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SOCIAL CONTEXT AND DISTRESS

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Summary of the MRP

Section A: A review

This review considers the association between class inequality, wellbeing and employment. The review starts with a background to the topic area. Specifically some of the main factors that explain the negative association between class and mental health are discussed, relating to: Microsystems, mesosystems, macrosystems, exosystems and chrono-systems (Bronfenbrenner, 1979). The review continues with a discussion of nine identified studies to answer the questions: 1) Does work mitigate the effects of low social class on people's wellbeing? 2) How can the identified studies' findings explain/ be explained by what has been discussed about the link between class and mental health? Three studies found unemployment was associated with poorer mental health in people in lower class groups, indicating a positive association between work and mental health. The remaining six studies found mixed results. Positive associations were only relevant to good quality work and people in lower class groups were more likely to occupy stressful jobs. Work served as a means to gain access to goods and services and so was identified as having a positive effect on well-being, but prejudice and discrimination resulting from status attached to work was highlighted as having a negative impact. Internalisation of derogatory societal views was also noted, as well as a pressure to 'keep up with the joneses'. Variable association between work, wellbeing, and class, dependant on area level economic inactivity and area level SES were also noted. Structural and material explanations for the findings were discussed.

Section B: A discourse analysis

There is a consistent research base that shows that class and inequality are associated with poorer mental health and experiences of distress. Various explanations for this link have

been proposed, including psychological, social, structural, material and political factors; nevertheless, psychology focuses predominately on explanations and interventions at the individual level. Using IAPT as an exemplar for wider psychology services, Foucauldian discourse analysis of official IAPT texts and transcripts of supervision talk was completed to explore this incongruence. Specifically focussing on how distress in relation to the social world was constructed, what identities were created, and what practice implications resulted from such constructions. In the texts the following discourses were identified and discussed:: ‘Diagnosis, symptom reduction and recovery: treating patients’, ‘Faulting thinking (and behaviour)’, ‘IAPT: reducing social exclusion through increasing access to services and facilitating employment’. In the supervision talk the following discourses were identified and discussed:: ‘It’s hard to balance doing what’s clinically appropriate and having your work distorted by the IAPT targets’, ‘Diagnosis- unsafe certainty?’, ‘Mental health problems are the result of dysfunctional personal living’, ‘Problems are created by families and must be solved by the individual’, ‘there is no such thing as society’.

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SECTION A

Does work mitigate the effect of class on well-being?

Word Count: 7969 (plus 380)

Abstract

This review considers the association between class inequality, wellbeing and employment. The review starts with a background to the topic area. Specifically some of the main factors that explain the negative association between class and mental health are discussed, relating to: Microsystems, mesosystems, macrosystems, exosystems and chrono-systems (Bronfenbrenner, 1979). The review continues with a discussion of nine identified studies to answer the questions: 1) Does work mitigate the effects of low social class on people's well-being? 2) How can the identified studies' findings explain/ be explained by what has been discussed about the link between class and mental health? Three studies found unemployment was associated with poorer mental health in people in lower class groups, indicating a positive association between work and mental health. The remaining six studies found mixed results. Positive associations were only relevant to good quality work and people in lower class groups were more likely to occupy stressful jobs. Work served as a means to gain access to goods and services and so was identified as having a positive effect on well-being, but prejudice and discrimination resulting from status attached to work was highlighted as having a negative impact. Internalisation of derogatory societal views was also noted, as well as a pressure to 'keep up with the joneses'. Variable association between work, wellbeing, and class, dependant on area level economic inactivity and area level SES were also noted. Structural and material explanations for the findings were discussed.

Introduction

Increasingly the financial impact of poor mental health has been recognised and discussed. For example, the Sainsbury Centre for Mental Health (SCMH, 2004) estimated the total cost of mental illness to be £77.4 billion separated into three categories: a) health and social care costs of services provided by the NHS and local authorities and informal care given by family and friends; b) human costs relating to quality of life; c) output losses to the economy resulting from the impact of mental illness on an individual's ability to work, covering both absenteeism and presenteeism.

Growing concern of the unaffordability of mental illness formed the basis of a proposal for the widespread national programme, Improving Access to Psychological Therapies (IAPT), which aimed to reduce the financial implications of mental illness by making CBT for depression and anxiety easily accessible (Layard, 2006). Layard argued that the costs of training a workforce of 10, 000 and offering therapy over 250 teams nationally would be offset by reducing absenteeism and presenteeism due to mental illness. IAPT is now the first line treatment for depression and anxiety in the UK.

Around the same time, a large-scale review of the literature into work and mental health was conducted (Waddell & Burton, 2006) and formed much of the research around which the report 'working for a healthier future' was based (Black, 2008). Although these reports recognise psycho-social stressors related to work that have a negative effect on mental well-being, the main conclusion was that work is good for mental health.

Together, IAPT and 'Working for a healthier future' set in motion policies and services with a 'back to work agenda'. Media coverage of 'welfare cheats' soon followed, implying that work is available and beneficial and people who choose not to work are lazy and

‘scrounging’. It has been argued that this discourse has been used to justify discriminatory and oppressive practices seen in recent welfare policy changes (Friedli & Stern, 2013).

The economic and historical context is important to understand. Labour market and economic policy changes in the last two decades of the 20th century saw a shift from manufacturing to service industries and a break-up of established work trajectories. Working class people were not able to easily transition from manual work to skilled non-manual work, resulting in a sharp rise in unemployment and relative poverty within this group (Wadsworth 1997; Graham 2002). Typically work available for those in lower class groups is now characterised by poor pay, poor working conditions, lack of control and autonomy, and low status, factors associated with poor mental health (Waddell & Burton, 2006). Additionally, long established research shows a negative association between class and mental health problems (Black, 1980; Marmot, 2010; 2004; Wilkinson, 2005; 1996; 1998) based on a range of social factors, as discussed later in this review

Thus the relationship between class, work, and mental health is likely to be complex and it may not be possible to extrapolate findings from one class to another. Neither Layard (2006), Waddell and Burton (2006), nor Black (2008) consider the implications for working class people or discuss the political, economic or social milieu within which their conclusions are made. Given the consistent findings that the wider context has a significant impact on individual wellbeing, there is a need for a review of the literature that does.

Aims and Rationale of the Review

The aim is to review the literature that explores the relationship between work and mental health in people in lower class groups. This is an important area because social, political and economic contexts likely make the psychological or psychosocial relationship between social class, work, and mental health complex.

As Waddell and Burton (2006) reviewed the employment literature in 2006, the present review will include studies from 2006 onwards. This also coincides with the largest global recession since before the First World War (Gregg & Wadsworth, 2010) making this a more pertinent area in need of understanding. Political, economic, and social contexts differ from country to country so only UK studies will be included in the review.

Context

Before reviewing the studies, contextual information will be given related to controversies defining class and mental health before considering some of the factors that may contribute to explaining the link between class/inequality and mental health. A review of the studies investigating the implications of work for the mental health of low class people will then follow.

Class: Definitions and Controversies

The terms 'socioeconomic status (SES)' and 'social class' can broadly be defined as describing groups of people who cluster together in relation to socio-economic markers such as wealth, social standing, income, education, occupation, neighbourhood and home-ownership. Members also share common goals, desires, values, and identity. Different formulas for combining socio-economic markers exist but all position greater income and status as higher up a socio-economic, political, cultural hierarchy.

The term 'socio-economic status' subtly masks the hierarchical nature of socio-economic distribution and obscures power dynamics that may be a real part of someone's life. If there is no way of talking about or understanding these processes, powerlessness and oppression is internalised as personal failing and shame (Smail, 2005). 'Social class' as defined by Marx (Marx & Engels, 1967) and Weber (1947) makes the hierarchical nature of class groups clear by ranking class groups into strata, one above the other (Seagert et al. 2007) but differ in the power and agency they afford to the individual. Marx argues that

power is always rooted in economic power and means of production essentially rendering the person a powerless, passive victim of circumstance, unable to affect any part of their own destiny. Weber, on the other hand, argues that power may also exist on other grounds such as status, or honour in the community, and party, or 'access to life chances'. A Weberian perspective allows other ways of exercising agency and fits more with contemporary thinking about power and agency (e.g. Orford, 1992; Orford, 2008).

The term 'class' will be used in this review to reflect a Weberian perspective that recognises the hierarchical nature of class position and also allows for other expressions of agency and power rather than solely economic power. Throughout this review the term 'lower class groups' is used to represent working class and unemployed people because they typically experience more social disadvantage and have been linked to poorer mental health (e.g. Black, 1980). It is important to note that while people in these groups may have similar experiences, this does not represent a homogenous group and there are likely to be differences both within and between the class groups discussed. The term 'lower class groups' used in this review is not meant to imply a moral judgement, although inherent in the term is an implication of lower societal status that many people in these groups often experience.

Mental Health: Definition and Controversies

Increasingly, understanding wellbeing (or absence of) relates to diagnostic categories of mental health problems defined in the DSM-V (American Psychiatric Association, 2013) and the ICD-10 (WHO, 1992). Although psychology favours formulation over diagnosis, there are a growing number of diagnosis specific formulations and psychological services are increasingly organised around diagnostic categories, perhaps most explicitly seen in IAPT. Consequently research and service evaluation increasingly relate to diagnostic categories. Research must conform to using measures of diagnoses to be included in NICE guidelines

and research that does not is discounted. This limits what can be said and known about distress and links to oppression.

Diagnosis is a way of describing common clusters of symptoms and can help demystify a person's experience by putting a name to an otherwise overwhelming and confusing experience; however, diagnoses lack reliability and validity (Bentall, 2004; Kirk & Kutchins, 1992) and reduce distress to a set of symptoms with little consideration of the contextual factors associated with such symptoms (House & Loewenthal, 2005). As discussed with the term socioeconomic status, this obscures socio-political factors leaving the individual responsible for distress caused at the societal level (Smail, 2005) and also ignores other psychological difficulties that may be important to the person.

This review takes a wider approach to defining psychological distress, including diagnostic categories as an indicator of distress as well as other psychological difficulties, such as interpersonal difficulties.

Class and Mental Health

The association between low social class and poor mental health has been consistently shown and is so direct, strong, and consistent (Black, 1980; Marmot et al., 2010; 2004; Wilkinson, 2005; 1996) that it is widely referred to as 'the social gradient'. Wilkinson and Pickett (2010) demonstrated how relative inequality in a country is detrimental to health outcomes. Those at the bottom of the social hierarchy had worse health and mental health than those at the top of the social hierarchy in all countries studied, but countries with greater inequality had poorer health outcomes at all levels of the social hierarchy. Methodological limitations related to the within-country data sets and the novel measure of income inequality used raises doubt as to the validity of the findings (Judge, 1995). Additionally, Fiscella and Franks (1997) found that the relationship between income inequality and mortality disappeared when individual income was accounted for, a finding replicated mathematically

by Graville (1998). On the other hand, Kennedy, Kawachi, Glass and Prothrow-Stith (1998) and Kennedy, Kawachi, Prothrow-Stith, Lochner and Gupta (1998) have shown that income inequality has a modest independent effect on health after controlling for individual income. Studies with better within-country data sets and alternative measures of income inequality have replicated Wilkinson and Pickett (2010) findings (e.g. Kaplan, Pamuk, Lynch, Cohen & Balfour, 1996; Kennedy, Kawachi & Prothrow-Stith, 1996; and Lynch et al., 1998). Thus although individual class position is likely to have a larger impact on individual wellbeing, relative income inequality of the country is also a relevant factor to all individuals in the country.

Despite this evidence of the importance of class and income inequality in understanding wellbeing, it is a neglected area within the mental health professions. In a content analysis of 3915 articles published in three counselling psychology journals between 1981 and 2000, Liu et al. (2004) found only 98 studies included social class as a core variable. Similarly a search of PSYCInfo combining each of the search terms: Class, SES, social, political, structural, material, power with IAPT returned only one relevant study. Whilst this is not a systematic review it demonstrates the neglect of considering mental health within its social context within IAPT literature.

In the following sections some of the main factors relevant to understanding the link between class and inequality and mental health are outlined, drawing on literature from epidemiology, sociology, psychology, and social policy. The material is organised using ecological systems theory (Bronfenbrenner, 1977) to show how environmental and psychological factors interact at different levels.

Microsystems and mesosystems. Microsystems relate to the interaction between the individual and their immediate environment. This may include family or peer relationships, school, work, and neighbourhood. Mesosystems refer to the interactions, linkages, and

processes between two or more microsystems. This may include the interaction between employment and housing or the interaction between health, social services, and neighbourhood for example.

Micro and Meso systems represent proximal influences on wellbeing that are more readily identified. Mental health professionals largely incorporate microsystems into their understanding of wellbeing. With regards to a psychological understanding, the relationship between the individual and their environment is conceptualised differently depending on therapeutic modality: CBT emphasises the individual's cognitive and/or behavioural response to situations to determine their helpfulness and promote change in the individual if not; psychodynamic approaches emphasise relational dynamics and attempt to understand how the individual relates interpersonally, including the defence mechanisms used by the individual; and systemic approaches emphasise the context in which difficulties occur, locating difficulties as arising within the system rather than an individual. Occasionally mental health professionals incorporate meso-systems into an understanding of a person's distress, particularly in relation to children and young people where these processes may be more pertinent, for example considering the relationship between school and parents. Largely structural and material associations with distress are overlooked.

Diderichsen, Evans and Whitehead (2001) propose a model, consistent with research evidence that identifies three structural influences on health and mental health resulting from social stratification:

- Differential exposure- those in lower class groups are more likely to be exposed to health damaging contexts such as poor housing (Evans, Wells, & Moch, 2003; Schell and Czerwnyski, 1998), low status or low quality employment (Milburn, 2009), low income or poverty (Brewer, Muriel, Phillips & Sibieta, 2009; Jenkins & Lambert, 1997) and crime. These factors are likely to impact on health through a variety of

mechanisms including through increased pathogens and stress and impacts on health behaviour (Wilson, Kirtland, Ainsworth & Addy, 2004).

- Differential vulnerability- those in lower class groups are often exposed to an increased number, frequency, and duration of risk factors to health (Hallqvist, Diderichsen, Theorell, Reuterwall & Ahlbom, 1998), which overwhelms psychological and biological resources such that the response to any given stressor may be accentuated or exaggerated. They are also less likely to have access to good quality services (Dubay, & Kenney, 2001; Davis, Gold, & Makuc, 1981) or social support (Oakley & Rajan, 1991) to buffer potentially adverse effects of stressful events (Cohen & Wills, 1985) and promote resilience through the experience of bonding (Ryff & singer, 2001).
- Differential consequences- those in lower class groups are more likely to experience more severe consequences in response to poor health and mental health, which in turn affects health. This includes loss of employment, reduced income or poverty (Evans, 1989); and in the case of mental health care, diagnosis of more severe mental illness, increased levels of psychiatric admission, and more invasive treatments (Thornicraft, 1991; Jarman, Hirsch, White & Driscoll, 1992).

Whilst this model provides a useful understanding of some of the proximal structural and material influences on mental health it is limited in that it does not make explicit the discrimination and exclusion experienced as the result of social stratification or the psychological effects of such oppression. Additionally it cannot account for findings that relative inequality in a country is detrimental to wellbeing at all class positions.

Wilkinson (2005) emphasised the role of social meanings attached to material circumstances that affect how individuals feel about themselves. Within this framework, competition and social comparison results in increased anxiety and stress, which is turned

inside the body via the body's internal stress system. A lack of trust and social cohesion is also a contributory factor to poor health, as is health damaging and risk taking behaviour.

This explanation is limited as it ignores the real discrimination and prejudice that occurs, instead portraying it as individuals' perceptions. It is unsurprising given the many ways that people and society communicate contempt and disapproval that people in lower class groups internalise messages of devaluation (Moane, 1993). Wilkinson (2005) also underplays the role of class relations and other inequalities in power such as gender (Muntaner & Lynch, 1999). Powerlessness has been shown to effect mental health through learned helplessness (Wallerstein, 1992) and internalisation of fatalism (Martin-baro, 1996a).

Macrosystems and Exosystems. Macrosystems relate to the wider cultural context in which individuals live. This includes belief systems, bodies of knowledge, material resources, customs, lifestyles, opportunities, and structures that influence the particular conditions and processes of the microsystems. These represent distal influences that are harder to understand and so become embodied as distress (Smail, 2005). Exosystems are interacting systems that influence the individual without the individual's direct involvement, often bridging the gap between micro-systems and macro-systems. As with macro-systems, exo-systems are largely unaccounted for in understandings of distress and represent a distal influence that is often hard to understand or verbalise.

One route through which political forces affect wellbeing is through influencing ideology. There are different definitions of ideology (Prilleltensky & Fox, 2007) but here I refer to the traditional Marxist meaning whereby the ruling class impose a set of ideas, principles, and values on the general population, justifying the status quo. Foucault (1980) describes how ideology operates in relation to individual subjectivities and how the interests of the dominant groups are incorporated into the processes of "governing" the individual via self-regulation.

Ideologies of relevance are individualism, consumerism and meritocracy, which arise from the needs of capitalism. Individualism hinders connectedness, community, mutuality, trust and social cohesion (Fox, 1985); ‘there is no such thing as society. There are individual men and women and there are families’. The breakdown of social networks also prevents social capital (e.g. Putnam, 1993; Carpiano, 2006) and helps dominant groups maintain power through weakening subordinate groups as described by the social dominance theory (Sidanius & Pratto, 1999), discussed later in this review. Consumerism contributes to individualism by selling the idea that possessions, not social relations, increase happiness, creating an unending sense of dissatisfaction (Cushman, 1990) and a pressure to work long hours to afford unneeded things. This process is as relevant to people in privileged positions as it is to those in disadvantaged positions (Diener & Biswas-Diener, 2008). The ideology of meritocracy obscures structural inequality by creating unfounded belief that if you work hard you will be rewarded, thus inequality is a result of personal failing.

Mental health disciplines may collude with individualist ideologies by offering explanations of distress that focus on individual dysfunction. The focus on unhelpful thoughts espoused by CBT may have some justification because oppressed people often internalise aspects of their social reality and current societal ideology; however, CBT has no way of conceptualising the societal, structural, and political basis thus framing oppression and inequality as individual failing (Smail, 2005). Treatment becomes a method of social control, changing people’s thoughts to better accept their disadvantaged position (Friedli & Stern, 2013). Pilgrim (2008) argued that IAPT with its ‘back to work’ agenda is an example of psychology being used to perform a social engineering or economic mission.

Chrono-systems. There is also a life course element to structural inequalities that have health damaging effects. Graham (2002) argues that three models are relevant, working in a complimentary and interlocking way:

- Critical period model- health damaging effects of disadvantage are transmitted in utero (e.g. Barker, 1991)
- Pathway model- restricted opportunities for education and employment maintain and perpetuate disadvantage which effects health (e.g. Pensola & Martikainen, 2004)
- Accumulation model- the accumulation of disadvantage at different life stages creates further disadvantage and health inequalities (e.g. Hallqvist)

Bronfenbrenner also proposed that the relevance of the historical and cultural moment in time should be considered.

Power and oppression

Power is recognised as ‘the single most important organizing concept in social and political theory’ (Ball, 1994). Traditionally, in its Marxist sense, power refers to one social class over another, usually through the control of resources, labour, and production; however, power is now widely accepted as operating through different means and in different contexts. Foucault (1980) has particularly influenced the notion of power in his writings that recognised the power relations running through all relationships, settings, routines, rituals, and disciplines. In particular Foucault identified the operation of power in the shaping of individual subjectivities, through discourse and the control of knowledge. Although power does not necessarily lead to oppression, inequalities in power are at the heart of oppression and oppressive practices (Watts & Serrano-Barcia, 2003).

Social dominance theory (Sidanius & Pratto, 1999) draws on psychological, social and structural theories to explain issues of prejudice, stereotyping, discrimination and oppression. According to social dominance theory societies tend to be stratified by age, gender and one or more ‘arbitrary sets’ such as class, ethnicity or religion, which creates a social hierarchy. Maintenance of the social hierarchy is driven at the individual and societal level. At the individual level, social hierarchy is driven by social dominance orientation (SDO), which

relates to the degree to which the individual supports group-based hierarchy, domination, and oppression. At the societal level it is driven by three proximal processes: accumulated, often inconspicuous, acts of discrimination; institutional discrimination, ranging from deliberate and overt to unintentional and covert; and behavioural asymmetry, whereby dominant groups defend the hierarchical asymmetry more strongly than subordinate groups resist it. Often those in subordinate groups contribute to their own subordination by aspiring to join the dominant group, whilst denigrating their own.

Hierarchy-enhancing and hierarchy-attenuating forces play an important part in the maintenance of the social hierarchy. An example of hierarchy-enhancing forces relate to shared or societal beliefs and ideologies that support hierarchical social relations and oppression. This may include sexist, racist or religious beliefs for example or more covert ideas that assign responsibility and blame to oppressed groups. In the opposite direction, hierarchy-attenuating forces include feminism, socialism, human rights movements and social change movements. Social dominance theory proposes that these opposing forces exist in equilibrium, with the equilibrium point varying in different societies, thus determining the level of status difference based on age, gender and other arbitrary sets.

This theory has strength in that it draws on psychological, social and structural theories to explain issues such as prejudice, stereotyping, discrimination and oppression. It also allows for an understanding of covert forms as well as overt and draws on ideas from 'realistic group conflict' theory to incorporate inter-group discrimination, prejudice and competition. Within the theory, individuals have agency and subordinate groups can resist dominant groups to alter the strength of status difference, however, it is pessimistic over the long-term achievements of social change. A final drawback is that it does not include psychological factors such as internalisation of devaluing beliefs.

Summary

SES and class are often used interchangeably to describe groups of people who cluster together in relation to socio-economic markers such as wealth, social standing, income, education, occupation, neighbourhood and home-ownership. The term class makes the hierarchical nature and power relations more explicit by ranking class groups one above the other. This review uses a weberian perspective to recognise that power not only exists on monetary grounds but is also based on social standing in the community, honour, and access to life chances.

Distress is largely conceptualised as a diagnosable mental health problem. This review uses a wider conceptualisation of distress to include other psychological factors and interpersonal difficulties.

Several factors likely play a part in the negative association between well-being and class. These include differential exposure to health damaging situations, differential vulnerability to health damaging situations and differential consequences of ill health. A break-down in social relations, lack of trust, lack of social cohesion and negative social comparison may also be relevant factors. Wider influences include macro-economic policies that drive inequalities and ideologies such as individualism, consumerism, and meritocracy that likely impact on individuals and relationships by increasing competition and decreasing connectedness. Disadvantage is also likely to accumulate over time and with disadvantage at one stage causing a knock on effect at subsequent stages. Running through all these factors is inequalities in power and oppressive and discriminatory practices.

The current literature related to employment and well-being does not consider class or the complex social factors relevant in understanding the effects of employment. This review seeks to place an understanding of the relationship between employment and well-being in the context of class.

Review

Search Methodology and Inclusion Criteria

A literature search was completed of ASSIA, CINAHL, MEDLINE, PsycARTICLES, PsycINFO, and Social Policy and Practice.

The following search terms were used:

- employ* OR unemploy* OR work* OR occupation* OR job* AND
- mental health OR mental illness* OR stress OR depression OR anxiety OR distress OR psychological AND
- social class OR socioeconomic status OR low-income OR poverty

Due to the paucity of research in this area all relevant studies were included in the review.

Review Questions

Nine studies that explored the relationship between work and wellbeing in people of low social class were identified and used to answer the following questions:

- 1) Does work mitigate the effects of low social class on people's well-being?
- 2) How can the identified studies' findings explain or be explained by what has been discussed about the link between class and mental health?

Positive Associations Between Work and Wellbeing

Buck, Barnes, Cohen and Aylward (2010) used a cross-sectional survey design to investigate whether psychosocial risk factors, 'yellow flags', moderate the relationship between common health problems, including mental health, and daily life and work. A sample representative of the UK in terms of age bands, gender, and working status was recruited through quota sampling and the Cardiff Health Experiences Survey (CHES), developed for this study administered. This allowed collection of the following data: common health problems, assessed using a 14 point checklist of symptoms and two three-point likert

scales to measure extent (severity*frequency) of health problems; yellow flags, assessed using a checklist to measure catastrophisation, avoidance, vigilance, and acceptance; perceived causes of health problems, assessed through open question and response; interference with daily life, assessed using a 3-point scale of interference in a range of daily activities; and time off work, assessed using a 4-point scale relating to amount of time taken off work due to illness. Socio-economic status (SES) was assessed using the National Statistics Socio-economic Classification (NS-SEC) system based on current or previous occupation.

Data was analysed using stepwise multivariate linear regression and bidirectional elimination. Increased age, being female, being unemployed, and having low SES was associated with higher number of health problems, the model explaining 52% of the found variance. These factors were also associated with greater extent of health problems, the model explaining 43% of the found variance. Work status and gender were found to have significant independent associations with both number and extent of health problems, with gender having the largest effect of the two. These results indicate that within this model both low SES and unemployment were associated with poor mental health. The independent association of work status indicates that being employed may help alleviate the negative association of low SES and mental health but as gender showed a stronger independent association, this effect may be superseded by gender. Each of the yellow flags were individually correlated with interference with daily life, time off work, and number and extent of health problems. This led the researchers to conclude that the results support a bio-psychosocial approach to managing health conditions and that interventions designed to address yellow flags would be beneficial. Yellow flags were entered into the initial stepwise regression analysis and were not included in the final model indicating that age, gender, employment status and class explain more of the variance than yellow flags. These factors are

all factors by which society is stratified and form the basis for experiences of prejudice, discrimination, and oppression, identified in the social dominance theory (Sidanius & Pratto, 1999). This could point in the direction of oppression as an explanation rather than a bio-psychosocial approach that emphasises personal coping strategies as the problem. This hypothesis was not actively tested and no measures of power, discrimination or oppression were collected, so there could be alternative explanations for the findings.

This study has further limitations: there was no breakdown by health condition and it is unknown what the effects were on mental health specifically; the measures used to assess health problems, mental health problems and yellow flags were crude and their validity is unclear; and the cross sectional design means causality cannot be assumed. One strength is that the study used statistical procedures to compensate for low responses from individuals of low SES.

Wilkie, Peat, Thomas and Croft (2007) used cross sectional postal survey data of 7878 participants aged 50 and over to examine the associations between perceived participation in everyday tasks, health (including mental health) and various socio-economic and socio-demographic factors. The following measures were used: The Hospital Anxiety and Depression Scale (HADS, Zigmond & Snaith, 1983) to measure depression and anxiety; SES, measured by combining current employment status, occupational class, perceived adequacy of income and educational attainment; health problems, measured using self-report data of a checklist of problems; participation restriction, measured using the Keele Assessment of Participation (Wilkie, Peat, Thomas, Hooper & Croft, 2005); and activity limitation/impairment, measured using The Medical Outcome Study Short Form-36 (Ware & Sherbourne, 1992). Data was analysed using logistic regression analysis and multivariate analysis employed. As would be expected, number of health conditions and activity impairment were most strongly related with restriction in everyday/social tasks. Number of

health conditions was associated with SES. Health conditions, activity limitation and SES were associated with restriction in everyday and social tasks, after adjusting for age and gender. Those with disadvantaged SES were restricted most. This strength weakened, but remained significant, after adjusting for number of health conditions and activity limitation. Participation restriction was associated with increased depression and anxiety.

Taken together these findings provide support for and can be explained by the model described by Diderichsen et al. (2001) that identified three structural associations between SES and health:

- Differential exposure- participants with low SES were exposed to a higher number of mental health damaging factors, in this case health problems
- Differential vulnerability
- Differential consequences- participants with low SES experienced increased restriction and increased mental health problems in response to their health conditions.

This study could not provide evidence that work mitigated the negative impact of class on wellbeing, but positive individual associations were found between participation, associated with wellbeing, and perceived adequacy of income and employment status.

The cross-sectional design means that causality cannot be assumed and other confounding or mediating factors could explain the results. Two further limitations were noted. Firstly, health problems were measured using self-report which may have resulted in biased recall, biased perception or participants' unawareness of health problems. Secondly, participants with incomplete data, thus excluded from the analysis, were noted to have higher levels of activity limitation, participation restriction, and be older, female, anxious, depressed and cognitively impaired. These factors call into question the validity of the results of this study.

In a longitudinal study using five years of Growing Up in Scotland (GUS) data the effects of job loss were investigated (Chanfreau et al. 2010). The following variables were included: chaotic home environment, measured using four questions from the 15-item Confusion, Hubbub, and Order Scale (CHAOS) designed to assess turmoil across four areas: disorganisation, noise, having a calm atmosphere, and having a regular routine at home (Matheny, Wachs, Ludwig & Phillips 1995); parent-child relationship, measured using items from the Pianta scale designed to assess 'warmth' and 'conflict' (Hobcraft & Kiernan, 2010); maternal mental health, measured using the Medical Outcomes Study 12-item Short Form mental health component (Ware, Kosinski & Keller, 1996); and SES, measured using household tenure, social class, income and area deprivation. Multivariate analysis was used to explore associations between loss or substantial reduction in work and subsequent home environment, parent-child relationship and maternal mental health. The results from this study show that lone parents were more likely to experience job loss or a substantial reduction in work than two-parent families. Both couple families and lone parents were more likely to experience job loss if they were in a lower social class, did not own their own home, and lived in a deprived area. Job loss was associated with subsequent chaotic home environment, high parent-child conflict, and in lone parents, mental health problems. Families with stable employment did not share the same outcomes. These results suggest differential exposure to and consequences of health damaging situations based on SES (Diderichsen et al. 2001). Increased maternal mental health problems were only experienced in lone-parent families, indicating that social support may be an important mitigating factor, consistent with previous research that social support can mitigate some of the negative impacts of class on wellbeing (Cohen & Wills, 1985; Ryff & Singer, 2001), however, this did not extend to other measures of wellbeing. Being in a couple or a lone-parent family is a

crude measure of social support and previous research has highlighted social cohesion and a sense of community, not measured in this study, to be important.

The longitudinal design means that causal inferences can be considered in a way that cannot for cross-sectional designs, previously discussed; however, it is also important to consider confounding, moderating and mediating variables. The families who lost their jobs may have experienced other unmeasured life events or experienced an accumulation of life events that accounted for or contributed to the changes observed. The study made no attempt to measure or control for confounds. Another possibility, is that the negative association of job loss was mediated by a loss of income; therefore, the results may suggest a link between unemployment and future measures of dysfunction, but cannot imply causality.

Job factors

Meltzer, Bebbington, Brugha, Jenkins, McManus and Stansfeld (2010) explored the relationship between job stressors and depression and how this is affected by socio-economic circumstances. A stratified, by place and SES, random probability sample of 3581 participants in the third national survey of psychiatric morbidity in Great Britain was selected. Fieldwork was carried out and information collected regarding: common mental disorders (CMD), generalised anxiety, depression, obsessive-compulsive disorder, phobia, panic and mixed anxiety and depression as identified by the Revised Clinical Interview Schedule (CIS-R; Lewis & Pelosi, 1990); debt, measured by inability to pay for bills in the last year; SES based on NS-SEC; and job insecurity, measured by one-item 4-point likert scale. The findings indicated that undesirable change, lack of respect from manager, job insecurity, debt, and low social class were all independently associated with depression. The relationship between job insecurity, depression and individual socio-economic circumstances of debt and class were analysed. Job insecurity and debt were combined and shown to have a negative association with depression. This suggests that work may ameliorate the negative

association between class and mental health, mediated through adequate income and may also impact negatively on wellbeing when it is of low quality. Women who were in debt and experienced job insecurity were twice as likely as men to experience depression.

Butterworth, Leach, McManus and Stansfeld (2013) also explored the relationship between job stressors and depression. The sample included 2603 adults between 21 and 54 who had completed the English Adult Psychiatric Morbidity Survey (APMS) and were either unemployed or employed in work of varying quality. A stratified random sample was used to obtain a representative sample in terms of place and SES. Psychosocial work characteristics were measured using adapted versions of the ERI questionnaire (Siegrist, Wege, Pühlhofer & Wahrendorf 2009), measuring job demands and job rewards and the JD-C model used in the Whitehall II Study (Stansfeld, 2002), measuring job control. SES was indicated through measures of social disadvantage (debt, low income, and unskilled occupational background). The Revised Clinical Interview Schedule (CIS-R) was used to identify potential mental health diagnoses. Poorer mental health was reported by participants who were unemployed compared to those with optimum jobs or jobs with one stressor. Participants employed in jobs with two or more stressors showed comparable mental health to those who were unemployed. These findings remained regardless of social measures: debt, low income and social class which suggests that any benefits of work apply to good quality work and that poor mental health is associated with an accumulation effect of work stressors rather than particular work stressors being associated with poor mental health. This is consistent with Diderichsen et al. (2001) assertion that an accumulation of stressors increase vulnerability to the negative impacts experienced. Thus good quality work can ameliorate the association between class position and mental health. Work can also reverse the positive association of higher social class and mental health. The work demands measured in this study have been shown to

increase in response to the needs of the market (Chomsky, 1999) providing an example of how macroeconomic influences the individual.

Causality cannot be assumed due to the cross-sectional design of this study. It is also not clear how missing data is managed. This study uses short forms of existing measures but does not report the reliability score of these measures. That said it uses a large sample and there is consideration of the wide range of job factors that can affect work quality.

Social factors

Dolan (2007) conducted a thematic analysis to explore what groups of working class men perceived the impact of their material circumstances on their health to be. Working class men were selected from relative affluent and non-affluent areas and households as determined by: social class, levels of unemployment, housing tenure, household access to own transport, and levels of overcrowding. This created four groups: Affluent area/affluent household; affluent area/non-affluent household; non-affluent area/affluent household; and non-affluent area/non-affluent household. Informal semi-structured interviews were used to gather data from 11 men. Both positive and negative aspects of work on mental health were identified. The main positive aspect identified by all groups was related to income. The men agreed that material circumstances reflect the effort and skill of the individual and all made distinctions between deserved and underserved income. This reflects current ideology relating to fairness and meritocracy. All participants valued that income allowed them to purchase goods and services. For the men in non-affluent households in non-affluent areas often living without essential goods and services, lack of material resources had a huge impact on day-to-day living and their physical and mental health. Work thus served as means to gain access to goods and services, supporting a materialist explanation of the negative association between SES and well-being and providing support for the ameliorative effect of work, through income. Participants from affluent area/ affluent household believed

differences in income exist to push people's aspirations linking to ideology based around meritocracy. This discourse was not drawn upon by any of the other groups, perhaps due to an internalised sense of powerlessness in groups lower down the social hierarchy (Moane, 2003; Martin-baro, 1996a).

All of the men reported that stratification and income inequality created a drive to 'keep up with the joneses' and work harder, resulting in a negative impact on health and mental health, which supports Wilkinson (2005). Social stratification by employment caused other negative effects: each man reported that those higher up judged him. Participants in the non-affluent area also felt they were looked down upon as a group. Participants from non-affluent area/ non-affluent household communicated a sense of hopelessness, stating that to move up is not within the realms of possibility and were resigned to the fact that they would work in poor quality jobs or remain unemployed. This is consistent with explanations of internalisation of powerlessness (Wallerstein, 1992) and fatalism (Martin-baro, 1996a). These reflections suggest that work would not ameliorate the impact of class on mental health, pointing instead to changes in discrimination and oppression.

The interviews used in this study were informal and the men were encouraged to follow their own interest in the topics proposed. The benefit was that issues most pertinent to the participants, rather than the researcher, were discussed. Although some of the data collected in this study referenced the positive aspects of work, the majority focussed on negative aspects, which will be discussed in the following section.

Barnes, Buck, Williams, Webb and Aylward (2008) conducted thematic analysis of focus groups to investigate attitudes to common health problems, including mental health, and work in different socio-economic areas of South Wales. Seventy-nine participants were organised into 16 groups based on employment status and class, so that some groups included participants similar to each other and some were mixed. SES was measured using the NS-

SEC. Out of all health problems stress and depression was talked about more readily, frequently, and intensely. Depression and stress was believed to have increased. The reasons for this were attributed to changes in work and society resulting from a consumerism, which led to unending sense of dissatisfaction and want, a drive to work longer hours unnecessarily and identity and lifestyle confusion. Changes in working conditions, loss of 'jobs for life', commuting and job insecurity were also noted, although more pertinent in the more deprived areas. This is consistent with the literature indicating that the needs of the market influence individuals through ideological and structural forces. This supports both psychosocial explanations that emphasise the individual's response to their environment and materialist explanations. These findings suggest that the relationship between work, mental health, and class is complex. Poor quality work was associated with poor mental health, particularly in people in lower class groups, and overworking contributing to poor mental health in all class groups through driving an insatiable desire for more material possessions. Good quality work may ameliorate the negative association of class on mental health but work may also exacerbate poor mental health. These findings point towards changes in ideology as needed to improve wellbeing.

This study has strength in that it recruited a good cross-section of the population by gender, age, socio-economic and working status and recruited from non-health settings which limited bias. Focus groups allow analysis of different voices and how meaning is co-constructed in a social context but rely on the skill of the facilitator. The same three facilitators were used in each focus group improve interpretation and to aid the smooth running and consistency of the groups. Emerging themes were summarised in the focus groups so that members could agree with or refute the interpretations being made. Following transcription, analysis was aided by use of Nvivo software and interpretations checked with members during a debriefing session.

Place

Fone, Dunstan, Williams, Lloyd and Palmer (2006) used multilevel linear regression models of 10,653 adults aged 18-74 nested within 36 census wards to compare mental health, SES and economic activity. Mental health status was assessed using the Mental Health Inventory (MHI-5) scale of the Short Form-36 (Ware, Snow, Kosinski & Gandek, 2000) health status questionnaire, and socio-economic status determined by combining employment status, social class, household income, housing tenure and property value. They found evidence that being economically inactive due to permanent sickness or disability rather than other reasons, such as retirement or being being a full-time parent, was associated with poorer mental health. This suggests that poor wellbeing affected ability to work rather than lack of work per se being the causal factor affecting mental health. An interesting finding occurred when considering the results in the context of neighbourhood. Incapacity for work was associated with poor mental health but only when participants lived in a ward with a higher proportion of incapacity claimants. Incapacity for work was not associated with poor mental health when participants lived in a ward with a lower proportion of claimants. This is suggestive of an area level association between SES, unemployment and mental health.

Weich, Twigg and Lewis (2006) investigated differences in the onset and maintenance of CMD's, using the General Health Questionnaire (GHQ; Goldberg & Williams, 1988) in relation to: SES, measured by employment status, household income; and electoral wards, characterised by Office for National Statistics classification and by population density. The sample included 7659 adults aged 16-74 living in 4338 private households, nested within 626 electoral wards. They found that SES and employment status had no effect (moderating or confounding) on the onset of mental health problems. A relationship between maintenance of mental health problems and low SES was identified, but only when using SES of the area and these effects were not confounded or mediated by household income or individual SES or

employment.

Both studies used cross-sectional data so cannot assume causality. Also these studies did not attempt to explain why the associations exist. It may be that areas low in economic activity or SES may have structural disadvantages impacting on health (Diderichsen et al. 2001) or experience more damaging effects of oppression (Moane, 1993). Alternatively, different cultural norms may explain the associations. In any case the association between area and wellbeing was shown to be largest and not ameliorated by work.

Discussion

Summary and critique

The literature regarding work and mental health in low class people was sparse; the present literature search returned only nine relevant studies. This is consistent with previous research finding small amounts of studies relating to social class (Liu et al. 2004). Only two studies came from psychological literature indicating the neglect of consideration of employment and class within psychology.

Seven of the nine studies were epidemiology studies, one advantage being that they used large numbers of participants and so have good power. Another strength evident in these studies is that they used stratified sampling methods to gather and compare a good cross-section of the population in terms of social class and other relevant factors. Six of the studies employed cross-sectional design, so causality cannot be assumed. Further two used postal surveys, so there may be response biases affecting the results.

These studies used well defined terms which is a strength in that measures were often validated and clear; however, in doing so some of the complexity may be lost and some of the measures used were crude, for example using one four-point likert item or using debt as a measure of SES. Different measures of wellbeing were used ranging from parent-child relationships to formal measure of mental health problems, which is a strength in that a broad

spectrum of factors indicative of wellbeing were considered but may make it hard to compare these findings against each other. Similarly different measures of class were used. In addition one study combined health and mental health, making it impossible to know what the relationship between work and mental health specifically was.

Two of the studies used qualitative research methods. Qualitative studies allow consideration of the complexity relating to the studied topic (Sliverman, 2013). Particular strengths of these studies lie in the methods for data collection used which allowed data relevant to the participant rather than that imposed by the researcher to come to the fore. There is of course the potential that participants gave less honest responses due to pressure to report socially desirable responses or those that fit with current ideology, though this in itself is considered important information for this review.

Three out of nine studies indicated that work was good for mental health in people from low class backgrounds. Wilkie et al. (2007) found an association between being unemployed and poor mental health and Buck et al. (2010) found that employment could help mediate the negative association between low SES on depression. Chanfreau et al. (2010) found that job loss was associated with a lack of wellbeing measured at a later time and a relationship between job loss and future mental health problem was found in single parents only. None of these studies examined why employment had a positive association.

The remaining studies reported mixed results, for example Meltzer et al. (2010) and Butterworth et al. (2013) both found that positive effects of work were only relevant to good quality work. Butterworth et al. (2013) reported that an accumulation of work stressors made work damaging to mental health in people of all classes and that people in lower class groups were more likely to occupy these jobs. Meltzer et al. (2010) reported that job insecurity in particular was related to damaging impact of work. This may support materialist

explanations for a positive effect of work on mental health as those in insecure jobs are likely to worry about the financial implications of losing a job.

Work served as means to gain access to goods and services, supporting materialist explanations of the negative association between SES and wellbeing and providing support for the ameliorative effect of work, through income. Prejudice and discrimination resulting from status attached to work was highlighted as having a negative impact on wellbeing and the effects of powerlessness and internalisation of derogatory societal views was also noted, as well as a pressure to 'keep up with the joneses'. Similar themes were noted by Barnes et al. (2008) and linked more explicitly by participants to consumerism. Buck et al. (2008) also reported overworking contributing to poor mental health in all class groups through driving an insatiable desire to attain material possessions.

Fone, et al. (2006) and Weich et al. (2006) also noted a variable association between work, wellbeing, and class, dependant on area level economic inactivity (Fone et al. 2006) and area level SES (Weich et al. 2006). Higher area levels of inactivity and lower area SES were associated with poorer mental health. This may be because of structural disadvantages impacting on health, the effects of oppression or different cultural norms.

None of these studies explored the effects of ethnicity. Studies that compared the relationship between class, work, and wellbeing found that the negative association between unemployment or poor quality work and wellbeing was stronger for women suggesting a 'double jeopardy' of oppression.

As a whole, these studies provide support for both psychosocial and materialist explanations of the links between employment, mental health, and class; however, the small number of disparate studies leaves large gaps and makes conclusions difficult. The research suggests that work may ameliorate the negative association between class and wellbeing, but only if the work is of good quality and neighbourhood and wider societal influences are also

important factors to consider. There was some evidence that these factors influence the relationship between work, class, and wellbeing.

Future directions

Given the large gaps in the literature, there is a need for further research into the area of work and wellbeing in the context of class. Specifically research investigating wider social, political and cultural correlates would be welcome as this was particularly neglected within the included studies. Studies that find positive associations between work and mental health would benefit from exploration of the reasons why the experience was positive.

None of the included studies conducted research within the context of IAPT despite IAPT having an explicit agenda to get people back into work. Research assessing the impact of or experience of the employment services attached to IAPT is one example of research that could be conducted within IAPT.

This review also points to broadening out the topics under investigation. Class per se is under-researched in mental health research, as is the impact of wider societal forces. IAPT in particular has been criticised for its neglect of the social and material world and a preliminary search of the literature confirmed this. It would be interesting to investigate if and how the impact of societal influences, including, but not limited to, employment and social stratification on mental health are conceptualised within IAPT.

References

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing.

Attenborough, L. E., Hawkins, J., O'Driscoll, D., & Proctor, G. (2000). Clinical psychology in context: The impact of the sociopolitical environment. *Clinical Psychology Forum* (pp. 13-17). London: DCP, BPS.

Ball, T. (1994). New faces of power. In: T. Wartenberg (ed.), *Rethinking power*. Albany: SUNY Press.

Barker, D. J. (1991). The foetal and infant origins of inequalities in health in Britain. *Journal of Public Health*, 13(2), 64-68.

Barnes, M. C., Buck, R., Williams, G., Webb, K., & Aylward, M. (2008). Beliefs about common health problems and work: A qualitative study. *Social Science and Medicine*, 67(4), 657-665.

Bentall, R. P. (2004). *Madness explained: Psychosis and human nature*. London: Penguin Books.

Black, C. M. (2008). *Working for a healthier tomorrow: Dame Carol Black's review of the health of Britain's working age population*. London: The Stationery Office.

Black, D., Morris, J., Smith, C., & Townsend, P. (1980). *Inequalities in health: Report of a research working group*. London: Department of Health and Social Security.

Brewer, M., Muriel, A., Phillips, D., & Sibieta, L. (2009). *Poverty and inequality in the UK: 2009*. London: Institute for Fiscal Studies.

Bronfenbrenner, U. (1977). Toward an experimental ecology of human development. *American psychologist*, 32(7), 513-531.

Buck, R., Barnes, M. C., Cohen, D., & Aylward, M. (2010). Common health problems, yellow flags and functioning in a community setting. *Journal of Occupational Rehabilitation*, 20(2), 235-246.

Butterworth, P., Leach, L. S., McManus, S., & Stansfeld, S. A. (2012). Common mental disorders, unemployment and psychosocial job quality: Is a poor job better than no job at all? *Psychological Medicine*, 1(1), 1-10.

Carpiano, R. M. (2006) Toward a neighbourhood resource-based theory of social capital for health: Can Bourdieu and sociology help? *Social Science and Medicine*, 62, 165-175.

Chanfreau, J., Barnes, M., Tomaszewski, W., Philo, D., Hall, J., & Tipping, S. (2011). *Growing up in scotland: Change in early childhood and the impact of significant events*. Edinburgh: The Scottish Government.

Chomsky, N. (1999). *Profit over people: Neoliberalism and global order*. London: Seven Stories Press.

Cohen, S., & Wills, T. A. (1985). Stress, social support, and the buffering hypothesis. *Psychological Bulletin*, 98(2), 310-357.

Cushman, P. (1990). Why the self is empty: Toward a historically situated psychology. *American Psychologist*, 45(5), 599-611.

Davis, K., Gold, M., & Makuc, D. (1981). Access to health care for the poor: Does the gap remain? *Annual Review of Public Health*, 2(1), 159-182.

Diderichsen, F., Evans, T., & Whitehead, M. (2001). The social basis of disparities in health. In T. Evans, M. Whitehead, F. Diderichsen, A. Bhuiya & M. Wirth (Eds.), *Challenging inequities in health: From ethics to action* (pp. 13-23). New York: Oxford University Press.

Diener, E., & Biswas-Diener, R. (2011). *Happiness: Unlocking the mysteries of psychological wealth*. Chichester: Wiley.

Dolan, A. (2007). 'Good luck to them if they can get it': Exploring working class men's understandings and experiences of income inequality and material standards. *Sociology of Health and Illness*, 29(5), 711-729.

Dubay, L., & Kenney, G. M. (2001). Health care access and use among low-income children: Who fares best? *Health Affairs*, 20(1), 112-121.

Evans, G. W., Wells, N. M., & Moch, A. (2003). Housing and mental health: A review of the evidence and a methodological and conceptual critique. *Journal of Social Issues*, 59(3), 475-500.

Evans, T. (1989). The impact of permanent disability on rural households: River blindness in Guinea. *Institute of Development Studies Bulletin*, 20(2), 41-48.

Fiscella, K., & Franks, P. (1997). Poverty or income inequality as predictor of mortality: Longitudinal cohort study. *British Medical Journal*, 314(7096), 1724-1726.

Fleming, I., & Burton, M. (2001). Teaching about the individual and society links on the Manchester clinical psychology training course. *Clinical Psychology*, 6, 28-33.

Fone, D., Dunstan, F., Williams, G., Lloyd, K., & Palmer, S. (2007). Places, people and mental health: A multilevel analysis of economic inactivity. *Social Science and Medicine*, 64(3), 633-645.

Foucault, M. (1980). *Power-Knowledge: Selected interviews and other writings, 1972-1977*. C. Gordon (Ed.). Pearson Education.

Fox, D. R. (1985). Psychology, ideology, utopia and the commons. *American Psychologist*, 40, 48-58.

Friedli, L., & Stearn, R. (2013). Whistle while you work (for nothing): positive affect as coercive strategy - The case of workfare. Retrieved from Centre for Medical Humanities website <http://medicalhumanities.wordpress.com/2013/12/10/whistle-while-you-work-for-nothing-positive-affect-as-coercive-strategy-the-case-of-workfare/>.

Goldberg, D. P., & Williams, P. (1988). The user's guide to the General Health Questionnaire (1st edn). Windsor: NFFR Nelson.

Graham, H. (2002). Building an interdisciplinary science of health inequalities: The example of life-course research. *Social Science and Medicine*, 55, 2005-2016.

Graville, H. (1998). How much of the relation between population mortality and unequal distribution of income is a statistical artefact? *British Medical Journal*, 316, 382-385.

Gregg, P., & Wadsworth, J. (2010). The UK labour market and the 2008-9 recession. *National Institute Economic Review*, 212(1), 37-51.

Hallqvist, J., Diderichsen, F., Theorell, T., Reuterwall, C., & Ahlbom, A. (1998). Is the effect of job strain on myocardial infarction risk due to interaction between high psychological demands and low decision latitude? Results from Stockholm Heart Epidemiology Program (SHEEP). *Social Science and Medicine*, 46(11), 1405-1415.

Hobcraft, J. & Kiernan, K. (2010). Predictive factors from age 3 and infancy for poor child *outcomes at age 5 relating to children's development, behaviour and health: Evidence from*

the millennium cohort study, York University. [Online] Available at:

<http://www.york.ac.uk/depts/spsw/staff/documents/HobcraftKiernan2010PredictiveFactorsChildrensDevelopmentMillenniumCohort.pdf>.

House, R., & Loewenthal, D. (Eds.). (2008). *Against and for CBT: Towards a constructive dialogue?* Ross-on-Wye: PCCS Books.

Jarman, B., Hirsch, S., White, P., & Driscoll, R. (1992). Predicting psychiatric admission rates. *British Medical Journal*, 304(6835), 1146-1151.

Jenkins, S. P., & Lambert, P. J. (1997). Three 'I's of poverty curves, with an analysis of UK poverty trends. *Oxford Economic Papers*, 49(3), 317-327.

Judge, K. (1995). Income distribution and life expectancy: A critical appraisal. *British Medical Journal*, 312, 1282-5; 1285-7.

Kaplan, G. A., Pamuk, E. R., Lynch, J. W., Cohen, R. D., & Balfour, J. L. (1996). Inequality in income and mortality in the United States: Analysis of mortality and potential pathways. *British Medical Journal*, 312(7037), 999-1003.

Kennedy, B. P., Kawachi, I., Glass, R., & Prothrow-Stith, D. (1998). Income distribution, socioeconomic status, and self rated health in the United States: Multilevel analysis. *British Medical Journal*, 317(7163), 917-921.

Kennedy, B. P., Kawachi, I., & Prothrow-Stith, D. (1996). Income distribution and mortality: Cross sectional ecological study of the Robin Hood index in the United States. *British Medical Journal*, 312(7037), 1004-1007.

Kennedy, B. P., Kawachi, I., Prothrow-Stith, D., Lochner, K., & Gupta, V. (1998). Social capital, income inequality, and firearm violent crime. *Social Science and Medicine*, 47(1), 7-17.

Kirk, S. A., & Kutchins, H. (1992). *The selling of DSM: The rhetoric of science in psychiatry*. Hawthorne NY: Aldine De Gruyter.

Layard, R. (2006). *The depression report: A new deal for anxiety and depression*. London: London School of Economics and Political Science.

Lewis, G., & Pelosi, A. (1990). *Manual of the revised clinical interview schedule (CIS-R)*. London: Institute of Psychiatry.

Liu, W. M., Ali, S. R., Soleck, G., Hopps, J., & Pickett Jr, T. (2004). Using social class in counseling psychology research. *Journal of Counseling Psychology*, 51(1), 3-18.

Lynch, J. W., Kaplan, G. A., Pamuk, E. R., Cohen, R. D., Heck, K. E., Balfour, J. L., & Yen, I. H. (1998). Income inequality and mortality in metropolitan areas of the United States. *American Journal of Public Health*, 88(7), 1074-1080.

Marmot, M. (2004). *The status syndrome: How social standing affects our health and longevity*. New York: Owl Books.

Marmot, M. G., Allen, J., Goldblatt, P., Boyce, T., McNeish, D., Grady, M., & Geddes, I. (2010). *Fair society, healthy lives: Strategic review of health inequalities in England post-2010*.

Martín-Baró, I. (1996). Toward a liberation psychology. *Writings for a liberation psychology*, 17-32.

Marx, K., & Engels, F. (1967). *The communist manifesto (1848)*. Trans. AJP Taylor. London: Penguin.

Matheny, A. P., Jr., Wachs, T.d., Ludwig, J.L., & Phillips, K. (1995). Bringing order out of chaos: Psychometric characteristics of the confusion, hubbub, and order scale. *Journal of Applied Developmental Psychology*, 16, 429-444.

Meltzer, H., Bebbington, P., Brugha, T., Jenkins, R., McManus, S., & Stansfeld, S. (2010). Job insecurity, socio-economic circumstances and depression. *Psychological Medicine*, 40(08), 1401-1407.

Milburn, A. (2009). *Unleashing aspiration: The final report of the panel on fair access to the professions*. London: The Cabinet Office.

Moane, G. (2003). Bridging the personal and the political: Practices for a liberation psychology. *American Journal of Community Psychology*, 31(1-2), 91-101.

Muntaner, C., & Lynch, J. (1999). Income inequality, social cohesion, and class relations: A critique of Wilkinson's neo-Durkheimian research program. *International Journal of Health Services*, 29, 59-82.

Oakley, A., & Rajan, L. (1991). Social class and social support: The same or different?. *Sociology*, 25(1), 31-59.

Orford, J. (1992). *Community psychology: Theory and practice*. Chichester: Wiley.

Orford, J. (2008). *Community psychology: Challenges, controversies and emerging consensus*. Chichester: Wiley.

Pensola, T., & Martikainen, P. (2004). Life-course experiences and mortality by adult social class among young men. *Social Science and Medicine*, 58(11), 2149-2170.

Pilgrim, D. (2008). Reading Happiness: CBT and the Layard thesis. In House, R. and Loewenthal, D. (Eds). *Against and for CBT: Towards a constructive dialogue*. Hertfordshire: PCCS Books.

Prilleltensky, I., & Fox, D. (2007). Psychopolitical literacy for wellness and justice. *Journal of Community Psychology*, 35(6), 793-806.

Putnam, R. (1995). Bowling alone: America's declining social capital. *Journal of Democracy*, 6, 65-79.

Ryff, C. D., & Singer, B. H. (Eds.). (2001). *New horizons in health: An integrative approach* (Vol. 277). Washington, DC: National Academies Press.

Saegert, S. C., Adler, N. E., Bullock, H. E., Cauce, A. M., Liu, W. M., & Wyche, K. F. (2006). *APA task force on socioeconomic status (SES)*. Washington, DC: American Psychological Association.

Sainsbury Centre for Mental Health. (2003). *The economic and social costs of mental illness*. London: SCMH.

Schell, L. M., & Czerwinski, S. A. (1998). Environmental health, social inequality and biological differences. In S. S. Strickland & P. S. Shetty (Eds.), *Symposia-society for the study of human biology* (pp. 114-131). Cambridge: Cambridge University Press.

Sidanius, J., & Pratto, F. (2001). *Social dominance: An intergroup theory of social hierarchy and oppression*. Cambridge, UK: Cambridge University Press.

Siegrist, J., Wege, N., Pühlhofer, F., & Wahrendorf, M. (2009). A short generic measure of work stress in the era of globalization: Effort-reward imbalance. *International archives of occupational and environmental health*, 82(8), 1005-1013.

Silverman, D. (2013). *Doing qualitative research: A practical handbook*. London: SAGE Publications Limited.

Smail, D. J. (2005). *Power, interest and psychology: Elements of a social materialist understanding of distress*. Ross-On-Wye: PCCS Books.

Smail, D. J. (1993). *The origins of unhappiness: a new understanding of personal distress*. London: Harper Collins.

Stansfeld, S. (2002). Work, personality and mental health. *The British Journal of Psychiatry*, 181(2), 96-98.

Thornicroft, G. (1991). Social deprivation and rates of treated mental disorder: Developing statistical models to predict psychiatric service utilisation. *The British Journal of Psychiatry*, 158(4), 475-484.

Waddell, G., & Burton, A. K. (2006). *Is work good for your health and well-being?* London: The Stationery Office.

Wadsworth, M. E. J. (1997). Health inequalities in the life course perspective. *Social Science and Medicine*, 44(6), 859-869.

Wallerstein, N. (1992). Powerlessness, empowerment, and health: Implications for health promotion programs. *American Journal of Health Promotion*, 6(3), 197-205.

Ware Jr, J. E., & Sherbourne, C. D. (1992). The MOS 36-item short-form health survey (SF-36): Conceptual framework and item selection. *Medical Care*, 30(6), 473-483.

Ware Jr, J. E., Kosinski, M., & Keller, S. D. (1996). A 12-item short-form health survey: Construction of scales and preliminary tests of reliability and validity. *Medical Care*, 34(3), 220-233.

Ware, J. E., Snow, K. K., Kosinski, M., & Gandek, B. (2000). *SF-36 health survey: Manual and interpretation guide*. Lincoln: Quality Metric Incorporated.

Watts, R. J., & Serrano-García, I. (2003). The quest for a liberating community psychology: An overview. *American Journal of Community Psychology*, 31(1), 73-78.

Weber, M. (1947). *The theory of social and economic organization*, translated by A. M. Henderson and T Parsons. Edited with an introduction by T Parsons. New York: Free Press.

Weich, S., Twigg, L., & Lewis, G. (2006). Rural/non-rural differences in rates of common mental disorders in Britain Prospective multilevel cohort study. *The British Journal of Psychiatry*, 188(1), 51-57.

Wilkie, R., Peat, G., Thomas, E., Hooper, H., & Croft, P. R. (2005). The Keele assessment of participation: A new instrument to measure participation restriction in population studies. Combined qualitative and quantitative examination of its psychometric properties. *Quality of Life Research*, 14(8), 1889-1899.

Wilkie, R., Peat, G., Thomas, E., & Croft, P. (2007). Factors associated with participation restriction in community-dwelling adults aged 50 years and over. *Quality of Life Research*, 16(7), 1147-1156.

Wilkinson, R. G. (1996). *Unhealthy societies: The afflictions of inequality*. London: Routledge.

Wilkinson, R. G. (2005). *The impact of inequality: How to make sick societies healthier*. London: Routledge.

Wilkinson, R., & Pickett, K. (2010). *The spirit level: Why equality is better for everyone*. London: Penguin Books.

Wilson, D. K., Kirtland, K. A., Ainsworth, B. E., & Addy, C. L. (2004). Socioeconomic status and perceptions of access and safety for physical activity. *Annals of Behavioral Medicine*, 28(1), 20-28.

World Health Organisation. (1992). *ICD-10 classifications of mental and behavioural disorder: Clinical descriptions and diagnostic guidelines*. Geneva: World Health Organisation.

Zigmond, A. S., & Snaith, R. P. (1983). The hospital anxiety and depression scale. *Acta psychiatrica scandinavica*, 67(6), 361-370.

SECTION B

Environment, power, distress and IAPT: A discourse analysis

Word Count: 7424 (plus 1104)

Abstract

There is a consistent research base that shows that class and inequality are associated with poorer mental health and experiences of distress. Various explanations for this link have been proposed, including psychological, social, structural, material and political factors; nevertheless, psychology focuses predominately on explanations and interventions at the individual level. Using IAPT as an exemplar for wider psychology services, Foucauldian discourse analysis of official IAPT texts and transcripts of supervision talk was completed to explore this incongruence. Specifically focussing on how distress in relation to the social world was constructed, what identities were created, and what practice implications resulted from such constructions. In the texts the following discourses were identified and discussed: 'Diagnosis, symptom reduction and recovery: treating patients', 'Faulting thinking (and behaviour)', 'IAPT: reducing social exclusion through increasing access to services and facilitating employment'. In the supervision talk the following discourses were identified and discussed: 'It's hard to balance doing what's clinically appropriate and having your work distorted by the IAPT targets', 'Diagnosis- unsafe certainty?', 'Mental health problems are the result of dysfunctional personal living', 'Problems are created by families and must be solved by the individual', 'there is no such thing as society'.

Introduction

Social determinants of mental health.

The association between low social class and poor mental health, widely referred to as 'the social gradient', has been consistently shown (Black, 1980; Marmot et al. 2010; 2004; Wilkinson, 2005; 1996). Wilkinson and Pickett (2010) used extensive epidemiological data to argue that income inequality, rather than absolute income, is detrimental to health, mental health and a range of other social problems. Those at the bottom of the social hierarchy had worse health outcomes than those at the top of the social hierarchy in all countries studied, but countries with greater inequality had poorer outcomes at all levels of the social hierarchy. Wilkinson's findings have been questioned due to methodological limitations (Judge, 1995) and contradictory evidence that found the relationship between income inequality and mortality disappeared when individual income was accounted for (Fiscella & Franks 1997; Graville, 1998); Nevertheless, the findings have been replicated in studies with better data sets and measures of income inequality (e.g. Kaplan, Pamuk, Lynch, Cohen & Balfour 1996, Kennedy Kawachi, & Prothrow-Stith 1996 and Lynch et al., 1998).

The explanation posed by Wilkinson and Pickett (2010) is broadly consistent with Layard (2005) who, based on evidence from genetics, neuroscience, medicine, philosophy, psychology, sociology and economics, identified 'Seven causes of happiness': good family relationships, enough money to avoid absolute poverty, enjoyable work, community engagement and friendships, good health, personal freedom and a clear personal value system. Layard (2005) argued that the 'causes' of unhappiness arise from capitalism and individualism which encourage a lifestyle at odds with the 'seven causes of happiness' through increased social comparison, chronic dissatisfaction and a loss of trust and respect. Wilkinson and Pickett (2010) also identified competition, break-down in social cohesion and

increased health damaging and risk taking behaviour as contributing to poor mental health in countries with higher income inequality.

One of the limitations of the explanation posed by Wilkinson and Pickett (2010) is that the role of social meanings is emphasised while the real material circumstances and factors such as discrimination, prejudice, power and oppression are downplayed (Muntaner and Lynch, 1999).

Structural and Material Factors. Diderichsen, Evans and Whitehead (2001) proposed a model, consistent with existing literature, to explain the material and structural correlates between class and well-being. They proposed that people in low social classes experience: differential exposure to health damaging situations or contexts; differential vulnerability to stressors due to being overwhelmed and having less access to services and resources; and differential consequences of poor health and mental health, such as higher rates of psychiatric admission or unemployment, which have further health damaging effects. These three factors impact on the individual in an inter-related way to reduce well-being.

Power and Oppression. Inequalities in power relations are at the heart of oppression and oppressive practices (Watts & Serrano-Barcia, 2003), operating at the individual, relational and collective level. At the individual level, disadvantaged people internalize psychologically damaging social narratives about themselves, often leading to self-blame and feelings of worthlessness (Moane, 2003) as well as engaging in behaviour that is self-fulfilling through the internalisation of fatalism (Martin-baro, 1996a). At the relational level, disadvantaged people are treated as inferior; in British culture 'chav-bashing' is seen as an acceptable and amusing past-time (Jones, 2012). At the collective level oppressive social policies and community settings create oppressive structural arrangements within which individual and relational aspects of oppression are embedded.

An Ecological Theory. It is likely that the factors explaining the association between class position and well-being are varied. The ecological model proposed by Bronfenbrenner (1977) provides a useful way to understand interactions between the individual and the environment in five nested systems:

- Microsystems relate to the interaction between the individual and their immediate environment e.g. relationships, school, work, neighbourhood.
- Mesosystems refer to the interactions, linkages and processes between two or more microsystems e.g. the interaction between employment and housing or the interaction between health, social services and neighbourhood.
- Macrosystems relate to the wider cultural context in which individuals live. This includes belief systems, bodies of knowledge, material resources, customs, lifestyles, opportunities and structures that influence the particular conditions and processes of the microsystems.
- Exosystems are interacting systems that influence the individual without the individual's direct involvement, often bridging the gap between micro-systems and macro-systems.
- Chronosystems relate to the influence of the particular historical and cultural moment in time, as well as considering the impact of the individual's life-course.

Individualisation of mental health problems

Despite consistent evidence of social and economic associations with distress, these factors are largely overlooked within mainstream psychology. Clinical psychologists tend to focus on the individual, incorporating understandings of microsystems and sometimes mesosystems into their work. Socio-political factors represented in macro-systems and exo-

systems are widely considered to be beyond the disciplinary boundary (Attenborough, Hawkins, O'Driscoll & Proctor 2000; Fleming & Burton, 2001; Smail, 1993). Additionally, Smail (2005) argues that it is in psychology's interest to conceptualise distress at the individual level as this affords interventions at the individual level, provided by psychologists.

Improving access to psychological therapies (IAPT). IAPT provides an example of the individualisation of psychology. In the report that formed the basis for IAPT, Layard (2006) argued:

'What is the biggest single cause of misery in our community? Most people would answer 'poverty'. But they would be wrong. If we try to predict who is unhappy we find that the strongest predictor is a person's prior mental illness. Prior mental illness (ten years earlier) explains more current unhappiness than poverty does.'

This shifted the cause of (and solution to) distress away from socio-political and socio-economic factors previously identified (Layard, 2005) towards treating the individual for mental illness. Based on an economic rationale and use of evidence-based therapies, IAPT was rolled out nationally and is now the first line treatment for depression and anxiety.

The main treatment option available at IAPT, Cognitive Behavioural Therapy (CBT), has been criticised for focusing on the individual and neglecting interpersonal processes and social contexts (e.g. House & Loewenthal, 2008). CBT conceptualises distress as arising from the meaning attached to experience and the influence of this on feelings and behaviour. Smail (2005) argues that this implies that distress is down to faulty thinking or problematic behaviour and makes the individual responsible to change what may not be in their power to change.

Further criticisms echo Foucault's (1979) analysis of social regulation, whereby internalization of cultural prescriptions becomes a form of social control through self-regulation (Parker, Georgaca, Harper, McLaughlin & Stowell-Smith, 1995).

Advocates of CBT argue that understanding the influence of our inherent meaning-making on experiences of distress is one of CBT's strengths and although cognitive interpretations are central to CBT, a five systems model incorporates situational factors and environmental triggers.

Theoretical Background and Rationale

Discourses are "systems of thoughts composed of ideas, attitudes, courses of action, beliefs and practices that systematically construct the subjects and the worlds of which they speak." (Lessa, 2006). Discourse is controlled by objects, what can be spoken of; ritual, where and how one may speak; and the privileged, who may speak. Thus language, discourse and power are closely interrelated. Language reflects and constitutes current discourses and is therefore action, performing a function and having a real effect in the social world (Austin, 1962). Foucault (1972) emphasized discourse as part of a wider social process of legitimating and power, focusing on how 'truths' are constructed and maintained and the embedded power relations. 'Analysis of discourse tries to elucidate webs of meaning and the relations and consequences of competing meaning frameworks' (Burman & Parker, 1993).

As previously discussed, competing ideas exist regarding how much emphasis is given to different factors identified as important to understand distress. Largely individualist conceptualisations dominate psychology, though psychosocial factors are also viewed as relevant (e.g. DSM-V, American Psychiatric Association, 2013) and social materialist explanations have been posed (Cromby et. al, 2012). It would therefore be interesting to analyse how the tensions between these competing meaning frameworks are managed within psychological services. Specifically, analysing the work done through language to favour

one or other of these positions, or to marry seemingly competing ideas. It would be interesting to consider what is said about distress in relation to the environment, by whom and when, and the effect this has in the social world.

Given its strong focus on individualist interventions, analysing discourses related to IAPT is likely to represent a good exemplar for discourses operating in wider psychological services. This study will add to the limited literature in this area, highlighting dominant discourses and placing them within a historical and cultural context, challenging truth claims and allowing for any new discourses to be systematically documented and heard more widely.

Research questions

The study aimed to answer the research question: 'how is the relationship between environment, power and psychological distress discoursed (talked about and practiced) within IAPT texts and practice talk?'

The following, more specific questions were considered in relation to the above question:

- What representations are made about the material world (e.g. wealth, resources, practical problems) and its impact on well-being?
- What subjects/identities are created (e.g. for service users, carers, clinicians, wider society)?
- What agency, rights and responsibilities are afforded or constrained to the individual in relation to their “problems” and potential solutions?
- How are issues of Power represented?

Methodology

Design

This study employed a non-experimental qualitative design, analysed in two parts: a) key texts related to the development and practice of IAPT; b) Transcripts of supervision and case discussion meetings of CBT high-intensity therapists at IAPT.

Analysis

Two main approaches were utilised: Discursive Psychology and Foucauldian Discourse Analysis (FDA). Discursive Psychology considers how language is used to negotiate and manage social interactions to achieve interpersonal objectives (Willig, 2008). FDA is interested in wider social processes of legitimisation and power. Power relations, supported by institutional practices and ideology, within which individuals and objects are constructed is a core feature of FDA (Parker, 1992). This study draws on both approaches with FDA adopted as the main framework.

Analysing key documents related to the development and practice of IAPT allows analysis of how people's problems and potential solutions are discourses within a political context. Analysing supervision sessions allows analysis of the same questions within the context of practice.

Sample

Inclusion and exclusion criteria.

Part a. A sample of texts recognised by IAPT training providers as important to the development and practice of IAPT were included. Documents available on the IAPT website only were eligible.

Part b. High-intensity therapists practicing CBT at IAPT and their supervisors were eligible for inclusion. Trainee high-intensity therapists were also eligible. Exclusion criteria included: low-intensity therapists as the severity and intensity of the intervention may not

warrant exploration of contextual factors; and therapists practicing alternative therapeutic modalities because CBT is the main treatment option at IAPT. Individual and group supervision or case discussion meetings were used.

Sample characteristics.

Part a. Seven texts were included as follows: a) The IAPT Data Handbook; b) IAPT Supervision Guidance; c) Manual of the Revised Cognitive Therapy Scale (CTS-R); d) The Map of CBT Competences and CBT Competence Lists; e) Supervision Competencies Framework; f) Commissioning Talking Therapies for IAPT 2011; and g) Commissioning IAPT for the Whole Community.

Part b. There were 12 participants, including therapists and supervisors, three of which were clinical psychologists and the remaining nine were CBT therapists trained at IAPT. Four one-hour individual supervision and one two-hour group supervision were recorded and transcribed.

Procedure

Recruitment and data collection.

Part a. Providers of the IAPT training programme were contacted via e-mail (Appendix 2) and asked to rank the ten most important documents in the development and practice of IAPT. Two responses were received and the six documents identified in both responses were downloaded from the IAPT website. The document 'Commissioning IAPT for the Whole Community' was referenced frequently in these documents and was relevant to the research question and so was also included.

Part B. Following an e-mail request sent to the manager(s) (Appendix 3) of identified IAPT sites, the researcher attended six team meetings to explain the study and provide information sheets (Appendix 4). A reminder was sent via e-mail (Appendix 5) one week later. Participants were not told the research questions prior to data collection so that

interactions during supervision were as natural as possible. Once consent had been established from all participants in the supervision session, arrangements were made to record a supervision session. The session recorded was part of the clinicians' normal working pattern and the discussion topics were based on clinical need and chosen as would normally be chosen. Turpin et al. (1997) recommend a minimum of five hours of material for clinical psychology doctoral level projects. It was ensured that the data collected met these requirements. The participants were de-briefed after all data was collected.

Data analysis. The texts were read through in their entirety and initial themes noted. Recurring themes relevant to the research question were noted and extracts related to the themes copied into separate topic files. These extracts were then analysed using Parker's (1992) 20 steps as guidance.

Quality assurance. The researcher acknowledged that they were approaching this study from a particular standpoint and with a particular opinion, therefore this potentially created a conflict of interest. To minimise bias the researcher kept detailed field notes (Appendix 6) reflecting on the position taken and how this impacted the analysis. Evidence of both under and over representation of the factors of interest, as well as times when they were not represented at all, were actively searched for. The researcher reflected on what was surprising and what was not to further explore the position taken and highlight potential biases. Throughout, the researcher discussed analyses with supervisors who also highlighted potential areas of bias. A sample of interpretations was discussed with participants to check validity and accuracy of interpretations.

Ethics

Ethical approval was gained from Fulham Research and Ethics Committee (REC) (Appendix 7). Research and Development (R&D) approval was gained from the local NHS

Trust (Appendix 8). A summary of the project was sent to the REC, R&D and participants (Appendix 9).

Results

IAPT Texts

Although each document focuses on the issue relevant to the document, the discourses discussed here are mentioned in all of the documents. Each document refers to the other documents and there are few instances of contradictions. Where there are contradictions or conflicts of interest these are presented as being compatible and beneficial. Throughout the texts various manoeuvres are used to legitimise the position taken, such as calls to authority, emotive language, and appeals to common sense. Thus it is hard for the reader to argue or resist the discourses. Before discussing the identified discourses the position taken by IAPT is discussed.

IAPT is positioned as supporting or helping the wider institution of the NHS and implementing what has been decided by NICE: ‘ The Improving Access to Psychological Therapies (IAPT) programme has one principal aim: to help primary care trusts (PCTs) implement National Institute for Health and Clinical Excellence (NICE) guidelines for people suffering from depression and anxiety disorders’ (Commissioning IAPT for the Whole Community, p4). Aligning itself with these powerful institutions allows IAPT to borrow some of their power and status but it is also a reminder that IAPT is governed by these powerful institutions and in return it must operate within their medical, evidence-based discourses.

Diagnosis, symptom reduction and recovery

The dominant discourse was diagnosing and treating patients. Distress was represented as a mental health problem for which, depending on the cluster of symptoms, a diagnosis is made and appropriate treatment on the basis of this diagnosis delivered.

Entwined with this medicalized view of distress were discourses related to expert-patient relationships, evidence-based practice and positivism. Individualist discourses were also present.

Throughout the texts depression and anxiety were referred to as known entities, their validity and usefulness taken for granted. 'Knowledge of mental health problems' was indicated as an expected competency in both 'The Map of CBT Competences and CBT Competence Lists' (p. 1) and 'the supervisor competencies framework' (p.1). This seemed to prescribe what can be said and known about distress. Therapists risk being constructed as incompetent if they are not knowledgeable about (or challenge) the existence of mental health problems. Those who determine what distress is i.e. researchers, policy makers etc. have power. Therapists must operate within the parameters set and have less power. Those who experience distress have least power and are positioned as 'suffering' an illness.

A psychological, rather than biological, cause and solution to diagnosable mental illness was privileged. This was presented as a 'patient sought-after alternative to medication' (Commissioning Talking Therapies for 2011, p. 4); however, the following quote illustrates the similarities to a medicalised discourse with a focus on a technical fix, based on positivist assumptions that the right treatment exists: 'Treatment should not end until the patient has received at least one adequate dose of treatment: patients who do not respond to low intensity treatment should be given at least one dose of high intensity treatment as well' (Commissioning Talking Therapies for 2011, p. 7). The Medical language used here (patient, treatment, dose, respond) calls to mind discourses of expert-doctors and passive-patients. The use of the words: 'received' and 'given' indicates a one directional rather than a collaborative approach, constructing service users as passive recipients of treatment. The treatment schedule was predetermined and little agency and responsibility was afforded to the 'patient' in affecting treatment progression.

In relation to the passive patient, the therapist is positioned as ultimately responsible and accountable. The ‘patient’s’ outcome is linked implicitly to the therapists’ competency: ‘Therapists in the IAPT programme need to be able to carry out the same interventions and to the same level of competence, as therapists in controlled trials (which demonstrate the efficacy of these approaches, and hence forms the basis for NICE guidelines)’ (IAPT Supervision Guidance, p. 6). This quote also illustrates the explicit link between treatment and science that was evident throughout.

Therapists were given a ‘duty’ to collect ‘the data standard’, at every session. The data standard was used to: ‘identify therapy targets (intrusive thoughts, avoidance behaviour, hopelessness, etc) and manage the therapy process’ (The Data Handbook, p. 12), ‘help patients understand more about their condition’ (The Data Handbook, p. 12), ‘chart their progress towards recovery’ (The Data Handbook, p. 15), and ‘build a robust data archive to inform evolving service improvement strategies, locally or centrally’ (The Data Handbook, p. 10). Thus the data standard seemed to regulate the therapy process at all levels, from what happens in sessions to how services are organised and evaluated. Measures of diagnosable mental health problems were a large part of the data standard. Using the data standard in this way reinforces the idea of mental health problems as real entities that exist to be treated. This representation of distress is imposed on the patient, as is a predetermined idea of what recovery is. Extensive use of outcomes data also positions the therapist as a scientist-practitioner observing and responding to objective measurable symptoms with the ‘appropriate’ intervention. In this context, other factors that influence distress may be unspeakable or unknowable.

The data standard included demographic and socio-economic markers, used to ‘ensure equitable access’. There was no explicit measure of class and it is unclear if socio-economic markers were used to measure SES. ‘The Work and Social Adjustment Scale’ (The data

handbook, p. 41) is the only measure of environmental correlates with distress. The direction assumed was of mental health affecting the person's functioning at work, home management, social leisure, private leisure and close relationships. This positions mental health as a problem that affects not only the individual but also their functioning or 'adjustment' in society and constructs the individual as maladjusted and a burden. Therapists are positioned as social engineers helping the maladjusted to adjust.

Faulty thinking (and behaviour)

CBT was given a privileged position because of its evidence-base and endorsement by NICE. Through CBT distress was represented as the result of thoughts, and to a lesser extent, feelings and behaviours that maintain a person's problems. There was considerable overlap with medicalised discourses, particularly relating to expert-patient relationships, evidence-based practice based on positivism and individualist discourses.

The patient should be helped to gain an appreciation of the history, triggers and maintaining features of his/her problem in order to bring about change in the present and future. The therapist should help the patient to gain an understanding of how his/her perceptions and interpretations, beliefs, attitudes and rules relate to his/her problem. A good conceptualisation will examine previous cognitions and coping strategies as well as current ones. This theory-based understanding should be well integrated and used to guide the therapy forward. (CTS-R, p. 12)

In this quote cognitions are privileged and presented as central to the understanding of the 'patient's' distress. The use of the words 'appreciation' and 'understanding' imply that there is an objective truth to be learnt. As with diagnosis, the 'patient' is expected to accept this representation of their distress. The use of the word 'should' implies an obligation, duty or correctness and is used in relation to both the therapist and the 'patient'. The 'patient' is given more responsibility to 'bring about change', once they appreciate their problem, than

traditional medicalised discourses. Here it seems the therapist is positioned as expert-teacher and the patient as eager-student.

IAPT workers select from a repertoire of CBT techniques presented as competencies in the 'CTS-R' and 'The Map of CBT Competences and CBT Competence Lists'. This echoes medicalised discourses that require the selection and application of a technical fix. The techniques largely include helping 'patient's' to 'identify and modify' cognitions (The Map of CBT Competences and CBT Competence Lists, p. 1) and 'overcome or disrupt dysfunctional behavioural patterns' (CTS-R, p. 10). Only one suggested technique, 'problem solving' (CTS-R, p. 5; The Map of CBT Competences and CBT Competence Lists, p. 1) related to change in anything outside of the individual. This further implies a person's distress is down to faulty thinking and behaviour and places a responsibility on them to change. As discussed in the previous section, there is no discussion of environmental factors. This leaves these factors unspeakable and unknowable.

Tensions. Expert-driven vs patient-centred. Medicalised discourses that create expert-patient relationships based on unequal distributions of power and pre-determined criteria for distress conflict with discourses relating to patient-centered and collaborative care, also present in the documents. The following quote illustrates attempts to position patient-centered assessment and diagnosis as compatible, or even complimentary:

Experience of the first few years of the IAPT programme has shown that the following service features are most likely to lead to the best outcomes. These include:

- Conducting a person centred assessment that includes characterising clients' presenting problems in terms of the relevant ICD-10 codes which offers a provisional diagnosis. (Commissioning Talking Therapies for 2011, p.7)

As in this extract, person-centered assessment was only represented in the context of diagnosis, with a provisional diagnosis as the expected outcome. This positions person-centered assessment as an adjunctive to diagnosis and the person-centred assessment become another tool or technique used to fulfil the tasks of medicalised discourses. This maintains the privileged position of diagnosis while paying lip-service to other valued discourses.

Responsibility. The responsibility and agency afforded to the service user is another area of tension as shown in this extract:

There must be clear evidence of productive teamwork, with the therapist skillfully encouraging the patient to participate fully (e.g. through questioning techniques, shared problem solving and decision making) and take responsibility. However, the therapist must not allow the patient to ramble in an unstructured way. (CTS-R, p. 5)

The first sentence places the therapist and ‘patient’ as on a level footing and active contributors through the use of the words ‘productive teamwork’; However, the assignment of responsibility shifts throughout the extract. The service user is expected to ‘participate fully’ and ‘take responsibility’ but their participation and responsibility is curtailed and ‘must’ only operate in a prescribed way (the therapist must not allow the patient to ramble in an unstructured way). The therapist is given ultimate responsibility for ensuring the correct level of participation and responsibility.

IAPT: reducing social exclusion. The final discourse established social exclusion as an important factor and IAPT as reducing social exclusion. This will be discussed in two strands: Strand one, access to psychological services; Strand two, employment.

Access to services. This strand was referenced minimally in all documents and elaborated more fully in ‘Comissioning IAPT for the Whole Community’, which will form the basis of this discussion. This report was written to help commissioners ‘deliver Improving Access to Psychological Therapies (IAPT) services that are effective and appropriate for the whole

community, using innovative ways of meeting the needs of local people' (Commissioning IAPT for the Whole Community p. 1). Specifically it focussed on BME people, older people, people with medically unexplained symptoms, people with long term health conditions, people with perinatal mental health problems, offenders and veterans.

As shown in the following quote social exclusion was referred to and presented as a problem with health damaging effects for all of the groups discussed. There was no exploration into why social exclusion might be related to the group of people or how social exclusion may be related to health and mental health: 'Offenders and their families represent one of the most socially excluded groups in our society. They have some of the highest levels of morbidity in terms of both physical and mental health problems' (Commissioning IAPT for the whole community, p. 13). Here, it is not explicitly stated that one causes the other but presenting it together, the reader makes the link without understanding more detail. Presenting social exclusion in this way keeps social factors mystified and potentially suggests that exclusion is an inevitable part of belonging to that group of people.

Elaboration of the impact on services use soon followed, shifting the focus slightly and constructing access to services as the 'real' problem.

People from BME communities may face additional barriers involving ethnicity, culture, language or faith... Along with other social factors, these barriers may affect the perception, availability, use and, potentially, the outcome of an IAPT service (Commissioning IAPT for the whole community, P. 16)

Here the different ways that access to IAPT services may be affected are listed and elaborated on later in the document. The operation of 'other social factors' and how they influence service use was not fully discussed, further mystifying and obscuring the social and political aspects of social exclusion and discrimination. Discrimination was also presented as

occurring at the individual level further masking structural and/or societal discrimination operating at a service level:

Three other factors with important potential to affect access to psychological therapy services have also been identified by the SIGs. These are the views, attitudes and behaviour of the person experiencing common mental health problems, who would benefit from a psychological intervention; primary care professionals; and people working in specialist mental health services. (Commissioning IAPT for the whole community, p. 15)

This quote also demonstrates the shift from discussing the impact of discrimination and social exclusion on the individual to presenting access to IAPT as the ‘real’ problem to be tackled. Thus the solution was constructed as increasing access and engagement (continued access) to psychological therapies, rather than addressing the sources or consequences of social exclusion more broadly. A variety of strategies were suggested including the workforce being called upon to be ‘sensitive to age, culture, disability, ethnicity, gender, language, religion and spirituality, and sexuality.’

Presenting social exclusion in this way offers a relatively simple solution to a complex problem. This is politically useful and maintains the status quo while also being consistent with wider (accepted) discourse of equality of opportunity.

Employment. This strand was evident in all documents and positioned IAPT as reducing social exclusion by supporting a return to employment. Research evidence was used to give authority to the assertion that work is good for mental health and lack of work bad for mental health:

It is widely accepted that work is generally good for mental health – including for people with mental health conditions¹⁶. It is established that the longer people are absent or out of work, the more likely they are to experience depression and anxiety.

Therefore, employment advice delivered as a core part of an IAPT service can be integral to the success of that service. There are many examples of successful IAPT employment advice services and it is crucial that this good practice is maintained and extended to all IAPT sites. (Commissioning Talking Therapies for 2011, p. 9)

Language such as ‘widely accepted’ and ‘established’ further affirm a truth-value, though hedged (generally good). Evidence that some aspects of work can be damaging to mental health is not presented. Selective use of the evidence base both supports and obscures the economic mission of IAPT by presenting the drive to help people back to work as wholly in the person’s interest. Employment advice services are constructed as ‘crucial’, ‘integral’ and ‘core’ to reducing depression and anxiety and also, as the next quote shows, to increasing social inclusion:

One area of development for supervisors of both PWP and high intensity therapists relates to employment and social inclusion. These should be dealt with in the training provided by courses and additional further training sessions, particularly for qualified staff, organised by either IAPT Employment Advisors or local employment support agencies should be considered. (IAPT Supervision Guidance, p. 11)

By referring to employment and social inclusion together, a common pattern throughout the documents, an implication about the crossover of the two constructs is made. Suggesting that additional training for both issues be provided by employment agencies further conflates employment and social inclusion and positions employment as a way to achieve inclusion.

Supervision Sessions

Compared to the texts there was less consistency in the way that wellbeing, distress and options for help were constructed through the supervision talk. The dominant discourse overarching all other discourses was summed up by the therapist in transcript three: ‘It’s hard to balance doing what’s clinically appropriate and having your work distorted by the IAPT

targets' (Transcript 3, line 574). This constructs clinical need and clinical provision as incompatible. The use of the word 'targets' referred to 'did not attend' rates, recovery rates, number of sessions and also symptoms and interventions 'targeted' by IAPT, echoing language from official IAPT texts that presented symptoms and interventions as 'targets'. The use of the word distorted, implies that IAPT targets supersede clinical need, imposing its own agenda onto the service user. This created a dilemma for the therapist:

- T And it's that, it's that attention like you say to doing what you think is
 clinically appropriate and clinically right and ethically and morally right
- S I know, I know
- T Versus... you know, the rest of it. (Transcript 3, lines 597-600)

The therapist is positioned as having a legal and moral responsibility to do what is 'right' and to resist IAPT targets constructed as in opposition to what is 'right'. The therapist also has a legal duty to work within the policies and guidelines of their employer and as noted by the supervisor, the therapist may be personally disadvantaged for resisting too much: 'I know how good your work is so I don't want your data to show you at a disadvantage' (transcript 3, line 577).

There was evidence in all supervision sessions of the therapist and supervisor grappling with this moral and ethical dilemma. A number of strategies were consistently employed to manage the dilemma. The most often used strategy was to resist the imposition of IAPT targets by straying off CBT. Concepts from psychodynamic, systemic, mentalisation, attachment theory, motivational interviewing and narrative therapy were all used to talk about distress at different points and more or less explicitly in every supervision session. Often this was then translated back to CBT and re-constructed to construct a similar but changed version of how distress is understood and what can help. Other strategies, particularly where the client was viewed as having complex needs or having additional areas to work on, included

drawing on discourses: 'they can always re-refer' and 'you have to find that focus'.

Through this overarching discourse of balancing the discrepancy between clinical need and clinical provision, distress and its relation to the material world was constructed in a number of different ways. Four sub- discourses of interest were noted.

Diagnosis: Unsafe certainty? Every case discussion included a diagnosis or symptom(s) linked to a diagnosis within the first sentence or two, often as the opening piece of information. This seemed to function to orient the supervisor to the main difficulties before further discussion of other factors could commence. Mostly, no further description of the diagnostic category was given and the supervisor did not seek this. This constructs diagnostic categories as valid, well-known entities for which there is no need for elaboration. At other points, however, the descriptive power of diagnosis was constructed as less clear:

T: And also I guess the over compensating the way he was in the room he wasn't like someone if someone is socially, socially anxious then they are actually, quite you know like... but I guess they all over compensate as well though

S: Yea they can but it's. um

T: I dunno I don't know

S: A lot of what we're looking at when somebody comes in with social phobia.. it's actually mainly the avoidance

T: Mm

S: And the reason that social phobia's become a problem is because they're avoiding or becoming so highly distressed in social situations and I don't get that feel from him. (Transcript 5, lines 301-310)

Here social phobia is constructed as a real thing, something that exists in the real world that you can 'feel'. The use of the term 'actually' constructs this as a fact or truth; however the same 'truth' was not shared.

Throughout the transcripts there were frequent attempts to distinguish between different categories or symptoms: 'So I was just thinking about the relationship of the... all the disorders, like if you work with PTSD, does it have any impact on depression? Low self esteem? Are they all really inter related or are they separate from one another?' (Therapist, transcript 2, lines 199- 201). Thus it is not always easy to identify the 'target' for treatment. Diagnosis is constructed as inadequate and confusing in the face of complexity. Often discussions of diagnosis were followed by more lengthy discussions of relationship factors, perhaps indicating the perceived inadequacy of diagnosis in the minds of the therapists to explain service users' distress. Despite this, diagnosis is referred to freely and attempts are made to distinguish between diagnoses. Attempts are made to tease out a discrete symptom amongst complex and varied problems as the focus of treatment.

Mental health problems are the result of dysfunctional personal living. Throughout the discussions prescribed ways of being in the world were constructed and service users were compared against these. Judgments based on the prescribed markers, commonly employment, close relationships and emotional resilience were made and service users positioned as 'doing well' or 'not coping'. At the extreme end service users were constructed as fragile and potentially risky. The next extract shows this discourse in operation:

T: Erm, so it turns out that he has a massive debt of about 25 thousand pounds and

S: Ah ok, so he's hiding from debt collecting agencies

T: Er and he wouldn't share anything about that so that second session was a lot about that, about his debt and how it accumulated. Other information that he shared was relationship problems. He said that it's not sexual relationship that his wife is the main breadwinner, he has an interest in music and has had some success with it but he's not employed at the moment

S: Hm hm

T: And he's doing some kind of workshop in the community but that's not paid... but even when he shared information about that I couldn't quite make sense of it, when I asked him about goals he said something that it has to do with the relationship but also he wanted – his own words – he wanted to learn to live as an adult

S: Hm hm

T: He wanted to be confident, to know in his own words – to know my choices are right – to have a career. (Transcript 4, lines 510- 518)

Here the therapist recounts the main factors against which functioning is compared: relationships (he shared was relationship problems. He said that it's not sexual relationship that his wife is the main breadwinner), employment (he has an interest in music and has had some success with it but he's not employed at the moment; And he's doing some kind of workshop in the community but that's not paid...) and in this case added debt problems (he has a massive debt of about 25 thousand pounds). Through this retelling the service user is constructed as not functioning or living up to the standards expected in society. The therapist maintains a distance from what is being said by using reported speech (these are his words) and disavowing ownership (I couldn't quite make sense of it), perhaps indicating discomfort with the way the service user was being constructed. This is particularly apparent towards the end of the extract where the social value-laden implications are made explicit (to learn to live as an adult, to know my choices are right). Here repeated reaffirmation that these are 'his words' was made.

Problems are created by families and must be solved by the individual. Family background and family dynamics were mentioned as a contributory factor of distress in every case discussed. While diagnosis or symptoms of diagnoses were usually mentioned first, family was often talked about soon after and in more depth, despite the fact that symptom

reduction is the primary target for IAPT.

The following extracts demonstrate how 'family' was positioned in relation to the individual and their distress:

S: Well I think you're spot on. Mum has been around from the start and it was mum who brought him back that time and said he was back to square one and he wasn't

T: And it was her who brought him to the assessment as well. Same things you know 'I need to come in, you need to do something, He's a mess'

S: It's frustrating with IAPT being the way that it is we can't offer family interventions. (Transcript 1, lines 430- 436)

The mother was constructed as undermining therapy (it was mum who brought him back that time and said he was back to square one and he wasn't) and undermining the service user (I need to come in, you need to do something, he's a mess). Through the retelling of the mother's positioning of the service user, they were constructed as passive and a 'mess', incapable of doing anything for themselves. The therapist was positioned as responsible for 'doing something'. The mother and the family relationships were constructed as the problem requiring an intervention that is unavailable (It's frustrating with IAPT being the way that it is we can't offer family interventions).

There was no option to work with the family and so the therapist and supervisor made several attempts to construct a solution at an individual level:

S: I mean so I think just helping him to get in touch with his emotions about it so it's very much about imparting his agency because mum isn't involved in the therapy well she is indirectly but you can't work with her so all you can do is work with him and help him to see what his options are and the implications of that and this might be another piece of work for the future you might want to

say 'what might make him know that he wants to come back. to therapy and if so what would it be for?'(Transcript 1, lines 576- 582)

Here the service user was constructed as passive yet at the same time as having agency to weigh up the pros and cons of his current relationship with his mother and act accordingly. This constructs relationships and negotiation of relationships as resulting from a conscious, reasoned, decision-making process. The service user was constructed as having options and the right (or responsibility) to make choices for himself. This almost forces a responsibility and agency on to the person that they may not possess. Within the service constraints there is no alternative option and the therapist and supervisor seem aware of the inadequacy of their intervention, perhaps explaining their frustration in the previous quote and their focus on preparing him to re-refer in the future.

Through this discourse, two things happen: the family is problematized and what has been discussed as a relational 'problem' is individualised by offering a solution at individual level.

There is no such thing as society? The context within which cases were understood largely related to diagnosis, employment or education, close personal relationships and personal coping. The influence of wider social milieu within which the individual lives, including factors such as gender, class, ethnicity, culture, societal norms, neighbourhood and ideology were largely silent. There were some limited discussions of these factors, one of which will be discussed next:

- S: Sorry I'm left thinking there's a man from south Africa, I've just got all these questions: when did he come over? How long has he been here? Erm... South African culture, is that playing a part? Is he white South African
- T: He is he is Yep
- S: Does that play a part in that kind of idea of his masculinity

T: I think it does.. we talked about it, we talked about it in the sense that... although it's very hard for me to judge you know as to how much of this is objective and how much of this is objective within his family it's very black and white in terms of male and female roles (transcript 4, lines 129- 137)

The supervisor in this discussion attempts to construct South African culture in relation to masculinity. This is picked up by the therapist and related to the family (it's very hard for me to judge you know as to how much of this is objective and how much of this is objective within his family). This has the effect of attributing what may be cultural norms and ideas to the family, problematising the family and disconnecting individuals and families from wider social forces.

Later in the discussion the supervisor attempts to re-introduce the construct of culture:

S: Yes it always fascinates me the impact of culture and the influence and how much is cultural difference and how much is that kind of distorted thinking

T: Yea

S: That comes with depressions but well keep doing what you're doing but see if you can weave some of that

T: Well what should I do about the number of sessions?

S: Well I would extend by another 6 sessions (Transcript 4, lines 371- 377)

Here the supervisor constructs cultural difference and distorted thinking as different objects, although hard to differentiate. In suggesting the therapist 'weave some of that in' the supervisor took a position of resistance against the dominant discourse that 'it's all about faulty thinking' as discussed in the previous section related to IAPT texts and to wider discourses that 'there is no such thing as society'. The therapist responds by changing the direction of the conversation to more practical easily resolved questions (well what should I do about the number of sessions?), perhaps indicating the difficulty and complexity that

thinking about culture creates. Moving back to the IAPT targets positions these questions as out of her remit and means that the anxiety created by such complexity can be managed.

Discussion

A number of discourses were identified. There was some difference and some overlap of discourses between those in IAPT texts and those in the supervision discussions, largely the discourses operated differently.

Medicalised discourses relating to diagnosis were dominant within the texts and the supervision sessions. Although generally associated with the biological model, it has been argued that diagnosis does not necessarily pre-suppose a biological model (Follette, 1996; Follette and Houts, 1998; Wakefield, 1998). Consistent with this argument, diagnosis in the texts was conflated with CBT; however, medicalised discourses run throughout. Distress was represented as a disorder or problem, based on faulty thinking or coping. Consistent with previous critiques of diagnosis, this study noted that although based on clinical judgment and interpretation, diagnosis was presented as an objective fact (Kirk & Kutchins, 1994; Butler, 1999), a real entity that represented something categorical about the subjects (Mirowsky & Ross, 1989). This understanding of distress as a diagnosable mental health problem was imposed on 'patients' and little room for consideration of other factors was afforded. This is consistent with Terkelsen's (2009) findings that not only was diagnosis imposed on service users, but those who disagreed with their diagnosis were often labeled as 'lacking insight'. Similarly a pre-determined notion of recovery was also imposed on the 'patient'. Recovery used in the texts contrasts greatly to the notion of recovery in survivor discourses that value finding personal meaning in life and that consequently often reject diagnoses in pursuit of inclusion and empowerment (Bassman, 2007; Deegan, 1993; Longden, 2010; May, 2000).

The certainty of diagnosis was less consistent in the supervision talk. Different ideas about what constitutes the core feature(s) of a particular diagnosis were evident in the

discussions and therapists sometimes seemed unclear about which diagnoses applied and to what extent. This is consistent with evidence showing low reliability and validity of mental health diagnoses (Boyle, 2002; Bentall, 2004; Johnstone, 2008; Moncrieff, 2010). Mason (1993) argues 'premature certainty', professing to understand too quickly, stifles dialogue and creates opportunities for misunderstanding. Diagnosis may represent an example of 'premature certainty' and what Mason (1993) terms 'unsafe certainty'. It seemed that therapists were regularly faced with the complexity of distress, where people could not easily be categorised into discrete diagnoses. During the discussions moments of moving from positions of certainty to uncertainty in relation to diagnosis were noted. Mason (1993) argued that adopting a position of safe uncertainty, encourages curiosity and allows alternative perspectives and possibilities to be considered. Similar processes were seen in relation to CBT and alternative approaches, although translated back to CBT, were considered.

Discourses related to social exclusion also operated differently between official IAPT texts and supervision sessions. In the texts social exclusion was explicitly referenced and IAPT was positioned as reducing social exclusion by increasing access to psychological therapy and helping re-employment. Levitas (1999) identified three main discourses that are drawn upon when discussing social exclusion: redistributive discourse (RED); Social Integration discourse (SID); and moral underclass discourse (MUD), with SID dominating current policy. SID places exclusion in the context of employment; social exclusion is the result of economic inactivity and unemployment. Paid work is represented as the only legitimate means of achieving social integration with unpaid or voluntary work deemed unimportant and ways that employment fail to prevent exclusion unaccounted for. SID featured prominently in IAPT discourse. The provision of IAPT is dependent on increasing economic activity (Layard, 2006), thus setting help as a trade-off and creating an expectation and responsibility on the client to return to work.

Social exclusion was not explicitly discussed during the supervision sessions, although factors indicative of social exclusion such as unemployment, isolation, and lack of civic involvement (Gordon et al, 2000) were. The discussions echoed that of the work and social adjustment scale in the texts whereby service users were constructed as not functioning in relation to key social factors and as deficient. These findings echo critiques that mental health is used to explain moral problems (e.g. Sczas), therapists used to enforce a moral code (e.g. Foucault, 1979) and that individuals internalise societal prescriptions (Moane, 2003) and self-regulate (Parker, Georgaca, Harper, McLaughlin & Stowell-Smith, 1995). It is reminiscent of labelling and deviancy theories that suggest mental health labels are used as a sanction when rules, including societal norms, are broken.

An individualist, rather than a social or political, understanding of distress was constructed through the discourses employed in both the texts and supervision sessions. Discourses for understanding distress which focus on understanding distress as an illness, faulty thinking or dysfunctional personal living is congruent with and supportive of wider discourses that value independence, autonomy, and competition etc., core values within a capitalist society, dependent on consumerism. These ideas are politically useful and serve psychology: an individual illness with an effective treatment is marketable to commissioners, politicians and the general public (Smail, 2005).

Attempts were made to resist these dominant discourses, although constrained, opening the way for a wider conceptualisation of distress. A dominant discourse that emerged within the supervision discussions related to that of family. Through attempts to understand the complexity experienced, therapists and supervisors constructed distress as arising within the context of family. Prilleltensky (1994) argued that family therapy does not go far enough and through something new being brought in, critical insight is obscured, a process referred to

as dislocation. Thus although drawing on interpersonal processes extends the understanding of distress, going further may also be helpful.

Limitations of the study

The sample was recruited from one mental health trust. Although the trust was spread over a wide geographical area and the sample was recruited from different teams within the area, it is possible that the results reflect the culture of that specific trust, rather than being able to say anything about discourses within IAPT generally. Additionally, it was hard to recruit to this study, possibly because of feelings of scrutiny as reflected in my field notes (Appendix 5). This may mean that only enthusiastic therapists participated, affecting the representativeness of the data. Similarly, feelings of scrutiny may have tempered the discussions; indeed there were several references to the session being recorded noted in the audio recordings.

This study was an analysis of words in the context of official texts and practice talk. My analysis was not intended to be a service evaluation or to say anything about the people as they might actually be.

I was aware that my own views that the social world is neglected within psychology and psychological thinking may have led me to be slightly more biased towards discourses that problematize individuals. As discussed in the quality assurance section, measures were put in place to reduce this bias. The analysis was examined by and discussed with my supervisor, allowing the potential for alternative readings, however this analysis cannot, and does not profess to, present the 'truth'. The analysis represents a version of identified discourses in the text and talk. Other readings and versions are likely to be possible.

Clinical and research implications

Several themes of interest, but not relevant to the research questions of this study, were noticed during the analysis. One area for future research would be to complete a re-analysis of the data with a different focus.

The dominant discourse identified in the analysis of supervision sessions related to managing clinical need and service expectations. It would be interesting to complete further analysis of client sessions to see how the ideas in supervision are translated into practice. The following questions would be useful to analyse: are ideas related to family or wider social 'causes' of distress translated into CBT interventions or is CBT abandoned altogether? If so how is this discourses? Can CBT assimilate additional complexities or does it supersede competing ideas? Or is CBT resisted completely?

In terms of practical applications, this study points towards widening what can be said about distress and what help is available. Discourses arising from the supervision sessions illuminate the dilemmas faced by therapists working within the constraints of IAPT. IAPT has started to expand the therapies offered and this study indicates further expansion would be beneficial, perhaps through making family therapy available, but also through expanding consideration of the social context and making this a focus of future training.

References

American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.). Arlington, VA: American Psychiatric Publishing.

Attenborough, L. E., Hawkins, J., O'Driscoll, D., & Proctor, G. (2000). Clinical psychology in context: The impact of the sociopolitical environment. *Clinical Psychology Forum* (pp. 13-17). London: DCP, BPS.

Austin, J. L. (1962). *How to do things with words*. New York: Oxford Univervisty Press

Bassman, R. (2007). *A fight to be: A psychologist's experience from both sides of the locked door*. New York: Tantamount Press.

Bentall, R. P. (2004). *Madness explained*. London: Penguin.

Black, D., Morris, J., Smith, C., & Townsend, P. (1980). *Inequalities in health: Report of a research working group*. London: Department of Health and Social Security.

Boyle, M. (2002). *Schizophrenia: A scientific delusion? (2nd Ed.)* Hove, New York: Routledge.

Bronfenbrenner, U. (1977). Toward an experimental ecology of human development. *American Psychologist*, 32(7), 513-531.

Burman, E. E., & Parker, I. E. (1993). *Discourse analytic research: Repertoires and readings of texts in action*. London: Routledge.

Butler, P. V. (1999). Diagnostic line-drawing, professional boundaries, and the rhetoric of scientific justification: A critical appraisal of the American Psychiatric Association's DSM project. *Australian Psychologist*, 34(1), 20-29.

Cromby, J., Diamond, B., Kelly, P., Moloney, P., Priest, P., Smail, D., & Soffe-Caswell, J. (2012). Draft manifesto for a social materialist psychology of distress. *Journal of Critical Psychology, Counselling and Psychotherapy*, 12(2), 93-107.

Deegan, P. E. (1993). Recovering our sense of value after being labelled mentally ill. *Journal of Psychosocial Nursing and Mental Health Services*, 31, 7–11.

Diderichsen, F., Evans, T., & Whitehead, M. (2001). The social basis of disparities in health. In T. Evans, M. Whitehead, F. Diderichsen, A. Bhuiya & M. Wirth (Eds.), *Challenging inequities in health: From ethics to action* (pp. 13-23). New York: Oxford University Press.

Fiscella, K., & Franks, P. (1997). Poverty or income inequality as predictor of mortality: Longitudinal cohort study. *British Medical Journal*, 314(7096), 1724.

Fleming, I., & Burton, M. (2001). Teaching about the individual and society links on the Manchester clinical psychology training course. *Clinical Psychology*, 6, 28-33.

Foucault, M. (1972). *The archaeology of knowledge*, trans. A. Sheridan. London: Tavistock. (Originally published 1969 in French as *L'Archéologie du Savoir*, Editions Gallimard).

Friedli, L., & Stearn, R. (2013). Whistle while you work (for nothing): Positive affect as coercive strategy - The case of workfare. Retrieved from Centre for Medical Humanities website <http://medicalhumanities.wordpress.com/2013/12/10/whistle-while-you-work-for-nothing-positive-affect-as-coercive-strategy-the-case-of-workfare/>

Gordon, D., Adelman, L., Ashworth, K., Bradshaw, J., Levitas, R., Middleton, S., ... & Williams, J. (2000). *Poverty and social exclusion in Britain*. Joseph Rowntree foundation.

Graville, H. (1998). How much of the relation between population mortality and unequal distribution of income is a statistical artefact?. *British Medical Journal*, 316, 382–385.

House, R., & Loewenthal, D. (Eds.). (2008). *Against and for CBT: Towards a constructive dialogue?* Ross-on-Wye: PCCS Books.

Johnstone, L. (2008). Psychiatric diagnosis. In T. Turner & B. Tummey (Eds.) *Critical issues in mental health*. Hampshire: Palgrave MacMillan, pp.5-22.

Jones, O. (2012). *Chavs: The demonization of the working class*. London: Verso Books.

Judge, K. (1995). Income distribution and life expectancy: A critical appraisal. *British Medical Journal*, 312, 1282–5; 1285–7.

Kaplan, G. A., Pamuk, E. R., Lynch, J. W., Cohen, R. D., & Balfour, J. L. (1996). Inequality in income and mortality in the United States: Analysis of mortality and potential pathways. *British Medical Journal*, 312(7037), 999-1003.

Kennedy, B. P., Kawachi, I., & Prothrow-Stith, D. (1996). Income distribution and mortality: Cross sectional ecological study of the Robin Hood index in the United States. *British Medical Journal*, 312(7037), 1004-1007.

Kirk, S., & Kutchins, H. (1994). The myth of the reliability of the DSM. *Journal of Mind and Behaviour*, 15, 71–86.

Layard, R. (2005). *Happiness: Lessons form a New Science*. London: Allen Lane.

Layard, R. (2006). *The depression report: A new deal for anxiety and depression*. London: London School of Economics and Political Science.

Lessa, I. (2006). Discursive struggles within social welfare: Restaging teen motherhood. *British Journal of Social Work*, 36(2), 283–298.

Levitas, R. (1999). Defining and measuring social exclusion: A critical overview of current proposals. *Radical Statistics*, 71, 10-27.

Longden, E. (2010). Making sense of voices: A personal story of recovery. *Psychosis: Psychological, Social and Integrative Approaches*, 2, 255-259.

Lynch, J. W., Kaplan, G. A., Pamuk, E. R., Cohen, R. D., Heck, K. E., Balfour, J. L., & Yen, I. H. (1998). Income inequality and mortality in metropolitan areas of the United States. *American Journal of Public Health*, 88(7), 1074-1080.

Markon, K. E. (2013). Epistemological pluralism and scientific development: An argument against authoritative nosologies. *Journal of Personality Disorders*, 27(5), 554-579.

Marmot, M. (2004). *The status syndrome: How social standing affects our health and longevity*. New York: Owl Books.

Marmot, M. G., Allen, J., Goldblatt, P., Boyce, T., McNeish, D., Grady, M., & Geddes, I. (2010). *Fair society, healthy lives: Strategic review of health inequalities in England post-2010*.

Martín-Baró, I. (1996). Toward a liberation psychology. *Writings for a Liberation Psychology*, 17-32.

Mason, B. (1993). Towards positions of safe uncertainty. *Human Systems*, 4(3-4), 189-200.

May, R. (2000). Routes to recovery from psychosis: The roots of a clinical psychologist. *Clinical Psychology Forum*, 146, 6-10.

Mirowsky, J., & Ross, C. E. (1989). Psychiatric diagnosis as reified measurement. *Journal of Health and Social Behavior*, 30, 11-25.

Moane, G. (2003). Bridging the personal and the political: Practices for a liberation psychology. *American Journal of Community Psychology*, 31(1-2), 91-101.

Moncrieff, J. (2010). Psychiatric diagnosis as a political device. *Social Theory and Health*, 8, 370- 382.

Muntaner, C., & Lynch, J. (1999). Income inequality, social cohesion, and class relations: A critique of Wilkinson's neo-Durkheimian research program. *International Journal of Health Services*, 29, 59-82.

Parker, I. (1992). *Discourse dynamics*.

Parker, I., Georgaca, E., Harper, D., McLaughlin, T., & Stowell-Smith, M. (1995). *Deconstructing psychopathology*. London: Sage.

Prilleltensky, I. (1994). *The morals and politics of psychology: Psychological discourse and the status quo*. New York (NY): SUNY Press.

Smail, D. J. (1993). *The origins of unhappiness: A new understanding of personal distress*. London: Harper Collins.

Smail, D. J. (2005). *Power, interest and psychology: Elements of a social materialist understanding of distress*. Ross-On-Wye: PCCS Books.

Terkelsen, T. B. (2009). Transforming subjectivities in psychiatric care. *Subjectivity*, 27, 195-216.

Turpin, G., Barley, V., Beail, N., Seaire, J., Slade, P., Smith, J. A., & Walsh, S. (1997). Standards for research projects and theses involving qualitative methods: suggested guidelines for trainees and courses. *Clinical Psychology Forum* (pp. 3-7). London: DCP, BPS.

Waller, G. (2009). Evidence-based treatment and therapist drift. *Behaviour Research and Therapy*, 47(2), 119-127.

Watts, R. J., & Serrano-García, I. (2003). The quest for a liberating community psychology: An overview. *American Journal of Community Psychology*, 31(1), 73-78.

Wilkinson, R. G. (1996). *Unhealthy societies: The afflictions of inequality*. London: Routledge.

Wilkinson, R. G. (2005). *The impact of inequality: How to make sick societies healthier*. London: Routledge.

Wilkinson, R., & Pickett, K. (2010). *The spirit level: Why equality is better for everyone*. London: Penguin Books.

Willig, C. (2008). *Introducing qualitative research in psychology (2nd ed.)*. Maidenhead, England: Open University Press.

Appendix 1: Summary of studies reviewed

Study (date)	Aims	Sample	Design and Analysis	Measures	Findings
Buck, Barnes Cohen and Aylward (2010)	To investigate whether psychosocial risk factors, 'yellow flags' moderate the relationship between common health problems (including mental health) and daily life and work. Although not the main focus, this study did compare differences between social classes.	Quota sampling of 1000 working aged adults in a UK community setting was used to recruit a sample representative of the UK in terms of age bands, gender and working status (i.e. working or not working). Of these, 816 participants indicated that they had one or more common health problem and were included in the rest of the analysis.	Cross sectional fieldwork survey using moderator multivariate analysis.	The Cardiff Health Experiences Survey (CHES) was developed through literature review, focus group and pilot study. The survey included the following measures: - Common health problems, assessed using a 14 point checklist of symptoms and two 3-point likert scales to measure extent (severity*frequency). - 'yellow flags', assessed using a checklist to measure catastrophisation, avoidance, vigilance and acceptance. - Perceived causes of health problems, assessed through open question and response. - Interference with daily life, assessed using a 3-point scale of interference in a range of daily activities - Time off work, assessed using a 4-point scale relating to amount of time taken off work due to illness,	1) Model with age, gender, working status and SES resulted in a significant relationship to number and extent of health problems. 2) Gender and work were the only factors independently associated with number and extent of health problems. 3) Extent of problems explains 26% of interference to life but only 5.3% of variance in time off work 4) Age and SES were independently associated with time off work (explained 12.3% of variance). - conclusion: need to further understand socio-economic and occupational contexts as well as individual factors - socio-economic factors need to be considered when designing interventions targeting sickness or presenteeism.
Wilkie, Peat, Thomas and Croft (2007)	To examine the associations between perceived	7878 participants aged 50 and over	Cross sectional postal survey data was collected and logistic	The Hospital Anxiety and Depression Scale (HADS) to measure depression and anxiety	1) After adjusting for age and gender all health conditions, socio-economic and socio-demographic factors were associated

	<p>participation in every day tasks, health (including mental health) and various socio-economic and socio-demographic factors.</p>		<p>regression analysis and multivariate analysis employed.</p>	<p>SES determined by combining current employment status, occupational class, perceived adequacy of income and educational attainment</p> <p>Health problems measured using self-report data of a checklist of problems</p> <p>Participation restriction measured using the Keele Assessment of Participation</p> <p>Activity limitation/impairment measured using The Medical Outcome Study Short Form-36.</p>	<p>with restriction in everyday tasks.</p> <p>2) Participation restriction is higher in those who were unemployed and experienced mental health problems and low SES.</p> <p>3) Income, employment status and occupational class were related to participation in everyday after controlling for health conditions</p>
<p>Chanfreau, Barnes, Tomaszewski, Philo, Hall and Tipping (2010)</p>	<p>To investigate the effects of job loss or substantial reduction in work on subsequent home environment, parent-child relationship and maternal mental health.</p>	<p>Data from the babies (the 'birth cohort'), of which 3,833 took part in the 2009/10 study and 3,621 took part in all five years of the study.</p>	<p>Longitudinal design and multivariate analysis employed. Data analysed every year.</p>	<p>'Chaotic home environment' measured using four questions from the 15-item Confusion, Hubbub, and Order Scale (CHAOS)- assessed turmoil across four areas: disorganisation, noise, having a calm atmosphere, and having a regular routine at home</p> <p>Parent-child relationship, measured using items from the Pianta scale designed to assess 'warmth' and 'conflict'</p> <p>Maternal mental health, measured using the Medical Outcomes Study 12-item Short Form mental health component</p> <p>SES determined using household tenure, social class, income and area deprivation.</p>	<p>1) Lone parents were more likely to experience job loss or a substantial reduction in work than two-parent families.</p> <p>2) Both couple families and lone parents were more likely to experience job loss if they were in a lower social class, did not own their own home and lived in a deprived area.</p> <p>3) Job loss was associated with subsequent chaotic home environment, high parent-child conflict and in</p> <p>4) Lone parents who lost their jobs were more likely to experience mental health problems.</p> <p>5) Families with stable employment did not share the same outcome.</p>

<p>Meltzer, Pebbington, Brugha, Jenkins, McManus, Stansfeld (2009)</p>	<p>To examine if and how the link between job insecurity and mental health, namely depression, is affected by SES.</p>	<p>A stratified (by place and SES) random probability sample of 3581 participants in the third national survey of psychiatric morbidity in Great Britain was selected.</p>	<p>Fieldwork was carried out and information collected regarding depression, debt, SES and job insecurity.</p>	<p>Common mental disorders (CMD), generalised anxiety, depression, obsessive-compulsive disorder, phobia, panic and mixed anxiety and depression as identified by the CIS-R</p> <p>Debt measured by inability to pay for bills in the last year</p> <p>SES based on NS-SEC</p> <p>Job insecurity measured by one-item 4-point likert scale.</p>	<p>1) Both men and women reported some degree of job insecurity (21.4%)</p> <p>2) Men reported increasing job insecurity with age.</p> <p>3) Other job features of concern were: jobs had become more demanding (66.4%) there were more interruptions or disturbances in their job (65%) and heavy work load and time pressure (63.5 %).</p> <p>4) factors associated with depression were undesirable change, lack of respect from manager and job insecurity.</p> <p>5) job insecurity, debt and lower social class were all independently related to Depression.</p>
<p>Butterworth, Leach, McManus and Stansfeld (2013)</p>	<p>To compare psychiatric diagnoses among those who are unemployed or employed in work of varying quality.</p>	<p>2603 adults between 21 and 54 who had completed the English Adult Psychiatric Morbidity Survey (APMS) and were either employed or looking for work were included. A stratified random sample was used to obtain a representative sample in terms of place and SES.</p>	<p>Quantitative analysis using national survey data and logistic regression models.</p>	<p>The Revised Clinical Interview Schedule (CIS-R; Lewis et al. 1992) was used to assess psychiatric diagnosis.</p> <p>Psychosocial work characteristics were measured using adapted versions of:</p> <ul style="list-style-type: none"> - the ERI questionnaire (Siegrist et al. 2009), that measures job demands and job rewards. - the JD-C model used in the Whitehall II Study (Stansfeld et al. 2002), measuring job control. <p>SES was indicated through measures of social disadvantage (debt, low income and unskilled occupational background)</p>	<p>1) poorer mental health was reported by participants who were unemployed compared to those with optimum jobs or jobs with one adversity.</p> <p>2) participants reporting being employed in jobs with 2 or more adversities showed comparable mental health to those who were unemployed.</p> <p>3) These findings were consistent regardless of social backgrounds relating to debt, low income and social class.</p>

<p>Dolan (2007)</p>	<p>To investigate how working-class men understand and experience differences in income and material circumstances and how this impacts on well-being. The study compared the perceptions of men from relative affluent and non-affluent areas and relative affluent and non-affluent households</p>	<p>22 working class men.</p>	<p>Qualitative study using thematic analysis.</p>	<p>Semi-structured interviews.</p>	<p>1) all said managing well but differences in what this meant practically - those living in the non affluent area were often living without essential services and goods and affording to live day-to-day was a struggle - those living in affluent area/non affluent household living without luxuries - affluent households could afford what they wanted when they wanted.</p> <p>2) Income stratification - all said material circumstances reflect effort and skill. - all categorised deserved and underserved income. - those from non affluent area keen to appear not to be wanting something for nothing - participants from affluent area/ affluent household believed differences in income exist to push people's aspirations - participants from non-affluent area/ non-affluent household communicated a sense of hopelessness: to move up is not within the realm of possibility.</p> <p>3) Income inequality - all felt that income inequality put a pressure on people to 'keep up with the joneses', to work harder despite the negative impact on health and mental health - all felt anger and resentment that they were looked down upon by those higher</p>
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					<p>than them</p> <ul style="list-style-type: none"> - participants in non affluent area also felt that as a group they were looked down upon <p>4) Differences in the way they conceptualise mental health.</p> <ul style="list-style-type: none"> - Non-affluent area- daily living standards and stress creates anxiety and panic - affluent/non affluent- loss of employment led to anxiety - affluent/affluent- stress, migraines sleeplessness caused by work. - all viewed work as major source of stress.
Barnes, Buck, Williams, Webb and Aylward (2008)	To investigate attitudes to health (including common mental health problems) and work in different socio-economic areas.	79 participants of different gender, age, socio-economic and working status living in either Cardiff or the South Wales valleys.	Qualitative study using thematic analysis.	<p>6 focus groups organised by the following dimensions:</p> <ol style="list-style-type: none"> 1. employment status= working, not working and mixed 2. class= mixed, 1-3 and 4-5. <p>SES measure- National Office of Statistics NS-SEC five-class system</p>	<p>1) Out of all health problems stress and depression was talked about the more readily, more frequently and more intensely.</p> <ul style="list-style-type: none"> - men talked more about illness than women across all groups <p>2) Depression and stress was believed to have increased</p> <ul style="list-style-type: none"> - the reasons for this were attributed to changes in society <p>3) The relationship between social and economic pressures and work and common mental health problems was a common theme discussed</p> <ul style="list-style-type: none"> - same across all groups - detrimental effects of consumption, particularly the effects on identity and lifestyle confusion was highlighted.

					<ul style="list-style-type: none"> - structural changes and the influences on work and mental health was relevant in the valleys group only. - women were more likely to experience role conflict and role overload (particularly not working women) <p>4) Morality and legitimacy of absence</p> <ul style="list-style-type: none"> - in all groups regardless of personal circumstances people presented themselves as only taking time off due to legitimate reasons - working women talked more about what constitutes a legitimate reason to take time off work - those who were unemployed talked a lot about their illness being legitimate as if trying to prove to the others in the group - college students seemed more allowed to take time off because of minor illnesses than grown-ups with 'proper jobs'. - working people talked about illness in relation to work pressures and were more likely to attend work when sick. Issues of presenteeism were discussed. - Not working people related their time off work to major life events e.g. death - work was believed to be a primary stressor across all groups
Fone, Dunstan, Williams, Lloyd and Palmer (2006)	To investigate if individuals' mental health is associated with area economic activity due to sickness after	A random sample stratified by ward was selected and resulted in a total of 10, 653 participants nested with 36 wards in Caerphilly	A cross sectional postal questionnaire survey using multilevel modelling.	Mental health status was assessed using the Mental Health Inventory (MHI-5) scale of the Short Form-36 health status questionnaire SES determined by combining	Incapacity for work associated with poorer mental health but only if living in a ward with higher proportion of incapacity claimants than those living in wards with lower proportion of claimants.

	adjusting for employment status and socio-economic markers.	county borough. The mean number of respondents per ward was 345.		employment status, social class, household income, housing tenure and property value.	
Weich, Twigg and Lewis (2006)	Investigated differences in the onset and maintenance of common mental health problems in relation to the following area level factors: SES and population density	The sample included 7659 adults aged 16-74 living in 4338 private households, nested within 626 electoral wards.	Data were analysed using multilevel statistical modelling.	Common mental health problems were assessed using the General Health Questionnaire (GHQ) Electoral wards were characterised by Office for National Statistics classification and by population density.	1) SES and employment status had no effect (moderating or confounding) on the onset of mental health problems. 2) Maintenance of mental health problems were significantly associated with place but only when using SES status of the area rather than population density. These effects were not mediated by individual economic status or household income.

Appendix 2: Email to academic providers

Dear XXX

I am a student on the Clinical Psychology doctoral training programme. As part of the programme I will complete a major research project and I am planning to do my research into the current discourses (ways of talking and practicing) related to psychological distress and help in current IAPT services.

Two sets of discourse material will be analysed using principles taken from Foucauldian Discourse Analysis:

A selection of 8-12 key policy and practice texts (identified by IAPT training providers).
Recordings of 8-12 hours of supervision sessions attended as part of the normal practice of high-intensity therapists offering CBT at IAPT services.

As an academic provider you are well placed and familiar with the key policy texts relating to the creation and continued development and evaluation of IAPT. I would be grateful if you could e-mail me in rank order the 10 policy and practice texts that you feel are most important.

I have attached a participant information sheet that gives more information about the study. If you have any further questions please don't hesitate to contact me at: (EMAIL ADDRESS).

I look forward to hearing back from you.

Kind Regards,
(NAME)
trainee clinical psychologist,

Appendix 3: Recruitment request e-mail to IAPT service managers

(forwarded by second supervisor who had contact with the management team)

Dear XXX

I am a student on the Clinical Psychology doctoral training programme. As part of the programme I will complete a major research project and I am planning to do my research into the current discourses (ways of talking and practicing) related to psychological distress and help in current IAPT services.

Two sets of discourse material will be analysed using principles taken from Foulcauldian Discourse Analysis:

A selection of 8-12 key policy and practice texts (identified by IAPT training providers).
Recordings of 8-12 hours of supervision sessions attended as part of the normal practice of high-intensity therapists offering CBT at IAPT services.

I am hoping to recruit high-intensity therapists across IAPT sites in SLAM initially and hoped that I may be able to come to a team meeting to explain the research and potentially recruit participants to the study?

I would be looking to recruit high-intensity therapists (qualified or still in training) and supervisor's of high-intensity therapists who provide CBT at IAPT services.

Their participation in this study would involve recording one supervision session that they attend as part of their normal practice. I would arrange a convenient way to do this with the relevant practitioners. It is anticipated that this would take place sometime between July and September, but could be extended if needed.

It would be helpful to the study if participating clinicians could also discuss a sample of interpretations I make from their recorded supervision session so that I can incorporate this into the analysis (this helps to make the analysis more accurate/valid), though this is not compulsory. It is anticipated that this will take place around December 2013- February 2014. I can negotiate the most convenient way to do this, including the amount of time needed.

I have attached a participant information sheet that gives more information about the study. If you have any further questions please don't hesitate to contact me at: (EMAIL ADDRESS).

If this all seems OK, it would be great if I could come to a team meeting to explain the research to potential participants or contact them by e-mail if this is preferred?

I look forward to hearing back from you.

Kind Regards,
(NAME),
trainee clinical psychologist,

Appendix 4: Research information sheet and consent form

How are people's problems talked about within IAPT and how does this relate to our understanding of distress and the types of help available?

My name is (NAME) and I am a trainee clinical psychologist at Canterbury Christ Church University. I would like to invite you to take part in a research study which I am conducting as part of my Doctorate in Clinical Psychology. My research has been approved by Fulham NRES (ethics committee) and local R&D approval gained.

Before you decide whether to participate or not, it is important that you understand why the research is being done and what it would involve for you. Talk to others about the study if you wish.

Part 1 tells you the purpose of this study and what will happen to you if you take part.

Part 2 gives you more detailed information about the conduct of the study.

N.B. When reading the information sheet please be aware that anonymity will be assured for all clients and therapists. This is covered in more detail in part 2.

Part 1

What is the purpose of the study?

This study aims to analyse supervision sessions to identify current discourses (ways of talking) relating to clients' problems and potential solutions within IAPT services. This is important because often there becomes a dominant discourse (way of talking) which emphasises certain areas but overlooks others. Discourses (ways of talking) in healthcare influence and are influenced by the way people's problems are understood and the types of help available. The information we get from this study will help us to understand which aspects have come to be emphasised and which have not when therapists talk about people's problems. This may help to highlight factors that are not routinely considered when understanding people's problems but which might be important. It may also help to highlight other ways of helping.

Please note that this is not meant to be a quality assurance check. Discourse is about language in use and how this reflects social practice determined by social structures. The purpose of the study is to analyse how therapists collectively think and talk about clients problems and potential solutions rather than analyse the skill of one therapist.

Why have I been invited?

I plan to record and analyse supervision and case discussion meetings to identify current discourses within IAPT. As a high-intensity therapist within an IAPT site, I would like to record some discussions that you are a part of.

Do I have to take part?

It is up to you to decide whether or not to join the study. If you agree to take part, I will then ask you to sign a consent form. You are free to withdraw at any time, without giving a reason.

What will happen to me if I take part?

You will be expected to take part in supervision and case discussion meetings as usual and I will record one of these. I will arrange with you a convenient way to do this. It is likely to be that I attend the beginning of the supervision session to start the recording and then leave while you complete supervision as usual. Following the supervision I will complete a debrief session and take the recording with me to transcribe.

I will also ask you to look over a sample of interpretations as a way of checking the quality of my analysis. This is likely to be in March. I will arrange a convenient way to do this with you.

What are the possible disadvantages and risks of taking part?

This study is not intended to assess your skills as a therapist in any way, it is intended to identify the discourses that exist within IAPT so please be assured there are no disadvantages or risks in that respect. Most people become accustomed to being recorded very quickly, although you may feel uncomfortable initially.

What are the possible benefits of taking part?

The information we get from this study will help us to understand which aspects have come to be emphasised and which have not when therapists talk about people's problems and potential solutions. This may help to highlight factors that are not routinely considered when understanding people's problems but which might be important. It may also help to highlight other ways of helping.

What if there is a problem?

Any complaint about the way you have been dealt with during the study or any possible harm you might suffer will be addressed. Detailed information on this is given in Part 2.

Will my taking part in the study be kept confidential?

Yes. I will follow ethical and legal practice and all information about you will be handled in confidence. Detailed information about this is included in Part 2.

This completes part 1.

If the information in Part 1 has interested you and you are considering participation, please read the additional information in Part 2 before making any decision.

Part 2**What will happen if I don't want to carry on with the study?**

If you decide you want to withdraw from the study you can do so at any time without giving a reason by contacting me, (NAME), on (NUMBER). If you withdraw from the study, any data about you will be removed from the study.

What if there is a problem?

If you have a concern about any aspect of this study you should contact me, (NAME), on (NUMBER) and I will do my best to answer your questions. If you remain unhappy and wish to complain formally you can do this by contacting my supervisor, (NAME AND NUMBER) in the first instance.

Will my taking part in this study be kept confidential?

All information which is collected about you during the course of the research will be kept strictly confidential. Discussions that you take part in will be recorded using digital recording equipment and then stored on an encrypted memory stick. I will ask you to use a pseudonym when talking about your clients and leave out any identifying information such as their address during discussions.

Voice recordings will be transcribed within one week and will be deleted once they have been transcribed. I will not attach your name or any other identifying information to the transcript. To preserve anonymity and confidentiality any electronic notes will be password protected. Any written notes will be stored in locked filing cabinets. Any data that is transferred will be transferred on encrypted memory sticks.

Only I will have access to voice recordings and transcripts. In addition, my supervisors will have access to a sample of transcripts for quality assurance purposes.

It is a requirement that the data is stored for 10 years after the study is completed. This will be kept in encrypted form on a password protected CD in a locked filing cabinet. After this time it will be destroyed securely.

Usual limits to confidentiality apply and I may need to pass on information if I am concerned that someone's safety is at risk or if a criminal offence that the Police aren't aware of is disclosed.

What will happen to the results of the research study?

The results of the research will be written into a report and submitted to Canterbury Christ Church University. I also intend to publish the report in relevant academic journals. Anonymised quotes from discussions may be used in published reports, though you will not be identified in any report/publication.

Who is organising and funding the research?

Canterbury Christ Church University.

Who has reviewed the study?

All research in the NHS is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by Fulham Research Ethics Committee.

Further information and contact details

If you would like to speak to me and find out more about the study or have questions about it answered, you can leave a message for me on a 24-hour voicemail phone line at (NUMBER). Please say that the message is for me, (NAME), and leave a contact number so that I can get back to you. Alternatively you can e-mail me on (EMAIL ADDRESS).

CONSENT FORM

Name of Researcher: (NAME)

Please initial box

1. I confirm that I have read and understand the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my legal rights being affected.

3. I understand that relevant sections of my data collected during the study may be looked at by the lead supervisor [Anna Martin/ Louise Goodbody]. I give permission for these individuals to have access to my data.

4. I understand that relevant data collected during the study, may be looked at by individuals from Canterbury Christ Church University, from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to this data.

5. I agree that anonymous quotes from my interview may be used in published reports of the study findings [if applicable]

6. I agree to take part in the above study.

Name of Participant _____ Date _____

Signature _____

Name of Person taking consent _____ Date _____

Signature _____

Appendix 5: Follow- up e-mail to participants

Follow up e-mail to clinicians following initial contact.

(To be forwarded to clinicians, as agreed by manager).

Dear high-intensity therapists and supervisors.

I enjoyed meeting with you last week to talk about my research. I hope that you have had a chance to think about the research and to talk to others about it if you wanted to. If you had any further questions or would like to register your interest in participating in the study it would be great to hear from you.

You can contact me on XXX

I am also happy to meet with you or to talk over the phone. You can contact me on the above e-mail address to arrange this.

I look forward to hearing from you.

Kind Regards,

Charlotte Cox,
trainee clinical psychologist,

Appendix 6: Research diary

So far it has been very difficult to recruit to the study. My supervisor is helping me to gain access to the trust she works in through contacts she has but the plan is to also recruit from other services. So far I have sent several e-mails to managers and had no responses. Also it seems to be taking a long time to actually recruit from the trust I have access (in theory) to- lots of discussions with managers etc before I can actually speak at a team meeting. It is all frustratingly slow. In the meantime I am planning to analyse the documents, but I just hope that the recruitment speeds up a little soon- I just need to make sure I keep up momentum with it.

I have just finished my first 'go' at discourse analysis with one of the texts. I decided to start with The Data Handbook- seemed as good a place as any to start. With hindsight it might have been a harder text to start with as it's not obvious how 'distress' and 'help' are constructed in the text and so I really had to work hard to find this. I'm hoping that the other text will be easier though I'm not sure that will be the case, especially if assuming that a lot of it will be taken for granted. I decided to analyse this text thoroughly and look for all discourses I could see rather than just those that relate to my research question so that I could become more practiced at DA. I quickly realised how time consuming the process is and will be. And how challenging it is. There seemed to be so many different themes and categories that although not identifiable as discourses yet, could potentially be developed into discourses. I also noticed that a lot of the time the same quote could be used for different themes/categories and for different reasons i.e. the same quote could perform different functions. The other issue is that I have noticed some interesting themes (that could potentially lead to discourses) that are not really relevant to my research questions- part of me feels disappointed that I won't be able to include some of what I've worked hard to develop, even if I'm only at the very early stages. The other part of me is a bit concerned that I could easily stray away from my research questions and go off on a tangent or become overwhelmed and confused. There seem to be so many directions I could go in- how will I ever know which way go to develop my discourses? And how will I ever be able to form a coherent narrative? But I'm probably getting ahead of myself. For now I just need to focus on staying with my research questions and holding them in mind more when analysing my data. I think the thing that will really help is to start the next texts by reading through and taking out portions of the text that relate to my research questions and then analysing these sections further.

I had quite an interesting discussion with a friend today about the 'work and social adjustment scale' part of IAPT's routine data collection. I asked a relatively well-educated friend- not into psychology or the helping professions but open minded and respectful- what they thought of this questionnaire. They said they didn't have a problem with it. Initially I thought maybe I was being sensitive and reading too much into the questionnaire. I asked how they would feel having to fill this in if they were seeking help and they said it wouldn't surprise them- if they were seeking psychological help they would already know that they weren't exactly adjusted, that would be why they were there. I was surprised by this statement coming from this person but it also reminded me how taken for granted some ideas can be.

I had supervision with my primary supervisor today and we went through some of my coding so far. I'm still at the early stages with just initial coding done for a couple of the documents and so the main purpose was to go through some of this to see if I'm on the right track. On

the whole I feel reassured by the discussions. It seems like what I've done so far makes sense. There was one interpretation that we had a discussion about as my supervisor disagreed with my interpretation of the section and the subsequent code I attached to it. Thinking about it, my interpretation could reflect a bias on my part as my interpretation was of a more scrutiny/surveillance feel of the therapists at IAPT than my supervisor noted. At my current stage of training I can definitely say I feel scrutinised and in some respects I can recognise bringing some of my feelings about that to my analysis of the data. On the other hand our interpretations differed based on the structure of a sentence and how we interpreted the definition of the word 'ultimately' in the sentence. I looked up 'ultimately' in the dictionary and found two different definitions- both fit the sentence and change the overall meaning accordingly. Things to take forward: acknowledge projection and bias, look for alternative readings of sentences, think about the meanings of the words used, consider if alternative definitions can be substituted into the sentence, and consider the current interpretation in relation to other instances- DA is about looking for patterns, not one off instances.

As I've been analysing the documents I noticed that a document 'commissioning IAPT for the whole community' is referenced in many (all?) of the documents and judging by the title I thought it is likely to have more reference to the social world and its relationship to distress than the other documents so far have. After speaking to my supervisor I decided to include this document in my analysis. I've just finished reading it and there seems to be barely anything that I can use. The document just seems to have vague facts about the association between social exclusion, mental health and service use of different groups IAPT have decided to focus on. There's no expansion or exploration of the factors involved. There's no mention of class or SES and how this fits in either. I'm really surprised and very disappointed. It constantly feels like there's nothing to say in relation to my research questions. Q. 'how is the relationship between environment, power and psychological distress discoursed (talked about and practiced) within IAPT texts and practice talk?' A. Errr. it's not. I honestly thought there'd be more to go on than that. I'm going to have to come back to this another day and think about what is there- what is the function of what is written? What does it do? How is it constructing distress and help?

Supervision with my primary supervisor today- it was really helpful to start thinking about the next steps that are needed to make this a DA rather than a thematic analysis. I'm starting to be able to more naturally think 'what is this utterance doing? What function does it serve? What subject(s) or subject position(s) are being constructed?' which I think is more discursive- I'm still hesitant on the language- but my thinking hasn't yet progressed to some of the other more FDA concepts. The conversations today have started me on a path to think about power relations, institutions, other discourses etc. The one question that is ringing in my head that I don't have an answer to and worry I might never is: 'what world does this create?' More thinking, reading, thinking, re-reading is needed for sure!

I always expected recruitment to be difficult as I know that it is difficult to challenge IAPT- there is limited published research that is critical of IAPT and I know from my own experience as a PWP that critiques of IAPT were not welcome. I also anticipated that therapists might be wary of being involved for fear that their skill and competence would be being evaluated so I imagined that would also make recruitment hard. I hadn't anticipated it would be this hard though. I have approached several trusts and had virtually no response to e-mails and no returned telephone calls. So far I have only gained access to one trust where my second supervisor has contacts and has helped push this through. This makes me wonder

about the trust- is it more open to other ideas than the typical IAPT service? Will this represent the average IAPT service? Similarly I have been to 2 team meetings and although people seem really enthusiastic in the team meeting no one has yet come forward to participate. I am really worried that I won't be able to recruit enough people. Supervision with my second supervisor has helped shed some light on the difficulties- it seems that the level of scrutiny and pressure that therapists are under far surpasses what I was aware of. Therapists are now actively being compared against each other on a range of 'targets' including DNA rates, recovery rates, total number of sessions, total numbers of referrals on to other services, and how far into therapy referring on occurred. My supervisor is also aware of rumours that in other trusts there's a 'scores on the doors' culture. While she is unclear about whether this is truly happening, this is the climate people are working in and the level of anxiety people are operating at. There is also a huge work-load and time pressure and services are being commissioned on the numbers actually seen- that means DNA's are not included- so therapists are under increasing pressure to overbook their clinics. I had no idea that therapists were under this level of stress and need to think about how to address concerns in the next team meetings I present my research at.

Finally I have my first recording! I am surprised to say the least by the content- lot about service boundaries, power relations etc, strayed off CBT in client discussions, almost no mention of what I would expect to be typical CBT techniques- core beliefs NAT's, though did do exposure work. Much more talk about family dynamics and work. Could be because nearing the end of treatment? It was also a psychologist so maybe more interested in other stuff than the average CBT therapist? I Will keep an eye out for these observations in other transcripts.

Appendix 7: Ethics Approval

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Appendix 8: R&D Approval

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Appendix 9: Annotated Transcript

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Appendix 10: Theme development

Themes/ discourses	What does the discourse say about how people’s problems are understood?	What does the discourse say about the potential solutions?	What subjects are identified? (e.g. service users, therapists)	What agency, rights and responsibilities are afforded or constrained to the individual?	What world is created by this discourse- what can be said/ done? How are objections handled?
<p>Diagnosis</p> <p>L.16: she was stepped up the reason that she was low mood</p> <p>L. 142: I explained that she had symptoms of low mood blah blah ↑blah</p> <p>L. 248: He presented with post traumatic stress</p> <p>L. 267: But also one of the things I remember from my notes is that actually his scores haven’t gone up</p> <p>L. 500: Well I think she’s as afraid as you know he was when you know one of the symptoms that he expressed when he first came was a sort of hypervigilance towards</p>	<p>People’s problems= symptoms of illness. So well known and accepted that no elaboration of the symptoms is given in most cases that diagnosis is referred to- there is one exception. L.142: Therapist trails of with blah blah blah, possibly indicating boredom, also no need for elaboration. Scores are relevant as they relate to measures of diagnoses. Final quote implies a discrete line between wellness and illness and that the experience of this is discrete and linear rather than fluctuating mood being ‘normal’.</p>	<p>Focused work (CBT) on the symptom/s. Monitoring symptoms.</p>	<p>Service user= nothing, absent. (e.g. language such as ‘stepped up’, referring mainly to people in terms of their diagnosis and lack of expansion on the diagnosis, focus on scores) In this case get more of a sense of ‘the mother’-may be specific to this case (i.e. he is particularly passive) may be a general thing. May relate to the objection from the mother.</p> <p>Therapist= expert position</p>	<p>Little agency in terms of deciding focus of work (e.g. L40, L304), deciding what recovery is (recovery based on outcome measures- predetermined by academics), deciding when recovery has been reached, deciding when the last session will be (L316). Therapist also constrained by the service.</p>	<p>Creates mh as a discrete problem from other health and social care needs and from the environment. This may create othering us and them (the sick and the well, There are suggestions that talking about MH as an illness anyone can get has increased fear of mh and increased stigma as per ‘time to change’ project). Also implies cannot live a meaningful fulfilling life- instead seen as suffering with an illness.</p> <p>So MH is feared, can get you any time, is something that is suffered and prevents a fulfilling life</p> <p>Clear example of</p>

<p>danger in the streets, people lurking in shadows and everything around him</p> <p>L. 40: she would be perfectly suitable for.. CBT for Depression. er from IAPT</p> <p>L. 304: coz I sort of said you now our focus is going to be on the S: Yeah T: traumatic um event um so towards the end of our intervention when we were planning the ending he and his family started requesting an assessment (for aspergers) and I put them in touch with a charitable organisation um who I don't think</p> <p>L. 273: So we saw each other and obviously I was quite nervous that things may have gone backwards for him. Actually they very much hadn't.</p>					<p>objections to the discourse with mother-expert position and outcome measures used to defend the position (L.267 in response to mother saying things back to square one, L273 also), importance of aspergers assessment dismissed.</p>
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<p>S: Really? Good. Good. T: The scores had remained as they were</p> <p>L. 316: So he's now focusing very much on that and we you know spent the last session talking that through because we don't really need to do anything more on PTSD to be honest that's that's kind of done. We're ending now. That's that's done.</p>					
<p>MH abnormal/ not coping/ not functioning</p> <p>L. 265: and although he felt- <u>he</u> felt actually that although he was reacting understandably to something that just happened</p> <p>L. 300: And yeah he seems to be functioning quite well. He's started to have thoughts again about trying to get back into</p>	<p>Certain markers can be used to determine if 'coping'- impact on work, expressions of emotion. Reminds me a bit of Brave New World in that sense- emotions, negativity should be avoided. CBT like soma.</p>	<p>Watchful waiting to see if it is 'just a normal reaction' and if not, then some 'coping skills'- CBT.</p>	<p>SU's= maladjusted/ not coping. Places them as a victim or weak 'a mess'. Within this discourse 3 positions may be offered- one of not coping and needing help (disempowered), one of struggling but learning coping skills (allows more autonomy, almost a respect for someone</p>	<p>Responsibilities- learn to cope with life's problems so can carry on functioning (working), also have responsibility to tell others to learn to cope (L361)</p>	<p>Expressions of unhappiness/ distress not allowed within this discourse, particularly if this impacts on functioning, otherwise seen as not coping. Has negative connotations, links to resilience- somehow do not have internal capacity to cope with life. Hard to imagine</p>

<p>work.</p> <p>L. 361: and he said 'well she's having real problems coping with this whole arson thing and she's really upset and she doesn't want me to come to my session and leave her on her own' so I'm concerned, I must admit and I said to him you know do you think that it would be helpful for your mum to refer herself to us for some help with this and he said that he'd spoken to her about that several times actually I'm so proud of him</p> <p>S: Yeah</p> <p>T: 'cause actually it sounds like he's actually now the one saying to his family look I've done this work and it has been really helpful and your not coping and you need help</p> <p>L. 388: I asked Z how his father is coping and Z has said to me that his father</p>			<p>struggling to overcome adversity), one of stoic acceptance of lifes hurdles.</p> <p>Therapist= helper/ saviour, knowing what's best for people</p>		<p>how emotion and a drop in functioning could be</p> <p>L. 606: giving people skills to go away</p>
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<p>is very laid back um doesn't seem to be openly I'm sure he's bothered but you know he doesn't seem to you know he's coping lets put it that way</p> <p>L. 445: And it was her who brought him to the assessment as well. Same things you know 'I need to come in, you need to do something, He's a mess'</p> <p>L. 518 .Because it may be he just feels 'my goodness if I do that mum will have a break down, mum will never survive mum will be angry'</p> <p>L. 276: the arrangement we had was that Z and I agreed that we would need to let this situation brew for a bit to see if you know he was having just an understandable reaction to something that had just happened. We both felt that he was. His</p>					
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<p>mum on the other hand didn't think that so we agreed to have a two week break</p> <p>L. 606: giving people skills to go away</p>					
<p>Relational factors as important</p> <p>L. 529: Because it may be he just feels 'my goodness if I do that mum will have a break down, mum will never survive mum will be angry'</p> <p>L. 577: I think it's very difficult because you don't want to um be negative about what mum's doing I think you need to positively connote it as how worried she is and how protective she is but try and think with him what are the advantages about that what are the disadvantages of that and</p>	<p>Brings in relational element of experiences of distress. There's an idea here that mum has mh problems too (e.g. L529), some identification of inter-relation (L419), but often presented as individual meaning attached (e.g. 529, L509)</p>	<p>No family therapy available (preferred choice as mentioned in L447) so only other option is to make it about the meaning the individual makes of the inter-relational dynamics (L577, 567, 518). There are attempts to work with the dynamics (seen here as SU lacking autonomy and dependence) by 'imparting agency'</p>	<p>SU constructed as having the right to make choices for himself and being held back by family (mum). SU constructed as passive yet at same time as having agency to weigh up pros and cons for him of current relationship and act accordingly. Constructs relationships and negotiation of relationships as resulting from a conscious, reasoned decision making process.</p>	<p>SU constructed as having the right to make choices for himself and being held back by family (mum). SU constructed as passive yet at same time as having agency to weigh up pros and cons for him of current relationship and act accordingly. Constructs relationships and negotiation of relationships as resulting from a conscious, reasoned decision making process.</p>	<p>Assimilated into CBT framework- focus on the individual meaning and behavioural response</p>

<p>also get his view because it's really hard to know because for example do you think it irritates him does it make him feel looked after</p> <p>L. 419: S: But it was cancelled because mum. Was it him or mum or both of them not wanting her to be on her own?</p> <p>L. 430: S: Well I think you're spot on. Mum has been around from the start and it was mum who brought him back that time and said he was back to square one and he wasn't T: And it was her who brought him to the assessment as well. Same things you know 'I need to come in, you need to do something, He's a mess'</p> <p>L. 576: I mean so I think just helping him to get in touch with his emotions about it so it's very much</p>					
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<p>about imparting his agency because mum isn't involved in the therapy well she is indirectly but you can't work with her so all you can do is work with him and help him to see what his options are and the implications of that and this might be another piece of work for the future you might want to say 'what might make him know that he wants to come back. to therapy and if so what would it be for</p> <p>L. 447: S: It's frustrating with IAPT being the way that it is we can't offer family interventions. T: Yeah absolutely S: Um because you know in an ideal world. You know I would be quite happy with. If it was appropriate and I have had other suggestions but we are only allowed to offer behavioural couple therapy for depression</p>					
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<p>because that's what NICE recommends</p> <p>L. 509: I would use that to have a conversation about why it's so difficult to make the last session and to come on the bus and to talk entirely about his view about his mother's difficulty about him trying to do these thing to sort of try to tease out what the meaning of that is</p> <p>L. 518 . . Because it may be he just feels 'my goodness if I do that mum will have a break down, mum will never survive mum will be angry' I don't know but you could sort of think through it help him problem solve around that. And also what are the implications for him coz you could say to him depending on what you think now you could say I can offer you one more but if you are not able to</p>					
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<p>come to that one then I'm afraid. I won't be able to offer you any others and then you can think about the implications for Z of not then attending the last session with you</p> <p>L. 576: I mean so I think just helping him to get in touch with his emotions about it so it's very much about imparting his agency because mum isn't involved in the therapy well she is indirectly but you can't work with her so all you can do is work with him and help him to see what his options are and the implications of that and this might be another piece of work for the future you might want to say 'what might make him know that he wants to come back. to therapy and if so what would it be for</p>					
<p>Contextual factors as irrelevant/ something</p>					

<p>else</p> <p>L. 292: He's actually been booked for an appointment for an assessment for adults aspergers through his GP he's quite nervous about that, we've had quite a lot of discussion around the meaning about that. S: Is that, is that assessment separate from your work T: Completely separate</p> <p>L.309: aspergers err syndrome which might be preventing him from moving forward in his er work life</p> <p>L. 316: So he's now focusing very much on that and we you know spent the last session talking that through because we don't really need to do anything more on PTSD to be honest that's that's kind of done. We're ending now. That's</p>	<p>Some recognition aspergers might make it difficult to move forward with work. No mention of other ways aspergers may relate to other difficulties. Seen as 'completely separate', 'slightly different', or a reaction to the end. No talk of how it could relate to experience of distress. Focus has been on what a positive diagnosis would mean- unsure whether referring to practical or emotional meaning. Does it just relate to work?</p>	<p>Potential solution= go to specialists/experts that deal with this- 'Allowed' a session to talk about it- brings back to individual meaning making</p>	<p>Creates experiences of distress as disconnected from other contextual factors. Maintains other discourses re MH as an illness or lack of coping</p>	<p>Therapist decides how much to 'allow' therapy to stray off the focus (PTSD)</p>	<p>Compartmentalises human experience. Experiences become disconnected from each other- lack of integration and coherence between different aspects of the self.</p> <p>How are objections handled? S: And that's important, that target</p> <p>S: And you know the beauty of primary care is about finding that focus doing that bit of brief work T: Yeah S: And giving people skills to go away and they can always self refer</p>
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<p>that's done.</p> <p>L.337: 'is this assessment for aspergers, and I'm not meaning to say that its not relevant, but I'm wondering if it is a response to the ending, that they are possibly generating a new presenting problem as it were</p> <p>L. 400: and also its kind of not you know it's a slightly different thing (aspegers)</p> <p>L. 342: I've allowed him a session to talk through the possible outcomes of a positive diagnosis or in fact a</p>					
<p>Promoting independence/ psychological empowerment</p> <p>L. 475: I would suggest is if there's a call again from mum I would definitely</p>		<p>How can agency be 'imparted'? In this case suggestion is that agency can</p>	<p>Assumption can make a rational, cognitive based decision, despite issues of</p>	<p>Forces a responsibility and agency on to the person that they may not possess. Have</p>	<p>Discourses where SU is passive</p>

<p>make it clear that you need to hear directly from Z T: Mm mm S: coz we know he can do it now so I think that's really important. T: Mmm mm S: So that's one thing to do um and be really firm about that and I think if he does ring again keep reinforcing that you are very glad it's him ringing</p>		<p>be imparted through talking.</p>	<p>power previously discussed. Individualises what has been discussed as a relational 'problem' in offering a solution at individual level.</p>	<p>to do this, because no alternative- no option in IAPT to work with the family. And the work has been done now.</p>	<p>Comment [ps145]: Promoting independence/ responsibility</p>
<p>L. 492: T: Coz one of the things we had arranged for the last session is that he was going to get the bus here. S: Yes yeah I remember that T: And he was going to come here you know under his own steam</p>					<p>Comment [ps146]:</p>
<p>L. 509: I would use that to have a conversation about why it's so difficult to make the last session and to come on the bus and to talk entirely about his view</p>					<p>Comment [gc147]: Therapist power to decide when the last session will be and what to use the telephone call for.</p>

<p>about his mother's difficulty about him trying to do these thing to sort of try to tease out what the meaning of that is </p>					<p>Comment [gc148]: Takes it back to the individual- the meaning they make.</p>
<p>L. 522: and obviously try to make that as therapeutic as possible () um a bit like if someone's agoraphobic you know we offer home visits purely to see if we can get them to come to the clinic so obviously the aim would be for you together to see if you can find a way for him to be able to come to finish </p>					<p>Comment [ps149]:</p>
<p>L. 531: but you could sort of think through it help him problem solve around that. And also what are the implications for him coz you could say to him depending on what you think now you could say I can offer you one more but if you are not able to come to that one then I'm afraid. I won't be able to</p>					<p>Comment [ps150]:</p>

<p>offer you any others and then you can think about the implications for Z of not then attending the last session with you</p>					
<p>L. 581: You know as you say he's more pre-occupied with looking after his mum in which you could ask him some future oriented questions of 'what's going to happen when if get a job and you you know at some stage you know you want to leave home</p>					<p>Comment [up151]: Assumption can make a rational, cognitive based decision, despite issues of power previously discussed. Forces a responsibility and agency on to the person that they may not possess. Have to do this, because no alternative- no option in IAPT to work with the family. And the work has been done now.</p>
<p>L. 518 . . . Because it may be he just feels 'my goodness if I do that mum will have a break down, mum will never survive mum will be angry' I don't know but you could sort of think through it help him problem solve around that. And also what are the implications for him coz you could say to him depending on what you think now you could say I</p>					<p>Comment [ps152]:</p> <p>Comment [up153]: Distress as not coping. But also brings in relational element- someone's behaviour/ experience based on the social context and interactions they have.</p>

<p>can offer you one more but if you are not able to come to that one then I'm afraid. I won't be able to offer you any others and then you can think about the implications for Z of not then attending the last session with you</p>					<p>Comment [pd154]: Constrained by service and resources</p> <p>Comment [ar155]: Assumption can make a rational, cognitive based decision, despite issues of power previously discussed. Individualises what has been discussed as a relational 'problem' in offering a solution at individual level.</p>
<p>L. 576: I mean so I think just helping him to get in touch with his emotions about it so it's very much about imparting his agency because mum isn't involved in the therapy well she is indirectly but you can't work with her so all you can do is work with him and help him to see what his options are and the implications of that and this might be another piece of work for the future you might want to say what might make him know that he wants to come back. to therapy and if so what would it be for</p>					<p>Comment [pd156]: Forces a responsibility and agency on to the person that they may not possess. Have to do this, because no alternative- no option in IAPT to work with the family. And the work has been done now.</p> <p>Comment [pd157]: first explicit mention of emotions as important</p> <p>Comment [pd158]: emotionally unaware or not attuned.</p> <p>Comment [pd159]: How can agency be 'imparted'? In this case suggestion is that agency can be imparted through talking. Forces a responsibility and agency on to the person that they may not possess. Have to do this, because no alternative- no option in IAPT to work with the family. And the work has been done now.</p> <p>Comment [ar160]: Assumption can make a rational, cognitive based decision, despite issues of power previously discussed. Individualises what has been discussed as a relational 'problem' in offering a solution at individual level.</p>
					<p>Comment [pd161]: brings in relational element- someone's behaviour/ experience based on the social context and interactions they have.</p> <p>Comment [gc162]: already an idea that more work might be needed. Feeling that the work is incomplete.</p> <p>Comment [pd163]:</p>

<p>L. 518 . . Because it may be he just feels 'my goodness if I do that mum will have a break down, mum will never survive mum will be angry' I don't know but you could sort of think through it help him problem solve around that. And also what are the implications for him coz you could say to him depending on what you think now you could say I can offer you one more but if you are not able to come to that one then I'm afraid. I won't be able to offer you any others and then you can think about the implications for Z of not then attending the last session with you</p>					<p>Comment [up164]: Distress as not coping. But also brings in relational element- someone's behaviour/ experience based on the social context and interactions they have.</p> <p>Comment [pd165]: Constrained by service and resources</p> <p>Comment [ar166]: Assumption can make a rational, cognitive based decision, despite issues of power previously discussed. Individualises what has been discussed as a relational 'problem' in offering a solution at individual level.</p> <p>Comment [pd167]: Forces a responsibility and agency on to the person that they may not possess. Have to do this, because no alternative- no option in IAPT to work with the family. And the work has been done now.</p>

Discourse	How does it represent power?	How does it relate to institutions? Which institutions are attacked or supported by the discourse?	Which categories of person gain/ lose from the discourse?	How does the discourse relate to other discourses? How does the discourse relate to other discourses that sanction oppression?	What competing discourses exist?
Diagnosis	Knowledge/Power link. Power of those who decide what distress is- service users forced to assimilate this into their way of understanding distress (e.g. through use of outcome measures to determine what is and isn't distress). Power of those who use the outcome measure and have 'facts' to support their opinions. In therapeutic encounter therapist has power to make decisions etc but constrained by service	Supported by and supports NICE, NHS, academic institutions, science, DSM/ ICD	SU's can both gain and lose from this discourse- gain as access to service, lose as disempowered, experiences reduced to set of symptoms. Decontextualised. People who's problems relate to social probs particularly loose out as this cannot be explained by this discourse- may then be blamed for not getting better. Psychology gains- links to dominant medical discourses. Politically advantageous- obscures socio political correlates with mh	Relates to science, EBP, Scientist-practitioner model (diagnostic categories ad CBT built on scientific evidence base- limitations of this ignored) individualism meritocracy	Survivor movement, recovery as personal journey (outside of text). Within text- themes re promoting independence challenges the passive subject position of SU's in this discourse
Risk	Presented as one way				

	SU can exercise power/ control/ autonomy				
MH abnormal/ not coping/ not functioning	Power in not showing emotion or a drop in functioning outside of determined societal constraints or 'rules'	IAPT is supported by the discourse. Could support and assimilate survivor movement as it is often seen as advantageous to cope	IAPT/ CBT gains- can 'teach' coping strategies. Other psychological approaches that don't teach coping skills lose out. People with ongoing stressors particularly lose as expected to carry on and cope with stress, rather than deal with cause of the stress- may not have power to change the stressors	Links to self help discourses. Discourses of competition and 'survival of the fittest'	
Relational factors as important	Power as operating at distal level interactions- detracts from wider contexts	NICE attacked as doesn't allow family therapy. Supports institutions re systemic therapy and family therapy. However within this context, moulded to fit diagnosis lead discourses. Family as an institution	Family rather than individual become the source of the 'problem'- imperfect families lose out- blamed	Attacks institution of family- relates to individualist political discourses 'there is no such thing as society, there are individuals and there are families'. Sanctions oppression by denying the responsibilities that society has to each person.	

				<p>Individualising people limits their collective power and ability to combat oppression</p> <p>Prilleltensky (1994) maintain the status quo through dislocation- something new is brought in which obscures and mutes the critical insight. E.g family therapy not going far enough.</p>	
<p>Contextual factors as irrelevant/ something else</p>	<p>Dominant groups maintain dominance through fragmenting peoples experiences- lack of understanding prevents fighting against.</p>	<p>Supports a fragmented and decontextualized system evident in way health and social care services are set up and run</p>	<p>All people lose out. Dominant groups maintain dominance through fragmenting peoples experiences- lack of understanding prevents fighting against.</p>	<p>Relates to discourses re categorisation- basis for discrimination and prejudice.</p>	
<p>Promoting independence/ psychological empowerment</p>	<p>Psychological empowerment- critiqued by Rappaport- not 'real' empowerment</p>				

Appendix 11: End of study report for Research Ethics Committee and Research and Development department

End of study report

Full title of study: Environment, power, distress and IAPT: A discourse analysis. (REC reference: 13/10/1919)

Background

The association between low social class and poor mental health, widely referred to as ‘the social gradient’, has been consistently shown (Black, 1980; Marmot et al. 2010; 2004; Wilkinson, 2005; 1996). The factors affecting this association are complex and varied, but likely include: structural and material disadvantage (Diderichsen, Evans & Whitehead (2001), oppression (Watts & Serrano-Barcia, 2003; Jones, 2012), psychological factors such as social comparison, competition, lack of trust (Wilkinson & Pickett, 2010). Additionally, income inequality of a country is associated with poorer mental health at all points of the social hierarchy (Wilkinson & Pickett, 2010), which has been linked to capitalist ideologies (Layard, 2005).

Despite this body of research, psychology largely focuses on intra-psychic processes of the individual.

Research questions

The study aimed to answer the research question: 'how is the relationship between environment, power and psychological distress discoursed (talked about and practiced) within IAPT texts and practice talk?'

Method

Two sets of discourse material were analysed using principles taken from Foucauldian Discourse Analysis (Parker 2012):

- Seven key texts, identified by IAPT training providers as important for the development and practice of IAPT.
- Transcripts of six hours of supervision sessions attended as part of the normal practice of high-intensity therapists offering CBT at an IAPT service.

Findings

There were some differences and some overlap in the discourses identified in the texts and in the supervision sessions.

Texts:

The dominant discourse identified was that of diagnosing and treating patients. Within this discourse distress was conceptualised as an illness to be treated by an expert and little power was given to the patient in determining their own understanding of distress or what can help. Conflated with this medicalised construction of distress, with its reliance on expert- non expert relations and reliance on a technical fix, was the discourse that distress is the result of

faulty thinking and, to a lesser extent, behaviour. Another discourse identified related to social exclusion. Here social exclusion was presented as a problem and IAPT as reducing social exclusion through two means: increasing access to psychological services and increasing employment. The social and material circumstances of the individual were largely overlooked within the IAPT texts.

Supervision discussions:

The dominant discourse in the supervision sessions related to trying to manage what was presented as competing demands between clinical need and service provision and expectation. Through this dominant discourse distress was constructed in different ways. Diagnosis featured in all of the discussions, though the utility and coherence of diagnosis was often questioned. In most cases a brief reference to diagnostic category was usually followed by a lengthy description of family dynamics, likely indicating this was viewed as the most salient 'problem' and constructing distress as the result of difficult family relationships. Due to the framework of CBT family problems were individualized and individual solutions offered for interpersonal problems. There was also frequent reference to social markers, against which service users were compared and deemed to be coping or not, indicative of wider discourses that mental health problems are the result of dysfunctional living or represent a moral deficiency. Throughout the discussions there was limited inclusion of wider social factors, consistent with political discourse that 'there is no such thing as society'. Discussions that did include these factors were often individualised or linked to family.

Clinical and research implications

This study points towards widening what can be said about distress and what help is available. Discourses arising from the supervision sessions illuminate the dilemmas faced by therapists working within the constraints of IAPT. IAPT has started to expand the therapies offered and this study indicates further expansion would be beneficial, perhaps through making family therapy available, but also through expanding consideration of the social context and making this a focus of future training.

Feedback to participants

Participants were consulted when interpreting the data to check accuracy of interpretations. This summary report has also been disseminated to the participants.

Publication and dissemination of findings

The findings of this study will be disseminated to the research site and will be submitted to the Journal of community and Applied Social Psychology.

References

Black, D., Morris, J., Smith, C., & Townsend, P. (1980). *Inequalities in health: Report of a research working group*. London: Department of Health and Social Security.

Diderichsen, F., Evans, T., & Whitehead, M. (2001). The social basis of disparities in health. In T. Evans, M. Whitehead, F. Diderichsen, A. Bhuiya & M. Wirth (Eds.), *Challenging inequities in health: From ethics to action* (pp. 13-23). New York: Oxford University Press.

Jones, O. (2012). *Chavs: The demonization of the working class*. London: Verso Books.

Judge, K. (1995). Income distribution and life expectancy: A critical appraisal. *British Medical Journal*, 312, 1282–5; 1285–7.

Layard, R. (2005). *Happiness: Lessons form a New Science*. London: Allen Lane.

Marmot, M. (2004). *The status syndrome: How social standing affects our health and longevity*. New York: Owl Books.

Marmot, M. G., Allen, J., Goldblatt, P., Boyce, T., McNeish, D., Grady, M., & Geddes, I. (2010). *Fair society, healthy lives: Strategic review of health inequalities in England post-2010*.

Parker, I. (1992). *Discourse dynamics*.

Watts, R. J., & Serrano-García, I. (2003). The quest for a liberating community psychology: An overview. *American Journal of Community Psychology*, 31(1), 73-78.

Wilkinson, R. G. (1996). *Unhealthy societies: The afflictions of inequality*. London: Routledge.

Wilkinson, R. G. (2005). *The impact of inequality: How to make sick societies healthier*. London: Routledge.

Wilkinson, R., & Pickett, K. (2010). *The spirit level: Why equality is better for everyone*. London: Penguin Books.

Appendix 12: Author guideline notes for Journal of Community and Applied Social Psychology

Manuscript Submission Journal of Community and Applied Social Psychology operates an online submission and peer review system that allows authors to submit articles online and track their progress via a web interface. Please read the remainder of these instructions to authors and then visit <http://mc.manuscriptcentral.com/casp> and navigate to the Journal of Community and Applied Social Psychology online submission site. **IMPORTANT:** Please check whether you already have an account in the system before trying to create a new one. If you have reviewed or authored for the journal in the past year it is likely that you will have had an account created.

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Book

Paloutzian, R. F. (1996). *Invitation to the psychology of religion* (2nd ed.). Boston: Allyn and Bacon.

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Natarajan, R., & Chaturvedi, R. (1983). *Geology of the Indian Ocean* . Hartford, CT: University of Hartford Press. Heslen, J., Carpenter, K., Moriber, H., & Milsop, A. (1983). *Computers in the business world* . Hartford, CT: Capital Press. and so on. The abbreviation et al. is not used in the reference list, regardless of the number of authors, although it can be used in the text citation of material with three to five authors (after the initial citation, when all are listed) and in all parenthetical citations of material with six or more authors.

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