experience working in adult mental health. They reported having a wide range of additional psychology experience including Learning Disability, Homelessness, Primary Care, Community Psychology and Health Psychology. The participants included psychologists across a number of pay bands; some held *de facto* management roles and others leadership positions in their teams. All were UK trained in a variety of centres in London and around the country.

5.4 Data Collection

5.4.1 Interviews

Interviews were chosen as the mode of data collection. Naturally occurring text and talk has been suggested to be important in both discursive psychology (Potter & Hepburn, 2005) and discourse analysis (Willig, 2001). Nevertheless interviews were chosen for a number of reasons. Firstly, there have been suggestions that the construct “insight” is no longer used in adult mental health services (BPS, 2014). Therefore it is possible that by sampling naturalistic talk “insight” may not come up directly. Taylor (2011) suggests that service users are not aware of the term insight. However, Dillon (2011) proposes that service users can readily identify with clinical insight as defined by David (1990). It seems plausible that insight is used in some contexts but not in others. Thus interviews present an opportunity to explore if insight is used, when it’s used, and if other analogous terms are deployed in practice.

A pilot interview was conducted with a clinical psychologist who met the inclusion criteria but did not work for XXFT. This was used to test all elements of the interview protocol. No major changes were incorporated into the study at that time and this data was not used in the analysis.

Interviews took place in a number of NHS sites (except one that was conducted in UEL). All interviews followed a semi-structured interview schedule (Appendix H). All participants were required to complete a consent form (Appendix I). However, consent was deemed to be an active process throughout the interview process, and participants reserved the right to terminate the interview at any stage and withdraw their data up until the 31st March 2015. Each interview ended with a participant debrief.

5.4.2 Transcription

Nine participants produced a total of 517 minutes of data (range 48-76²⁰ minutes; \bar{x} =57.5 minutes). Interviews were recorded digitally and transcribed using a Jefferson-lite approach (Appendix J) adopted from Banister, Bunn, Burman et al. (2011). The full data set amounts to 8668 lines typed on MS Word for Mac 2011 and stored on XXFT sanctioned encrypted memory stick.

5.5 Analysis

The analysis looked at both subject positions and wider power-knowledge constellations in processes of subjectification. That is, how “insight talk” was deployed to extend, transform and limit subjectivity in the clinical contexts. Subjectivity of service users, colleagues and the clinicians themselves were considered. Claims and counter-claims made in the interviews were thought about in relation to discursive and non-discursive practices.

In line with Wetherell (1998) the researcher attended to variability, interpretative repertoires, and ideological dilemmas raised and negotiated in the interviews. The research adopted a hermeneutic circle approach of reflexively reading and rereading the text in dialogue with theoretical ideas drawn from the literature on insight, subjectification and clinical psychology. Specifically four questions²¹ guided the analysis:

1. What is the object being talked about and how is this object identified?
 - The research considered how “insight talk” made possible “insight” as an object (focus) in practice. Is the object the insight of service users, colleagues, systems etc.?
2. What new specifications of subjectivity are made possible in this talk?
 - Attention was paid to the ways in which participants talk transformed the subject i.e. as having/lacking insight. Consequently, what opportunities does this make possible for psychologists?

²⁰ Interview 4 actually comprised of two interviews due to technical fault (24+52=76)

²¹ Adopted from Foucault (1982)

3. What power-knowledge arrangements are drawn upon as discursive resources to promote positioning?
 - What ways are “truth” claims made and legitimised at the expense of others in psy-encounters?
4. What devices or technologies are deployed to promote these power-knowledge constellations?
 - What psy-technologies (e.g. assessment, formulation, etc.) are deployed in “insight talk”?

The hermeneutic circle began at the point of collecting the first interview. Audio files were replayed to get a sense of the interview and reflexively think about the interview process and possible modifications. For example, in response to the second participant’s insistence that insight “is not used” in their service, the researcher adopted questions that attended not only to the concept “insight” but also directly asking about components of David’s (1990) insight:

1. Acceptance of mental illness
2. Compliance with prescribed treatment
3. Ability to re-label unusual experiences as pathological

The researcher transcribed all the interviews. Ideas, questions, and considerations were noted throughout which forms an audit trail of the hermeneutic process. During preliminary readings the researcher asked broad questions, e.g. “what is the text doing, and how is this being achieved?” (Willig, 2008). Each reading was used to clarify extracts from the interviews that more directly addressed the research questions. While the entire text was coded to attend to variability, the write-up focused on extracts that more directly referenced the research questions. Subsequent readings focused on coding for rhetorical devices, variability, subject positions and ideological positions in text (see Appendix K-L). Throughout, the entire analysis the researcher engaged in additional theoretical literature in response to the data.

The final component of the analysis involved the writing. This necessarily involved a clarification of ideas that had up to this point been in note format. It also necessitated selecting some extracts at the expense of others.

5.6 Reflexivity

Social constructionism posits multiple possible readings of reality, and thus rejects grand narratives or universal truths. Foucault (1969) noted that his own analysis was limited and deliberately so. Perhaps in somewhat analogous fashion, I am suggesting that my analysis is limited and necessarily so. In this sense as a researcher I should be at least somewhat aware of the problematic status of my own knowledge claims and the discourses used to create them (Willig, 2008). As a researcher taking a critical stance on what can be deemed to be a contested construct positions me in certain ways. Yet, within the interview process I was drawn to join with, contest, and be curious about participants' accounts to try and make sense of what they were saying. This involved taking up various and often contradictory positions within the interviews to explore the extent and limits of these accounts. So as much as I have attempted to explore the subjectification processes in the interviews I have also attempted to interrogate what I am drawn to and avoiding in my theorising and thinking in order to contextualise the regime of truth that I am constructing (O'Farrell, 2005).

5.7 Evaluation Criteria

Rigour and coherence have been suggested to be hallmarks of good qualitative research (Yardley, 2008; Elliot, Fischer & Rennie, 1999). Discourse analysis specific criteria have been proposed by Antaki, Billig, Edwards & Potter, (2003), who suggest attempting to avoid:

1. under-analysis through summary or taking sides;
2. under-analysis through over-quotation or through isolated quotation;
3. the circular identification of discourses and mental constructs;
4. false survey;
5. analysis that consists in simply spotting features.

However, it is worth noting that there is a growing industry producing ever more repetitions of ways of doing and ways of measuring qualitative methods. Foucault's (1969) critique of scientific practice as just one set of codified relations between a precisely constructed knower and precisely constructed

object, with strict rules governing the formation of concepts is worth raising in light of this “turn to criteria” evident in qualitative research literature. No doubt these criteria provide useful guides to early career researchers. However, the research community may do well to notice the implications of fetishising these criteria and circling research practice around the words and ideas of a few discipline²² leaders to the detriment of alternative models. Indeed this research draws heavily on some of these people (e.g. Wetherell, Antaki etc.).

As well as drawing on Antaki and co.’s shortcomings, the evaluative criteria applied here will draw on coherence, transparency and rigour, impact, and attention to researcher reflexivity (Yardley, 2008; Burman, 2004).

²² Foucault’s “docile-utility” is noteworthy

6 ANALYSIS

I will briefly review the analytic approach and structure of the analysis that will be organised into micro, meso, and macro politics of insight talk.

Taking a social constructionist stance, I used a discourse analytic model that integrates the text and context to promote a dialogue between the subject and the social (Wetherell, 1998). Within this I acknowledge that, not only this reading but also, the whole process is constituted by and constitutive of my own historical and cultural context (Van Dijk, 2011). Indeed through positioning myself I am *de facto* creating the conditions of possibility for this reading which while methodically rigorous must be theoretically idiosyncratic. Therefore, I am not only suggesting, but advocating that one applies an “être/et” lens (Deleuze & Guattari, 1980/2013) to the analysis. Therefore this is one, but not the only, possible reading of the data.

The analysis is structured around the constructions of insight in adult mental health. Extracts are presented in sections to aid contextualisation and limit reductionism (Willig, 2003). MM refers to the interviewer and P refers to the participant (Appendix J). Each extract was considered in terms of

1. what object is identified and constructed in the talk
2. how is subjectivity created, resisted and/or transformed in this talk
3. what power-knowledge constellations are recruited
4. how does this affect subjectivity

Extracts will be used to explore how rhetorical devices are deployed to manage accountability and stake (Edwards & Potter, 1992). Each transcript will illustrate a range of interpretative repertoires that are drawn on to achieve a variety of subject positions within the text. The subject positions will be linked to wider discourses that make possible power-knowledge constellations.

Grounding the research in examples has been suggested to be an important evaluative criteria in qualitative research (Elliot, Fischer & Rennie, 1999). However, the choice to use extracts of data rather than single line or isolated quotes has potential ramifications. Primarily the use of extracts could be

considered to limit the amount of different examples that are presented in the analysis. However, as noted one must balance the charge of under analysis between the poles of over-quotation and isolated quotation (Antaki et al., 2003, see section 5.7). There are a number of reasons why extracts were favoured in an attempt to strike this balance.

Firstly, as mentioned by Willig (2003) the reporting of extracts can be used as a means to contextualise the data. In line with the analytic focus (i.e. an integrated approach attending to micro and macro level constructions of insight), the use of extracts enables an exploration of the research themes in a wider discursive context. Secondly, reporting extracts can promote, what Yardley (2008) refers to as, “sensitivity to context”. That is, an attempt to account for inconsistencies and complexity in participants’ accounts. By presenting extracts one can expose and explore the inconsistencies in participants’ accounts and in so doing enable an analysis of the movement between subject positions within accounts. Therefore, extracts are not only desirable but vital to consider how participants take up various, and often inconsistent, subject positions in their accounts. Finally, I will briefly consider the use of extracts in terms of rigour and transparency (evaluative criteria returned to section 7.3.2). The extracts presented broadly account for the ways in which clinicians talk about insight in their practice. Nevertheless several decisions were required to move from the entire data set to a set of reported extracts. The audit trail to account for this process has been summarised in Appendix K-L and is a way of “making public” these decisions. Furthermore, I have sought to be transparent in all aspects of the method and the epistemological position taken up in this research. Specifically, in outlining my social constructionist position, I have proposed the *être/et* stance (p. 41). Thus, one should not see the extracts as representing the truth or one definitive explanation. But rather, one might consider the extracts to represent one, of many possible, readings of the data.

I have decided to order the analysis from micro to macro level. This was done in the interest of parsimony and is not intended to suggest a movement in either direction or that they are separate spheres in any way. More over at each point I will attempt to relate to discursive and non-discursive practices in a dialectical fashion, each constituted by and constitutive of the other (Van Dijk, 2011).

6.1 Micro-politics

Micro-politics is an attempt to consider local constructions when the object of insight is the conceptualisation of insight of the clinician themselves and its application in the most proximal sense. That is a construction of insight as deployed in their speech about their own ideas and application directly in service user contact. As noted, this slightly arbitrary demarcation is not meant to delineate the extent of the discursive resources deployed in this domain. Thus, while the object remains centred on micro-politics of self, the discursive resources deployed, maintained and resisted are wide and varied. For example, the psychologists interviewed drew on systemic discourses, positivism, and humanism while constructing insight in this proximal sense.

The majority of participants suggest insight to be of limited value, a product of psychiatric discourse and theorising, and a concept that was either used more in the past or is used by other teams. All of the participants could readily cite the basic tenets of psychiatric insight i.e. compliance with treatment and acceptance of team conceptualisation of their distress. However, their constructions are often made possible by drawing on similar discursive resources that support the psychiatric construct. Possible effects of this will be discussed in turn.

Micro-politics will look at insight discourses in terms of “insight as a psy-model”, “narrative insight”, and “formulation”. This section will draw on governmentality, i.e. modes of instruction, dissemination and enforcement of specific institutionally sanctioned ideas (Foucault, 1978/2002). It will also focus on the dynamics of power reproduction/re-production (Hollway, 1998). The former considers discursive and non-discursive practices that reproduce existing ideas and a conformist tendency. The latter, is proposed as enabling novel productive and transformational potential for subjectivity, which is considered to have a more radicalising tendency.

6.1.1 Insight As A Psy-Model

Insight was constructed in relation to analogous psychological models.

However, while the mainstream psychiatric constructs are inextricably linked to pathology; psychological theories are often assumed to describe universal human characteristics that can then be applied to psychopathology. Moreover psychology broadly and clinical psychologically specifically has been suggested to historically co-opt, adopt and extend existing theories rather than create new ones (Danziger, 1997; Pilgrim & Treacher, 1992). Insight talk and psy-models are suggested to be sites of co-option, adoption and extension and thus exemplars of “power reproduction/re-production”. This has implications for processes of subjectification deployed in speech.

(5009-5022)

MM so, I guess wh::-, when you use the word insight, what you mean by that, what does that mean to you?

P6 it's interesting, I, I thought a lot eh, I did Google 'cause I've never had an insight lecture in training and then I thought, oh that's interesting actually everything we do is insight, that might be why, it's like empathy it's the same as empathy ((MM: mhm)) it's an awareness of what's around you in the here and the now, what's around you during the day, what happened before, wh::-, what's happening ((2)) i::t's mentalising, metacognition, {BR} I, I kind of thought it appears in everything

MM yeah

P6 but I suppose what's my sense of insight? {BR} em::, it's really interesting because em, eh, {BR} phe:: it's, it's, it's so subjective in some ways what it is, eh, one could argue that insight is about knowledge and the more you know the more you can see it.

There are a number of discursive strategies deployed in this extract. Firstly, one might consider the generality in the talk to be consistent with the rhetorical device systematic vagueness (Edwards & Potter, 1992). This has the effect of providing enough information for general impression to be made, but not enough to enable the ideas presented to be contested. Indeed the movement between contradictory positions mitigates potential conflict.

The psychologist notes that they've "never had an insight lecture in training". Nevertheless, they go on to connect lay description ("empathy" and "awareness") with technical professional language ("mentalising, metacognition"). This can be considered one site of "reproduction/re-production power".

Empathy and awareness are traits related to, but not monopolised by, professional clinical psychology. Thus their deployment here, suggests a reproduction potential of insight beyond the psy-encounter, which de-legitimises professional involvement. This creates the potential for novel lay understandings about what insight can mean and thus novel power relations between object(s) and subjects in psy-encounters.

By contrast mentalising and metacognition can be thought of as attempts to reproduce existing power relations. Mentalisation is a model that suggests people's innate ability to understand the mental state of oneself and others (Fonagy, Gergely, Jurist, & Target, 2002). While metacognition is a related model that stresses the importance of the ability to think about thinking (Dimaggio & Lysaker, 2010). Both theories are essentialist and draw on the Humanist idea of the unitary rational subject as an object of psychological theorising and intervention (Venn, 1998). Their recruitment constructs insight as a cognitive construct and thus a legitimate object of psychological theorising and assessment. Furthermore, as a cognitive construct, insight linked to rationality has implications for those deemed to have/lack insight in the psy-encounter. This can be considered reproductive power, in that lay understandings are subsumed into professional theoretical constructs, and in so doing attempts to replicate existing power asymmetries.

One thread that links across multiple constructions of insight is the idea of self-knowledge as important to gain from therapy. This extract links insight to "knowledge and the more you know the more you can see it". This interestingly presents self-knowledge as malleable, potentially cultivatable, and thus a legitimate object of intervention by professionals. In the creation of this object, psychologists can be positioned as experts in this field. One can see traces of

the Humanist project in this line of thinking i.e. the ideal individual has a core self that can be realised through personal pursuits.

However, this construction places limits on scope of this knowledge too. Invoking the “more you know the more ..” calls for an objectification of the subject, who in turn becomes subjected to this construct of self (Foucault, 1975). It also suggests that capacity for growth is an essential part of the process. On the one hand it suggests that both the language and technology for accessing and developing self-knowledge is part of psychology’s repertoire and on the other a tacit recognition that the layperson must display some of this in order to access “more”. Yet, this is tempered somewhat by the description of insight as “subjective”; this importantly positions the object “insight” outside of the positivist frame and suggests limits to the claims one can make about insight and/or the self-knowledge that others hold about themselves and their experiences. Here again the psychologist moves between legitimising and de-legitimising positions; between controlling and giving away psychological knowledge. This has practical implications in terms of making insight judgements in terms of what a clinician can claim about a service user, what a service user can claim for themselves, and whose claims are privileged.

The tendency to simultaneously give away and hold onto the professional language and *modus operandi* of psychology has been noted previous (Rapley & Miller, 2003). This is raised in several interviews by connecting self-knowledge to the ability to access and gain benefit from services. This could be read as an expression of cultural capital (Bourdieu, 1986). That is a set of social assets and skills that enable social mobility and/or access to circumscribed social contexts. Cultural capital can be linked to statement “(the) more you know the more ..” Throughout the interviews, access to therapy was linked to insight of self in terms of e.g. “willingness and ability” (P2), “responsibility” (P4), “suitability and readiness” (P5), and “the frame” (P9). Like self-knowledge these constructs can be considered essentialist and yet problematic as signifiers without signified (Žižek, 2006). More critically as a reflection of the Humanist subject they can be said to embody a bourgeois individualism (Venn, 1998). That is, a knowing rational self, with recourse to the discourses of psy-

professionals and western Humanism is privileged over other forms of self-knowledge e.g. mystic/spiritual narratives.

6.1.2 Narrative Insight

All of the psychologists interviewed described the importance of understanding the service users' views of their distress. This is perhaps not surprising in some ways given the nature of professional training that promotes the use of multi-theory, person-centred approach of people's distress. Person-centred here refers to a wider movement within healthcare provision (Darzi, 2008; DH 2013a; Goodrich & Cornwall, 2008). This movement in mental health perhaps owes its origins, in part, to the anti-psychiatry movement of the 1960s and 1970s (Pilgrim & Treacher, 1992) and an orientation to community care and de-institutionalisation promoted in subsequent decades (Warner, 2005), and the service user movement of more recent times (Campbell, 2005; Dillon, 2011).

The person-centred approach has been directly formulated for adult mental health. Interestingly, two papers calling for the implementation of person-centred model of care in psychiatric nursing (DH, 2006) and psychiatry (DH, 2005) failed to propose a definition of what this means. NICE (2011) forwards a definition that privileges service users' needs, preferences, and strengths to establish care based on informed decision-making and a partnership approach. However, NICE also includes a qualification based on capacity legally enshrined in the Mental Capacity Act (2005). Thus, the state sanctioned definition is linked to the dominant construction of rationality and madness. This power-knowledge constellation privileges psy-profession's meaning-making regime in terms of a rational subject and thus their "insight". This in turn has implications for the extent of the "partnership" possible in this context. The deployment of person-centred approach can be seen as an expression of governmentality (Foucault, 1978/2002).

However, as mentioned in the introduction this idea has also begun to be theorised in the insight literature as narrative insight (Roe & Kravetz, 2003). Narrative insight suggests the importance for the service user to be able to articulate a story about their experience(s) and understand the consequences

of this way of storing their distress. Of note is an extension of the idea of cultural capital discursive resource proposed previously. While service user narratives are canvased, those expressed within professionally available theories can be given more legitimacy. The extension of these theories, to include “spiritual” explanations has implications for available discursive resources and processes of subjectification. Thus, here again we can see the dynamics of power reproduction/re-production in the psychologists talk.

(4189-4209)

MM okay, can you, can you give me an example that might help me to understand how you might use it, and if, if in the same example has somebody else not, used it slightly differently, is that?

P5 so:: I:: might be ((3)) eh, referred someone and someone might say “ well yeah they’re hm::” {BR} I often get referred people “yeah they need some insight work”

MM okay

P5 which, i:: often is they need to know it's schizophrenia:: and they need to take the medication:: ((MM; mhm)) em:: and I (()) I don't know what insight work is frankly, you know there isn't a therapy which is insight therapy ((MM; mhm)) and I think that oversimplifies a lot of what's going on in terms of somebody {BR} understanding that they have, some difficulties and what that's about ((MM; mhm)) em:: {LS} so if someone was referred, saying “oh, this person has:: yeah, needs to have more insight”, I suppose to me I’d:: be thinking:: and trying think about it outside just a medical explanatory model ((MM; mhm)), so thinking a bit about {BR} what do they, what is, {BR} what do they think is a problem?

MM mhm

P5 so do they acknowledge that there is a difficulty or not, and what do they think that's due to and it doesn't have to be something that necessarily has medical eh, cause according to them, so they could have you know, a level, they can have insight that there is a problem ((MM; mhm)) but they might put that down to em spiritual issues ((MM; mhm)) or {LS} em:: ((3)) you know stress caused by something else, you know family difficulties, whatever, they might not see that necessarily, or trauma, they might not see that as “right, I have schizophrenia” per se.

The psychologist in this extract takes up the subject position as thoughtful multi-theory practitioner; which can be compared to the construction of the referrer as reductionist in their understanding. Firstly they acknowledge the referrer's request as a "reproduction" of David's (1990) classic conceptualisation of insight i.e. the service user "know it's schizophrenia" and that "they need to take their medication". However, immediately a counterclaim is presented as this "oversimplifies a lot of what's going on". Both the oversimplification and request for insight work are linked to "medical explanatory model". The effect is to position this model as less useful and thus those ascribing to it in a degraded subject position. The psychologist's appraisal distances them from this and enables potential alternatives.

The psychologist cements this shift by suggesting a movement away from reductionist theory to what the service user "think is a problem". Here the psychologist is positioned a-theoretically and aligned with the service user views. However, one could see this position as made available by, and a reproduction of, the person-centred approach, a discursive resource strongly promoted within adult mental health. This position is further supported by two prominent explanatory models; one from service user discourses and the other from mainstream psychology.

Firstly, drawing on "spiritual issues" the psychologist is positioned as thoughtful, critical and open to thinking of explanation outside of what could be seen as positivist medical model. The use of spiritual explanations for distress as an important part of people's meaning making has been well documented (Romme & Escher, 1993, 2000; Peters, 2001). It could be seen as drawing from survivor and service user movements and presents as an alternative model resisting hegemonic pathologising and simplistic discourses made available through bio-medicalism (Harper, 2004). Thus this could be seen as a process of "re-production" enabling the possibility for transformed subjectivity and novel service user "insights" into their distress.

Secondly, the psychologist formulates “stress” as a potential explanatory factor. This could be considered an opposing position to the service user aligned position previously articulated. This is in turn supported by recourse to stress emerging from the professionally evidenced domains of “family issues” (Vaughn & Leff, 1976) and “trauma” (Read & Ross, 2003). Interestingly the use of a lay term “stress” prompts a “reproducing” of professional discourses, thus possible restrictions on subjectivity. Stress is often formulated through the diathesis-stress model, which has been critiqued as standard biopsychosocial model that implies individual vulnerability and thus veiled bio-medicalism (Pilgrim, 2002). Thus, implicitly endorsing discourses and practices that privilege deficit based constructions may restrict access to other possible constructions e.g. strengths based (White & Epston, 1990)

The recruitment of these discourses enables the psychologist to take up different and sometimes oppositional subject positions both aligned to and rejecting service user and bio-medical models of distress. Being able to take up both-and positions enables the psychologist to position themselves as mediators between the service user and medic (Pilgrim & Treacher, 1992; Cole, Diamond & Keenan, 2013). In the process of canvassing service users’ views, psychology also attempts to organise, theorise and legitimise targets for intervention based on them. This is achieved by deploying the professional practice of formulation.

6.1.3 Formulation

Formulation has been suggested to be an important tool available to psychologists to help to organise and make sense of a person/systems’ presenting problems. So, while narrative insight in this context was linked to canvassing service users’ views; formulation is constructed as a psychology specific technology of ordering and systematising those views.

Psychological formulations tend to make specific theory-practice links and attempt to move beyond descriptive and static conceptualisations (Johnstone & Dallos, 2013). Formulation can be considered a collaborative and active process of meaning making (Harper & Moss, 2003) and has been suggested to be a legitimate alternative to diagnosis (Kinderman & Tai, 2009). It has also

been afforded the status of an officially sanctioned technology of psychology when working in adult mental health (BPS, 2014). However, formulation is dependent on other available discursive and non-discursive practices to inform how it achieves its goals. Some of these might include the commission of work (i.e. the request of referrer/presenting problems) and the orientation of the clinician. It has been suggested that bio-psychosocial formulations that promote deficit discourses and de-politicise distress are repackaged bio-medicalism (Pilgrim, 2002; Read, 2005). Thus the suggestion that it can be a viable alternative to diagnosis is dependant on the variety and legitimacy of theories recruited to support its use. In this way formulation as a technology also reflects a dimension of power reproduction/re-production dynamics in adult mental health.

Formulation as a technology was recruited throughout the interviews as an alternative to reductionist bio-medical language and explanations of distress.

(365-383)

MM Em, is that, is that a concept that you would use?

P1 no

MM no, and

P1 {LG}

MM and can you tell me about why that's different then, what do you bring that's different or how do you think about it, like in that example em, or in a recent example

P1 Em, well I, I, li-, I, like the whole concept of insight I find particularly problematic, so it's not a concept that I try to use at all, em and try to steer clear from it as much as possible, em, because I think its, it's a very complicated idea, which is never em, is frequently used but rarely defined

MM mhm

P1 em, and there's always sort of an assumption that we all know what we are talking about, when we talk about insight when actually I have a suspicion that we are all talking about quite different things {LG}

MM mhm

P1 {LG}, so that's why I kind of steer clear of it, but it, it is a term, you know, it is one of those terms that's widely used in mental health services and its, it's an easy to reach for phrase too, which, which, seems to explain something but in reality doesn't really explain anything

MM yeah

P1 so, I would, I would try and formulate what's really going on for the person, and try, and try, and understand why that might be impacting on the person's engagement

The psychologist begins by rejecting "insight" as "problematic". They go on to notice an inherent tension in all communication i.e. the tension between intended and inferred meaning (Wittgenstein, 1953/2001). This idea is supported by reporting insight as "frequently used but rarely defined" and that it "doesn't really explain anything". The psychologist deploys the words "actually", "reality" and "really" to emphasise the lack of clarity. This is contrasted with the use of profession specific technology that enables the psychologist to "formulate what's really going on for the person". The rhetorical device of category entitlement enables the psychologist to manage stake here and gives weight to the privileging of formulation as reality defining tool (Edwards & Potter, 1992).

By highlighting "insight" as problematic; psychology's tool formulation is considered the antidote to ill defined constructs e.g. insight. The psychologist also uses formulation as a vehicle to understand the service user and move beyond the "easy to reach for". Thus the psychologist is again positioned as a thoughtful practitioner that attempts to join with and understand the service user as oppose to label them. This suggests formulation as a tool of power re-production creating conditions of possibility for "thick" descriptions (Geertz, 1973) of service users insight, distress, engagement etc.

However, the psychologist's statement "understand why that might be impacting on the person's engagement" is important. It draws us to the "reproducing" potential of formulation. The referral for "lack of insight" was often presented in the context of non-engagement. In this sense, the production of thick descriptions can make available more thoughtful understanding of service

users' positions and/or more sophisticated modes of coercion. As such, formulation might start as a collaborative meaning-making enterprise but could be utilised by others to achieve different ends. I am not suggesting that this was the case in the interviews but highlighting the transformative potential of formulation that re-produces thick descriptions and/or reproduce "easy to reach for" models to manage complexity.

6.2 Meso-politics

Meso-politics considers constructions of insight at the level of team interactions. I will specifically draw out two common threads in the psychologists' constructions of insight, namely the constructions of their colleagues as objects of insight and the negotiation of subjectivities in contested social spaces. Both will be linked to processes of pastoral power and disciplinary power.

The psychologists interviewed tended to use "insight talk" (during referral meetings and/or team discussions) as an opportunity to deconstruct the notion of insight and help foster ostensibly more complex and thoughtful reconstructions of service user distress. However, this is accomplished through the construction of their colleagues as an object of insight assessment. This will be considered as part of the broader discourse in clinical psychology to foster psychologically-minded services and will be used to introduce pastoral power.

Foucault (1982) described pastoral power as a process of promoting the transformation of the subjectivity of others. In relation to insight, this will be adopted as follows:

- Salvation orientated – the promotion of psychological mindedness as a transformative discursive resource in mental health
- Oblative – psychologists' positioning within teams to strategically promote pragmatic conceptualisation and team formulations about insight
- Totalizing – the extension of psychologists' responsibility beyond service users to the whole team/system
- Specialist – psychological mindedness as a unique meaning making ideology with applicability at every level.

Secondly the psychologists recognise the challenges of promoting alternative views and ideologies within what are largely considered to be medically dominated mental health services (Speed, 2011). An analysis of contested social spaces will be used to introduce disciplinary power (Foucault, 1975). That is the ways in which discipline related discursive and non-discursive practices attempt to regulate social activity. In this sense the principle disciplinary ideologies compete for and influence processes of subjectification. For example, “disciplines” of psychiatry and survivor movement can ascribe the label “schizophrenic” or “voice hearer” to a person, who might be further labelled “patient” or “service user”. Each labelling process has multiple competing conditions of possibility and limitations for the subject.

In the interviews the psychologists take up a variety of subject positions to acquiesce to and resist bio-medicalism in this sector. The positions described should be considered radically contingent, with the social actors recruiting multiple subject positions and selectively, but contingently, forging alliances to resist dominant ideologies (Laclau & Mouffe, 1985). This radical contingency can be seen as a sophisticated strategy, that requires selectively maintaining and resisting a number of power-knowledge constellations. A task that requires continued and reflexive analysis of power and relationships at this meso-level. For example, a psychologist might draw on DSM-V categories in order to refute a diagnosis with the ultimate goal of promoting an alternative construction of distress. However, within this the psychologist is also possibly drawing on discourses that enable psychologists to deploy team formulation skills (Onyett, 2007) and ideas around strategic systems change²³ (Bateson, 1972). Furthermore, psychologists have been promoted as experts in team working, consultation and leadership (Lavender & Hope, 2007) and therefore psychologists working at the meso-level can also be seen to reflect wider political discourses.

²³ “the difference that makes the difference”

6.2.1 Objectifying Colleagues Insight

All but one of the psychologists talked about either being referred people for “insight work” or being involved in team discussions in which a service users’ insight was the central object of that assessment. This section deals with a tendency to invert the assessment focus and construct their colleagues as an object of insight. Thus, making possible new sites of subjectification.

(5226-5255)

P6 well, its inter:: it interesting because we don’t give those labels although we’re encou:: we, we’re going to do SCID²⁴ training and, and I do think psychologists, we’ve got a lot of expertise, we should be key in whose deciding who’s what

MM mhm

P6 but often in secondary care, you get the name of the person and the diagnosis, it’s already spelled-out

MM right

P6 it’s already {BR} categorised

MM right right

P6 and largely they fit a, a pattern of relating, a borderline em:: ((MM: mhm)) but then em:: ((2)) but eh wh-wha::, this is the system we’re in, this is the thing:: if it was a different, if it was more formulation, a biopsychosocial model

MM yeah

P6 {BR} we wouldn’t ha:: staff would understand actually it’s their way of relat-, relating is:: key in the intervention

MM yeah

P6 it’s not just giving a drug and making sure they take that’s key ((MM: right okay)) it’s how we are were with people

MM yeah and is that why then you say that em, it’s personality, psychosis is a bit more black-and-white but personality is, is a bit more

P6 because it’s relat- (()),

MM complex

²⁴ Structured Clinical Interview for DSM-IV (First, Spitzer, Gibbon, & Williams, 2012).

P6 because I think eh, eh people have to look at themselves and understand their own transferences, and have insight into themselves or::

This account can be thought of as two sections both describing tensions encountered in accepting a referral for a problematized service user. One could consider this extract as pivoting on the phrase “bio-psychosocial model”. In the initial section psychologist takes up an expert subject position from where they can contest existing disciplinary power-knowledge arrangements; in the second section colleagues are constructed as an object of insight assessment and thus subject to pastoral power processes.

The psychologist appears to vacillate between positions as they try to negotiate, resist and reframe the imposition of the service users difficulties that has been decided *a priori*. Initially the psychologist rejects the use of diagnostic categories in “we don’t give those labels”. From what could be considered a devalued role the psychologist responds by deploying the rhetorical device of category entitlement (Edwards & Potter, 1992). As a psychologists “we’ve got a lot of expertise” and should be involved in “deciding who’s what”. The use of “we” promotes agreement with the interviewer (consensus device – Edwards & Potter, 1992). This position of expertise is further consolidated by citing training in SCID. This expert subject position gives weight to the remaining statements.

The psychologists then appears to vacillate once more, appearing to acquiesce to the existing power-knowledge constellation by stating “this is the system we’re in, this is the thing”. Within this is a subtle critique of the system. Žižek (2006) proposes a Hegelian negation in tautology contains a radical violence. For example the law is the law, or in this case the system is the system. The primary clause “the system” which divides roles and responsibilities between professions in mental health holds medics responsible for diagnosis. However, this is now negated by the second clause. The second “system”, the alternative system is the one guided by “more formulation, a bio-psychosocial model”. However, this is also set against the psychologist previous statements, which suggests they are also poised to take up a more diagnostics role in this system – using expertise and SCID in “deciding who’s what”. Thus, the psychologist’s

resistance of existing disciplinary power arrangement has enabled the conditions for an extension and transformation of their existing expertise to include a bio-psychosocial diagnostician.

This transformed and extended subjectivity guides the rest of the extract. The psychologist focuses primarily on the insight of colleagues as the object and a site to promote psychologically minded workforce. What is interesting is the positioning of “relating”, “how we are with people” and ability to “look at themselves and understand” as key tools in the intervention. The psychologist connects these human qualities to a specific technology of psychology i.e. “transference”. In so doing they formulate the everyday within a psychological framework. Deleuze and Guattari, (1980/2013) suggest that the presence of a discourse is always imperialist and despotic – colonising and subjugating the other possibility and limiting gnosiology²⁵, epistemology, and ontology. In this case the totalising effect of linking the personal and professional could be seen in this light. This formulation of staff as a whole to transform them to “understand actually” and “have insight into themselves” can be considered dimensions of pastoral power in the promoting of ideology of a psychologically minded workforce.

The extension and transformation of clinical psychology within mental health can be seen to part of wider processes of establishment of the professional within an already dominated hegemonic space. This has meant that UK based mental health service provision has historically developed as a site of contested meaning where professional extension by one faction can be perceived as threatening by another (Pilgrim & Treacher, 1992). For example, the extension of clinical psychology can be seen as threatening to psychiatry; similarly the extension of IAPT can be seen as threatening to clinical psychology. Some elements of this tension will be explored in the following section.

²⁵ Gnosiology refers to an 18th century philosophy of knowledge when linked to aesthetics but also is linked to mystical or spiritual knowledge. The more modern homonym “nosology” referring to the classification of diseases may have been the intended translation. Nevertheless the former is retained to emphasise potential subjectification beyond psy-professional discourses.

6.2.2 Negotiating Subjectivity In Contested Social Space.

Psychologists working in adult mental health have been suggested to be the “magician’s assistant” (Coles, Diamond & Keenan, 2013). This refers specifically to psychologists’ use of individualising talking therapies that implicitly endorse depoliticised and decontextualized constructions of distress. In this way psychologists’ orientation, models and methodologies are positioned as promoting and supporting the enterprise of bio-medicalism. However, one could also say there is a growing recognition of limitations of this model (Harper, 2014; Kinderman & Tai, 2009; Read, Bentall & Fosse, 2009). Furthermore, the magician’s assistant idea, while seductive, may simplify the complexity of this social space. There has been increased interest in theorising the challenges of working in systems in which psychologists disagree (Boyle, 2013; Itten & Roberts, 2014; Speed, 2011). Psychologists have also been promoted as practitioners with broad theoretical knowledge and formulations skills that can be deployed to negotiate complex systems (Lake, 2008).

The psychologists presented multiple instances of negotiating subjectivities in the context of contested ideas. The subject positions of strategic helping, pragmatist, and subversive will be discussed.

6.2.2.1 Strategic helping position

This psychologist’s talk enables them to take up a “strategic helper” position by drawing on multiple theoretical frameworks to promote meaning and join with colleagues. This joining with is made possible by formulating the potential for teams to problematize “helping” and by proxy the “helper”. The promoting of psychological formulations from a bio-psychosocial framework will be linked to mechanisms of pastoral power and implications for subjectification.

(7643- 7668)

MM what would you do with a referral, what would your response be?

P8 when I first get the referral?

MM yeah

P8 I guess I would, would just think about with the person em ((3)) again what was going on, wh- j::ust asking a lot of questions about {BR} em, their, the persons background and context and why it might be important to them {BR} ((3)) the meaning of their beliefs, the, the kind of role that

maybe their presentation is playing in terms of protecting them from some other stuff that might be going on {BR} em, and I guess at the same time being very mindful that as a psychologist you don't want be seen as someone who was being kind of all woolly and not actually being very helpful and not {BR} em, not, and not agreeing with the team

MM right

P8 I think it's just about hold:: holding onto different ways of looking at stuff and validating just how difficult it is when someone is doing something risky and you're worried about them and they can't see that this is something that is causing them problems, that's really difficult, eh totally acknowledging

MM mhm

P8 {BR} that but then also trying to get behind why, {BR} em why is it is happening now, what's going on, wh:- what is this behaviour, is this protecting them, are those grandiose ideas actually helping them in some way right now because they feel terrible about themselves and if we're say "no this is all mental health, this isn't ((2)) " what does that leave this person with

The central concern of the psychologist is to resist being positioned as "all woolly" and "actually not being very helpful" by the team when presented with a referral about a service user who is deemed to lack insight. The presentation of psychologist as "all woolly" may reflect the positioning of the profession in general as a soft science in contrast the positivist, objective hard science of medicine. This is interestingly supported by the requirement to "agree(ing) with the team". The linking of helpfulness and agreement is important. There have been several widely reported warnings of the perils of hierarchical systems that instil communal acquiescence (Janis, 1971; Kennedy, 2001; Francis, 2013). Despite this it appears that this tension still has the potential to exert pressure in clinical settings. Nevertheless, it can also be seen as a strategic manoeuvre deployed to negotiate complex systems and demonstrate understanding of the various perspectives articulated in multi-disciplinary teams. It also, potentially negates a legitimate confrontation by including multiple theoretical models and thus facilitates being able to take-up a "helper" role.

The psychologist draws on the person-centred approach to negotiate the aforementioned pressure. This also enables a formulation of the service user and team simultaneously. The positioning as person-centred practitioner in relation to the service user is supported by application of a bio-psychosocial formulation of the service user. This has the effect of providing a thick description to sit alongside the thin one already ascribed to the patient (Geertz, 1973). They subsequently position themselves as person-centred in relation to their colleagues, by joining with and “validating” the experience of staff. In so doing they acknowledge the institutional privileging of “risk” and construct their colleagues as caring-professionals. This joining with can be seen as strategically important, as others can take up critique in this context as an attack on their professionalism and caring nature (Rogers & Pilgrim, 2010). Finally they join with the ultimate meaning-makers in adult mental health i.e. psychiatry. By drawing on the psychiatric terminology (“grandiose ideas”) they suggest an alternative psychological formulation (“protecting them”) to sit alongside this and potentially create the possibility for an alternative narrative and extended subjectivity. The integration of competing theories in a systemic formulation enables them to negotiate the social space and respond “helpful[ly]”.

Strong et al. (2012) suggest several strategies can be deployed by counsellors to resist DSM constructions in clinical practice. They noted that clinicians modified pathologising discourses with alternative descriptions of clients, similar to that produced by formulating in this extract. It is also somewhat related to Goldie’s (1977) eclectic position in which clinicians offer tentative opposition without instigating radical reform. This type of strategic helping may also reflect elements of the promotion of psychologically minded teams as previously mentioned.

Deleuze and Guattari (1980/2013) note that epistemology is never innocent. In this context, the subject position “helper” requires an object to help. The promotion of psychological mindedness can be thought of as objectifying teams in this way. This can be seen a reflection of pastoral power where psychologists are presented as purveyors of specialists knowledge that has transformative potential for the whole community.

The use of formulation as a technology extends beyond promoting a construction of the reality of service users and systems for colleagues, to a technology of self-control i.e. the self-reflexive clinical psychologist. Self-reflexivity can be thought of both “reflection in action” and “reflection on action” (Schon, 1987). This can enable possibilities and/or constraints on the subject and object of reflection, depending theoretical frameworks available e.g. person-centred, bio-psychosocial and bio-medical etc. Thus while clinical psychologists are promoted as self-reflexive practitioners (Hedges, 2010), this may also reflect broader processes of governmentality. As such, the “self-reflexive psychologist” is simultaneously enabled and disabled by broader theoretical ideologies. This idea will be extended in the discussion section with reference to clinical psychology training.

Finally, one could also consider the various and radically contingent social alignments as serving multiple strategic goals for the psychologist. The contingent nature enables a dynamic subjectivity that continually interacts, modifies and shapes the hegemonic field (Laclau & Mouffe, 1985). This is instructive in suggesting possibilities of on-going analysis of, and potential strategic response to, power asymmetries in practice.

6.2.2.2 *Pragmatist position*

Psychologists can apply multiple and, often, competing theoretical frameworks in adult mental health settings. Pragmatism, though not overtly alluded to, does provide an over-arching ideology that accounts for this discursive resource. Pragmatism is here considered to be a pluralist, critical, non-relativist, and action-orientated approach to theory and clinical practice (Cornish & Gillespie, 2009). One could see pragmatic approaches in clinical psychology as apt in light of the professions continuous modification and transformation in response to changing theoretical, political and economic landscapes (Pilgrim & Treacher, 1992).

(3966-3986)

P4 these might not be delusional ideas, em, are ideas associated with insight, in other words paranoid schizophrenic, em, classically in the literature, in theory, has narratives about threats to them, which are very other focused, and eh, just involve conspiracies which may be associated with something that is special about an individual and which don't tend to focus on {BR} things eh:: things that, you know, the person has done for which might hold themselves responsible lead::ing to other people wanting to harm them

MM mhm

P4 whereas in this guys case he has a clear narrative about things he's done that have upset other people {BR} and led them to want to harm him ((.)) even if he thinks that's still wrong

MM yeah

P4 {BR} and in so doing, although I'm challenging the idea that he's not insightful, I'm still actually, sort of, eh:: implicitly endorsing ideas of what a paranoid schizophrenic would be expected to do

MM right, okay

P4 eh:: how a paranoid schizophrenia impairs a person's insight, I'm saying he doesn't fit that profile therefore maybe he's not paranoid schizophrenic or maybe doesn't lack of insight

In this extract the psychologist recruits not only the hegemonic model (e.g. psychiatry) but also the epistemological frame, which supports it (e.g. positivism and logic) to construct an alternative version of the clinical problem. This is managed locally by recruiting the rhetorical devices, empiricist accounting ("classical literature") and rhetoric of argument²⁶ (Edwards & Potter, 1992).

By taking up a pragmatic position the psychologist can approach the local problem and present immediate but localised solutions. Aligning with and using psychiatric discourse to think about the clinical problem has the effect of not criticising the overall hegemonic structure and instead produces a contingent understanding as applied to this context.

²⁶ the creation of a logical sequence of if-then statements that have the effect of rendering alternatives implausible

In terms of insight specifically the deconstruction of service users diagnostic label negates the practicality of a traditional insight discourse. Again, the psychologist sidesteps a collision with the dominant ideology and merely applied its own terms to question the validity of its application and outcome in this instance. The effect is not to challenge the discourse of diagnosis, but use its own terms to attempt to extend the subjectivity of the service user in this instance. However, the psychologist also provides an alternative – a service user “narrative”. This coherent narrative accounts for behaviour, causation and cognitions and thus the psychologist presents him as a rational subject. Recruiting service user views has been an important policy shift in the NHS (Coulter & Collins, 2011). Its deployment in this context can be seen as strategic.

This extract might be thought about in terms of the compliant position and the eclectic position (Goldie, 1977). Eclectic in that the psychologist draws on competing theoretical frames to create the potential for expanded and transformed subjectivity in this instance. However, it is this localising and failure to overtly challenge the diagnostic discourse that permits an association with a compliant position. One might say that this eclectic-compliant tension is indicative of western liberal agenda that has sanitised dissent to point of promoting the faux-revolutionary i.e. a revolution without confrontation and thus radical endorsement of the status quo (Žižek, 2008). Nevertheless late Foucauldian interpretation of critical analysis promoted the possibility of systemic change from within (Bracken & Thomas, 2010; O’Farrell, 2005). In this sense psychologists can generate “niche(s) of resistance” alongside patients and staff to challenge hegemonic ideology. In this instance the psychologist suggests a collaboration with the service user has taken place²⁷ to challenge the diagnosis and create this alternative narrative (Parker, 1999; Strong et al., 2012). This narrative extends the subjectivity of the service user and the psychologist beyond pathologised/pathologiser into other domains e.g. meaning-maker/meaning-facilitator, albeit within a limited theoretical frame.

²⁷ this is described in detail in another part of the transcript – see line 3461-3504 Appendix M

This pragmatist approach simultaneously enables eclectic-compliant responses to disciplinary power-knowledge constellations. This could potentially lead to repetition of the *status quo*. However, this formulation assumes a static construction of power relations. Laclau and Mouffe (1986) suggest that the strategic alignment between not only social agents (e.g. service users) but also social discourses (e.g. bio-medicalism) can perturb the hegemonic field. Thus the continued strategic deployment of resources in this way results in small but inevitable shift in hegemonic discourses e.g. recruiting diagnostic *modus operandi* to negate its use and promote revised local practices. Diagnosis in mental health has proven remarkably resilient in the face of reasoned and rigorous critique (Boyle, 2002). Nevertheless taking up pragmatic subject positions can enable psychologists to engage in practice-based and localised innovations.

6.2.2.3 Subversive position

Some of the psychologists positioned themselves as subversive. That is, accepting an insight referral but using the therapeutic space as a non-discursive resource to construct an alternative focus for the work (Strong et al., 2012). Thus the subversive position creates the possibility to resist disciplinary power-knowledge constellations and offer transformative potential for subjectivity. The protected nature of the therapeutic space and the availability of collaborative-therapist discursive resource contribute to this process.

(613-632)

P1 we do get some referrals saying you know, "this person has no insight can you, can you help them gain insight" em, so we kind of get those referrals, em, and I think, think about it, often I suspect what happens in those cases is that we, in the psychology team, will then go off and do some work with that person if they're, if they're interested and willing to do some work.

MM mhm

P1 and, and then there probably isn't that much interaction with the care coordinator about this perceived lack of insight and what is or isn't going on, em, but actually what we'll be doing with that person, wont, wont, wont be trying, you know, to convince them that they've got a mental

illness, of course it will be something that they, as a person, are interested in doing.

MM mhm

P1 and sometimes that may be around understandings of their difficulties

MM yeah

P1 and whatever that is, but then, I wouldn't be using the term insight, so

MM Ok

P1 the, the, {BR} the nature of that discussion would be quite different to I think what perhaps the referrer was expecting it to be.

Here the psychologist's talk constructs actual and potential subversive activity. However, it might be considered a strategy bridging the eclectic and radically opposed positions proposed by Goldie (1977). The hegemonic model of insight is presented in the form of the referral but resisted in the therapeutic practice engaged in. The hegemonic discursive resource of insight as a legitimate intervention target is articulated in "this person has no insight" but resisted by drawing on the collaborative-therapist resource. What the service-user "is interested in doing" is a powerful bottom-up redefinition of the referral.

In this instance, the psychologist does not overtly ask the referrer to clarify what they mean by insight. It is implied in the subversive response. The psychologist links the referrers request "this person has no insight" to "convince them that they've got a mental illness". Messari and Hallam (2003) noted service users experience of therapy (CBT for psychosis) as an invitation to persuade under the auspices of pedagogy. This is one example of the "magician's assistant" critique outlined earlier and can be seen to reflect coercive rather than collaborative approach. However, the psychologist distances themselves from this coercive potential with a disclaimer ("but actually") and draws the researcher into collaborating ("of course") with the alternative (Edwards & Potter, 1992).

The collaborative potential is realised by rejecting the referrer's request and taking up the person-centred position. Thus engaging in "something that they, as a person, are interested in doing" creates the platform for a transformed and extended subjectivity. From here "understanding of their difficulties" can be constructed from the service user perspective again drawing on the relative importance of a narrative approach in psychologists' talk.

The potential for on-going subversion is realised in the notion that the work is conducted without systemic surveillance of the psychologist. It is noted that there is little interaction between psychologist and referrer about the commission of work i.e. lack of insight. Also, that therapeutic "discussion would be quite different" to what was expected in absence of surveillance creates considerable potential for subversive activity.

The psychologists interviewed privileged the relationship with their colleagues and thus on-going monitoring of the work may not be common in the light of positive relationship with and valence on the work of psychology. Nevertheless, it may become increasingly difficult to work outside of the commission of work in adult mental health with the impending implementation of payment by results (Cohen-Tovée, 2012) and increased institutional pressure on clinicians to record and account for their clinical time on electronic record systems (e.g. RiO). The model of clustering may also lead to a prescription type approach to interventions and an increased focus on evidenced and state sanctioned interventions *à la* NICE²⁸ guidance. However, clinical documentation can be deployed as therapeutic documentation with subversive potential. It can be used to re-author, reformulate, and challenge existing narratives (Madsen, 2007) held at the meso-level about service user. If deployed in this way, it can promote psychological ideas and extend service user voices beyond the therapeutic room.

As noted, psychologists are uniquely positioned to acknowledge hegemonic models of distress and join with service users in the therapeutic space to deconstruct these and reformulate alternative narratives. Psychologists can

²⁸ e.g. National Institute for Health and Clinical Excellence: Schizophrenia (2009)

overtly accept diagnostic labels while working on other issues in therapy, and join with service user to co-create and re-story their distress outside of DSM categories (Strong et al., 2012). By making strategic alliances with service users the psychologists can take up subversive positions to deterritorialize pathologised-pathologising discursive fields, and reterritorialize alternatives, that are *ipso facto* subversive (Deleuze & Guattari, 1980/2013). Thus emphasising the creative potential of resistance to disciplinary power-knowledge mechanisms. In this instance, the creative potential is again limited to local (micro and meso) levels leaving wider problematic discursive resources and practices unchanged. Vaclav Havel (1986) reflected that the structures and actions of totalitarian regimes “relegate personal conscience and consciousness to the bathroom”. In this case one is reminded that the dilemma of retreating into the therapeutic space can be balanced with transformative potential of subversive activity therein.

6.3 Macro-politics

Macro-politics considers insight talk at the level where the team interacts with wider systems. In this section the object of insight assessments is constructed as the team/system. The extension of psychologists’ remit to macro systems and the deployment of insight talk will be considered in terms of pastoral power and governmentality. By thinking, theorising and practicing at this level the psychologist is positioned as having transformation potential at every level of the system.

Transforming clinical psychology into professional leaders in healthcare could trace its roots in several discursive and non-discursive practices. Applied psychologists draw on both systemic and psychodynamic theories to guide working with groups (Obholzer & Zagier Roberts, 1994). There has also been an interest in the application of ideas from Liberation Psychology, Feminism, critical theory, and Post-colonial theory in working directly with the community (Afuape, 2011). It has been suggested that psychologists are uniquely positioned to make a difference to staff morale, service delivery and innovation, and the promotion of service users voices within the system (Onyett, 2012). Also, that the profession evolved in an already dominated hegemonic field and

thus leadership in clinical psychology is predicated by the paradoxical position of psychiatry. Psychiatry historically can be seen as both instrumental in endorsing the fledgling discipline of clinical psychology in its early days but also creates the *raison d'être* for resistance more recently (Pilgrim & Treacher, 1992).

It would be misleading to suggest that these skills and theories are the preserve of clinical psychology as they are also evident in other mental health professions. But, there has been a considerable institutional drive to promote psychology as a leadership profession e.g. “Organising and Delivering Psychological Services” (DoH, 2004); “NWW” (Lavender & Hope, 2007); and “Clinical Psychology Leadership Development Framework” (BPS/DCP, 2010). The promotion of clinical psychologist as leaders could be considered an attempt to privilege psychological theories and/or ways of working in this context. This is often presented as a benevolent apolitical enterprise akin to Miller’s (1969) call to give psychology away. However, as mentioned it has been suggested that while giving “it” away, psychology has also simultaneously monopolised theory and practice in professional frameworks (Rapley & Miller, 2003). In this way it not just epistemology but language that is not innocent (Andersen, 1996).

The way insight is talked about in the promotion and practice of leadership and the privileging of psychological theories will be considered in terms of commissioning, psychologically minded workforce and oversight.

6.3.1 Commissioning

The psychologists' talked about working in an evolving mental health landscape and the importance of being positioned to influence service provision and design. However, being positioned politically does not militate against depoliticised constructions of distress nor apolitical subject positions in this arena. The extension of psychologists' remit to influence the "insight" of commissioners is discussed. Rather than extend psychological ideas across the team as in the meso-political domain, this talk served to construct commissioners as legitimate objects of psychological thinking and thus can be considered an extension of pastoral power.

(5287-5315)

MM it sounds to me like you're describing there's a lot of maybe confusion in the system about what it is that we're dealing with, is that fair to say?

P6 it's interesting, because one example, I was in a meeting just before with a primary-care lead, and we, we have primary secondary care interface meetings, and {BR} primary care is becoming:: really, like a big machine, you're in you're out, you've got to be th-, if, if you're not this, if you've got this disorder we don't accept you:: it's becoming this F::ascist regime in some ways

MM mhm

P6 kind of, like, not what it used to be:: although I can understand they've got to see more people, although what commissioners seem to think, well if you put more money in primary care, you'll stop psychosis

MM mhm

P6 but that's the same thing as saying if you put on antiseptic cream you'll stop skin cancer

MM mhm

P6 that's not going to stop the cancer

MM yeah

P6 to stop cancer you maybe need gen::etic treatment or:: stop them smoking or stop them from ((2)) doing something that's actually causing it, giving a little bit of two session therapy, "oh that's sorted out their attachment problems which are a vulnerability factor for their psychosis",

and {BR} I think the insight of mental health is really lacking outside of mental health professionals

MM right, right

P6 and so, we've got a lot to do w::(()), I think what we've got {BR} it's wonderful time now:: I think its a great time 'cause things are picking up more, and society's now thinking about mental health

In this extract the psychologist constructs themselves in relation to wider systems in a number of ways. Firstly, they present primary care as a “Fascist regime” – this is one of the most potent *persona non grata* that can be invoked in British culture. Primary care is described as a rigid, disorder driven, and prescriptive orientated service. In effect, it is positioned as inhumane but also as a de-humanising “big machine”. A series of disclaimers (Edwards & Potter, 1992) follow which enable the psychologist to negotiate a number of subject positions. Initially the psychologist appears to accept the “big machine(s)” need to “see more people” with the first use of the disclaimer “although”. This is itself negated by the second “although” that critiques the idea that more money will “stop psychosis”.

However, it's not just more money but it's the perceived use of this in a simplistic way that is at stake. This draws on previously mentioned discourse that positions medics as purveyors of simplistic models to understand mental health. Thus making available the position of mental health experts and managers of complexity for psychologists take up. The psychologist does this by making a medical analogy with cancer. The analogy hinges on a formulation using a causal model, which borrows heavily from the prescriptive model of healthcare provision. This is not to assume that the psychologist believes in this type of care but it enables them to suggest a legitimate site of intervention in mental health “attachment problems which are a vulnerability factor for their psychosis”. This formulation is notable in that it privileges a depoliticised construction of distress i.e. individual vulnerability here is a reformulation of the previously mentioned diathesis-thesis model. Conversely, formulation itself can be said to be directly political in that privilege psychological explanations for mental health problems

Lastly, within this extract the psychologist democratises expertise to all “mental health professionals”. This can be considered part of the totalizing effect of promoting psychological ideas. In this instance, these experts are positioned *vis-à-vis* the commissioners. The psychologist appears to finish on a positive note seeing the lack of insight outside the expert subject as an opportunity to extend expertise into these areas.

6.3.2 Psychologically Minded Workforce

Psychologists take up subject positions that enabled them to promote psychology as both ordinary and esoteric. That is ordinary in that these skills reflect everyday human quality and esoteric as specific psy-technologies. By constructing ordinary-esoteric couplet, psychology can colonise the ordinary under esoteric and thus legitimise an extension of pastoral power into this domain.

This has implications for subjectivity that is transformed within these discursive manoeuvres but also the available subjectivities of the systems they work in.

(963-993)

P2 this wasn't about using a psychological therapy, this was just thinking about, eh, I guess engaging in, eh, potential eh, empathic eh, thinking with them about what might going for this patient. What are some of the reasons, the broad reasons in which people struggle to take em, medication rather than this being a rather simplistic, {BR} eh, oppositional thing, deviance

MM yeah

P2 em, and then, and then I guess in thinking about psychological approaches this would be more specific stuff, so, this would actually be then maybe formulating more specifically someone's current distress for example,

MM mhm

P2 so, again, we might have {BR}, some basic information but being able to posit eh, eh, other eh, factors, that aren't just eh, reducing it to sort of simplistic eh, “they're like this because they're depressed” {LG}

MM OK

P2 em, of course lets think about what are some of the factors that might have led this person to feeling as they are feeling at the moment

MM yeah

P2 whether this be internal mechanisms, in terms of the way they are thinking about themselves, ruminating, or whatever {BR} or:: thinking about the sort of psycho-social interactions that actually we know this person has struggled with domestic abuse, or been threatened with housing, or you know, they have just lost their job

MM mhm

P2 {BR}, so I guess from my point of view eh, eh a lot of the stuff, I kind of end up bringing, is sort of a broad psychological theory em

MM right

P2 that's sort of, em, the different perspectives that we are taught as clinical psychologists, and actually in my, in my triage work there is only a small amount of work that I would actually do in terms of therapy

Throughout this extract the psychologists construct ordinary-esoteric couplet. This enables formulations that facilitate joining with the service user as non-expert collaborative practitioner but perhaps a distancing from colleague as expert teacher.

Over the course of the extract they refers to two psychological technologies i.e. therapy and formulation. Therapy as a technology is removed from the exchange early. The intervention “psychological therapy” is set against the ordinary human tools to intervene (“engagement” and “empathic”). The implications are to move beyond discipline specific intervention to one that everyone should be doing. The psychologist is positioned as an expert about, not only, what “might be going on for this patient” but how the system might also know and relate to the “patient”. This focusing on the service user, as noted, is part of a wider discourse person-centred care across the entire healthcare landscape. Despite this, psychologists’ position themselves as having a specialist role in promoting the person-centred approach that might be considered synchronise with the promotion of a psychologically-minded workforce.

The remaining section focuses on the use of formulation as a tool to model for the system how it might come to know about and relate to the “patient”. As with other extracts the system is positioned as simplistic and the psychologist’s technology (i.e. formulation) helps them to move beyond the “simplistic” bad (“deviance”) and mad (“depressed”) formulation presented by the system for non-compliance. “Broad psychological” theory is presented as a way to understand. The broad psychological theory implied (“internal mechanism”, “ruminating”, “domestic abuse”) might be summarised as the psychosocial model.

As previously stated the way we talk about and the systems of thought we use to order reality can influence the power-knowledge constellations that are made available to us. In the project for promoting a psychologically minded workforce and its connecting with person-centred care agenda it is worth asking if psychologists posturing is strictly apolitical? One can hardly argue that promoting service users’ voice is not a legitimate enterprise. Psychologist taking up a position of responsibility in terms of this can serve to positively reinforce their position as advocates for service users in the system. However, it can also be seen as threatening to other professional groups who may have to adopt different relational and interactional roles with service users.

Finally, it may be worth reflecting on the processes of governmentality being played out here. The project for a psychologically minded workforce is at once both dependant on available discourses and a vehicle for their propagation. Thus the models of psychology privileged by the psychologist become those shared to the workforce. It is worth asking, if mental health services will be better served by more people who can formulate using psychological approaches?; or if psychology as an approach will be better served by mental health services that use this model? Similarly, person-centred care is now total discourse dominating the healthcare landscape. Nevertheless, non-discursive practices may not always serve to reinforce this effect e.g. the *realpolitik* of choice in mental health *vis-à-vis* forced detention and treatment. Thus can a person-centred approach transform mental health structures; or is the person-centred approach trapped inside existing mental health structures?

6.3.3 Outsight And Insight

Outsight will refer to a way of thinking that seeks to promote a demystification of the psy-technologies e.g. therapy and/or formulation (or indeed the profession itself). It seeks to promote an understanding of the environmental factors that can be worked with and changed to make a material difference in people's lives (Smail, 2006). Smail called for an orientation towards oversight rather than insight. However, here oversight and insight is preferred. In this sense it is the self-reflexive potential of teams (i.e. their insight) that can create conditions for oversight. For many service users, psychologists and the systems they work in are one environment that was talked about in relation to insight.

(6869-6876)

P7 I think that the systems, we need, we're the ones who need the insight and the oversight

MM the oversight

P7 the oversight, yes, so that we can kind of, reflect on how:: you know, what are the external factors in ((2)) influencing us as well, that make us do these crazy things like divide people's difficulties into these little packages and em, you know

This extract represents a summary of oversight/insight discourse. To extrapolate the point further without breaching anonymity it was necessary to provide an extract from an early point in the interview that did not directly reference the team.

(6107-6119)

P7 now to me that seems like a pathological way of relating

MM hm::

P7 not by the client by the system you know

MM mhm

P7 and, {BR} and that there was no self reflection in that, there was no insight {LG} in a sense, as to how {BR} as a system, you know, ((3)) i:: it was dealing with this, this woman and her issues {BR} em:: ((3)) and then ((3)) you know t:: eh, phe her complaints about the system, I think

were all being understood as something about her:: way of relating and nothing about::, you know, the, the systemic issues

MM how the system works

P7 yeah exactly, exactly {BR} um, ((2)) so, ((2)) yeah, that's, that's you know kinda one example, that yeah

Here the psychologist talks about the system's lack of insight. The psychologist talks about the system as a collective with psychology as part of this "I think that the systems [...] we're the ones". Previously we have proposed that psychologists are positioned, or position themselves, in contradictory spaces. For example, re-producing-reproducing individualising models of care at micro-level; and extending the object of insight as assessment to proximal colleagues at the meso-level; and attempts to reframe hegemony with the promotion of psychologically minded services at the macro-level. In each case the psychologist is positioned as marginal moving between various discursive and non-discursive practices. Here the psychologists constructs a totality "we" "the system". This creates the conditions of the psychologist not just acting strategically on the system but with self-reflexive potential.

In the example, the psychologist constructs the system's lack of insight in relation to a service user's complaint. By positioning the system as "pathological" and unwilling to "relate" or try to "understand" the service user they are simultaneously positioning themselves as outside of this. They note that within this, the service user is dismissed and her "complaint" is formulated as "something about her". This is a potential example of "crazy things [the system does] like divide people's difficulties into these little packages". This is particularly pertinent given the increasing economic and political pressure to role out package based approaches e.g. IAPT and clustering. However, it also alludes to the broader discourses that support these "little package(s)" approaches i.e. individualising and depoliticising constructions of distress embedded in hegemonic mental health models (Pilgrim, 2014).

This theme was replicated in a number of other interviews and involved similar constructions in multi-disciplinary teams. Critically, the psychologist draws on a psychology technology self-reflexivity to suggest that the team lacked the ability to think about this service user outside of a very limited range of discursive recourses, namely those that constructed a “complaint” as part of an individual’s pathology. However, by invoking “we’re the ones who need the insight and the oversight” creates the possibilities of extending pastoral power and the promotion of psychologically minded workforce within the reflexive frame. Thus, through reflexivity, the psychologist can be considered an active social agent that is both constituted by and constitutive of system wide discursive and non-discursive practices.

7 DISCUSSION

This section will summarise the main findings from the analysis and then consider practical implications across each of the three domains (micro/meso/macro-politics). This will focus on “reproductive/re-productive” power as a dilemma in the psy-encounter, the adoption of pragmatism, and the promotion of psychologically minded workforce respectively. The critical review will consider epistemological and personal reflexivity (Willig, 2008). That is, the degree to which a set of validity criteria can be applied to this research and the position of the researcher as a co-constructor of discourse in the interview process will be considered.

7.1 Analysis Summary

This research focused on two main questions:

1. How do clinical psychologists’ construct the notion of insight and how does this informs their practice?
2. To explore the kind of subject positions these constructions makes available?

The three sections described in the analysis are not intended to be discrete domains but interacting and connected spheres of social action. Each domain necessarily draws on the discursive and non-discursive resources of the others. They might be considered analogous to interacting strata or plateaus that permit multiplicity (Deleuze & Guattari, 1980/2013). That is, dynamic domains that dialogically co-create and re-create each other. Thus the subjectivities discussed must also be seen as dynamic, relational, and both constituted by and constitutive of the contingency of the social space. As such, the subjectivities can be considered to have a “range of potential” through access to the available horizon of truth (Deleuze & Guattari, 1980/2013). In this research power-knowledge constellations were considered one determining factor that both extends and limits the horizon of truth.

At the micro-political domain “insight talk” considered insight as psy-model, narrative insight, and formulation. Power was conceived of in terms of governmentality and reproduction/re-production processes. In terms of Q.1, the majority of participants recognised the term “insight” but reported that it did not feature in their practice. Nevertheless, they deployed analogous ideas to formulate “problematised” service users. In terms of Q.2, this offered opportunities to “reproduce” individualising and depoliticised constructions of distress. However, it also created opportunities to “re-produce” alternative constructions with the potential to transform and extend subjectivity. Narrative insight was considered one way in which person-centred “insights” could be co-constructed in the psy-encounter. Formulation was seen as a key psy-technology to augment bio-medical “thin” descriptions with “thick” descriptions (Geertz, 1973).

At the meso-political domain psychologists’ “insight talk” positioned them in relation to their colleagues. In terms of Q.1, they inverted “insight talk” about service users to construct their colleagues as the object of insight assessments. However, this interaction was constructed as part of a general negotiation of contested sites in mental health contexts. In response to Q.2, as one of the contested sites, “insight talk” enabled psychologists to articulate this negotiation in terms of strategic helping, pragmatist, and subversive positions. Meso-politics was considered in terms of disciplinary power and the impact on subjectivity of various resistance strategies deployed to work with and against hegemonic bio-medicalism. Pastoral power was introduced to think about the emergence of a radical response to bio-medicalism and developed further at the macro-political domain. Pastoral power was discussed in relation to the pedagogic exercise of promoting alternative models of understanding distress.

At the macro-political level “insight talk” was thought of in terms of the wider system. In terms of Q.1, the research proposed the construction of commissioners and systems as lacking insight. In answer to Q.2, oversight and the promotion of a psychologically minded workforce were considered as an antidote to this. The positioning of psychologists as leaders legitimises this critique and antidote. Developing a psychologically minded workforce can be

seen as an expression of pastoral power with the potential to transform and extend both the available roles of psychology but also subjectivity across the entire system. That is, to extend the available “regimes of truth” to think about themselves and others in psy-encounters. Nevertheless, this can also be seen to reflect wider professional and policy discourses and thus also an expression of governmentality.

7.2 Implications

7.2.1 Micro-implications

The reproduction/re-production tension at the micro-political domain presents a series of dilemmas for psychologists working in adult mental health. Principle among them is the potential to reproduce bio-medicalism through the development of analogous theories and practices. As noted previously, bio-psychosocial formulations of madness can be more appropriately labelled bio-bio-bio formulations (Read et al., 2009). Formulation itself can be seen as an organising psy-technology and thus entirely dependent on the available theories and models applied in its use. For example, formulations organised using CBT (Garety, Kuipers, Fowler, Freeman, & Bebbington, 2001) or systemic/family life-cycle (Carter & McGoldrick's, 2004) models privileges different types of information thus enabling various power-knowledge constellations with resulting impact on subjectivity. Nevertheless, narrative approaches to insight (and of distress in general) that privilege the service user and reposition them as the authors of their own experience present as a potential alternative. However, situating this at the micro-political level simultaneously limits the impact it can have on challenging or changing dominant paradigms.

Furthermore, service users who have been in contact with services for many years may have learned how to deploy medicalised constructions of themselves to their advantage (Goffman, 1961; Bourdieu, 1986). For example, Dillon (2011) reports that service users are not encouraged to speak about their “unusual experiences” in inpatient settings. This is echoed by Duggins (2010) who suggests ward review are characterised by “good patients” who unambiguously accept care plans, while “difficult patients” question treatment rationale and want to discuss their distress.

It has been suggested that clinicians should be more aware of the impact of the language they use and more explicit about limitations of the knowledge deployed in practice (Lofgren, Hewitt & das Nair 2014). Therefore, the application *carte blanche* of narrative approaches potentially runs the risk of re-colonising and suppressing the service users' meaning making capacity with another "regime of truth". The present research suggests that a reflexive approach to the theories and language used in the psy-encounter promotes different opportunities for both service users and practitioners to extend the subjectivity beyond limited and limiting bio-medical formulations.

7.2.2 Meso-implications

The adoption of a pragmatic approach dovetails with this reflexive stance. Pragmatism in this instance reflects a pluralist, critical, non-relativist, and action-orientated practice (Cornish & Gillespie, 2009). Reflexivity applied here permits an iterative and critical approach by the practitioner to the available discursive and non-discursive tools in psy-encounters. This construction of the subject departs from traditional discourse analytic circles and proposes the subject as both constitutive of and constituted by discourse (Davies & Harré, 1990; Wetherell, 1998). In so doing, it facilitates the construction of the pragmatic practitioner who is able to reflexively engage with theory and apply this in practice. By adopting elements of multiple models the practitioner can strategically and contingently align with a variety of actors to achieve selected goals. Thus the cynical appraisal of ideology "they know very well..." holds even greater radical potential than assumed at first glance (Sloterdijk, 1983/1988; Žižek, 1989). The pragmatist position simultaneously recruits and critiques available discourses (e.g. bio-medicalism). This research suggests forging local alliances can enable radical contingency i.e. the capacity to affect the legitimacy of hegemonic discourses and thus the entire ideological *façade* (Laclau & Mouffe, 1986).

However, pragmatism in psychology can be seen as part of an intellectual and theoretical compromise analogous to the eclectic practitioners that emerged in the 1960s and 1970s (Goldie, 1977; Pilgrim & Treacher, 1992). As a compromise it may lead to adopting contradictory and perhaps incompatible epistemological, ontological and ethical positions. Pragmatism might offer practical and localised solutions to emerging issues; conversely, it might present an inconsistent approach that negates a sustained and coherent challenge to bio-medical constructions of distress. In either event, pragmatism expands the conceptualisation of a static hegemonic bio-medicalism to a dynamic and malleable mental health discursive field that can be moulded.

7.2.3 Macro-implications

The construction of psychologists as having a legitimate role in shaping discourses in mental health can be seen in the enterprise to develop a psychologically minded workforce. This raises a number of important points, for example what is “psychologically minded” and who decides? That psychology has received a political mandate to provide educational opportunities to other staff groups is not new, being first muted in the 1980s Mowbray review (Pilgrim & Treacher, 1992). It has also been promoted more recently in the form of the leadership agenda within psychology (Lavender & Hope, 2007; BPS, 2010).

However, it is worth reflecting the clinical psychology of the 1980s is markedly different from that practiced today. One might consider the profession as emerging and evolving in the shadow of continual crises that has resulted in multiple expressions of what comes to be called “clinical psychology” at that time. It has been suggested that the profession went through three distinct phases up to 1979, i.e. psychometrics, behaviourism, and eclecticism (Richards, 1983 cited in Pilgrim & Treacher, 1992). The 1980s and early 1990s heralded the era of “managerialism” (Pilgrim & Treacher, 1992). Managerialism led to rapid expansion and consolidation of the profession but also the beginnings of an attempt to atomise the work of clinical psychology. Thus the price of expansion and full state recognition was increased control. One might see IAPT²⁹ as one current incarnation of this tendency. It could be argued that

²⁹ Improving Access to Psychological Therapy

this phase has given way to the “leadership phase” and this is reflected in processes of governmentality e.g. the overt orientation to leadership in clinical training and practice (BPS, 2010).

However, to a greater or lesser degree clinical psychology has promoted itself as a “scientist” profession. The “scientist-practitioner” model initially proposed at the Boulder conference has been the dominant expression of “scientism” by the profession since the 1950s (Albee, 2000). While initially refuted by influential psychologists in the UK (Eysenck, 1949), it was eagerly adopted as the profession evolved beyond the psychometrics phase (Pilgrim & Treacher, 1992). Nevertheless, there appears to be a subtle but discernable shift away from this model in training. The term “scientist-practitioner” does not appear in any of the three North Thames training group information material³⁰. This shift is very recent as at least one course (UEL) contained a reference to it in the promotional material for the training cohort 2008-2011. This means that entrants to the programme in 2015 could well be supervised by psychologists who were, at least to some degree, exposed to different forms of governmentality in relation to what it means to be a psychologist. It is also noteworthy that the terms “reflexive”, “reflective” and “reflexivity” all appear in the current perspectives of these courses.

What I am proposing here is that there are different ideological expressions of what “psychology” is. Thus there are potentially, multiple expressions of what a psychologically minded workforce should be (scientist-practitioner, reflexive-practitioner, evidence-based-practitioner etc.). Is it possible that we are entering a new phase of profession, leaving behind “leadership” in favour of “reflexivity”? Who decides what psychology is, deserves greater scrutiny and may be a useful avenue for future research in this area.

One facet of reflexivity might consider the impact of the language we use in practice (Hedges, 2010). A reflexive approach to language may result in an orientation away from a view of language as a means to circulate meaning to a mechanism to distribute contradictory regimes of truth (Deleuze & Guattari, 1980/2013). If the central tenet of ideology is to hide the true effect of power

³⁰ <http://www.leeds.ac.uk/chpccp/> lasted accessed 1.5.2015

(Marx, 1867/1976; Horkheimer & Adorno, 1944/2002; Žižek, 1989) what would be the impact of creating a mass of critically minded reflexive practitioners in mental health? It is also worth noting that a reflexivity based on pragmatism may reflect a radical extension of individualism i.e. idiosyncratic locally tailored formulations to meet immediate ends. While we have seen an expansion, and to some extent an endorsement, of individualism in the form of neo-liberal politics since the 1980s this paradoxically does not necessarily result in greater local autonomy for those working in mental health in the public (Pilgrim & Treacher, 1992) or community/charity sector (Speed, 2011). Thus in highlighting the enterprise to promote a “psychologically minded workforce” and what might be called the “reflexive-turn” in the profession, I am suggesting that more research is merited to explore this enterprise in greater detail. Furthermore, clinical psychology has displayed great flexibility in adapting to emerging socio-economic and political contexts in its short history. Nevertheless, a critical appraisal of the utility of eclectic and pragmatic approaches may be required to continue to evolve as a profession.

7.3 Evaluative criteria

As stated in the method section the evaluative criteria applied here will draw on coherence, transparency and rigour, and impact (Yardley, 2008). Researcher reflexivity (Burman, 2004) will be discussed in section 7.4.

7.3.1 Coherence

Coherence refers to being sensitive to both the micro and macro level patterns in the text (Potter & Wetherell, 1997). This was achieved by attending to the exceptions in the data and led to an expanded formulation of power. Initial readings focused on “disciplinary power” and tended to privilege a reading of top-down power application and implications. Through supervision and the aforementioned hermeneutic circle I was able to consider what else might be happening in the text in relation to subjectivity and power. This led to a reading that proposed a polyvalent and productive power. This can be seen in the extension of disciplinary to “re-production/reproduction” power and the extension of governmentality to pastoral power.

7.3.2 Transparency And Rigour

Transparency and rigour are important to contextualise qualitative research (Yardley, 2008). In this research, I have clearly outlined by rationale for developing the research questions. In the methodology, I outlined how the analysis was approached and the shortcomings proposed by Antaki et al. (2003) were attended to throughout. The audit trail (Appendix K-L) gives an account of the analysis from start to finish.

7.3.3 Impact

As noted, I have created the platform to engage in a dialogue with the participants and services about this research. In many ways, this can be said to have started in the interviews themselves where many participants reported finding it useful to think about how insight and related constructs are applied in practice. The following extract echoed this theme that ran throughout the interviews.

(8658-8662)

P9 I think it's been very interesting and it makes me think {BR} about how ((3)) {LS} you know a lot of these things once you questioned them they're quite amorphous you know, there, there's less shape really, and I think I ((3)) I, I, ha:- have a sense that, they've got more of a shape than they do in fact

The psychologist here reflects on the idea that “a lot of these things” (psychological constructs) are assumed to have more shape than they do and that the process of reflecting on them has prompted a re-recognition of this. This suggests that the establishment, and maintenance, of reflective forums can be usefully used to critique established and establishment practices. This creates a dilemma for practitioners wishing to justify such forums. In the face of increasingly stringent economic climate establishing practices not directly linked to revenue streams (e.g. service user contact) may be difficult. However, recourse to research and initiatives linked to patient-centred care approaches may well support an argument for such forums. This research proposes that a

reflexive approach to “insight talk” (language and practices) can enable service users voices to be heard and thus evidence for the utility of such forums.

7.4 Critical Review

7.4.1 Epistemological Reflexivity

I have previously proposed that epistemology is not neutral (Deleuze & Guattari, 1980/2013). In taking up a social constructionist position in the research I have in effect engaged in act of intellectual colonisation. That is, it can be said to be part of a language game that legitimises some claims over others (Rorty, 1979). One claim I have made is to propose that subjectivity is both constituent and constitutive of language. This was, in part, an attempt to integrate these poles that are the source of the dilemma of subjectivity in social constructionism. This *être/et* position can itself be said to be a replication of the eclecticism, that has been critiqued as an intellectually sterile compromise (Pilgrim & Treacher, 1992).

However, I have tried, where necessary, to outline some of the philosophical debates that support this *être/et* position. This may be taxing for the reader. Yet ideas around subjectivity and what it means to work in and with contested social spaces are complicated matters. Therefore, allowing multiple narratives “to be”, “and” be open to not understanding too quickly is a central concern in theory and practice (Anderson & Goolishian, 1988). Thus eclecticism, as a language game, need not be sterile but requires a radical reflexive dialogue. A dialogue that actively interrogate ones own knowledge(s) but also attempts to knit in complex ideas stitch by stitch into fabric of ordinary interactions (Weingarten, 1998).

7.4.2 Personal Reflexivity

In line with the social constructionist stance of this research one can legitimately claim that the interview, like all sites of interaction, is a site of co-constructed meaning (Burr, 2003). Willig (2001) suggests it is important to recognise the extent to which the researcher shapes the interview by leading, prompting, directing and avoiding topics in conversation. Thus, a brief note on some

possible ways in which I shaped (constitutive) and was shaped (constituent) by the interview process will be discussed.

7.4.2.1 *Shaping interviews*

As a white-male in the UK my Irishness can be subverted in social interactions. This can be doubly obscured in “professional” contexts. In this way my subjectivity becomes limited by and subjected to an image of ideal-patriarchy i.e. white, male, middle-class, British. This is in stark contrast to a view I have of myself as an outsider deeply critical of, and concerned, with patriarchy in various forms. This is a paradoxical space in which I often oscillate between conformity and resistance. Race, gender etc. were largely obscured in the interviews though this might be an obvious site to explore the interaction between constructions of insight-rationality in mental health. This might be a reflection of my attempts at strategic alignment with various positions in the social space (Laclau & Mouffe, 1985). However, it may also reflect a post-colonial attitude to oppression and liberation (Moane, 1999). This central post-colonial paradox revolves around a tension to love-loath and respect-resist that, which you cannot have.

In the interviews, I attempted to hold up a critical lens to all interviewees and myself in interaction. This required a delicate balancing act to join with and criticise simultaneously. Bio-medicalism is an obvious patriarchal model evident in mental health care. However, some, but not all, of the interviewees expressed views broadly similar to mine. I hope that I was able to engage in sufficient critical discussion in these interviewees, in particular, to push these theories to sufficiently explore the implications for subjectification in their articulation and practice.

7.4.2.2 *Shaped by interviews*

It has been suggested that discourse analytic models should favour naturalistic text/talk where possible (Potter & Wetherell, 1987) as other co-constructed spaces necessarily involve stake management (Willig, 2001). This is particularly pertinent in an interview space between a trainee and practicing clinical psychologist. In some respects an interview of this type presents as a potentially revealing social space. Therefore, it is understandable that interviewees may seek to act to present favourable representation of

themselves. This is further amplified by expectations of what a “UEL trainee” might believe in and the way a “UEL graduate” might be expected (or expect themselves) to practise³¹. To some extent this dramaturgical dimension could be anticipated as a legitimate strategy to manage the self in any social interaction (Goffman, 1959). Furthermore, the participants were a self-selecting group and thus some assumptions about their readiness and willingness to expose their practice can be made i.e. they were more willing. It is noteworthy, that participants drew on a number of ideas about “insight” highlighting both positive “use-value” and “useless” connotations attached to its deployment in clinical practice. On the flip side, as a self-selecting group, it does raise questions about what, if any, alternative discursive and non-discursive resources may not be accounted for in this research.

The interviews in this research presented the challenge of “unpackaging (of) the gloss” (Jefferson, 1985). That is, how to avoid colluding with unproblematic accounts in the interview? Thus, within every interview I attempted to self-reflexively manage and monitor what was not being talked about. It is beyond the scope to cover every strategy, but two examples may help to illuminate how this was managed.

Firstly, I attempted to actively enquire about alternative narratives and instances that might go against what was being proposed by the speaker. Secondly, the position of trainee via a relatively powerful other presents a considerable challenge to this “unpackaging”. As a trainee soon to graduate I felt an expectation to demonstrate research skills, critical acumen, good rapport etc. befitting of a final year trainee. This is in the context of a critical analysis of potential future employers and colleagues. In being the interviewer, it felt at times as if I was being interviewed. This required actively attending to myself both in the interviews, in reflections after, and in the on going dialogue with the texts. Thus, the interview process became an expression of a relational dilemma – becoming aware of the desire for recognition and the recognition of desire (Žižek, 2006).

³¹ UEL’s critical ethos and resultant expectations were directly mentioned in 6/9 interviews.

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APPENDIX A: INSIGHT SCALES

Table 1: Summary of dimensions covered by insight scales (Adopted from Tranulis, Corin & Kirmayer, 2008 p. 231).

Dimensions	PANSS	ITAQ	SAI	SUMD	BCIS
1. acceptance of illness label	X	X	X	X	
2. awareness of having a mental disorder			X	X	
3. perceived need for treatment		X	X		
4. awareness of treatment benefit				X	
5. attributions of benefit of treatment		X			
6. awareness of signs & symptoms			X	X	X
7. attribution of signs & symptoms to having mental disorder				X	X
8. awareness of social consequences of illness				X	X
9. lack of judgment		X			
10. self-reflectiveness					X
11. Self-certainty					X

PANNS: Positive and Negative Syndrome Scale (Kay et al., 1987)

ITAQ: Insight and Treatment Attitude Questionnaire (Mc Evoy et al., 1989)

SAI: Schedule for Assessing the three components of Insight (David et al., 1992)

SUMD: Scale to Assess Unawareness of Mental Disorder (Amador et al., 1993)

BCIS: Beck Cognitive Insight Scale (Beck et al., 2004)

APPENDIX B: PSYCINFO SEARCH

Table 2: PsycINFO search 20th November 2012

Search Terms in "subject fields"	Number of results
Hearing + Voice* + Haloperidol	0
Hearing + Voice* + Olanzapine	0
Auditory + Hallucination* + Haloperidol	9
Auditory + Hallucination* + Olanzapine	13
Hearing + Voice* + Schizo*	15
Auditory + Hallucination* + Schizo*	654
Olanzapin+ Schizo*	1388
Haloperidol+ Schizo*	1462

* denotes a truncation used to extend the search terms. Using it includes, e.g. schizophrenia, schizophrenic, schizo-affective etc. This was used in an attempt to capture as many variations of the term used in the search.

Haloperidol is a typical anti-psychotic. Olanzapine is an atypical anti-psychotic.

PsycINFO is an abstract database that provides systematic coverage of the psychological literature from the 1800s to the present. Similar trends were observed in PubMed, and as a result are not reported. PubMed is a search engine with a broader remit including both biomedical and life science journals.

APPENDIX C: EXAMPLE OF SUBJECTIFICATION

An example of the process of subjectification applied to labels attached to users of mental health services.

An example from the current health care landscape may be illustrative. People accessing mental health services can both identify with and be referred to using a number of labels, each permits and limits; maintains and resists; reproduces and produces a variety of power relations and subjectification. Power relations can be considered ways in which social action and discourses attempt to define and fix the power relationships between social actors (O'Farrell, 2005).

Subjectification relates to processes that produce subjectivity and to make subject to (Henriques et al., 1986). Subjectivity in this sense is related to identity, but rather than an internal stable entity, it is proposed as relational and contingent. Thus, in this social constructionist reading, subjectivity is preferred as this enables a dynamic subject to make available multiple and contradictory positions with social relationships. In this sense the subject is positioning (actively producing subjectivity) and positioned by (subject to this idea).

So, with this in mind let us return to the example. People accessing services can be referred to as service users, patients, survivors, consumers etc. For example, "patients" and "consumer" might identify as such in only a limited number of social situations e.g. mental health assessment. Thus, this subjectivity is only part of multiple other subjectivities that they can take up e.g. mother, friend, colleague and so on. However, in the assessment a "patient" and/or "consumer" might enable various positions to be taken up in relation to the truth claims made by the clinician, view of self in relation to this professional "opinion", and availability of choice(s) in response to treatment(s) offered.

However, in a variety of ways people might take up different positions within one context. It should also be noted that the position of health care "consumer" is promoted in the current NHS landscape (Speed, 2011) yet this position is also undermined by institutional practices of forced treatment and detention promoted ideologically through, for example, diagnosis and risk of bio-medicalism and enshrined legally in the apparatus of the Mental Health Act (2007) and Mental Capacity Act (2005). Thus, subjectivities can be thought of multiple, contradictory, and dynamic.

APPENDIX D: LIST OF RHETORICAL DEVICES

Edwards and Potter (1992, p160-163) & Taylor, 2011

CL ³²	Category Entitlement	Claim supported by recourse to the entitlement of the category membership of the speaker.
VD	Vivid description	Rich in descriptive detail gives impression perceptual re-experience as well as idea that speaker has particular observational skills of the speaker e.g. quotation – s/he said ...
N	Narrative	Closely related to VD – account given as part of long narrative, often fuse description and causation
SV	Systematic vagueness	Opposite to VD – lack of clarity and thus can negate refuting account presented
EA	Empiricist accounting	e.g. scientific talk – reify entities or give agency to objects in and of themselves
RA	Rhetoric of argument	Constructing claims in the form of logic – e.g. if-then formulations
EC	Extreme case formulation	Providing extreme case to legitimise own account e.g. everybody does it or nobody use it here
CC	Consensus and corroboration	Blend consensus with normativity – used to forge alliances in speech
LC	Lists and contrasts	Creating lists e.g. 3 part list thus gives impression
SI	Stake inoculation	Attempts to remove own interest from account therefore claim to objectivity
SC	Show concession	Often presented in 3 part structure, claim, concession (okay), reprise (but) – presents counter argument but undermines it to strengthen validity of initial claims

³² Abbreviation of rhetorical devices marked on left hand side of text.

APPENDIX E: UNIVERSITY OF EAST LONDON RESEARCH ETHICS COMMITTEE

SCHOOL OF PSYCHOLOGY

Dean: Professor Mark N. O. Davies, PhD, CPsychol, CBiol.



School of Psychology Professional Doctorate Programmes

To Whom It May Concern:

This is to confirm that the Professional Doctorate candidate named in the attached ethics approval is conducting research as part of the requirements of the Professional Doctorate programme on which he/she is enrolled.

The Research Ethics Committee of the School of Psychology, University of East London, has approved this candidate's research ethics application and he/she is therefore covered by the University's indemnity insurance policy while conducting the research. This policy should normally cover for any untoward event. The University does not offer 'no fault' cover, so in the event of an untoward occurrence leading to a claim against the institution, the claimant would be obliged to bring an action against the University and seek compensation through the courts.

As the candidate is a student of the University of East London, the University will act as the sponsor of his/her research. UEL will also fund expenses arising from the research, such as photocopying and postage.

Yours faithfully,

Dr. Mark Finn

Chair of the School of Psychology Ethics Sub-Committee

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The University of East London has campuses at London Docklands and Stratford
If you have any special access or communication requirements for your visit, please let us know. MINICOM 020 8223 2853



APPENDIX F: NHS R&D COMMITTEE ETHICS

XX³³ Trust (XXXFT) R&D Committee Confirmation

From: XX XX [XX.XX@XX.nhs.uk]

Sent: 04 September 2014 11:28

To: XX XX

Cc: Manus MOYNIHAN; Moynihan Manus

Subject: RE: Re: Project Requiring Ethical Approval

Dear XX,

This project has approval from the Clinical Director to proceed and been reviewed by the Chair of the Ethics Committee.

Kind regards,

XX XX

From: XX XX

XX XX Quality Outcomes & Experience Analyst

XX NHS Foundation Trust

Trust Headquarter, XXXXX

Tel: XXX

Email: XX.XX@XX.nhs.uk

³³ X denotes a redaction to preserve anonymity of the Trust, services, participants

APPENDIX G: THE INFORMATION SHEET

UNIVERSITY OF EAST LONDON
School of Psychology
Stratford Campus
Water Lane
London E15 4LZ



The Principal Investigator(s)

Manus Moynihan

Email: u1236141@uel.ac.uk Telephone: 020 8223 4174

Consent to Participate in a Research Study

The purpose of this letter is to provide you with the information that you need to consider in deciding whether to participate a research study. The study is being conducted as part of my Professional Doctorate in Clinical Psychology degree at the University of East London.

Project Title

Clinical Psychologists' constructions of insight in adult mental health

Project Description

What is the aim of the research?

I am interested in understanding more about the way the notion of insight is constructed by clinical psychologists working in adult mental health settings and how this informs your work with service users, families and other team members.

What will the study involve?

Participation in this study will involve taking part in a single, 40-60 minute long interview with the investigator, which will be audio-recorded. During the interview you will be asked some questions about your work and your day-to-day activity in mental health services. You can talk as much or as little as you like about each question. The interview will take place at a location that suits you, but cannot take place in a public place e.g. a café.

Are there any risks to participation?

I do not think that there are any risks to taking part. However, in the unlikely event that the material discussed raises some distressing feelings, the researcher will offer a break from the interview or to terminate it at your request and offer you support with these feelings. It is not envisaged that the interview will reveal any information of concern regarding harm to you or to others. However, should a disclosure of this nature emerge in the interview, the researcher is duty bound to report this to the relevant person. This will be discussed with you prior to the interview.

Please turn over sheet →

Are there any benefits to participation?

I do not think that there will be any direct benefits in taking part in this research. However, many psychologists may enjoy the opportunity to think and talk about their practice. It could be considered an interesting time to do this with radical changes promised to service provision structures, ever increasingly complexity of service user needs, and the evolving nature of mental health narratives (e.g. recently published DSM-V). A summary and/or full report of the research will be made available upon request. You can also request to have the researcher come to your team to present the ideas generated in the research.

Confidentiality of the Data

All personal information will be stored on encrypted files on the researchers computer. No personal details will be linkable to raw data files or anonymized transcripts, which will be locked in separate encrypted files. The transcripts will be coded so that your name is not associated with any of the information you provide and all subsequent use of the data will be completely anonymous. Anonymized transcriptions will be stored in encrypted files for additional analysis for five years following completion of the study. I may use direct quotes from you in the final report and/or dissemination emerging from the research. However, any identifying data such as your name and where you come from will remain completely anonymous.

Location

Interviews can take place in mutually agreed location. I appreciate the considerable workload of NHS staff working in this setting, and will be flexible to travel to the place of your place of work should this be required. However, no interview can take place in a public place.

Disclaimer

You are not obliged to take part in this study and should not feel coerced. You are free to withdraw at any time up the end of data collection (31st March 2015). Should you choose to withdraw from the study you may do so without disadvantage to yourself and without any obligation to give a reason. Should you withdraw after the 31st March 2015, the researcher reserves the right to use your anonymized data in the write-up of the study and any further analysis that may be conducted by the researcher.

Please feel free to ask me any questions. If you are happy to continue you will be asked to sign a consent form prior to your participation. Please retain this invitation letter for reference.

If you have any questions or concerns about how the study has been conducted, please contact the study's supervisor Dr. David Harper, School of Psychology, University of East London, Water Lane, London E15 4LZ. (Tel: [020 8223 4174](tel:02082234174). Email d.harper@uel.ac.uk)

or

Chair of the School of Psychology Research Ethics Sub-committee: Dr. Mark Finn, School of Psychology, University of East London, Water Lane, London E15 4LZ. (Tel: 020 8223 4493. Email: m.finn@uel.ac.uk)

Thank you in anticipation. Yours sincerely, Manus Moynihan

APPENDIX H: SEMI-STRUCTURED INTERVIEW SCHEDULE

Interview schedule – Clinical Psychologists insight in adult mental health

- Information sheet (read and understood – opportunity to ask questions), right to withdraw, consent and confidentiality
- Check audio recording equipment
- Outline time frame (40-60 minutes)
- Take questions about the study at the end

Main topics & prompts

1. Can you tell me a little bit about your background and your training?
2. What ways do you work in your team?
3. Are there different ideas in your team about how you could be working?
4. Interested in term “insight” is this something you use?

If yes:

- How does insight help you in work – example
- When is not helpful – example
- Do you think and talk about insight differently with teams/service users/family?
- Why might this be?

If no;

- What other words or concepts do you use to think about these clinical concerns?
- Do you talk very differently about this?
- What does this look like in your clinical work?
- What does this look like with your team members?
- What does this look like with service user/families?

5. Word and notion – explore how view this as different

- Is insight important word in adult mental health?
- Do you think there are other ideas about insight in the team?

6. Is it important that people:

- Recognise they are unwell
- Engage with services – accept treatment offered
- Accept diagnosis

7. I am Interested in different views on service user engagement?

- What role does psychology (you) have in client engagement?

<u>Consultancy</u>	<u>One to one work</u>	<u>Compliance / treatment options / admission</u>
<u>Stuck-ness:</u>	How do you think about this?	How is this thought about
What do the team come with	How do you work with team	in the team?
How talk about it?	on this?	What input do you have?
How resolve ? - example	What resources do you draw on?	

- How do you think about engagement/ non-engagement?
- Does the team differ on how they think about engagement – why might this be?
- Example “good” engagement – why was this so? Diagnosis, prognosis, meaning
- Example “bad” engagement – why was this so?
- Does the team think psychology is useful with this? When useful – when not ?
- Is engagement thought differently: gender – ethnicity

8. Access

Who, when and how do people refer to psychology in your team?

What ideas inform those decisions? (can you give a recent example of a referral and the discussions you had about it)

What ideas inform your decision to accept, reject or define alternative way of working with the SU & team member

6. Service User disagreement in terms of diagnosis, treatment options etc. (e.g. cause and categorisation of experience as “illness”)

- How does your team talk about service user disagreement?
- Can you give me an example – has this been helpful? – why?
- Can you add this to this conversation - has this been helpful? – why?
- When has this not been helpful – example? – why?

APPENDIX I: CONSENT FORM



Consent to participate in a research study

Title of study: Clinical Psychologists' constructions of insight in adult mental health

Name of researcher: Manus Moynihan
Thank you for taking part in this research study.

Initial

- I have read the information sheet relating to the above research study and have been given a copy to keep. The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information. I understand what is being proposed and the procedures in which I will be involved have been explained to me. _____
- I understand that my involvement in this study, and particular data from this research, will remain strictly confidential. Only the researcher involved in the study will have access to identifying data. It has been explained to me what will happen once the research study has been completed. _____
- I hereby freely and fully consent to participate in the study which has been fully explained to me. Having given this consent I understand that I have the right to withdraw from the study at any time without disadvantage to myself and without being obliged to give any reason. _____
- I also understand that should I withdraw after 31st March 2015, the researcher reserves the right to use my anonymous extracts in the write-up of the study and in any further analysis that may be conducted by the researcher. _____

Participant's Name (BLOCK CAPITALS)

.....

Participant's Signature

Researcher's Name (BLOCK CAPITALS)

.....

Researcher's Signature

Date:

APPENDIX J: TRANSCRIPTION CONVENTIONS

(.)	Indicate a pause of less than 1 second
((x))	Indicate a pause of more than 1 second, with x replaced with the number of seconds e.g. 3 seconds as ((3))
{LG}	Laughter
{LS}	Lip smack
{BR}	Intake of breath
::	Emphasis and/or exaggeration of letter sound e.g. not::
-	Indicates a breakoff of utterance e.g. th-
th- (+there)	Indicates a breakoff of utterance, where reasonable guess can be made of the intended word
(())	Unintelligible speech
XXX	Replace any place name to preserve anonymity
mhm/mmm/eh	Sounds transcribed phonetically
Px	Participant followed by a number to denote which participant e.g P6 = participant 6
MM	Interviewers initials

APPENDIX K: EXAMPLE OF CODED TEXT

EAL: of course? effect of disordered reality on of medic fx:

943 medication. Eh, as I was hearing this, actually what I was hearing
 944 'cause they were struggling to, to eh, to take medication and eh, the,
 945 the medic, the psychiatrist was frustrated with this patient and, and, so
 946 forth, and talking about how we needed to manage this better and how
 947 the patient needed to learn to take this, and eh {BR}, the psychological
 948 intervention, or the way that I was thinking, was thinking of course was fx technology
 C.E. 949 what was the psychology of patient, what their struggle was and fx
 950 potential block to this and, and that led to eh, eh, in terms of reflections,
 951 and led to the team considering eh, other reasons why this person
 952 might have been struggling to take medication from a psychological
 953 point of view, that was linked to this sense that some how medication
 L.C. 954 was sign of weakness, and eh, this was linked, to eh some of the
 100s 955 history we had been given in, in their letters. So suddenly this opened meaning-maker
 956 kinda' opened up thinking, a little bit, so consider eh, {BR}, maybe that meaning-maker
 957 would be something that, eh, people could, eh, think about with the
 958 person next time
 959 MM yeah
 960 P2 eh, next time they were to meet so
 961 MM hmm
 962 P2 this wasn't about using a psychological therapy, this was just thinking
 963 about, eh, I guess engaging in, eh, potential eh, empathic eh, thinking
 964 with about what might going for this patient. What are some of the not a but normal behavior
 965 reasons, the broad reasons in which people struggle to take em,
 966 medication rather than this being a rather simplistic, {BR} eh,
 967 oppositional thing, deviance statement in reverse; this is not discipline skill everyone should but it do
 968 MM yeah, yeah
 969 P2 em, and then, and then I guess in thinking about psychological
 970 approaches this would be more specific stuff, so, this would actually be
 971 then maybe formulating more specifically someone's current distress
 972 for example,
 973 MM mhmm fx
 974 P2 so, again, we might have {BR}, some basic information but being able fx as tool of complexity
 975 to posit eh, eh, other eh, factors, that aren't just eh, reducing it to sort
 976 of simplistic eh, "they're like this because they're depressed" {LG}

APPENDIX L: AUDIT TRAIL

Initial themes

Psychologist as TMT	As thoughtful multi-theory practitioner, exceptional, work with complexity, antidote to biomedical reductionism
Psychologist as critical	As critical, ethical, advocate for service user
Psychologist as self-reflexive	Praxis (reflection-action) what we bring
Psychologist as curious	Exploring concepts, enquiring more information, asking questions
Psychologist as strategic	Movement around systems, people, concepts, in order to achieve therapeutic goals or conflict
Psychologist as skilled	Positions psychologist as uniquely skilled via others (neo-Weberian)
Psychologist as subversive	Get referral for insight, but proceed as always do, don't necessarily link to request (link collaborative – strategic)
Psychologist as meaning maker	Help team make meaning (link TMT) Help service user make meaning (link – skills, subversive, narrative)
Psychologist as collaborative	With service user and link TMT, meaning maker, With team combat, strategic, subversive
Psychologist as leader	Showing leadership qualities, taking up positions of leadership, assumes senior roles either through character or position, exercise authority
Psychologist as pragmatist	pluralist, critical, non-relativist, and action-orientated approach to theory and practice
Psychologist as bio-psychosocial	Biological, social and psychological theories
Them no us	We (psychology/team) don't use insight but other professionals and/or groups do

Technologies

Fx	Formulation	CC	Cultural Capital	Dx	Diagnosis
Ax	Assessment	R	Risk	Ix	Intervention
EBP	Evidence based practice	SR	Self-reflexivity		
ΨM	Psychologically minded	S	Supervision		

Power conceptualisations

Reported constructs	Major themes	Initial conceptualisation	
		Relationships	Technology
Reproductive v re-productive	Contested v con-tested	Resist – acquiesce	Formulation
		Complexity	Assessment
		expertise	Evidence based practice
			Self reflexivity
Governmentality	Bio-power Professional-power	Teacher – pupil	Cultural capital
		Policy power	Formulation
		Humanism	Assessment
		Political	Evidence based practice
Pastoral Power	Bio-power Transformative power	Teacher – pupil	Self reflexivity
		Leadership	Cultural capital
		Psychological mindedness	Formulation
		Strategic - conflict	Assessment
Disciplinary	Resist – acquiesce	Hegemonic power	Evidence based practice
		Biomedicalism	Self reflexivity
			Cultural capital
			Formulation

APPENDIX M: ADDITIONAL TEXT RE: FOOTNOTE 5

Re: footnote 5 the following extract describes in more detail the collaboration between psychologist and service user alluded to in the analysis

(3461-3504)

MM on, on the concept of say insight or whether say somebody, a service user has an illness, or is unwell, and requires our, an intervention?

P4 yeah, oh okay, em, ((3)) I'm not sure if this will answer your question, it's something that's been quite recent in my work and being quite interesting em, eh, and so there's an individual, the first person that I talked about that showed up and had a knife, he has ideas, he has recollections of being severely assaulted in 2006 and 2009, he says that between 2006 and 2008 he went to Somalia where he was imprisoned and tortured, em, and eh, all these things are treated as sort of fixed ideas, also he says he's harassed my a sister and threatened by people in the community

MM mhm

P4 {BR} em::, I suppose because there are or other aspects of his behaviour that are a bit odd, and there is no corroborative evidence that these assaults actually happened

MM hmm

P4 em {BR} but in talking with him, so, so, this is, the orthodox view that these sort of {BR} hm::, the official stance on this individual is he's paranoid schizophrenic with fixed ideas about things that happened

MM hm::

P4 although his care coordinator when he was referred to me did say, "you know, I don't know if some of this stuff has happened"

MM mhm

P4 but over the course of talking to him, I felt that his narrative was actually quite coherent, sort of he::, sort of, what's the word? em, sort of held together reasonably well, was unusual for somebody not to h::, who would be deemed not to have insight

MM mhm

P4 he gave quite a clear account as to eh, clear, and from my view plausible account to how the original assault happened {BR}, and eh, {BR}, which involves him taking ownership and responsibility for eh various things that led up to the assault, not to say that it's his fault, but he was able to say, "I did these things, people felt this, and then they attacked me".

MM okay (22:00)

P4 I also phoned a relative of his in Somalia the other day, which was an unusual thing

MM mhm

P4 em, and she basically corroborated as much of his story as she'd be able to, including the idea yeah he was in prison in Somalia for two years em, {BR}, and, so, basically, having gathered all this eh, {BR}, collateral history, eh:: brother back to speak to the psychiatrist, and the social worker, and it was interesting 'cause, em, they were, kind of like, struck, and open to the idea that maybe this guy was telling the truth.