TITLE

Clients' Constructions of
The Keyworker Relationship in Adult Mental Health:
A Collaborative Alliance?

by

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ABSTRACT

The aim of the present study was to describe the keyworking relationship in adult mental health from the point of view of clients. The precise nature of this relationship is not well defined. Whether what people want from service providers and what is offered match is not known. More specifically this research set out to explore clients’ perceptions of the keyworker relationship, with particular reference to: the role of the keyworker, the aims and functions of keyworking, and the aspects of the keyworker relationship that are perceived as more or less helpful. The aim of this was to explore the experiences of six clients. All six participants were interviewed using a semi-structured format and the interviews were analysed using a social constructionist revision of grounded theory. Based on the analysis, a core category was identified and termed developing understanding within a working alliance. A dynamic process model highlighted particular factors and characteristics that enabled engagement. Empathic understanding, positive regard, instillation of hope and trust were seen to be characteristics of a good keyworker. Participants highlighted therapeutic context rather than content. This main finding indicated that person-centred approaches informed the general style of preferred engagement for participants. However, although these factors were seen to be helpful, the lack of clarity around the role of the keyworker generated anxiety and confusion for some participants. The findings are discussed in the light of previous research on psychological helping and keyworking in other settings. Some preliminary recommendations for working more effectively with clients are made. Implications in terms of clinical psychology training and clinical practice are discussed.
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A Note on Terminology

Few groups of people have been given so many different labels as people with mental health problems. A label once considered acceptable comes to be seen as pejorative or inaccurate, only to be replaced by a series of others (Campbell, 1996). Services for people with mental health problems have adopted the terms ‘clients’, ‘patients’, ‘consumers’, ‘recipients’ or ‘service users’ to refer to those receiving services.

‘Keyworker’ is the term usually used for a member of staff who has overall responsibility for the care of a particular client (within the present study this includes clinical psychology, occupational therapy, mental health nursing, and social work).

All names of participants and keyworkers referred to in the research are pseudonyms in order to preserve confidentiality and anonymity.
CHAPTER 1: INTRODUCTION
1. Introduction

1.1 Overview

The growing emphasis on care in the community, and the recent implementation of the Mental Health (Patients in the Community) Act (Department of Health, 1996a), reinforces the need for community mental health workers to be aware of the significance that this may have on the keyworker relationship. The precise nature of this keyworker role is not well defined. Such a role poses important questions for mental health workers’ practice, their relationships with ‘clients’, and the wider society.

In a recent report examining advances in understanding ‘mental illness’ in the United Kingdom, the British Psychological Society (2000) emphasised the need for all psychological interventions to be based on a trusting, collaborative working relationship between the professional and the client. It is stated that this is often the main ‘active ingredient’ (DoH, 1996b), and that ‘service users should be able to find a therapist or worker with whom they feel comfortable.’ It is further suggested by the British Psychological Society (2000, p. 68) that “it is only by listening to what service users and ex-users have to say about services and treatments that professionals can learn what really is helpful to people.”

There have been no published empirical investigations which have examined the client-keyworker relationship. This study will consider the keyworking relationship in ‘community care’ from the perspective of clients. More specifically, it will aim to identify aspects of the keyworker relationship that are perceived as more or less helpful.

The first section of the literature review “Community Care”, begins by looking at changes in care provision and at consideration of the changes in the Mental Health (Patients in the Community) Act (DoH, 1996) and how these may impact upon the keyworker relationship. Changes to the Mental Health Act are likely to have some impact on clinical psychology, as current government proposals suggest that “consultant psychologists” will be given powers equivalent to those of a Responsible Medical Officer with an increased emphasis on the protection of the public (Cooke, Harper & Kinderman, 2001). Little has been written about the keyworker relationship in this population and
thus the literature review will focus on what has been written about the helping relationship in other contexts.

The second section of the literature review, "The Helping Relationship" proceeds by looking at the spectrum of relationships in which some form of psychological help is offered. It has been proposed that all helping relationships have certain elements in common, and that the mechanism for this is what has come to be known as "non-specific factors" or "common factors." The main focus of this section will be on common factors, as it seems possible that at least some elements of the processes will also be instrumental in the formation and development of keyworking relationships. The common factor, which has recently received the most empirical attention, is that of the therapeutic alliance. Various aspects of the therapeutic alliance will be explored: the role of the therapeutic alliance in psychotherapy; client and therapist influences in the alliance; and the role of the therapeutic alliance in other forms of helping relationships. The section continues by considering other factors that may determine social exclusion: the association between mental illness and social networks, and the impact stigmatisation may have on the person who has "mental illness."

1.2 Community Care

Mental health is currently high on the political agenda (Department of Health, 1996a; National Service Executive, 1996; Department of Health, 1999). The renewed impetus given to community care and mental health services emerges from the White Paper Caring for People and subsequent policy guidance (Department of Health, 1989, pp. 55-8; 1990a, pp. 75-83).

Community Care is not a new idea in the provision of mental health services. As early as 1953, ideas were being expressed about how to make less use of long term hospital care. There was a growing awareness of the changes affecting people who were spending much of their adult lives in psychiatric institutions – loss of drive, loss of personal identity, loss of dignity as well as a diminishing of ability in daily living skills (Richter, 1984). The emphasis had changed from relying on long-term institutional care, towards improving people’s rights of self-determination and control over forces affecting them,
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through “improved” opportunities in the community. Statistically, in the United Kingdom, the number of patients occupying mental health hospital beds reached a peak at 143,000 in 1954 (Richter, 1984), reduced to 56,200 in 1989 (Ryan, Ford and Clifford, 1991).

The need for long-stay hospitals has therefore diminished with the main provision of mental health services being community based, with an increased emphasis upon informal networks of carers, such as family and friends to provide support and long-term care. The White Paper postulated that patient choice, control and independence should be the bedrock in the provision of services to all people with severe and enduring mental health problems, and stipulated that services need to respond flexibly and sensitively to individual needs, to provide a range of choices and to intervene no more than is necessary to foster independence.

The last decade has seen a substantial move towards empowering the service users of health care services in the United Kingdom through the promotion of choice and shared decision making. This concept underpins government legislation (e.g. Department of Health, 1990a), and at first sight may appear to reflect an anti-paternalistic stance. Yet, in contrast, the recently implemented Mental Health (Patients in the Community) Act (DoH, 1996) gives legislative power to individual mental health professionals to apply to those deemed most at risk of harm to self or others, or of defaulting on treatment (Rogers, 1996) thus indicating a paternalistic approach. Within this group, those deemed to be a risk to themselves or others are identified as requiring special ‘policing’ in relation to their care programme. This ‘policing role’ will be mainly undertaken by community mental health workers. This dichotomy would suggest a dilemma for the mental health worker. Indeed the legislation may add tension and suspicion to the relationship with such clients (MIND, 1995).

The need to be seen to supervise the individual may lead to a custodial mind set in which the user’s everyday life is over regulated, fostering dependency on the keyworker. Compliance thus may be seen as positive, whilst independent decision making on the part

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1 Paternalism can be defined as an action 'which restricts a person's liberty justified exclusively by consideration for that person's good or welfare and carried out either against his present will or his prior commitment' (Garrisson & Davis, 1983, p.18).
of the user as threatening. It has been well documented that practitioners are less well disposed toward the ‘difficult’ user (Ellis, 1993), something the new legislative context may well exacerbate. Repper and Perkins (1995) appear to support this contention, on the basis of research carried out on the characteristics of client referrals rejected by a community care service. Their findings indicated that such rejected clients were often identified by the service as ‘difficult’, meaning aggressive or violent, or unwilling to accept that they needed care input. It could therefore be argued that these clients were denied access to services because they were of a non-compliant disposition.

The message appears to be that whilst patient choice is important, this may be overridden, for some, when it is considered to be in their best interests. This would seriously question the presence of any real choice for certain users of the mental health services. Characteristically, people with long-term mental health problems can have severe and persistent disturbances of thought, feeling and behaviour as a result of mental ill health. People frequently have a wide range of needs across social, medical and personal domains (Ford, Beardsmore, Repper, Cooke & Norton, 1993), yet they often find it difficult to access or accept services that may help them to attain and maintain a maximum level of independence or a reasonable quality of life (Meltzer, Hale, Malik, Hogman & Wood, 1991).

The problems associated with developing relationship with clients have been described by Burnard (1988) who suggested that: ‘it is not clear what constitutes a “therapeutic relationship” or what interventions hinder or help another person’s life’. Case Management has been placed at the cornerstone of community care in the United Kingdom (Department of Health, 1989). Additionally the ‘care programme approach’ (Department of Health, 1991), with its emphasis on assessment, planning and review by named ‘keyworkers’ has its origins in case management systems.

1.3 The Helping Relationship

Until relatively recently, the study of psychological helping has been examined in a number of areas in virtual isolation to one another. One particular focus of investigation has been into training and practice in the various helping professions, particularly
psychotherapy. While much of the research into helping relationships has focused on psychotherapy, it has been estimated that at least 95% of helping interactions take place outside this formal helping relationship (Cowen, 1982).

1.3.1 Common Factors in the Psychotherapeutic Process. A common conclusion from studies looking at the comparative effectiveness of various types of psychotherapy is that there are few consistent differences in outcome between therapies (Smith, Glass & Miller, 1980). Stiles, Shapiro and Elliott (1986) addressed the question of equivalence and discussed various explanations for this finding. Three different possible explanations are hypothesised: i) that various therapies produce outcomes that are not distinguishable; ii) that participants in different forms of therapy respond in similar ways; and iii) that psychological change is achieved through similar mechanisms or common factors between therapies.

The third proposal, that psychological change is achieved through common factors, can be seen in the earlier work of Rogers (1957). However, Rogers believed that the common factors of empathy, warmth and genuineness were the basis of all helping relationships, not exclusively of psychotherapy. Frank (1973) also argued that all healing endeavours, not just psychotherapy, operate through common factors. He proposed that four common factors found in psychotherapy are i) an emotionally charged confiding relationship with a helper; ii) a healing setting; iii) a rational, conceptual theme, or myth; and iv) a ritual or therapeutic method (Frank, 1982). Nevertheless, it was not until the late 1970’s that there was an upsurge of research into common factors in psychotherapy with a number of authors claiming that the specific techniques of various therapies contribute less to psychotherapy outcome than non-specific or common factors (e.g. Frances, Sweeney & Clarkin, 1985).

1.3.2 The Working Alliance. The hypothesised common factor that has received the most empirical attention is that of the therapeutic alliance. The working alliance, or therapeutic alliance, has been found to be a significant factor in the effectiveness of psychotherapy (Luborsky & Aurebach, 1985). It has been defined as “the feeling that both participants have for each other and that they can and will work productively towards a shared goal” (Kokotovic & Tracey, 1990, p.16). Bordin (1979) argued that the concept of the working
alliance is applicable to all forms of psychotherapy as all psychotherapies involve some agreement on goals and all require some bonds to be established. Moreover, the concept of the alliance is much more interactional than Rogers' (1957) hypothesis that empathy, genuineness and warmth on the part of the helper were necessary and sufficient for therapeutic change. The alliance is the product of the contribution of both helper and the person who seeks help.

Various measures have been developed to measure the quality of the alliance between client and therapist (Luborsky, 1984; Moras & Strupp, 1982). One measure, which has been widely used in research studies, is the Working Alliance Inventory (WAI, Horvarth & Greenberg, 1989) which is based on the theoretical model of the alliance developed by Bordin (1979, 1989). According to this model, the alliance has three elements: bonds, goals and tasks. Bonds refer to the personal relationship factors between client and therapist and include variables such as mutual trust, acceptance and confidence. Goals refer to the mutual agreement on the aims of therapy or the outcome of it. Tasks relate to the process factors in the therapy which, in a well functioning relationship, both parties must see as helpful and relevant.

1.3.3 Client and Therapist influences on the alliance. The personal histories of both client and therapist are likely to have an impact on the formation of an alliance (Horvarth & Luborsky, 1993). For example, Gelso and Carter (1985) proposed that the client’s ability to form a sound therapeutic alliance is related to ability to trust others and ability to form secure attachments. This proposal was borne out by the work of Kokotovic and Tracey (1990) who discovered that the ability of clients to form a working alliance was related to the quality of their past and current relationships: those who had poor family relationships were less likely to develop strong alliances. Other client factors such as pre-treatment severity of mental ill-health have also been investigated but have been found to have little influence on the alliance (see review by Horvarth & Luborsky, 1993).

With regard to the qualities of the therapist, there is some empirical evidence to support that a friendly, sympathetic attitude towards the client contributes positively to the formation of the alliance (Kokotovic & Tracey, 1990). Bordin’s (1979) model of the alliance hypothesised that empathy and trustworthiness on the part of the therapist were
prerequisites for alliance development, and research also indicates that a sense of collaboration and agreement with the tasks of therapy are closely associated with positive outcome (Horvarth & Greenberg, 1989). Hence, successful treatment appears to be the result of both interpersonal and intrapersonal factors.

1.3.4 The working alliance outside of traditional psychotherapy. There has recently been an interest in the role of the therapeutic alliance in other forms of helping relationships. For example, when Goering, Wasylenski and Farkas (1988) considered the alliance between case managers on a rehabilitation programme and clients with severe and persistent mental illness, they concluded that “the relationship between the case manager and the patient may be the most potent therapeutic factor within the programme” (p. 275). When Goering and Stylianos (1988) asked clients what they perceived to be the most helpful aspects of their relationship with their case manager, the clients identified the importance of having someone who cared about, accepted and understood them.

The Working Alliance Inventory (Horvarth & Greenberg, 1989) has been used to measure the strength of the therapeutic alliance between case managers and ‘seriously mentally disabled clients’ (Solomon, Draine & Delaney, 1995). Clients who had a more positive relationship with their case managers were less symptomatic, had a better quality of life and were more satisfied with the overall service they received. Of course, it is possible that clients were satisfied with their case managers because they had experienced some improvement in their symptoms (perhaps due to medication or some other external influence). This alternative explanation is acknowledged by Solomon et al., who suggest that further research into this question is necessary. They also propose that future studies of consumer care management should try to elicit from clients what they see as the benefits of having a case manager and look at variables such as empathy and personal attention.

The social work profession has emphasised the importance of the quality of the worker-client relationship in the helping process (Hollis, 1970; Perlman, 1979). Perlman (1979) saw the helping relationship as one which had a specific and identified purpose, and which used a compassionate, supportive working alliance in order to fulfil its objectives. Although it has been acknowledged that the worker-client relationship is an important
element, there seems to be little research into the nature of the relationship and how it contributes to the helping process. Coady (1993) has argued that the worker-client relationship has been overlooked in social and health care research and called for empirical investigation into the role of relationship factors in these fields.

1.3.5 Keyworking. One particular form of helping relationship found across health, social services and voluntary sector organisations is that of keyworker-client. Rodway (1979), stressed the importance of imparting clear information about the role of the keyworker. Furthermore, Rodway advocated that the clients’ perceptions and views about keyworkers should be discussed with them in order to help them reach some understanding about the meaning of the role. Rodway maintained that the ultimate objective of keyworking should be to improve standards of service to the clients. More specifically, Mallison (1989) suggests that keyworking can empower clients by enabling them to effect choice in decisions about their lives.

However, not all authors are as positive about the role. Douglas and Payne (1980) suggested that the concept had at least two major weaknesses. Firstly, they noted that the concept was ambiguous and that the role had been interpreted in a number of ways. For example, Douglas and Payne (1980) found that in one group of homes, keyworkers were the people who co-ordinated care plans and were overseers of organisational issues, whereas, in other homes, keyworkers were the people who were assigned to form a special relationship with the clients. In a third group of homes, keyworkers were expected to perform both functions. Secondly, although Douglas and Payne saw problems of definition as a weakness in the keyworker concept, they saw a potentially dangerous flaw in it in that it had the capacity to encourage and create inflexible roles and relationships in residential services.

Payne and Douglas (1983) again drew attention to the fact that there seemed to be little agreement within services about what keyworkers should actually do. They questioned whether the keyworker role was meeting the needs of the organisation, of the staff or of the clients and they argued strongly that keyworking was unlikely to be successful without role clarification, training and ongoing supervision.
Despite the conceptual ambiguity of the keyworker role, keyworking has been affirmed and adopted by various bodies within the National Health Service, Social services and the Voluntary sector (Dant & Gearing, 1990). The Barclay Report (Barclay, 1992) into the nature of social work roles and tasks, gave unmitigated support to the keyworker role. It was not made clear however, to which of the interpretations of the role they were giving support. More recently, Bland (1997) examined the contribution of the keyworker role to standards of good practice in residential homes for older people. Bland concluded that, on the whole, the concept of keyworking was not well understood or developed, and tended to contribute to the power of the staff more than to the well being of the residents.

1.4 Mental Illness and Social Disability

Wing and Brown (1970) identified the association between mental ill health and an impoverished social environment. Mueller (1980) observed that people with enduring mental health problems can have very restricted social networks, often consisting only of family members. Various factors may be involved here, including social withdrawal, which is often a feature of mental ill health, estrangement from friends because of the stigma of being mentally ill, over-protection and segregation from society by the family, or social drift away from the family.

Ideas about social disability in relation to enduring mental health problems have been developed from the work of Wing and Morris (1981). Within these models a person is seen as socially disabled if they are unable to perform socially to the standards they expect of themselves or that others expect of them. Living within the community without psychiatric symptoms does not ensure that people with enduring mental health problems are socially integrated (Leff & Trieman, 1997).

Caplan (1974) argued that social support has a major contribution to make in the cognitive and educational areas of individuals’ lives, and in helping them with concrete tasks. Caplan considered that a supportive network experienced within the family, through a group of friends or through members of the individual’s wider community, can assist the “mentally ill” person in developing coping strategies for daily life through the provision of positive feedback and reassurance that problems can be tackled.
Several studies however, have failed to demonstrate a positive correlation between the management of symptoms and improved social functioning (Shepherd, 1992). It has been found that community contact appears to be low despite the severity of an individual's disability (Dilks & Shattock, 1996). This may indicate that people with severe and enduring mental health problems experience difficulties in being able to function within a social environment. It may be that major psychological and social problems continue to be pervasive during the recovery phase which preclude people from being able to function independently (Perkins & Dilks, 1992). This is noteworthy as it suggests that treating symptoms successfully will not necessarily improve social functioning. The way in which a person copes with their problems substantially influences their level of disability (Shepherd, 1984). It may be that a person may consider being “mentally ill” so abhorrent that they reject the notion that they have any problems at all and are thus reluctant to accept support. Others may see themselves as hopeless and useless as a consequence of their mental health problems, lose confidence and withdraw.

Holmes-Eber and Regier (1990) suggest that the social networks of people who have recurring hospital admissions are more likely to include more health professionals than family. This suggests that for some individuals this relationship may only include that with their keyworker. However, Freeman and Henderson (1992) state that having a ‘severe’ mental illness need not necessarily isolate people from the benefits of social networking, as these depend far more on the quality as opposed to the quantity of relationships. This is lent further support by Orford (1992) who argued that it is the qualities of social relationships that are important to address. Emotional support, the raising of self-esteem, companionship, material support and the supply of appropriate information are the main areas for support socially.

Within the last decade, psychosocial interventions have constituted the main focus within psychiatric rehabilitation (Lam, 1991). The supposition has been that if individuals with enduring mental health problems enhance their social functioning, they are more likely to adapt to life in the community. However, external factors are likely to exist which disadvantage people socially, including stigma, unemployment, inadequate housing and poverty (Wing & Morris, 1981). It is likely that such factors will impact on the individual
in terms of his or her opportunities to develop socially supportive relationships, with the possible consequence of exacerbating social disability, and promoting withdrawal.

1.5 Stigma and Mental Illness

The response of others to people with mental health problems has been identified as a factor influencing their psychological well being (Taylor & Taylor, 1989, in Carrier & Kendall, 1997). It appears that public attitudes are particularly relevant when care is provided within the community. Public attitudes towards people with mental health problems continue to be marked by rejection rather than acceptance (Nieradzik & Cochrane, 1985). Hence, the relationship between peoples’ attitudes and their behaviour towards people with enduring mental health problems is important to consider when examining the stigma of ‘mental illness.’

Presumably, if a person is aware that he or she is a member of a stigmatised group, then stigma should have negative effects on self-image and coping. This argument suggests that people who do not believe that they are ‘mentally ill’ should cope better. However, there is an opposite view, which holds that acceptance of the fact of illness should lead to a better outcome (Warner, Taylor, Powers & Hyman, 1989). This argument suggests that people who accept that they suffer from ‘mental illness’ will show better adherence to engagement, treatment and better understanding of how to cope with their ‘illnesses’. Nieradzik and Cochrane (1985) discovered that negative attitudes towards people with ‘mental illness’ were linked to severity of illness, a lack of a valued role, and the existence of a psychiatric diagnostic label. Nieradzik and Cochrane further argue that a willingness to be treated may help to promote a more favourable attitude than when the client is withdrawn or difficult to engage with.

Bhugra (1989) suggested that people are more likely to be defined as ‘mentally ill’, and therefore rejected, not because of their identified problems, but through having contact with psychiatric services. Therefore, if a relationship with mental health services leads to being labelled as having a ‘mental illness’, it suggests that people might prefer to withhold information about any previous or current contact with psychiatric services (Bhugra, 1989). It is therefore understandable that people with ‘mental health problems’
might want to avoid contact with others in the community, for fear of possible rejection from others.

1.6 Implications of the literature and rationale for the present study

Where research does exist on mental illness and keyworking relationships, the focus has been mainly on identifying support resources, rather than exploring what type of support is received by people with ‘mental illness’ and how they themselves perceive that support. Studies that have been carried out within the helping relationship literature may assist in providing a framework for understanding the keyworking relationship. In particular, outcome research, which has shown few consistent differences between therapies, has led some authors to suggest that non-specific factors or common factors are an important element of the relationship. Exactly what these non-specific factors are is not clear, but several theorists have made a number of propositions. For example, Rogers (1957) has proposed that empathy, warmth and genuineness are necessary and sufficient for therapeutic change. However, research on the therapeutic alliance is much more dynamic than this and requires the contribution of both helper and the person being helped (Bordin, 1979). Recent research into the worker-client relationship outside of formal therapy has also suggested that the quality of the alliance may be a key factor in forming an effective relationship (Solomon, Draine & Delaney, 1985).

Given that the effects of therapeutic interventions are mediated through perceptions of the client (Elliott, 1989), and given that it is the client who changes, more investigation on how clients view the alliance seems warranted. The finding that client perceptions of the relationship have proved, in general, to be more consistent predictors of improvement as compared with other evaluative perspectives (Marziali, 1984), lends support to the usefulness of continued investigation of the client’s perspective in research on the alliance.

Within the field of community mental health keyworking, the question of how relationship factors contribute to the helping relationship appears to have been overlooked, leading some authors to call for empirical investigation into this area (Coady, 1993). Recent studies (Rogers, Pilgrim & Lacey, 1993) suggest that a substantial
discrepancy exists in the way in which professionals and 'users' of services construe mental health problems and treatments. Rogers (1993) suggested that where there are discrepancies in the conception of problems, there is also likely to be less satisfaction with service delivery and other aspects of professional-'patient' contact.

The keyworker relationship is one worker-client relationship, which originated in the field of social work and has been adopted by other bodies as an effective way of delivering services. However, the precise nature of the keyworker role is not well defined. In some cases, it would appear to be a worker who provides practical support, in other cases, emotional support and in yet others, a combination of the two (Douglas & Payne, 1990). Research is needed to clarify what happens in the keyworking relationship, in order to see what keyworkers actually do and how their help is perceived.

The aim of the present study is to identify particular aspects of the keyworker relationship that are perceived as more or less helpful. Ultimately these descriptions may be used to inform some preliminary recommendations for staff training in keyworking.

1.7 Research Questions

The main research question is:
‘How do clients experience the keyworking relationship?’
The following three subsidiary questions relate to more specific aspects of the main question.
‘How do clients perceive:
1) the role of the keyworker
2) the aims and functions of keyworking
3) the characteristics of a helpful or less helpful keyworking relationship?’

1.8 Rationale for the use of qualitative research methodology

It was believed that the aims of the research clearly indicated the use of qualitative methodology for several reasons. Patton (1990) has listed several situations for which qualitative methodology would seem to be well suited. These situations include: a) new
fields of study where there are few definitive hypotheses and little is known about the phenomenon; b) process evaluation, as processes are dynamic and participants’ perceptions are a key consideration in this situation; and c) the adding of depth or detail to quantitative studies.

A qualitative framework, whilst not claiming to abandon the researcher’s assumptions, attempts to make them explicit, while encouraging an open approach to the data. The procedures that were used to address the researcher’s reflexivity are discussed in the following chapter, where the values of the researcher are also stated.

This is clearly helpful in generating new ideas as well as facilitating the expression of a group of people who can be seen as being marginalised. Thus it could be argued that using a qualitative research paradigm, encourages people to reflect on the very system which has been party to that marginalisation and validates views which may conflict with that system. In essence, a qualitative approach to research could be seen as a means of empowerment.

It can be argued that representing members of groups to which researchers do not belong (especially groups which could be construed as being oppressed in ways they are not) is not, however, a straightforward enterprise. Wilkinson & Kitzinger (1996) argue that representations of ‘others’ by dominant groups can be a form of control over the processes of representation of that marginalised group. The ‘other’, thus becomes a construction or a set of discourses through which the dominant group defines itself. Historically, this has culminated in the representations of others being dismissed as neither credible nor coherent (mental illness is a prime example). A strategy for dealing with the difficulties of ‘othering’ is recognising the categories that are created in the representations and acknowledging that they are never just descriptive, but serve a constitutive and regulatory function.

Little is known about the relationship between the ‘mentally ill’ person and the community keyworker. Moreover, the relationship between two people is a dynamic process, which is well suited to investigation by qualitative methodology. Turpin, Barley, Beail, Scaife, Slade, Smith & Walsh (1997) suggest that the use of qualitative methods
may be particularly favourable when studying psychological phenomena not extensively researched. This further supported the case for qualitative methodology, given the paucity of research that existed regarding the relationship between the 'client' and keyworker. Dingwall, Murphy, Watson, Greatbach and Parker (1998) lend further support, in their view that qualitative research may help in closing the gap between what is known to be efficacious in broad terms as regards therapy, and the ability to apply it with an individual.

Furthermore, the literature suggests that the role of the keyworker is a broad and ill-defined term that may be understood in a variety of ways. It was assumed that this would be reflected within participants' narratives, with the aim of providing a coherent account, which might resonate with the reader (Elliott, Fischer and Rennie, 1999).
CHAPTER 2: METHOD
2. Method

2.1 Overview

As stated in the previous chapter, it was felt that the most suitable mode of enquiry for the present study was to use the qualitative method of grounded theory. This chapter proceeds by giving an overview of the qualitative research paradigm and grounded theory as a particular mode of qualitative inquiry. This comprises a review of grounded theory’s development, structure and use by researchers.

The chapter continues by detailing the specific procedure used to recruit participants, and the subsequent collection and analysis of the data. Finally, the issues that relate to reliability, validity, and reflexivity are considered.

2.2 An Overview of Qualitative Research

There is a general consensus that the value of qualitative research methods in health research is being increasingly recognised (Yardley, 2000), with a concurrent growth in appreciation of different ontological and epistemological positions within the broad church of qualitative research. Denzin & Lincoln (1994 p. 2) provide an initial generic definition of qualitative research suggesting:

"...qualitative research is multimethod in focus, involving an interpretive, naturalistic approach to its subject matter. This means that qualitative researchers study things in their natural settings, attempting to make sense, or interpret phenomena in terms of the meanings people bring to them."

The researcher who adopts a qualitative approach to the collection of data also views the world through a particular type of lens which regards the social world as variable, fluid, and changing over time and place. The researcher is fundamental to the sense that is made of the issue under investigation (Parker, 1994). The gathering and analysis of non-numerical data is deemed to be desirable within this paradigm because it frees the researcher to explore, and be sensitive to, the multiple interpretations and meanings which may be placed upon the gathered information (Henwood & Pidgeon, 1995).
Consequently, the generation of theory is the principal aim of the grounded theory method, to be achieved in the absence of an *a priori* conceptual framework or hypothesis (Henwood & Pidgeon, 1992). According to Lincoln & Guba (1985) what makes the data valid in qualitative methods is the privileged access to the world-view of the participants with sufficient intensity and duration of time.

### 2.3 Grounded Theory

The idea of grounded theory, as a method was developed and described in 1967 by two sociologists, Barney Glaser and Anselm Strauss in their book *The Discovery of Grounded Theory* (Glaser & Strauss, 1967). The term ‘grounded theory’ was originally chosen to express the idea of theory about a phenomenon that is grounded in an iterative process involving the consecutive sampling and methodical analysis of qualitative data (Pidgeon, 1996). The approach of grounded theory is suitable for use with any form of unstructured material, including interview transcripts or fieldwork observations of participants’ accounts, or documentary evidence (Henwood & Pidgeon, 1995). The term grounded theory is also used to describe a method for developing theory that is grounded in data (e.g. Rennie, Phillips & Quartaro, 1988; Charmaz, 1995).

#### 2.3.1 The history of grounded theory.

During the 1960s Glaser and Strauss (1967) noted that, at that time, sociological practice was becoming almost wholly reliant upon the use of quantitative methods (Pidgeon, 1996), and that the status of qualitative methods was essentially at an all-time low. There was a preoccupation with the quantitative testing of propositions derived from a few highly abstract ‘grand’ theories. Glaser and Strauss (1967, p. vii) argued that this led to theory that was impoverished, and therefore advocated that a radical change of philosophy was required to close this ‘embarrassing gap between theory and empirical research.’ Glaser and Strauss (1967) recognized the primacy of the quantitative paradigm in sociology research at that time, and highlighted the need to achieve a more equitable balance for those researchers who wished to focus upon the generation of theory.

Through their development of grounded theory as a position regarding the state of qualitative research and as a method, Glaser & Strauss (1967) disputed the prevailing
view of qualitative research as only a harbinger to quantitative projects, making claim to
the justification of qualitative research in its own right.

Rennie, Phillips & Quartaro (1988) argue that grounded theory methods provide the
opportunity of a systematic approach to discovery, and the creation of theory in subject
areas that are difficult to access with traditional approaches to psychological research, yet
are inherent in the subject matter of psychology.

2.3.2 Key Characteristics of Grounded Theory. Charmaz (1995; p. 28) has ascertained
several distinguishing characteristics of grounded theory methods (see Charmaz, 1990;
Glaser and Strauss, 1967; Strauss and Corbin, 1994), which include:

1) simultaneous involvement in data collection and analysis phases of research;
2) creation of analytic codes and categories developed from the data;
3) the development of middle-range theories to explain behaviour and processes;
4) memo-making, that is, writing analytic notes to explicate and fill out categories, the
   intermediate step between coding data and writing-up;
5) theoretical sampling, that is, sampling for theory construction, to refine categories and
   discover variation between them and;
6) delay of the literature review.

A central contribution of grounded theory methods has been the development of rigorous
procedure, which has offered a challenge to the view of qualitative research as only
intuitive and impressionistic. Two fundamental analytical commitments shape the
methodological stance adopted by Glaser & Strauss (1967), these are the method of
constant comparison and the use of theoretical sampling.

2.3.3 Constant Comparative Method. The core focus of grounded theorizing is the
development of theory through constant comparative analysis (Strauss & Corbin, 1994),
which is used as a systematic tool for developing and refining theoretical categories and
their properties. The method of constant comparison proceeds in four stages which
include: i) incidents in data being coded into categories, ii) the integration of categories
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and their properties, iii) theoretical saturation, in which no new properties of categories appear and no new interaction occur, and iv) writing the theory.

2.3.4 Theoretical Sampling. Glaser & Strauss (1967) advocated that through theoretical sampling a researcher might extend and broaden the scope of an emerging theory. Charmaz (1995) proposed that theoretical sampling assists the researcher fill out categories, discover variation within the categories and define any gaps between them. As the analysis proceeds, theoretical sampling involves the active sampling of new cases. Pidgeon (1996) states that since the aim of grounded theory is the elaboration of a conceptually rich, dense and contextually grounded account, there is no compunction to sample multiple cases where this would not extend or modify the emerging theory. Sampling accordingly is driven by theoretical concerns, and is not merely for generalizing the findings of research. It has been recommended by Charmaz (1995) that theoretical sampling is conducted later in the research, to ensure that premature closure does not occur and to ascertain that relevant issues have been specified.

Taken together, the commitments of constant comparison and theoretical sampling involve the researcher in a highly interactive and iterative process in which the traditional distinction between the data collection phase and the data analysis phase of a project often breaks down (Pidgeon, 1996). Theoretical sampling is discussed further in section 2.7.5, with reference to the current study.

2.3.5 Grounded Theory in Clinical Psychology. Rennie, Phillips and Quartaro (1988) give a widely cited account of the application of grounded theory in clinical psychology and psychotherapy research. Rennie in particular has produced a series of substantive papers reporting on his representation of the client's experience as a whole (e.g. Rennie, 1990, 1992); in addition he has presented a series of papers which examine resistance, deference, storytelling and client agency. Indeed, within clinical psychology, researchers have used grounded theory approaches in wide ranging areas such as in the counsellor's construal of success in psychotherapy sessions (Frontman & Kunkel, 1994) and the analysis of staff perspectives within the learning disabilities field (Clegg, Standen & Jones, 1996).
Clegg & King (1998) advocate that the use of grounded theory methodology is particularly suited to clinical research because it enables a close fit with the data, and thus is meaningful to participants, yet leads to rich conceptual development. Clegg (1998) suggests that grounded theory is commonly used to encapsulate processes by which clients experience services or comprehend their difficulties.

2.3.6 Differences between Grounded Theory Researchers. According to Stern (1994), Glaser, who has a background in statistical analysis, insists on allowing the theory to emerge, whereas Strauss, whose sociology was firmly rooted in the Chicago school (i.e. a school of sociology which has its roots in the symbolic interactionist tradition, Robrecht, 1995), prefers a method that is tightly prescriptive. Stern (1994) also suggests that Glaserian grounded theory would be expected to be immediately applicable to individuals and groups who shared this problem under study and would be expected to be testable.

However, theory produced using Strauss’ version of grounded theory has its applicability downplayed according to Stern (1994). The crux of the dichotomy is, according to Glaser (1992), the fundamental difference between emerging and forcing, in that it asked directing rather than neutral questions. Glaser (1978) claimed that Strauss’ evolution is a departure from the original methodology and represents an erosion of grounded theory, and that it restores the rational approach to theorizing that the grounded theory method was designed to offset. Indeed, Glaser (1978) asserts that the two methodologies should have different names, with Strauss’ version being termed full conceptual description.

Rennie (1998) suggests that these revisions have created a methodology which is rationalistic, verificational, and both inductive and deductive. Rennie (1998) takes this argument further, by stating that without a coherent logic to justify grounded theory, it is not known whether the development of theory from the data is a hypothetico-deductive process or an inductive process. Rennie (1998) further posits that it is likely that theories might be less well grounded in light of these changes, with the methodology having more power over the data, and warns of the danger that systematic and deliberate hypothesizing from the earliest stages of the analysis may predispose the researcher prematurely to import theoretical frameworks.
2.3.7 Constructivist Revisions. The critiques have prompted revisions in the grounded theory approach. In more recent uses of the method the dilemmas of interpretative processes are being acknowledged, Henwood and Pidgeon (1995) argued for the adoption of a constructionist perspective as a more insightful use of grounded theory. In accordance with this perspective, inquiry is always context bound and 'facts' are viewed as both theory-laden and value-laden. Knowledge is seen as actively constructed with meanings of 'existence' only relevant to an experiential world. Thus there is not a concern with the discovery of an ontological 'real' world but only a focus on how people construct knowledge within individual and social context.

The nature of the inquirer and the inquired-into is in itself interactive and self-influencing (Gale, 1993). Awareness of this perspective emphasises the tensions between the striving to find emergent theory by use of distinct coding strategies while remaining honest and vigilant about the many interpretative processes influencing what is found.

Henwood & Pidgeon (1995) further argue that the contextualist position is conflicted by a tension within grounded theory between realism and constructivism, a feature of grounded theory which has also been noted by Charmaz (1990). Henwood & Pidgeon (1995) explored such tensions in the varied uses of the method and they propose that there seems to be a simultaneous commitment to, firstly realism inductively reflecting participants' accounts and naturalistic contexts, and secondly constructivism, which includes actively promoting the researcher in the creative and interpretative process of generating new understandings and theory.

Charmaz (1990) illustrated how her interpretative perspective shifted in appreciating different aspects of the data. Charmaz advocated that the researcher needs to have a perspective from which to seek and actively build analyses, but without merely applying it to new data. This perspective might include awareness of substantive interests guiding the questions asked, a philosophical stance which provides a store of sensitizing concepts and one's own personal experiences and values. Charmaz reinforces Glaser and Strauss' original claim that the researcher does not approach the data as a tabula rasa (1967: 3) and also proposes the full use of the 'flip flop' process between data and interpretation noted by Henwood and Pidgeon (1992).
Annells (1997) argues further that it is this tension within grounded theory, which has led to the development of different versions of grounded theory in practice. Annells considers the classic view of grounded theory (e.g. Glaser & Strauss, 1967) is postpositivist, premised on a critical realist stance, which assumes a reality does exist but can only be approximately known, and an objectivist epistemology with a detached observer seeking an objective view. However, Annells considers that the more recent developments in grounded theory (e.g. Charmaz, 1990; Strauss & Corbin, 1990) have moved away from this view and are more appropriately located within the constructionist paradigm of inquiry. The constructivist approach appears to have been most forcefully presented by Charmaz (1990) who posited that the outcome of any research using grounded theory was ‘a social construction of the social constructions found and explicated in the data.’

This division certainly contributed to the debate between Glaser and Strauss. Stern (1994) proposed that the dispute could be linked to differences in the ontological and epistemological premises of the two proponents, with Glaser retaining a post-positivist view and Strauss and Corbin moving toward a more constructivist view.

The author proposes that providing the researcher explains what he/she has done and how he/she did it, straying outside the boundaries of one particular version is less of an issue than limiting the potential depth of understanding that strict adherence to one version might produce. As Charmaz (1995, p.27) proposed ‘grounded theory methods provide a set of strategies for conducting rigorous qualitative research.’

2.3.8 Creativity and reflexivity in grounded theory. Few would dispute that qualitative methods invariably involve interaction between the researcher and the data. Turner (1981) reasoned that in social inquiry there is an interaction between the researcher and the world that he/she is studying. Indeed, Altheide & Johnson (1994) expounded that reflexivity refers to researchers being part of, rather than separate from, the data. However, while there appears to be little argument that grounded theory inevitably involves interaction between the researcher and the world he/she is studying, how this affects the emerging theory remains a matter for debate. Morse (1994) contends that qualitative methods (including grounded theory) have been plagued with conflicting
advice concerning the application of prior knowledge, including the researcher's previous experience and knowledge, which he/she brings to the study.

Berger & Kellner (1981) advocate that the qualitative researcher needs to become aware of his/her own personal preconceptions, values and beliefs and then hold them in abeyance. They add that if these processes are not carried out, the scientific enterprise collapses and the researcher will perceive a mirror image of hopes/fears and not the social reality. These beliefs and values are made explicit and taken into account so that ‘rather than engaging in futile attempts to eliminate the effects of the researcher, reflexive researchers try to understand them (Hammersley & Atkinson, 1995, p.18).’ A counter argument exists that claims that it is the reflexivity and the researcher’s creativity within this reflexivity that makes grounded theory valuable. Turner (1981, p. 228) stated:

“... competent development of grounded theory rests in part upon a sensitivity to these often tacit processes of perceiving and understanding, and upon a willingness and an ability to bring them into the open for discussion.”

Lincoln & Guba (1985, p. 208) constructed similar arguments when they stated:

“...admitting tacit knowledge not only widens the investigator’s ability to apprehend and adjust to phenomenon in context, it also enables the emergence of theory that could not otherwise have been articulated.”

Hence there is a need for the grounded theory researcher to acknowledge his/her prior knowledge and tacit knowledge, to bring such knowledge into the open, to discuss how it has affected the theory development (Turner, 1981) and allow the interplay between the researcher’s knowledge, values and beliefs and the data to occur. It is also necessary to allow the researcher to explore and articulate theoretical links. Stiles (1993) lends further support to the promotion of high quality standards in qualitative research, by recommending that the researcher discloses his or her expectations for the study, with details of any preconceptions and theoretical orientation. This helps the reader to gauge the assumptions and stance the researcher may hold. Indeed the researcher and all his/her
knowledge and prior experience is bound up with the interactive processes of data collection and analysis.

As Strauss & Corbin (1994) indicated, the analyst is also a crucially significant interactant and Glaser (1978) offered similar remarks when he argued that everything is data. The use of a 'reflexive diary' has been suggested as a method to keep account of the researcher’s reflections and note any changes (Lincoln & Guba, 1985).

2.4 Interviewing

Mischler (1979, p.10) argued that meaning must be viewed within the social context in which it occurs. This would seem to be ideologically opposed to the objectifying approach taken in studies developed from the natural sciences. Within qualitative research, the interview is a flexible method of gathering qualitative data that is detailed and personal (McLeod, 1994). Moreover McLeod (1994) reports that face-to-face interviews can promote the building of a ‘research alliance’ between the researcher and the participants, in much the same way that a therapeutic alliance can be built between a therapist and a client. According to Patton (1990), the researcher needs to adopt a stance of ‘empathic neutrality’, that is, empathic engagement with the stories the participants share, but neutrality regarding the content of the material generated.

Cowles (1988) advises a cautionary note with regard to interview procedure, as interviews have the potential to re-stimulate painful memories or unresolved emotional conflicts on the part of the participants both during and after the qualitative enquiry. Qualities such as active listening, accurate understanding, warmth, acceptance and genuineness have been established as being of importance in encouraging and promoting a good rapport between researcher and participant (Mearns & McLeod, 1984). According to McLeod (1996), interviews are always to a greater or lesser extent reactive, with the attitudes and personality of the interviewer shaping what the informant will say. Thus, the quality of the data developed in an interview may in part be linked to the skill of the researcher, the recollecting and reflective capacities of the participant, and the relationship that is developed between them (Polkinghorne, 1991).
Lincoln & Guba (1985) have suggested that a role of the interview is to enable the researcher and participant to move back and forth in time, reconstructing the past and interpreting the present and future. Qualitative interviewing encourages considering research participants as co-researchers rather than as ‘objectified subjects’ (Tripp-Reimer, Sorofman, Peters & Waterman, 1994). It was suggested by Stiles (1993) that this sort of ‘engagement fosters an internal and thus usually compassionate view of human experience. It deepens understanding aesthetically and emotionally, as well as cognitively (p. 605).’

Silverman (1993) has suggested two central views on the role of the interview. A positivistic view may regard interview data as our gaining access to ‘facts’ about the world, with the limited flexibility of what is ordinarily a standardised protocol. Conversely, an interactionist view may regard interviews as essentially concerned with symbolic interaction, with the social context of the interview an essential ingredient to the understanding of information collected (Silverman, 1993). The interview process may therefore be more flexible and open-ended.

2.5 Procedure

2.5.1 Participants

The sample frame from which the participants were selected was defined by several criteria. Firstly, participants had to be current clients of professionally trained mental health keyworkers (including clinical psychologists, mental health nurses, occupational therapists and social workers) working in adult mental health services. A second factor defining the sample frame was that participants were from within the area covered by the Leicestershire Adult Community Mental Health Teams.

A selection criteria imposed on the sample frame was that participants should have had a history of mental health problems and also formal contact with their keyworker for a period of not less than two years. This ensured that clients had a significant time frame on which to base their perceptions of the keyworker relationship.
2.5.2 Recruitment of Participants

Ethical approval was received from Leicestershire Health Authority (Appendix 1). Following this, two research presentations were made to two Community Mental Health Teams. Individual meetings were arranged with Keyworkers, who were then asked to select up to two of their current clients with the agreement of the Consultant Psychiatrist, whose approval was required in order to satisfy the conditions of the local medical ethics committee. (Appendix 2).

Keyworkers stated that their choice was influenced by whom they believed would co-operate, and by who would be interested in the research area. Potential participants were initially approached by their Keyworker, and informed that the researcher was interested in finding out about their experiences, and that interviews would be audiotaped and transcribed. A typical letter and the accompanying information regarding the research was given to potential participants by their Keyworker (Appendices 3 and 4). This ensured confidentiality. If people were willing to participate, they were asked by the Keyworker to return written confirmation to the researcher, stating their agreement for initial contact to be made. Of eleven people who were initially approached, 6 were willing to participate. Following this, 6 individual interviews were carried out.

Theoretical sampling actively entails seeking participants who are considered likely sources of information, which would further develop the emerging theory (Glaser and Strauss, 1967). This process can only begin following some initial analysis. However, there were constraints to carrying out theoretical sampling, as detailed in 2.7.5. The age range of participants was 35-58, of whom 5 were female and 1 was male (see Appendix 6). Contact with keyworkers covered a period of from two years to a duration of ten years.

All six participants lived independently in the community. Four of the participants had been previously treated in hospital. Two of the participants had been previously detained under sections of the Mental Health Act. Two participants had been given a diagnosis of manic depression, two participants had been given a diagnosis of schizophrenia, one
participant had been given a diagnosis of health anxiety concurrent with depression, and one participant had been given a diagnosis of depression.

Glaser & Strauss (1967) state that the selection of participants in grounded theory research should be a directed, rather than a random process. Glaser (1978) acknowledges that in the initial stages of a study, researchers 'will go to the groups which they believe will maximize the possibilities of obtaining data and leads for more data on their question.' It may be argued that knowing where to start the initial sampling is a problem common to most qualitative studies.

Six participants were selected and gave their agreement to be interviewed for the study. Further recruitment was constrained by the limited time available to complete the research. The total number of participants should be determined by the concept of saturation, when the core categories are 'saturated' (Pidgeon and Henwood, 1995). That is when the analysis of supplementary data does not lead to the development of new categories or the identifying of new properties of existing ones.

Those potential participants who responded and expressed some interest in the research were contacted directly by telephone. This allowed the researcher to answer any immediate questions, and provide a fuller description of the procedure. If the respondent still wished to proceed and he or she met the selection criteria, then an interview was arranged. A letter to the Consultant Psychiatrist (Appendix 2) provided information about the research, and provided an opportunity to object to their client’s inclusion as a participant. This was intended to obviate any possibility of the interview having an adverse effect on the well-being of the participant. No objections were received from the Consultant Psychiatrists.

2.5.3 Interview Procedure

Five participants chose to be interviewed in their homes, and one participant at the Community Mental Health Team base. The location for the interview was decided upon by the participants, as it was assumed that choice of environment would lessen any existing anxieties.
Initially, the purpose of the research was outlined, and participants were informed of the sequence of events before, during and after the interview. The confidentiality of information was discussed, encompassing storage of written and recorded data, and the anonymisation of personal details in any reports. Participants were assured of their right to withdraw from the study at any time. This latter assurance was important to emphasise to participants, as the flexibility of the qualitative approach can mean the research can follow unexpected directions. Holloway (1997) highlights this point as the researcher is not able to inform participants of the exact path of questioning, prior to the interview.

The purpose of tape recording was explained to the participant as a way of ensuring that none of their information was missed by the researcher. The researcher proposed that if the participant described situations, which they did not want to be recorded, then the tape recorder could be switched off. This occurred at different junctures in two of the interviews, with agreement given by participants to continue recording following gaps.

If the participant indicated that he or she had understood the information provided about the research and the interview procedure, then he/she was asked to read and sign the consent form (see Appendix 5). Participants were provided with a copy of this form. Of the six participants who were selected and agreed to meet with the researcher, all gave their consent and participated in the research.

The interviews lasted approximately 45 minutes to 1 hour. Initially the researcher asked questions pertaining to biographical information, and as the interview progressed questions were more open-ended and focused on participants’ understanding and experience of the Keyworker relationship. The interview schedule (Appendix 8) was applied flexibly to structure the interview for all participants. The use of open questions and also of active listening skills were used, allowing the interviewer the freedom to follow up interesting areas that arose, as well as follow the participant’s interests or concerns. This format was helpful in establishing rapport as it encouraged a more ‘natural’ conversation than a structured interview. At the same time, the presence of pre-determined questions and prompts adds some structure to the interviews.
A semi-structured interview seemed appropriate for this research study, as it allowed the specific research agenda to be addressed whilst remaining open and flexible to new ideas (Smith, 1995). This was important in the latter stages of data collection when specific questions could be asked regarding the emerging themes. The guide was flexible and aimed to explore the perceptions and experience of the keyworker relationship from the participants' view by focusing on the following areas:

1) Background information about how they came into contact with mental health services.

2) The initial thoughts and feelings about engaging in therapy.

3) Perceptions of the keyworker.

4) Experiences of the relationship with the keyworker.

An example of the interview guide is included in Appendix 8.

There is an emphasis in grounded theory on the simultaneous collection and analysis of data. Throughout the course of data collection, the interview schedule was revised to take account of emerging themes. The interviews closed with a ‘wind down’ section which was intended to gain participants’ general views on the research and discuss any concerns about the interview.

Charmaz (1995) has emphasised the value of the researcher describing the context of research interviews following each interaction. Thus, the researcher’s perceptions regarding the interview and the process, were written in the researcher’s field diary following each interview.

2.5.4 Confidentiality

The data collected highlighted concerns around the confidentiality of the information and the subsequent presentation of the results. In quantitative research, the transformation of personal experience into numbers means that it is relatively easy to guarantee anonymity (McLeod, 1996). In contrast, the nature of qualitative research makes it much more
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difficult to conceal the identity of participants, as accounts are unique to individuals. As such, confidentiality was given careful consideration as discussed in the following section.

2.5.5 Data Management

As previously mentioned, all participants were asked for their consent for the interview to be tape-recorded, and they were offered their own copy of the tape recording. Only one of the six participants interviewed wished to be sent a copy. With regard to data management, any identifying names (of family, friends, or professionals) were excluded. The terminology employed in transcription used “JE” to denote the researcher and “P” for the participant thus identifying interviewer and participant in the interview process. Numerical codes were used as script identifiers thereby maintaining confidentiality and anonymity for the participants. All pages, and lines were numbered and any pauses in the transcripts were identified with the following symbol (.). Due to reasons regarding confidentiality, transcripts are not bound in this thesis. Instead, the full transcripts are bound separately (see addendum 1). Open access to transcripts will not be available through the library, as consent was not sought from participants for transcripts to be made available to people other than clinical and academic supervisors. Transcripts will subsequently be available on request from the author, c/o Department of Applied Psychology (Clinical Section), University of Leicester. A glossary of colloquialisms used by several participants is positioned following the transcripts (see addendum 1).

Although time and labour intensive, it should be acknowledged that the data produced from audio-recorded material represent an impoverished record of the research encounter, since it reflects only a structural representation of the interview. It is also important to acknowledge that the researcher's experience and memory of the interview may also be affected, and thus is not a completely objective record of events.

The importance of the researcher transcribing the interviews has been highlighted by Charmaz (1995). Therefore this guideline was followed in this study, with the researcher transcribing each of the interviews himself. This enabled the researcher to begin the process of studying the emerging data, in order to become aware of implicit meanings.
2.6 Rationale for the use of grounded theory methodology

A grounded theory approach was chosen, as it is a general methodology for developing theory that is grounded in data systematically gathered, and analysed. It is often used to explore a research topic on which ‘existing theory is incomplete, inappropriate or entirely absent (Henwood & Pidgeon, 1992: 102).’ Providing ‘service users’ with a forum through which they could “voice” their own experiences was a central component of the study. As indicated earlier, grounded theory was selected as the method, which is most relevant to exploring process and action and developing theory (Miles and Huberman, 1994).

Pidgeon (1996) suggested that grounded theory is particularly suited to the study of local interactions and meanings as related to the context in which they actually occur. Therefore this method is considered to be particularly useful for psychologists who wish to study the varied groups of people with whom they work. Grounded theory methods are also designed to study process and thus allow the researcher to explore the development, maintenance and change of individual and interpersonal processes (Charmaz, 1995).

The grounded theory approach was chosen for this research in order to maintain a certain amount of rigour in this study. The researcher recognised that his experiences (both professional and personal) would sensitise him to certain issues in the data (see sections 2.10.1 and 4.4.5) which may have excluded other issues from being discovered.

2.7 Data Analysis

In order to conduct the data analysis, two different versions of grounded theory were used. Charmaz’s (1995) model and Henwood and Pidgeon’s (1995) were referred to and drawn upon. The specific model that was used during the analysis was that of Charmaz (1995). The procedures described below, of constant comparison (open coding, line-by-line coding and focused coding), and memo-writing were applied rigorously yet flexibly throughout the study.
In order to analyze the data from the interviews, the tape-recordings of the interviews were transcribed verbatim. A section of transcript is presented in Appendix 7.

The first stage of data analysis was coding each interview transcript; this was done in conjunction with listening to the audio recording of the interview. Listening to the recording repeatedly allowed the researcher to increase his familiarity with the raw data.

2.7.1 Line-by-line coding. Data analysis proceeded after each interview by examining each line of data and defining the action or event as represented by it. Charmaz (1995) recommended that line-by-line coding assists the researcher in not only staying close to the data but helps the researcher to see process in the data.

Similarities and diversities in the data were compared by asking questions of the data such as:

- 'What is going on here?'
- 'What are people doing?'
- 'What is the participant saying?'
- 'What do these actions and statements take for granted?'

Codes were framed as specific and 'active' as possible. The aim at this stage was simply to describe the data, rather than to interpret or reduce it. The codes therefore adhered closely to the participants' own words. This enabled the researcher to break the data into categories and see processes in the data that would otherwise have remained implicit.

Additional questions were asked of the data such as:

- 'What process is at issue here?'
- 'Under which conditions does this process develop?'
- 'How do the participants think, feel and act while involved in this process?'
- 'When, why and how does this process change?'
- 'What are the consequences of this process?'

As certain codes began to appear regularly in the data, increased emphasis was placed on focused coding.
Method

2.7.2 Focused coding. The use of focused coding assisted the researcher in taking earlier codes and using them to sift through the data. This coding enabled the researcher to be more selective and more conceptual. The process of moving to focused coding was not a linear process, and prompted the researcher to continually return to earlier data and re-examine participants' statements. Codes were recorded on index cards. These records comprised a reference number, the descriptive label and the location of the segment in the transcripts. The reflective field diary was used to record thoughts whilst reflecting on the data while coding. Focused coding enabled the researcher to create and try out categories for capturing the data.

2.7.3 Constructing categories. The process of categorizing highlighted certain codes as having overriding significance, with categories subsuming common themes and patterns in several codes. Charmaz (1995) suggests that the selection of codes need to bear significance to the research question. Categories were initially put in vivo codes taken directly from participants' discourse, which later represented a substantive definition of what was happening in the data. Once a code was seen as relevant, then its properties were explicated, with the assumption that it was significantly different from those already in existence.

The index of codes was used to search for data, which was relevant to the code to be developed. A process of constant comparison between data meant that similarities and differences could be identified. Constant comparison was a key aspect of the coding procedure (Pidgeon and Henwood, 1996). Similarities and differences between concepts, both within and between cases, were noted, to ensure that the complexities and subtleties of the data were explored. Text describing these properties was used to define the categories. Analysis thus moved to a more abstract level of conceptualisation.

The titles given to the categories were generally 'active', to represent the processive nature of the way that participants perceived and experienced the relationship with the keyworker. At the final stage of the analysis, one 'core category' was specified, with five main categories being represented. The process of focused coding assisted the researcher to sift through large amounts of data more efficiently. Codes continued to be written on to
the transcripts. The codes were used to represent greater segments of data, which were identified as properties of the emerging categories.

2.7.4 Theoretical Memo-writing. The way in which the categories were extended and linked, required that the researcher moved beyond the data. This was achieved by linking concepts within and between categories. Charmaz (1995) suggested that memo-writing helps to elaborate processes, assumptions and actions that are subsumed under the code. As such, memo-writing took many forms. Most frequently it took the form of ideas and hunches comparing categories. Through memo-writing, the researcher was able clarify which categories were major and which were minor.

Abstraction ends when a core category or theme is defined. This category is described as being linked to as many others as possible and representing a re-occurring theme in the data. The resulting grounded theory comprises a core category as well as lower levels of abstraction, which are helpful in achieving understanding of the phenomenon.

A memo is referred to from this current study. As the researcher considered a specific category and its properties, he became aware of particular understanding that appeared to be implicit within the accounts. The category non-specific relationship factors, and the examples provided by participants attributed positive qualities to the keyworker, for example ‘attributing positive regard.’ Such qualities were clearly one of the properties of the category. No reference was made however to negative qualities, which the researcher surmised could also be a property of this category that associated the relationship with positive and negative qualities. Therefore, the researcher speculated whether participants were associating the relationship wholly with positive qualities, whereas it is possible that there may have been differing feelings at certain stages of the relationship. It appeared that this was not a category that had been fully developed within the accounts.

During the course of the analysis, two procedures were incorporated to check for, and minimise, any idiosyncrasies or biases in the researcher’s interpretation of the data. The aim was to ensure, as far as possible, that the researcher’s interpretations ‘fit’ the data. Firstly, another qualitative researcher, who was not part of the project, independently examined a portion of the data and allocated lower-order categories into higher-order
themes. There was good agreement between the original analysis and the external researcher's analysis, and the few discrepancies, which arose, were resolved through discussion.

Secondly, the researcher presented a portion of the data to a qualitative research support group. Within the group, the researcher discussed emergent findings and how the categories were labelled and linked.

2.7.5 Theoretical Sampling

As has been previously noted, theoretical sampling is the process of collecting, coding and analysing data concurrently, in order to use the understanding achieved to guide further data collection, and develop the theory (Glaser and Strauss, 1967). There are two distinct aspects to this process. Firstly, theoretical sampling may refer to the process of focusing upon emerging themes during the later stages of data collection. Alternatively, theoretical sampling may refer to the strategy of selecting participants on the basis of the theoretical account that is emerging.

It has been emphasised by Charmaz (1995) that decisions regarding further data collection may stem directly from the researcher highlighting the discrepancies and gaps in the account. One concept that emerged during the analytic process, was that the relationship factors within the keyworker relationship would vary between specialties, i.e. forensic mental health services. That is, there would be greater variation between participants who were subject to mental health legislation. Due to pragmatic considerations and time available, this strategy was not followed. However, whilst obviously being limited by the number of participants willing to participate in the research, an attempt was made to sample individuals who had diverse experiences of intervention (such as the duration and type of interventions received).

The process of theoretical sampling leads to saturation; that is, when no additional data may be discovered for developing the categories (Glaser and Strauss, 1967). As previously stated, saturation was not fully achieved within this study due to time
constraints. However, it is hoped that the account, which has been developed, is appropriately ‘substantive’, in that it explains the phenomena of interest to the reader.

2.8 Validity

One response to constructivist accounts of research practice has been to claim that the imposition of criteria for judging quality is inappropriate (Smith, 1984). However, a range of issues are discussed in the literature, that are argued to have some bearing on the notion of validity within qualitative research. The strategies of constant comparative method, comprehensive data treatment, and the method of deviant case analysis have been highlighted by Silverman (2000). Some researchers have used the method of respondent validation to promote validity within qualitative research, however a limitation to this has been suggested. Respondent validation would have involved asking participants to evaluate and comment upon the interpretations made by the researcher. However, as Henwood and Pidgeon (1995) have pointed out, this is a complex issue especially if one accepts the role of power relations, discourse and ideological systems in underpinning the outlooks of both respondents and researchers. This method therefore was not employed within this study.

2.8.1 Constant comparative method. This method has been highlighted as the core strategy of grounded theory, therefore it was used extensively throughout this study. The specific procedures that used this method were described in detail in sections 2.7, 2.7.1, 2.7.2, and 2.7.4, and so will not be repeated here. The constant comparative method means that the researcher should compare individual segments of data at the beginning of the analytic process, as well as comparing higher order categories at the end of the analytic process. As such, the implication of using this method ensured that the analysis remained close to the meaning of the text, thereby enhancing the validity of the account that was developed.

2.8.2 Comprehensive data treatment. It has been noted by Silverman (2000), that within qualitative research each aspect of pertinent data needs to be included within the analysis. Silverman suggests that such comprehensiveness goes beyond what is normally demanded in many quantitative methods.
Within this study, several strategies were used by the researcher to demonstrate comprehensiveness. Each interview was fully transcribed. All segments of the interviews were coded, either by using line-by-line coding or focused coding. Demographic information has been used to situate the sample (see section 2.5.1, 2.5.2, and Appendix 6). As previously stated, the coding of the interviews was not a linear process, and required the researcher to revisit earlier interviews as categories were developed in later transcripts. This re-examination of some aspects of data occurred several times.

The notion of transparency may be understood as comprising the issues of coherence and grounding in examples, emphasised by Elliott et al. (1999). Coherence refers to representing the understanding in a way that achieves integration, whilst preserving nuances in the data. Two procedures have contributed to this. A hierarchical structure is shown throughout the analysis, which organises the account around the core category (Figure 2). There are five ‘main categories’ encompassed by the core category. The lower order ‘sub-categories’, which were the initial categories to be developed through focused coding and memo-writing, are subsumed beneath the ‘main categories. The use of 5 figures are presented throughout the findings, to show relationships between the categories.

Grounding in examples refers to the researcher providing examples of the data to illustrate both the analytic procedures used in the study and the understanding developed in light of them. Throughout the analysis, excerpts from the interviews are provided to illustrate the properties of the categories, and to substantiate each analytic claim that is made (see Chapter 3).

2.8.3 *Deviant case analysis*. This method is an aspect of comprehensive data treatment, as it implies the researcher actively seeking out and addressing deviant cases (Silverman, 2000). This is where an element of the suggested pattern is not associated with the other expected elements. Within this current study, the researcher attempted to seek out deviant cases, and integrate them into the account of the data.
2.9 Reliability

The inclusiveness of that which is recorded has certain advantages. According to Perakyla (1997) the researcher does not normally know at the outset of the study what exactly the phenomena are that he or she is going to focus on. Those moments of the discourse where participants paused were thought to be of significance and were included in the verbatim transcriptions. Silverman (2000) noted that the reliability of the interpretation of transcripts might be jeopardised by not transcribing pauses and overlaps. In the interests of maintaining consistency, these aspects are included in the excerpts of the accounts presented in the following chapter.

Perakyla has highlighted that checking reliability is related to assuring the accessibility and quality of the ‘raw material’ that the researcher is using. This ‘raw material’ refers to the tape recordings and transcripts of the interviews in the method of grounded theory. Perakyla (1997) has argued that these materials have certain advantages over materials used in other areas of qualitative research, in that they provide detailed, accessible representations of social interaction. In order to allow the reader access to the transcripts within this study, they have been included as an addendum to the thesis.

2.10 The Researcher

If researchers operate within the constructionist paradigm it is important to be aware of or demonstrate a reflexive engagement with one’s assumptions, values and history as well as with the relationship with participants (King, 1996). The aim of inclusion of this section is to bring to attention some of my own background in the hope that this will enhance the reader’s awareness of the possible interactions between researcher and participant.

This research was conducted in my final year of training as a clinical psychologist. Prior to training I had worked for thirteen years as a mental health nurse in a variety of settings within the National Health Service. I had no prior experience of using a grounded theory approach. I have, however, had previous involvement in quantitative research studies, prior to and during clinical training.
The researcher felt that a social constructionist approach to understanding the research process and production of data provided the most appropriate framework for addressing the diversity of meanings attached to the experience of the keyworker relationship. Researchers adopting this approach would doubt that objective knowledge exists, but rather that there are multiple realities of viewing the world which are relative to culture, location and history (Holloway, 1997).

2.10.1 Researcher’s Assumptions. My own professional experience within clinical psychology and mental health nursing, had some impact on the choice of topic area researched and the development of the research question. The research question was partly developed from my own experience of working as a keyworker with people with mental health problems, and from some difficulties I experienced in relation to engaging people in a helping relationship. Participants selected were aware of the researcher’s background (the dual role of researcher and clinical psychologist in training).

Throughout the study my expectations, assumptions, the seeing of emerging themes, and general feelings and thoughts about the research were recorded in a reflective diary. The aim of this was to enhance my awareness of issues regarding reflexivity, and to point up the importance of remaining aware of one’s own decision making processes.

Emergent themes were also discussed within a qualitative support group. The group consisted of four trainee clinical psychologists who were all conducting qualitative research in the final year of their training. The group was facilitated by an experienced qualitative researcher who provided guidance and advice regarding methodological issues. The aim of the group was to provide support and advice and it was also a forum for sharing information.

2.10.2 Extracts from reflective field diary (post-interviews): 

<table>
<thead>
<tr>
<th>Interview Number</th>
<th>Date</th>
<th>Participant Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>28th November 2000</td>
<td>Interview with participant known as ‘Tom’. I am increasingly aware of the privileged position I am in as a researcher, not only in terms of listening to aspects of the relationship he has with his keyworker, but the fact of being in ‘good’ health and paid employment which I have taken for granted for so long. I was struck by ‘Tom’s’ willingness to speak with me, given that he prefers ordinarily to keep issues hidden from others. Another aspect may be the perceived power that I am accorded as a researcher.</td>
</tr>
</tbody>
</table>
Method

7th December 2000 – Interview Number 4
Interview with participant known as 'Linda'. I felt unsure as regards my interviewing technique. I wondered how structured I needed to be. Aware that this is now the fourth interview and the study is very much underway. I was very aware of the distress expressed by 'Linda' at various points, however felt that I was able to help her deal with it as best as I could. Spent some time after the interview checking out how she was, whether she needed any extra support from services, also whether she felt ok having the interview included. 'Linda' stated she was very clear how important it was to be included in the study.

2.11 Overview of the research procedure

The following flow chart (Figure 1. p. 44) illustrates the specific steps taken in this study to move from the collection of data to theoretical outcomes.
Method

Keyworkers informed about the research by presentation and by letter, and asked to identify potential participants

Responsible Medical Officer informed about the research and given the opportunity to exclude the potential participant

Keyworkers contact potential participants

Potential participants contacted by letter and follow-up phone call some days later following receipt of agreement to be contacted by researcher

Information about the study is provided and those willing to participate are asked to sign the consent form

Participant is interviewed and audio-taped

Transcription

Coding of the transcription

Draw preliminary interpretations by identifying common themes, associates and anomalies

Final analysis of the interviews to develop concepts and their links i.e. theory building

Write a final account

Disseminate information e.g. to local services and publication

Further interviews focused by preliminary findings

Figure 1. Flowchart of the procedure
CHAPTER 3: ANALYSIS
3.1 Overview of the Analysis

This section provides an account of the analysis. As a result of the analysis, five main categories were identified, from which the core category emerged. This is summarised in Figure 2 (p.48), which illustrates the relationships between the main categories and the core category.

A summary of the core category, the main categories and their relationships will be described first. This is the general structure within which the results of the analysis are structured. It thus provides an overview of the results.

The five main categories developed by the analysis have been identified from the interview texts of all the participants. Intermediate and sub-categories have been identified in the texts of at least two of the participants. A negative case example is presented as an illustration of where an account deviates from the main analysis.

Through analysis of the interview texts, one core category was identified. This is termed as **DEVELOPING UNDERSTANDING WITHIN A WORKING ALLIANCE**. Five main categories are also described that form a dynamic process model. These encompass **Disruption to Mental Health, Beginning Phases of Engagement, Emerging Collaborative Bond, Non-Specific Relationship Factors** and **Perception of Evolving Outcome**. An illustrated summary is presented in Figure 2. These will be discussed in the following sections.

The diagrams of each main category and their sub-categories will be followed by a detailed account of their relationships, grounded in participants’ statements. All verbatim material is written in italics followed by a pseudonym identifying the participants and line number(s) in brackets. Statements preceded by P were participant quotations and those preceded by JE were the interviewer’s. Long pauses are indicated by (.).
For the purposes of clarification, the different category levels are distinguished by different type. For example:

Core category – **DEVELOPING UNDERSTANDING WITHIN A WORKING ALLIANCE**
Main category – *Emerging Collaborative Bond*
Intermediate category – *Power and Control*
Sub-category – *Increasing Self-Empowerment and Independence*
Figure 2. The core category and dynamic process model
3.2 The Core Category:

DEVELOPING UNDERSTANDING WITHIN A WORKING ALLIANCE

The core category was identified in the analysis as a common theme and was termed DEVELOPING UNDERSTANDING WITHIN A WORKING ALLIANCE. Participants developed accounts within the interview process of their subjective experiences of the keyworker relationship. From participants’ descriptions of their experiences of the keyworker relationship, a dynamic process model was developed (see Figure 2).

The participants’ accounts included their experiences of mental ill health and the affective responses generated by the keyworker relationship.

The working alliance between participants and their keyworkers was described as being influenced by the emerging collaborative bond, which developed over time, including non-specific relationship factors, which participants described as supportive and beneficial. This research suggests that the non-specific relationship factors experienced in the keyworker relationship may serve an important function in helping the individual understand and cope more effectively with their mental health problems.

3.2.1 Reflections on the Research Process. On reflection on the research process, one participant mentioned:

"Well. The thing is (...) You won’t be asking for the other side of the story, will you? It’s obviously just how I see things."

([P1] ‘Margaret’: 153-154, 156)

It was evident that in her clarification of the research process, this participant sought to acknowledge the existence of another perspective as well as her own.

"I mean I was humming and hahing about doing the survey because I didn’t know how much I’d got to say to you like, so I thought well, you know, I’ll do it, like, you know. I mean Sue said to me, you know, I’d like you to take part in the survey because I think you’ve got some opinions on the Health Service. Well, I suppose I have, the other side of it, you know."

([P3]: ‘Tom’: 350-355)
This appeared to be a reflection on the working alliance between the participant and the keyworker, the participant having been encouraged to voice his perspective on the relationship.

"It's possible to accumulate information about a lot of different patients' insights and ask them to get the main trends, if you like, and to help other people in the future which would be better." ([P4]: 'Linda', line 323-325)

This closing statement expressed by the participant represented her belief that asking for the insights of different patients might promote the improvement of clinical services.
Figure 3. Disruption to mental health
3.3 Main Category – Disruption to Mental Health

All participants identified the category Disruption to Mental Health. They each expressed some part of their experience of psychological distress. Within the data there were links made with sub-categories, which included Receiving Medical Interventions, Experiencing Stigma, Supporting Relationships, Increasing Self-Awareness and Influencing Self-Concept. A diagrammatic representation summarises the relationships between these categories (see Figure 3, p. 51). Participants disclosed narratives regarding their distress.

The participants’ narratives included descriptions of their experience of ‘illness’, comprising feeling numb, being devoid of any emotion, lacking a sense of control and direction, lacking a sense of motivation, experiencing decreased cognitive abilities, and being lethargic.

‘Margaret’ appeared to resist the label of depression and therefore ‘treatment’ for some time. ‘Margaret’ reported that her perception of depression was influenced by her relationship with the keyworker with her ensuing self-acceptance regarding the illness.

“It has taken me years and a lot of support particularly from ‘Jane’ to realise that my experience of depression is not what I would have thought depression would be. I don’t feel miserable particularly, I don’t feel sad and woe is me. I feel numb. I feel (...) nothing, just nothing. Just dejection. To say, just devoid of any emotion.”

“Empty, that’s it. It’s not that I feel miserable, I just don’t feel anything. I think that’s why I really resisted (...) that label as I saw it and therefore treatment. Because I thought no, this isn’t depression.”([P1]: ‘Margaret’: 183-187, 189-191)

“But when I just felt as if I was battered about and completely rudderless (...) she was one anchor point that I had, you know. So I would say we are close. You know I think that there’s times when I really have depended on her. She has been the one that I have rung when I have been up tall buildings, when I thought I might cut my hand off, when my best
friend died and she's always been the one that's made me feel O.K. about having a major psychiatric illness."

([P1]: ‘Margaret’: 517-523)

“Um. (.) You know I cannae recall. (.) Like I say my memory's bad. Just down, not interested in anything. What's the point to things? That sort of feeling, you're useless, you're no good at anything. What are you here for? All that you know, that sort of thing.”

([P2]: ‘Rachel’: 186-189)

“I think the initial diagnosis was that I am schizoid, but for me to try and understand the condition I label it all under schizophrenia, realising that schizophrenia applies to many different sorts of conditions (.) I don't have voices in my head telling me to do things or (.) even to make me feel that I'm sort of Napoleon or whatever. Um, but, um I do think that people are discussing me and usually in surroundings I'm not familiar with. Um, it's a problem that's, it has physical effects on me as well, this condition. I feel tired, I feel not motivated to do anything.”

([P4]: ‘Linda’: 45-52)

Some participants said their ‘illness’ affected their employment and lifestyle. ‘Rachel’ disclosed her fears of having no hope of recovery from depression, as if she would come to a halt. In contrast, another participant, ‘Linda’ recognised the symptoms of her ‘illness’, but did not feel seriously incapacitated by it and attempted to manage her daily life.

“Battling with it, that's right, yeah. Battling with it, definitely. Yeah. It's slowed me down no end. I mean I'm all the time reminding her things that used to do what I wouldn't dream of doing now, what I probably couldn't do now! You know. I used to do landscape gardening as well. Block paving and that on the side. You know. I used to work for a big housing association. You know. Ever since I left college I've been in constant employment, like. But not ever since I've had the illness like which is about three years now. It'll be three years at Christmas, like. So. It's slowed me down summat terrible with the tablets as well.”

([P3]: ‘Tom’: 246-249, 259-264)
“Ah the thing that does worry me and I’ve said this to them before is that I’m always frightened that I go into one of these depressions and I never come out. I stop like that, you know, in this zombified thing. And that worries me a bit.” ([P2]: ‘Rachel’: 220-223)

“I’ve had symptoms but I haven’t been seriously incapacitated by it. I’ve been able to come from my house to here to talk about my condition rather than Tracy coming to my house, although she’s volunteered quite often that she would do that if I wanted that. In general I can get about, do my shopping, various things, go out and about. Yes, I get symptoms but I do my best to ignore them and get on with my life. So really, it’s never really been, got to the stage perhaps where I would feel seriously disturbed in having a relationship with ‘Tracy’, if you see what I mean.” ([P4]: ‘Linda’: 262-270)

‘Rachel’ struggled with her understanding of her psychological distress, placing emphasis on the unpredictability of her distress.

“It’s a funny thing, mental illness. It’s difficult to understand. Really difficult. I mean I don’t understand fully this thing myself, you know. And how you can get into such a deep depression and that, and next minute you are in a high. But I think it’s the high that comes first.” ([P2]: ‘Rachel’: 328-331)

This struggle was also evident within another participant’s experience, with ‘Tom’ expressing his desire for increased understanding coupled with a wish for predictable, efficacious intervention.

“It would be nice for somebody to turn round and say, “Well look, you’ve got this physical illness. This is what it is. This is how it’s going to progress. Or this is how we’re going to treat it. You know what I mean.”” ([P3]: ‘Tom’: 415-417)

Summary

As illustrated in this main category the participants’ shared experiences encompassed a diverse range of opinions regarding the disruption to their mental health. Activity including employment and lifestyle were affected, feelings of powerlessness, uncertainty
regarding direction and the future, and the impact of these on the stability of their emotional lives.

3.3.1 Sub-Category — Receiving Medical Interventions. Most participants shared information about other interventions that were experienced as a result of the disruption to their mental health. These have been entitled Receiving Medical Interventions as they encompassed experiences of medication, ECT, hospital admission, time with Psychiatrists. The medical interventions as perceived by participants were of a negative nature, in contrast to their reports of keyworker intervention.

“I mean I’ve been quite a few years just on tablets and going to see doctor every six months or so and talking for five to ten minutes and going away, and that would be that. Um I was left really to get on with it by myself. Um (.) this (.) um (.) treatment with my keyworker was a new thing to me. I wasn’t used to having a keyworker or discussing my problems on a regular basis every two weeks.”

([P4]: ‘Linda’: 226-234)

‘Linda’ described feeling left to get on with it, by herself, prior to keyworker involvement, receiving only medication and six monthly appointments with the doctor, the implication being that this medical intervention did not wholly meet her needs.

‘Linda’ compared this to the role of the keyworker who provided regular contact.

“I don’t want to get on the wrong side of either of them. (laughing) They’re there as an integral part of the machinery, but I think if the keyworker feels that I’m getting somewhere and I’m constantly being told how hard I work, but sometimes I think, “All right”. But for him to agree, she’s obviously spoken to him, and he’s in agreement that I don’t see him until she feels that I want to do which is the last thing that’s happened. I’m quite happy about it. But to go and see a man out of context who doesn’t know what you’ve been working on, I can’t really see the point unless he is either going to terminate the course of treatment that you’re having or that you’re just starting the treatment. Yes I can see it there, but not interim phases. If that’s what you want.”

([P6]: ‘Ruth’: 323-333)
Again this participant questioned the benefit or need for the doctor’s input, feeling that the doctor’s role was minimal in comparison to the keyworker. She implied that the relationship with the keyworker had developed somewhat.

“I have far more care in the community than I did in hospital. I think hospitals can be quite damaging really. I’ll not go back.” ([P1: ‘Margaret’: 461-462)

This participant appeared to have experienced interventions in different environments and expressed a strong preference for therapy intervention at home, in a familiar environment. This has possible implications for the keyworker relationship and levels of engagement. From this information, it can not be assumed that this arrangement to be seen at home would necessarily meet the needs of others.

Finally, one of the participants explored the impact that medication had had on her emotional life:

“Really what my keyworker was doing was focusing me on how I felt about things which had rather got lost with the Stelazine which sort of deadened my feelings, if you like. So I was just functioning mentally with my brain, but not emotionally.”

([P4]: ‘Linda’: 89-92)

It is apparent that the participant had opportunities to explore her feelings within the keyworker relationship, as distinct from psychiatric medication, which suppressed her feelings.

3.3.2 Sub-Category – Experiencing Stigma. It was evident that participants experienced concern regarding how others might regard them in relation to their ‘illness’, fearing social avoidance, rejection, and anxiety about disclosing their ‘illness’ to others.

“I can’t tell people that I know what’s wrong with me now ‘cos I’m embarrassed or worried about the way they might react, you know, like.”

([P3]: ‘Tom’: 403-405

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‘Rachel’ expressed her perception that others do not care, or might be disinterested. Conversely, she experienced her relationship with the keyworker to be respectful, caring and that she had belief in her. She implied that the keyworker did not regard her with fear, as she had experienced from others.

“You know, you’re ill, you feel nobody cares, or nobody wants to know because what people can’t see, they’re frightened of. So when you’ve got your keyworker there. She’s there for you and respects and cares and believes in you.” ([P2]: ‘Rachel’: 312-315)

In a similar vein this participant put it that if she had a physical injury then this would be somehow more acceptable and readily understood by others.

“Well, because it’s a mental illness um and they don’t understand what’s going on, you know, they back away. I mean if you’ve got a cut you can show them... but they seem to sort of shy away or they dunno know what to say, they’re frightened. You know so they avoid you.” ([P2]: ‘Rachel’: 321-322, 324-325)

‘Margaret’ expressed her initial response to engagement with the keyworker as problematic, as she struggled with the idea of receiving help from a mental health professional, fearing this process as casting a stigma.

“I mean, at that time I was, I think, terrified of it being thought that I needed that sort of help.” ([P1]: ‘Margaret’: 93-94)

Summary
From the data it is evident that for some participants the notion of receiving help from a keyworker, in relation toward their psychological distress, was experienced as useful, whilst one participant struggled with her own preconceptions about receiving psychological help.

The perceived attitudes of others to the participants has been identified as a factor that might influence their psychological well being, leading to speculation that if the
participants are aware of being members of a stigmatised group, then stigma may have negative effects on self-image and coping. The construction of mental health intervention as casting a stigma may have some broader ramifications for others in relation to engagement with mental health services.

3.3.3 Sub-Category – Influencing Self-Concept. Self-concept is viewed as integral to psychological well being, as borne out by the following narratives.

"I was still a bit (.) withdrawn. That's what it's like. You go into like a shell, don't you? So like it's a slow process of building back up. But I'm a lot, lot better. You know what I mean. I would say I'm back to myself now. Ok. With the help that 'Susan' gave me."
([P2]: 'Rachel': 177-180)

The metaphorical imagery of the shell illustrates this participant's unease with her view of herself, and emphasises the gradual process of her journey to recovering her sense of self. This participant identified the keyworker playing a role in this process. It could be speculated that 'Rachel's withdrawal, as if she were retreating into a shell, might have been a form of self-protection against further psychological distress. Another participant 'Tom', described feeling pessimistic about the prognosis of his 'illness', and expressed that there are limitations to help. This appeared to have an adverse effect on his self esteem.

"...Rather than schizophrenia where there ain't really a lot anybody can do about, besides a few tablets, you know, that don't really have much effect. It doesn't make me feel good about who I am..."  ([P3]: 'Tom': 418-420)

In contrast, following a considerable time span of keyworker involvement, 'Ruth' remarked that she had some degree of self-acceptance. This assumes a prior dissatisfaction with her self-concept.

"I'm more satisfied with what I am and where I am."  ([P6]: 'Ruth': 242-243)

These participants experienced some alteration to their self-concept as a consequence of their psychological distress.
3.3.4 Sub-Category – Increasing Self Awareness. These three participants made reference to the keyworker having enabled them to consider their needs in relation to the disruption to their mental health. This included understanding what some of the issues were about, as well as possible precipitants, which culminated in increased awareness of their own psychological health.

"With the benefit of hindsight and with the benefit of the support that I've had subsequently, I think I've realised it, I'd actually postponed my own grieving, really I kind of put that on hold, and I think I had this need to look after everybody else and, you know, I'll be all right kind of thing, a bit stoical, meanwhile getting more and more stressed at work and not coping." ([P1]: ‘Margaret’: 48-53)

"‘Susan’ is trying to help me see things before they take over. Well, having said that, I must have seen something because I went to the GP, so perhaps that was it. I was seeing summat was coming or happening because I was extra tearful."
([P2]: ‘Rachel’: 338-339, 341-343)

In a similar vein the following participant acknowledged that she was more able to anticipate her own needs with the benefit of increased insight. ‘Margaret’ recognised the possible ramifications of putting others’ needs first, to the detriment of her own needs, and she highlighted the role the keyworker played in facilitating this heightened awareness.

"I mean ‘Jane’ has made me realise that there is something in me that wants to rush in and rescue people and I think I do that and pointing that out to me has helped me not to do it at times when it wouldn’t be in my best interests to do it."
“... ‘Jane’ has been brilliant at helping me see things like that for myself that I just would never have realised.”
([P1]: ‘Margaret’: 443-446, 452-453)

‘Jean’ also commented on her heightened awareness in relation to her emotional state, over the course of the keyworker relationship.

"I realised that for years I had been walking around in this terribly uptight state."
([P5]: ‘Jean’: 174-175)
The data suggests that self-awareness may be a key step within the development of the working relationship with the keyworker, as well as the promotion of psychological well-being. It could be speculated that by having an increased awareness of psychological needs for well-being, participants may have felt more empowered and thus more in control.

3.3.5 Sub-Category – Supporting Relationships. For these participants the significance of the supportive relationship is borne out in the following accounts. The themes of dependence and stability are illustrated in their statements.

"...when I just felt as if I was battered about and completely rudderless (.) she was one anchor point that I had, you know. So I would say that we are close. You know I think that there’s times when I really have depended on her."
([P1]: ‘Margaret’: 517-520)

This participant experienced a lack of direction almost as if she had no internal locus of control, implying that her experience of distress was comparable to being in a stormy sea. She appeared to see the keyworker as offering a significant anchor point providing stability or safety in the face of adverse events.

"I think I realised that ‘Jane’ actually was more significant as a support than I had realised she was."
([P1]: ‘Margaret’: 348-349)

Keyworker support is seen as significant. Both the following participants however also make reference to the importance of family support.

"I mean I really find myself lucky that I have got the support of a keyworker and the family’s been there.” ([P2]: ‘Rachel’:349-351)

‘Jean’ described a shift from dependence upon her husband and the keyworker towards increased independence, with the implication being of an internalisation of self-reliance from the therapy.

"...I mean it was like transferring the reliance or dependence from Charles to ‘him’ almost, I would think.”
Analysis

"And then gradually as I got through the therapy that went away, as I became more to rely on myself, emotionally. So yes, he was the stable, the only thing that kept me going, really."  
([P5]: 'Jean': 279-280, 282-284)

In essence, participants had found the support of the keyworker beneficial towards combatting their psychological distress.

Summary

Given that the interviews were exploring participants’ experience of their relationship with their keyworker, each participant voiced narratives regarding their mental health experience. This enabled a contextual foundation to be laid both for the participants themselves as well as for the author. This foundation appeared necessary in order to facilitate further disclosure regarding the keyworker relationship.

As shown diagrammatically in Figure.3, some of the participants voiced their experiences of not only battling with their mental health, but with the experience of ‘medical’ interventions against a background of stigma. As a consequence, participants at various points in their narratives described decreased awareness, altered self-concepts and lack of support at various junctures, with some participants experiencing traumatic life events such as bereavement. However, there was some evidence to suggest that their relationship with their keyworker influenced the aforementioned issues in a positive way.
Figure 4. Beginning phases of engagement
3.4 Main Category – Beginning Phases of Engagement

The main category *Beginning Phases of Engagement* includes the responses expressed by participants towards the referral made to the keyworker and towards the initial stages of the relationship with the keyworker.

Within the data there were links made to sub-categories, which included *Expectations*, *Blocks to Engagement*, and *Experiencing Family Support*. Relationships between these categories are shown diagrammatically in Figure 4 (p.62).

A number of diverse responses were expressed by the participants in relation to the early stages of engagement. Preceding responses to the referral being made comprised unhappiness, fear, uncertainty, and disappointment.

"...it was her that said I want to refer you to Mental Health Services and it was a community psychiatric nurse in the first instance, which was like an awful blow for me...I wasn’t happy about it but I had enough respect for the GP to think if she thought it was a good idea then I would go along with it.”

([P1]: ‘Margaret’: 65-67, 76-77)

What seems apparent from this first participant, is that she was engaged in an existing relationship with the referring General Practitioner, which appeared to have influenced her decision to proceed. However, ‘Margaret’s response to the initial contact with the keyworker was evidently hostile when she recalled her feelings. She questioned how the keyworker could be of any benefit to her, and implied that this was an encroachment upon her independence. ‘Margaret’ continued to struggle with the initial stages of the relationship.

"So when ‘Jane’ came out and I think I was probably very hostile, probably gave her a really hard time. It wasn’t good. Who she thought she was that she could do any good for me that I couldn’t do for myself and I think I probably did give her quite a hard time.”

([P1]: ‘Margaret’: 81-84)
For ‘Margaret’, contact with the keyworker was experienced as a continual reminder of her struggle against acceptance of the psychiatric diagnosis, which left her feeling hostile towards the keyworker.

“Initially, as I said I was hostile to the whole idea. And because I knew what she was driving at and what I knew her ultimate aim was, you know to get me to accept this diagnosis and to come to terms with it, and to feel at ease with it, I thought, ‘I don’t like you’.”

([P1]: ‘Margaret’: 317-320)

‘Tom’s’ narrative suggests that he felt as if his keyworker had preconceived ideas about him, from the information obtained prior to their meeting. He clearly had concerns that his own story had not been heard, and that he was in some way being judged. What seemed most important to him was that he felt denied the opportunity to tell his own story. It can be inferred that this had some bearing on his initial engagement with the keyworker. This may have implications for initial contact with the client, and the way in which prior information is used by the keyworker.

“Yeah. I think as far as the keyworker bit goes I haven’t (.) you know, if I’d got a lot to say about ‘Sue’ as far as slagging her off was concerned I would, but I haven’t but I think it would be better for all concerned if they’d got more time with each patient, you know. I did think that at first and I did think that she hadn’t really got to know what (.). All she knew about me and my illness was what she’s read from the reports when I was in hospital or whatever. I did think she was judging me on that rather than actually knowing my side of the story if you like. Rather than getting to know me as a person. I’m just saying this you are basing it on the keyworker so I’ll tell you it might be useful, you know. But I did think that you know, she was getting all her information off the Health Service rather than any off me when I first met her, like, you know. ...I did think she could have said ‘Well, what was all that about’, you know. ‘I understand you were bothered by this, and what was all that about?’”

([P3]: ‘Tom’: 321-331, 335-337)

Initially ‘Linda’ appeared to experience a sense of obligation regarding her contact with the keyworker. It is not clear how much of this experience may be linked to her
perception of the relationship she has with the referring Psychiatrist, and to the position she places this professional in. ‘Linda’ clearly expressed her uncertainty about the direction of the relationship with the keyworker. This may be linked to her lack of knowledge about the keyworker’s role and function. It transpired that ‘Linda’ also questioned her own role within the relationship.

“Dr Walker said to come along and see Tracy every two weeks. So I did that and I started off by talking to her, not really knowing where it was going or quite what I was supposed to be doing but sitting there thinking, ‘Well I suppose she’s, I don’t know, observing the symptoms or something’. ... ‘To start off with I thought it was something I had to do.’”

([P4]: ‘Linda’: 199-202, 214-215)

Similarly, ‘Jean’ voiced her uncertainty regarding her expectations towards the relationship, which evidently caused her to be fearful. This main category has some clear links with the sub-category Expectations.

“And the very first time I went I know I was absolutely rigid with stress, whatever it was, anxiety, fear, because I didn’t know what to expect just (.) it took quite a long time to get rid of that. ...whether I would be able to trust him to be able to talk to him or not.”

([P5]: ‘Jean’: 306-308, 311-312)

‘Margaret’ also expressed her fears regarding the keyworker relationship and the wider relationship with psychiatric services, particularly regarding the psychiatric diagnosis and its implications. These fears appear to be strongly linked with the description of her late father’s ‘illness’ and her response to it.

“You know when I’ve been frightened about what they’re saying to me about my diagnosis or whatever, I’ve found the whole relationship frightening because I’m really frightened about what they’re saying. I don’t know whether that’s how it’s meant to work, but it seems to be how it does.”

“My father had manic depression and I (. ) loved him dearly. We were very, very close, but I just couldn’t cope with the fact that this was what I was dealing with. What I knownow to be in denial about it.”

([P1]: ‘Margaret’:103-106, 432-435)
‘Ruth’ voiced how isolated she felt in relation to her distress, and expressed how much she had wanted help but felt thwarted by her own ambivalence to reach out for it herself.

“Well, I think in the early days my keyworker said, “Where did I feel as though I was now?” And I said, “Well I felt as though I was in a little coracle, going round and round with no oar and nowhere wanting to go. Nothing on the horizon and just not wanting to be able to reach out and invite somebody else in the boat. Um, and therefore I wanted the hand to be reached out (.) I wanted somebody to help us understand. I wanted someone to take the rudder so badly, but I don’t think anybody does understand how you feel.”

([P6]: ‘Ruth’: 60-66)

Summary

What seems evident from some of these narratives, is that the early phases of engagement were permeated by powerful emotional responses, following the setting up of the keyworker relationship.

3.4.1 Sub-Category – Expectations. It appears that expectations of help and of the keyworker relationship were of a varied nature. Not every participant commented on this issue. Comments given ranged from ambitious hope regarding the amelioration of psychological distress to a more pessimistic frame of mind.

‘Ruth’ described her previous experience of feeling isolated with her distress, and endorsed her view regarding the limitations of any help being capable of providing any relief or solution.

“You are alone. And my experience has proven beyond a doubt in the past that if you have got a worry you take it to somebody else, they can’t help you because they’ve got worries of their own.”

([P6]: ‘Ruth’: 68-70)

‘Ruth’ continued to discuss her reflections regarding her expectations, implying a lack of provision of information regarding the function of the keyworker. This may have
contributed to ‘Ruth’ feeling ill prepared. Similarly, following engagement and during therapy with the keyworker, she expressed the difficulty in having a choice to end the relationship.

“I just feel that the ambience of seeing a keyworker, you’re not promised anything so one is wandering around in a wilderness, because you don’t know what you’re going to meet. You aren’t forewarned, therefore you can’t be forewarned. And I am told, like this interview, I can terminate at any time but having been told that as at this moment I don’t want to terminate it because I’m unsure of what is going to happen if I do. So you’re in a quandary, there’s a big question mark still there.” ([P6]: ‘Ruth’: 283-289)

‘Rachel’ presented an overly optimistic outlook, which led to early disappointment, as her expectations could not be met.

“I was expecting a cure immediately. I wanted them to give me something and to say “Right, here y’are, you get well. And it just didn’t happen.” ([P2]: ‘Rachel’: 147-149)

In contrast to the previous participants’, ‘Jean’ claimed that she had no expectations.

“No idea. I hadn’t got any thoughts on that at all.” ([P5]: ‘Jean’: 330)

The narratives suggest a link between the expectations of the participants and the beginning phases of their engagement with the keyworker.

3.4.2 Sub-Category – Experiencing Blocks to Engagement. Out of the data there emerged impasses of some significance that impacted upon the beginning phases of engagement with the keyworker. It is of note that several of these participants either conveyed a note of uncertainty or referred to something that was “difficult at the time”. There appeared to be no long-term damage to the development and maintaining of the keyworker relationship.
'Margaret' identified her struggle with the diagnostic label presented to her, which appeared to have a subsequent influence on her willingness to engage with 'treatment'. It could be speculated that she might have more readily engaged with services had a diagnostic label not been ascribed to her.

"I just don't feel anything, I think that's why I really resisted (.) that label as I saw it and therefore treatment."

([P1]: 'Margaret': 190-191)

'Ruth' acknowledged, with the benefit of hindsight, that a degree of resistance lay within her. There appeared to be a dichotomy between wanting to and not wanting to confide in the keyworker. In addition, 'Ruth' questioned the value of keyworker intervention, construing it as not achieving what she perhaps wanted.

"Hard work. Lots of tears, thinking that this wasn't getting me anywhere. And probably with hindsight putting up a resistance to bringing up painful things. Not wanting, not feeling able to confide and yet wanting to."

([P6]: 'Ruth': 53-55)

'Ruth' continued in a similar vein, by describing her perception that she was not achieving what she wanted from the relationship. She proffered an explanation, ascribing trying to protect family pride through fear that disclosure might irrevocably alter the family image.

"I just had the feeling that I wasn't getting anywhere and therefore she'd realised that I wasn't getting anywhere and maybe that was the end solution, that we weren't going to go any further. I mean it took me probably eighteen months before I actually spoke about my two children, and it was probably about the same amount of time before I actually brought my father really into conversation or spoke about some of the things (.) one tends to be very cautious and there's an element of pride in these things. No pride that you've hidden it for so long but pride in a family instance that you don't want somebody else's persona to be altered. And you don't do that against members of your family, you don't really want to do it against anybody who's a friend or acquaintance. It's not a crime that can be punished so why put down somebody who can't defend themselves."

([P6]: 'Ruth': 182-193)
‘Jean’ echoed some of the previous participant’s reflections by acknowledging her own internal resistance to keyworker intervention. It could be inferred however that she was able to work through these issues to some extent.

“...everything that he’s ever told me to do or explained has always worked eventually, depending on how much resistance I put up to it in the first place.”

([P5]: ‘Jean’: 433-435)

The themes of resistance and wariness regarding trust appeared to be prevalent in the data concerning the blocks or hindrances to engagement in the work with the keyworker. Despite these blocks, a working alliance emerged between each participant and keyworker. It is possible that this process somehow cemented the relationship.

3.4.3 Sub-Category – Experiencing Family Support. Some of the participants mentioned that their spouses played a role in promoting the keyworker relationship. The participants who did not make comment on this issue were at the time ‘single’ people as far as was known.

“However she did persevere and I did talk it over with my husband. My husband is a rock. I just don’t think I would have been here without him quite honestly. He’s just the most wonderful man I could have, he is my soulmate and I’m very, very lucky. And I think he’s often tried to say, “Well, you know, do you think maybe ‘Jane’s’ got a point. No, it couldn’t do any harm”, and very, very gently. I mean he always knew at what point to back off because I know that if people push me too far I will go in completely the opposite direction.”

([P1]: ‘Margaret’: 164-171)

‘Margaret’ attested to the fact that her husband had a particular approach in raising the issue of engagement with the keyworker. What is known from the data, is that ‘Margaret’ had demonstrated considerable hostility and unease in response to the keyworker’s early attempts to cultivate a working relationship. It can be posited that ‘Margaret’ perceived her husband’s encouragement and support as a key ingredient in the establishment of the relationship with her keyworker.
‘Jean’ suggested that her husband gave practical support. She acknowledged however that he might have had some misgivings about the process.

“I might add that my husband was totally supportive of me. He took me regularly every week to Leicester and he’s always been totally supportive, even when he sort of bristled a bit in the middle bit, his ego’s felt a bit knocked, you know.”

([P5]: ‘Jean’: 475-478)

It is significant that the respective spouses have an awareness of their partners’ psychological distress. Consequently they supported and sustained the keyworker relationship.

Summary

What can be surmised from the main category and interlinking sub-categories, is that there were considerable difficulties as perceived by the participants in relation to the establishment of a working alliance with their respective keyworkers. It can be suggested that the opportunities participants’ had to explore and work on these difficulties might be construed as a necessary part of the process of engagement.
Figure 5. Non-specific relationship factors
3.5 Main Category – Non-Specific Relationship Factors

This main category comprised five sub-categories, which included Attributing Positive Regard, Affirming Skill and Knowledge, Experiencing Instillation of Hope, Receiving Empathic Understanding, and Experiencing Supporting Relationship. Relationships between these categories are shown diagrammatically in Figure 5 (p.71). These non-specific or common factors may be construed as important as the specific techniques utilised by the keyworkers.

3.5.1 Sub-Category – Attributing Positive Regard. Participants’ attributed a wide range of positive qualities to their respective keyworkers. What does seem evident is that as the relationships developed, the perceptions of the participants altered significantly. These positive statements have been subsumed under the umbrella term of positive regard for the keyworker.

‘Rachel’ suggested that the relationship had a positive outcome, highlighting the issue of being able to talk openly with her keyworker in a manner that was distinct from that of talking with her partner.

“Well, it’s worked well for me. I mean I found it a good help. The fact that ‘Susan’ would come in and I can talk to her. Perhaps being able to talk to her like I couldn’t perhaps say things to my partner ‘cos my partner’s been through it, dunno want to know perhaps.”

([P2]: ‘Rachel’: 73-76)

This participant elaborated further, by stating that trust was important in the establishment of their ‘good’ relationship. She commented about her experience of the keyworker being consistent within their first relationship, and the re-commencement of that relationship following a ten-year gap from contact with mental health services:

“I feel as though I know her, um and she won’t let me down. The trust, that’s right, the trust’s there. I can trust her. And I know she’s still doing the job and there are certain things that you know, you need to (.) But I think we’ve got a good relationship.”

([P2]: ‘Rachel’: 299-300, 302-304)
Another participant gave a contrasting view, regarding the monitoring role her keyworker might adopt. She regarded the keyworker as someone who presented as 'genuine' and someone who did not use technical language within their work.

"I mean she’s probably making notes about me far as keeping a record of how I am is concerned, but she’s not giving me theories back or anything."
([P4]: ‘Linda’: 182-183)

‘Ruth’ identified the importance of having clear boundaries within their relationship, valuing confidentiality as integral. It may be inferred that ‘Ruth’ may somehow have been re-affirming the boundaries of the research interview.

"I think the only thing that you have and that I have, is the fact you feel that whatever you’ve said stops with her."
([P6]: ‘Ruth’: 206-207)

It is striking that ‘Margaret’ demonstrated a shift in how she has regarded the keyworker relationship, moving from an earlier position of fearfulness and hostility to a subsequent point of acceptance, emphasising the value of humour as a key ingredient in their working relationship.

"She’s just damned good at her job. I mean we have a laugh when she has students in. I am naughty; I’m really naughty. I have told students she comes round for a whiskey and we get drunk. And she goes to sleep on the sofa. (laughter) "I have to respect somebody in her position and I do really respect her, and respect her judgement. I mean she’s earned it."
([P1]: ‘Margaret’: 524-527, 544-545)

What does seem evident from the above narratives, is that the keyworkers are described in a positive way. There is evidence to suggest that the keyworkers have related in a genuine, non-professionalised, accessible manner. It appears that trust is a key ingredient bound with genuineness, consistency and respect.
3.5.2 Sub-Category – Affirming Skill & Knowledge. Many participants also regarded the keyworker as being in possession of a knowledge base of mental health issues. This might have had some influence on the level of confidence that some participants had in their respective keyworker.

This participant ascribed a breadth of experience to the keyworker, having known her for at least two years. It is unclear as to whether this was of direct benefit to him but it can be deduced that his keyworker had experience that might have been of value.

“I know with her being who she is, she’s seen a lot of this before.”
([P3]: ‘Tom’: 333-334)

Latterly ‘Tom’ makes a clear link between his keyworker’s experience and her understanding as being of proven therapeutic value, differentiating between the role his keyworker provides and that of his family.

“I mean I know she hasn’t got it, like I don’t think she has, but you know it’s useful to be able to talk to somebody that does at least understand a bit you know. That’s seen a lot of the illness and can relate to it, you know, and she’s able to listen to me like my family can’t. Definitely.”
([P3]: ‘Tom’: 463-466)

In a similar vein, ‘Linda’ substantiates ‘Tom’s account in terms of the understanding the keyworker provides.

“Well, from the perspective of mental illness, you’ve either got to have experience of mental illness or experience of dealing with people with mental illness really to get the right perspective on it. Um, you can talk to somebody, if you like, a lay person about it and they might understand what you are saying, but they won’t have been there, if you like.”
([P4]: ‘Linda’: 109-113)

In contrast, when ‘Jean’ attempts to implement a self-help technique that the keyworker has introduced, she compares the efficacy of her own efforts against the keyworker’s
efforts. It seems as if ‘Jean’ places the keyworker on a pedestal at the cost of downplaying her own skills.

“And it’s not as good as when he does it, obviously, but it does reinforce.”
“I mean he’s incredibly clever.”
([P5]: ‘Jean’: 201, 220)

It is striking that ‘Tom’ and ‘Linda’ share the view that in order to be understood, it is important that the ‘other’ in the helping relationship should primarily have the experience of having had mental health problems or at least experience of having worked with people with mental health problems.

3.5.3 Sub-Category – Experiencing Instillation of Hope. Participants claimed that the belief and support of their respective keyworkers had instilled hope in their situation. This subsequently promoted positive expectations and self-belief for participants in managing their psychological distress. This participant affirmed how her feelings and desires could change from being ‘low’ to becoming more hopeful.

“...having the ongoing support of my keyworker which gives me hope especially when I am at a low ebb.”
([P4]: ‘Linda’: 311-312)

‘Rachel’ also shared how she had moved to a more positive stance. She described her increased self-confidence, improved understanding of herself and consequent self-acceptance. ‘Rachel’ also demonstrated her internal dialogue, as inspired by the relationship she had with the keyworker.

“...giving you the confidence like. Making you see things like, I would’nae think myself, you know, she boosts you up, gives you the confidence to be positive, that’s it, instead of being negative all the time. That makes me feel I can live wi’ things more and mibbee feel okay about myself.”
“Go for it”. You know, “You can do it”. You know, like if I was sit here and say, “Well, I cannae do this”, like I always do and I cannae do...” “Why not? Why can’t you?” You know. “You’re a person, you know, of course you can. Have a go. Try it. You know, keep doing it until you can or
whatever”. So I mean, it’s like (.) that’s what I suppose you need. Somebody saying “Yeah, go on (.) you can do it”. Like, because I would say I started getting right about January.” ([P2]: ‘Rachel’: 154-158, 169-175)

‘Rachel’ emphasised the keyworker’s belief in her, and remarked on how this experience has provided sustenance through ‘difficult’ times.

“...she understands and she knows, especially when I’ve given up on myself, she sees me through it.” ([P2]: ‘Rachel’: 86-87)

The theme of sustenance features in the following narrative as does a changed perception towards the possibility that her ‘illness’ is something that can be battled with and overcome.

“And kept me going. Made me realise. Yes, this is something that can be beaten.” ([P1]: ‘Margaret’: 458-459)

It is evident that participants experienced considerable shifts in how they saw themselves at ‘crisis points’ and over the course of the relationship with the keyworker. It appears that participants were more able to contemplate working through ‘difficult phases’ and positive changes. They were supported in this process by the keyworkers’ instillation of hope and belief in them.

3.5.4 Sub-Category – Receiving Empathic Understanding. This sub-category Receiving Empathic Understanding encompasses the understanding felt by participants as communicated by their keyworkers. It appears that keyworkers generally intervene in a flexible manner in helping participants achieve partial resolution of presenting difficulties. Keyworker approaches appeared to take into account the changing needs of participants.

Empathic understanding was shown by the keyworkers towards some of the participants, demonstrated by their sensitivity and adaptability to meet changing needs.
"But the way I found with 'Sue' is that, you know she'll come and she'll spend a period of time here with you, but if you have got a lot to say, and you are upset about something, you know, not literally crying or anything but just upset about something. You're not sure about something, she'll spend more time with you, like, you know. The time she spends varies quite a bit depending on how you actually are.”  

([P3]: ‘Tom’: 185-190)

"'Susan's' always there you know. Whether it's a high or a low. But obviously, I mean like I say, I cannae always remember a low. So she obviously approaches it differently, the highs to the lows.”  

([P2]: ‘Rachel’: 271-274)

‘Margaret’ acknowledged her keyworker’s ability to be non-collusive in her approach, valuing her objectivity, professionalism and caring role.

“'She's always been gentle. Well, no. When I've needed someone to be gentle she's been gentle but when I have needed to be told she won't collude with me and I've realised I've tried at times to get her to collude with me, but, you know, that's not going to be her role and that's why I really value her, because she is totally objective and completely professional.””  

([P1]: ‘Margaret’: 409-413)

‘Linda’ implied that her keyworker did challenge her appropriately within the working relationship. The keyworker, though, was able to hold back when she was aware that ‘Linda’ was not in a position to deal effectively with therapeutic challenge, demonstrating her attunement with ‘Linda’s’ state of vulnerability at that time.

“'I think wisely she hasn't probed or challenged me too much because I've got quite a lot else to cope with at the moment, and is attuned to how I am feeling which I find reassuring.””  

([P4]: ‘Linda’: 156-158)

‘Ruth’ experienced her keyworker as being attuned to her readiness for change and pacing the ‘work’ accordingly.

“'And I think my keyworker has been very patient and waited for when I was ready.”"
"... she just knows exactly how either to let me wander or interject. And we never actually change subjects violently. It's a gentle directional change and she is very, very genuine."
([P6]: ‘Ruth’: 145-146, 268-270)

Interestingly, ‘Ruth’ questioned the limitations of how far reaching keyworker intervention can be, almost as if she were questioning the efficacy of intervention, attributing any change as more of an internal process. It can be deduced that ‘Ruth’ is more in a position of ownership of the part that she has within ‘the work’.

"But how that can help you, (.) e.g. me (.) unless you really think about there is nothing very much that she can say. It's a bit like a solicitor, you've entrusted what you have with them and it doesn't go any further therefore it can't be altered. So back to my little thing. The changes I mean have just got to come within me. And I'm not there yet."
([P6]: ‘Ruth’: 209-213)

Several factors formed the participants’ experience of Receiving Empathic Understanding. There was partial understanding and consciousness of the dual nature of the ‘work’ as implied by ‘Ruth’, whereas other participants appeared not to acknowledge the duality of the work. It may be speculated that this may be due to participants’ recalling ‘difficult’ phases over the course of time, and only considering the role of the keyworker at the cost of discounting their own part in the process.

The knowledge and experience keyworkers had of the participants appeared to be utilised in anticipation of their changing needs and adaptation of their approaches. The excerpts provide an illustration of the varied facets of empathic understanding as experienced by participants within the keyworker relationship. As can be seen, several factors mediate this sub-category, including participants experience of keyworker attunement to changing needs, pacing interventions accordingly in relation to readiness, and maintenance of a non-collusive manner.

3.5.5 Sub-Category – Experiencing Supporting Relationship. This sub-category, although linked to the main category of Disruption to Mental Health, is relevant to other non-
specific factors in the matter of relationships. Additional narratives demonstrated the nature of the keyworker support.

"Like I were having this baby and I was low. And I was like (.) you’ve got no interest. You need things to go into hospital or whatever and I got no interest so her come wi’ me (.) her come wi’ me. And like, because you’re slow and you ain’t got no self-confidence I didnae know like, because you’re slow and you ain’t got no self confidence I didnae know what to choose or whatever. I can remember this. And she’d say, “Oh what do you think?” You know, sort of making me have that little push to help to choose, to think for myself. I suppose it’s to bring you back out of it or whatever.”

([P2]: ‘Rachel’: 287-294)

Support as perceived by ‘Rachel’ is experienced as practical problem solving with recognition that this approach might be of potential benefit.

"Very, very supportive. Um. It’s just a lifeline. If I hadn’t had the experience of knowing this keyworker and having therapy I would have been. I don’t know."

([P5]: ‘Jean’: 79-80)

‘Jean’ viewed the keyworker’s support as critical and questioned whether she would have managed without it.

What seems evident within the main category Non-Specific Relationship Factors is the overlap between several of the sub-categories. This can be understood as due to the dynamic nature of the factors involved within the relationships. The boundaries between the sub-categories are not clearly distinct, and thus become closely interlinked. This is exemplified by the sub-category Experiencing Instillation of Hope, which can be construed as supportive.
Figure 6. Emerging Collaborative bond
3.6 Main Category – Emerging Collaborative Bond

This main category was defined by three intermediate categories comprising *Attributing Functional Roles, Power and Control*, and *Process Issues*. These categories assist in linking the sub-categories within the main category of *Emerging Collaborative Bond*. Relationships between these categories are displayed diagrammatically in Figure 6 (p.80).

Collaborative working appeared to be an egregious feature providing integration between emergent categories. The term collaborative bond is defined as including elements of joint participation, unified by the work carried out between the keyworker and the participant.

3.6.1 Intermediate Category – Attributing Functional Role

This intermediate category comprises *Educating Role, Coordinating Role*, and *Accessibility*. It appears that this category is construed as mainly functional, with the keyworker’s role described in practical terms. The sub-categories are analysed in more detail.

3.6.2 Sub-Category – Educating Role. The keyworker’s role is construed by one participant as an information source. Furthermore, the keyworker is experienced as giving instruction in some situations.

‘Tom’ described the keyworker’s usefulness in advocating his claim for possible financial allowances. ‘Tom’ also perceived his keyworker to be persistent in her level of support. Furthermore his keyworker investigated other forms of help in conjunction with her support.

“I mean she is useful. Like, I’m not claiming Disability Living Allowance, which quite a few people that I know seem to think that you’re entitled to. But I’m not claiming that and she keeps pressing me to claim that. You know, she’s quite, you know, on your side, like. You know. She’s found out like information. Like I joined the National Schizophrenia Fellowship but I hadn’t got a clue who the
workers in the area, or anything like that which you’d thought they’d told you when you joined. And she did come back with a number for somebody. You know, things like that, you know. Yeah.”

([P3]: ‘Tom’: 205-212)

‘Jean’ illustrated her experience of implementing an intervention, which appeared to have been wholly didactic in nature, which she described as successful.

“I can remember the first time that my keyworker got me to go into a shop and take something back. And he told me what to say and do and I did it, and it worked.”

([P5]: ‘Jean’: 106-108)

From these excerpts, some participants perceived their keyworkers to be informative, with some intervention experienced as educational in nature.

3.6.3 Sub-Category – Coordinating Role. It appears from these narratives that coordination of care is emphasised as valuable to enable collaborative working between those involved. The first two accounts illustrate this point, whereas the latter account reflects some absence of coordination. Within the initial account the participant described how the keyworker had taken a pivotal role in orchestrating care meetings. It appears that ‘Margaret’ felt very included in her care plan, thus it can be deduced that a collaborative approach has been used.

“We’ve had meetings, five of us, with ‘Jane’, the GP. The Keyworker has called the meeting (.) look we need to get together because we need to all know what each other is doing. So Alan and myself, ‘Jane’, Dr Parker, we’ve met up at the surgery or here and we have sorted out various things and various strategies and what we’re going to do.”

([P1]: ‘Margaret’: 213-217)

‘Tom’ described how his keyworker relayed information to the doctor concerning pertinent mental health issues. This appeared however to be what she considered to be relevant.

“But ‘Sue’ will sit here for a lot longer time than I am with the doctor and she sees me a lot more frequently and she
"But through my keyworker who said "Oh you missed them, we’ll have to make some arrangement about being reminded, I feel when I see him I get nothing out of it. I mean that sounds awful to say that. But you go and see him once every so often. What do you see him for? Possibly to review medication. But in the meantime if I want to change my medication I have to wait until I see him again which is odd. And when you see him. "How are you. How have you been? Blah de blah". At the end of it nothing. “Come and see me again in what have you”. So (.) That would be better if it was left to the keyworker to maybe say, “You know I think we ought to see the consultant”. I don’t know. Perhaps that’s what consultants are about. They want their money and they don’t (.).”

([P6]: ‘Ruth’: 310-320)

Summary

There appears to be a theme of lack of coordination within the latter narrative, as opposed to the first two excerpts where collaboration was evident and experienced in a positive light. The first account suggests that the participant’s involvement is integral and the team has agreed a clear plan of action together. As a consequence of this collaboration, the participant’s full awareness of the care plan may be likely to promote a positive outcome. The latter account indicates dissatisfaction with the medical input offered, and thus appears not to meet the participant’s needs. The participant suggested that her dissatisfaction arose partially due to the lack of coordination between services.

3.6.4 Sub-Category – Accessibility. The following participants shared a variety of experiences regarding the frequency of contact with and the accessibility of their respective keyworkers.
Analysis

‘Rachel’ had had contact with her keyworker ten years previously. When this relationship was re-established, her familiarity with the keyworker appeared to facilitate the work.

“Well, I knew the person that was coming which made it easier.”
([P2]: ‘Rachel’: 65)

‘Tom’ initially visited his keyworker at the Community Mental Health Centre with subsequent meetings arranged at home. He identified that the keyworker adapted the frequency of contact in relation as to how she perceived his psychological state.

“Well I was allocated one by the psychiatrist, I think. Dr Pearce. I was allocated a CPN and it was arranged for me to meet with ‘Sue’ at the Mental Health Centre. And then she came here every week or every fortnight after that, like, you know. So (.) Yeah, up until now.... Sometimes if I’m a bit anyhow um, more frequently like (.) once a week maybe....
‘Sue’ reads the situation as she finds it and she’ll decide that she’s coming, you know next week rather than in the next fortnight, you know.”
([P3]: ‘Tom’: 73-76, 79-80, 90-92)

‘Linda’ said that her initial contact with the keyworker emerged as a result of the psychiatrist’s request.

“I come to see ‘Tracy’ every couple of weeks really, after Dr Walker prescribed that as part of the treatment....”
([P4]: ‘Linda’: 73-74)

In contrast, this participant experienced more control by directly accessing the keyworker and arranging their contact.

“It started sort of infrequent appointments because I could ring him up and say, “I need to come and talk to you”. And he’d say, okay, come so and so”. I didn’t have to go through the doctor.”
([P5]: ‘Jean’: 48-50)

‘Ruth’ reflected upon a time when her keyworker did not appear to be available, although she struggled to recall the precise reason for the absence. ‘Ruth’ sought alternative
support at this time from an independent source. Her statement suggests a possible admission of 'guilt' from her actions.

"Then I met a Psychiatrist, who happened to be the organist of one of the local churches, and he did a bit of sideling himself and unbeknown to 'Sally' and everyone (.) I think 'Sally' may have been away at the time. She had a couple of sessions of obviously being ill or unavailable and I went to see Dr Neuberger who had then retired but took private patients. Well, he suggested that I stopped taking the tablets altogether. They weren't suiting me anyway. I did try it for a little while and then I went back to Sally and admitted what I'd done." ([P6]: 'Ruth': 32-39)

These excerpts illustrate a variety of arrangements relating to the participant's access to the keyworker. The continuity of contact was construed as positive, other emergent themes were related to frequency and direct access. The utility of direct access can be understood as simplifying the referral process that may be experienced as bureaucratic by the participant. This simplification may have consequences for the boundaries of the relationship. There appear to be some conflicting feelings regarding the nature of medical involvement.

3.6.5 Intermediate Category – Power and Control

This intermediate category includes the sub-categories Increasing Self-Empowerment and Independence, and Assuming Personal Responsibility. The contrast between self-empowerment and the 'power' of the keyworker was wide ranging over the course of the relationship, with several participants giving increased recognition to their own independent thought, action and responsibility.

3.6.6 Sub-Category – Increasing Self-Empowerment and Independence. It appears to be evident, as five participants divulged, that they recognised the validity of their own contribution within the working relationship. This can be termed self-empowerment, as it conveys the feeling of power within the individual, as if it is an internal, individual
possession. Participants described actions in which they felt more competent and able to influence events, as well as increasing their knowledge and understanding.

‘Margaret’ described having undertaken her own research in a quest to inform herself regarding her ‘illness’. Interestingly this appeared to provide a breakthrough in terms of increased collaboration with her keyworker. It can be deduced that ‘Margaret’ had a greater awareness of what her keyworker and significant others were attempting to do. It is possible that her ‘self discovery’ had the additional gain of making her feel less helpless.

“Until I started doing my own research. And, of course, I found out that... You know, I buried myself at times at the library at Queens at Nottingham and I found out all about the DSM criteria, and all the rest of it. And I thought, “Yeah”. And reading about these things in a book or books obviously over a period of time made me realise that there was a scientific structure to what they were doing. Because they were trying to establish how many episodes there were, over what period of time, and all the questions that had been asked there were purposes for. And that I realised the way I had to answer them implicated me. You know. But that helped a tremendous amount because I thought in a library, you know, I can’t object to the librarian because she’s just handed me the book. It’s not her fault. And I think I was just with ‘Jane’ shooting the messenger.”

([P1]: ‘Margaret’: 332-342)

‘Linda’ elaborated about having reflective space in which she was able to think through issues for herself, as well as valuing independent decision making. It appears to be important that this participant had freedom within the relationship to do this.

“To me it is because I value being able to make my own mind up and to be able to think about things and end up with something which might seem a bit cock-eyed but at least feels right for me.”

([P4]: ‘Linda’: 191-193)
‘Linda’ continued in a similar vein, by stating what she regarded as the limitations of past professional help, and asserted her own path of discovery regarding the value of self-help.

“Over the years because nobody could definitely tell me what caused my condition or (.) although they could give me theories and suggest possible causes, and that type of thing, nobody could give me a clear-cut answer about it. So it made me try to find more about it over the years so that I could help myself with it. And it has also made me determined to try and learn to cope in general.”

([P4]: ‘Linda’: 288-293)

‘Linda’ continued by affirming the facilitative role the keyworker took within their relationship, and the respect accorded by the keyworker regarding her independent thought.

“And I think to have a keyworker, as far as my condition is concerned, is a beneficial thing as opposed to the treatment before where I just had the tablets and had to find my own way. However, having found my own way for quite a few years and also coming from quite an independent family, I suppose I have independence and ‘Tracy’ respects that.”

([P4]: ‘Linda’: 325-330)

‘Ruth’ described her rather isolated home situation and the adaptive self-management strategies she had taken towards addressing this concern. It seemed as if there has been a considerable shift in her capacity to tolerate being on her own, whereas previously she had felt unable to do this, thus achieving some equilibrium.

“I managed for the first three weeks of this month, but I’m slowly thinking twice a month. Buy something different, going somewhere different because as you can see here it’s a very tucked away place, so tucked away that you’re off the beaten track so your friends don’t go by so therefore I felt as though I’d got to go out – I felt as though I’d got to keep in contact with people. I didn’t like being by myself and therefore I would go and see somebody or ring somebody up. Those times are getting less.”

([P6]: ‘Ruth’: 236-242)

‘Tom’ spoke about using bibliography as an aid to his understanding, however he appeared to discount the value of a psychiatric textbook on its own.
“Well, I’ve read bits and bobs. I mean I’ve bought a silly textbook upstairs...£26 from that bookshop in Leicester. One of the big ones.”
([P3]: ‘Tom’: 227-228)

‘Jean’ described a self-help technique learnt from her contact with the keyworker.

“Then when you do it yourself. You lie, well I lie down to do it. And you imagine the keyworker talking to you, picture where you are when you’re normally having hypnosis and imagine him talking to you which is a really strange thing because it’s your mind creating something for you to listen to.”
([P5]: ‘Jean’: 191-195)

Despite the self-help technique having independent value, ‘Jean’ described using visualisation involving the keyworker’s presence.

Summary

It can be seen that the majority of participants valued independent reflection and action. Within the situations described the keyworker appeared to assume less of an active role. It is not clear, in some instances; to what extent the input from the keyworker has been facilitative.

3.6.7 Sub-Category – Assuming Personal Responsibility. The term responsibility can be defined from the text as illustrative of taking personal responsibility for one’s feelings and actions within the relationship. This sub-category has some links with the previous sub-category Increasing Self-Empowerment and Independence. This is evidenced in the following account whereby ‘Linda’ described the importance and value of independent reflection within the keyworker relationship, which appeared to enable further therapeutic work to be carried out.

“...that was the point really for me to consider as to why I felt like that and to try and get my feelings sorted about it and then I would go back in a week or two’s time and having resolved that and feeling comfortable about it and no longer weepy about it....”
Analysis

“If we hit on something that particularly upsets me then it’s a point to be looked at. She doesn’t try to look at it for me. She supports me to go away and think about it by myself, which I value because I’d rather do it that way.”  ([P4]: ‘Linda’:  98-102, 175-178)

‘Ruth’ described her view of the relationship with the keyworker as being equal in terms of the balance of power and responsibility. It seemed that the process of talking and exploring things through was enough to facilitate some resolution.

“I don’t control it and I don’t feel controlled either. I’m very much at ease. There isn’t any. I don’t feel her subject neither does she feel my subject and I don’t feel that I dominate and I don’t feel that she dominates. It’s a precious space in a world apart, and probably by talking to her and exploring things through and bringing up fears and quandaries that I’m answering myself anyway.”  ([P6]: ‘Ruth’: 263-268)

‘Jean’ spoke as though she had no choice available to her within the working relationship, perceiving the keyworker to have made all the decisions regarding treatment. It appeared as if she was not acknowledging her own personal responsibility, attaching a degree of mystique to the keyworker’s methods within the treatment process.

“Well, I think I’ve gone down all the pathways that he’s wanted me to go down without realising it. You see I don’t know, I still, to this day, don’t know, I can’t see always how he’s working. Sometimes you can spot it and then I’ve said to him “I know what you’re doing, you’re so and so just so I tell you whatever.”  ([P5]: ‘Jean’: 151-155)

‘Jean’ initially appeared to take some degree of responsibility for bringing issues to the fore with her keyworker. She thought that the next stage in the process of therapy was less her own responsibility and implied that it was for the keyworker to take this on. It seems as though she perceived therapy as something that she might receive from the keyworker as opposed to its being a process of a collaborative nature.

“But I mean I decided right at the beginning there was no point in saying anything to my keyworker that wasn’t
Analysis

"absolutely the truth as I saw it, and I'd just shell out and he sorts the wheat from the chaff."
([P5]: 'Jean': 155-157)

'Margaret' highlighted the keyworker's emphasis on joint responsibility within the relationship.

"But she, I mean she'll say I think we really need to watch out."
([P1]: 'Margaret': 543)

'Linda' illustrated how she takes responsibility in using a self-help problem solving technique in deconstructing presenting problems.

"I sometimes find that if there's a problem is really to release it is to sit down and write it down and then it sorts itself out that way." ([P4]: Linda': 137-138)

There seems to be wide variation in the above narratives, highlighting the difference in how responsibility is conceptualised by participants. It appears that a positive outcome may be linked to where joint responsibility is taken for the work within the relationship.

3.6.8 Intermediate Category - Process Issues

This intermediate category comprises the sub-categories Disclosing, Experiencing Therapeutic Tools and Conceiving Ending. These sub-categories can be understood as essential to the progression, maintenance and resolution of the relationship, and are thus analysed in further detail.

3.6.9 Sub-Category - Disclosing. The majority of participants identified self-disclosure to their keyworkers as an important part of the process towards building the relationship and the reasons are depicted in the following narratives.
‘Margaret’ emphasised her need to share her feelings of helplessness during the course of two critical episodes. She identified her keyworker as fulfilling a cathartic, supportive role in these situations. It seems evident that this relationship developed into providing a much needed therapeutic space, where she felt ‘safe’ enough to fully express her emotions in a way with the keyworker that was different from that with anyone else.

“‘But I think I was at risk at that point. When I came home, I phoned ‘Jane’ because I couldn’t tell Alan about it. I couldn’t, I couldn’t tell him.”
“But I could be helpless in a way with ‘Jane’ at a time when I just needed to be when my friend was dying. I mean I could just cry and say what I was frightened of in a way that I just couldn’t be to anybody else.”” ([P1]: ‘Margaret’: 358-360, 454-457)

In continuation of the aforementioned theme, ‘Rachel’ affirmed the significance of self-disclosure to the keyworker, restating the difficulty of sharing particular concerns with family or friends.

“All I know is ‘Susan’s’ been there for me to talk to in a way that I cannae talk to others about things that bother me.” ([P2]: ‘Rachel’: 294-296)

‘Linda’ also highlighted the gains of having a keyworker to talk to, appreciating the non-interpretative role taken.

“But it is very useful to (.) have the opportunity to be able to talk to someone (.) a bit rather like your own psychoanalyst, except that she’s not analysing me to me.” ([P4]: ‘Linda’: 180-182)

‘Margaret’ described feeling ‘tortured’ by certain aspects of her illness with her disclosure acting as a cathartic release. She gives further recognition to the issue that ‘carers’ would be in a better position to meet her needs with this knowledge.

“But I did realise that I was much better off talking about it. I mean there are other strange ideas that I’ve had (.) that have actually, the ideas have been torturing me. I know I should say, not because I think I’m going to do anything,
but to get it out really, and also it does put the people who are caring for me in a position to be able to care for you better if they know what they are dealing with.”

([P1]: ‘Margaret’: 380-385)

This last narrative clearly illustrates the nature of collaborative work. There is recognition given to the therapeutic gains of sharing information with the keyworker. There appeared to be blocks, for many of the participants, in disclosing to significant others, with some acknowledgement of the benefits of talking with someone outside of the family situation.

3.6.10 Sub-Category – Experiencing Therapeutic Tools. The participants perceived that the keyworkers were using therapeutic tools or techniques within their working relationships. These included cognitive behavioural interventions for understanding and managing anxiety, cognitive therapy, hypnosis, counselling techniques, bibliography, and the use of allegory to assist understanding. The tools or techniques used in helping provide structure to the work that occurs between keyworkers and participants.

‘Jean’ acknowledged the learning of a self-help technique and her effective application of it in managing her anxiety about her health.

“The other technique my keyworker taught me was, well, when you do something like when you check yourself, monitor yourself doing it but you’re satisfied. And then if you feel this unnatural impulse to go and do it again, refer your mind back, well when you did it you were happy with it. Rely on that. And that helps a lot.”

([P5]: ‘Jean’: 263-267)

‘Jean’ recalled how the keyworker’s demonstration of allegories enabled her to develop an alternative perspective on her situation, by giving her a different narrative.

“But he’s very good at demonstrating allegories. Explaining your situation in terms of another scenario. And it’s like ‘Tania’ said I’m sure he makes them up, but it doesn’t really matter.”

(P5): ‘Jean’: 234-237

‘Margaret’ gave recognition to her keyworker’s skill in the use of cognitive therapy as an intervention. Her description suggests its implementation is meaningful and is at a point where she can reap the benefits.
Analysis

“She will stop me and point out how my thinking has gone. You know this is the Cognitive Therapy bit. You know she’ll do it, very subtly, very informally.”
([P1]: ‘Margaret’: 419-421)

Another participant lends further endorsement for the support of cognitive behavioural intervention in relation to the influence of cognition upon her affect and behaviour, thus demonstrating her recognition of potential for change if she so desired.

“I’ve learned that it’s what you think that makes you how you are, so if you can think differently you’ll be different. It’s like mind over matter. If you don’t mind it doesn’t matter.” (Laughter)
“Only the trick is, apparently, not to fight to be different, it’s to relax into thinking differently (.) making an effort in a relaxed way which is a bit of a paradox, but that’s how I understand it should work.”
([P5]: ‘Jean’: 401-403, 405-407)

‘Linda’ outlined how her keyworker used a counselling technique which brought about greater focus on pertinent issues, on which they were then able to work on collaboratively.

“I generally start the conversation by saying briefly how I’ve been over the last couple of weeks, when she’s listened to me over a period of time she knows roughly the areas that are problematic um she will sort of talk in general terms to begin with and then focuses in. If we hit on something that particularly upsets me then it’s a point to be looked at.”
([P4]: ‘Linda’: 172-176)

The use of bibliography was described by ‘Ruth’ as an adjunct to the therapeutic work she engaged in, however it is not known how effective this was, as it was a recent addition.

“I don’t think there’s anything particularly sparkling that happened. I’ve recently in the last month started to go through a new book for survivors of sexual abuse....”
([P6]: ‘Ruth’: 121-123)
It can be stated that the aforementioned therapeutic techniques all function as working tools that appear to have been experienced as collaborative by some participants. It is generally not clear as to how efficacious the techniques have been perceived. Although ‘Jean’ did acknowledge the utility of the self-help technique.

3.6.11 Sub-Category - Conceiving Ending. From the data it is apparent that the theme of ‘ending’, with regard to the participants’ relationship with the keyworkers, was of current concern to the participants, and the following excerpts exemplify this.

This participant appeared ambivalent with regard to the imminent ending of his keyworker relationship, and questioned what might happen with his care following the keyworker’s departure. It appeared from the narrative that this participant had limited or no choice over these circumstances.

“She told me that she was going yesterday. I mean, she hasn’t even handed her notice in yet. But she told me she was going yesterday, she felt she ought to and I dunno what’ll happen after she’s left. I suppose I shall have another (.) another keyworker, like, whoever that might be, like, you know. But I don’t really know.”

“It’s just (.) you know (.) there’ll be another keyworker and how I get on with them that remains to be seen. You know. We’ll have to wait and see how I get on. I got on with ‘Sue’ all right. Like I say, I find her pretty good. How I get on with my new keyworker we’ll have to see, like you know. Might not be as impressed with my next one.”

([P3]: ‘Tom’: 142-151)

This participant was emphatic in recalling her anxieties about the relationship finishing, and appeared to attribute much to the keyworker’s technique in managing and containing her anxieties. It could be argued that this participant’s narrative is dominated by the according of much significance to the keyworker’s skill and knowledge, thus marginalising her own level of participation.

“Because I can remember I used to say, “Look you won’t finish this off, will you, before I’m ready (.) this therapy?” and he would always say, “No, no I won’t”. But by some technique, I don’t know whether what he was doing was working, the idea of finishing the relationship didn’t seem to matter as much. Appointments become further apart and
then eventually that was it you know, that was it, and it didn’t worry him at all. Which is, I think, a measure of his skill in. (.)”  ([P5]: ‘Jean’: 287-293)

At an earlier stage in the relationship, ‘Ruth’ described her concerns that the ending was imminent, and would thus be terminated by her keyworker. She attributed this to her perception of the slow pace of progress, and recalled feeling as if the relationship had come to a standstill.

“At one stage I really worried that she was going to say “We’ve finished (.) you can’t see me any more.” I just had the feeling that I wasn’t getting anywhere and therefore she’d realised that I wasn’t getting anywhere and maybe that was the end solution that we weren’t going to go any further.”  ([P6]: ‘Ruth’: 179-180, 182-184)

The perceived reason as to why the keyworker relationship might come to an end was also evident in ‘Linda’s’ narrative. She however took a more positive attitude as towards the probability of this occurrence. There is a sense of some resolution having being experienced by ‘Linda’, although she highlighted the issue of not having returned to work as yet.

“I don’t know how much longer it will continue for. I feel that a lot of the problems that were causing the pressures, making my condition worse are now resolving themselves, so that I don’t know how long it will continue for. I don’t go to work as yet. Maybe it will end up that I see her less often (.) it’ll be just occasionally. Um (.)”  ([P4]: ‘Linda’: 231-235)

The following account stands in contrast to the previous narratives, in that this participant appeared to be in a quandary regarding having choice over concluding the relationship. ‘Ruth’ raised several questions about what the outcome might be if she decided to end the relationship, seeking clarification regarding this process. Ending by choice does not necessarily have a positive bearing as exemplified by ‘Ruth’. She emphasised that there needed to be some form of explanation from services for clients. This would ease ‘ending’ and facilitate any future contact with services.
"But going to see the keyworker, I wish sometimes that I wasn't going but then a little question mark crops up "But what happens if you don't?" And it would be really difficult for the Service to tell me anything about it anyway. Because it's an area that nobody knows about. But what does happen at the end of the time? You know. And it's all very well for her to say to me "Well you don't have to, you're in control. You don't have to come, you don't have to talk to me". But it's very scary from my point of view, to know what's going to happen if I say "Stop". Am I going to have to go through and start right again from the bottom of the pile and work my way up again? Would I get my own keyworker back again? Would I be able to see them? How long would I have to wait? And if it takes the six or eight weeks that it took to get to her anyway in the first place, it's an awful long time when you've been seeing someone. So that would be really helpful for a client to know."

([P6]: 'Ruth': 293-306)

Within the keyworker relationship, the theme of 'ending' is experienced as significant by many participants, leaving some anxieties and concerns unanswered or perhaps not addressed adequately. Each of the above narratives appear to represent crucial points where the participant’s anxieties, concerns or wishes have come to the forefront, and may be of consequence to the collaborative work within the relationship and therapeutic outcome.

A view of ending might imply that the work carried out between the participant and keyworker has achieved what it set out to do. It has been demonstrated however that there is wide variation in meaning across the spectrum. It could be speculated that some of the above issues may not have been acknowledged between the participants and keyworkers. It is possible that they were only voiced within the framework of the research interview, with the implication that this was a valued opportunity to do so.
3.7 Main Category – Perception of Evolving Outcome

The main category *Perception of Evolving Outcome* encompasses the responses made by all participants regarding perceived changes that may have been influenced by the keyworker relationship. This includes some positive affirmations as well as the limitations as experienced by some participants.

Within the data there may be some evidence of links between participants’ expectations and their experience of outcome. It is apparent that this is borne out in this participant’s experience. ‘Ruth’ is emphatic in stating her experience of the limits of professional help.

“*So even in the professional way you can’t (.) they can’t do anything for you, they can’t suggest, because ethically it’s wrong, they can’t suggest what you do, but have to sit and listen to you bringing out all these problems. And I didn’t really want to share my problems because I thought where’s the point in talking to somebody about something if they can’t alter it.*”

([P6]: ‘Ruth’: 72-76)

However, ‘Ruth’ continued by highlighting a shift that had taken place not only within herself, but also within the keyworker relationship. ‘Ruth’ suggested that this shift was made possible by her own disclosure and by the nature of the collaborative work carried out.

“I think she realised with her experience, that I was showing a facet, a level that I was only prepared to show, and we needed to get below that subterranean rather than on the top. Although that layer was probably a layer below the layer I was showing the outside world.”

“The outside world was sort of the crust and I’m under the crust with her in the beginning and then we’re now getting below that level.”

([P6]: ‘Ruth’: 154-157, 159-160)

The sense of dissatisfaction and limited outcome can be further illustrated in the following narrative. There appears to be an inference that this participant’s needs have not been fully met, and that possibly he expected a ‘better’ outcome from services, with
the supposition that this also included the keyworker. ‘Tom’s belief that there are ‘better’ clinical services available appeared to be of some significance for him.

“I mean if I won the lottery I would go and find out who was best with the old schizophrenia. Which clinic was best, and I’d go and check myself in for a few weeks, like. If I won the lottery like. I mean if I really wanted to I could go now, but I wouldn’t want to put that drain on anybody’s resources, like, you know. But that’s how I feel about it.”

([P3]: ‘Tom’: 378-383)

‘Tom’ reaffirmed his perception of service limitations, and implied that in contrast to ‘schizophrenia’, a physical illness was more likely to be understood and thus receptive to treatment. It is not known but it could be speculated that this ‘understanding’ might be related to other peoples’ views including those of his own.

“It would be nice for somebody to turn round and say, “Well look, you’ve got this physical illness. This is what it is. This is how it’s going to progress. Or this is how we’re going to treat it”. You know what I mean. Rather than schizophrenia where there ain’t really a lot anybody can do about, besides a few tablets, you know, that don’t really have much effect.”

([P3]: ‘Tom’: 415-419)

From the above narratives it is evident that some participants have had ambivalent feelings regarding the outcome of their relationship with the keyworker, which appeared to extend to a systemic view of mental health services. One participant whilst stating some of the limitations of professional help, was able to also draw out the positive changes experienced.

In contrast to the previous narratives, some of the following participants perceived a more positive outcome from their relationship with their respective keyworker. ‘Linda’ made a distinction between the ‘personhood’ of the keyworker relationship and her earlier experience of pharmaceutical intervention, implying that this was an isolated time in her life. An emphasis is made on her current treatment being a markedly improved experience, with increased awareness of her affective response within the context of enhanced support.
"I can appreciate the value of actually speaking to somebody about it as opposed to it all going around in my head."  
([P4]: ‘Linda’: 122-124)

"Well it has put me in touch with my feelings which is what I couldn’t have done on my own, I don’t think."  
([P4]: ‘Linda’: 218-220)

"And I think to have a keyworker, as far as my condition is concerned, is a beneficial thing as opposed to the treatment before where I just had the tablets and had to find my own way."  
([P4]: ‘Linda’: 325-328)

These excerpts are further examples of ‘positive’ outcome as perceived by some of the participants.

"But I’m a lot, lot better. You know what I mean. Ok. With the help that ‘Susan’ gave me."  
([P2]: ‘Rachel’: 179-180)

"So I am far more able to recognise it and do something about it when I realise that what’s happening."  
([P1]: ‘Margaret’: 197-198)

The above excerpts illustrate outcome, as defined by these participants, as having different meanings. One participant expressed her frustration regarding her perception of the constraints of the keyworker role in providing help, with the implication of a mismatch between her original expectations and treatment delivery. It is possible that this may be linked to perceived role ambiguity of the keyworker. Interestingly, a demonstrable shift occurs in her perception, made possible by disclosure and a shift towards a relationship based on collaborative working.

Another participant provided further corroboration of dissatisfaction regarding treatment delivery, and made a distinction between physical health and mental health problems, implying that physical health problems were not only more treatable, acceptable, but cast less of a stigma.
One participant considered the keyworker relationship to have made a marked difference on her quality of life. As a result she felt less alone with her problems. The provision of more information led to increased insight for another participant and thus greater control.

Deviant Case – ‘Jean’. This participant attributed any personal change mainly to the influence of her keyworker, the implication being that she had a minimal part in this process. As has been shown previously within the sub-category of Assuming Personal Responsibility, it could be speculated that this participant appeared to invest a responsibility for change or ‘control’ in her keyworker. Thus the equilibrium of this relationship appears unequally balanced.

“If I hadn’t had the experience of knowing this keyworker and having therapy I would have been. I don’t know. Completely unable to. I don’t know. I can’t see. It helped me a lot because confidence and everything. I’m a completely different person. I was totally emotionally dependent before.” ([P5]: ‘Jean’: 79-83)

Within her narrative, ‘Jean’ included reference to the keyworker’s therapeutic relationship with the participant’s daughter. The keyworker appeared also to have had contact with ‘Jean’s’ husband although this can not be considered a formal therapeutic relationship. ‘Jean’ continued by referring to her relationship with the keyworker as if it were a friendship.

“And he’s sort of talked to him in relationship to myself and our other daughter. So he is really, really a good friend.” ([P5]: ‘Jean’: 59-60)

It is possible that ‘Jean’ perceived the relationship in different terms from that of the other participants, and this may be due to the keyworker’s extended involvement with other family members. As suggested in this example, the data implies the existence of possible boundary diffusion for ‘Jean’.

Unsurprisingly, participants had markedly different constructions regarding ‘outcome’, with some participants having voiced more positive affective responses than others. It can
not be presumed that the "outcome" is an effect of the intervention process, but it may in fact be attributed to a variety of meanings according to the individual participant.
CHAPTER 4: DISCUSSION
4. Discussion

4.1 Overview of Discussion

This chapter provides a summary and interpretation of the findings, and is considered in the light of existing psychological literature. A critical evaluation of the study follows. In this the methodology of grounded theory is considered, the specific procedure that was utilised in this study is examined, and the impact of the study upon the researcher is described. Implications of the findings for clinical practice, clinical psychology, theory, and organisations are explored.

The aim of this study was to provide a theoretical account of participants' understanding and experiences of the keyworker relationship, and of the helpful and hindering processes that might occur in the relationship. Six participants were interviewed in total, and the qualitative method of grounded theory was the means by which the core category and dynamic process model were developed. These will be discussed forthwith.

4.2 Developing Understanding within a Working Alliance as the Core Category

From the analysis, the development of understanding within a working alliance emerged as a core category for participants. The term to “understand” means ‘an individual’s perception or judgement of a situation, a sympathetic awareness or tolerance; perceiving meaning of, perceive significance or explanation or cause or nature of, know how to deal with, infer especially from information received’, (The Pocket Oxford Dictionary, 1978). The term “alliance” means ‘an informal or unspoken agreement or arrangement, a union or association between persons or an organisation (The Pocket Oxford Dictionary, 1978).’

Participants construed the understanding of their psychological distress, as a developing, dynamic concept, taking place in the context of a working alliance with their respective keyworkers. The working alliance was described as being influenced by the emerging collaborative bond, which developed over time, including non-specific relationship factors.
4.2.1 Summary of the analysis

The participants identified how their experiences of ill health had impacted upon their lives. They had been brought into contact with their keyworkers and mental health services. These experiences of distress were encompassed by negative affect and a change in self-concept, with marked disruption to many aspects of their lives (e.g. cognitive, social and occupational functioning). The long-term impact that these experiences had on participants was marked by a number of losses. For some, these included loss of work roles, relationships and some loss of self belief.

For some participants, the beginning phases of engagement were crucial to the development of the alliance. Participants’ expectations influenced their capacity to engage in the relationship, including the perceived outcome. Some participants experienced marked ambivalence towards contact with the keyworker, fearing this process as casting a stigma. Family support was seen by some participants as important in the developing relationship with the keyworker.

Several non-specific relationship factors attributed to the keyworker were of significant therapeutic value to the establishment of the working relationship. These were seen as exerting a positive influence upon the participants, in that trust and confidence were established, understanding was achieved, and support was provided which sustained participants through critical periods.

As previously stated, the working alliance was shaped by the emerging collaborative bond. As part of its core philosophy, the Division of Clinical Psychology (2001) recommend that:

"Clinical psychologists should treat all people – both clients and colleagues – with dignity and respect and will work with them collaboratively as equal partners towards the achievement of mutually agreed goals".
Some participants perceived the role of the keyworker to be functional, offering education and advocacy. Coordination was experienced as pivotal by some participants to receiving additional services; in contrast, other participants felt there had been a gap or limitation in this care delivery. Constancy, continuity and direct access to the keyworker were some of the variables experienced by participants.

Many of the participants valued their capacity for independent thought and action over the course of the relationship, reinforcing the notion of self-empowerment. The extent of joint participation with the keyworker differed amongst the participants, with varying degrees of personal responsibility assumed with regard to work carried out.

The development of the relationship was facilitated in part by the process of participants’ self-disclosure, which for some was experienced as cathartic or serving some other therapeutic gain. It was notable for some participants, that either family or friends might have hindered disclosure. A range of therapeutic techniques was perceived to be helpful to the progression and maintenance of the work as carried out between participants and keyworkers. These techniques appeared to be experienced by some participants as collaborative in nature. The extent of their efficacy however is unknown. The perceived ending of the relationship was reflected upon by several participants and marked by anxieties and unanswered questions as regards the future. The emergence of a collaborative bond appeared to be influenced by a range of factors. The interplay between non-specific factors and collaborative bond contributed towards developing understanding within working alliances.

Outcome at a personal level was a theme in the analysis. Participants’ accounts reflected different meanings, of which some were perceived as positive, whilst others perceived some limitations.

4.3 Disruption to Mental Health

This study demonstrates that participants’ perception of disruption to mental health was idiosyncratic. The implication is, how individuals resolve their distress, and what level of assistance they require to do this, will be wide-ranging. It was evident that participants
experienced concern regarding how others might regard them in relation to their ‘illness’, fearing social avoidance, rejection, and anxiety about disclosing their ‘illness’ to others. The relationships participants found most supportive depended on individual circumstances, with reference made to the support of the keyworker and that of the family. This support included promoting increased awareness of psychological needs in relation to the disruption to their mental health. Underlying all of these though, was the singular importance of acceptance – surely the antithesis of discrimination. This seemed especially important for participants living in a society where a mental illness diagnosis carries such potential for discrimination and isolation. Recent research by Wright (2001) revealed that when people are told about their friends’ distress, they are sometimes shocked or frightened, leading to a lack of understanding.

When asked what had been most helpful to them during this disruption, participants identified the relationships with keyworkers and/or family as a being a dominant and recurring theme.

4.3.1 Beginning Phases of Engagement

It was evident from several participants’ accounts, that there were considerable difficulties in the beginning phases of engagement with the keyworker. Themes of resistance and wariness regarding trust appeared to be prevalent in the data. This may have been a consequence of a mental health system that is ‘based primarily on an illness model in which an ‘expert’ defines the problem as primarily a defective chemical mechanism in the patient’s brain that needs to be repaired by an expert’ (Fisher, 1994, p. 914). This appears to be exemplified by this participant’s narrative.

“I just don’t feel anything. I think that’s why I really resisted (.) that label as I saw it and therefore treatment.” ([P1]: ‘Margaret’: 190-191)

It could be understood that any withholding of ‘expert’ or professional information about diagnosis, plan of treatment and medication effectively retains control and power with the professional. Moreover, it positions the consumer as a passive recipient of mental health care. These results suggest that there is a need for community mental health services to
involve ‘service users’ in the development of treatment plans from the outset of engagement. Despite the identified inadequacies with information about treatment and rights, the participants reported positive relationships with their keyworkers.

4.3.2 Non-Specific Relationship Factors

There was general consensus about the non-specific factors which participants perceived as important. The participants’ affirmation of keyworker qualities of positive regard and empathic understanding were qualities which participants referred to, which suggests a need for a relationship where these qualities are present. Unconditional positive regard, empathic understanding and genuineness are all qualities described by Rogers (1957) as essential components of psychotherapy.

Narratives revealed characteristics perceived as helpful or as less helpful to keyworking. A theme in the accounts of participants was that of trust. Participants’ descriptions of their relationship with keyworkers were marked by frequent references to trust, with and without prompts from the researcher. The importance of trust appeared to lie in its value in defining the quality of the relationship. Trust was also seen to play an important part in engaging the participants so that they felt able to confide their problems in the keyworker. On reflecting upon the initial stages of engagement with keyworkers, participants frequently referred to feelings of uncertainty and fear. As relationships developed over time, trust became more firmly established.

The participants in this study were able to perceive and value similar qualities in those relationships that they defined as supportive or helpful. Of crucial importance in building relationships, as seen by the participants, was the willingness and ability of the keyworkers to envisage themselves in the participant’s situation in order to understand it.

Keyworker understanding was seen to convey, depending on the participant, accurate identification or interpretation of meaning, or a more global response disposition, which was marked by perceived sensitivity of the keyworker or the feeling of being “really understood”. This ‘empathy’ can be understood as developing over an extended period of time. Listening to and empathizing with the participant’s view of their situation was
therefore essential in building a relationship with participants, providing a means by which keyworkers might better understand the participants wishes.

Frank and Frank (1991) argued that the presence of an emotionally charged relationship with a therapist who is both hopeful and determined to help works to “re-moralize” clients. Indeed research carried out by Snyder, McDermott, Cook and Rapoff (1997) demonstrated the critical role of helpers’ hope in enabling clients to change. From this present study, it seems evident that some participants accorded importance to being able to rely on and trust the keyworker to guide them when they were demoralized in their own problem-solving efforts. As Frank and Frank (1991) noted, such individuals are

“conscious of having failed to meet their own expectations or those of others, or of being unable to cope with some pressing problem...[and] feel powerless to change the situation or themselves” (p.35).

Some participants described how their respective keyworkers had not only attended to the remediation of goals in problem areas of the participants life, but also built on the areas of strength that were already evident. Thus keyworkers were reported to have focused on what is functional in participants’ lives as opposed to focussing on “weaknesses”.

It is of interest to note, that whilst a few participants were able to describe their initial dissatisfaction with the perceived limitations of keyworkers, others may have been more reluctant to do so. Rennie (1992) identified several reasons why patients hid their negative feelings from therapists, they feared being considered irrational, their feelings not legitimate and they feared that the therapist would also disapprove of their feelings. This study may suggest that the fears voiced by Rennie’s study may not be unfounded.

4.3.3 Emerging Collaborative Bond

4.3.4 Attributing Functional Roles. Accounts revealed that keyworkers appeared to fulfil a range of roles and types of relationships with participants, including supportive roles that emphasized listening and teaching, more formal psychotherapy, as well as coordinating and monitoring roles. Whether the differences between participants’
accounts represents true differences or differences in perception of activities (e.g. one keyworker’s therapy is another’s “coordinating”) is difficult to assess. Not all keyworkers fulfilled all of these roles, and it seemed that most keyworkers took a certain position in response to the needs of the participants.

Early in the history of the keyworking concept, Rodway (1979) emphasised the importance of imparting clear information to clients about the role of the keyworker. Moreover, he stressed that clients and keyworkers should discuss the aims of keyworking together in order to reach a clear understanding of and agreement about the role. Hence, it may be useful for keyworkers and clients who are having difficulties in keyworking to discuss their perceptions of the aims together. This difficulty is evident in ‘Margaret’s’ account of the early stages of engagement with the keyworker.

It has also been proposed that if mental health workers are frustrated, unclear or overwhelmed within their roles, they are probably unable to relate warmly and consistently as ‘clients’ need them to, as well as being at personal risk of illness or depression (Maslach, 1982). Hornby (1993) concurred that when a professional role lacks a clear identity, the individual practitioner’s identity is insecure, causing difficulties in critical self-appraisal and collaboration in practice.

Douglas and Payne (1980) identified two major weaknesses of the keyworker concept shortly after its introduction: the ambiguity of the concept and the fact that it had been interpreted in a number of different ways. Another area of this relates to what was identified as another potential flaw in keyworking also addressed by Douglas and Payne: that the keyworker concept was in danger of creating inflexible roles and services. In this study, keyworkers are described by participants as providing a flexible and individual service. Hence, although there are perceived ambiguities about the role, the reverse side of this is that it allows for individuality, creativity and flexibility.

Although one participant realised that in receiving support from her keyworker she was also being monitored, she did not appear to resent this, indeed it may have been reassuring.
Discussion

“Well I suppose she’s, I don’t know, observing the symptoms or something.” “To start off with I thought it was something I had to do.” “I mean she’s probably making notes about me far as keeping a record of how I am is concerned, but she’s not giving me theories back or anything.” ([P4]: ‘Linda’: 202, 214-215, 182-183)

The participant’s acceptance of support in this way depended upon the development of a sound relationship. This may have been linked to a perceived need for intervention other than solely receiving psychotropic medication. Despite the participant perceiving the keyworker to have a monitoring role, she did not feel coerced and it is probable that she would not have accepted the service if she had been. Therefore, this participant accepted this role, partly because she felt supported and understood, and had a choice.

4.3.5 Coordinating Role. Acting as an advocate involved accessing services from other sources on behalf on the participants, and can be seen effectively as an ‘indirect’ service function. Advocacy may be understood as presenting potentially conflicting priorities for keyworkers since limitations occur within the advocacy role, particularly if one is representing an agency that is involved in the care.

In 1993, Morgan stated that it was impossible for health professionals to be independent owing to legal obligations to their employer and to budget constraints. Under the NHS and Community Care Act 1990 and Care Programme Approach Policy, the keyworker role is to meet user needs, but the pressure of being legally accountable for coordinating care may have implications. It is possible that this may affect the keyworker’s ability to follow ‘service user’ needs, particularly if they conflict with legal obligations.

In the researcher’s experience, emphasis on compliance with medication and the involvement of medical officers has often been prioritised and actively and directly pursued in an attempt to allay anxiety regarding ‘client’ relapse and admission to hospital. Unsurprisingly, several participants had conflicting feelings with regard to taking psychiatric medication, describing how medication can deaden feelings, affect self-concept, and limit the power one might have regarding any desired changes to one’s prescription.
Perhaps better understanding of participants’ reasons for ambivalence about medication, might arise by the prescribing doctors placing less pressure on participants and allowing more time and space to understand his or her position. This may contribute to exploring wider alternatives in maintaining the wellbeing of several participants.

4.3.6 Accessibility. Participants recognised consistency and valued it. Two participants had had previous contact with their keyworkers; the familiarity of this relationship can be understood as having been facilitative of the work. What appears to stand out as a theme running through many of the accounts is a strong sense of their recognition of the keyworker’s constancy: the keyworker was seen as having a long term perspective on participants’ lives and the care they needed. There was a sense of feeling ‘known’ and understood by the keyworker. It was clear from interviews with participants that the long-term nature of the contact with keyworkers was valued. Accessibility then was an essential ingredient in enabling participants’ needs to be met.

This idea of constancy is crucial for wider understanding of the importance of stability in the lives of these participants. Given the high staff turnover in mental health services, the importance of this accessibility and constancy is perhaps unsurprising. In summary, there appears to be one central issue emerging from the narratives of the functions of keyworking, that differing expectations can be detrimental to the relationship and thus it may be useful to discuss them explicitly.

4.3.7 Power & Control

4.3.8 Increasing Self-Empowerment and Independence. Mallison (1989) argued it is important to use keyworking to provide choice and to empower clients. The findings of this study lend support to his assertion. The importance of appropriate information needing to be made available to participants, was evident from the findings of this study. The notion of ‘informed choice’, in relation to the access to and the provision of information, has been investigated through work that has focused on ‘user’ experiences of mental health services. Issues associated with power and powerlessness have also emerged from this study and are considered central to both the provision and the use of services (Brandon, 1991).
Discussion

Bland (1997) criticised the keyworker concept for appearing to contribute more to the power of keyworkers than to the well being of clients. Overall, this does not seem to be the case from the narratives in the present study, however they suggest that keyworkers need to be mindful of the power inherent in their role.

In line with research on the therapeutic alliance, participants' narratives pointed to agreement on the tasks of keyworking as being an important element of the relationship. In formal therapeutic relationships, a sense of collaboration and agreement with the tasks of therapy are closely associated with a positive outcome (Horvarth & Greenberg, 1989). Although there are no clearly defined goals of keyworking, it seems likely that agreement on tasks as well as on features such as empathic understanding may lead to more useful outcomes for the participants.

4.3.9 Assumption Personal Responsibility. Several participants acknowledged the importance of their own contribution within the working relationship. Participants highlighted the importance of personal choice to influence events and take action. Those who did have choice, acknowledged that it gave them a sense of control and confidence. In contrast, one participant perceived her keyworker as holding all responsibility within the relationship, and appeared to attach a sense of mystique to the keyworker’s methods.

4.3.10 Process Issues

4.3.11 Disclosure. In the research presented here, disclosure was said by participants to be a necessary feature of the relationship with the keyworker, but more likely to occur under optimal therapeutic conditions (i.e. where trust had developed between participant and keyworker).

Confiding in friends or family, by either the female or male participants was rare and occurred with reservations. Brown & Harris (1978) mention the presence of a close, confiding relationship as a protective factor against depression. Several participants stated that people who had experienced problems themselves were more likely to be understanding. They did however, include their keyworkers, as they perceived them to have experience of working with people with mental health problems.
"But I did realise that I was much better off talking about it. I mean there are other strange ideas that I’ve had (.) that have actually, the ideas have been torturing me. I know I should say, not because I think I’m going to do anything, but to get it out really, and also it does put the people who are caring for me in a position to be able to care for you better if they know what they are dealing with". ([P1]: ‘Margaret’: 380-385)

It is possible that participants see disclosure to others as a risky business, in that the costs may outweigh the benefits. This may be linked with the fears expressed by participants, about how others might view them in relation to their mental illness. Disclosure was seen as problematic at times because of fears of exacerbating problems. There may have been a need for participants to regulate self-disclosure at different stages within the development of the helping relationship. This may reflect fears about potential consequences such as judgement and may represent the dilemmas faced by participants when wanting to be open but needing also to protect themselves against possible censure. Barham & Hayward (1991) suggested that individuals are involved in both the management of tensions and the management of information to avoid stigma.

The emphasis that participants placed on how other people might respond negatively and unhelpfully to disclosure raises the question of the degree to which such expectations are accurate. In a review of the literature on interpersonal aspects of disclosure, Kelly and McKillop (1996) suggest that, in general, people do have a low tolerance for other people’s disclosures of emotional distress. Indeed this may have limited the range of self-disclosure for some participants in the beginning phases of engagement. Seeking help may result in a diagnosis, which in turn is a double-edged sword. The possibility of cure or alleviation appears possible and yet at the cost of disclosure and potential labelling and stigma. This discrimination is likely to put some people off seeking help at all, not only because some fear admitting to themselves that they may have a ‘mental illness’, given the loss of status that they predict will follow, but also because they may have previously encountered aspects of the mental health services that reflect discrimination in the wider society rather than providing a haven from it. By keyworkers recognising and addressing these issues it may be possible to improve the experience of disclosure itself.
In summary, there would appear to be two central issues regarding disclosure: i) disclosure was thus seen as helpful – enabling some participants to disclose what they wish about themselves in their own time, and hindering in ii) that it exposed the participants to potential risks or consequences in help-seeking as this required an acknowledgement that self is different from others, or "aberrant" within the normative dictates of a wider society.

4.3.12 Experiencing Therapeutic Tools. The most common type of strategy mentioned in the interviews was a form of client-centred educational process, either practical problem solving skills or using cognitive behavioural techniques. Alongside the use of these strategies, the keyworkers also included offering forms of counselling to impart information, or encourage insight. What emerged from the interviews was not only the importance of being able and willing to offer a wide range of skills in a truly individualized manner, but the ability to do this in a way that participants found acceptable.

The interventions experienced by participants were varied, but they shared two key qualities: first that they could only be used non-coercively, and secondly that they occurred within the context of a trusting relationship. These approaches encouraged participants to develop a different understanding of their difficulties. The styles of intervention are described as predominantly 'facilitative', but with elements of 'advocacy', and some degree of 'proactive' work. The degree of 'proactivity', perhaps to the point of unwanted intrusion into service users lives, is an important ethical issue (Dennis and Monahan, 1996) This, however, was not perceived in a wholly negative way by the participants in the present study.

4.3.13 Conceiving Ending. In the present study, several of the participants were concerned about the potential of the keyworker relationship ending. Each of the participants described concerns, which may have been of import to the collaborative work within the relationship and therapeutic outcome. For several participants there was recognition that it was not their choice and it was not in their control. The exception was 'Ruth' who appeared to be in a dilemma as to having a choice to end contact.
The importance of preparation for endings has long been recognised in psychotherapy literature (Weiner, 1975). Although there are differences between more formal psychotherapy and keyworking, important similarities also exist. Both situations involve emotional support and the development of a close relationship between client and helper. In situations of this kind, preparation can ease the pain of ending.

Weiner (1975) points out that if the therapist ends the relationship suddenly, with limited time for discussion, the client may wonder about the motives behind the therapist’s behaviour. This was of immediate concern to ‘Tom’, who had just been told by his keyworker of her imminent departure, leaving him ambivalent about and possibly wary of any further keyworker relationship. Mattison & Pistrang (2001) further emphasize that clients may feel that they themselves are responsible, for example, and that they have done something ‘bad’ to cause the therapist to leave. As Zinkin (1994) suggests, ‘there is a difference between bringing something to an end and just stopping (p.18).’

The ending process may impose particular strains because in some way it involves a departure from what is ordinary. By definition it is about change, and very often it is brought about by change. It is surely important, that participants’ unacknowledged anxieties about ending and feelings regarding imminent ending are accorded the therapeutic space due. Ending is clearly something, which needs more research and may be useful to address in any kind of training in keyworking.

4.3.14 Perception of Evolving Outcome

Several participants described how they experienced illness as intruding on many aspects of their lives, including their ability to form and maintain social relationships. As such, the social framework within which participants encounter their keyworkers appears to be one where the balance of power firmly resides with the latter, both objectively and in terms of participants’ subjective experiences. From participants’ perspectives, the effectiveness of services and interventions appear to be judged, not just in terms of how they reduce symptomatology, but also:
Discussion

(1) whether and how individuals recognise that they have mental health needs which make them potential ‘users’ of mental health services and the barriers they encounter in seeking help;

(2) whether the process of assessment and service delivery is based on a relationship of understanding, respect and dignity rather than one which is experienced as devaluing, stigmatizing or even oppressive and;

(3) whether the keyworkers and interventions address the effects of mental illness on different aspects of their life, functioning and sense of identity.

As suggested above, participants’ evaluation of the treatment and care they received depended not only on the reduction of symptoms but also on the nature and quality of the relationship that developed between them and their respective keyworkers. It can be argued that from the perspective of the participants, the nature of the process is itself an outcome. Participants’ perceptions of outcome related to how these needs were met from the initial stabilisation of symptoms through to facilitating the process of re-integration into everyday life. It appeared that participants were seeking a response from keyworkers, which sought to understand the origin of the illness within the context of an individual relationship. It is perhaps not surprising that some participants placed a high value on the quality of the relationship with the keyworker. As has been suggested by Barnes & Wistow (1994), treating people with respect whose views are worth hearing is of therapeutic value to those

‘who have been devalued as a result of their mental distress and whose self-esteem has been severely damaged’ (p.537).

The limitations of keyworkers are illustrated in two participants’ narratives as:

“So even in the professional way you can’t (.) they can’t do anything for you...And I didn’t really want to share my problems because I thought where’s the point in talking to somebody about something if they can’t alter it.”

([P6]: ‘Ruth’: 72, 74-76)

“It would be nice for somebody to turn round and say, “Well look, you’ve got this physical illness. This is what it is. This is how it’s going to progress. Or this is how we’re going to treat
it. "You know what I mean. Rather than schizophrenia where there ain't really a lot anybody can do about, besides a few tablets, you know, that don't really have much effect." ([P3]: ‘Tom’: 415-419)

From the above narratives it is evident that some participants had ambivalent feelings regarding the outcome of their relationship with the keyworker, which appeared to extend to a systemic view of mental health services.

Summary

In summary, several components were perceived to characterise a helpful keyworking relationship. Facilitating choice was seen as helpful. With regard to helpful qualities in keyworkers, participants identified empathic understanding, trust, positive regard and instillation of hope as being central. Developing understanding was highlighted as being particularly helpful to the working alliance.

Furthermore, the findings of the present study support the work, which has been conducted on the importance of the therapeutic alliance outside of formal therapy relationships (Goering and Stylianos, 1988). When Goering and Stylianos asked clients what they perceived to be helpful aspects of their relationship with their case manager the clients identified the importance of having someone who cared about, accepted and understood them. The participants in this study also identified these variables as being important aspects of their relationships with their keyworkers.

4.4 Methodological Limitations

A number of limitations were evident in the study. These derived mainly from the restrictions imposed by the methodology and its impact on the brief period of time available for research. The issues of sampling, validity, reliability, saturation, reflexivity and generalisability contribute to the discussion of methodological limitations and will be dealt with in turn.
4.4.1 Selection of participants

The research procedure had specific limitations, which related to the process through which participants were sampled. One limitation was that the recruitment procedure, in which keyworkers invited their clients to participate, might have introduced a selection bias. It is conceivable that keyworkers might have recruited their “best” clients or perhaps that those clients who were not positive about their keyworkers declined participation.

It may be presumed that keyworkers took into consideration factors such as the client’s interest in the project and whether he or she would find it unduly stressful. Thus, the keyworkers’ decisions may have resulted in the recruitment of a group of clients characterised by relatively ‘good’ working alliances compared with other clients on the keyworkers’ caseloads. Those clients who refused to participate may have had a less positive view of keyworking.

In addition, all participants were involved in long term relationships with their keyworkers, and so trust was likely to be well established. If the keyworkers indeed tended to nominate their ‘best’ clients, this tendency did not result in a consistently positive portrayal of the clients’ experience of the keyworker relationship. This result can be interpreted to mean that even the ‘best’ working relationships include the occasional undercurrent of negativity.

The sample was essentially governed by the factor of convenience, as it consisted of those who responded to an invitation to participate. It has been asserted by Silverman (2000), that it is important when selecting cases, to explore negative instances, which are not likely to support the developing account. Therefore it would have been helpful to extend the theoretical sampling to additional participants with a more ambivalent attitude towards keyworkers and mental health services. Due to pragmatic considerations and the time available, this strategy was not followed. It would be important for future research however to seek out such participants, with the purpose of developing and refining the account.
As in all self-report methods the interviews are subject to social desirability. It seems probable, in the view of the participants, that the researcher was aligned with mental health work or at least in a position of authority. As such, it is recognised that participants may have been at times, reluctant to disclose certain aspects of their experience. Although participants were reassured that what they said would be confidential, they may have been concerned that their keyworkers would find out what they had said. This may have led some participants to be cautious about being too negative about their keyworkers; one participant questioned whether the researcher would be interviewing keyworkers as well.

Given the results suggesting that variables such as empathic understanding, instillation of hope and positive regard were important elements in the keyworking relationship, it would be useful to develop ways to assess these more concretely and quantitatively. The broad nature of the questions asked in the semi-structured interviews and the variability in the length of time participants and keyworkers had been working together, means that the results give a somewhat global picture of keyworking.

4.4.2 Validity

In 1995, Marshall and Rossman argued that the strength of a qualitative study lies in its ability to demonstrate validity. In general terms, this refers to the process of determining whether such a study is true, correct and in conformity with reality. It is postulated that a qualitative study will confirm its validity in a variety of ways. Firstly it provides an in-depth description of the complexity of variables and interactions embedded in data, which has been derived from the particular research setting. Hence, the aim of validity is to ensure that the emergent analytic account is one, which has been derived systematically and can be justified by the data.

Secondly, in grounded theory, it includes the notion of consensual validation; an informal procedure was used through the qualitative research support group involving other post-graduate clinical researchers. This determines that the more people who concur in a proposition the more likely it is to be valid. It embodies the principle that “systematic
support of a particular position grants it a greater acceptability to others" (Reber, 1985, p. 808).

Internal coherence refers to whether the arguments presented in the study are internally consistent and justified by the data. Linked to this, presentation of the evidence refers to verbatim evidence from the transcripts of participants' narratives being shown in the research paper. This presentation of the evidence is intended to allow the reader to examine the interpretations and conclusions of the researcher. In the present study an attempt was made to illustrate how the themes and categories were derived. Moreover, in presenting the results, a significant number and variety of quotes were used to allow the reader to consider the researcher's interpretations.

Future studies could perhaps use some audiotaped samples of actual communication between clients and keyworkers in order to establish a more in depth picture of what happens in the contact between keyworkers and clients. For example, certain types of questions may be experienced as more or less helpful.

Stiles (1993) addresses a further form of validity which is of relevance to the present study – catalytic validity. Catalytic validity refers to the degree to which the research process reorients, focuses and energises participants. A striking aspect of the interviews with participants was that they expressed interest and enthusiasm for the study and welcomed the opportunity to discuss their experiences of the keyworking relationship.

As previously mentioned, respondent validity is a check on the interpretation achieved by asking the participants whether the analysis is an accurate portrayal of their experiences. As Henwood and Pidgeon (1995) have highlighted, this is a complex issue and thus was not employed in this study. However, it may have provided the researcher with a fuller understanding of the emerging theory by including the participants' views into the conceptual development of it. It is important to emphasise here, that this was not an attempt to discover an absolute truth about their experiences.
4.4.3 Reliability

Given the characteristics of qualitative research, conventional notions of reliability are frequently deemed inappropriate by qualitative researchers. The issue of reliability is important in qualitative work because the objectivity of a piece of research is said to be at stake. In broad terms, qualitative research aims to produce rich descriptions of a social world which occurs under controlled conditions and which corresponds to the social world being described. Thus, its objective is to represent rather than reproduce reality (Hammersley & Atkinson, 1995).

In 1986, Kirk and Miller asserted that reliability in qualitative work is delineated by the “degree to which the finding is independent of accidental circumstances of the research” (p. 203, quoted by Perakyla, 1997). In effect, this refers to the issue of data collection: its range, quality and detail via recording, observation and transcription. The limitations to reliability in the current study may lie not only in the limited range of research questions, but also in whether a sufficiently large enough collection of cases was made for the purpose of theory building.

4.4.4 Saturation

As previously described in section 2.3.3, the notion of saturation is the position when no additional data may be discovered for developing the categories. The level of saturation that was accomplished within this study varied between categories. As can be seen, this study’s conclusions are based on the analysis of six interviews. It has been suggested by Turpin et al. (1997) that this is an adequate number of participants for this type of study, however it is clear from the analysis that saturation of some of the sub-categories was not complete and based on only a few participants’ descriptions. Due to the time constraints placed upon the study, it cannot be claimed that this research reached saturation point.

The lack of theoretical sampling does have implications in terms of the emerging theory. As theoretical sampling helps to fill out categories and to discover diversity within and between them (Charmaz, 1995), the emerging theory may not be as rich, dense or conceptually grounded than if theoretical sampling had been implemented.
An alternative stance to the investigation of this area would have been to restrict the focus of the study to particular elements of the relationship, for example the concept of what constitutes trust in the early stages of engagement. This may have led to an increased level of saturation of the data. It is likely however that such an approach would not have allowed for an exploration of the breadth of the concept. It can be argued that this may be more indicated for a future investigation.

4.4.5 Reflexivity and the Role of the Researcher

According to Alvesson and Skoldberg (2000),

'reflective research has two basic characteristics: careful interpretation and reflection.' (p.76)

such that attention is turned inwards towards the personhood of the researcher, the research participants, the research context and society as a whole. Definitions of reflexivity appear to be neither unanimous nor harmonious, which arguably mirror the concept of reflexivity itself. Alvesson and Skoldberg (2000) suggest further that:

'There is no one way street between the researcher and the object of study; rather, the two affect each other mutually and continually in the course of the research process.' (p.94)

As the researcher within this study, I was in a unique position in accessing participants' accounts of their relationship with their keyworkers. This was a privilege, intriguing, but also anxiety provoking at times. As the study developed, I was aware of feeling uncertain with this particular research process, which may be partially explained by my previously limited exposure to the use of qualitative methodology in research practice. Kleinman & Copp (1993) suggest that in entering a setting as a student and learner, qualitative researchers must relinquish control. It is only in this fashion that they can truly enter the world of another.

It is likely that this process influenced my interviewing technique as the study progressed. Initially, I was aware of sometimes asking what could be considered leading questions, which on occasions led participants away from what they were describing. Therefore in
later interviews, I adopted a more flexible open style, asking a greater number of open questions, which gave the participants more opportunity and space to channel the interview as he or she perceived to be fit. Bogdan & Bilken (1992) describe how the qualitative researcher enters the participants’ world,

"...not as a person who knows everything, but as a person who has come to learn: not as a person who wants to be like them, but as a person who wants to know what it is like to be them." (p.79)

At times in the early interviews, I experienced a sense of losing direction, of not knowing where the participant’s world was leading. The temptation to regain control was ever present, and on reflection can be understood as a need to give more focus to the research. This potential to influence and shape the individual stories of those involved as well as participating in the reconstruction of new stories was acknowledged, and I attempted to place an emphasis on collaboration, working with participants rather than experimenting on them.

The interviews promoted the development of an alliance between the researcher and the participants. The use of therapeutic skills such as acceptance, empathy, genuineness and warmth helped in developing a rapport between the researcher and the participants. Often this process was more to do with my nonverbal behaviour and tone of voice than with what was actually said. This was particularly important during the informal and unrecorded introduction prior to the interviews taking place. However, it was difficult to balance the dual roles of on the one hand, being a research interviewer and on the other, being a therapist and utilising therapeutic skills. Of particular concern to the researcher, was the interview with the participant ‘Linda’, it was evident that the interview had restimulated painful memories and feelings. Lee (1993) suggests that, when faced with a distressed participant, an interviewer should be able to ‘undertake the difficult task of enduring and sharing the pain of the respondent’ (p.106). Hence, the researcher’s deployment of counselling skills were fruitfully employed with this participant. Once the interviews were complete it was important to allow participants to talk about the interviews, their experiences of answering the questions and any other issues relating to the research interview. The de-briefing time was therefore valuable and important. The
use of research supervision and of the qualitative research support group were both useful forums where I was able to address these issues.

Pulling the strands of the story together, at times, was a confusing experience blinkered by anxiety. During the development of the categories, it was difficult to conceptualise all the differences present in the data, and to understand how to present a theory, which would encompass each individual’s perspective. It became apparent however, how difficult it would be for one theory to reflect the diversity of different peoples’ perspectives and experiences.

This confusion began to clear when I began to build a visual representation of the account, as I constructed flashcards with category labels on and arranged these relationally. The composition of this picture led to awareness that a dynamic process of events was occurring as opposed to a set of discrete events. The use of working memos helped to integrate this story. Therefore, this research does not aim to make generalisations about participants’ experiences necessarily; but recognises the importance of the difference between individuals.

I became increasingly aware of the importance of remaining focused in my ability to listen to participants. This included time for reflecting, as well as accurate interpretation of material according to the methods of grounded theory. This has enabled further critical examination and developing awareness of my listening skills within my own clinical practice.

Reflexivity was considered to be a central component of the trustworthiness of the current study, involving the continual evaluation of both my subjective responses and the method of research. I felt this process allowed me to identify and articulate personal frames of reference, thus demonstrating my awareness of influences and personal values as well as ensuring that the methods identified were appropriate and effective (see 2.3.8, 2.10, and 2.10.1 for further procedures used to address reflexivity).

My past experiences as a keyworker in mental health led to curiosity about what would engage people, as well as a growing awareness of ‘service users’ exclusion from having
an active voice in research despite their contact with statutory mental health services. Giving a voice to a somewhat marginalised group was a fundamental aim of this research study.

4.4.6 Generalisability

It has been argued by Marshall and Rossman (1995) that positivist notions of reliability assume that an unchanging universe exists in which inquiry could logically be replicated. Thus, the generalisation of findings provides evidence of external validity in research. This contrasts with the interpretive assumption that the world is constantly being constructed, and suggests that research must demonstrate dependability and account for changing conditions in the phenomenon selected for study.

However, within qualitative research it is more of a question of determining the transferability of findings within a research study. Thus, qualitative research must also demonstrate confirmability, which broadly equates with objectivity. This asks whether the findings of one study could be confirmed by another, an evaluation which is based on the data itself.

It is suggested that strategies need to be built into qualitative research to balance potential bias in interpretation. Factors, which may have interfered with validity, encompass the relationship between researcher and participant, the participant’s history, differences between those studied and those not studied and possible contamination of the researcher by the area under study. In the research presented here, such potential bias was accommodated by the following strategies.

- The method of constant comparison which entailed checking and re-checking data and examining alternative hypotheses for emerging phenomena.

- The use of memos to inform the progress of ideas within the research. These included coding, theoretical and operational memos.
Discussion

- The use of theoretical sampling did not occur because of the time constraints of the study. However, as can be seen from the data analysis, the requirement of generality within the sample was broadly met. That is, participants presented a range of experiences in terms of their keyworker relationship.

Qualitative research is not intended to be replicable. In contrast, it concentrates on recording the complexity of inter-relations and situational contexts as they occur. Thus, the study is unique in that it cannot be repeated. It could however be extended by further research.

Summary

Although the above limitations must be kept in mind when interpreting the research findings, it is also worth noting the benefits of the qualitative interview approach. The use of this methodology yielded a rich picture of how the participants think and feel about their relationship with their respective keyworkers. Whilst each participant's experience might be unique, the themes that emerged from the analysis of the interviews may be used to generate ideas about the client-keyworker relationship.

4.4.7 Key Criticisms of Grounded Theory

The central criticisms of grounded theory appear to relate to the division between grounded theory as a method and grounded theory as an epistemology. Charmaz (1995) has suggested that grounded theory methods establish a bridge between interpretative analyses and traditional positivist assumptions. This is because they are used for the purpose of discovering participants' meanings within a quasi-empirical enterprise by following a set of procedures. In this way, Charmaz suggests that grounded theory methods can be used by researchers who subscribe to what she terms "objectivist assumptions" as well as those whose interest lies in constructivist perspectives. Thus a major criticism lies in its adherence to ways of thinking which ally it to empirical methods of investigation.
It is of note, that to date, grounded theory methods have not focused on individual narratives. In contrast, they have been concerned with fracturing data sets in order to define their total analytic properties. This is because the aim of grounded theory is to discover and define processes of action and interaction by identifying patterns. Thus, participants’ stories are used to illustrate points as opposed to providing complete portrayals of their lives.

The role of the researcher in grounded theory research in Glaser & Strauss’ (1967) version of grounded theory was explained as ‘the researcher does not approach reality as a tabula rasa’ (p.3). It omitted however addressing the role of the researcher’s theoretical background, relationship with the participants or the interactional construction of the data (Charmaz, 1995). Charmaz (1990) advocates a constructionist revision of grounded theory; this is further supported by Henwood & Pidgeon (1995).

Pidgeon (1996) argues that it is apparent that some aspects of grounded theory rest squarely upon a positivist, empirical epistemology. Pidgeon suggests that this is most obviously seen when Glaser & Strauss (1967) talk of the way in which theory is discovered from the data. As such, the implication is that a set of social or psychological relationships exist objectively in the world, are reflected in qualitative data, and can be captured. This model implies an over-determined view of human experience and subjectivity which stands in contradiction to the premises of symbolic interactionism, the assumption being that researchers can directly access their participants’ lived experience (Pidgeon, 1996).

Layder (1982) has levelled additional criticisms of the grounded theory approach. The uniqueness of the style of the researcher as well as the interactional contexts in a given time period makes it difficult for studies to be replicated. Rennie, Phillips and Quartaro (1988) observe that grounded analyses are typically conducted on a small number of participants, which may pose difficulties in terms of the generalizability of the theory. They suggest however, that it is the intimacy of the phenomenon that grounded theorists seek in terms of detailed theory.
This study used a social constructionist framework and thus a constructionist revision of grounded theory was adopted. As a consequence the researcher exercised a degree of flexibility when implementing grounded theory techniques. Charmaz's (1995) techniques were used; however, these methods were not adhered to in a prescriptive manner. Other less standardised methods were used to enhance the development of the emerging theory as outlined in Pidgeon (1996).

In the research presented here, emphasis has been placed on describing ‘service users’ experiences in the area of helpful and hindering factors within keyworking relationships. In order to enhance theoretical sensitivity constant comparisons were made between different stages of the help seeking process and the experiences of ‘service users.’ This enabled the researcher to move between participants’ accounts and develop patterns between the different concepts. Variation in the data was achieved through the exposition of a deviant case example.

However, further substantive comparisons might have been made between the experiences of other ‘service users’ less engaged with mental health services, i.e. those subject to the Mental Health Act (1995). This represents what Henwood and Pidgeon (1995) have termed “focused conceptual development” which refers to the full exploration of the properties of a defined set of categories. Their selection is determined by their particular relevance to the problem under investigation and are stated to generate “depth of vision” rather than “breadth of coverage”.

If the focus had been on generating formal theory, then a comparative analysis would have to be made between different types of substantive cases and theories without relating the resulting theory to any one specific substantive area (Glaser, 1968). In this, cycles of interpretation are aimed at increasing theoretical scope in the face of limited initial data or the need for further interpretation of key categories. In this sense, this research does not represent a formal or total theory, but has provided an initial study of key conceptual and contextual elements of helpful and hindering factors in relation to the area of keyworking relationships.
4.5 Implications for Clinical Practice

- Given the above limitations, caution should be exercised in attempting to generalise the findings of the study. However, it is hoped that this study contributes to the potential value of qualitative research in a field, which has tended to be dominated by studies which focus on statistical trends.

- This study enabled an examination of ‘clients’ perceptions and experiences of keyworking relationships. The qualitative design assisted in providing an open forum for participants to recount their experiences and perceptions. Individual variability was present throughout the narratives and indicates that caution should be taken about what variables are essential to a ‘good’ keyworking relationship. Despite this variability, key themes emerged which may be useful to clinical psychology as well as to a range of mental health professionals working with this client group.

- The process of initial assessment and the early stages of engagement for some participants were fraught with uncertainty and anxiety about the role of the keyworker and mental health services involvement. This highlights the importance of continuous and appropriately targeted information (which, like help seeking itself, does not end with service contact).

These findings suggest that more information earlier may preempt the trial and error that some ‘services users’ experience. It may also reduce the potential for developing problems i.e. such as the perception of services as carrying a stigma, which might inhibit engagement during more active stages of help seeking.

- The context of the keyworker relationship appeared to hold more substance for participants than the content of encounters. Those aspects of the keyworker relationship that emphasised empathic understanding, positive regard, instillation of hope and trust, all contributed to the participants feeling understood. These appeared to be valued above all.
Thus, therapeutic style seems to be an important factor when considering how to work with clients. This is analogous to general psychotherapy literature in which joint collaboration has been identified as an integral component of exchanges in therapy (Styles and Shapiro, 1995). Overall, it appears that person-centred approaches in the tradition of Rogers (1951) would appear to inform the general style of engagement.

Safran, Crocker, McMain and Murray (1990) have suggested that the quality of the therapeutic alliance is the best predictor of outcome. As suggested by Pilgrim & Treacher (1992), clinical psychology training places an emphasis on teaching a range of technical procedures at the cost of under valuing the personhood of the trainee. It may be that there is a need for clinical psychology training programmes to place more emphasis on the development of the clinical trainee as a person in parity with the acquisition of therapeutic techniques. It can be argued that increased emphasis needs to be focused on clinical psychologists and other mental health professionals being aware of their contribution to the therapeutic alliance. This self-reflexivity can be developed during training within clinical supervision, with an emphasis on it being a continued process throughout clinical practice.

A system of training evolved from evidence-based treatments should not only focus on the acquisition of skills that are linked with an evidence based therapy. It could also assist trainees in developing the skills required to facilitate the optimum therapist-client alliance for a given treatment, whilst enabling understanding of the model of therapeutic change underlying therapy (Calhoun, Moras, Pilkonis and Reum, 1998).

- The therapeutic tools or techniques used by keyworkers were less remarked than relationship factors, but were acknowledged as being important aspects of the work carried out. The strategies appear to be delivered in a collaborative way, and the styles are described as predominantly ‘facilitative’.

- It is not known to what extent keyworkers assess, review and amend goals collaboratively with participants. Applying these principles, however should be an
integral part of the process between keyworker and participant. It is thought that this would help balance the perceived power base between ‘clients’ and keyworkers, thereby establishing a more equitable working relationship.

- A key aspect included perceived ambiguity regarding the role of the keyworker, which was highlighted in the initial phases of engagement. This appeared to have been the cause of significant anxiety and confusion for several participants. It appeared that the reasons for referral to mental health services and keyworkers had not been discussed with participants by their referrers. This may also have contributed to several participants having felt uncertain and mistrustful of initial contact with keyworkers at what could be considered a critical stage.

- These anxieties may have been allayed by keyworkers discussing their purpose and role with participants. This would have served as a valuable opportunity for looking at any uncertainties, misgivings or expectations present for participants. It would be helpful if keyworkers could provide written information in advance of meeting clients. This might include some clarification of their role and that of mental health services. It might also be helpful for keyworkers and mental health teams to liaise more closely with referrers, to impart information about what services are available. This would enable the community mental health teams to explain that they acknowledge the different needs of different ‘service users’, and are able to provide help on an individual basis.

- The present study may have implications for research related to outcome in keyworking and the training of keyworkers. The present findings advance conceptualization of the alliance as it relates to the perspective of the involved participants. Thus, participants cannot be viewed as a homogenous group with regard to perceptions of the keyworker relationship.
4.6 Theoretical Implications

- The aim of the current study was to explore ‘clients’ perceptions of helpful and hindering processes within the context of a keyworker relationship. It has been described how the interplay between non-specific relationship factors and the emerging collaborative bond was important to developing understanding within the working alliance.

- The account of the process offered here demonstrates that the discrete fracturing of elements of a process (i.e. through the use of separate and distinct explanatory models), has limited meaning in the overall context of the relationship as perceived. Rather, the relationship is revealed as a continuous, dynamic process.

- The model, which emerged from participants’ narratives, remains hypothetical at this stage. It is acknowledged that its production may raise questions about validity of content because of its separation from “live” experiences (Davies, 1992). However, the model does provide a “depth of vision” over time of the different facets deemed to be important in the keyworker relationship.

4.7 Organisational Implications

These implications are drawn principally from what participants in this study have shared with the researcher, as well as from theoretical literature. The study also draws attention to some of the skills that are being used by some clinical psychologists and other mental health professionals, in community care settings. These recommendations are presented as follows.

- In term of broader service delivery, it seems particularly important that keyworkers have the time and space to reflect on what they bring to the keyworker relationship, and consider the impact this has on the ‘clients’ they work with. Moreover, given the perceived uncertainties surrounding the role, it seems important that keyworkers also have a forum to discuss any issues and to express their own feelings and concerns.
• Participants' accounts highlighted other important factors. It was evident that keyworking can be often demanding, given the pressure of referrals in adult mental health and keyworkers clinical caseloads. Keyworkers may welcome some affirmation of the work. It seems that facilitating this dialogue is an area where it may be useful for clinical psychologists to become involved in a consultative role or in staff training.

• Furthermore, the consideration of the keyworkers' differential influence on keyworking appears an essential component of a further research strategy, which could be used to inform clinical practice. In a recent edition of Clinical Psychology Forum, it was argued by May (2001) that whilst clinical psychologists might have the expertise of techniques and working towards solutions, the 'client' also has an expertise. This includes not only their non-clinical experiences of life and their current difficulties, but also the experience of receiving mental health services. Thus, explicitly learning from 'clients' is something of a challenge to the positivist interpretation of the scientist-practitioner model still embodied in clinical psychology training courses.

• The marginalisation of people with mental illness within community care and day care (Sayce, Craig, and Boardman, 1991), and the frequent low morale and high turnover of staff working with this client group, might be remedied if more direct care professionals were given the opportunities, support and time to apply the same approaches and strategies as these keyworkers. Indeed, it is essential that psychologists and other mental health professionals become more adept at relating with 'service users', and at maintaining relationships in accordance with individual need, in order to both engage effectively and to work together in a collaborative way.

4.8 Conclusions

In conclusion, while acknowledging the limitations of this study, some of the findings would appear to add to the existing literature. The findings of this study help to demonstrate:
Discussion

i) the potential contribution of qualitative approaches to the literature on keyworking;

ii) how the keyworker concept has been understood by participants;

iii) characteristics which appear to be important in the formation and development of keyworking relationships.

This research has identified the need to develop a broader understanding of what factors are considered to be helpful to ‘service users’ within the keyworking relationship. A central question emergent from this research includes what does being understood mean in practical terms, i.e. how can this be put into practice in clinical contact?

Further development of this research may include interviewing keyworkers, in order to establish their perceptions of the keyworking and clinical role. Given the importance attached by participants to feeling understood not only by keyworkers, but also by others who have themselves experienced mental health problems, further consideration might be given to the possibility of ‘users’ perceiving themselves as prospective ‘keyworkers.’

The importance that participants place on the ‘user-professional’ relationship indicates that further research into the nature of the “alliance” between participants and keyworkers is relevant. The importance of the ‘user-professional’ relationship has often been cited, yet little is known empirically about this relationship with regard to positive outcome. The education and training of keyworkers would also improve with a clearer explication of the actual functions performed in the role.

- Furthermore, the findings of this study indicate the opportunity for clinical psychology to take more of a lead in staff training and consultancy within multidisciplinary adult mental health teams.

- Clinical Psychology Training courses can also place more focus upon training in establishing and developing therapeutic alliances of high quality. This extends to the profession of clinical psychology needing to promote an increased self-reflexive approach to clinical practice.
Discussion

- Mental health workers will need to embrace uncertainty and be prepared to make changes that contribute to more inclusive ways of talking and practising in mental health. The process and outcome of this study suggest that a process of partnership is important and highlights the important role that keyworkers can have in the delivery of mental health care that ‘users’ want. Clinical Psychologists are well placed, with their emphasis on understanding experience and on collaborative approaches to embrace these changes.

- Rogers, Pilgrim and Lacey (1993) state that there is now clear acceptance within health policy circles that more credence and authority should be given to the patient’s perspective. They feel that attention to ‘psychiatric patients’ views and levels of satisfaction with services has lagged behind that given to other client groups using health service facilities. Incorporating ‘users’ perspectives encourages the consideration of the entire course and experience of mental illness, and not merely the period of contact between the person who is ill and the professional or service. Secondly, it encourages a conceptualization of outcomes which are both more holistic and whose specific features change with the course of the illness. Moreover, it challenges an over-simplistic concept of consumerism based primarily on enhancing the flow of information to individuals in order that they are enabled to make more rational and informed choices. It poses, in addition, the concept of ‘users’ as ‘experts’ in their own illness, where the onus is on psychologists and other mental health professionals to seek out and understand ‘users’ experience of illness and coping strategies alongside the professionals own knowledge and expertise.

- May (2001) argued that a shift is required from a position of “safe certainty” supported by a ‘superior’ knowledge base, where clinicians guide ‘clients’ to better health, to embracing a position of “safe uncertainty.” Mason (1997) suggested that:

   “This position is not fixed. It is one that is always in a state of flow, and consistent with the notion of a respectful, collaborative, evolving narrative, one which allows a context to emerge whereby new explanations can be placed alongside rather than instead of, in competition with the explanations that clients and therapists bring.”

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• It may be helpful for further studies to begin to assess alliance between clients and keyworkers shortly after initiating the service and at subsequent intervals thereafter. A poor alliance may well be related to why some clients disengage from mental health services. Future studies should seek to link alliance more closely with the anticipated benefits of having a 'service user' as a keyworker, such as identification, empathy, more personal attention.
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APPENDIX 1: Letter of ethical approval
Mr J Easton  
Trainee Clinical Psychologist  
University of Leicester  
Department of Psychology – Clinical Section  
New Building  
University Road  
Leicester LE1 7RH

Dear Mr Easton

“Clients perceptions of keyworking relationships” – our ref. no. 6039

I have received your letter dated 7 October 2000 responding to the points raised by the Ethics Committee concerning the above study.

On behalf of the Leicestershire Research Ethics Committee, and by Chairman’s action, final approval is given for you to undertake the above-mentioned study.

Yours sincerely

M Sursham

Rev P Harbord  
Chairman  
Leicestershire Research Ethics Committee  
(Signed under delegated authority)

(NB All communications relating to Leicestershire Ethics Committee must be sent to Leicestershire Health)
[Date]

Dear [GP/Consultant]

Re: [PARTICIPANT’S NAME, D.O.B. & ADDRESS]

I am currently undertaking a research project as part of the Doctorate in Clinical Psychology course at Leicester University. I am interested in how individuals understand and experience their relationship with their keyworker. In particular I am keen to find out what meaning individuals assign to the role of the keyworker, the aims and functions of keyworking, and the characteristics of what interventions hinder or help. This information would be useful to health care professionals, in relation to furthering understanding about what is helpful within a working relationship.

To obtain this information I intend to carry out semi-structured interviews with individuals who are currently linked in with keyworkers. Individuals who consent to participate in this study will be interviewed on one occasion for approximately one hour. These interviews will be audiotaped.

The above named person is currently being seen by [Keyworker], Profession. I would like them to participate in the research. However, before I approach them, I would like to know if you have any objections to their participation in the research. Please would you contact me within the next two weeks if you object to their participation, or if you have any queries about the research.

Yours sincerely,

James Easton
Trainee Clinical Psychologist
APPENDIX 3: Letter of invitation to the participant
[Date]

Dear [Participant],

My name is James Easton, and I am currently carrying out some research as part of my training to become a Clinical Psychologist. I am interested in finding out how people understand and experience the keyworker relationship. For some people their way of understanding their problems may have been influenced from seeing the keyworker, and we would therefore like to find out what changes have taken place. This information would be useful in terms of understanding what is helpful. Finding out how clients perceive help is important and will be useful for workers when working with others in the future.

To help me, some keyworkers have agreed to send letters like this one to people they have had contact with. This means I do not know your name or address, so it ensures your privacy.

This letter is to ask you if you would be willing to take part in this research. Please would you read the enclosed information sheet, which explains more about the research and what you would be asked to do if you agreed to participate. If you decide you are willing to take part in this research complete your name and contact details on the slip below. Once I have received confirmation of your agreement I will contact you to answer any questions, and arrange a convenient time to meet further.

I look forward to speaking to you.

Yours sincerely,

James Easton
Trainee Clinical Psychologist

I am interested in finding out more about the research. Please contact me.

Name (please print) .............................................. Address ..............................................

Name (please sign) .............................................. ..............................................

Date .............................................. Telephone ..............................................
Participants Information Sheet

I am approaching people who have problems, which have led them into seeing a community mental health keyworker. I am interested in your understanding and experience of this relationship. For some people their way of understanding their problems may have been influenced from seeing a keyworker, and I would also like to find out about what changes have taken place.

This information is useful because in order to work successfully with clients, it is important to have an understanding of what is helpful. Finding out how clients perceive help is important and will be useful for workers when working with others in the future.

Ethics committees at Leicester University and Leicestershire Health Authority have granted approval for this research.

What will it involve?
If you agree to this request I will visit you either at home or in another convenient place. The interview will last up to one hour. I would like to audiotape this conversation, as this will allow me to get as full a picture as possible and not miss anything you might say. I will also ask you for some background information and some personal details (such as age, etc).

Do I have to participate?
No. If you would rather not participate this will not interfere in any way in the help and treatment you receive now, or in the future.

Will anyone else be told about my responses?
Some information given will be included in the study but all personal identifying information will be disguised in order to maintain confidentiality.

How long will it take?
About 1 hour.

Will I be able to get feedback on the study if I wanted to?
Yes. A further appointment can be arranged to do this.

You will be contacted by telephone or letter in the next few days only if you decide to give your initial agreement for participating in this research, and also to answer any questions you might have.

If you wish to speak with me in relation to this study you can contact me by leaving a message on Tel (0116) 225-6250.

James Easton
Trainee Clinical Psychologist
APPENDIX 5: Consent Form
Consent Form

I have had the nature of the research explained to me. I understand that any information I give will be anonymised and will not be able to be traced to me as an individual. No names, addresses or other information, which identifies individuals, will be held on a computer or included in any report of the research.

I have had the need for audiotaping of the interview explained to me and I give my consent to the recording of the interview. I understand that if I give my consent to participate, I can change my mind and withdraw my consent at any point in the future. My decision to participate or not will not affect any current or future treatment.

I give my consent to be interviewed and for the interview to be audiotaped and transcribed.

Name (please print) ............................................................................

Name (please sign) .................................................................

Date ................................................................................................

If you have any further questions I can be contacted at the following address and messages may be left by calling the telephone number.

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APPENDIX 6
Appendices

Appendix 6: Socio-demographic information about the participants

The table below summarises socio-demographic information obtained about the participants interviewed in this research.

<table>
<thead>
<tr>
<th>Number (Interview order)</th>
<th>Pseudonym</th>
<th>Sex</th>
<th>Age</th>
<th>Background</th>
<th>Location of interview</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>'Margaret'</td>
<td>female</td>
<td>42</td>
<td>White British</td>
<td>Home</td>
</tr>
<tr>
<td>2</td>
<td>'Rachel'</td>
<td>female</td>
<td>45</td>
<td>White British</td>
<td>Home</td>
</tr>
<tr>
<td>3</td>
<td>'Tom'</td>
<td>male</td>
<td>35</td>
<td>White British</td>
<td>Home</td>
</tr>
<tr>
<td>4</td>
<td>'Linda'</td>
<td>female</td>
<td>50</td>
<td>White British</td>
<td>C.M.H.T. Base *</td>
</tr>
<tr>
<td>5</td>
<td>'Jean'</td>
<td>female</td>
<td>52</td>
<td>White British</td>
<td>Home</td>
</tr>
<tr>
<td>6</td>
<td>'Ruth'</td>
<td>female</td>
<td>58</td>
<td>White British</td>
<td>Home</td>
</tr>
</tbody>
</table>

* C.M.H.T. Base – Community Mental Health Team Base
APPENDIX 7

Example of Data Conceptualisation
APPENDIX 7

TRANSCRIPT 01 – EXAMPLE of DATA CONCEPTUALISATION

P1 When I’ve been frightened about me I’ve been frightened about my relationship and interactions with her. When my friend was dying I actually realised that what she said was looking pretty bad two months before she would actually die. I mean, I...I...I needed ‘Jane’ a lot at that time because I just couldn’t cope with it, without her. Somebody who is facing a terminal illness and who had nobody really strong about her and a young family. I mean ‘Jane’ has made me realise that there is something in me that wants to rush in and rescue people and I think I do that and pointing it that out to me has helped me not to do it at times when it wouldn’t be in my best interests to do it. Things like that have been very useful. I’ve had a couple of other relationships where I feel there’s a bit of dependency and I’m actually manipulated and perhaps exploited because I’ve got mug written all over me and I’ll do anything for anybody. And I’m very happy to but sometimes people take advantage and I don’t realise they’re taking advantage. And it’s not in my interests to drop everything and go and rush and help other people. And ‘Jane’ has been brilliant at helping me see things like that for myself. That I just would never have realised. You’re never objective enough to analyse your behaviour. But I could be helpless in a way with ‘Jane’ at a time when I just needed to be when my friend was dying. I mean I could just cry and say what I was frightened of in a way that I couldn’t be to anybody else. And kept me going. Made me realise. Yes this is something that can be beaten. I mean I felt, you know I could face the trauma of helping someone who has a terminal illness. It sounds pathetic but she did keep me going and I ended up in hospital. I have far
more care in the community that I did in hospital. I think hospitals can be damaging really.
Appendix 8: Interview Schedule
Appendix 8: Interview Schedule

**Introduction**
Introductions, background to research, confidentiality, format (including tape recording), consent form, any questions from participant.

**Background**
Age, (gender), occupation, living situation (family, who is in the house, who else is important day-to-day)

**Reasons for coming into contact with mental health services/keyworker**
- How did you come to have contact with mental health services?
- Background to these difficulties.
- How long is it now that you have known your keyworker?
- I am interested in hearing about how you experience your relationship with your keyworker? Tell me about your experience.
- Can you tell me what understanding you have of the role your keyworker has in relation to working with you?
- What do you understand to be the aims and functions your keyworker has in relation to working with you?
- Is this a relationship you rely on in times of difficulty or stress?
- How might you describe your relationship with your keyworker?
- Is there anything that this relationship provides that has been helpful/unhelpful?
- Explore this relationship further (e.g. reciprocity? dependency?).
- Future and ideal expectations regarding dependent relationships.
- How does the keyworking relationship you have described compare with the social relationships in other peoples’ lives?
- Can you describe what it is that has influenced (changed, made worse/better) the problem(s)?
- Perceived reasons for ‘success’/‘failure’ of intervention.

**Ending**
- Is there anything else you would like to add?
- Feedback on experience of being interviewed
- Review consent
- Provide debriefing (thanks, any questions, how to contact me, what happens next, would they like feedback of results).

**General Probes**
- Can you say a bit more about those feelings you have had?
- Could you say a bit more about that?
- Is there anything else you want to say about that?
- Do you have any ideas about......?
- What did you think of that..........?
- What does that mean for you......?

The above questions will provide a framework for the interviews, however the structure will not be prescriptive, and will be flexible in order to explore the issues raised by the participants.
ADDENDUM

Transcripts 01 – 06

For reasons of confidentiality this appendix is removed to a separately bound appendix and is available only to bona fide researchers.