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African Caribbean men with severe mental illness and conduct disorder: reducing violence and improving therapeutic engagement.

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**AFRICAN CARIBBEAN MEN WITH CONDUCT
DISORDER AND SEVERE MENTAL ILLNESS:
REDUCING VIOLENCE AND IMPROVING
THERAPEUTIC ENGAGEMENT.**

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DECLARATION FOR MAJOR RESEARCH PROJECT

DECLARATION

This work has not previously been accepted in substance for any degree and is not being concurrently submitted in candidature for any degree.

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STATEMENT 1

This thesis is the result of my own investigations, except where otherwise stated. Other sources are acknowledged by footnotes giving explicit references. A bibliography is appended.

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Summary of the Portfolio

Section A: Literature Review

A review of literature focused on African Caribbean men with diagnoses of both conduct disorder (as an indicator of antisocial behaviour) and severe mental illness. The review concludes that disorganised infant attachments appear to be predictive of conduct disorder, psychosis and poor engagement with services in a reciprocal 'vicious circle'.

Section B: Empirical Paper

This is an exploration of the attachment relationships of African Caribbean men with current severe mental illness and past conduct disorder. Four participants were interviewed in outpatient and community settings. Texts were analysed using a psychosocial approach. All participants showed signs of disorganised attachment and all had had adverse encounters within mental health services although all could also cite discrete experiences which had been helpful and supportive. Each participant held different views about the interaction of race with care.

Section C: Critical Appraisal

A critical reflection on the research process, including: thoughts on learning experiences; retrospective changes to the study; clinical implications; and ideas for future research.

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Section A: Literature Review

Abstract

This is a review of literature focused on African Caribbean men with previous conduct disorder (correlated with violence and antisocial behaviour) and current severe mental illness. These men constitute a clinical subgroup with high levels of unmet needs. The review concludes that disorganised infant attachments appear to be predictive of conduct disorder, psychosis and, also, poor engagement with services in a reciprocal 'vicious circle'. The underlying mechanism is hypothesised to be a deficit in the socio-cognitive skills involved in reflective functioning and mentalisation. Lack of these skills also predicts antisocial behaviour and violence towards the self and others: a key reason for compulsory admission. Attachment theory appears to be a useful theoretical framework for reducing violence and improving early engagement within mental health services for this group of men.

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1. INTRODUCTION

1.1 Terms of Reference

African Caribbean (AC) Agyemang, Bhopal and Bruijnzeels (2005), in their work on ethnic labelling in the health arena, conclude that, “1) describing the population under consideration is of paramount importance (2) the word African origin or simply African is an appropriate and necessary prefix for an ethnic label, for example, AC or African Kenyan or African Surinamese (3) documents should define the ethnic labels (4) the label Black should be phased out except when used in political contexts.” (p.1014).

The term African Caribbean /Afro-Caribbean when used in Europe and North America usually refers to people with African ancestral origins, who migrated via the Caribbean islands. Although the term is often used inconsistently in the UK, this review will adopt the definition of Agyemang et al. (2005) and use it to refer to people who are Black and of Caribbean descent. This review will also follow these authors in not including “Black” as an ethnic label (unless it has been used as a definition in cited research): “...while the term Black has a psychosocial and political significance, in epidemiology and public health, such a broad term is usually unhelpful.” (p.1016).

Severe mental illness (SMI) refers to “mood, thoughts and/or behaviour, which can have a major effect on nearly all aspects of a

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person's life at some stage of their illness. People with a severe mental illness often require long-term treatment and support from mental health services" (Rethink, 2008). In clinical practice, this definition generally refers to disorders like psychosis and schizophrenia.

Definitions that rely on continuing high levels of service usage are not useful in the case of this review.

Conduct disorder or disordered conduct (CD) refers to problem behaviours in childhood such as fighting, stealing, truanting, cruelty and disobedience. A formal diagnosis of childhood-onset Conduct Disorder is associated with antisocial behaviour, violence and victimisation in adulthood and is a prerequisite for an adult diagnosis of Antisocial Personality Disorder (American Psychiatric Association, 2000).

1.2 The present review focuses on attachment theory as applied to a clinical subgroup: AC men with a history of conduct disorder and severe mental illness. This particular constellation of gender, ethnicity and disorder represents a priority for mental health services (Bruce, personal communication, 2010).

1.3 Hypotheses about both conduct disorder and severe mental illness can be usefully formulated within attachment theory. There is a particular style of infant relating known as disorganised attachment in

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which the child can develop no coherent strategy or response to frightened, and frightening, caregivers. Disorganised attachments have the greatest predictive power for pathology of all insecure infant categorisations (Dozier, Stovall & Albus, 1999). Sociocognitive hypotheses about disorganised attachment are linked with the type of diagnoses that AC men receive throughout the lifespan.

Epidemiological studies indicate that black children (and boys) are more likely to be diagnosed with conduct disorder (Meltzer, Gatwood, Goodman & Ford, 2000). Evidence for the link between conduct disorder and disorganised attachment will be explored first in this review. As an example, controlling behaviour in middle childhood is likely to be an expression of disorganised infant attachment in high-risk families and environments (Lyons-Ruth, 1996). People of AC heritage are also more likely to be diagnosed with psychosis and schizophrenia (Bhugra, Mallet and Leff, 1999). This review, then, will continue by looking at papers that link disorganised attachments to severe mental illness, particularly positive and negative symptoms of psychosis (Dozier and colleagues; 1995, 1998, 1999).

1.4 The next part of this review will concentrate on the evidence that explores attachment style, help-seeking and engagement with services. In adults, disorganised attachment is classified as 'unresolved' on the Adult Attachment Interview (AAI; George, Kaplan and Main, 1985). Bartholomew (1990) conceptualised a type of avoidance known as 'fearful', associated with a fear of rejection, which

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can encompass an originally disorganised style. An avoidant state of mind in adulthood could therefore also be the result of a disorganised state in infancy (Main, Hesse & Kaplan, 2005). In this case, avoidance, in the deactivation of affect, represents a defensive strategy to cope with irresolvable fear. Avoidant styles are hypothesised to be central to inhibiting help-seeking and engagement with services, through a variety of mediating perceptions (Schaffer, Vogel & Wei, 2006).

1.5 The next step for this review is to investigate the presence of disorganised attachments within the AC community. There is scant evidence that insecure attachment styles appear more or less frequently than in other minority groups. Studies indicate that attachment findings are transmissible across generations (Fonagy, 1999) and that their effects are not moderated by ethnicity (Futh, O'Connor, Matias, Green & Scott, 2008). However, insecure attachment may be underpinned by differing sociocultural pressures and practices (Bakermans-Kranenburg, van Ijzendoorn & Kroonenberg, 2004). One of the factors that may contribute to disorganised attachment in an AC population in particular is intergenerational trauma due to migration. This is crystallised around the separation-reunion experience (Smith, Lalonde & Johnson, 2004). There are also the psychological sequelae of growing up in an unequal society. An environment such as “a highly segregated neighbourhood where violence is an everyday occurrence,” (Suarez-Orozco and Suarez-Orozco, 2010, p. 332) will exacerbate attachment

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vulnerabilities in children, making individuals more sensitive to "issues of employment, discrimination and acculturation" (Smith et al., 2004, p.119).

1.6 In short, disorganised attachment is a contributor to certain disorders; disorders that are often diagnosed in people of AC heritage. It also inhibits help-seeking and predicts antisocial behaviour and violence. There is also some evidence for particular life events that might disrupt attachment in an AC population. The final step is to relate attachment theory to existing research on how AC people experience services today in the UK. The key element here is reciprocal fear.

1.7 The AC community has been shown to have the greatest difficulty of any ethnic minority group in accessing and using health care and social services (Keating, Robertson, McCulloch & Francis, 2002). In their experience, they are not listened to at primary care level, so they do not readily seek help. AC people are referred less frequently to secondary level: they are less likely to receive 'talking therapies', for instance (Mclean, Campbell & Cornish, 2003). People may become violent and present in crisis at tertiary level. Indeed, AC people are the most overrepresented group at this level of services. Access to mental health care within this ethnic group is often therefore compulsory rather than voluntary. This generates a skewed perception of mental health services as controlling rather than helpful. The title of the

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Keating et al. publication, *Breaking the Circles of Fear* (2002) was a description of the relationship between mental health services and minority, especially AC, communities. Within this relationship, services were perceived to be both neglectful and intrusive, ignoring people when they asked for help and then dealing with the inevitable crises in a punitive manner, turning people into "zombies" (p.37) with drugs or interning them on wards. Keating et al. note that, "A striking feature of this review was the level of fear and apprehension expressed when acute care was discussed," (2002, p. 40). The fear was that mental illness would eventually lead to confinement in a high-secure setting; or death as a result of police intervention.

1.8 According to Keating et al., the AC community is also "the social group to which the greatest level of fear seems to be directed within society as a whole as well as within mental health services" (2002, p.13). AC men in particular provoke this fear. AC men and men of other African origin are disproportionately more likely to be compulsorily detained for treatment: this is both a result of, and a trigger for, violence. African and Caribbean men are therefore seen as threatening by staff, who then feel both hostile and helpless.

Parenting that is both neglectful and intrusive, where the caregiver seems both hostile and helpless, is exactly the type of care that results in disorganised attachments. This would make help-seeking and help-receiving much less straightforward, as damaging repetitions of abusive or neglectful infant experiences are played out. It might

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therefore be reasonable to expect that disorders stemming from attachment disturbances might worsen on contact with services. This risk would increase in the case of AC people in general and AC men in particular.

1.9 Determining the mechanisms by which disorganised attachments can lead to conduct disorder, severe mental illness and help avoidance would better inform clinical practice with this group of people. One important concept that makes empirical (and visceral) sense is that of reflective function and mentalisation: the ability to represent psychological processes in the mind of the self and of others (Fonagy, Bateman, Jurist and Target, 2002). This will be explored further in the Discussion section. This review, then, will examine disorganised attachment and impaired reflective function as a major risk factor for both conduct disorder and severe mental illness. Disorganised attachment as a predictor for poor engagement with services will also be considered. This review will, finally, demonstrate how the AC experience with mental health services in the UK today feeds into the cycle.

2 REVIEW

2.1 Every effort was made to select papers that fulfilled Greenhalgh's (2001) criteria for best evidence, such as longitudinal or cohort studies with large samples and controls in the absence of randomized

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control trials. Meta-analyses and systematic reviews have also been privileged (The Centre for Evidence-based Medicine (CEBM), 2011).

2.2 Disorganised attachment and conduct disorder in childhood

According to Moffit's (1993) hypothesis, there are intrinsic causal and prognostic differences between childhood-onset conduct disorder and that developing in adolescence: but for AC men with psychosis, even adolescent-onset disordered conduct is not necessarily normative or transient (Bruce, in preparation). This introduces the subject of ethnic bias in diagnostic labelling (Bell & Baker, 1999). A diagnosis of conduct disorder is associated with antisocial behaviour and is a prerequisite for an adult diagnosis of Antisocial Personality Disorder. Yet AC people do not get as many diagnoses of Personality Disorder as a comparable white group (Lloyd & Moodley, 1992; Mikton & Grounds, 2007).

The first conceptualisation of attachment theory linked insecure attachments with antisocial conduct (Bowlby, 1944) and they have more recently been shown to correlate with disordered conduct in childhood and later antisocial behaviour (Fonagy, Gergely, Jurist and Target, 2002). A large-scale review by DeKleyen and Speltz (2001) found that, in high-risk populations only, attachment insecurity increased the probability of antisocial behaviour as part of a constellation of other risks.

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Lyons-Ruth, Alpern and Repacholi (1993) found that nursery-age children in a low-income sample with very hostile behaviour were six times more likely to have been classified as disorganised in their infant attachment relationships than to have been classified as secure. For the majority, the disorganised behaviour included a high level of avoidance. A later review demonstrated that disorganised/avoidant attachment behaviours in particular were found to be predictive of aggression towards peers at school age (Lyons-Ruth, 1996). This finding holds true for boys but not for girls (Futh et al., 2008). Aggression towards, and therefore alienation from, peers is another risk factor for extreme behavioural problems (Rutter, 1994).

A later study by Lyons-Ruth and colleagues found a link between hostile-aggressive behaviour at age 5 and certain relational aspects: in particular, maternal attitudinal inflexibility and disrupted, hostile interactions (Najmi, Bureau, Chen & Lyons-Ruth, 2009). This was in a larger high-risk sample (n=76). The transactional effect of these interactions can constitute a “vicious circle” leading to emotional dysregulation (Guionnet, Viaux-Savelon & Mazet, 2010, p.220).

Another notable study on the mechanisms that lead to aggression showed that 5 – 8 year-old boys (n=41) referred for disruptive behaviour problems showed greater dysregulated aggression and less

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intentionality, or less ability to give an interpersonal interpretation of events, in response to story stems intended to evoke conflict and distress. This was in comparison with a non-clinical group of 25 boys (Hill, Fonagy, Lancaster & Broyden, 2007). This was interpreted as an avoidant strategy to reduce anxiety in the face of threat. DeKleyen and Speltz (2001) pointed out that a limited capacity to mentalise, exacerbated by poor peer relations, would make violating the rights of other people a routine and acceptable strategy. Violating the rights of others is one of the diagnostic criteria for both Conduct Disorder and Antisocial Personality Disorder in DSM-IV-R (American Psychiatric Association: APA, 2000).

2.3 Disorganised attachment and psychosis in adulthood

Emerging evidence shows that insecure attachment is intimately linked with psychosis; and that disorganised / avoidant styles carry the greatest risk. What remains to be thoroughly explored is the developmental nature of the pathway.

Insecure attachment negatively affects the way that people think about themselves and others. Negative beliefs are key in cognitive models of psychosis (Garety, Kuipers, Fowler, Freeman & Bebbington, 2001) and studies have now shown that it is avoidant styles in particular that are important predictors, being positively correlated with paranoia as well as both positive and negative symptoms of

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psychosis (Freeman, Garety, Kuipers, Fowler & Bebbington, 2002; Berry, Barrowclough & Wearden, 2008). Mistrust, interpersonal hostility and social withdrawal, all features of avoidant styles, will exacerbate psychotic symptoms. Dozier and colleagues used the AAI with a large clinical sample with diagnoses of severe mental illness. Classification using Kobak's (1989) Q-set provided a continuous 'deactivation-hyperactivation' continuum rather than discrete categories, potentially a more useful way of conceptualising attachment strategies. The majority of interviews were coded as 'dismissing'; or 'deactivating' as opposed to 'hyperactivating.' In a relatively large study (n=76) on a clinical population with serious psychopathological disorders the 'dismissing' group were rated as experiencing more delusions, hallucinations, and paranoia. Case managers also rated them as more psychotic (Dozier & Lee, 1998; Dozier & Tyrrell, 1998). These findings were not confounded by symptom severity (Berry et al., 2008); but higher levels of depression in clients with psychosis were correlated with poorer engagement (Blackburn, Berry and Cohen, 2010).

Liotti and Gumley (2006) elaborated on the cognitive model by exploring the etiological pathway from disorganised attachment to psychosis. They hypothesised that trauma translates into dissociation through the fragmentation of the self. However, fragmentation may be at the root of several dissociative disorders. The route to positive psychotic symptoms in particular could be explained through a failure

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of mentalisation. Mentalisation and theory of mind is impaired in those with diagnoses of schizophrenia. This was the finding of Sprong, Schothorst, Vos, Hox and van Engeland (2007) in a meta-analysis described in the British Journal of Psychiatry as "an excellent piece of scientific work" (Pousa, Ruiz & David, 2008, p.312). However, the finding that this held true also when the symptoms were in remission was questioned by Pousa et al.; Sprong et al. agreed that studies on remitted patients were limited and sample sizes were small (2008) although the effect size was significant. Theory of mind impairment was certainly found by both groups of authors (Sprong et al., 2007; Pousa et al., 2007) to be a trait marker for psychotic symptoms.

2.4 Disorganised attachment and asking for help

Goodwin, Holmes, Cochrane and Mason (2003) concluded after 2 clinical trials on their 25-item Service Attachment Questionnaire (SAQ) that "attachment is relevant to the relationships clients have with mental health services," (p.145). Goodwin (2003) also noted that, "... it is generally accepted in the literature that the therapist-client relationship can be defined as an attachment relationship" (p.46).

Berry et al. (2008), referred to, "a self-perpetuating pattern, whereby avoidant individuals reject help, which reinforces the negative perceptions of others." (p.1281). This is a robust finding. Many excellent studies looking at attachment and services concentrate on

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particular disorders such as psychosis (e.g. Tait, Birchwood & Trower, 2003): but there are more general papers. Schaffer et al. (2006), in an empirical large-scale study (n=821) of undergraduates seeking counselling, found through structural equation modelling that higher attachment avoidance and less intent to seek help was mediated by lower anticipated benefits, higher anticipated risks and less positive attitudes towards seeking help.

2.5 Attachment and intergenerational transmission in UK-based African Caribbean families

Avoidant people, then, will tend towards encountering services only when in crisis. This increases the likelihood that their experience will be negative in some way and therefore contribute towards further problems such as relapse. Membership of an ethnic minority can have a further adverse effect through life stressors (Smith et al., 2004) and its systemic effect upon the relationship between staff and service users as has already been described (Keating et al., 2002). There could also be empirical reasons for disorganised attachments occurring in the AC community as well as other minorities.

Attachment disorders are transmitted from generation to generation; childhood ratings demonstrate concordance with maternal attachment (e.g. Fonagy, Steele, Moran, Steele & Higgitt, 1993). Disorganised attachment behaviour is significantly linked with the caregiver's

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unresolved loss or trauma (van Ijzendoorn, 1995). Therefore the effect of particular disruptions may persist through generations. The concept that different social and cultural groups may have different routes to disorganised attachment has been mentioned in the Introduction. A special feature of AC migration (Christiansen, Thornely-Brown and Robinson, 1982) is the back-and-forth movement of grandparents, parents and children between the UK and their countries of origin. Features of this staggered, or serial, migration such as lengthy separation and reunion have been found to affect the quality of interactions between caregivers. There is also the possibility that some more authoritarian Caribbean child-rearing practices are antithetical to adjustment in a more Westernised society (Smith & Mosby, 2003; Baptiste, Hardy & Lewis, 1997a & b).

Arnold (2006) looked at 20 women born in the Caribbean whose birth mothers had emigrated between 1950 and 1970 and left them in the care of other relatives, the reunions being typically more than a decade later. The study developed an instrument to look at their narratives (the Separation Reunion Interview Schedule) and in view of the small sample any conclusions must be circumspect. However, all the women reported relationship and self-esteem difficulties: specifically, problems with trusting others and feelings of being unwanted. These findings were gender-specific although tentative parallels can still be drawn. Smith et al. (2004), in a retrospective analysis of 48 children of AC immigrants, found potential disruptions

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to parent-child bonding and concurrent effects on children's self-esteem and behaviour using a range of previously validated measures. Lengthy separation made it hard for children to identify with the parent or conform to their expectations, leading to great difficulty around the period of reunion. Time did not ameliorate these relationships. An important finding for this review was the effect of gender: around the time of reunion, boys reported significantly higher levels of deviance, worse self-esteem and were less likely to conform. Serial migration and its consequences is also part of the conceptual model of etiology proposed for the higher incidence of schizophrenia in AC people (Bhugra et al., 1999).

However, it must be emphasised that for most families the problems of serial migration are short-lived and the advantages are many, as shown by Suarez-Orozco and Suarez-Orozco (2010): “While some immigrants will display acute symptoms that should be treated, others – perhaps most – feel only transient discomfort and adapt to their circumstances with relative ease” (p.333). Futh et al. (2008) also found a non-significant but notable protective effect on disorganised attachment from the extended AC family.

3 Discussion

3.1 Disorganised attachment is neither a necessary nor sufficient condition for any of the issues discussed above. The effects seem to

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work in interaction with "the myriad of endogenous and exogenous forces that shape, catalyze and produce patterns of thinking and social behaviour "(Rich, 2006, p.17). It has been noted, though, that the mental health problems reported by AC people in North America and England do tend to be those associated with separation and reunion. This holds true especially for men (Baptiste, Hardy & Lewis, 1997a). Themes picked out by a number of authors include, "issues of loyalty, identity development, discipline and authority, isolation, rejection and counter-rejection, estrangement, abandonment, disillusionment and bereavement," (Smith et al., 2004, p.110). This review has attempted to both explore some of these areas and delineate the mechanisms that might produce both the disorders, the concurrent antisocial behaviour and the engagement problems that make all these aspects worse. An explanation upheld by the findings that does encompass thinking and behaviour is the capacity to reflect and the complex sociocognitive processes that this implies. It is hypothesised that deficits in some or all of these skill areas can lead to a variety of distressing experiences for the person and for other people. Some of these symptoms may cluster into pathologies such as conduct disorder and/or psychosis: Hodgins, Tiihonen and Ross (2005) found that men diagnosed with schizophrenia were more likely to have been diagnosed with conduct disorder before age 15.

3.2 Reflective function unfurls through the earliest interactions with caregivers, allowing the containment of primitive emotions like rage

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and fear and their transformation into a symbolic form. A lack of parental mirroring impairs the ability to mentalise, or to represent psychological processes in the self and others. This dyadic malattunement is transactional (Guionnet et al., 2010). As the relationship continues, the external is equated with the internal in a state called "psychic equivalence" (Target & Fonagy, 1996). Regression to this mode "is an essential precondition for violence" (Fonagy, 2004, p.27) and may contribute to the aggression, hostility and issues with "discipline and authority" (Smith et al., 2004, p.110) seen from infancy in the child with a diagnosis of conduct disorder. The inability to distinguish thoughts from reality is also a marker of schizotypal thinking and psychotic states.

3.3 Lacunae in a person's psychic world will encourage the development of compensatory strategies to defend against unbearable anxiety. A disorganised infant may grow into an adult who experiences "isolation, rejection and counter-rejection, estrangement" (Smith et al., 2004, p.110) within relationships, seeing no perceived reward in intimacy. Guionnet et al. describe their conduct-disordered client as having "superficial, interchangeable relations with his peers. He displayed little empathy; he showed no interest in others; and could be harsh towards the more fragile and isolated inpatients. He showed absolutely no interest in romantic relationships," (2010, p.221; author's translation). Empathy and an "intentional stance" (Dennett, 1987) is not only vital in relationships; it also organises ongoing

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experience into a structured sense of self, the identity development highlighted by Smith et al.(2004). Disruptions in identity development make the psyche vulnerable to trauma and may result in a range of disorders.

3.4 Attachment theory holds powerful possibilities for clinical intervention. Indeed, there are currently several attachment-based programmes being trialled and evaluated (Keiley, 2002). A focus on relationships means (with optimism) that at least one part of the interaction is amenable to change. Yet theoretical knowledge is filtered through the economic, social and political realities of healthcare (Marrone, 1998). Insights get lost. Research that seems hard to operationalise, or likely to result in uncomfortable findings, does not get undertaken: "One of the striking issues to emerge for professionals was that there seemed to be a fear of talking about issues of race and culture in a safe and honest manner," (Keating et al., 2002, p.27). This poses considerable risk and ethics issues for healthcare services and institutions. Silence persists because of the fear of being labelled racist and the concept of collective responsibility rather than individual blame is lost. Stereotypes cannot therefore be challenged. AC staff and clinicians, especially in primary care, are clearly a "key resource in bridge building" (Keating et al., 2002, p.11). However, there is a lack of nuance in the idea that AC clinicians will automatically be "better" for AC clients; further research within an

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attachment perspective may well reveal unexpected complexities within such relationships.

3.5 Another issue that needs to be carefully considered is whether any sort of clinical relationship that might foster attachment bonds is actually possible within a tertiary service. Berry et al. (2007) point out that, "Although psychiatric staff have been conceptualised as attachment figures in the literature, as their role is to provide a safe haven in the face of stress and a secure base to promote psychological development, the extent to which all staff and patient relationships...meet these criteria is not clear." (p.470). The majority of research on the transactional alliance has been done in a psychotherapeutic context. Even in Arnold's (2006) study on loss and separation, half of the Caribbean-born women had received "counselling or psychotherapy". Yet it is known that people from a AC background are the least likely sector of the general population to receive a talking therapy (McLean et al., 2003). Marrone (1998), writing from an attachment perspective, posits that many forms of healthcare are about exclusion and social control, or containing the very worst behavioural manifestations of psychological disturbance. Holmes (2001) agrees that service provision often focuses on the short-term rather than the long-term. Goodwin et al. (2003) also point out that within the Assertive Outreach paradigm the attachment is not to an individual but to a team.

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4 Methodological Limitations and Future Research

4.1 Berry et al. (2007) emphasise the need for larger samples and prospective and longitudinal designs to determine the validity, reliability and predictive power of attachment status. Many authors note the need for more rigorous ways of measuring adult attachment in particular. Instruments such as the AAI have been validated in large-scale studies (van Ijzendoorn, 1995). The use of Kobak's (1989) Q-set and other developments aids interpretation further. However, there will always be question marks over the reliability of the coding and the constructs used to assess attachment style. Eagle (1997) challenges the AAI's operational conceptualisation of secure attachment as a coherent biographical narrative. When measuring outcomes of therapy, for instance, Eagle suggests that a subjective account of the client's relationship should perhaps be privileged.

4.2 One of the key methodological limitations is the fact that attachment insecurity as a predictor for psychopathology seems to work in interaction with a host of other factors. For example, a large scale review by DeKleyen and Speltz (2001) found that, in high-risk populations only, attachment insecurity increased the probability of antisocial behaviour as part of a constellation of other risks. This makes the precise effects and clinical implications even harder to delineate, although this review has shown that progress is being

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made. Aspects like reflective function, or the affective and cognitive parts of theory of mind, need to be disentangled (Pouza et al., 2008).

4.3 There are several mental illnesses and developmental disorders hypothesised to have some root in insecure attachment. However, current research necessarily deals in clear diagnoses. One major methodological problem mentioned earlier that has the potential to invalidate many previous findings was that of ethnic bias in diagnosis. Along with this goes concurrent concern around undiagnosed Personality Disorder and the consequent unmet needs. One of the of the most critical gaps in the research literature concerns the specific needs of Black and Minority Ethnic (BME) individuals suffering from co-morbid Personality Disorder and mental illness (Ndegwa, 2003; Bruce, in preparation).

5 Clinical Implications and Future Research

5.1 A clear future priority is to link attachment-based research to practice in an iterative cycle that might benefit hard-to-reach client populations.

“If clinicians could understand difficult interpersonal behaviours in terms of attachment styles that were functional in the context of past experiences with significant others, they would be less inclined

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towards negatively appraising such behaviours and consequently less inclined towards critical or hostile attitudes towards the patient."

(Berry et al, 2008, p. 1280).

5.2 Although this review has included studies that attempt to tease out the myriad mechanisms that result in transactional circles of fear as well as in disorders, what works for whom remains largely personal. Holmes (2001) notes that institutions are not, intrinsically, worse or more damaging places than the community. Therefore it is important to look carefully at the raw subjective quality of each individual's experience within the system. A qualitative approach that privileges the client's perspective about what is helpful and unhelpful would add rich data for quotidian clinical practice. Service user research provides a helpful model (Goodwin, Holmes, Newnes & Waltho, 1999). A qualitative approach might also highlight common familial experiences and their psychological effect upon caregivers, such as a history of painful separations and reunions due to serial migration (Smith et al., 2004).

6 Conclusion

Both conduct disorder and psychosis, as problems suffered by AC men, may have similar roots in disorganised attachment. This in itself is a possible corollary of serial migration and/or societal pressures

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that disrupt parental bonding. Disorganised attachment may result in an impairment of reflective functioning. Although the two disorders may have different etiological pathways they can, and often do, co-exist. The severity of symptoms may be mediated through the type of care that clients receive. If the client also belongs to a disadvantaged group such as the AC population, for whom mental health services are the source of, as well as the solution for, the fear, the original dyadic relationship is more likely to be replicated, producing a fearful/avoidant response. The resulting cycle of potential violence, coercion and repulsion may mean that future symptoms are partially iatrogenic. Further research and robust practical recommendations that might ameliorate this cycle are the responsibility of both society and of the healthcare system as a whole.

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Section B: Empirical Paper

Abstract

This study examined the relationships of African Caribbean men with severe mental illness and a history of conduct disorder, linking this to engagement with services. This was explored qualitatively using attachment theory and Lacanian discourse analysis within a psychosocial methodology. Four interviews were conducted and the texts were analysed. The findings echo the evidence base in showing that, according to this interpretation, all participants showed signs of disorganised attachment. All had had adverse encounters within mental health services although all could also cite discrete experiences which had been helpful and supportive. Each participant held different views about the interaction of ethnicity with care.

Introduction

This Introduction will first summarise the literature around this clinical subgroup. Next, the reader will be oriented to the epistemological landscape. Two explanatory models have been chosen for their relevance: attachment theory and Lacanian discourse analysis. These are combined with a psychosocial methodology (Frosh and Baraitser, 2008).

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Violence in the context of severe mental illness (SMI) is of paramount concern within services (Dean et al., 2007). A recent study (Bruce, in preparation) examined criminal convictions within acute inpatient settings in a group of self-identified white British, African and AC men. Bruce's findings indicated that significantly more AC men have both violent and non-violent convictions compared to the other two ethnicities. However, the difference in violent convictions became non-significant when a diagnosis of schizophrenia was controlled for. AC men, though, continued to be at significantly increased odds compared to African men of having both violent and non-violent convictions, even after controlling for numerous risk factors.

This study will concentrate on the experience of AC men within mental health services, in a specific urban context in the UK. The intention is not to contribute to the 'risk agenda' (Keating, 2007) but to consider individuals and attempt to explore how they wish to be treated. The purpose is to provide an in-depth, qualitative exploration of a niche group of individuals, set within the wider quantitative research carried out by Bruce.

The literature review in Section A explored AC men with SMI, previous conduct disorder and poor engagement with services. Disorganised attachment was found to be a potential interpersonal denominator for all three. This is a particular insecure style of relating developed in

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infancy, generally in response to frightened, and frightening, caregivers. Disorganised attachments have the greatest predictive power for pathology of all insecure infant categorisations (Dozier, Stovall & Albus, 1999). Etiological mechanisms could include a deficit in reflective function (the ability to represent psychological processes in the self and others) (Fonagy, Gergely, Jurist & Target, 2004). Such deficits are "an essential precondition for violence" (Fonagy, 2004, p.27).

In this way, disordered conduct is likely to be an expression, in part, of disorganised infant attachment, certainly within high-risk families and environments (Lyons-Ruth, 1996). Both positive and negative symptoms of psychosis in adulthood have also been explicitly linked to avoidant / disorganised attachments (Dozier & Lee, 1995; Tyrrell & Dozier, 1997). Further studies have suggested that there may be some historical and cultural basis for disorganised attachments within the AC community (Smith, Lalonde & Johnson, 2004; Arnold, 2006). Finally, this style of relating in adults also predicts poor engagement with mental health services (Schaffer, Vogel & Wei, 2006).

Attachment theory captures how interpersonal relationships get displaced onto larger social structures (Adshead, 2004). A social constructionist perspective adds to this, taking into account the systemic, unequal experience of black and minority ethnic communities in the UK, across all measures of economic and social

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well-being (White, 2002). The transactional nature of cultural constructions around ethnicity is encompassed in *Breaking the Circles of Fear* (Keating, McCulloch, Robertson & Francis, 2002), a socially embedded review of the relationship between mental health services and sectors of the AC community:

“It is clear that young black men end up with an extremely racialised profile of their mental health. Being seen as ‘big, black, bad, dangerous and mad’ can lead to conceptions that they are less deserving of treatment that would lead them to pathways of recovery. Therefore, the evidence shows that more punitive and restrictive forms of treatment are meted out to these groups” (Keating, 2007, p.7).

Within the AC community, these feelings were reciprocal. For some, “a real and potent fear exists that engagement with mental health services will lead to their death” (Keating, 2007, p. 3). Therefore internally-driven mechanisms such as disorganised attachment interact with toxic social constructions. A qualitative exploration of AC men with SMI and disordered conduct must acknowledge the transactional interplay between what is inside and what is outside. The choice of epistemological framework has to reflect this without dividing the two.

1. A Psychosocial Epistemology

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Accordingly, the aim of a psychosocial approach is “to conceptualize and research a subject that is psychosocial without falling into the familiar psychological / social dichotomy” (Frosh and Baraitser, 2008). Billig (1997, 2006) goes some way towards demolishing the difference between “inside” and “outside” by considering defence mechanisms as discursive activity. Theoretically, it is possible to observe repression 'live' within conversational interaction, in the form of courtesies or absences. Evaluating attachment status through the Adult Attachment Interview (AAI: George, Kaplan & Main, 1985) also “comes close to the unconscious process via the mistakes, Freudian slips and breaks in the text” (Lamott, Fremmer-Bombik & Pfafflin, 2004, p.87). However, neither Billig’s approach nor the AAI encompass the personal, interpersonal and the social simultaneously.

In order to do this, Frosh’s work develops and describes an integrated psychosocial (as opposed to psycho-social) approach, emphasising the need to resist narrative integration, or the imposition of themes from above:

“Of central concern is holding onto a reading of the text that articulates its incoherences without offering a logical account of subjectivity, expressing the fragmentary and unsettled quality of psychic life because of the interpenetrability of the social with the deeply personal” (Savile Young & Frosh, 2010, p.512).

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Incoherence, absences and “disintegration” (Frosh, 2007) are central to a Lacanian approach to language (Parker, 2005). According to Lacan, it is when we start to use speech that we realise how imperfect it is as a system of self-expression; we experience language as something outside of ourselves, imposed upon us. “The necessary otherness of language to the subject makes all ‘analysis’ an analysis of discourse” (Parker, 2005, p.172). Being born represents “the entrance of the individual into an order whose mass supports him and welcomes him in the form of language, and superimposes determination by the signifier onto determination by the signified” (Lacan, 2006, p.47).

The Lacanian view of the subject is therefore psychosocial. Structures created by society are imposed and then internalised to the extent that, developmentally, “the unconscious is the Other’s discourse” (Lacan, 2006, p.10). Lacan represents the metaphorical agency that introduces the individual to society and its structures with “Le nom-du-pere” (Name-of-the-Father). This concept captures all the symbolic and imaginary elements of ‘father’ as well as the reality of a father: and a mother.

Lacanian ontology, with its recognition of the fatherly “superimposition” of the rules of the masses onto the subject, is also eminently suited to encompassing cultural difference. Social constructions around ethnicity, fear and power, already referenced in

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the context of mental health services, are also unavoidable within the research process. The pressure of the interview situation is compounded by the interviewer's notional membership of hegemonic structures: in this case, the white British middle class. Moncayo pointed out that: "Lacan's critique of an ego-mastery ideal does, in fact, coincide with how Western values and cultural standards are scrutinised within the minority mental health literature."

Moncayo goes on, "instead of attempting to "adapt" the minority client to the frame, the frame should be adapted to match the cultural and linguistic styles within which the unconscious of the subject is ciphered" (2008, p.259).

Moncayo's view is in tune with Frosh's idea of "bottom-up" rather than "top-down" understanding. As will be seen, the participants in this study each had a unique way of expressing themselves that departed from convention; interpretation and analysis must work within their specific frame of reference. When the Name-of-the-Father is unavailable (or "foreclosed") it has an effect on how a person can use language and signifiers and cuts them off from "the field of common sense" (Zizek, 2008, p.88). This is argued to lead to psychosis and to the special way that language relates to psychoses.

SMI as traumatic dissociation and its expression through language are also linked to attachment theory. Liotti and Gumley (2006) explored the etiological pathway from disorganised attachment to

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psychosis, hypothesising that trauma translates into dissociation through the fragmentation of the self. 'Fragmented' has been posited as a separate insecure category within the AAI to encompass particularly incoherent accounts classified as U (Unresolved trauma) and CC (Cannot Classify) (Lamott, Fremmer-Bombik and Pfafflin, 2004). A CC classification has previously been associated with the infant 'disorganised' classification (Adshead, 2004). This study takes the position that psychosis in and of itself represents disordered attachment. The presence of SMI and the speech fragmentation of residual psychosis will therefore not be viewed as a confounder when analysing the accounts but as another aspect of the splintered lens.

Within a psychosocial model, then, this study aimed to explore the experiences of a subgroup of AC men. The guiding research questions were:

- How might the text illustrate each individual's subjective attachment experiences; and;
- How does this intersect with their therapeutic needs and their relationship to help (Berry, Barrowclough & Wearden, 2008)?

Method

This was an interview-based qualitative study of four men self-identified as AC. Each participant endorsed a history of childhood

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conduct disorder and had a diagnosis of SMI. The interviewer conducted four interviews in outpatient settings, mainly specialist community mental health teams. The interviewer in all cases was the researcher on the project. Data saturation was reached with a sample of four, which accorded with considerations of sample sizes from an IPA perspective (Smith, Flowers, & Larkin, 2009) and also from that of discourse analysis (Starks & Trinidad, 2007).

Savile Young and Frosh's (2010) paper was used as a model; other guidance on quality standards in wider qualitative research was also used. Psychosocial methods fulfilled Yardley's (2000) four quality assurance checks of transparency and coherence. The researcher's differential gender, ethnicity and professional role may have influenced participants' responses. This was carefully considered and is made explicit in some of the analyses below. The researcher's subjectivity with regards to interpretation is considered as part of a more detailed explanation of psychosocial methodology, below. The study was submitted to the Ethics Committee, North West London One and was passed.

The design of the study consisted of a single interview lasting from between thirty minutes to one hour. Each interview was in two parts: childhood and schooling; and involvement with authorities including mental health services. The interview schedule was developed collaboratively with a service user belonging to the same clinical

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subgroup as the participants. The interviewer used a free association narrative interview technique (Hollway and Jefferson, 2000), asking open-ended questions and prompting as little as possible. The aim was to allow participants to develop their own narratives around ideas raised by the interviewer. There was a psychoanalytic focus on intersubjectivity; as part of this, the researcher's subjectivity / countertransference was utilized as an interpretative tool (Savile Young and Frosh, 2010). Extensive process notes were made immediately after each interview recording the fine details of interactions and the interviewer's feelings about the participant, the relationship and the narrative created between them. Interviews were transcribed as soon as possible and non-verbal detail included in the transcription. This manner of recording subjective experience with immediacy was a way of promoting validity and adhering to the quality standards of qualitative research, "facilitating an accountable and transparent approach to the interviewer's contribution to the material" (Savile Young & Frosh, 2010, p. 517). In addition, subjective responses were used in another way to uphold standards. The recordings, process notes and detailed transcriptions were shared in supervision sessions to allow further reflection and "metabolisation" of experience. As advocated by Hollway (2008, p.13), another mind and another set of subjective responses to both the interviewer and the participants, "...provide a kind of triangulation and contribute to the analysis of the material."

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Each interview, then, was recorded, transcribed, anonymised and subjected to analysis as a single case study, following Saville Young and Frosh (2010). Although similarities existed and were brought out in the Discussion section, the aim was to avoid the imposition of cohesive overarching themes.

This method of analysis is conceptualised as “concentric reflexivity” (Saville Young & Frosh, p. 517). The text is the central “analytic unit” (p.518). The first step, or circle, was to identify themes or discourses that recurred within the text; in Lacanian terms, “master signifiers”. Such discourses were considered to open up or shut down certain subject positions. The next step was to retranscribe a core illustrative section of the text (Emerson & Frosh, 2009). This meant that attention was given to individual words, pauses and rhythms. The final part of the analysis integrated text and process notes to consider the implications of attachment theory and its sequelae. This part of the analysis is also concerned with the qualities of disorganisation, incoherence and absence so important in a Lacanian reading. “A Lacanian discourse analysis ...would be searching out the signifying elements that do not make sense and specifying the role these nonsensical elements play in organising and disrupting the flow of the text” (Parker, 2005, p.168).

Each case study therefore has three parts: a participant case summary; an analysis of the master signifier or core subject positions;

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and an exploration of attachment through disruption, absence and incoherence in the text. Line numbers from selected extracts are in brackets.

Results

Case Summary: 'Allen'

Allen is a young AC man in his late teens who has spent time in a young offenders' institution and has been in and out of tertiary care many times. He grew up alone with his mother after the early death of a younger sister whom he does not remember. He describes himself as “a miserable baby” and links this directly with his absent father.

Allen answered clearly during the shorter exchanges. However, when he began to tell a longer, more emotional story his narrative became fragmented and unintelligible.

Analysis

At the beginning of the interview, Allen says that his first memory is, “Coming OUT”, referring to his birth. In the core extract, Allen is then asked about his first contact with mental health services and after a pause he begins “tell you what they did” (3). “They” seem to be a shifting group of persecutors. “They” mock Allen’s masculinity, “calling me a pussy” “taking the piss () writing big graffiti everywhere” and he continues, “can’t take that all their laughter () right outside the door” (4-7). The mockery and the laughter are understood to be a deliberate affront: Allen’s construction of himself as “the WARRIOR”

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(8) appears to mean that he has to respond according to rules to avoid consequences: “I have to or people get killed” (10). He finishes this section of narrative with an emphatic statement, “if you let a (killer) know, you die every day” (11).

Allen retains absolute ownership of his short narrative by rebuffing the interviewer’s assumptions about what went on next. “How do you know?” he asks. He resists the attempt to co-create the narrative and the interviewer responds in a way that satisfies him by saying “you know best” (12-14). This is then underlined by the exchange that follows, “I never ask for help (*You never ask for help*) NEVER” (18).

A few lines later, Allen describes how during an interview with mental health services “they tried to stick put a name on me” (31). He rejects labelling by outside agencies in the same way as the name-calling and the graffiti on his front door. The interviewer’s attempts to ‘help’ Allen are again subverted: “(*Can you remember what, what you thought about that, what you thought about that person?*) Which person? (*The person that interviewed you*) What, like this?” (38,39). Allen creates barriers through using the interviewer’s own questioning technique and she is identified loosely with other authorities in the past.

Allen’s extreme masculine position as a lone warrior is picked up a few lines later again: “TRUST NO-ONE IN HOSPITAL MAN” (50).

Allen’s final comment on metal health services occurs later, “they

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think they can CONTROL a man they think they can CONTROL me they think I'm a big BABY or something" (96,97). BABY is the polar opposite of WARRIOR: completely dependent, trusting and controlled.

In the last part of the interview Allen takes up another, related masculine subject position, that of the "player". This is his only expressed alignment that could be described as 'relational' as players are defined through their power over women: Allen explains to the interviewer that "a player don't have no FEELING" (106) . Allen seems quick to answer here, maybe because the interviewer is directly according him the expert position. Allen has a girlfriend but he is clear about who is in control, "I'm not believing in trusting girls and all that I just do what I want to do" (104,105).

Attachment and language

The extremity and fragility of Allen's positioning becomes clear through a reading of the text focused on the absences implied by the master signifier or the "recurring metaphors and discourses" (Frosh, 2010, p.518). These can be divined through the clusters of language formed in the text around self-reliance, trusting no-one, being a warrior and being a player. What cannot therefore be talked about, the 'absences', are vulnerability, dependency and his own need for protection or connection. Allen admits only when pressed that he has "maybe friendships" with his support worker and care coordinator. In

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terms of stereotypical gender roles, Allen embraces extreme masculine positions while rejecting the feminine.

Allen's investment in these positions is repeatedly undermined by his own words as language "uses" him (Frosh, 2010, p.523). Boys at school "punch him in the nose"; girls are scheming behind his back; his mother is scared for him; others "take the piss"; he wants respect but does not get it. Allen does not in fact "just do what he wants to do": he is constrained by others' actions as they inform upon him and incarcerate him. Mental health services are part of the controlling "them" and Allen hates "coming to this place" (85) (the Community Mental Health Service).

Allen also does not differentiate between individuals: "*(If someone had had a Jamaican background or something like that, would that have made things better?)* No DIDN'T MATTER I didn't want to be in hospital. (75)"

Allen's relationship with his absent father is dismissed by him, although Name-of-the-Father concepts such as male authority ("they") saturate the text. Allen's relationship with his mother is complex and shifting. Earlier in the interview, Allen comments that she thinks she is "too perfect" for him; she is a "liberty-taker" who informs upon him and her deceit is echoed by that of women in general. Straight after his 'baby' speech, Allen begins talking about his mother in derogatory

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terms. “They” have “worked on her” to the extent that she might be an impostor, “her face and mine ain’t the same like there’s this fat bitch coming round trying to say she’s my mum and that I don’t listen” (100-102). From “coming OUT” at the beginning of the interview to here at the end, Allen’s struggle to distance and separate himself physically and mentally from his mother comes through the text. Allen’s account show “features of both enmeshed and dismissing states of mind” and is often “highly incoherent” as might be expected from disorganised (CC) attachment (Adshead, 2004, p.151).

Allen cannot be pinned down: this, again, is a feature of insecure narratives which tend “to leave the listener baffled and frustrated about who the speaker really is” (Adshead, 2004, p.151). Yet within the text, the allure and control Allen imputes to himself are not illusory. Allen foils attempts at imposing meaning on his narrative and he repeatedly eludes the “diagnostic gaze” (May, 2006). At times, Allen is clearly aware that the positions he is taking are unrealistic, that his self-creation is a performance. Statements like “a player don’t have no FEELING” are said with a half-smile. Perhaps Allen is also performing as an AC man, both meeting and subverting the interviewer’s perceived expectations.

Case Summary: 'Benjamin'

Benjamin is an AC man in his mid-fifties. He had been alternately abandoned by his mother and then by his father, raised haphazardly

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between the two of them with periods with friends or relatives. He had experienced extreme poverty. His father was now living abroad; his mother, who had been diagnosed with paranoid schizophrenia when Benjamin was a teenager, had recently died. Benjamin's story strands were clear but he mixed up his tenses and temporal references, most notably regarding his mother. He also used strange grammatical constructions, frequently mistaking the case of a word, and odd usages of everyday terms.

Analysis

Benjamin's main subject position is that of carer and nurturer. "YES I ALWAYS DO, I ALWAYS SEEM TO HELP PEOPLE! That's my NATURE!" (2,3) Throughout the text he is preoccupied with having a family and with looking after others: he opens the extract by talking about his role as carer to his mother, "And that was part of the reason I was ill in the first place, because I looked after her for 27 years."

Benjamin was "...practically looking after my mum's flat, paying the bills, doing the shopping, carrying her around places". "Carrying her around" implies a burden and this is an aspect of Benjamin's position as carer; he is somehow forced into giving the help to his family ("...they wouldn't let me SLEEP, they never (.) they took ALL MY MONEY, because they said to me that I had got LOTS of it"). The help is never enough, remaining fundamentally unsatisfactory to the recipient: "It's the same thing with my girlfriend, now [*with your girlfriend, now*] yeah I'm looking after her but she expects MORE from

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me”. Care is enforced or compromised, resulting in abandonment and loss. The deep ambivalence involved in such transactions is manifested in the text, when Benjamin speaks of his longest relationship to date:

“I used to feed her habit, **she didn’t used to love me**, that’s the only reason why [*you were caring for her*] well I used to feed her habit, she used to drink and smoke, I mean SMOKE, and she used to drink whisky and wine and [*so she had addiction problems*] cider drinks, yeah she had her problems, but I used to feed her habit, **and she used to be in love with me as well.**” (62-67, author's bold).

Attachment and language

The discourse thickens up around the master signifiers of nurture, having children and feeding. Hypothetically repressed material is covered up, in the form of contradiction and justifications. Benjamin's construction of his relationships with both his mother and his father were painful to listen to because of this gap between reality and construction; again, language “uses” him. Perhaps the lack of love and basic care that Benjamin experienced as a child is too unbearable to talk, or think, about. Despite the fact that his mother abandoned him shortly after birth and never reclaimed him, when asked about her Benjamin replies, “She used to treat me good!” He positions her as a caring person: “my mother was like that, she used to help people socially, from friends, relatives, people that she meets, she just helps

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people.” (77-79) (Note the present tense). There appears to be some confusion / enmeshment between Benjamin and his mother that recurs: “I tried to intervene while they came to my mum’s flat to take her away, and they took me away, that’s why I got involved, because there was nothing wrong with me at that time, I got involved in the mental health, **instead of taking me away (..) taking her away** (..)they took ME away, and drugged ME up, that’s how I got into the mental HEALTH”. (Author's bold).

Similarly, the interviewer asks, “How was your dad, as a parent?” and Benjamin contradicts himself within his reply:

“He was a GOOD PARENT he used to LOOK AFTER me, yeah he LOOK AFTER me, he used to TAKE CARE of me, he used to make sure NOTHING HAPPENS to me but as I said I never used to have my MEALS on recall, on a regular basis where I could function and do well at school or (..) function to be a normal person (..).”

In the same way, his father's abandonment when Benjamin was ten years old is viewed as a rational decision, taken in Benjamin's best interests. In this construction of events, Benjamin was not ignored by his all-knowing father but was, in contrast, the absolute focus of his attention: “I would NOT COPE, how he studied me, from raising me from small, at a small age. But he would have TOOK me, if he had known I would have COPEd out there.”

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The classification Unresolved-traumatised (U) from the AAI resonates:

“...the text becomes broken and incoherent at those points in the interview when a concrete trauma such as separation, maltreatment or abuse is talked about. Here spatial and temporal disorientation often occur. The topic is usually unresolved sorrow to do with the loss of an object in childhood,”

(Lammott, Fremmer-Bombik & Pfafflin, pp. 89-90).

Other insecure classifications can be identified throughout the text. Benjamin's carer subject position, analogous to an avoidant stance sometimes characterised as ‘compulsive caregiving’ (Adshead, 1998), appears to make it difficult for him to accept help. He is asked about this and describes himself as a model patient: “I'm very SOCIAL, that's why they DISCHARGE me [*so quickly*] I RESPOND to treatment, I'm very SOCIAL, and in no time they DISCHARGE me” (7-9).

When Benjamin does become ill it is due to a lapse in care by the parental system: “I've relapsed, I've come off the medication myself, instead of being weaned off with the doctors”. Benjamin makes frequent use of the word “weaning” throughout the text. Yet medication is not nutrition but poison: at one point he uses the word “ANTIDOTE” (130) when describing a story about an injection that put him in a coma. Benjamin perceives that medication makes him sterile, which would fundamentally undermine his nurturing subject position:

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“the medication er affects my immune system sexually I CAN'T HAVE children.”

At the end of the interview, Benjamin talks about an incident he remembers from hospital that made a difference: “Oh just an ordinary circumstance where I was crying because I wanted to kill myself, when I was admitted in hospital in [PLACE], I wanted to knife myself, half to death, because I didn't think I was worth living for, and a foreign person had to talk me out of it, who was working in hospital, I think the lady that used to make teas and coffees, and give cakes and sandwiches (*so she wasn't a-*) she talked me out of it, she told me to come to the table, come and have something to eat and drink, and your life is more valuable than that! Just that simple action (..) of circumstance (..) is why I had my always (..) remembrance.” (183-192)

The interviewer asks Benjamin more about his positive experience on the ward, attempting to pinpoint aspects of the alliance that appealed to him. “(*so there's something about warm and normal [warm] so instead of being professional, somebody going, oh come and have a cup of tea?*) Well, cos it was the circumstance, and I was talked out of not stabbing myself, and I was also talked into a snack, I remember that circumstance well. Cos I could have stabbed myself cos they were practically ignoring me cos in those days there was limited staff, and nurses were too busy attending patients who were in trouble, and I had trouble (..) so [*this is a problem isn't it*] she actually talked me out

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of stabbing myself or killing myself and she made me feel good and I had wanted (..) somebody (..) to help someone to help me out (*somebody cared*) cared, yeah.” (193-203)

Notably, Benjamin gets help and support from “foreign people”, “black people” and non-professionals, such as the tea lady while psychiatrists and psychologists were conflated, all medicating him “because that's how they get paid”. Benjamin also comments on a lack of consistency in the ‘friendliness’ shown by mental health professionals and their tendency to dismiss his concerns as pathology: “they like conversing with me, they find that I’m a very, I’m a laugh to converse with, social, but when it comes to the facts they tend to refer away from it. When I start raising issues or referring to facts, they say its part of my illness.” (137-140)

Case Summary: 'James'

James is an AC man in his early forties. He is the youngest of eight children, has two children of his own and is now part of a close-knit extended family. His mother migrated to this country just before he was born; his father followed. His father is now dead although his mother is still alive. His narrative is coherent but repetitive. James would often echo a phrase several times in different configurations: this increased when he was relaying traumatic experiences.

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Analysis

In the beginning, James talks about growing up as the youngest in a large family; his time at school where he "got on average" and was "quite popular"; and his flair for electronics and subsequent job in the industry. The interviewer then asks James about his experiences with the mental health system and James' subject position of 'little brother', a "sheep" or a "copy" of his siblings explodes into a discourse around sex and violence.

James had been made redundant at this time and was dealing in pirated videotapes, "And I sold to my neighbour downstairs (.) and then (.) when I went into his flat (..) he KISSED me on the cheek and touched my bum then I retaliated by petrol-bombing his flat and the next thing they put me under the mental health and (.) that's it" (15-18). The narrative is straightforward, told without affect or emphasis apart from the KISSED. This is made clear again later on: "(*so there was this one incident*) one incident where I petrol-bombed the guy's house **because he kissed me**" (22,23) (Author's bold). James' position reflects an underlying code within which arson and perhaps murder is a just punishment for homosexual advances under talion law. The neighbour's threat to James' 'masculinity' is equivalent to annihilation (Fonagy, 2004).

There follow lines where James wrestles with what is self-evident to him versus, perhaps, the possible opinions of the interviewer: "... I

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DONT LIKE I don't like gays I don't MIND I DON'T MIND 'EM but as long as they not come near me" (24,25). James is anxious to point out that his homophobic ideas are not idiosyncratic but acceptable within his family culture: "Like that's what we believe in that's how we were all brought up so we're not really INTO gays there's no gays in our family you know what I mean (*so there was quite a strong feeling when you were growing up*) towards GAYS (*that yeah OK your mum and your dad taught you*) yeah that you SHOULDNT be gay." (30-32)

James' narrative is most dense and incoherent around an experience of violence in hospital. He returns to it again and again. This is unsurprising as, given the trigger for his offence, it represents his worst fears:

"The NEEDLE the needle [*you didn't like needles*] I was frightened of it I didn't like needles [*and so they*] I prefer tablets and they said they not going to give me tablets I had to have the injection (*so that's a shame they didn't listen to you*) they didn't listen to me no they didn't listen to me they just came into the room TEN OF THEM came into the room GRAB my arms GRAB my legs put me on the floor FACE DOWN pulled down my trousers I can remember them pulling down my trousers then (..) I can remember the injection and I felt a SHARP PAIN in my BOTTOM and then that was it." (94-98)

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Finally, James recalls the distress of lying vulnerable and immobile: "I was CONSCIOUS BUT I COULDN'T MOVE! For TWO DAYS!" (79,80) To this violation is added the trauma of being recalled to hospital three times by force: "The police came to my house em (..) they broke in the door with-you know that red thing they use [*yeah*] the RAMMER they broke in the door with that came in with RIOT gear RIOT POLICE came in you know the helmet and the shield" (127-129).

Attachment and language:

The confusion and emotion around homosexuality in James' narrative may signal the extreme fragility of his masculine identity (Frosh, Phoenix and Pattman, 2002). James seems to still be in an 'adolescent' state, in conflicted and unable to separate from his wider family. Memories of his parents are ambivalent, though. Recalling his time alone with his mother earlier in the interview, James states, "Well she was always (.) she was always on the telephone(.) and she as always writing. To my dad. Do you know what I mean? To communicate. And(..). Um(..) It was LONELY to tell you the truth, cos it was just me and (..) it was just me.". The last part is poignant: James was perhaps going to include his mother, but after a pause he does not. When asked to describe her, James says "VERY STRICT. Very strict [*strict*] very strict," and remembers, "She used to hit me. With a slipper."

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When asked about his parents' relationship, James replies, "Well my dad used to drink a lot. Yes that means he used to drink a lot. He used to come in drunk. More than drunk. And that er (..) that caused arguments with my mum [] (*so were there quite a lot of rows*) there was a lot of rows when I was younger."

James' account has complexity: the split between the "sheep" and the violent, vengeful warrior; his fearful, rigid construction of his masculinity. As well as a dread of punitive men who are bigger and stronger (and the disturbing detail of "that red thing they use...the RAMMER") intimacy in the form of kissing is also a horror. The text does give "the impression of being incoherent, chaotic" (Lamott, Fremmer-Bombik & Pfafflin, p.102) with "inconsistent experiences". James' account becomes breathless (literally, this is the experience he is describing) and overwhelmed / overwhelming when he answers the interviewer's final question about changes to the system:

"SOME OF THE STAFF ARE VIOLENT the way they hold me in a HEADLOCK on the ward you understand what I mean they're holding you in a HEADLOCK they're holding you in a HEADLOCK some of the staff are VIOLENT some of the staff are HEAVY-HANDED you know what I mean like they WRESTLE you (..) you see what I mean the MALE staff cos you have some male staff that are (..) QUITE BIG you understand what I mean QUITE BIG and they're MUSCULAR and they do WEIGHT TRAINING and when they have a hold of you you CAN'T

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BREATHE (*that's frightening*) they're FRIGHTENING yeah what it is some of the staff are big and when they have HOLD of you you CANT BREATHE cos they get you in a HEADLOCK that is you cannot move your HEAD you see what I mean once they get you in a headlock once they had me in a headlock and it nearly broke my NECK my neck was BRUISED I couldn't turn my neck when I turned my neck to the left or to the right I used to feel PAIN after they finished with me understand what I mean?" (249-260)

For James, all these aspects combine to create the perception of a Kafkaesque experience where patients have no voice or system of redress.

“(if that happens to you what do you do about it?) (..) to court try and bring it to COURT (*could you do that?*) Well (..) it'd be HARD cos a mental health patient bringing staff to court well who's the court going to listen to? (*do you feel they wouldn't-*) the court wouldn't LISTEN to me the court wouldn't listen to me the court WOULDN'T LISTEN to a mental health patient they'd rather listen to the STAFF than a mental health patient because when you're a mental health patient you're a kind of (..) ILL you understand what I mean and you're not in the right frame of mind and that means right if I was to go into court I wouldn't win the court case you understand what I mean [*hmm*] so that's a DOWNER (..) you can't bring em to court and you can't HIT em so

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there's nothing you can do about it see what I mean you has to just
LET IT GO.” (249-260)

In contrast to this, however, James is also able to explain what makes staff in hospital likeable rather than fearsome:

“It's respect RESPECT it's how they talk to you how they talk to you the way they talk to you the way they talk to you MATTERS if they SHOUT at you or talk to you crossly then you're not going to get on with them you understand what I mean it depends how they talk to you of they've got time for you some staff ain't got TIME for you understand what I mean like they're always BUSY understand what I mean can I have a cup of tea no I'm BUSY ask someone else I don't like that attitude you know what I mean [*yeah*] you understand what I'm saying?” (194-201)

Case Summary: 'Edward'

Edward is an AC man in his sixties who was raised in Jamaica until he was sixteen, when he came to the UK with his father. He is the fifth child in a family of fourteen children; the rest are half-siblings with different fathers. His mother remained in Jamaica and his father has now been dead for twenty years. Edward was married in the year his father died; he then divorced seven years later. Edward's speech is difficult to understand. He uses poetic neologisms that resonate with

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the perserverative ideas that he holds ("clairvushionists", "upliftment", "overstanding").

Analysis

The Name-of-the-Father suffuses Edward's account. He begins, in answer to a question about his first memory, "I was all the child of my father" (1) to emphasise his uniqueness in that family and he takes it up later, "...cos I was only child of my father but my mother have other children and my stepfather should have been love me cos I was skillful in culture () so I was the end of my family and kind of got the name (..) my father was independent and very intelligent () it was like in society (so he was your mentor?) yeah" (45-49).

Edward's father, like Benjamin's, is not allowed to be less than perfect: "...my father was my GUIDANCE work method took steps to teach a person (so your father was the person who disciplined you?) yeah yeah (was he strict?) No he never beat me" (39-41). Later in the excerpt the boundaries between the real and the symbolic father begin to blur. Edward talks about the difference between religions in their conception of god: "ONLY I have a relationship with their their FATHER but my father was INDEPENDENT, you understand me," (77,78).

The dual subject positioning now becomes more extreme as chosen one / outcast: it is messianic, and indeed Edward makes this explicit

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later in his account, "(.) so the Christian on the ward manage me as JESUS because of the relationship with me and the Christian society uplift- overstanding with Bible security and by KNOWLEDGE come my overstanding it was part of a vast overstanding" (96-98).

Attachment and language

In Edward's case, the signifiers are clustered into the messiah position. Various negative aspects (being outcast, being lonely, being betrayed, being misunderstood) are set against overriding positive qualities (being special, being watched over). To 'believe' in his mental illness Edward might have to relinquish the positive aspects of his positioning. "No I have no mental sickness [*you've got no mental sickness*] yeah" (119,120).

The defensive quality of the positive aspects of Edward's positioning becomes clear when tertiary care threatens to dismantle them. When Edward was asked about his experiences with mental health services, the narrative was almost incomprehensible. Edward may have trouble accepting help because his beliefs about himself mesh with his insecure attachment style. Although mostly showing unclassifiable features and the confusion symptomatic of unresolved trauma, there is also a detached, dismissive quality that can be detected. The language Edward uses to describe his parents does not give a sense of reality: his mother is his "soulmate" and his father is his "guidance"

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(38, 40). This, as well as his sketchy yet beatific account of his early years (25-29), are familiar from "dismissive" dimensions of the AAI.

This account is ostensibly the most disordered yet Edward also has some interesting things to say. In this last quote, he emphasises the social and interpersonal causes of mental illness and the way they are situated within cultures:

*“(OK if you were in hospital and you had Caribbean staff is that better?) better upliftment yeah and they understand [*they understand*] what is MADNESS yeah (*they have the same conception of madness mental illness as you*) well basically in the Caribbean like in Jamaica we understand that a FIGHT between some people [working] will become a FEAR [] and bring on mental illness [] we give them consoling and show them how themselves to purify themselves and clean theirself and their mind away from what they're THINKING the medication would ruin their mind because they would not be ABLE to cleanse themselves against the fear so we don't give them medication we give them CONSOLING (.) (*consoling*) yes yes yes” (154-163).*

Discussion

Although the accounts are treated as single case studies, this

Discussion will draw together salient points. Cohesive overall themes are not the tools of psychosocial analysis; but the use of attachment theory means that aspects of the accounts will mesh. This is relevant

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to the research questions: how the text illustrates each individual's subjective attachment experiences, and how these experiences might intersect with their therapeutic needs. These questions have been answered in the analysis and are further discussed here with specific reference to the therapeutic alliance.

First, then, the defensive function of violent behaviour arising from attachment experiences will be explored. Next, this Discussion will consider the importance of fostering secure attachments; and the attendant dangers of replicating the original traumatic bonds.

Therapeutic alliance and the problem of violence

Frightening (or frightened) inconsistent caregiving is hypothesised to be the common denominator for all these men, according to the interpretations. Mother and father are either absent, or laying down the law using physically punitive means. These characteristics intersect with Lacan's ideas about 'real' parents: "the ravaging effects of the paternal figure are to be observed with particular frequency in cases where the father really has the function of a legislator...with too many opportunities of being in a position of undeserving, inadequacy, even of fraud, and, in short, of excluding the Name-of-the-Father from its position in the signifier" (Lacan, *Ecrits* p. 218-9). This exclusion, in Lacanian terms, is the root of psychoses, which resonates with the myriad vulnerabilities, including SMI, that are a potential result of

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disorganised attachment. These vulnerabilities are defended against in a variety of ways and violence is intrinsic to these defences.

According to some interpretations of participants' accounts, violence appears to happen for several interlinked reasons. Firstly, relationships with services infantilise the men: “they think they can CONTROL me they think I’m a big BABY or something” (Allen). This central motif is a feature of all the accounts. Being coerced back into a childlike state engenders primal feelings of fear and lack of safety (Fonagy et al., 2004).

Indeed, all the men describe a strong interest in personal security that could be characterised as paranoid. Again, it is hard to see a clear demarcation between delusion and actual danger. These men *are* at risk, perhaps because of their AC identity; because of the dangerous areas in which they live; because they are made vulnerable by mental illness; and because they have poor reflective function and tend to react unthinkingly to their own projections. Glasser (1998) describes a primal type of violence known as 'self-preservative'. This is “aroused by anything that constitutes a threat to the psychological or physical self” (p.889). For those with poor reflective function the threshold for this will be low and will include the threat of abandonment and loss as well as perceived threats to identity and to control. Benjamin and James both describe a particular experience with a 'chemical straitjacket' when they were conscious but paralysed. This has a

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nightmarish quality in its evocation of infant helplessness. Negative experiences with medication overshadow the accounts: not only does it affect body and mind in unpalatable ways, but all three older men have experienced coercive treatment as a direct result of non-compliance.

For those with disorganised attachment patterns, force and intrusion in the service of care are going to provoke extremes of fear and therefore incidents of self-preservative violence. "Projections of anger and fear by patients are likely to resonate with the caregiver's own unconscious aggression. Caregivers may feel overwhelmed with feelings of fear and aggression, which are experienced as both alien and real," (Adshead, 1998, p.67). This will lead inevitably towards perceptions of lower anticipated benefits, higher anticipated risks and less positive attitudes towards seeking help on the part of service users (Schaffer et al., 2006). The cycle will then continue with the possibility of worsening symptomatology through iatrogenic retraumatisation; and help avoidance as a result of these experiences.

Therapeutic alliance and the problem of reparenting

The disordered/disorganised attachment to the archetypal parent is crystallised into the internal working models of 'care' provided by successive legislators. Relationships are essential yet again there is a painful dialectic: therapeutic services need to 'reparent' (del Casale, Munilla, Rovera de del Casale & Fullone, 1982) to provide the care

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that was lacking in infancy and childhood for these men; yet anything perceived as strongly 'parental' is understandably abhorrent to them. They therefore react negatively to this, feeding into "a self-perpetuating pattern, whereby avoidant individuals reject help, which reinforces the negative perceptions of others." (Berry, Barrowclough & Wearden., 2008, p.1281). They reject, and are rejected in their turn.

Positive experiences with inpatient services were characterised by interpersonal connections where a staff member took time, listened warmly and offered something concrete and helpful. Benjamin commented, "...she made me feel good and I had wanted (..) somebody (..) to help someone to help me out (*somebody cared*) cared, yeah." James also emphasizes the feeling of respect and regard: "...it's how they talk to you how they talk to you the way they talk to you the way they talk to you MATTERS."

In community relationships outside hospital, consistency and respectful friendliness were valued. The stigma and systems around managing SMI in the longer-term is infantilising in a more subtle, insidious way than tertiary care. The men are dependent and they cannot work. Services are compulsory like school but with more frightening consequences for non-attendance. Allen grudgingly admits that he had "maybe friendships" with his support worker and care coordinator but felt viscerally disrespected because of "coming to this place" (85). Many professionals are aware of this. The researcher was

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in general able to observe the warmth and respect between care coordinators / key workers / support workers and participants. In the more relational accounts of Benjamin and James, 'horizontal' relationships like this are seen to be more satisfying than 'vertical' ones. Clearly there will be transference issues and these relationships cannot be ideally equal and adult but there is at least the sense of reciprocity. Consistency is essential too: if someone is going to act in a friendly, 'horizontal' way, they need to carry it through. Benjamin identified that this is not always the case, when he comments on how swiftly professionals resort to treating him as a psychiatric patient when he asks difficult questions.

Yet it can be extremely difficult for mental health professionals to relate in a consistent way because of the interpersonal states, the counter transference, evoked by the clients themselves. All the men interviewed showed a certain childlike, 'odd' presentation. This impression was conveyed in two ways: a 'naive' quality to the manners and speech, with excited emphasis and mumbling incoherence; and the language used, including unusual phrasing, repetitions and frequent neologisms. This could also be an unconscious way of making the self appear harmless, thereby negating the 'big, black, bad, dangerous and mad' stereotype identified by Keating (2007, p.7).

The researcher found herself frequently wishing to inhabit a 'parental' role with participants. Although this is of course an individual

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response there may be some commonality in this reaction, particularly given the valencies of people who enter helping professions. It therefore seems important that staff maintain adult boundaries even in the face of powerful unconscious desires by clients to be treated as a child (Adshead, 1998). The therapeutic drive to reparent may be valid; but great care must be taken as this sort of relationship can easily become anathema to these men.

Conclusion

According to the literature, there was a possibility that disorganized attachment was an underlying feature for a clinical subgroup of AC men with SMI and conduct disorder. The texts of all interviews did demonstrate some evidence of disorganized attachment and its emotional and behavioural sequelae, within the parameters of a psychosocial discourse analysis. These emotional and behavioural difficulties also appeared to intersect with the participants' subjective experience of services and professionals. All of the men had, on occasion, experienced tertiary mental health care and its providers as intrusive and coercive; these experiences appeared to have had powerful and persistent effects. Further research could help illuminate the links between disorganized attachment and negative experiences of mental health care.

Yet on a more practical clinical level, participants were also able to express what had worked for them within a therapeutic alliance and

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what they appreciated about their encounters with mental health services. These features (time, warmth, respect, clarity and consistency) are widely accepted but perhaps difficult to adhere to in high-stress clinical environments. Relationships that strive to be equal and avoid authoritarian overtones were seen as helpful by all the men.

Finally, participants' subjective views on the intersection of care with race were diverse, although Benjamin, for one, feels that things are getting better: “They UNDERSTAND me now, they never understood me before, especially with like black people [*yeah*] they thought they were difficult cases with them [...] but they understand black people now”(110-115).

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Section C: Critical Appraisal

1. What research skills have you learned and what research abilities have you developed from undertaking this project and what do you think you need to learn further?

Initially, I explored a number of qualitative methodologies, searching for one that would range from the interpersonal to the systemic and would also allow me to bring pre-existing theory on relationships into data analysis. Attachment theory provided a useful way to address the relational basis of severe mental illness and violence through the concept of reflective function; it was also able to describe the 'ripple effect', the way that earliest dyadic relationships become superimposed on relationships with authorities and systems.

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Ethically, a sociocultural approach that privileged the participants' individual frames of reference as well as relational intersubjectivity was also important, because of the potential imbalance of power between researcher and participants. Lacanian discourse analysis was able to capture this; it was also able to capture the qualities of fragmentation and incoherence that characterise residual psychosis and are thought to characterise disorganised attachment. These two explanatory models overlapped in many ways, most notably in the idea that such inconsistencies in speech can be read out as the repression of traumatic material.

After carrying out extensive reading (e.g. Frosh, Phoenix & Pattman, 2002; Frosh, 2007; Hollway 2008; Saville Young & Frosh 2010) I concluded that psychosocial methods fulfilled Yardley's (2000) four quality assurance checks of transparency and coherence. In a theoretical and practical seminar on psychosocial research, I discussed my proposal with the facilitator who agreed that there was a fit between theory and method and that my analysis was viable (Hoggett, personal communication, 2011).

Although the preparatory reading was clear on ontology, epistemology, methodology and ethics, researchers had either carried out long-term, large-scale studies (Frosh, Phoenix & Pattman, 2002); or used single case studies to illustrate the practicalities (Saville Young & Frosh, 2010). There was little guidance on participant numbers. This

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information was therefore sought elsewhere in the qualitative methodological literature.

There are a number of parallels between psychosocial research and Interpretative Phenomenological Analysis (IPA). Both methodologies consider that 'sense making' is created with the research-participant relationship. IPA is influenced by a symbolic interactionist position (Smith, 1996) and psychosocial methods uphold the importance of the interviewer's counter transference. Depth of analysis is also privileged over number of cases. Both IPA and psychosocial research also advocate the value of a single case design approach. A sample size of between four and ten participants is thought to be suitable for a doctoral piece of research within IPA (Smith, Flowers, & Larkin, 2009). Similarly, within discourse analysis a valid sample "might be based on an in-depth analysis of just a few illuminating text excerpts" (Yardley, 2008, p.236). This informed the decision to interview four participants for this study. Four transcripts provided all the information required for a comprehensive analysis (Yardley, 2000). From a psychosocial perspective, a saturation point was reached with the data. Steps to ensure transparency, validity and other quality standards were also taken. These included a careful consideration of the interviewer's positioning and subjectivity (Savile Young & Frosh, 2010) and data triangulation (Hollway, 2008).

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A valuable ethical and philosophical learning experience was around conceptions of race within research. The field is fast-moving and there are now acceptable and less acceptable terminologies within different paradigms (Agyemang, Bhopal & Bruijnzeels, 2005). This taught me the difference between what is political and what is properly descriptive and when it is appropriate to use certain words and phrases. The process raised my awareness of issues such as diagnostic racial bias; the different social constructions of mental illness; and perceptions about mental health services and clinicians that prevail in various communities.

A notable practical skill was managing the progress of the application through agencies such as National Health Service Research Ethics Committees (REC) and Trust Research and Development boards. Initially, the REC forms demanded time, effort and exactitude. Discussions with members of both committees also meant that I had engaged critically with the project and was prepared to justify my theory and methods.

Practically, recruiting participants and arranging interviews took time, patience and persistence. I developed the ability to communicate a summary of my research, tailoring my approach to the intended audience and privileging the information that would be most pertinent. When presenting the research within a specialist service in an urban multicultural area, I was able to assume a certain amount of

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knowledge about the background to the study and conceptions of how race affected health care. For others, I would provide a more comprehensive rationale. Finally, developing theoretical and practical confidence with the help of supervision was useful in overcoming resistance and apathy in gathering the data required.

2. If you were able to do this project again, what would you do differently and why?

An interesting theoretical learning point was the realisation of the complexities of undertaking research within an attachment paradigm. The literature has highlighted some of the problems surrounding empirical measurement: Eagle (1997) challenges the AAI's operational conceptualisation of secure attachment as a coherent biographical narrative. When measuring outcomes of therapy, for instance, Eagle suggests that a subjective account of the client's relationship should be privileged. In retrospect I could have made a strong case for undertaking training within the Adult Attachment Interview model so I could explore and discuss its validity and appropriateness from a position of expertise.

Another ethical point to remember for future research is that sometimes the human element gets lost in the welter of documentation and administrative demands. Permission to collect data can seem like the endpoint of the process when it is only the

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beginning. I had considered in depth the effect of the questions on my participants and how best to avoid distress and contain any feelings afterwards. I should perhaps have given more consideration to the feelings evoked in me. I concluded in Section B that it was hard for professionals to remain consistent and manage the counter transference in challenging cases. Attachment disorder by nature often involves rapid and powerful interpersonal projections. All the participants were distressing to listen to in different ways and I found myself pulled into a 'parental' role which as a researcher I had to resist. Supervision and personal therapy helped me to do this; as did writing process notes. Looking back, I would have arranged debriefings or supervisor meetings more frequently during the data-gathering process, not only to contain these feelings but also to explore them contemporaneously in the context of the research methodology.

3. *Clinically, as a consequence of doing this study, would you do anything differently and why?*

Clinically, the primary point of difference would be the awareness that services themselves may have traumatised the person; and what this might mean in the context of assessment, formulation and intervention. For instance, all participants perceived medication as negative: discussing this openly, extrapolating the meaning of medication and exploring alternative strategies (not using needles, for

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instance) might be necessary. As a consequence, it would be clinically advisable to explore clients' experience with services and their relationship to help far more thoroughly (Berry, Barrowclough & Wearden, 2008). This would include the meaning of receiving therapy within the context of their past life and their particular social and cultural milieu.

Some of the coercive experiences suffered by the participants in this study inevitably affected the way they conceptualised representatives of services. Clinicians should perhaps be aware of this residual anger and fear, however supportive they feel themselves to be. In this way, I will personally be more aware of uncomfortable transferences. At least once, when transcribing, I detected a latent ambivalence or aggression that had gone unnoticed in the room. This has implications not only for the therapeutic alliance and possible resistance to therapy, but also for risk to the practitioner.

The Discussion and Conclusion considered in detail what each participant had found helpful and therapeutic in relationships with professionals. The key points about what to avoid (authoritarian, parental overtones) and what to embrace (consistency, equality and concrete help) are a clear clinical recommendation in improving engagement with services both in continuing care and in crisis.

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The issue of race and in particular the interaction with diagnosis should also affect practice. Professionals are not immune to the power of social constructions and it is necessary to actively suspend preconceptions before meeting people for the first time. The most obvious example is in the case of African Caribbean people and the diagnosis of schizophrenia versus the diagnosis of Personality Disorder. An awareness of diagnostic ambiguity will lead me to consider much more carefully the diagnostic 'fit' and the attendant assumptions: prognosis, recovery, medication and self-concept.

From an attachment perspective, more consideration should also be given to issues of separation and reunion. The interviews demonstrated for me that such issues can potentially continue to affect people throughout the lifespan. In assessing clients and families who had undergone migration experiences, more attention should be given to the impact of meeting and separating, the subjective meaning contained in those events for the clients and how relationships changed in the aftermath.

4. If you were to undertake further research in this area what would that research project seek to answer and how would you go about doing it?

There are several ways in which attachment and engagement with services in this particular population of African Caribbean men could

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be explored further. An interesting option would be to interview mental health professionals and trace the development of the relationship to see whether the social constructions characterised by Keating, Robertson, McCulloch and Francis (2002) also existed on the service side; and whether or not they were amenable to change through greater knowledge of the individual. There was also the issue of the background and origins of mental health staff, important in different ways to all four participants. Concentrating just on this one theme, a larger-scale study could look at the effects these have on care for both patients and staff. Further research like this within an attachment paradigm would be most valuable in exploring the interaction that takes place; that is what most of the theoretical literature is predicated upon, yet it is difficult to operationalise. Part of the problem with services was shown to be a reluctance to talk about race in an open and engaged manner (Keating et al., 2002) so any research that directly tackles constructions and assumptions around ethnic origin in mental health services would be a valuable addition to the evidence base.

The psychosocial methodology yielded a good deal of rich material through analysis; it appears well suited to explore the experiences of niche groups within the system whose needs are not currently being met. An interesting example is that of older people with undiagnosed personality disorder. I am currently carrying out a clinical governance project on service provisions for this population. Recent research (Van

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Alphen 2010) has shown that these problems are still extant in older adults but they manifest in different ways and are not straightforward for staff to recognise or to manage. There are therefore gaps in service provision and a quantity of unmet needs. This has parallels with the current project in many ways. Powerful social constructions prevail, such as the feelings of stigma that prevent presentation to primary care and the fear around mental health services (many older people will have experienced previous coercive or even abusive contact in the older institutions). Clinically, there is an unfortunate mixture of intrusion and inconsistency, so traumatising within an attachment model. Older people also have spells of tertiary care in crisis followed by abandonment, represented by a paucity of discharge provision and community care plans. The possibility for iatrogenic damage exists within this group and, potentially, in others.

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Appendix 1

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Appendix 2

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Appendix 3

You will be given a copy of this Information Sheet and the Consent Form to keep.

Participant Information Sheet

Name of study: Relational attachments in African Caribbean men with severe mental illness and conduct disorder

Name of researcher: Laura Smith

Email:

- I would like to invite you to take part in a research study. Before you decide if you want to take part, it is important for you to understand **why the research is taking place** and **what it will involve**
- Please take time to read the following information carefully. Please discuss it with others if you want to. Ask me if there is anything you do not understand, or if you want more information. Take time to decide whether or not you want to take part.

What is the purpose of the study?

- I am interested to know more about the relationships of men who identify as African Caribbean, who also have a diagnosis of conduct disorder (problem behaviours in childhood such as fighting, stealing, truanting and disobedience) and a diagnosis of severe mental illness as well. I am focussing on this group of people because they seem to have the most difficulty accessing services; the least helpful time when they do; and the poorest outcomes after treatment. 'Relationships'

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means everything from early childhood experience to how people relate to authorities, services and professionals.

- I hope that knowing more about this might help to guide mental health professionals to build better relationships with this group of men; and help them to get services they might be missing out on.

Why have I been asked to participate?

- Because I need to talk to people individually about their relationships so I can better understand the needs and issues of this group as a whole.

Do I have to take part?

- No. It is entirely up to you to decide. I will describe the study and then go through the information sheet and give it to you to keep. If you want to take part, I will ask you to sign a consent form. You are free to withdraw from the study at any time without giving a reason. This will **not** affect your care in any way.

What will happen if I take part?

- I will interview you for about an hour. During the interview, I will ask you questions about: what it was like for you growing up; the important relationships in your life; times you can remember getting into trouble; and how you feel about professionals, authorities and the help you received.
- You do **not** have to answer any questions you do not want to answer.
- **You will receive £20 for your time.**

What are the possible disadvantages of taking part?

- Talking about your past relationships might be upsetting or make you angry. If you feel that might be the case you can pass on the question or stop the interview at any time.

What are the possible benefits?

- I will try to use the information from this study to improve treatment and services for African Caribbean men who also have a diagnosis of conduct disorder and a diagnosis of severe mental illness.

Will the information be kept confidential?

- I will personally write up the recording I make of our interview. I will take out anything that might identify you, such as where you were born and where you went to school. I will give you a false name. Then I will wipe the recording.

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- The only other person who might have some knowledge of who you are is my supervisor, Dr Matt Bruce, who has helped me get in touch with you as part of the larger study he is doing.
- Confidentiality will only be broken if you tell us something that suggests you risk harming yourself or other people or if you report abuse of a person under 18. This is just the same as it would be in routine clinical practice.

Can I get independent advice about taking part?

- You can contact the Patient Advice and Liaison Service at [details of Trust PALS service, email and telephone number]

What if there is a problem?

- If you have any worries or concerns, you can contact me on the number at the top of the sheet and talk them through. If you are still unhappy and wish to complain formally, you can do this through the NHS Complaints Procedure. Details of this can be obtained from [details of Trust contact].

Who has reviewed the study?

- All NHS research is checked by an independent group of people, called a Research Ethics Committee. They are looking to protect your safety, rights, wellbeing and dignity.

What will happen to the research?

- I intend to publish the results to give health professionals more information about the requirements and needs of the group of people in the study.
- A short report of the results will be available; if you would like this, please let me know.

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Appendix 4

You will be given a copy of the Information Sheet and the Consent Form to keep.

Consent Form

Name of study: Relational attachments in African Caribbean men with severe mental illness and conduct disorder

Name of researcher: Laura Smith

Please tick

I confirm that I have read and understood the Information Sheet for the above study and that I have had the opportunity to ask questions.	
I understand that my participation is voluntary and that I am free to withdraw at any stage, without giving a reason, without my medical care or legal rights being affected	
I agree to take part in a confidential interview in which I will be asked questions about: what it was like growing up; important relationships; getting into trouble and the effect that had on other people; and authorities and services like schools or hospitals	
I understand that the interview will be recorded and transcribed anonymously. The material may be discussed with the researcher's supervisor	

Name of participant

Date

Signature

I have explained this study to the participant and answered their questions honestly and fully.

Name of researcher

Date

Signature

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Appendix 5

Revised Interview Schedule

The interview will be divided into 2 parts: a shorter section on intrafamilial relationships and then a longer section on relationships to authority and help. The questions listed are for guidance only.

Once the participant is ready to begin, the researcher will start with a small number of closed questions to build confidence and obtain information about family, such as:

Where were you born?

Did you grow up with your mum and your dad?

The researcher will then continue by exploring family relationships.

PART I

What is your first memory?

Prompts: Of your mother / father ?

Can you think of something that made you happy, as a child?

Can you think of something that made you frightened? Angry?

Can you tell me about who was around in your house while you were growing up?

What kind of person were they?

Who did you get on with best / worst?

Who did you run to if you hurt yourself, or had a problem?

Were there strict rules in your house? Who punished you if you were naughty?

Can you remember ever losing control, when you were growing up?

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Other people losing control?

PART II

Can you tell me what school was like?

How were the teachers?

Who did you get on with best / worst?

What were your friends like? (Prompt: ask for 5 words to describe them)

Was there anyone you went to if you had a problem?

Did you seem to get into trouble more or less than other people / your friends?

Why do you think that was?

Were you offered support when you got into trouble? From friends / family?

From the school /authorities?

What do you remember about the first time you came into contact with the police?

What were your feelings at this moment?

Can you tell me who was there for you, at that time? Who wasn't?

What kind of support did you get from authorities and / or professionals?

How did the police / social workers make you feel?

Were you treated with respect, do you think?

How might you have been treated better?

Did you ever get physically ill, or spend time in hospital, when you were growing up?

What was that like? how long did you stay?

Do you have any memories connected with this time? Of staff? Of other patients?

Can you remember the first time you came into contact with mental health services?

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Did you talk to anyone about this, when it began? Or not? Why?

Did you ask for help from professionals? Or not?

What might have made telling someone / asking for help easier?

Some people feel that this sort of problem is embarrassing or shameful...did you ever have that feeling?

What might have made that feeling better?

What was it like to be in hospital? What were your relationships like with ward staff and other professionals? (All these questions can be framed in the present tense. Also feelings and experiences may have changed if they have had multiple admissions over time)

Do you have any particularly strong memories attached to being in hospital / to the staff?

Was there anyone you felt close to?

Did culture and background matter, with the staff? How about where they did their training?

If you were given the choice of: an African; an African Caribbean; or a White primary nurse, what would be your preference? Why?

How do you think you were treated? With respect, or not?

Who did you trust? Was there anyone?

Can you think of one thing that might have made a difference? In yourself? In staff?

Who do you think bears the responsibility for making your experience good / bad / indifferent?

Appendix 8

This has been removed from the electronic copy.

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Appendix 9

Summary of Research

African Caribbean men with conduct disorder and severe mental illness: Reducing violence and improving therapeutic engagement

This study looked at the attachment relationships of African Caribbean men with current severe mental illness and past conduct disorder; and what this might mean for reducing incidents of violence and improving engagement with services. This was explored qualitatively, using attachment theory in tandem with a social constructionist approach, operationalised through a psychosocial methodology. The research questions were:

3. How might the text illustrate each individual's subjective attachment experiences; and;
4. How do these experiences intersect with therapeutic needs in services and relationship to help?

Method

Four participants fulfilling criteria were identified through the larger study, approached through their care teams and interviewed by the same researcher in outpatient and community settings. Texts were analysed using a psychosocial approach, drawing on ideas from attachment theory and Lacanian studies about trauma and repression contained within speech.

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Results

The study achieved its first objective in illustrating each individual's subjective attachment experiences through interpretations of the text. The findings resonate with the evidence base in showing that all participants showed signs of disorganised attachment and past trauma. The study achieved its second objective through asking participants specifically about their therapeutic needs and their relationship to help. All the men had had adverse encounters within mental health services although all could also cite discrete experiences which had been helpful and supportive. Each participant held different views about the interaction of race with care.

Conclusion

Participants all related difficult and unpleasant experiences with mental health services. These revolved around spells in tertiary care and the perceived punitive nature of crisis interventions. All but one of the participants also voiced objections to taking medication. However, participants were all also able to identify good experiences within services; and what particular qualities that made these interactions so positive.

Implications for clinical practice

Clinicians should be aware of: potential retraumatisation by services and how this might worsen symptoms and affect the therapeutic relationship; and racial bias in diagnostic labeling. Service professionals should also attempt to limit 'parental' approaches and preserve the equality, warmth and consistency in care relationships,

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as far as possible.

Dissemination and feedback

These results will be disseminated within the host Trust through presentations to specialist services. A short paragraph of feedback has will be sent to participants via the original contacts in each case. The study will be submitted as a stand-alone publication to Qualitative Research; and, in a different form, as part of the larger quantitative study upon which it is based.

Appendix 10

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Appendix 12

Transcripts have been removed from the electronic copy.

Transcription Notation Key

The transcription notation is adapted from Gee (1991) and Jefferson (1984):

(/) Each numbered line is made up of one or more idea unit. Where this is more than one idea unit in a line they are separated by a slash

(.) The shortest pause

(..) Longer pause

cu- A dash signals a sharp cut-off of the previous word or sound

(word) Word within brackets represents the transcriber's guess at an unclear section of the recording

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() Unclear speech with no approximation made by the transcriber

[] Square brackets denote overlapping talk

CAPITALS Stress added to a word through increased loudness, length or change of pitch tone

(italics) Italics in round brackets denote the interviewer's speech unless the talk is overlapping when square brackets are used.

Bold denotes author's emphasis

References

Gee, J.P. (1991). A linguistic approach to narrative. *Journal of Narrative and Life History*. 1 (1), 15-39.

Jefferson, (1984). On the organisation of laughter in talk about troubles. In Atkinson, J.M. & Heritage, J. (Eds). *Structures of Social Action: Studies in conversation analysis*. Cambridge: Cambridge University Press.

Appendix 13

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Appendix 14

Section A Search Strategy

A series of databases were searched without chronological criteria. These criteria were applied according to the relevancy of the article. Databases included:

- ASSIA
- Biomed Central
- CINAHL
- EBM Reviews - Cochrane Database of Systematic Reviews
- EBM Reviews - ACP Journal Club

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- EBM Reviews - Database of Abstracts of Reviews of Effects
- EBM Reviews - Cochrane Central Register of Controlled Trials
- EBM Reviews - Cochrane Methodology Register
- EBM Reviews - Health Technology Assessment
- EBM Reviews - NHS Economic Evaluation Database
- British Nursing Index and Archive, Maternity and Infant Care
- Ovid MEDLINE(R)
- PsycINFO
- Books@Ovid
- CCCU Journals@Ovid Full Text
- PsycARTICLES Full Text
- Social Policy and Practice.

"Attachment" was used as the principal keyword. This was combined using "and" with: "Conduct Disorder", "violence", "psychosis", "schizophrenia", "black", "Caribbean", "mental health services" (with wildcards). Initial exclusions were made on the grounds that the primary approach was not psychological or that the articles were evaluations of treatment programmes. Articles cited in the remaining studies were then followed up from the reference lists.