Mental Health Clinicians' Perceptions of the diagnosis of Bipolar Disorder: A Q-study

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Preface

The first two sections of this thesis have been written and referenced using Harvard referencing as per the submission guidelines for the proposed publication journal. Meanwhile, the final paper was formatted using Vancouver style so that it is easily read by the target audience. The submission guidelines for Paper 1 and 2 can be found in the relative Appendix. The term ‘client’ and ‘service user’ are used interchangeably throughout the project to represent an individual accessing mental health services. Similarly, the term ‘psychiatric diagnosis’ and ‘mental health diagnosis’ are also used interchangeably throughout the project to illustrate a diagnosis made based on mental health difficulties.

Contents

Thesis Abstract

This thesis was written to fulfil the requirements of the University's Doctorate in Clinical Psychology. The thesis is made up of three sections: a review of the research literature focused on service users' experience of psychiatric diagnosis, an empirical paper exploring clinicians' perceptions of the diagnosis of Bipolar Disorder and an executive summary outlining the study designed for dissemination in clinical practice.

The literature review identified four important aspects of mental health diagnosis for service users: whether service users wanted to be told about their diagnosis, the communication of the diagnosis, positive aspects of being given a psychiatric diagnosis and disadvantages of receiving a psychiatric diagnosis. Accuracy, timing and communication of diagnostic feedback were all thought to be important for service users receiving a mental health diagnosis, whilst fostering hope was paramount in positive experiences. The review concluded that service users held a wide variety of different perceptions of psychiatric diagnosis and recommended that clinicians were offered specific training on feeding back a mental health diagnosis to service users.

The empirical paper used Q-methodology to explore the subjective viewpoints of mental health clinicians on the diagnosis of Bipolar Disorder. This study noted the mixed literature on the use of the diagnostic label in mental health services and aimed to explore whether clinical practice mirrored the previous research. A total of 19 mental health clinicians completed Q-sorts in which they were asked to rank statements about the diagnostic label of Bipolar Disorder. Three main factors emerged: (1) Seeing the person and their experience, (2) Promoting quality through standardised processes and (3) Understanding the function of diagnostic labels. All three factors agreed that sufficient time should be taken to assess for Bipolar

Disorder and that communication using purely the diagnostic label was not helpful. Holding different perspectives on the diagnosis of Bipolar Disorder is likely to make it difficult to provide consistent, high-quality care for service users and it was suggested that services may benefit from better integration of these viewpoints moving forward. The executive summary outlines an overview of the empirical paper that can be disseminated to mental health services.

Paper One: Literature Review

‘What is known about service users’ perceptions of psychiatric diagnosis?’

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Contents

What is known about service users’ perceptions of psychiatric diagnosis?

Purpose: There is considerable disagreement amongst both clinicians and service users about the use of medical-style diagnostic categories for mental health difficulties. Despite this, mental health services regularly rely upon psychiatric diagnosis and these labels are becoming increasingly incorporated into common language. A literature review was undertaken to explore what is known about service users’ perceptions of psychiatric diagnosis and the diagnostic practices that are more likely to result in positive experiences for the service user.

Design: Sixteen papers were identified through searches of four health related databases and hand searches. The quality of papers was critically evaluated before results were synthesised.

Findings: Four important factors were identified: (1) Whether service users want to be told their diagnosis (2) Communication of the diagnosis (3) Positives about psychiatric diagnosis (4) Negative aspects of psychiatric diagnosis.

Value: Service users hold a large variety of perceptions surrounding psychiatric diagnosis which can influence their recovery. Important factors in the experience of people accessing services are the accuracy, timing and communication of their diagnostic feedback. Given the importance of fostering hope through the diagnostic process, it is recommended that clinicians receive specific training in this area.

Keywords: diagnosis, service user, psychiatry, mental health

INTRODUCTION

The application of a diagnostic model to mental health is the focus of long-standing debate since the rise of psychological approaches. Many clinicians and researchers argue that using categories and labels listed in diagnostic frameworks provide inaccurate descriptions of mental ill health as well as misleading or incomplete explanations (Van Heugten–van der Kloet & van Heugten, 2015; Wakefield, 2007; Kass, Skodol, Charles et al. 1985). Critics have argued that mental health difficulties rarely fit into distinct categories (Widiger & Samuel, 2005) and many clinicians challenge the presentation of diagnosis as fact instead of an interpretation based on clinical judgement (Frances, 2013; Kirk & Kutchins, 1994). Moreover, categorising and labelling individuals as mentally ill has been associated with increased social isolation and the experience of stigma both from the community and through self-stigma (Watson, Corrigan, Larson, et al 2007).

Nonetheless, diagnostic criteria have many uses for clinicians and service users. A diagnostic label can provide a description of service users' symptoms (APA, 2013) and assist in the creation of meaning around their experience (Craddock & Mynors-Wallis, 2014). It is also said to allow for the development of structured and standardised intervention (Rosenfield, 1997), and the development of a 'care pathway' to ensure service users' receive appropriate support. Proponents of a diagnostic approach suggest that categorisation provides scope for research into appropriate intervention and development of new theory. Psychiatric labels can provide an accepted language to enable clinicians, service users, the public and the media to communicate about mental health (Craddock & Mynors-Wallis, 2014). They can also offer a tangible entity for sociological circumstances including insurance and benefit systems (BPS, 2013) and for funding streams dedicated to mental health intervention such as payment by results (Mason & Goddard, 2009).

However, research on psychiatric diagnosis is diverse. One of the main aims of psychiatric diagnosis is to facilitate service users' recovery (South London and Maudsley NHS Foundation Trust, 2010). Acceptance of a psychiatric diagnosis is associated with improved treatment outcomes for individuals diagnosed with Bipolar Disorder (Yen, Chen, Ko, et al. 2007) and alcohol use disorders (Kurtz, 1981). Acceptance based therapies for positive symptoms of psychosis have also been associated with more open disclosure and a reduction in hospital admission (Bach & Hayes, 2002). Meanwhile, acceptance of a diagnosis of Psychosis saw service users experience greater perceived control over hallucinations (Farhall, Greenwood & Jackson, 2007) and the ability to resist acting on command hallucinations (Shawyer, Ratcliff, Mackinnon, et al. 2007). Contrastingly, acceptance of this diagnosis has also been associated with an increase in low mood (Osatuke, Ciesla, Kasckow, et al. 2008) and suicidal ideation (Lewis, 2004). Furthermore, Lysaker, Roe and Yanos (2007) reported that acceptance of a diagnosis of Psychosis led to the internalisation of stigma.

Research shows that mental health clinicians experience uncertainty surrounding the accuracy of diagnosis and its unclear prognosis (Moran, Oz & Kamieli-Miller, 2014). Clinicians' perception of the accuracy of psychiatric diagnosis and concerns regarding the impact of the diagnostic label are some of the factors that have been shown to make it less likely that clinicians will disclose a diagnosis to service users. Clinician's readiness to tell service users their diagnosis also depends on the type of label being given (Clafferty, McCabe & Brown, 2001; Luderer & Brocker, 1993; Gantt & Green, 1985; McDonald-Scott, Machizawa & Satoh, 1992). Other important factors were the clinician's belief that the service user would experience distress, the service user's perceived level of insight and their perception of medication (Cleary, Hunt & Walter, 2010). Furthermore, clinicians may withhold diagnostic information due to concerns regarding stigma (Green & Grantt, 1987) and fears that it would negatively impact the therapeutic relationship (Moran, Oz & Kamieli-Miller, 2014). Clinicians have also noted the power dynamic between clinician and service user during the process of assessment and disclosure (Crowe, 1999).

There are several alternatives to psychiatric diagnosis suggested by clinicians and researchers that acknowledge the importance of the social context in the understanding of mental health presentation (Kinderman, 2014; Johnstone, 2017). Recently, the British Psychological Society's Division of Clinical Psychology (DCP, 2018) outlined a new agenda that aimed to address the limitations of current models used to understand mental health difficulties. The document proposed a conceptual framework and suggested that emotional distress resulted from the combination of four interrelated elements: the operation of power and the threat posed by its misuse within an individual's context, the role of meaning that is created around the power and threat responses that are learnt as a consequence (Johnstone & Boyle, 2018). This acknowledges the use of diagnostic labels for service structure and economic purposes but stresses the importance of understanding behaviours as responses to adversity and power imbalances within an individual's social context (Johnstone & Boyle, 2018). This alternative way of understanding mental health aims to avoid labelling or blaming service users and instead empowers them to develop new coping mechanisms and regain control of their life (Johnstone & Boyle, 2018).

Due to the variety of clinicians using these criteria, the diversity of service users receiving a diagnosis, the range of functions of a diagnostic label and this contrasting research evidence, it is unlikely that every individual will reach a consensus on whether the diagnostic model should be used in relation to mental health. Consequently, Rose and Thornicroft (2010) suggest that the topic of interest should not be whether a psychiatric diagnosis should or should not be made, instead research should identify the practices most likely to result in positive experiences for service users, as well as factors improving their perceptions of and engagement with a psychiatric diagnosis. Potentially, these practices can be incorporated into services to improve service users' recovery. The aim of this literature review is to explore service users' perceptions of psychiatric diagnoses and the factors they find helpful so that services can integrate them into practices.

METHOD

A scoping exercise of available databases using broad search terminology was completed to ensure that this literature review was not duplicating any previous reviews that focused on perceptions of psychiatric diagnosis from service users with a variety of mental health difficulties. No existing literature reviews of this type were found when searching through the Cochrane Library, Google Scholar and available databases on the Health Advanced Search, despite the apparent importance of the topic and its potential benefits for service delivery.

Search Strategy

A systematic search methodology was used to identify relevant research papers for this review. The Health Databases Advanced Search website was used to search 4 electronic databases:

- CINAHL
- EMBASE
- PSYCINFO
- MEDLINE

The search included research up prior to the search date on May 1st 2017. A total of five sets of search terminology were developed from the initial scoping exercise and are listed in Figure 1.

The process of the literature search can be seen in Figure 2. Peer reviewed papers written in English were reviewed according to the pre-identified search strategy. Duplicates were removed, resulting in 703 papers. Research titles were then screened for relevance, leaving 38 papers. Twenty papers resulted from a hand search, creating a collection of 58 papers of potential relevance. These 58 papers were subject to in-depth review in accordance with predetermined inclusion and exclusion criteria (Table 1). A final total of 16 papers were then included in this literature review.

Figure 1: Terminology for review of the literature

'What is known about service users' perceptions of psychiatric diagnosis?'

Search terms: (Patient* OR Client* OR “Service User*” OR “Psychiatric Patient*” OR “Mental Patient*”)

AND

(View* OR Opinion* OR Attitude* OR Perspective* OR Perception* OR Insight OR Belie* OR Position OR Stance OR Understand*)

AND

(Qualitative OR “Focus group*” OR Survey* OR Questionnaire* OR Feedback)

AND

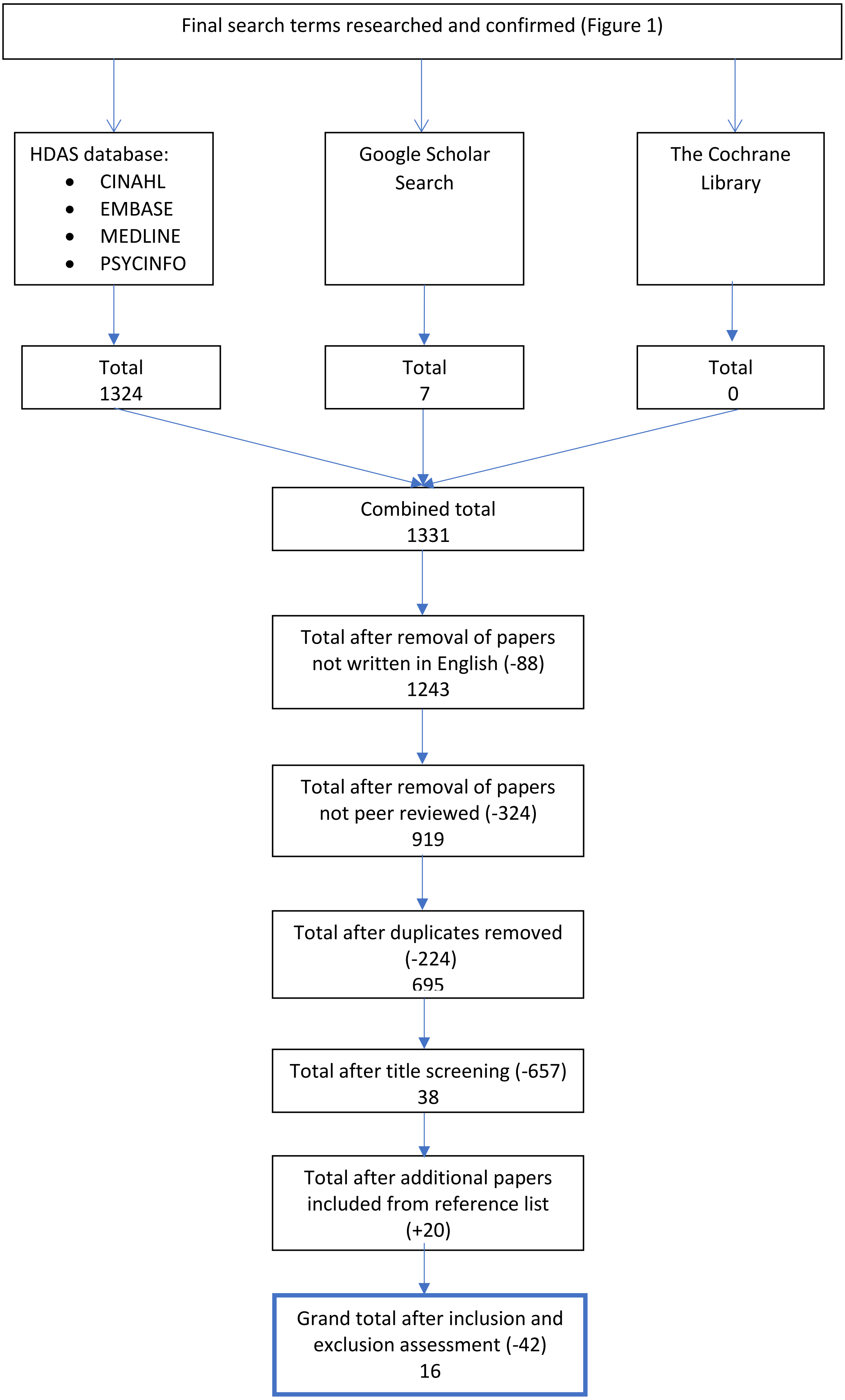
(Psychiatr* OR “Mental Health” OR Mental Disorder* OR Mental Disease* OR DSM OR “ICD-10”)

AND

(Diagnos* OR label*)

Basic information about the design and methodology of the research papers in this review can be seen in Table 2; whilst Appendix 1 details a summary of the general information taken from each paper.

Figure 2: Search strategy



All 16 papers were subject to quality review using the Critical Appraisal Skills Programme for Qualitative Research (CASP; Critical Appraisal Skills Programme, 2017a) and the Critical Appraisal Skills Programme for Cohort Studies (CASP; Critical Appraisal Skills Programme, 2017b). Critical appraisal tools can be used to assess the validity, results and relevance of each research paper in a systematic way (Hill & Spittlehouse, 2003). The reader rates each paper based on the checklist of quality items listed in the CASP using the responses 'Yes,' 'No,' or 'Can't Tell' (CASP, 2017a; CASP, 2017b). The results can indicate the potential quality of the research and allow for comparison across research.

Table 1: Inclusion and Exclusion criteria for literature search

Inclusion Criteria	Exclusion Criteria
Paper provides explicit information about viewpoints of a psychiatric diagnosis as defined in DSM-IV (APA, 1992), DSM-5 (APA, 2013) or ICD-10 (1992)	Information about viewpoints of a psychiatric diagnosis other than from a service user
Data is clearly focused on service users' experience of psychiatric diagnosis	Data is not clearly focused on service users' views of psychiatric diagnosis
Psychiatric diagnosis is functional, not organic	Data relates to neurodevelopmental/organic/learning disability diagnoses
Dated after 1992	Dated prior to 1992
From a peer reviewed journal	From a non-peer reviewed journal
Qualitative, quantitative or mixed method research papers	

Table 2: Design of research papers included in this review

Paper nº	Author	Date	Main Aims	Type of study	Sample size & country	Other sample details	Mental health diagnosis	Method of data collection	Method of data analysis
1	Bilderbeck, Saunders, Price & Goodwin	2014	Understand more about SU experiences of assessment in psychiatric secondary care	Qualitative	N=28 United Kingdom	No detailed exclusion criteria. No details on how participants were recruited	BD, BPD, Depression/anxiety	Semi-structured interview & researcher observing clinical assessment	Qualitative analysis through Ritchie & Spencer's (1994) Framework Technique
2	Cleary, Hunt, Escott & Walter	2010	To explore how SU experience receiving difficult news	Quantitative	N=100 Australia	Recruited from one mental health hospital. No exclusion criteria given.	Mixed - SCZ, Depression, BD, Other	Survey asking participants to rate satisfaction and importance of different factors relating to receiving difficult news on a Likert Scale or agree/disagree items	Observed rates & frequencies. Pearson Chi-square test for differences. Cronbach's alpha coefficient.
3	Delmas, Proudfoot, Parker & Manicavasagar	2011	Explore factors & processes involved with adjusting to a dx of BD	Qualitative	N=17 Australia	Recruited family members of those with a dx as separate arm of study	BD	Semi-structured interview	Phenomenology & lived experience framework (Todres & Holloway, 2004)
4	Gallagher, Arber, Chaplin & Quirk	2010	To explore SU experience of bad news	Qualitative	N=9 United Kingdom	Started with 10 participants	None given	Interview	Grounded Theory (Glaser, 1978; Glaser & Strauss,

			relating to their mental health & the impact this has on them. To list the approaches clinicians, use to give bad news to SU.			but excluded 1 due to lacking capacity. Participants had between 1-19 admissions to mental health wards. Recruited from 2 inpatient units & 2 CMHTs			1967)
5	Hayne	2003	To explore the views of those who have experienced a dx of a ‘severe and enduring mental illness.’	Qualitative	N=14 Canada	No exclusion criteria. Recruited from Canadian Mental Health Association & the Consumer’s Network	None given	Semi-structured Interview	Thematic Analysis
6	Holm-Denoma, Gordon, Donohue, Waesche, Castro, Brown, Jakobsons, Merrill, Buckner & Joiner	2008	Examine the effect of diagnostic feedback on participant’s emotional state	Quantitative	N=53 USA	Sample originally started at 91 – 3 excluded due to not meeting criteria for a psychiatric	Mixed – Mood disorders, Anxiety disorders, Substance Use disorders, Personality disorder, SCZ Spectrum	Global assessment of functioning (GAF). Negative life stresses rating. Visual Analogue	Repeated measures ANOVA

						dx. 19 dropped out during the research. 19 participant’s data was withdrawn due to researcher error	disorders, other psychiatric dx	Scale of positive and negative descriptors for rating on a 10cm line.	
7	Horn, Johnstone & Brooke	2007	Consider SU experience of their difficulties being describe by a diagnostic label	Qualitative	N=5 United Kingdom	Approached by their mental health professional	BPD	Interview	Interpretative Phenomenological Analysis (Smith, 1995; Smith & Osborne, 2003)
8	Inder, Crowe, Joyce, Moor, Carter & Luty	2010	Explore the experience of BD and how people make sense of their dx. Also, to explore factors that influence acceptance of the dx	Qualitative	N=15 New Zealand	Data taken from a larger RCT study on intervention outcomes	BD	Recording & transcribing of specific questions included in therapy sessions	Thematic Analysis (Boyatzis, 1998)
9	Loughland, Cheng, Harris, Kelly, Cohen, Sandhu, Varmos, Levin, Bylund, Landa & Outram	2015	Examine the perception & experiences of SU during diagnostic communication	Qualitative	N = 14 Australia	Age range 35 - 65	SCZ	Semi-structured interview	Thematic Analysis
10	Marzanski, Jainer & Avery	2002	Explore how much	Qualitative	N=35 United	18 declined or were	Mixed – SCZ, Psychosis,	Structured interview	Counting frequency of responses – no

			psychiatric inpatients know about their dx & explore what they would like to be told		Kingdom	'unable to take part' – does not say why this may be. Does not state how participants were recruited	Affective disorders, Personality disorder, Generalised Anxiety disorder		method stated
11	Milton & Mullan	2015	Explore SU views of the communication of a psychiatric dx	Qualitative	N=45 Australia	Recruited from 11 different sites	Mixed – SCZ, Schizotypal & Delusional disorders, mood disorders, neurotic, stress-related & somatoform disorders	Semi-structured interview	Thematic Analysis (Braun & Clarke, 2006)
12	Milton & Mullan	2016	Survey SU satisfaction when receiving a psychiatric dx. Explore factors influencing their experience of communication and acceptability of a dx. Explore the use of the 'Spikes' protocol in psychiatry	Quantitative	N=101 Australia	Recruited from 11 different sites. No exclusion criteria listed	Mixed – SCZ, BD, Schizoaffective disorder, other 'major' psychiatric dx	Paper questionnaire	Independent samples t-test, Independent samples Mann-Whitney U, Kruskal Wallis one-way ANOVA
13	Pitt, Kilbride,	2009	To explore SU	Qualitative	N=8	Recruited	Mixed – BD,	Interview by	Interpretative

	Welford, Nothard & Morrison		views of the impact of a dx when they are experiencing psychosis.		United Kingdom	from local mental health groups and psychology services	Schizoaffective disorder, SCZ & Personality disorder	two SU researchers	Phenomenological Analysis
14	Proudfoot, Barker, Benoit, Manicavasagar, Smith & MCrim	2009	Investigate the subjective experience of receiving a dx of BD	Qualitative	N=26 Australia	Data taken from a larger RCT study on intervention outcomes	BD	Emails from participants to 'Informed Supporters' during intervention	Phenomenology & lived experience framework
15	Shergill, Barker & Greenberg	1998	To test hypotheses: Inpatient SU with a dx of SCZ or BPD will be less likely to know their dx compared to those with other labels. Mental health day patients will want to know their dx and will retain and agree with their dx at 6 week follow up.	Quantitative	N=126 from inpatient service users N=27 from day services UK	Also recruited 24 Consultant Psychiatrists for a separate arm of the study. 27 were excluded from original sample of 200 of inpatient SU due to being unwell. 47 chose not to participate.	Mixed – SCZ, Depression, Anxiety, Personality Disorder, Other	Paper questionnaire	T-tests, Chi-squared

16	Thomas, Seebohm, Wallcraft, Kalathil & Fernando	2013	Investigate service users' views on the dx of SCZ and its impact on their lives	Qualitative	N=470 United Kingdom	Recruited through advert at 40 organisations & through social media	SCZ	Web-based survey	Thematic Analysis (Braun & Clarke, 2006)

Table Key:
Dx = Diagnosis
BPD = Borderline Personality Disorder
SU = Service User
BD = Bipolar Disorder
SCZ = Schizophrenia/Psychosis

RESULTS

Application of the critical appraisal tools to research papers in this review can be seen in Table 3 and Table 4. Tables were colour coded to facilitate visual representation and easy interpretation of results. A total of 16 papers were evaluated; 12 of these papers were qualitative in nature whilst four were quantitative. Six papers focused on whether the service user wanted to be told their psychiatric diagnosis (Loughland, Cheng, Harris, et al., 2015; Bilderbeck, Saunders, Price & Goodwin, 2015; Milton & Mullan, 2015; Marzanski, Jainer & Avery, 2002; Shergill, Barker & Greenberg, 1998; Cleary, Hunt, Escott & Walter, 2010) and nine papers explored service users' experiences of receiving a diagnosis and the communication involved in diagnostic feedback (Proudfoot, Barker, Benoit, et al., 2009; Loughland et al. 2015; Bilderbeck et al., 2014; Milton & Mullan, 2015; Milton & Mullan, 2016; Marzanski et al. 2002; Holm-Denoma. Gordon, Donohue, et al., 2008; Cleary et al. 2010; Gallagher, Arber, Chaplin & Quirk, 2010). Research by Delmas, Proudfoot, Parker and Manicavasagar (2011) and Inder, Crowe, Joyce, et al. (2010) also explored the adjustment to a psychiatric diagnosis and the construction of meaning behind the diagnostic label. The remaining four papers explored the impact of a psychiatric diagnosis on service users' mental health and wellbeing as perceived by the service user (Thomas, Seebolhm, Wallcraft, et al. 2013; Horn, Johnstone & Brooke, 2007; Pitt, Kilbride, Welford, et al. 2009; Hayne, 2003). The research conducted by Milton and Mullan (2016) explored the use of the six-step 'Spikes protocol': a selection of guidelines used for giving terminal or physical health diagnoses, applied to diagnoses in mental health.

The majority of papers were contemporary, being published within the last decade. Three earlier papers have been included in this review: research by Marzanski et al. (2002), Shergill et al. (1998) and Hayne (2003) and represent earlier work completed on this topic. The majority of research was conducted in the United Kingdom and Australia, with other research papers originating from New Zealand, United States of America and Canada. The sample size recruited for the research ranged from five to 470 participants.

Research Quality

Both qualitative and quantitative papers included in this review were thought to be good quality in general and offer a useful insight into service users' perceptions of psychiatric diagnosis that could inform service delivery. The majority of papers identified clear and specific aims of the research and were designed appropriately; only two papers (Bilderbeck et al. 2014; Hayne, 2003) lacked a clear statement of aims which make it difficult to identify study rationale. Research by Marzanski et al. (2002) failed to provide clear links between the aims and research design. All quantitative studies were thought to have appropriate designs for research aims, though in most cases it was unclear whether the study was designed to minimise bias and did not include the use of follow up data.

Sample characteristics used in 14 of the 16 papers were thought to be good or satisfactory. Generally, clear details were provided on the justification and method of recruitment, the number of participants recruited, demographic information and sample inclusion/exclusion criteria. Samples included participants across genders and age, and included people with different psychiatric diagnoses and number/length of hospital stays. There were initial concerns surrounding the representativeness of samples in two of the papers (Horne, Johnstone and Brooke, 2007; Smith, Flowers & Larkin, 2009) due to small sample sizes and a sample age being relatively high to capture people with a first episode of psychosis. However, these papers did yield some useful and interesting results. Attrition was a major limitation of the research as it was largely unreported throughout the studies, with only two referring to the attrition rate (Holm-Denoma et al. 2008; Shergill et al. 1998).

Information about the process of data collection and method of analysis in qualitative studies was largely well reported. A number of studies included information on the specific topics or questions asked during data collection and the framework they followed during analysis. Conversely, in research by Inder et al. (2010), data were collected through the use of recordings of therapeutic intervention sessions and therapists were asked to flag content of interest to the research on a tracking form. This was not well explained in the paper, making it difficult to replicate. Analysis by Marzanski et al. (2002) was thought to be lacking in depth and richness as qualitative data was collected but not used; instead researchers counted frequencies of types of responses and presented these to the reader. This did not appear to fit with the justification for using qualitative interviews. Furthermore, only four studies made sufficient reference to the role of the researcher in data analysis (Bilderbeck et al. 2014; Horn et al. 2007; Pitt et al. 2009; Hayne, 2003) raising concerns about the reflexivity.

All quantitative studies used questionnaires, with one study (Holm-Denoma et al. 2008) using a previously validated measure and the others using self-constructed measures based on literature. All four papers gave sufficient reference to the questions that were included in surveys and the way that participants were asked to respond (Cleary et al. 2010; Holm-Denoma et al. 2008; Milton & Mullan, 2016; Shergill et al. 1998). The methods of data analysis varied between studies. None of the studies reported confidence intervals or error figures in their results, making it difficult to judge precision. Unfortunately, due to the complexity of this research area, none of the papers could fully acknowledged or control for all confounding variables that could have influenced the results.

Just under half of the papers included in this review recounted that they had received ethical approval from relevant governing bodies suggesting that ethical principles were upheld during the design of the research (Delmas et al. 2011; Bilderbeck et al. 2014; Milton & Mullan, 2015; Milton & Mullan, 2016; Shergill et al. 1998; Cleary et al. 2009; Hayne 2003). However, in those that did not specify ethical approval, informed consent to the research was acknowledged by the researcher. Ultimately, clinical implications can be drawn from all papers, however only 15 of the papers explicitly outline potential changes to practice as a result of findings.

Table 3: Critical Appraisal of Qualitative Papers

Author Assessment Question	Bilderbeck, et al. (2014)	Delmas, et al. (2011)	Gallagher, et al. (2010)	Hayne (2003)	Horn, et al. (2007)	Inder, et al. (2010)	Loughland, et al. (2015)	Marzanski, et al. (2002)	Milton & Mullan (2015)	Pitt, et al. (2009)	Proudfoot, et al. (2009)	Thomas, et al. (2013)
1. Was there a clear statement of the aims?	N	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y
2. Is a qualitative methodology appropriate?	Y	Y	Y	Y	Y	Y	Y	CT	Y	Y	Y	Y
3. Was the research design appropriate to address the aims?	Y	Y	CT	Y	Y	CT	Y	CT	Y	Y	Y	CT
4. Was the recruitment strategy appropriate to the aims?	Y	Y	Y	Y	Y	Y	CT	CT	Y	Y	Y	CT
5. Was the data collected in a way that addressed the research issue?	Y	Y	Y	Y	Y	CT	Y	Y	Y	Y	Y	Y
6. Has the relationship between researcher & participants been adequately considered?	Y	CT	CT	Y	Y	CT	CT	CT	CT	Y	CT	CT
7. Have ethical issues been taken into	Y	Y	CT	Y	Y	CT	CT	CT	Y	CT	Y	CT

consideration?	🟩	🟩	🟧	🟩	🟩	🟧	🟧	🟧	🟩	🟧	🟩	🟧
8. Was the data analysis sufficiently rigorous?	Y	CT	Y	Y	Y	Y	Y	N	Y	Y	Y	CT
9. Is there a clear statement of findings?	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y
10. How valuable is the research?	Y	CT	Y	Y	Y	CT	CT	CT	Y	Y	Y	CT

Table Key: Red = No
Orange = Can’t Tell
Green = Yes

Table 4: Critical Appraisal of Quantitative Papers

Author	Cleary et al. (2010)	Holm-Denoma et al. (2008)	Milton & Mullan (2016)	Shergill et al. (1998)
Assessment Question				
1. Did the study address a clearly focused issue?	Y	Y	Y	Y
2. Was the cohort recruited in an acceptable way?	Y	CT	Y	Y
3. Was the exposure accurately measured to minimise bias?	CT	Y	CT	CT
4. Was the outcome accurately measured to minimise bias?	Y	Y	Y	Y
5a. Have the authors identified all important confounding factors?	N	N	N	N
5b. Have they taken account of the confounding factors in the design and/or analysis?	Y	Y	N	N
6a. Was the follow up of participants complete enough?	N	Y	N	N
6b. Was the follow up of participants long enough?	N	CT	N	N
7. What are the results of the study?	CT	Y	CT	CT
8. How precise are the results?	CT	CT	CT	CT
9. Do you believe the results?	Y	Y	Y	Y
10. Can the results be applied to the local population?	CT	Y	Y	Y
11. Do the results of this study fit with other available evidence?	Y	Y	Y	Y
12. What are the implications of this study for practice?	CT	Y	CT	CT

Table Key:
Red = No
Orange = Can’t Tell
Green = Yes

Information Synthesis

Results from all 16 papers were combined to form several conclusions about service users' perceptions of psychiatric diagnosis. Detailed inspection of the results and clinical implications of all 16 papers demonstrated four common themes that represent key findings and important considerations for service provision.

1. Choice to be told a diagnosis

Service users' reaction to being told their psychiatric diagnosis is likely to be influenced by whether they wished to be told by services. Bilderbeck et al. (2014) suggested that participants had a more positive experience if they had a choice in whether they were told. Loughland et al. (2015) used thematic analysis to explore service users views and concluded that participants believed there was a significant benefit to being told their diagnosis and highlighted that it was a human right (Loughland et al. 2015). Meanwhile, Cleary et al. (2010) found that over 65% of participants currently residing in in-patient mental health units felt they had a moral or legal right to this information. Participants believed that not being told their diagnosis felt more concerning, led to more negative consequences than being told (Loughland et al. 2015) and caused feelings of abandonment, uncertainty and confusion (Bilderbeck et al. 2014). Milton and Mullan (2015) further agreed that participants wanted to be told and encouraged positive and open information sharing.

Conversely, Marzanski et al. (2002) detailed that less than half of their participants wanted to be told their psychiatric diagnosis with results being obtained from a cross-sectional survey with psychiatric inpatients. Over a quarter of the sample stated they did not want to know, whilst a quarter declined to answer the question. This finding is contradictory to other papers in the review. Furthermore, Loughland et al. (2015) suggested that clinicians often incorrectly assumed service users knew they had a mental health difficulty that was going to be diagnosed by clinicians, and this was often not clearly explained prior to their appointment.

2. Diagnostic communication

Thomas et al. (2013) and Pitt et al. (2009) highlighted that the way participants learnt of their diagnosis was important to their experience. Loughland et al. (2015) identified that only 2 of 14 participants felt happy with the way they had been told their diagnosis, whilst many of the remaining 12 found out through indirect means such as a leaflet, being directed to a support group or seeing it written on documents. When they were told directly, participants felt that clinicians were often unable to provide full and thorough explanations that included potential cause and prognosis. Participants often felt the need to validate what they had been told through reading books or the internet (Inder et al. 2010; Loughland et al. 2015; Horn et al. 2007). Participants also felt that diagnostic feedback was often given with negative connotations (Horn et al. 2007) or presented through the eyes and judgement of the clinician (Gallagher et al. 2010), which impacted the way the information was received.

Milton and Mullan (2016) identified that participants had a more positive experience if clinicians described their difficulties through their symptoms rather than the diagnostic label. Interestingly, participants noted that clinicians were sometimes reluctant to use the diagnostic label during feedback even when prompted (Milton & Mullan, 2015). Milton and Mullan (2015) also found participants viewed psychiatric diagnosis more positively if they were encouraged to maintain an identity outside their diagnosis, rather than being defined by their label. Research also showed that empathy was one of the most important positive factors in the communication of a diagnosis (Milton & Mullan, 2016), and that participants preferred diagnostic information to be delivered from a supportive stance in a way that was accessible for them (Marzanski, Jainer & Avery, 2002). Furthermore, participants felt more positive if they were given enough knowledge and encouragement to self-manage their difficulties (Milton & Mullan, 2015; Hayne, 2003).

Participants believed that the process of being told a psychiatric diagnosis was ‘powerful’ and felt very ‘final’ (Hayne, 2003). Milton and Mullan (2016) explored the SPIKES protocol, a six-step framework that aids clinicians to deliver terminal diagnoses in a supportive and compassionate manner, and found that participants felt it would be useful for mental health clinicians delivering psychiatric diagnosis. Participants often preferred diagnostic feedback to be delivered by a doctor or nurse as opposed to a family member, hospital manager or mental health act commissioner (Marzanski et al. 2002; Cleary et al. 2010). Participants felt that diagnostic feedback was improved by the presence of a family member (Delmas et al. 2011; Bilderbeck et al. 2014; Horn et al. 2007; Milton & Mullan, 2015; Milton & Mullan, 2016), and was more positive if there was enough time for clinicians to adequately discuss the diagnosis (Gallagher et al. 2010) in a face to face capacity (Milton & Mullan, 2015) and in a private setting (Milton & Mullan, 2016). Moreover, the provision of education surrounding the diagnosis was also thought to facilitate more positive perceptions of psychiatric diagnosis.

Having to repeatedly provide often difficult information to a variety of clinicians negatively impacted participants’ experience (Bilderbeck et al. 2014). Delmas et al. (2011) identified that perceptions of psychiatric diagnosis were further worsened when clinicians’ responses to their symptoms did not make sense (Marzanski et al. 2002). Inder et al. (2010) found that participants had difficulty understanding medical terminology and information often felt meaningless (Gallagher et al. 2010). Diagnostic feedback that was not collaborative (Bilderbeck et al. 2014; Horn et al. 2007), lacked a sense of hope for the future (Milton & Mullan, 2015) and was rushed (Milton & Mullan, 2016) inhibited the formation of positive perceptions. There was a lack of direction to helpful literature (Milton & Mullan, 2016; Cleary et al. 2010) which was associated with disempowerment (Pitt et al. 2009). Furthermore, participants felt there was little direction to peer support which was seen as unhelpful (Cleary et al. 2010).

3. Benefits of Psychiatric Diagnosis

Participants were thought to view their diagnosis more positively if it led to access to treatment (Delmas et al. 2011) and consistent and continuous support from mental health clinicians (Bilderbeck et al. 2014; Inder et al. 2010; Milton & Mullan, 2016) or peer support (Pitt et al. 2009). There were a number of emotional benefits of psychiatric diagnoses described by participants in this research. Holm-Denoma et al. (2008) used visual analogue scales to measure mood in participants before and after they were given a diagnosis and concluded that being told their diagnosis was associated with an increase in positive emotions such as validation and hope. It did not increase negative emotions such as fear or shame. Research also described a sense of relief at gaining a name and explanation of their experiences (Delmas et al. 2011; Proudfoot et al. 2009; Loughland et al. 2015; Milton & Mullan, 2015; Pitt et al. 2009), and the development of deeper understanding (Inder et al. 2010; Pitt et al. 2009). Participants described feeling validated (Delmas et al. 2011) by their diagnosis.

Participants liked that their symptoms were linked to a physical illness (Loughland et al. 2015) as it gave them hope for recovery and dissolved feelings of blame and responsibility (Bilderbeck et al. 2014; Horn et al. 2007; Pitt et al. 2009). Horn et al. (2007), Hayne (2003) and Marzanski et al. (2002) also noted that diagnosis was associated with a sense of knowledge and control, which participants found helpful and elicited hope for the future. Furthermore, Pitt (2009) found that participants experienced a greater sense of support from healthcare professionals because of their diagnosis.

4. Disadvantages of Psychiatric Diagnosis

Participants found it hard to believe the diagnosis they had been given (Gallagher et al. 2010), thought that it was incorrect (Delmas et al. 2011; Inder et al. 2010) or found it hard to accept (Delmas et al. 2011). Some participants felt that the process of being diagnosed was complicated (Inder et al. 2010) and the label was often too simple and failed to fully explain participants' experience (Horn et al. 2007). Furthermore, some participants did not feel it was helpful to liken their difficulties to physical health (Gallagher et al. 2010). Being given a psychiatric diagnosis led participants to feel 'defective' (Delmas et al. 2011), experience denial (Proudfoot et al. 2009), feelings of fright (Cleary et al. 2010), distress and confusion (Hayne, 2003) and anger (Proudfoot et al. 2009; Marzanski et al. 2002).

Some participants were sceptical that receiving a diagnosis would ensure better or more appropriate support. Others felt increased pressure to provide clinicians with specific answers to their questions to fit a diagnostic category (Bilderbeck et al. 2014). Online questionnaires distributed by Thomas et al. (2013) found that some participants who had been given a diagnosis of Psychosis felt unable to disagree with clinicians because it would be interpreted through the lens of their diagnosis, rather than a valid disagreement. One participant furthered this by suggesting that once they had been given this diagnosis, all aspects of their life including their values, beliefs and interests were all seen as symptoms of an illness (Thomas et al. 2013).

Research showed that some participants believed that diagnosis led to changes in service provision and support was often withdrawn depending on the diagnosis (Bilderbeck et al. 2014) leaving participants feeling dismissed (Horn et al. 2007). Furthermore, Hayne (2003) suggested that psychiatric diagnosis had a negative impact on participants' sense of identity. It was also thought to make relationships with friends and family more difficult (Delmas et al. 2011). Thomas et al. (2013) found that diagnosis negatively impacted participants' employment opportunities and proved a barrier to travel because of difficulties with insurance. One participant felt that psychiatric diagnosis had prevented her from having a family as she was told her mental health difficulty was genetic (Thomas et al. 2013). Stigma was also mentioned in relation to psychiatric diagnosis (Pitt et al. 2009; Gallagher et al. 2010) with specific references to Borderline Personality Disorder (Bilderbeck et al. 2014).

DISCUSSION

The 16 papers in this review provide valuable insight in to service users' perceptions of psychiatric diagnosis. It was clear that there were four key themes that emerged from the findings of these papers: Whether service users want to be told their diagnosis, communication of the diagnosis and it's benefits and disadvantages. The literature shows that perceptions of psychiatric diagnosis are varied and can be contradictory, with service users often giving contradictory viewpoints similar to those seen in research on clinician's perspectives (Clafferty, McCabe & Brown, 2001; Luderer & Brocker, 1993; Gantt & Green, 1985; McDonald-Scott, Machizawa & Satoh, 1992). This demonstrates the personal nature of psychiatric diagnosis and the meaning that individuals create around it.

From the literature, it appears that the communication of a diagnosis can make a significant difference to how service users feel about their diagnostic label, with empathic and supportive communication from a doctor or nurse being preferred. Mirroring previous literature on the potential positives of psychiatric diagnosis, (Craddock, Kerr & Thapar, 2012; Craddock & Mynors-Wallis, 2014), participants identified that psychiatric diagnosis facilitated emotional benefits, provided meaning, explanation and the opportunity to gain knowledge and self-manage their distress. Conversely, research presented several negative aspects surrounding a diagnosis, including the experience of stigma, negative impacts on service users' identity and barriers to usual life events, many of which have been acknowledged previously (Watson, Corrigan, Larson & Sells, 2007; Wakefield, 2007).

Overall, the quality of research papers included in this review was good, however some elements in the critical appraisal tools could not be answered with certainty using information provided in the literature. In qualitative papers, there were areas where quality was lacking, specifically the lack of clarity surrounding ethics and the role of the researcher in data analysis. Quantitative papers were unable to fully control for all potential confounding variables that could influence results, such as previous experience of mental health, severity of symptoms and characteristics of the clinician delivering the information, amongst others. Despite this, all 16 papers were thought to add valuable information to the evidence base which can be utilised in clinical practice.

No papers in this review explicitly explored whether participants were aware of the diagnostic frameworks such as the DSM (APA, 2013) or the ICD (World Health Organisation, 1992). Some participants thought that it was helpful for their difficulties to be described using a medical style diagnosis that was likened to physical health (Loughland et al. 2015). In research by Horn, Johnstone and Brooke (2007), service users preferred their difficulties to be described using symptoms rather than via a diagnostic label, possibly representing that the diagnostic model fits for some. Yet research by Gallagher et al. (2010) disagreed with both viewpoints, indicating that the diagnostic model is not always a helpful way of conceptualising mental health. This discrepancy could be explained by variation in the sample characteristics as the three pieces of research were conducted using participants with different psychiatric diagnoses. The difference could also be related to the way individuals conceptualise mental health, the meaning they attribute to a diagnosis and their past experiences of contact with mental health services.

Benefits of psychiatric diagnosis noted by participants were largely emotive, with only four out of 16 papers explicitly mentioning access to intervention (Milton and Mullan, 2015; Holm-Denoma et al. 2008; Thomas et al. 2013 & Pitt et al. 2009). Two other papers alluded to changes in the provision of support, with some participants believing a diagnosis was a barrier to services (Bilderbeck et al. 2014) or that existing services were withdrawn following diagnosis (Horn, Johnstone & Brooke, 2007). The lack of focus on intervention could suggest that service users are often unaware of the systemic uses of psychiatric diagnosis such as service structure and payment by results (Mason & Goddard, 2009). Furthermore, it could indicate that psychiatric diagnosis holds different importance for everyone involved depending on their experience and standpoint.

Seven of the sixteen papers included in the review identified that diagnosis enabled them to put a name to their experiences and gave them a language to talk about their difficulties, supporting claims by the BPS (2013) that diagnosis forms a common and accepted language. However, Horn, Johnstone and Brooke (2007) supports suggestions that categorical guidelines are too reductionist to account for individuals' experience and diagnostic labels are too simplistic (Kass et al. 1985). Furthermore, participants were often uncertain about the accuracy of their diagnostic label which coincides with research findings from Moran, Oz & Karnieli-Miller (2014) who suggested that professionals are often uncertain about its truth. This illustrates that service users and clinicians agree on the limitations of categorising individuals using diagnostic frameworks (Widiger & Samuel, 2005). Furthermore, participants spoke of stigma resulting from their diagnostic label, both in the community and self-stigma as noted by Watson, Corrigan, Larson & Sells, 2007.

Participants were also aware of the power dynamic suggested by Crowe (1999), with participants feeling powerless to challenge or disagree with their diagnosis (Thomas et al. 2013). Participants believed that the diagnostic label was very powerful (Hayne, 2003) which could reduce their hope for future change. Participants also believed that clinicians were wrong to withhold information on their diagnosis (Cleary et al. 2010; Loughland et al. 2015; Bilderbeck et al. 2014), something that clinicians may do for a variety of reasons (Clafferty, McCabe & Brown, 2001; Luderer & Bocker, 1993; Gantt & Green, 1985; McDonald-Scott, Machizawa & Satoh, 1992, Green & Gantt, 1987; Moran, Oz & Karnieli – Miller, 2014).

It is necessary to note that this literature review has several limitations. Although the search strategy used to identify papers was designed in a systematic way, it was impossible to search every database and journal that potentially holds relevant material. Furthermore, the review looked to identify participants' perceptions across of variety of different psychiatric diagnoses to provide a more general viewpoint. Although this has much strength, the inclusion of different diagnoses could have led to the discrepancy in the findings between papers. Moreover, it was not possible to fully explore the literature in relation to a specific diagnosis and therefore precise or intricate differences within a single diagnosis could not be highlighted. The review included 16 papers; this high number of research papers made it difficult to extract and compare specific findings across papers and instead it was felt that highlighting shared themes would be more useful.

Nonetheless, the research highlighted many recommendations for clinical practice that could be utilised within mental health services and the process of diagnostic feedback. Focusing on the accuracy of information, careful planning and communication of feedback are important priorities for clinicians in mental health services providing diagnoses. It is essential that services take note of potential negative impacts of psychiatric diagnosis and the stigma that may be experienced. The review also recommends that treatment planning is collaborative between the clinician and service user and focuses on their needs and goals. It would be beneficial for clinicians to receive support in providing diagnostic feedback in a way that fosters a good therapeutic relationship, trust and hope for the future. Extra training for clinicians on the difficulties accepting psychiatric diagnosis and including families in the diagnostic feedback may also help service users. Finally, further research into the factors affecting the perception of psychiatric diagnosis held by service users would give insight into how services can tailor their diagnostic feedback to ensure person-centred care.

To conclude, the 16 papers in this review give valuable insights into how service users perceive their psychiatric diagnosis. Papers presented contrasting reviews on whether service users should be told their diagnosis and its importance in accessing mental health services. Participants believed that there were several benefits of receiving a psychiatric diagnosis but there were also many disadvantages. The wide variety of responses from participants included in this review demonstrates the personal nature of mental health. The conflicting findings are likely to be due to the huge number of factors that could potentially influence perceptions of psychiatric diagnosis including the diagnosis being given, who provides the diagnosis and when feedback is given. Although not explicitly explored in this review, it is likely that an individual’s experience of psychiatric diagnosis is influenced by their life events and previous experience of mental health. It is also probable that the process of assessment and feedback varies greatly between services.

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Appendices

Appendix 1: Summary of themes emerging from papers

Paper nº	**Whether participants wanted to be told**	**Important communication factors**	**Positive aspects of a diagnosis**	**Negative aspects of a diagnosis**	**Factors improving experience**	**Factors worsening experience**	**Clinical Implications**
1 Bilderbeck, Saunders, Price & Goodwin (2014)	Some participants felt 'abandoned' by services if they had not been given a dx	Being given an explanation of symptoms was more important than receiving a dx. Some felt sceptical it would result in support. Felt pressured to give 'correct' information to clinicians.	Sense of containment, recognition and validated their experience. Removal of blame and personal responsibility for actions.	Anxiety around dx stigma. Feeling that dx was dismissal from services. Questioning of meaningfulness and use in their lives.	Being able to access continuous and consistent care following dx. Having family or friends present in diagnostic feedback.	Having to repeat difficult personal information to many different professionals. The discussion not being collaborative & clinicians withholding information or not addressing stigma.	Clinicians should pay greater attention to service users' expectations & not assume dx is being sought. Involve family and friends in diagnostic feedback.
2 Cleary, Hunt, Escott & Walter (2010)	Yes - 65% felt they had a moral or legal right to know their dx, 62% felt they should be told. 51% felt they had received adequate information about their dx. 45% felt not being told their dx was more concerning that being told.	31% wished to receive the news in the presence of a family member, 30% wished to be told over several appointments. 57% felt a doctor was the most appropriate person to tell them their dx.	No results provided	35 participants felt information about dx was frightening	55% thought it helped when the clinician provided hope. 36 participants felt that terms other than the diagnostic label should be used to tell them about their dx. Receiving accurate information at a level that is understandable. Honest staff that are happy	-Not being given sufficient information regarding what symptoms they may experience, treatment side effects or information on peer support & websites	Clinicians should give accurate diagnostic feedback that is understandable for the service user which should be delivered empathically. Service users should be given the option of having a family member

					to address concerns.		present during diagnostic feedback.
3 Delmas, Proudfoot, Parker & Manicavasagar (2011)	No results provided	Participants did not always give complete information about their symptoms.	Sense of relief and validation of feelings	Incorrect diagnoses were often given. Viewing themselves as ‘defective.’ Negative impact on career & relationships. Difficult to accept implications – feeling the need for a new ‘framework’ for living	Reactions were most positive if they expected the dx or the information appeared fitted with their experience. Support from family. Education about dx. Early access to treatment.	Doctors not recognising correct disorder from list of symptoms. Stigma	Dx feedback sessions need planning and specific, accurate information to be delivered by clinicians
4 Gallagher, Arber, Chaplin & Quirk (2010)	No results provided	Not all participants believed dx. Clinician giving dx had prejudged whether the dx was ‘good’ or ‘bad’ and delivered the information with the connotation attached.	No results provided	Led to feelings of anxiety about stigma. Participants felt uncertain.	Dx communicated via a good therapeutic relationship. Being given time for discussion of the implications of a dx. Appropriate timing of communication. Dx being compared to physical illness	Information provided was complex & difficult to understand. Frequently being given different diagnoses. Dx being compared to physical illness.	Dx can be seen as ‘good’ or ‘bad’ news by service users and clinicians should be aware of this when giving feedback. Clinicians should note the importance of therapeutic relationship when delivering

							diagnostic feedback & allow enough time for sufficient discussion.
5 Hayne (2003)	No results provided	Powerful and penetrating communication to receive. Once told, participants could not ‘unknow’ this information	Feelings of recognition from others. Power from knowing about their difficulties. Allowed the possibility of healing.	Difficulties with sense of identity. Feelings of confusion and distress. Sense of de-legitimised being.	Knowledge given to empower participants and make them feel more knowledgeable about their mental health	No results given	Clinicians should be aware of the losses that service users may experience when receiving a dx. Clinicians should advocate a sense of healing through treatment as a result of dx.
6 Holm-Denoma, Gordon, Donohue, Waesche, Castro, Brown, Jakobsons, Merrill, Buckner & Joiner (2008)	No results provided	Diagnostic feedback improves mood & does not increase the experience of negative emotion. Feedback of any psychiatric dx is not harmful.	Can increase hope for intervention	No results provided	Information provided in a careful & empathic way	No results provided	Clinicians may increase service users’ experience of positive emotions by facilitating comprehensive feedback sessions in an empathic way.
7 Horn,	No results provided	Given little information	Gave knowledge	Seen as too simplistic &	Supportive relationships	Feeling that important	Diagnostic discussion

Johnstone & Brooke (2007)		about dx, information they were given was negative.	and a sense of control. Provided containment & clarity for participants. Sense of organisation to "chaos." Led to feelings of hope for future and possibility of change.	reductionist. Led to a rejection from services and withdrawal of support. Feeling judged by services and a removal of hope for the future.	with friends and family to facilitate hope	information was being withheld by clinicians. The clinician taking the 'Expert' position left participants feeling unsure.	should focus on what might be useful for the service user and facilitate trust of the clinician. Clear communication of what the label means & its impact. Clinicians should use service users own words rather than the diagnostic label.
8 Inder, Crowe, Joyce, Moor, Carter & Luty (2010)	No results provided	Felt that Psychiatrists were unable to explain dx. After being told the dx, participants needed to validate this through other sources such as books.	Provides meaning relating to the experience of symptoms.	Process of receiving dx was not straight forward, often misdiagnosed. Participants often questioned dx accuracy.	Receiving support from other clinicians following dx.	Lack of understanding of medical terminology. Previous wrong dx led to ambivalence.	Be aware of factors effecting acceptance of dx & work closely with service users to facilitate acceptance
9 Loughland, Cheng, Harris, Kelly, Cohen, Sandhu,	Yes – majority felt it was beneficial to be told their dx. Not being told	Clinicians should not assume that service users know they have	Relief that they had a medical dx for illness. Helped with	Feelings of disbelief when given dx	Being given information to take away to read later. Being given	Lack of clear information about illness, prognosis & future.	Non-explicitly outlined

Varmos, Levin, Bylund, Landa & Outram (2015)	had negative consequences.	a mental health difficulty. Most felt they were not given enough information on treatment	understanding & legitimising distressing experiences. Improved feelings of wellbeing.		‘realistic’ hope for future recovery. Being treated with respect & empathy by clinicians	Finding out dx through indirect ways instead of being told directly. Lack of rapport & empathy.	
10 Marzanski, Jainer & Avery (2002)	46% wanted to be told their dx, the nature of their illness and about their symptoms but only 25% had actually been told using the diagnostic label. 28.5% stated they did not want to know their dx. 25.5% did not answer this question	28% felt this information should come from a Doctor and 11% from a nurse.	Knowing about their illness is helpful	Feelings of anger and being misunderstood.	Information that is easy to understand.	20% stated that diagnostic communication did not make sense to them.	Psychiatric dx should not be routinely disclosed to service users. Instead service users preferences should be respected
11 Milton & Mullan (2015)	Yes – participants welcomed information sharing regarding dx	Communication should be supportive. Participants felt clinicians needed to adapt the level of information & check when clarification was needed.	Provides an understanding of the experiences & facilitated access to intervention	Self-stigmatization. Questioning of the value having a dx. Not seen as a priority.	Encouragement to maintain a sense of identity. Being given skills and knowledge to self-manage mental health. Face to face feedback. Being given sufficient	Diagnostic feedback that did not encourage hope. Changes in dx with little explanation	Service users need to be an active partner in conversations about dx. Treatment planning needs to be collaborative between

		Participants noted that clinicians were reluctant to put a name to their difficulty.			time for discussion & written information to take away. Collaborative information sharing. Involvement of family.		service user and clinician and service users need to contribute to decisions about operational aspects of services.
12 Milton & Mullan (2016)	No results provided	Participants preferred to be asked whether they wanted to be given dx. Empathy was most important factor in communication of dx. The SPIKES protocol for communication of diagnoses was seen as positive	No results provided	No results provided	If diagnostic feedback was given in private. If participants felt staff were being honest. Having family or carers involved in the discussion. Being given the information directly, through face to face conversation. Receiving support from other clinicians following dx	Lack of clear information about websites or any written information service users could read about their dx. Not being given enough time to discuss concerns or address stigma	Information giving and psycho-education should be part of diagnostic conversations. Staff should receive training on this. Support should be offered through a team-based approach
13 Pitt, Kilbride, Welford, Nothard & Morrison (2009)	No results provided	Some had found out their dx through indirect means	Access to treatment. Feeling of greater care and support from clinicians	Feelings of disempowerment. ‘Prognosis of doom.’ Lack of cultural awareness. Over-	Feeling able to be open with others about their dx. Availability of peer support	Lack of information led to lack of disempowerment	Clinicians should be mindful of the positive impacts of a dx & advocate

			& family. Provide a helpful framework for understanding experience. Feelings of relief. Externalising their problems & reduced responsibility	reliance on the diagnostic model. Experience of stigma & social exclusion. Negative impact on career.	networks		these in diagnostic feedback whilst minimising negative impacts. Provide a sense of hope for recovery. Provide information on peer support
14 Proudfoot, Barker, Benoit, Manicavasagar, Smith & MCrim (2009)	No results provided	No results provided	Relief to have a name for symptoms.	Feelings of shock, disbelief, denial & anger. Often misdiagnosed. Questioning what the dx meant about their sense of self. Negative impact on life events. Experience of stigma.	No results provided	No results provided	Negative impacts of dx should be kept in mind when developing intervention plans. Non-clinicians can help service users talk about their experiences
15 Shergill, Barker & Greenberg (1998)	Most inpatients wanted to discuss a dx with a consultant. Most participants who did not	More patients with a dx of SCZ did not know their dx than compared to those with other diagnoses. Participants who	No results provided	No results provided	Most wanted to be told by a junior Doctor or their key worker	No results provided	Clinicians should ask service users whether they want more information about their dx.

	know their dx felt it was “essential” to know.	knew their dx saw it as less real. More than half felt it was as real and important as a physical health dx					
16 Thomas, Seebohm, Wallcraft, Kalathil & Fernando (2013)	No results provided	Any disagreement with the psychiatrist during communication was interpreted as symptoms & they felt devalued. 63% stated they found out about their dx by chance	6% found the outcome of dx helpful	SCZ dx felt harmful due to associated stigma. Negative impact on careers, travel & relationships. Negative impact on parenting. “Life sentence with no recovery.”	No results provided	Clinician making a judgement prior to assessment. Dx changing depending on clinician.	Be aware of the harm the label may be doing to people with the dx in society and how it limits our understanding of the negative experiences these people may have.

Table Key:

Dx = Diagnosis

BPD = Borderline Personality Disorder

BD = Bipolar Disorder

SCZ = Schizophrenia/Psychosis

Appendix 2: Journal Submission Guidelines

Journal of Mental Health Training, Education and Practice

Issues for workforce development

Manuscript requirements

Please prepare your manuscript before submission, using the following guidelines:

Format	Article files should be provided in Microsoft Word format. LaTex files can be used if an accompanying PDF document is provided. PDF as a sole file type is not accepted, a PDF must be accompanied by the source file. Acceptable figure file types are listed further below.
Article Length	Articles should be between 3500 and 6500 words in length. This includes all text including references and appendices. Please allow 350 words for each figure or table.
Article Title	A title of not more than eight words should be provided.
Author details	All contributing authors’ names should be added to the ScholarOne submission, and their names arranged in the correct order for publication. • Correct email addresses should be supplied for each author in their separate author accounts • The full name of each author must be present in their author account in the exact format they should appear for publication, including or excluding any middle names or initials as required • The affiliation of each contributing author should be correct in their individual author account. The affiliation listed should be where they were based at the time that the research for the paper was conducted
Biographies and acknowledgements	Authors who wish to include these items should save them together in an MS Word file to be uploaded with the submission. If they are to be included, a brief professional biography of not more than 100 words should be supplied for each named author.
Research funding	Authors must declare all sources of external research funding in their article and a statement to this effect should appear in the Acknowledgements section. Authors should describe the role of the funder or financial sponsor in the entire research process, from study design to submission.
Structured Abstract	Authors must supply a structured abstract in their submission, set out under 4-7 sub-headings (see our "How to... write an abstract" guide for practical help and guidance):

	- Purpose (mandatory) - Design/methodology/approach (mandatory) - Findings (mandatory) - Research limitations/implications (if applicable) - Practical implications (if applicable) - Social implications (if applicable) - Originality/value (mandatory) Maximum is 250 words in total (including keywords and article classification, see below). Authors should avoid the use of personal pronouns within the structured abstract and body of the paper (e.g. "this paper investigates..." is correct, "I investigate..." is incorrect).
Keywords	Authors should provide appropriate and short keywords in the ScholarOne submission that encapsulate the principal topics of the paper (see the How to... ensure your article is highly downloaded guide for practical help and guidance on choosing search-engine friendly keywords). The maximum number of keywords is 12. Whilst Emerald will endeavour to use submitted keywords in the published version, all keywords are subject to approval by Emerald's in house editorial team and may be replaced by a matching term to ensure consistency.
Article Classification	Authors must categorize their paper as part of the ScholarOne submission process. The category which most closely describes their paper should be selected from the list below. **Research paper.** This category covers papers which report on any type of research undertaken by the author(s). The research may involve the construction or testing of a model or framework, action research, testing of data, market research or surveys, empirical, scientific or clinical research. **Viewpoint.** Any paper, where content is dependent on the author's opinion and interpretation, should be included in this category; this also includes journalistic pieces. **Technical paper.** Describes and evaluates technical products, processes or services. **Conceptual paper.** These papers will not be based on research but will develop hypotheses. The papers are likely to be discursive and will cover philosophical discussions and comparative studies of others' work and thinking. **Case study.** Case studies describe actual interventions or experiences within organizations. They may well be subjective and will not generally report on research. A description of a legal case or a hypothetical case study used as a teaching exercise would also fit into this category. **Literature review.** It is expected that all types of paper cite any relevant literature so this category should only be used if the main purpose of the paper is to annotate and/or critique the

	literature in a particular subject area. It may be a selective bibliography providing advice on information sources or it may be comprehensive in that the paper's aim is to cover the main contributors to the development of a topic and explore their different views. **General review.** This category covers those papers which provide an overview or historical examination of some concept, technique or phenomenon. The papers are likely to be more descriptive or instructional ("how to" papers) than discursive.
Headings	Headings must be concise, with a clear indication of the distinction between the hierarchy of headings. The preferred format is for first level headings to be presented in bold format and subsequent sub-headings to be presented in medium italics.
Notes/Endnotes	Notes or Endnotes should be used only if absolutely necessary and must be identified in the text by consecutive numbers, enclosed in square brackets and listed at the end of the article.
Figures	All Figures (charts, diagrams, line drawings, web pages/screenshots, and photographic images) should be submitted in electronic form. All Figures should be of high quality, legible and numbered consecutively with arabic numerals. Graphics may be supplied in colour to facilitate their appearance on the online database. • Figures created in MS Word, MS PowerPoint, MS Excel, Illustrator should be supplied in their native formats. Electronic figures created in other applications should be copied from the origination software and pasted into a blank MS Word document or saved and imported into an MS Word document or alternatively create a .pdf file from the origination software. • Figures which cannot be supplied as above are acceptable in the standard image formats which are: .pdf, .ai, and .eps. If you are unable to supply graphics in these formats then please ensure they are .tif, .jpeg, or .bmp at a resolution of at least 300dpi and at least 10cm wide. • To prepare web pages/screenshots simultaneously press the "Alt" and "Print screen" keys on the keyboard, open a blank Microsoft Word document and simultaneously press "Ctrl" and "V" to paste the image. (Capture all the contents/windows on the computer screen to paste into MS Word, by simultaneously pressing "Ctrl" and "Print screen".) • Photographic images should be submitted electronically and of high quality. They should be saved as .tif or .jpeg files at a resolution of at least 300dpi and at least 10cm wide. Digital camera settings should be set at the highest resolution/quality possible.
Tables	Tables should be typed and included in a separate file to the main body of the article. The position of each table should be clearly labelled in the body text of article with corresponding labels being clearly shown in the separate file.

	Ensure that any superscripts or asterisks are shown next to the relevant items and have corresponding explanations displayed as footnotes to the table, figure or plate.
References	References to other publications must be in **Harvard** style and carefully checked for completeness, accuracy and consistency. This is very important in an electronic environment because it enables your readers to exploit the Reference Linking facility on the database and link back to the works you have cited through CrossRef You should cite publications in the text: (Adams, 2006) using the first named author's name or (Adams and Brown, 2006) citing both names of two, or (Adams *et al.*, 2006), when there are three or more authors. At the end of the paper a reference list in alphabetical order should be supplied:

Paper Two: Empirical Paper

‘Mental Health Clinicians’ Perceptions of the diagnosis of Bipolar Disorder: A Q-study’

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Words: 7201

PREFACE

This study has been influenced by the researcher’s social constructionist epistemological position. This position argues that each individual creates their own reality through information learned and obtained from observing and interacting with others. Therefore, it suggests that more than one reality can exist. Q-methodology aligns itself well with this epistemological position, aiming to explore subjective viewpoints rather than seeking objective truths (Watts & Stenner, 2012).

Contents

‘Mental Health Clinicians’ Perceptions of the diagnosis of Bipolar Disorder: A Q-study.’

*Purpose***:** Research indicates a marked increase in the number of service users being diagnosed with Bipolar Disorder and that the diagnostic label is being both over and under used in mental health services. Disagreement between clinicians in how the diagnosis of Bipolar Disorder is perceived and how the label is used by services can make it difficult to establish and uphold consistent care. This may lead to the experience of negative emotions for service users and poor engagement with intervention. Therefore, this research aims to explore the perceptions of mental health professionals with the view of providing insight into how this may impact service provision.

*Design***:** Q-methodology was used to investigate the subjective viewpoints of 19 clinicians from Community Mental Health Teams who have experience of working with individuals with a diagnosis of Bipolar Disorder, using statements that had been collected from interviews with clinicians, research literature and internet fora. The completed Q-sorts were subject to analysis using the Q-methodology analysis software.

Findings: Three main factors representing the viewpoints of participants were identified: (1) Seeing the person and their experience, (2) Promoting quality through standardised processes and (3) Understanding the function of diagnostic labels. All three factors agreed that more than one assessment appointment was required before a diagnosis of Bipolar Disorder was given and that the focus should be on the difficulties experienced rather than the diagnostic label.

Value: These three viewpoints provide different perspectives of the diagnosis of Bipolar Disorder which are likely to impact on service provision. Services may benefit from a better integration of the viewpoints, noting the important functions of each viewpoint and being guided by individuals’ needs.

Keywords: Bipolar Disorder, Mental Health, Diagnosis, Diagnostic criteria, Q-methodology

INTRODUCTION

For many years there has been disagreement between professionals in the way that they conceptualise mental health difficulties. Medical models of mental health advocate that psychiatric difficulties result from a disease or abnormality of the brain (Andreasen, 1985), promote the use of discrete diagnostic criteria, and prescribe medication in a similar way to physical health (Freeth, 2007). Amongst other things, the medicalisation of mental health offers structure to services by determining ‘care pathways’ to ensure service users receive appropriate support for their difficulties and offers a legitimate name for experiences (Angermeyer & Matschinger, 2003). However, critics of the medical model argue there can be negative connotations to mental health diagnoses (Hinshaw, 2007), that it medicalises ordinary responses to life events (Illich, 2001), and fails to acknowledge the importance of early life experiences, relationships and attachments in the development of difficult or unhelpful behaviours (Engel, 1977).

Psychological models of mental health acknowledge the influence of an individual’s learning on their experience and consider the roles that cognitive and relational development can have on emotion regulation (Kinderman, 2005). Psychological approaches use person-centred formulation to create a shared understanding of the mechanisms underlying difficulties (Johnstone, 2008) in a bid to improve understanding of mental health problems as responses to challenging life events (British Psychological Society, BPS, 2011; Johnstone, 2017; Johnstone & Boyle, 2018). By doing this, individuals become more able to understand the origin of their difficulties and feel empowered to make change (Macneil, Hasty, Conus, et al. 2012). However, contextual factors such as poverty, environmental issues and lack of social support can prove to be a barrier to change (Lorant, Deliege, Eaton, et al. 2003), despite increased awareness of the impact of factors on mental health. Furthermore, the creation of a formulation is highly individualised and requires clinicians with specialist core skills (BPS, 2011).

These varying ideas about the conceptualisation of mental health are brought into focus over the issue of psychiatric diagnosis. A recent review of the literature on service users' perceptions of psychiatric diagnosis concluded that individual differences heavily impact on how diagnoses are perceived and understood. Some service users experience feelings of hope (Bilderbeck, Saunders, Price, et al. 2014), relief (Proudfoot, Barker, Benoit, et al. 2009) and validation (Delmas, Proudfoot, Parker, et al. 2011) when given a diagnostic label, whilst others experienced distress (Hayne, 2003), anger (Proudfoot et al. 2009) and fear (Cleary et al. 2010). Diagnosis was viewed more positively if it facilitated access to treatment (Inder et al. 2010; Milton & Mullan, 2016). Being given the choice on whether to be told their diagnosis (Cleary, Hunt, Escott et al. 2010) and how the diagnosis was communicated (Pitt, Kilbride, Welford, et al. 2009) were also defining factors in service users' attitudes towards medical style diagnosis.

The mental health difficulty conceptualised as 'Bipolar Disorder' has recently attracted significant attention in contemporary literature. The American Psychiatric Association (APA; 2013) suggest Bipolar Disorder is a psychiatric diagnosis characterised by alternating moods between two extreme states: depression and elation (APA, 2013). It was recently advised that Bipolar Disorder should be categorised separately to other mood disorders and that it existed on a spectrum (APA, 2013); a move welcomed by many clinicians (Akiskal, 2005; Angst, Cui, Swendsen, et al. 2010). New subtypes have also recently been added in a bid to account for the variation in service user presentation that is classified as Bipolar Disorder (Stratowski, Fleck & Maj, 2011; APA, 2013).

There has been a marked increase in the number of service users being diagnosed with Bipolar Disorder in recent years (Mitchell, 2012), but the reasons for this remain unclear. This could result from increased prevalence of difficulties associated with the label, increased media recognition or due to alterations in the diagnostic criteria (Ghouse, Sanches, Zunta-Soares, et al. 2013). The difficulties are seen to have a significant negative impact on daily functioning and quality of life (Martinez-Aran, Vieta, Torrent, et al. 2007). Furthermore, it can negatively impact an individual's physical health and decrease life expectancy (Kilbourne, Cornelius, Han, et al. 2004). Bipolar Disorder is thought to have cost the UK economy £2 billion through direct physical and psychiatric healthcare provision and indirect costs such as missed work days (Das-Gupta & Guest, 2008).

The research literature relating to the increase in diagnosis is sharply divided. Some research suggests that Bipolar Disorder is currently being under-diagnosed in clinical settings (Angst, Cui, Swendsen, et al. 2010), and that accurate diagnosis can take on average 7.5 years (Ghaemi, Boiman & Goodwin, 2000) with numerous other diagnoses being given first such as Borderline Personality Disorder and Depression (Bruchmuller & Meyer, 2009), demonstrating the inaccuracy of diagnosis in mental health. The consequences of this delay are significant: potential delay in access to mood stabilising medication (Zimmerman, 2011), unnecessary damage to physical health resulting from redundant psychiatric medication (Severus & Bauer, 2014), longer hospitalisation (Gonzalez-Pinto, Gutierrez, Mosquera, et al. 1998) and increased psychosocial impairment (Goldberg & Ernst, 2002). Failing to access support for difficulties associated with Bipolar Disorder is also linked to increased risk of attempted and successful suicide (Gonda, Pompili, Serafini, et al. 2012). The cost of under-diagnosis of Bipolar Disorder on mental health services is also substantial; including increased cost of care (Ghaemi, Bioman & Goodwin, 2000) and increased demand on crisis services that accompanies increased suicide attempts (Gonda, Pompili, Serafini, et al. 2012).

In contrast, an equally significant amount of research suggests that the diagnosis of Bipolar Disorder is currently being over-used (Ghouse, Sanches, Zunta-Soares, et al. 2013; Zimmerman, 2011; Zimmerman, Ruggero, Chelminski & Young, 2008), and that the recent alteration in the diagnostic criteria have contributed to many false positives (Zimmerman, 2011). Furthermore, this could be due to clinicians providing a diagnosis without sufficient information to fully understand service users' experience or based on retrospective qualitative information provided by service users rather than direct observation of difficulties (Zimmerman, 2012). Over-diagnosing Bipolar Disorder puts service users at increased risk of stigma and social labelling (Ghouse, Sanches, Zunta-Soares, et al. 2013), and harm to physical health resulting from needless medication (Singh & Rajput, 2006). Stratowski, Fleck and Maj (2011) highlight that the reliance on the diagnosis of Bipolar Disorder may lead to missed recognition of other mental health difficulties. Over-diagnosis is also likely to increase demand on mental health services through increased referrals, poor response to intervention and inappropriate distribution of resources. These factors, amongst others, are thought to contribute to burnout and work-related stress in mental health professionals (Edwards, Burnard, Coyle, et al. 2000).

Disagreement over how the mental health difficulty is conceptualised can lead to differences in the way interventions are operationalised (Timimi, 2014) and make it difficult to uphold high standards of care. Ensuring that care reflects the service user's needs and preferences, and that clinician's work together to facilitate recovery as understood by the service user is needed when supporting individuals presenting with Bipolar Disorder (Hummelvoll & Severinsson, 2002). Without this, intervention can feel unpredictable and fragmented, and service users can experience feelings of confusion and insecurity (Hummelvoll & Severinsson, 2002). Inconsistency in the communication surrounding diagnosis between professionals can also negatively impact the therapeutic relationship, result in reduced engagement with medication and reduce responses to intervention (George, McCray, Negatu, et al. 2016; Dziopa & Ahern, 2009).

Research, therefore, demonstrates clear inconsistencies in the way that Bipolar Disorder is understood by mental health clinicians and how the diagnostic label can be used in mental health services. The diagnostic label is a key factor that can impact individuals' access to and perception of services, their view of their recovery and the approaches taken by clinicians. These differences could negatively impact on the quality and consistency of care for service users. It seems important to examine whether there are significant differences in the way that clinicians understand the diagnosis of Bipolar Disorder in clinical practice. The aim of this research, therefore, is to explore the different perceptions of the diagnosis of Bipolar Disorder held by mental health clinicians in order to identify whether clinical practice mirrors the research literature. This may then provide insight into the potential impact on service provision and the continuity of care.

METHOD

Research Approval

Ethical approval was granted by Staffordshire University (Appendix 2) and the Health Research Authority (Appendix 3). Local permission was also granted by a local Research and Development team (Appendix 4) for recruitment and conduct of the research.

Design

Due to there being no accessible opportunity for the researcher to consult service users directly prior to the development and approval of research, perceptions of psychiatric diagnosis and the approach taken by services was informally discussed with carers at a local carer support meeting. From these discussions, it became clear that a design which explored subjective viewpoints whilst giving means of quantifying the relationships between them would be most appropriate for this study. Q-methodology is suitable for this purpose due to its focus on subjectivity (Watts & Stenner, 2012). Q-methodology attempts to understand a topic by quantifying participants' internal frame of reference (Corr, 2001) and sees each participant as a variable. Instead of striving for the external, practical and generalisable truth (Cross, 2005), individual opinions are compared for the meaning they portray around a chosen topic (Valenta & Wigger, 1997). The perspectives can then be quantified into a smaller number of common factors. This process combines qualitative and quantitative methods to ensure that the importance of subjectivity is not lost and that less dominant voices are heard (Watts & Stenner, 2012).

Participants

The sample consisted of clinicians working in Community Mental Health Teams across the West Midlands in the United Kingdom. Participants were required to be working within a National Health Service (NHS) community team that supports individuals with their mental health at the time of research. Participants were also required to have worked with at least five service users with a diagnosis of Bipolar Disorder during their career as, following discussion with the research team, it was felt that this would ensure participants had sufficient knowledge and beliefs about Bipolar Disorder to rank the statements in the Q-sort.

The study comprised of clinicians working in a secondary care community mental health team that was split into three different arms called pathways; the ‘psychosis pathway’ that supports service users with any difficulty associated with psychosis, the ‘non-psychosis pathway’ designed for service users with mental health difficulties such as anxiety and depression, and the ‘intensive life skills’ pathway that supports service users presenting with complex relational or personality difficulties. Participants were also recruited from other services such as psychiatric liaison and social inclusion. Participants were not able to take part in the research if they had been diagnosed with Bipolar Disorder themselves or if an immediate family member had been given the diagnosis due to the difficulties separating personal and occupational viewpoints.

Participants from a wide range of different professions were recruited for this research to ensure a variety of perspectives and backgrounds were included. Contrary to other research methods that strive for homogenous samples, Q-methodology attempts to explore the subjective perspective of all individuals who may have an opinion on the topic and therefore requires a balanced and unbiased sample (Watts & Stenner, 2012). A purposive sample was recruited through advertisements on NHS Trust intranet sites and posters placed in NHS Trust locations (Appendix 5). The researcher also approached managers of community teams and gave information about the research during team meetings. Moreover, participants were recruited via a snowball sampling method, in which participants' interest was drawn to the research by team members who had already taken part.

Table 1: Sample Details

Gender	
Male	6
Female	13
Job Title	
Community Psychiatric Nurse	5
Clinical Psychologist	2
Trainee Clinical Psychologist	3
Occupational Therapist	2
Healthcare Support Worker (HCSW)	2
Support, Time & Recovery Worker (STR)	1
Nurse Practitioner	2
Wellbeing Practitioner	1
Social Inclusion Worker	1
Teams	
Non-psychosis pathway	5
Psychosis pathway	9
Intensive Life skills	1
Psychiatric Liaison	2
Community Primary Care	1
Social Inclusion	1

The sample consisted of 19 staff members from various professions within the Community Mental Health Teams (n=19), who each completed one Q-sort. Characteristics of the sample can be seen in Table 1.

Procedure

Q-methodology is made up of two stages of data collection; the first being the creation of the concourse, a collection of relevant statements through interviews and literature searches and the second focusing on the ranking of the statements on a scale between two polarised opinions.

Stage 1 – developing the concourse

In Q-methodology, a concourse is a broad range of statements relating to the chosen topic and represents a fundamental part of the methodology (van Exel & Graaf, 2005). Statements are collected from a variety of sources to ensure a wide range of opinions are represented (Stephenson, 1953). In this case, the lead researcher collected statements from individual interviews with three clinicians: A Community Psychiatric Nurse, an Occupational Therapist and a Healthcare Support Worker, who all worked in mental health services, to provide viewpoints from a clinical perspective (Appendix 6). Statements were also gathered from an extensive literature search using both peer reviewed and grey literature, reviews of relevant media stories such as news reports and television programmes, and from exploration of discussion threads on service user internet forums that were focused on Bipolar Disorder.

Due to the exploratory nature of this research, statements were collected using an inductive approach and were based on the emerging themes from the data collected rather than using a theory driven, deductive approach. This resulted in 78 statements encompassing different aspects of the Bipolar Disorder diagnosis. Duplicate or ambiguous statements were removed, leaving a total of 51 statements which were thought to represent all the themes derived from the search. These statements were reviewed by the research supervisor and peers familiar with the methodology. This led to the removal of one statement and the amendments to the wording in three others. The final list of 50 statements formed the concourse (Appendix 7). Each statement was printed on a small individual card, numbered and laminated.

Stage 2 – Completion of the Q-sort

Participants met with the researcher individually in a quiet, confidential space on NHS Trust premises. Prior to completion, participants were asked to read the information sheet provided (Appendix 8) and if they were happy to take part then to sign the consent form (Appendix 9). Participants were asked to read each statement card and asked to allocate the card to one of three piles: ‘agree’, ‘neutral’ or ‘disagree.’

Following this, participants were asked to rate their statement cards by placing them onto the Q-grid, a continuum grid which is set out along a normal distribution curve from ‘Most Agree’ (+6) to ‘Most Disagree’ (-6) (Figure 1). They were encouraged to start with either extreme of the grid by selecting the statement from the corresponding pile that they felt most strongly about and then fill the remaining boxes on the grid based on their opinion until they had used all their cards in that pile. They were then asked to repeat this process with the remaining piles of cards until they had completed the Q-sort.

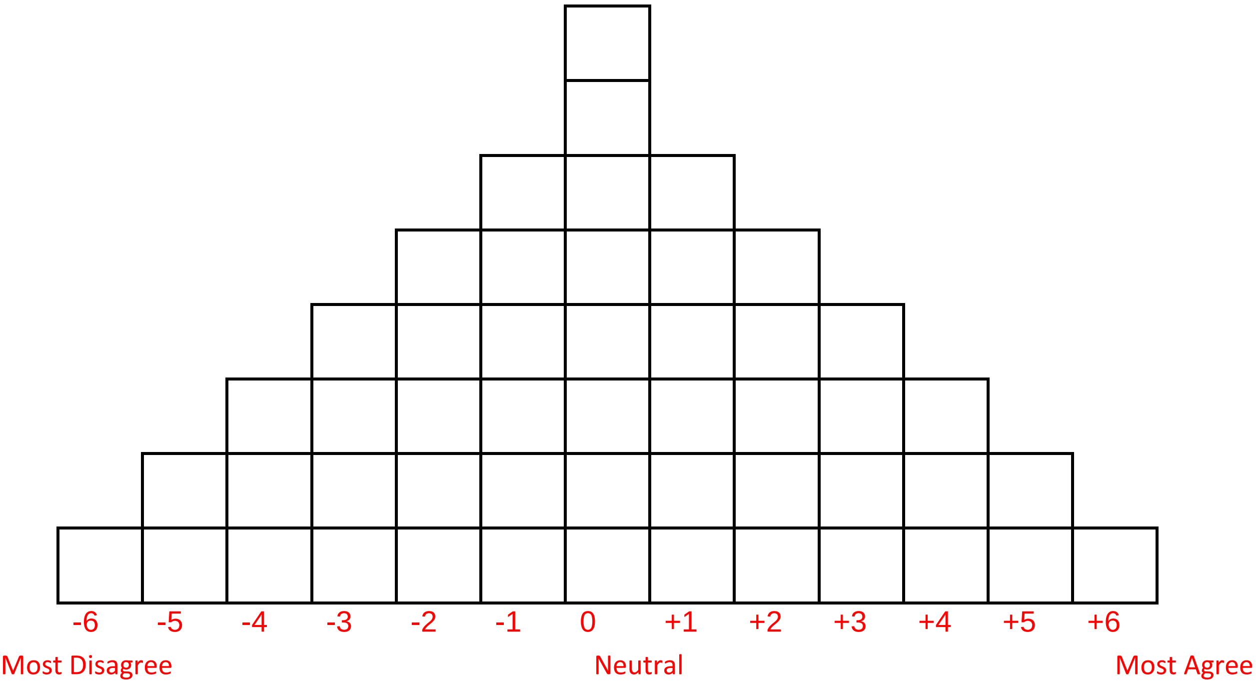

Figure 1: Blank Q-grid Template 1

This was a forced-choice exercise which prevented participants from allocating two cards to the same box or placing cards outside of the grid. When all the statements had been placed, participants were asked to comment on statements which they believed to be of significance and reflect on the reasons they had allocated them to that value. Responses were recorded on a dictaphone or noted down by the researcher to aid in analysis interpretation. Upon completion of this stage, the researcher noted the card numbers placed in each box on a blank Q-grid.

RESULTS

Analysis

The 50 statements obtained in stage 1 of the research and the 19 completed Q-sorts from stage 2 were entered into specific Q-methodology analysis software, Ken-Q (version 0.11.1. Banasick, 2018). The correlations between participants' completed Q-sorts were calculated (Table 2) as preliminary indications of relationships between Q-sorts (Howitt & Cramer, 2011). A significant correlation value was deemed to be ≥0.28 based on guidance from Brown (1980) using the formula: $p<0.05 = 1.96 \times (1/\sqrt{50})$. The table demonstrates that all Q-sorts significantly correlated with at least one other, showing an element of similarity.

Factor Analysis was then completed using the Ken-Q software (Banasick, 2018). Factor analysis is a way of identifying intervening variables that can explain relationships between large sets of data (Coolican, 2009). Patterns and themes can then be recognised through the reduction of a large number of variables into prominent factors (Howitt & Cramer, 2011). When applied to Q-methodology, factor analysis presents the main viewpoints (factors) that represent the completed Q-sorts (Stephenson, 1953). Centroid factor analysis was used to explore the number of factors present within this dataset. This identified 7 potential factors (Table 3).

Table 2: Correlation Matrix

	P1	**P2**	**P3**	**P4**	**P5**	**P6**	**P7**	**P8**	**P9**	**P10**	**P11**	**P12**	**P13**	**P14**	**P15**	**P16**	**P17**	**P18**	**P19**
P1	1.00	0.58*	0.19	0.11	0.42*	0.40*	0.57*	0.44*	-0.10	0.47*	0.32*	0.38*	0.37*	0.07	0.36*	-0.21	0.56*	0.11	0.53*
P2		1.00	-0.21	0.06	0.22	0.20	0.28*	0.20	-0.16	0.21	-0.01	0.33*	0.02	-0.04	0.01	-0.08	0.61*	0.03	0.42*
P3			1.00	0.33*	0.25	0.15	0.21	-0.03	0.30*	0.00	0.24	0.20	0.37*	0.04	0.28*	0.17	0.08	0.34*	0.05
P4				1.00	0.33*	0.03	0.10	-0.02	0.22	0.18	0.19	0.48*	0.20	0.15	0.17	0.42*	0.05	0.38*	0.05
P5					1.00	0.31*	0.23	0.30*	-0.01	0.51*	0.26	0.30*	0.33*	0.25	0.30*	0.30*	0.29*	0.31*	0.38*
P6						1.00	0.48*	0.24	-0.08	0.41*	0.16	0.12	0.22	0.13	0.45*	0.03	0.49*	0.23	0.58*
P7							1.00	0.45*	0.03	0.34*	0.31*	0.30*	0.23	0.21	0.48*	-0.03	0.35*	0.46*	0.35*
P8								1.00	-0.19	0.36*	0.10	0.19	0.43*	0.38*	0.34*	-0.12	0.26	0.12	0.23
P9									1.00	-0.09	0.07	0.16	0.20	0.17	0.17	0.07	-0.04	0.22	-0.16
P10										1.00	0.32*	0.41*	0.42*	0.16	0.27	0.09	0.41*	0.15	0.46*
P11											1.00	0.32*	0.11	0.18	0.28*	0.12	0.23	0.35*	0.12
P12												1.00	0.25	0.20	0.11	0.34*	0.29*	0.32*	0.27
P13													1.00	0.40*	0.39*	0.03	0.26	0.25	0.03
P14														1.00	0.28*	0.15	-0.04	0.27	-0.19
P15															1.00	-0.04	0.32*	0.25	0.06
P16																1.00	-0.04	0.40*	0.10
P17																	1.00	0.26	0.60*
P18																		1.00	0.09
P19																			1.00

*represents significant correlation using Brown's (1980) formula

Table 3: 7 Factor model

Factor Number	Eigenvalue	% Explained Variance	Cumulative % Explained Variance
1	4.65966	25	25
2	2.06653	11	36
3	1.20997	6	42
4	0.24451	1	43
5	0.88365	5	48
6	0.63224	3	51
7	0.56601	3	54

Eigenvalues give an indication of the statistical strength of a single factor and demonstrate how much variance that factor accounts for (Watts & Stenner, 2012). It is generally accepted that only Eigenvalues above 1 should be of interest (Brown, 1980) which is known as the Kaiser-Guttman criterion (Guttman, 1954; Kaiser, 1960; Kaiser, 1970). Watts and Stenner (2012) further suggest that an acceptable solution would account for between 35-40% of the variance in a model, with the variance accounting for the spread of data (Coolican 2009). According to these criteria, a three-factor model should be extracted here which would account for 42% of the variance. These three factors were then subject to varimax rotation. Table 4 shows the loadings of each Q-sort on to the three extracted factors and the variance explained by each factor after rotation.

Table 4: Factor loadings

Q-sort	Factor 1	Factor 2	Factor 3
1	0.71542	0.00565	0.37947
2	0.67572	0.03016	-0.18721
3	-0.09441	0.37603	0.35462
4	0.04344	0.67248	0.08521
5	0.43215	0.41328	0.27559
6	0.52951	-0.05177	0.3913
7	0.40801	-0.00275	0.63465
8	0.35052	-0.0355	0.37886
9	-0.28244	0.282	0.19793
10	0.52714	0.26014	0.2659
11	0.19783	0.27981	0.28444
12	0.38875	0.57002	0.13423
13	0.17147	0.21689	0.52495
14	-0.08667	0.18211	0.45755
15	0.127	0.05003	0.69332
16	-0.07825	0.59998	-0.07452
17	0.7032	0.01375	0.24912
18	0.05272	0.48412	0.43754
19	0.75393	0.03405	-0.02058
% Explained Variance	18	11	13

Auto-flagging was completed using the Ken-Q software (Banasick, 2018) to highlight the significant Q-sorts for each factor. A significant factor loading was calculated using Brown's (1980) guidance and the equation $p<0.05 = 1.96 \times (1\sqrt{50})$ and is indicated by the shaded boxes. Factor 1 was made up of Q-sorts from participants 1,2,6,10,17 and 19. Factor 2 consists of Q-sorts from participants 3,4,12,16 and 18. Finally Factor 3 is made up of Q-sorts from participants 7,8,13,14 and 15. The Q-sorts completed by Participants 5,9 and 11 did not load significantly on to any of the factors. Some Q-sorts are shown to load on to two of the factors when using Brown's (1980) formula to calculate significance. However, these Q-sorts can be seen to load more highly on to one of the factors, demonstrating that they align themselves more closely to that factor.

Ken-Q analysis uses the data to produce factor arrays which demonstrate the idealised viewpoint of each factor based on the statements that have been rated both positively and negatively (Watts & Stenner, 2012). Factor arrays assist in the data interpretation and explanation of the results (Watts & Stenner, 2012). These can be seen in Appendix 10.

Interpretation

Factor 1: ***Seeing the person and their experience***

Factor 1 accounts for 25% of the variance within this model and has the strongest Eigenvalue of 4.65966. The idealized Q-sort for this factor can be seen in Appendix 14. The completed Q-sorts of six participants loaded significantly on to this factor, including 4 females and 2 males. The six participants included all the qualified and trainee psychologists and one STR worker. Q-sorts loading on to this factor were completed by members of staff from a variety of teams including the psychosis pathway, the intensive life skills pathway, Psychiatric liaison and the non-psychosis pathway.

This factor presents a viewpoint that values person-centred care and the influence of an individual’s life story on their experience linking with Bipolar Disorder. Taking more time to hear about an individual’s experiences and the importance of their presenting difficulties was thought to be imperative. The negative impacts of giving a diagnosis of Bipolar Disorder on an individual, the potential consequences of incorrect diagnosis or lowering the diagnostic threshold also held high importance in these Q-sorts. Q-sorts loading on to this factor suggested that service users should be offered choice as to whether they are told their diagnosis and that it should be considered using a continuum rather than a distinct category. This suggests a more individual approach to the diagnosis of Bipolar Disorder should be taken than the current distinct categories. Furthermore, Q-sorts aligning with this viewpoint agreed that the diagnostic label is used too often in services and that service users are given this label too quickly.

There was significant disagreement that diagnosis should be the first step to accessing services and about the validity of the diagnostic criteria for Bipolar Disorder; qualitative information suggested that services should be based on need rather than a symptom checklist. Q-sorts loading on to this factor also disagreed that diagnosis made difficulties easier to understand for the service user, their families and clinicians. One participant commented that diagnostic labels fail to explain why an individual has the difficulties and does not help them to make sense of their experience – something which they felt was important for service users seeking support from services. Less emphasis was placed on the importance of diagnostic criteria for Bipolar Disorder, the presence of genetic or organic components and the similarity to physical health. Q-sorts in this factor also disagreed that a diagnosis of Bipolar Disorder led to the experience of positive emotions and hope for service users.

Factor 2: ***Promoting quality through standardized processes***

Factor 2 accounts for 11% of the variance within this model and has an Eigenvalue of 2.06653. The ideal Q-sort for this factor can be seen in Appendix 15. The completed Q-sorts of five participants loaded significantly on to this factor, including 1 male and 4 females. Participants completing Q-sorts that loaded on to this factor included a variety of roles including wellbeing practitioner, HCSW, nurse practitioner, community psychiatric nurse and inclusion worker, and came from both the psychosis and non-psychosis pathways, primary care services, Psychiatric liaison and social inclusion and support services.

This factor presents a viewpoint that values structured and standardised processes that work closely with the diagnostic criteria for Bipolar Disorder. Q-sorts in this factor also agreed that service users should have assessments over more than one session and the focus should be on their symptoms rather than the diagnostic label. However, they placed strong importance on the use of up to date and structured diagnostic criteria, the exploration of indicative factors such as genetics or family history, and the similarities between mental health and physical health diagnoses. Statements echoing the diagnostic criteria, such as ‘at least one manic episode is needed for a diagnosis of Bipolar Disorder’ were ranked highly. Q-sorts in this factor also represent a view that agreed that the diagnostic criteria were valid and that service users benefitted from being told their diagnosis through increased hope and understanding. The factor also suggests that using specialist members of staff who have extra training and a standardised assessment or screening process is also important in the diagnosis of Bipolar Disorder.

Q-sorts for this factor demonstrated strong disagreement that depressive episodes were more burdensome for service users experiencing Bipolar Disorder than manic episodes and did not agree that symptoms can be misinterpreted. They also disagreed that the diagnostic label is given too quickly or too often in services, that the diagnostic guidelines were unclear, and that diagnosis is often made based on clinician’s experience rather than the set criteria. Q-sorts also showed that participants felt lowering the diagnostic criteria would not lead to more inaccurate diagnosis. They did, however, suggest that the term ‘Bipolar Disorder’ was not easy to understand for service users and that diagnosis should not be the first step into services. Qualitative responses from participants suggest that having the diagnostic label can prevent service users from getting access to some services, and it should instead be based on the threshold of symptoms that they present with.

Factor 3: ***Understanding the function of diagnostic labels***

Factor 3 accounts for 6% of the variance within this model and has an Eigenvalue of 1.20997. The ideal Q-grid representing this factor can be seen in Appendix 16. The completed Q-sorts of five participants loaded significantly on to this factor, including 2 males and 3 females. This group consisted of Q-sorts completed by members of staff that were all working in the psychosis pathway in a variety of roles: community psychiatric nurse, occupational therapist and nurse practitioner.

The completed Q-sorts in this factor present a viewpoint that focuses on the role of the diagnostic label in service provision, as well as how the label can be used by service users. Statements relating to the difficulties facing services, such as ‘Diagnosing Bipolar Disorder is difficult because it is often comorbid with other mental health difficulties’ and ‘Diagnostic criteria apply well to the real world’ are placed at points of importance on the Q-grid. Similarly, statements relating to the uses of the diagnostic label, such as ‘A diagnosis of Bipolar Disorder allows family members to better understand clients’ difficulties’ and ‘Clients seek a diagnosis of Bipolar Disorder to increase access to disability benefits’ were also distinguishing statements for this factor compared to the other two factors. Q-sorts in this factor agree that services should complete more than one assessment appointment before diagnosing service users and believe that the label is currently being given too quickly and too often in services. There was general agreement that service users benefit from being told their diagnosis and that it assists in the understanding of their difficulties.

Q-sorts in this factor disagreed with the notion that the label was only important for access to treatments and disagreed that service users should be given a choice in being told their diagnosis. Q-sorts in this factor also disagree that the diagnostic label is easy to understand for service users or that if offers them hope but feel that it is easy for clinicians to recognise or distinguish from other mental health difficulties.

Comparison of Factors

The three factors presented viewpoints that acknowledged the important impact of the diagnostic label on the individual and advocate that sufficient time should be allocated to assessment of the service user's difficulties. They also all strongly agree that the focus of services should be on the service user's experience rather than using the diagnostic label. All three factors disagreed that obtaining a diagnosis should be the first step to accessing services.

Non-Significant Q-sorts

Three completed Q-sorts did not significantly load on to any of the factors, demonstrating viewpoints that were different to the other Q-sorts. These were completed by 1 male and 2 females from the psychosis and non-psychosis pathways. This group included 1 occupational therapist, 1 community psychiatric nurse and 1 HCSW. The fact that these Q-sorts loaded similarly on to more than one factor suggested that they do not align themselves closely with any single viewpoints.

Q-sorts completed by participants 5 loaded similarly on to factor 1 and 2 and agreed with the placing of many statements for Factor 1 but suggested that Bipolar Disorder should be diagnosed by specialist members of staff, and that it was as real as a physical health diagnosis. Participant 9 also loaded to a similar extent on factor 1 and 2 but loaded negatively on to factor 1 suggesting a strong opposition with the view that an individual's life experience and individual differences should be used to understand difficulties associated with Bipolar Disorder. The Q-sort completed by participant 9 agreed with the placing of many statements for Factor 2 focusing on the importance of diagnostic categories but felt that obtaining the diagnosis should be the first step to accessing services for service users, acknowledging the benefit of a standardised process. They also disagreed that the diagnostic label can have harmful consequences.

Participant 11’s Q-sort loaded similarly on to factors 2 and 3, presenting agreement with the notion that diagnosis should be the first step to accessing services and for the need for specialised clinicians in the diagnosis of Bipolar Disorder, demonstrating the desire for a structured diagnostic process. However, they disagreed that it was as real as a physical health diagnosis and that it was given too quickly which contradicted the general viewpoint presented in Factor 3.

DISCUSSION

The 19 Q-sorts completed by clinicians working in community settings with service users presenting with difficulties associated with Bipolar Disorder were subject to analysis. This led to the emergence of three main factors: (1) Seeing the person and their experience, (2) Promoting quality through standardised processes and (3) Understanding the function of diagnostic labels. These three factors accounted for 42% of the variance in the completed Q-sorts. All three factors agreed that sufficient time should be taken to complete a thorough assessment prior to diagnosis and that obtaining a diagnosis should not be the priority for new service users. Furthermore, all three factors suggested that the diagnostic label ‘Bipolar Disorder’ is less important than the symptoms experienced by the service user.

The results appeared to mirror the distinct perspectives seen in the literature in relation to diagnosis in mental health. ‘Seeing the person and their experience' appeared to represent a psychological viewpoint by highlighting the importance of a person-centred approach to mental health diagnosis, 'Promoting quality through standardised processes' could be considered to align with a medical viewpoint that can allow for consistent care through predetermined care pathways, and 'Understanding the function of diagnostic labels' focused on the function of diagnostic labels and their use in access to services and support; something that service users have suggested is important (Inder et al. 2010; Milton & Mullan, 2016). The Q-sorts also epitomised the mixed research literature on the use of the diagnostic label 'Bipolar Disorder' in that there was little agreement on whether the diagnostic label was currently over- or under used within services. Despite the apparently polarised positions and the lack of clarity in the literature, three stable and significant factors emerged amongst clinicians who work together in teams. Moreover, the model variance of 42% explained by these three factors was substantial according to the criteria outlined by Watts and Stenner (2012).

The first two factors represent particularly distinct and prominent viewpoints that echo the debate between medical and psychological approaches to mental health. Both approaches can be considered to attempt to facilitate recovery and improve service user's wellbeing. Bowlby (1988) suggests that the nature of early attachments with caregivers provides the base for future relationships with others through the development of an internal working model. Relationships are often considered to be more helpful if there is a sense that the caregiver is available, they are sensitive to feelings and behaviour, and encourage autonomy and choice in a safe and supportive way (Schofield & Beek, 2014). 'Seeing the person and their experience' promotes on the importance of individual relationships; it could be considered that these relationships aim to facilitate feelings of safety for service users, and for clinicians to provide a secure and supportive base from which service users can develop a narrative of their experience and improve their wellbeing (Bucci et al. 2015). The structured approach seen in the second factor, 'Promoting quality through standardised process,' may also aim to increase feelings of safety and security for service users based on consistent availability and the establishment of autonomy, demonstrated through the provision of consistency (Goodwin, 2003), clear structure (Rich, 2006) and transparent boundaries between service users and clinicians (Adshead, 2002).

Person-centred approaches to the diagnosis of Bipolar Disorder, as represented in ‘Seeing the person and their experience’, can be used to create a detailed formulation as a way of explaining difficulties influenced by an individual’s life experiences (Johnstone, 2017; BPS, 2011; Johnstone & Boyle, 2018). This approach to mental health difficulties aligns with the new ‘Power, Threat, Meaning’ framework proposed by the DCP, in which the importance of social context and the operation of power in the development of unhelpful threat responses is noted (DCP, 2018; Johnstone & Boyle, 2018). The operation of power and consequent threat responses can be identified through the creation of a formulation, and patterns of threat responses can be grouped into functional groupings as a way of understanding common experiences (DCP, 2018). Focusing on the individual, their needs and experience would provide service users with a tailored service that was guided by them and supported them to create their own meaning surrounding their experience. Taking this approach to Bipolar Disorder would prevent the over-use of the diagnostic label (Zimmerman et al. 2008) and offer empowerment through choice and control which is shown to positively influence wellbeing (Aggarwal, 2016).

Standardised processes can improve the reliability of the assessments of mental health difficulties (Ventura, Liberman, Green, et al. 1998; Noordgaard, Revsbech, Sæbye et al. 2012), and may prevent the diagnosis of Bipolar Disorder being missed or delayed (Angst, Cui, Swendsen, et al. 2010; Ghaemi, Boiman & Goodwin, 2000). Clinicians may also adopt this structure to help them manage notoriously high caseloads and workload demands that are put upon them in current mental health systems nationally

(Gilburt, 2015). Furthermore, using standardised processes that adhere to the evidence base within mental health care may reassure clinicians that they are offering a good quality service for service users presenting with difficulties associated with Bipolar Disorder, and that everyone receives a similar level of service. Supporting individuals experiencing mental health difficulties can also be challenging or stressful for clinicians providing care (Shapiro, Brown & Biegel, 2007). Using standardised process and maintaining clear boundaries may represent clinicians' need to protect themselves from the emotional burden of caring for individuals with mental health difficulties (Menzies, 1960). This may limit the likelihood of transference, the service users' unconscious repetition of patterns of relating to caregivers, occurring in the therapeutic relationship because sessions have a clear focus and boundaries. This may also reduce clinicians' experience of counter-transference, the emotions experienced by the therapist in response to service users' patterns of relating to others (Johnstone & Dallos, 2006). The experience of counter-transference is thought to contribute to clinician burnout which may lead to reduced outcomes for service users (Marriage & Marriage, 2005; Collins & Long 2003; Menon, Frannigan, Tacchi, et al. 2015).

The final factor, 'Understanding the function of diagnostic labels,' echoes the views of service users that diagnosis is more favourable when it leads to intervention or support (Inder et al. 2010; Milton & Mullan, 2016). There was agreement that the label was used too often in mental health services and highlighted the difficulties services experience in identifying the diagnosis. This may represent a practical approach to managing distress, ensuring clinicians engage in action to reduce the difficulties. This viewpoint may be more prominent for clinicians working alongside individuals with severe and enduring mental health difficulties who face the challenging task of supporting service users into recovery and preventing relapse. The focus on the function may represent clinician's knowledge that service users are likely to suffer long term negative impacts of their difficulties, and may be an attempt to moderate this through finding ways to support the service user.

Despite these three dominant viewpoints being present in the results, the data demonstrated that there were three Q-sorts that did not load on to any of the three factors extracted from the collected data. This could be explained through further exploration of their history of working with individuals presenting with Bipolar Disorder, their experience of working closely with colleagues from medical or psychological standpoints, or their training prior to their current role. It may also be that working with specific service users has influenced their viewpoint on the diagnosis of Bipolar Disorder. Moreover, this could also be due to difficulties understanding the Q-sort process or the individual statements.

Clinical Application

The results of this study suggest that clinicians have different priorities surrounding the diagnosis of Bipolar Disorder. This is likely to impact the way that individuals are assessed and diagnosed and the consequent intervention that they are offered within services. However, they are all united in their motivation to support the recovery of service users presenting with difficulties associated with Bipolar Disorder and each perspective can be seen to have an important function for this. It is therefore recommended that services work towards a better integration of these three viewpoints in clinical practice, resisting the temptation to take polarised perspectives and instead use a consistent approach that can include elements from all three approaches, based on what is most appropriate for the service user.

Clinicians may benefit from acknowledging the differences in their approaches towards the diagnosis of Bipolar Disorder, as well as the differences between each service user presenting to services, and the positive and negative impact the different approaches may have on service users. Furthermore, recognising common ground in person-centred practice and common goals for support, rather than engaging in polarised debate about the diagnosis of Bipolar Disorder may result in more efficient multidisciplinary working. A further key recommendation is also that services allow sufficient time for thorough assessment, rather than providing a diagnosis after a single assessment appointment. Finally, the results here suggest that clinicians and services should look to consider alternative ways of describing and understanding an individual's difficulties rather than relying solely upon diagnosis.

Research Strengths and Limitations

Although the completed Q-sorts offer a detailed view of the participants' perspectives, they can only represent participants' viewpoints at the time they are completed. Individuals' opinions are likely to change over time and in different contexts (Stephenson, 1988), meaning that if participants were to repeat the Q-sorts at a later date, their results could potentially be different. This, therefore, limits the reliability and generalisability of the results presented by Q-methodology. However, as the method's main focus is on subjectivity, qualities such as reliability and generalisability are not main priorities. By focusing on the meaning that participants create at the time of the Q-sort, Q-methodology can present powerful viewpoints that can challenge well-established preconceptions using Q-sorts from a small number of participants (Watts & Stenner, 2012), and ensures that less dominant viewpoints are heard (Stephenson, 1953).

Although participants were recruited from a wide variety of roles within a range of teams, the sample lacked viewpoints from psychiatry - the team members who provide the diagnosis. Psychiatrists embody a powerful position within mental health community teams, as they often hold the ultimate responsibility for service user care and are influential in the construction and development of services. There are various possible explanations for this; for example this may be due to increased pressure on psychiatrists within services to see growing numbers of service users with limited resources, a lack of knowledge and awareness of ongoing psychological research or apprehension about engaging in research on the controversial topic of diagnosis. Without this viewpoint included in the Q-sort, the results can only represent the viewpoint of those working with service users following diagnosis. The inclusion of psychiatry is an important recommendation for future research on this topic. Furthermore, the sample was not screened for information regarding the length of participants’ work experience with people with a diagnosis of Bipolar Disorder or their experience in their role and current team. Those participants who have worked in community teams for a long time may potentially hold different viewpoints to those who are relatively new to working with these service users, and this is likely to result in different viewpoints demonstrated in the Q-sorts. This could have offered useful information for the application of research findings to clinical practice.

The role of the researcher in the development and interpretation of the research is also a potential source of limitation. The selection of the statements that were included in the concourse was completed by the lead researcher and were based on the themes that they felt appeared most prominent. Furthermore, the researcher interpreted the factors extracted from the data and this was likely to be influenced by their own viewpoint. To address this, all relevant statements were taken from numerous sources and the final lists were also reviewed by the research team. The researcher completed her own Q-sort prior to analysis to improve awareness of her own viewpoints and how these may impact on the interpretation of factors.

CONCLUSION

Three main factors were found in this research: seeing the person and their experience, delivering quality through standardised processes and understanding the function of the diagnostic label. The presence of distinct factors that have little overlap is representative of the current literature, identifying that different viewpoints are taken towards the diagnosis of Bipolar Disorder. Services may benefit from integrating the three perspectives; providing care that acknowledges individual experience whilst working closely with the evidence base and giving the service user information that can be used in a practical way to help them move into recovery. Furthermore, findings demonstrate an agreement that assessments should be completed over more than one appointment, and that it is more beneficial for service users when services focus on their experience of symptoms rather than the diagnostic label.

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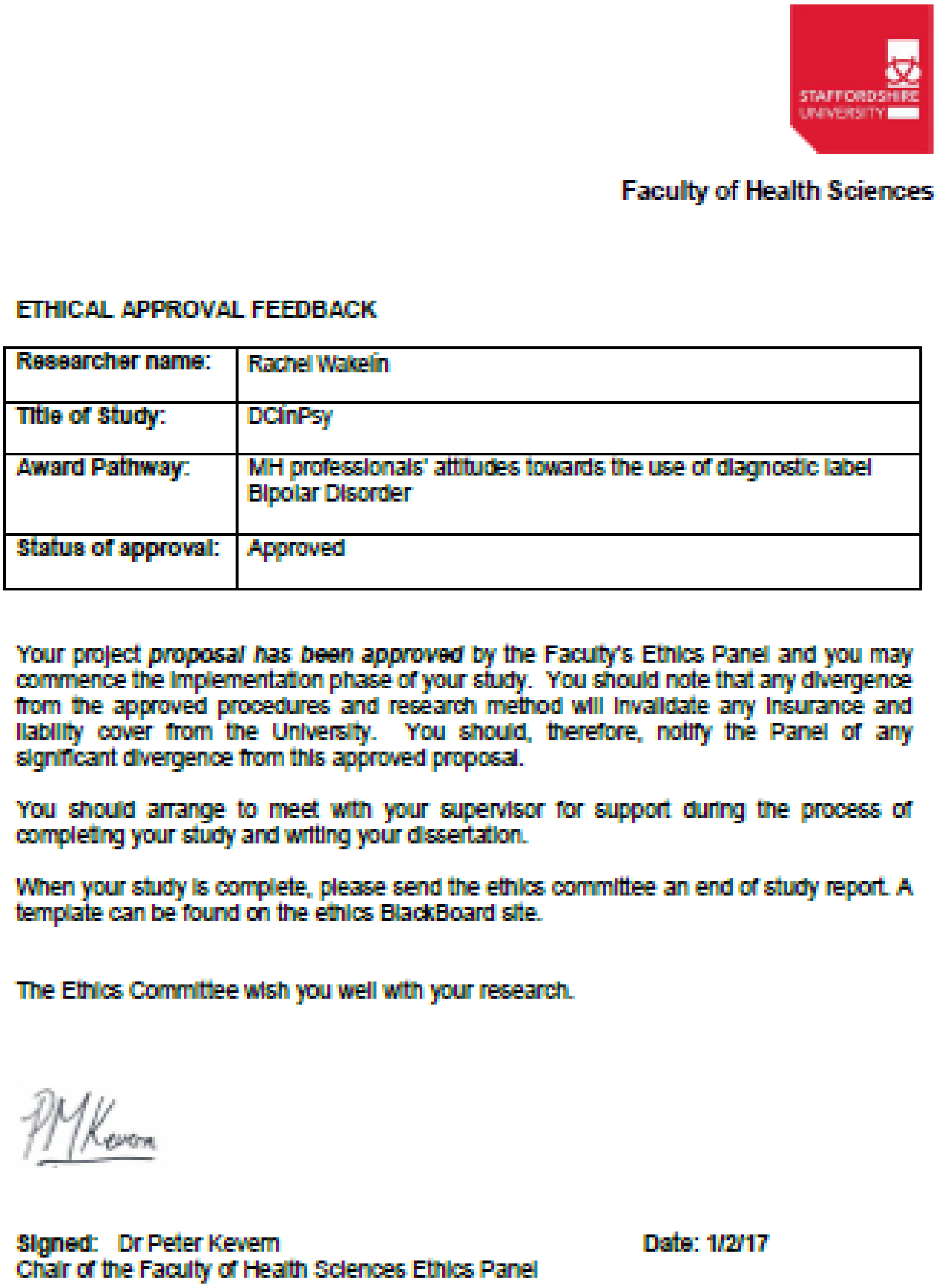
APPENDICES

APPENDIX 1 – Ethical Approval from Staffordshire University



STAFFORDSHIRE UNIVERSITY

Faculty of Health Sciences

ETHICAL APPROVAL FEEDBACK

Researcher name:	Rachel Wakelin
Title of Study:	DClinPsy
Award Pathway:	MH professionals' attitudes towards the use of diagnostic label Bipolar Disorder
Status of approval:	Approved

Your project *proposal has been approved* by the Faculty's Ethics Panel and you may commence the implementation phase of your study. You should note that any divergence from the approved procedures and research method will invalidate any insurance and liability cover from the University. You should, therefore, notify the Panel of any significant divergence from this approved proposal.

You should arrange to meet with your supervisor for support during the process of completing your study and writing your dissertation.

When your study is complete, please send the ethics committee an end of study report. A template can be found on the ethics BlackBoard site.

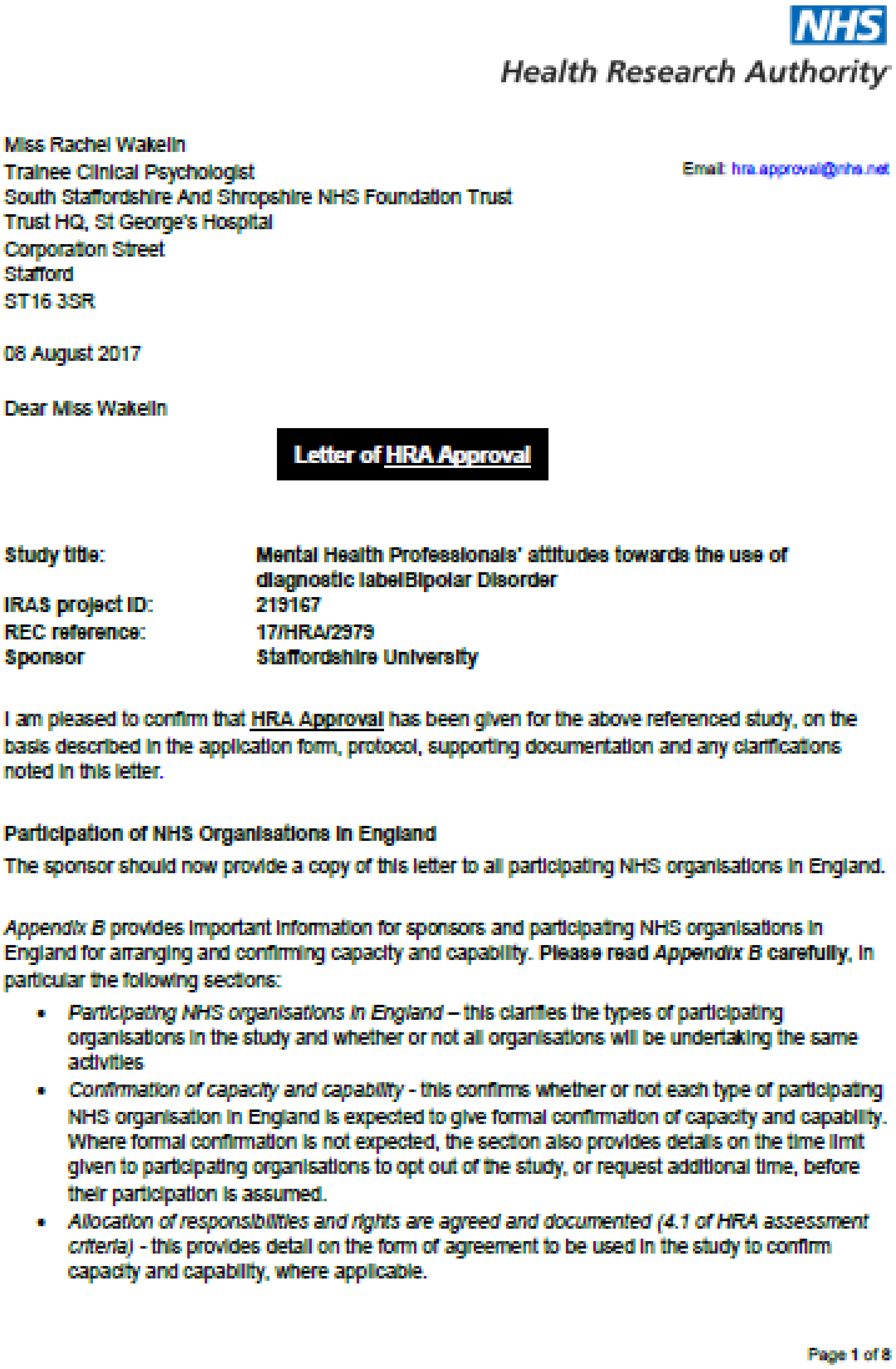
The Ethics Committee wish you well with your research.

PM Kevern

Signed: Dr Peter Kevern
Chair of the Faculty of Health Sciences Ethics Panel

Date: 1/2/17

APPENDIX 2 – Health Research Authority Approval



NHS
Health Research Authority

Miss Rachel Wakelin
Trainee Clinical Psychologist
South Staffordshire And Shropshire NHS Foundation Trust
Trust HQ, St George's Hospital
Corporation Street
Stafford
ST16 3SR

Email: hra.approval@nhs.net

08 August 2017

Dear Miss Wakelin

Letter of HRA Approval

Study title:	**Mental Health Professionals' attitudes towards the use of diagnostic labelBipolar Disorder**
IRAS project ID:	**219167**
REC reference:	**17/HRA/2979**
Sponsor	**Staffordshire University**

I am pleased to confirm that HRA Approval has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications noted in this letter.

Participation of NHS Organisations in England

The sponsor should now provide a copy of this letter to all participating NHS organisations in England.

Appendix B provides important information for sponsors and participating NHS organisations in England for arranging and confirming capacity and capability. **Please read *Appendix B* carefully**, in particular the following sections:

- *Participating NHS organisations in England* – this clarifies the types of participating organisations in the study and whether or not all organisations will be undertaking the same activities
- *Confirmation of capacity and capability* - this confirms whether or not each type of participating NHS organisation in England is expected to give formal confirmation of capacity and capability. Where formal confirmation is not expected, the section also provides details on the time limit given to participating organisations to opt out of the study, or request additional time, before their participation is assumed.
- *Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* - this provides detail on the form of agreement to be used in the study to confirm capacity and capability, where applicable.

Page 1 of 8

Further information on funding, HR processes, and compliance with HRA criteria and standards is also provided.

It is critical that you involve both the research management function (e.g. R&D office) supporting each organisation and the local research team (where there is one) in setting up your study. Contact details and further information about working with the research management function for each organisation can be accessed from www.hra.nhs.uk/hra-approval.

Appendices

The HRA Approval letter contains the following appendices:

- A – List of documents reviewed during HRA assessment
- B – Summary of HRA assessment

After HRA Approval

The attached document *"After HRA Approval – guidance for sponsors and investigators"* gives detailed guidance on reporting expectations for studies with HRA Approval, including:

- Working with organisations hosting the research
- Registration of Research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics and is updated in the light of changes in reporting expectations or procedures.

Scope

HRA Approval provides an approval for research involving patients or staff in NHS organisations in England.

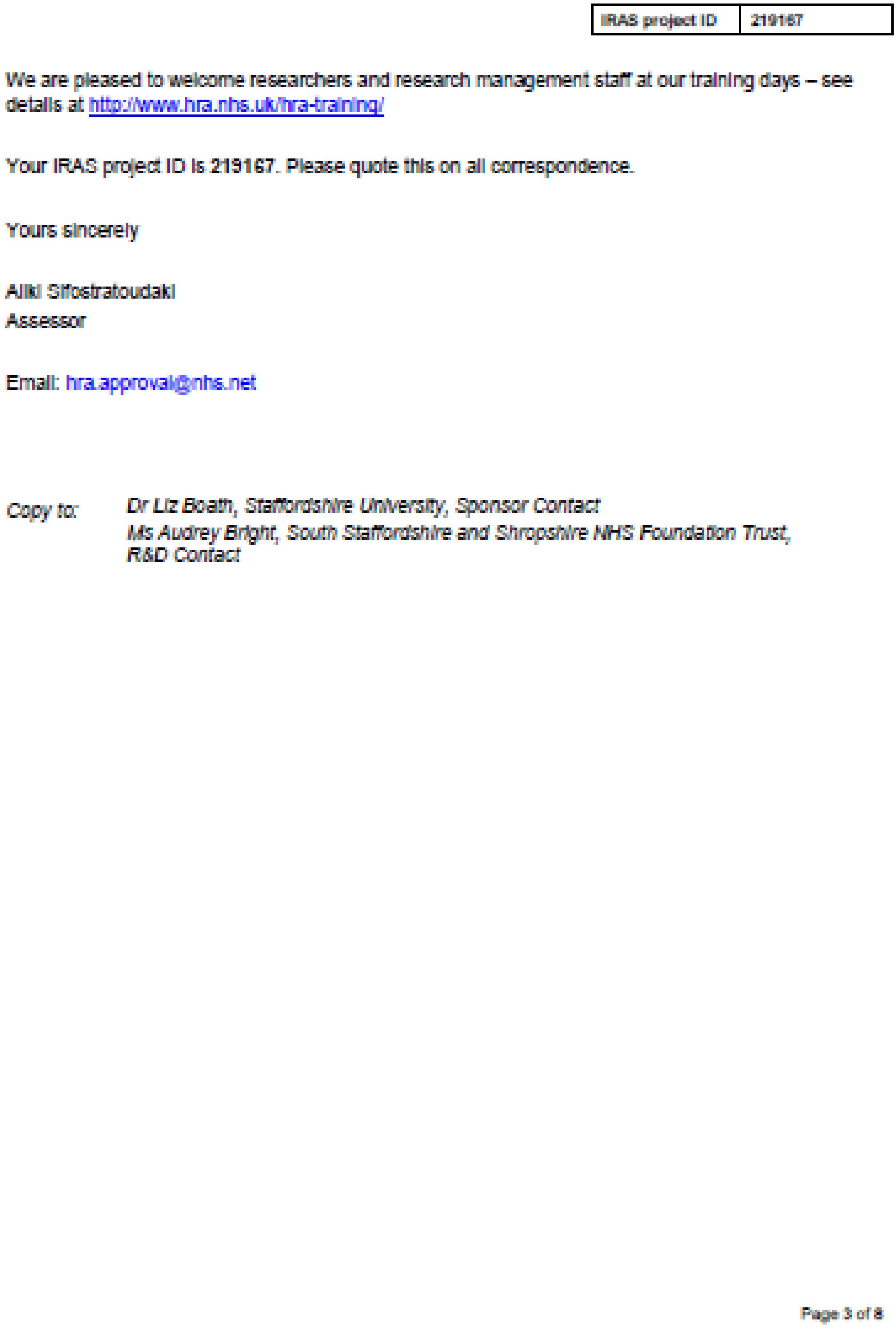
If your study involves NHS organisations in other countries in the UK, please contact the relevant national coordinating functions for support and advice. Further information can be found at http://www.hra.nhs.uk/resources/applying-for-reviews/nhs-hsc-rd-review/.

If there are participating non-NHS organisations, local agreement should be obtained in accordance with the procedures of the local participating non-NHS organisation.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/.

HRA Training



We are pleased to welcome researchers and research management staff at our training days – see details at http://www.hra.nhs.uk/hra-training/

Your IRAS project ID is **219167**. Please quote this on all correspondence.

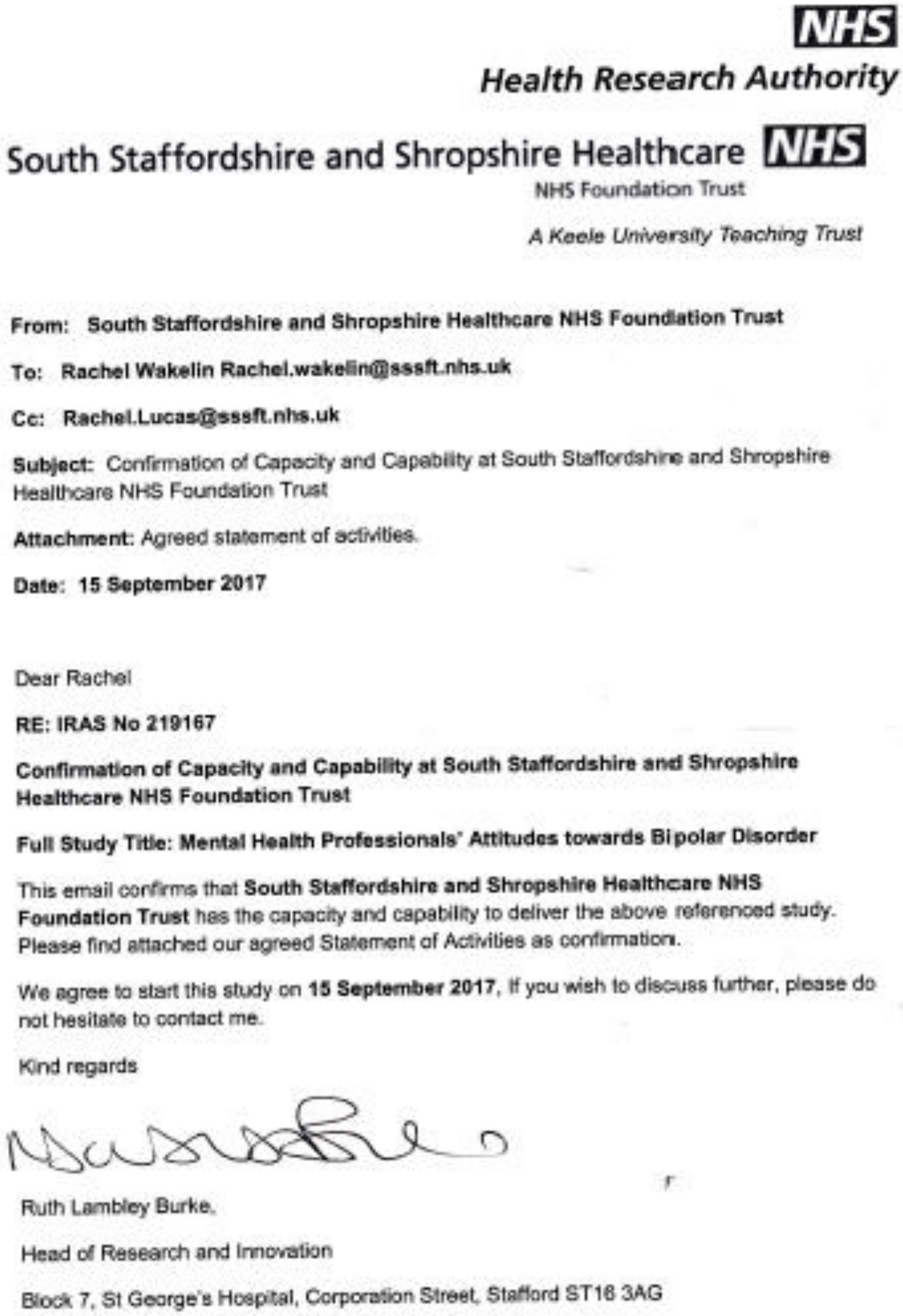
Yours sincerely

Aliki Sifostratoudaki
Assessor

Email: hra.approval@nhs.net

Copy to: *Dr Liz Boath, Staffordshire University, Sponsor Contact*
Ms Audrey Bright, South Staffordshire and Shropshire NHS Foundation Trust, R&D Contact

APPENDIX 3 – Local Approval



NHS
Health Research Authority

South Staffordshire and Shropshire Healthcare NHS
NHS Foundation Trust

A Keele University Teaching Trust

From: **South Staffordshire and Shropshire Healthcare NHS Foundation Trust**

To: **Rachel Wakelin Rachel.wakelin@sssft.nhs.uk**

Cc: **Rachel.Lucas@sssft.nhs.uk**

Subject: Confirmation of Capacity and Capability at South Staffordshire and Shropshire Healthcare NHS Foundation Trust

Attachment: Agreed statement of activities.

Date: **15 September 2017**

Dear Rachel

RE: IRAS No 219167

Confirmation of Capacity and Capability at South Staffordshire and Shropshire Healthcare NHS Foundation Trust

Full Study Title: Mental Health Professionals' Attitudes towards Bipolar Disorder

This email confirms that **South Staffordshire and Shropshire Healthcare NHS Foundation Trust** has the capacity and capability to deliver the above referenced study. Please find attached our agreed Statement of Activities as confirmation.

We agree to start this study on **15 September 2017**, If you wish to discuss further, please do not hesitate to contact me.

Kind regards

Ruth Lambley Burke.

Head of Research and Innovation

Block 7, St George's Hospital, Corporation Street, Stafford ST16 3AG

APPENDIX 4 – Poster Advertisement

Version 1 – Document Date 29/05/2017

Staff members needed for research into Bipolar Disorder!

Do you work in the Community Mental Health Team?
We want to know your thoughts on Bipolar Disorder...

Have you got experience of working with Service Users who have a diagnosis of Bipolar Disorder? We are looking to explore the way Mental Health Professionals view this diagnostic label and the way it is approached in your service.

A variety of different professionals will be asked how much they agree or disagree with a number of statements relating to the diagnosis of Bipolar Disorder in a novel and interesting way. Are you interested?

This research is being run in collaboration with Staffordshire University and South Staffordshire and Shropshire NHS Foundation Trust and has been passed by your Research and Development Team.

Contact Trainee Clinical Psychologist Rachel Wakelin on w027199f@student.staffs.ac.uk for more information

Rachel Wakelin – Research into Bipolar Disorder
W027199f@student.staffs.ac.uk

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APPENDIX 5 – Interview topics, Information Sheet & Consent form

Interview Topics

Version 1 – Document Date 29/05/2017

Interview Topics

Understanding of Bipolar Disorder – what does the diagnostic label mean to them?

What is the process for a client to be diagnosed with Bipolar Disorder in their service?

What impact do they feel receiving this diagnosis has on service users?

What impact do they feel the use of this diagnostic label has on therapeutic relationships with service users?

Have they seen a change in the number of people being given the label during their experience working in the CMHT?

What impact does the use of this diagnostic label have on service provision?

What needs to change? If anything?

South Staffordshire & Shropshire Healthcare NHS
NHS Foundation Trust

STAFFORDSHIRE UNIVERSITY

Version 1
Document date 29/05/2017 IRAS Project ID: **219167**
Participant Information Sheet – Interview

Title of Project: Mental Health Professionals’ attitudes towards the use of diagnostic label Bipolar Disorder

Thank you for your interest in this research!

The aim of this research is to explore Mental Health Professionals’ perception of the use of the diagnostic label ‘Bipolar Disorder’. Research suggests that the use of the diagnostic label for this condition may be controversial and that it may be over- or under-used in current mental health systems. This can lead to feelings of confusion and insecurity for service users along with poorer outcomes following intervention. In order to address this, research suggests that professionals should approach the difficulty from the same perspective and take a united stance towards helping service users. The research is therefore looking to explore what Mental Health Professionals feel is important about the diagnosis and whether there are differences in attitudes towards the use of the diagnostic label. This will then be used to make recommendations for future practice.

In order to take part in this research you must be currently working in a Community Mental Health Team and must have had experience of working with at least five service users who have had the diagnosis of Bipolar Disorder. Unfortunately, you are unable to take part in the research if you or a family member have been given a diagnosis of Bipolar Disorder in the past as it may be difficult to separate personal and work related opinions.

This section of the research would involve completing 20-30 minute interviews on this topic and will be conducted at your team base or Trust Headquarters. If you decide to take part in the research, you will be asked about your thoughts on the use of the label in your experience and how you feel this may impact on service provision and the therapeutic relationships that can be held with service users. The information from these interviews would be used in the second part of this research which asks professionals to rate how much they agree or disagree with a number of statements relating to the Bipolar Disorder diagnosis.

Interviews would be recorded on an encrypted Dictaphone to enable transcription by the researcher and would be stored securely. You would be entitled to stop the interview at any point without giving a reason and are able to request the withdrawal of your data from the research up to two weeks after the date that you completed the interview by contacting the researcher on the details below.

All interviews will be confidential and all identifiable information would be removed or anonymised during transcription. The transcripts would only be seen by the research team but there may be anonymised quotations from the interviews used in the later part of this research. The data collected during interviews will be kept for 10 years once the study has been completed and it will then be destroyed.

When completing the interviews, the research team request that you only disclose information that you feel comfortable and happy to discuss. Furthermore, if any information is disclosed during interviews that suggests imminent or serious risk to service users or staff then it will be escalated to team managers.

Many thanks,

Rachel Wakelin

Trainee Clinical Psychologist

Researcher

W027199f@student.staffs.ac.uk

The nature of this topic may be sensitive or cause individuals to feel stress. If you have been affected by this then please talk this through with the researcher or alternatively speak with your team manager if preferred. Alternatively, you can visit one of the websites listed below that will be able to provide support anonymously.

Talk to the Samaritans – a 24-hour advice line:
08457 909090
http://www.samaritans.org

International Stress Management Association: http://www.isma.org.uk/

ACAS: http://www.ACAS.org.uk/

INTERVIEW CONSENT FORM

South Staffordshire & Shropshire Healthcare NHS
NHS Foundation Trust

STAFFORDSHIRE UNIVERSITY

Version 1

Document Date 29/05/2017 IRAS Project ID: **219167**

Participant Identification Number:

Title of Project: Mental Health Professionals' attitudes towards the use of diagnostic label Bipolar Disorder

Name of Researcher: Rachel Wakelin

Please initial box

1. I confirm that I have read the information sheet dated 29/05/2017 for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am free to discontinue at any time without giving any reason. I understand that I can withdraw my interview data without giving a reason up to 2 weeks following the interview by contacting the researcher. ☐

3. I understand that all information collected during interviews is guaranteed to be kept confidential with these exceptions: ☐
    a. If there is a serious risk of harm to you or to others
    b. If specific criminal offences have been committed (specifically child protection offences, physical abuse of vulnerable adults, money laundering or terrorism-related offences)

4. I agree to take part in the above study. ☐

Name of Participant	Date	Signature
Name of Person Taking consent	Date	Signature

APPENDIX 6 – Statements that make up the Q-set

Statements

1. Focus of services should be on symptoms rather than the diagnostic label of BD

2. BD has a strong genetic component

3. Clients should be told about the likelihood of long term disability resulting from BD during diagnostic feedback

4. A diagnosis of BD is as real as a physical health diagnosis

5. Clinicians underestimate the impact of being told about a diagnosis of BD on clients

6. The term 'BD' is easy for clients to understand

7. The main symptom of BD is alternating mood between mania and depression

8. Depressive episodes are more burdensome for clients with BD than manic episodes

9. Normal improvements in mood are often misinterpreted as manic symptoms

10. Clinicians find it hard to distinguish between mania and hypomania

11. Depressive episodes in BD are more frequent than manic episodes

12. Clients experience distress if they are told they will NOT receive a diagnosis of BD

13. Clients should be told their diagnosis by a doctor or nurse

14. Clients experience negative emotions when they are told they have BD

15. Clients should have a choice in whether they are told their diagnosis of BD

16. Clients benefit from being told their diagnosis

17. Clients should seek information about their diagnosis from outside of services

18. The label of BD is used too often in services

19. Some cognitive impairment should be present for a diagnosis of BD to be made

20. BD is difficult to distinguish from other mental health difficulties

21. BD specialists with extra training should be used for diagnosis

22. First onset of symptoms should be acknowledged when making a diagnosis of BD

23. A screening questionnaire should be used to assist in the diagnosis of BD

24. Diagnosing BD is difficult because it is often comorbid with other mental health difficulties

25. Family history should be considered when making a diagnosis of BD

26. BD is difficult for clinicians to recognise

27. Obtaining a diagnosis should be the first step for new clients accessing services

28. At least one manic episode is needed for a diagnosis of BD

29. Clients should have more than one assessment appointment before receiving a diagnosis of BD

30. A diagnosis of BD is given to clients too quickly

31. Incorrectly diagnosing clients with BD has harmful consequences

32. A BD diagnosis is associated with an increased experience of stigma

33. A diagnosis of BD allows access to treatment

34. A diagnosis of BD can increase hope for clients

35. The diagnostic guidelines for Bipolar Disorder are unclear

36. Diagnostic criteria for BD apply well to the 'real world'

37. A diagnosis of BD negatively impacts a clients' sense of identity

38. Receiving a diagnosis of BD leads to increased positive emotions for clients

39. A diagnosis of BD allows clients to externalise their problems

40. A diagnosis of BD allows family members to better understand clients' difficulties

41. A diagnosis of BD helps clients understand their symptoms

42. A diagnosis of BD helps clinicians understand clients

43. Lowering the symptom threshold for BD will lead to more inaccurate diagnosis

44. A diagnosis of BD is often based on clinician's experience rather than diagnostic guidelines

45. Clients with a diagnosis of BD commonly appear in the media

46. The diagnostic label is only important for access to treatment

47. Clients seek a diagnosis of BD to increase access to disability benefits

48. A diagnosis of BD has many negative social consequences

49. Recent diagnostic criteria should be used to ensure mild symptoms of BD are not missed during diagnosis

50. BD should be considered using a 'continuum' approach

APPENDIX 7 – Participant information sheet Q-set

South Staffordshire & Shropshire Healthcare NHS
NHS Foundation Trust

STAFFORDSHIRE UNIVERSITY

Version 1
Document date 29/05/2017 IRAS Project ID: **219167**
Participant Information Sheet – Q-Sort

Title of Project: Mental Health Professionals' attitudes towards the use of diagnostic label Bipolar Disorder

Thank you for your interest in this research!

The aim of this research is to explore Mental Health Professionals' perception of the use of the diagnostic label 'Bipolar Disorder'. Research suggests that the use of the diagnostic label for this condition may be controversial and that it may be over- or under-used in current mental health systems. This can lead to feelings of confusion and insecurity for service users along with poorer outcomes following intervention. In order to address this, research suggests that professionals should approach the difficulty from the same perspective and take a united stance towards helping service users. The research is therefore looking to explore what Mental Health Professionals feel is important about the diagnosis and whether there are differences in attitudes towards the use of the diagnostic label. This will then be used to make recommendations for future practice.

<u>In order to take part in this research you must be currently working in a Community Mental Health Team and must have had experience of working with at least five service users who have had the diagnosis of Bipolar Disorder.</u> Unfortunately, you are unable to take part in the research if you or a member of your immediate family has been given a diagnosis of Bipolar Disorder in the past.

If you decide to take part in this research, you would be asked to view a number of statements relating to the diagnostic label ‘Bipolar Disorder’ and rate how much you agree or disagree with each statement. You will be asked to place each statement in a grid ranging from ‘Most Agree’ to ‘Most Disagree.’ Once you have rated each statement, the researcher will ask you to comment on any statements that stand-out for you from the selection and why.

This would be completed in a confidential space at your team base or Trust Headquarters and should last approximately 30 minutes. The completed grid would be saved to an encrypted memory stick for analysis. The verbal responses given at the end of the exercise would be recorded on an encrypted Dictaphone to enable transcription by the researcher and would be saved securely. You would be entitled to stop the exercise at any point without giving a reason. You are able to request the withdrawal of your data from the research up to two weeks after the date that you completed the exercise by contacting the researcher on the details below.

All ratings and verbal responses will be confidential and all identifiable information would be removed or anonymised during analysis. Completed grids and transcripts of verbal responses would only be seen by the research team but there may be anonymised quotations used in the write-up of this research. The data collected from this research will be kept for 10 years once the study has been completed and it will then be destroyed.

When completing this exercise, the research team request that you only disclose information that you feel comfortable and happy to discuss. Furthermore, if any information is disclosed during the exercise that suggests imminent or serious risk to service users or staff then it will be escalated to team managers.

Many thanks,

Rachel Wakelin

Trainee Clinical Psychologist

Researcher

W027199f@student.staffs.ac.uk

The nature of this topic may be sensitive or cause individuals to feel stress. If you have been affected by this then please talk this through with the researcher or alternatively speak with your team manager if preferred. Alternatively, you can visit one of the websites listed below that will be able to provide support anonymously.

Talk to the Samaritans – a 24 hour advice line:
08457 909090
http://www.samaritans.org

International Stress Management Association: http://www.isma.org.uk/

ACAS: http://www.ACAS.org.uk/

APPENDIX 8 – Consent form for Q-sort

South Staffordshire & Shropshire Healthcare NHS
NHS Foundation Trust

Version 1
Document Date 29/05/2017 IRAS Project ID: **219167**
Participant Identification Number:
Q-SORT CONSENT FORM

STAFFORDSHIRE UNIVERSITY

Title of Project: Mental Health Professionals' attitudes towards the use of diagnostic label

Bipolar Disorder

Name of Researcher: Rachel Wakelin

Please initial box

1. I confirm that I have read the information sheet dated 29/05/2017 for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am free to discontinue at any time without giving any reason. I understand that I can withdraw my data without giving a reason up to 2 weeks following the date of participation in the research by contacting the researcher. ☐

3. I understand that all information collected during interviews is guaranteed to be kept confidential with these exceptions: ☐
    a. If there is a serious risk of harm to you or to others

b. If specific criminal offences have been committed (specifically child protection offences, physical abuse of vulnerable adults, money laundering or terrorism-related offences) ☐

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

Name of Participant	Date	Signature
Name of Person taking consent	Date	Signature

APPENDIX 9 – Factor Arrays

Statement number	Factor Arrays		
	Factor 1	Factor 2	Factor 3
1	5	5	4
2	-3	4	-2
3	-1	-2	-1
4	-2	5	4
5	4	0	1
6	-3	-5	-5
7	4	0	3
8	0	-6	-3
9	2	-3	-3
10	0	-2	-1
11	0	3	-1
12	0	1	1
13	-4	1	-2
14	-1	-1	-1
15	3	2	-4
16	-1	2	2
17	-2	1	-2
18	3	-2	5
19	-3	-4	-6
20	-1	0	-2
21	0	4	-2
22	1	4	0
23	1	1	0
24	1	0	3
25	0	3	2
26	-1	-1	-3
27	-6	-4	-4
28	3	2	-1
29	6	6	5
30	2	-3	6
31	5	0	3

32	1	0	1
33	0	0	1
34	-2	1	-4
35	-1	-4	0
36	-5	2	-3
37	2	-2	-1
38	-2	-1	-3
39	2	-1	0
40	-4	-1	2
41	-2	3	2
42	-5	1	1
43	4	-3	0
44	1	-3	0
45	0	-2	1
46	1	-1	-5
47	-4	-5	4
48	2	0	0
49	-3	3	0
50	3	2	2

Appendix 10 – z score table for Factor 1

Statement Number	Statement	Z-Score
29	Clients should have more than one assessment appointment before receiving a diagnosis of BD	1.808
31	Incorrectly diagnosing clients with BD has harmful consequences	1.808
1	Focus of services should be on symptoms rather than the diagnostic label of BD	1.612
5	Clinicians underestimate the impact of being told about a diagnosis of BD on clients	1.612
7	The main symptom of BD is alternating mood between mania and depression	1.408
43	Lowering the symptom threshold for BD will lead to more inaccurate diagnosis	1.247
50	BD should be considered using a 'continuum' approach	1.16
15	Clients should have a choice in whether they are told their diagnosis of BD	1.153
18	The label of BD is used too often in services	1.147
28	At least one manic episode is needed for a diagnosis of BD	1.103
30	A diagnosis of BD is given to clients too quickly	0.843
39	A diagnosis of BD allows clients to externalise their problems	0.764
48	A diagnosis of BD has many negative social consequences	0.744
9	Normal improvements in mood are often misinterpreted as manic symptoms	0.717
37	A diagnosis of BD negatively impacts a clients' sense of identity	0.576
44	A diagnosis of BD is often based on clinician's experience rather than diagnostic guidelines	0.487
46	The diagnostic label is only important for access to treatment	0.334

24	Diagnosing BD is difficult because it is often comorbid with other mental health difficulties	**0.324**
22	First onset of symptoms should be acknowledged when making a diagnosis of BD	**0.306**
23	A screening questionnaire should be used to assist in the diagnosis of BD	**0.243**
32	A BD diagnosis is associated with an increased experience of stigma	**0.217**
45	Clients with a diagnosis of BD commonly appear in the media	**0.193**
11	Depressive episodes in BD are more frequent than manic episodes	**0.152**
21	BD specialists with extra training should be used for diagnosis	**0.137**
33	A diagnosis of BD allows access to treatment	**0.054**
10	Clinicians find it hard to distinguish between mania and hypomania	**-0.005**
25	Family history should be considered when making a diagnosis of BD	**-0.016**
8	Depressive episodes are more burdensome for clients with BD than manic episodes	**-0.076**
12	Clients experience distress if they are told they will NOT receive a diagnosis of BD	**-0.191**
3	Clients should be told about the likelihood of long term disability resulting from BD during diagnostic feedback	**-0.263**
16	Clients benefit from being told their diagnosis	**-0.271**
26	BD is difficult for clinicians to recognise	**-0.307**
20	BD is difficult to distinguish from other mental health difficulties	**-0.356**
14	Clients experience negative emotions when they are told they have BD	**-0.409**
35	The diagnostic guidelines for Bipolar Disorder are unclear	**-0.485**
38	Receiving a diagnosis of BD leads to increased positive emotions for clients	**-0.56**
17	Clients should seek information about their diagnosis from outside of services	**-0.658**
34	A diagnosis of BD can increase hope for clients	**-0.693**

41	A diagnosis of BD helps clients understand their symptoms	**-0.748**
4	A diagnosis of BD is as real as a physical health diagnosis	**-0.852**
49	Recent diagnostic criteria should be used to ensure mild symptoms of BD are not missed during diagnosis	**-0.901**
2	BD has a strong genetic component	**-0.99**
19	Some cognitive impairment should be present for a diagnosis of BD to be made	**-1.155**
6	The term 'BD' is easy for clients to understand	**-1.255**
47	Clients seek a diagnosis of BD to increase access to disability benefits	**-1.336**
40	A diagnosis of BD allows family members to better understand clients' difficulties	**-1.397**
13	Clients should be told their diagnosis by a doctor or nurse	**-1.423**
36	Diagnostic criteria for BD apply well to the 'real world'	**-1.698**
42	A diagnosis of BD helps clinicians understand clients	**-2.014**
27	Obtaining a diagnosis should be the first step for new clients accessing services	**-2.089**

Appendix 11: Z score table for Factor 2

Statement Number	Statement	Z-Score
29	Clients should have more than one assessment appointment before receiving a diagnosis of BD	**2.653**
4	A diagnosis of BD is as real as a physical health diagnosis	**2.079**
1	Focus of services should be on symptoms rather than the diagnostic label of BD	**1.847**
22	First onset of symptoms should be acknowledged when making a diagnosis of BD	**1.36**
2	BD has a strong genetic component	**1.345**
21	BD specialists with extra training should be used for diagnosis	**1.289**
25	Family history should be considered when making a diagnosis of BD	**1.161**
11	Depressive episodes in BD are more frequent than manic episodes	**1.006**
49	Recent diagnostic criteria should be used to ensure mild symptoms of BD are not missed during diagnosis	**0.96**
41	A diagnosis of BD helps clients understand their symptoms	**0.891**
50	BD should be considered using a 'continuum' approach	**0.875**
16	Clients benefit from being told their diagnosis	**0.726**
28	At least one manic episode is needed for a diagnosis of BD	**0.623**
36	Diagnostic criteria for BD apply well to the 'real world'	**0.459**
15	Clients should have a choice in whether they are told their diagnosis of BD	**0.406**
13	Clients should be told their diagnosis by a doctor or nurse	**0.389**
23	A screening questionnaire should be used to assist in the diagnosis of BD	**0.372**

34	A diagnosis of BD can increase hope for clients	**0.248**
12	Clients experience distress if they are told they will NOT receive a diagnosis of BD	**0.22**
23	A diagnosis of BD helps clinicians understand clients	**0.17**
17	Clients should seek information about their diagnosis from outside of services	**0.168**
24	Diagnosing BD is difficult because it is often comorbid with other mental health difficulties	**0.058**
33	A diagnosis of BD allows access to treatment	**0.009**
5	Clinicians underestimate the impact of being told about a diagnosis of BD on clients	**-0.04**
20	BD is difficult to distinguish from other mental health difficulties	**-0.043**
31	Incorrectly diagnosing clients with BD has harmful consequences	**-0.077**
7	The main symptom of BD is alternating mood between mania and depression	**-0.089**
48	A diagnosis of BD has many negative social consequences	**-0.222**
32	A BD diagnosis is associated with an increased experience of stigma	**-0.241**
38	Receiving a diagnosis of BD leads to increased positive emotions for clients	**-0.243**
26	BD is difficult for clinicians to recognise	**-0.256**
14	Clients experience negative emotions when they are told they have BD	**-0.276**
39	A diagnosis of BD allows clients to externalise their problems	**-0.277**
46	The diagnostic label is only important for access to treatment	**-0.433**
40	A diagnosis of BD allows family members to better understand clients' difficulties	**-0.449**
45	Clients with a diagnosis of BD commonly appear in the media	**-0.473**
37	A diagnosis of BD negatively impacts a clients' sense of identity	**-0.478**
3	Clients should be told about the likelihood of long term disability resulting from BD during diagnostic feedback	**-0.608**

18	The label of BD is used too often in services	**-0.642**
10	Clinicians find it hard to distinguish between mania and hypomania	**-0.723**
43	Lowering the symptom threshold for BD will lead to more inaccurate diagnosis	**-0.837**
9	Normal improvements in mood are often misinterpreted as manic symptoms	**-0.948**
30	A diagnosis of BD is given to clients too quickly	**-1.143**
44	A diagnosis of BD is often based on clinician's experience rather than diagnostic guidelines	**-1.386**
19	Some cognitive impairment should be present for a diagnosis of BD to be made	**-1.429**
35	The diagnostic guidelines for Bipolar Disorder are unclear	**-1.454**
27	Obtaining a diagnosis should be the first step for new clients accessing services	**-1.46**
6	The term 'BD' is easy for clients to understand	**-1.585**
47	Clients seek a diagnosis of BD to increase access to disability benefits	**-1.685**
8	Depressive episodes are more burdensome for clients with BD than manic episodes	**-1.816**

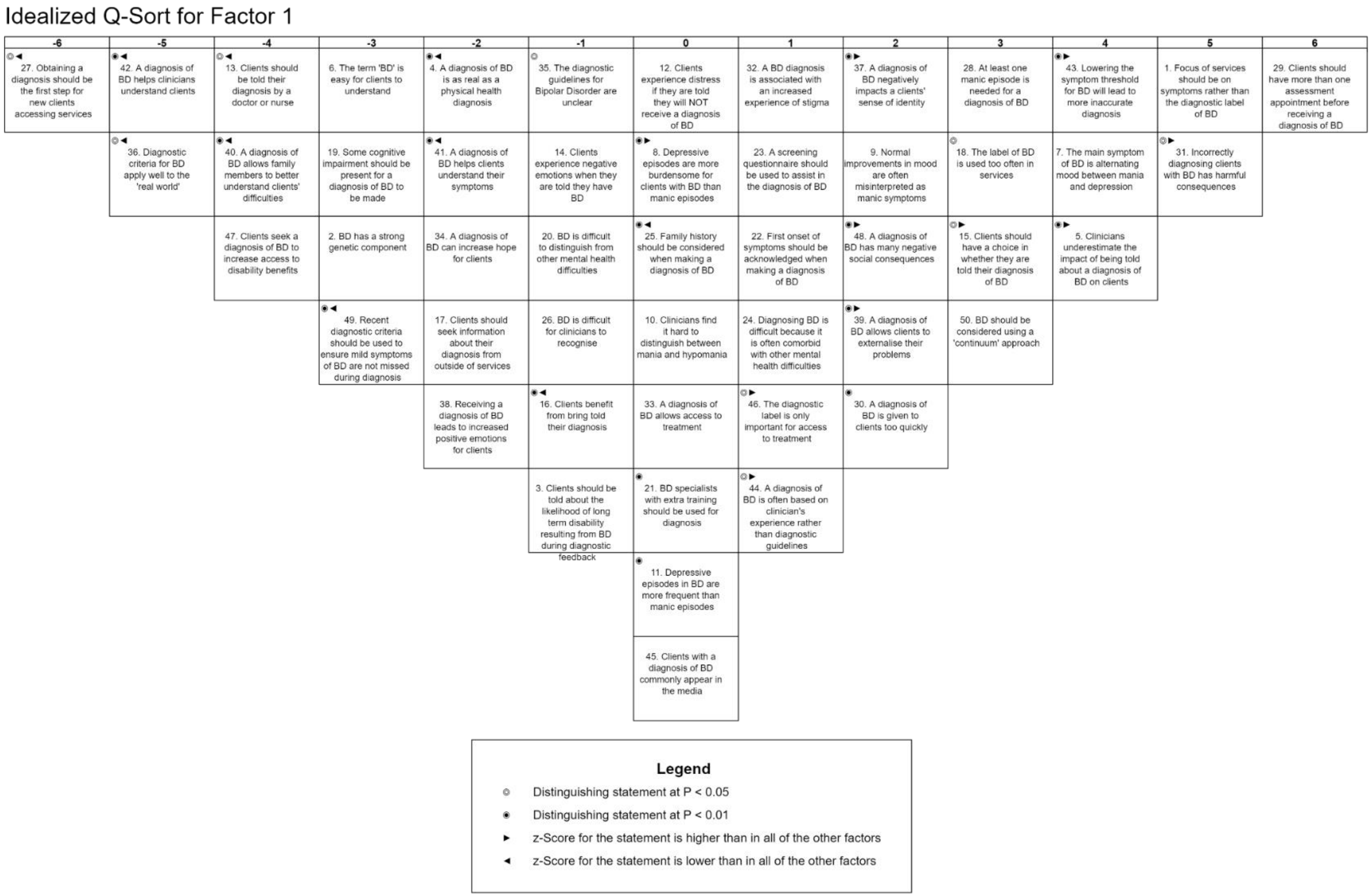
Appendix 12: X scores for Factor 3

Statement Number	Statement	Z-Score
30	A diagnosis of BD is given to clients too quickly	**1.889**
29	Clients should have more than one assessment appointment before receiving a diagnosis of BD	**1.822**
18	The label of BD is used too often in services	**1.789**
1	Focus of services should be on symptoms rather than the diagnostic label of BD	**1.723**
4	A diagnosis of BD is as real as a physical health diagnosis	**1.667**
47	Clients seek a diagnosis of BD to increase access to disability benefits	**1.353**
24	Diagnosing BD is difficult because it is often comorbid with other mental health difficulties	**1.308**
31	Incorrectly diagnosing clients with BD has harmful consequences	**1.15**
7	The main symptom of BD is alternating mood between mania and depression	**1.045**
9	Normal improvements in mood are often misinterpreted as manic symptoms	**1.02**
25	Family history should be considered when making a diagnosis of BD	**0.95**
41	A diagnosis of BD helps clients understand their symptoms	**0.666**
50	BD should be considered using a 'continuum' approach	**0.604**
40	A diagnosis of BD allows family members to better understand clients' difficulties	**0.533**
16	Clients benefit from being told their diagnosis	**0.5**
5	Clinicians underestimate the impact of being told about a diagnosis of BD on clients	**0.411**
33	A diagnosis of BD allows access to treatment	**0.373**

45	Clients with a diagnosis of BD commonly appear in the media	**0.308**
42	A diagnosis of BD helps clinicians understand clients	**0.221**
32	A BD diagnosis is associated with an increased experience of stigma	**0.167**
12	Clients experience distress if they are told they will NOT receive a diagnosis of BD	**0.138**
35	The diagnostic guidelines for Bipolar Disorder are unclear	**0.109**
43	Lowering the symptom threshold for BD will lead to more inaccurate diagnosis	**0.044**
49	Recent diagnostic criteria should be used to ensure mild symptoms of BD are not missed during diagnosis	**0.034**
48	A diagnosis of BD has many negative social consequences	**-0.109**
44	A diagnosis of BD is often based on clinician's experience rather than diagnostic guidelines	**-0.124**
23	A screening questionnaire should be used to assist in the diagnosis of BD	**-0.17**
39	A diagnosis of BD allows clients to externalise their problems	**-0.225**
22	First onset of symptoms should be acknowledged when making a diagnosis of BD	**-0.237**
37	A diagnosis of BD negatively impacts a clients' sense of identity	**-0.237**
14	Clients experience negative emotions when they are told they have BD	**-0.282**
28	At least one manic episode is needed for a diagnosis of BD	**-0.295**
10	Clinicians find it hard to distinguish between mania and hypomania	**-0.31**
3	Clients should be told about the likelihood of long term disability resulting from BD during diagnostic feedback	**-0.467**
11	Depressive episodes in BD are more frequent than manic episodes	**-0.617**
21	BD specialists with extra training should be used for diagnosis	**-0.647**
2	BD has a strong genetic component	**-0.656**
20	BD is difficult to distinguish from other mental health difficulties	**-0.726**

17	Clients should seek information about their diagnosis from outside of services	**-0.786**
13	Clients should be told their diagnosis by a doctor or nurse	**-0.796**
26	BD is difficult for clinicians to recognise	**-0.837**
38	Receiving a diagnosis of BD leads to increased positive emotions for clients	**-0.846**
36	Diagnostic criteria for BD apply well to the 'real world'	**-0.956**
8	Depressive episodes are more burdensome for clients with BD than manic episodes	**-0.985**
34	A diagnosis of BD can increase hope for clients	**-0.985**
27	Obtaining a diagnosis should be the first step for new clients accessing services	**-1.148**
15	Clients should have a choice in whether they are told their diagnosis of BD	**-1.288**
46	The diagnostic label is only important for access to treatment	**-1.82**
6	The term 'BD' is easy for clients to understand	**-2.052**
19	Some cognitive impairment should be present for a diagnosis of BD to be made	**-2.221**

Appendix 13: Idealised Q-sorts Factor 1



Idealized Q-Sort for Factor 1

-6	-5	-4	-3	-2	-1	0	1	2	3	4	5	6
◎◄ 27. Obtaining a diagnosis should be the first step for new clients accessing services	◉◄ 42. A diagnosis of BD helps clinicians understand clients	◎◄ 13. Clients should be told their diagnosis by a doctor or nurse	6. The term 'BD' is easy for clients to understand	◉◄ 4. A diagnosis of BD is as real as a physical health diagnosis	◎ 35. The diagnostic guidelines for Bipolar Disorder are unclear	12. Clients experience distress if they are told they will NOT receive a diagnosis of BD	32. A BD diagnosis is associated with an increased experience of stigma	◉► 37. A diagnosis of BD negatively impacts a clients' sense of identity	28. At least one manic episode is needed for a diagnosis of BD	◉► 43. Lowering the symptom threshold for BD will lead to more inaccurate diagnosis	1. Focus of services should be on symptoms rather than the diagnostic label of BD	29. Clients should have more than one assessment appointment before receiving a diagnosis of BD
	◎◄ 36. Diagnostic criteria for BD apply well to the 'real world'	◉◄ 40. A diagnosis of BD allows family members to better understand clients' difficulties	19. Some cognitive impairment should be present for a diagnosis of BD to be made	◉◄ 41. A diagnosis of BD helps clients understand their symptoms	14. Clients experience negative emotions when they are told they have BD	◉► 8. Depressive episodes are more burdensome for clients with BD than manic episodes	23. A screening questionnaire should be used to assist in the diagnosis of BD	9. Normal improvements in mood are often misinterpreted as manic symptoms	◎ 18. The label of BD is used too often in services	7. The main symptom of BD is alternating mood between mania and depression	◎► 31. Incorrectly diagnosing clients with BD has harmful consequences	
		47. Clients seek a diagnosis of BD to increase access to disability benefits	2. BD has a strong genetic component	34. A diagnosis of BD can increase hope for clients	20. BD is difficult to distinguish from other mental health difficulties	◉◄ 25. Family history should be considered when making a diagnosis of BD	22. First onset of symptoms should be acknowledged when making a diagnosis of BD	◉► 48. A diagnosis of BD has many negative social consequences	◎► 15. Clients should have a choice in whether they are told their diagnosis of BD	◉► 5. Clinicians underestimate the impact of being told about a diagnosis of BD on clients		
			◉◄ 49. Recent diagnostic criteria should be used to ensure mild symptoms of BD are not missed during diagnosis	17. Clients should seek information about their diagnosis from outside of services	26. BD is difficult for clinicians to recognise	10. Clinicians find it hard to distinguish between mania and hypomania	24. Diagnosing BD is difficult because it is often comorbid with other mental health difficulties	◉► 39. A diagnosis of BD allows clients to externalise their problems	50. BD should be considered using a 'continuum' approach			
				38. Receiving a diagnosis of BD leads to increased positive emotions for clients	◉◄ 16. Clients benefit from bring told their diagnosis	33. A diagnosis of BD allows access to treatment	◎► 46. The diagnostic label is only important for access to treatment	◉ 30. A diagnosis of BD is given to clients too quickly				
					3. Clients should be told about the likelihood of long term disability resulting from BD during diagnostic feedback	◉ 21. BD specialists with extra training should be used for diagnosis	◎► 44. A diagnosis of BD is often based on clinician's experience rather than diagnostic guidelines					
						◉ 11. Depressive episodes in BD are more frequent than manic episodes						
						45. Clients with a diagnosis of BD commonly appear in the media						

Legend

◎	Distinguishing statement at P < 0.05
◉	Distinguishing statement at P < 0.01
►	z-Score for the statement is higher than in all of the other factors
◄	z-Score for the statement is lower than in all of the other factors

Appendix 14: Idealised Q-sorts Factor 2

Idealized Q-Sort for Factor 2

-6	-5	-4	-3	-2	-1	0	1	2	3	4	5	6
◉ ◀ 8. Depressive episodes are more burdensome for clients with BD than manic episodes	47. Clients seek a diagnosis of BD to increase access to disability benefits	27. Obtaining a diagnosis should be the first step for new clients accessing services	◉ ◀ 44. A diagnosis of BD is often based on clinician's experience rather than diagnostic guidelines	10. Clinicians find it hard to distinguish between mania and hypomania	◉ 40. A diagnosis of BD allows family members to better understand clients' difficulties	32. A BD diagnosis is associated with an increased experience of stigma	42. A diagnosis of BD helps clinicians understand clients	◎ 15. Clients should have a choice in whether they are told their diagnosis of BD	41. A diagnosis of BD helps clients understand their symptoms	◉ ▶ 21. BD specialists with extra training should be used for diagnosis	1. Focus of services should be on symptoms rather than the diagnostic label of BD	◉ ▶ 29. Clients should have more than one assessment appointment before receiving a diagnosis of BD
	6. The term 'BD' is easy for clients to understand	◉ ◀ 35. The diagnostic guidelines for Bipolar Disorder are unclear	◉ ◀ 30. A diagnosis of BD is given to clients too quickly	◉ ◀ 18. The label of BD is used too often in services	◎ 46. The diagnostic label is only important for access to treatment	48. A diagnosis of BD has many negative social consequences	◉ ▶ 17. Clients should seek information about their diagnosis from outside of services	◉ ▶ 36. Diagnostic criteria for BD apply well to the 'real world'	◉ ▶ 49. Recent diagnostic criteria should be used to ensure mild symptoms of BD are not missed during diagnosis	◉ ▶ 2. BD has a strong genetic component	4. A diagnosis of BD is as real as a physical health diagnosis	
		19. Some cognitive impairment should be present for a diagnosis of BD to be made	◉ ◀ 9. Normal improvements in mood are often misinterpreted as manic symptoms	3. Clients should be told about the likelihood of long term disability resulting from BD during diagnostic	39. A diagnosis of BD allows clients to externalise their problems	◉ ◀ 7. The main symptom of BD is alternating mood between mania and depression	12. Clients experience distress if they are told they will NOT receive a diagnosis of BD	28. At least one manic episode is needed for a diagnosis of BD	◉ ▶ 11. Depressive episodes in BD are more frequent than manic episodes	◉ ▶ 22. First onset of symptoms should be acknowledged when making a diagnosis of BD		
			◉ ◀ 43. Lowering the symptom threshold for BD will lead to more inaccurate diagnosis	37. A diagnosis of BD negatively impacts a clients' sense of identity	14. Clients experience negative emotions when they are told they have BD	◉ ◀ 31. Incorrectly diagnosing clients with BD has harmful consequences	◉ ▶ 34. A diagnosis of BD can increase hope for clients	16. Clients benefit from bring told their diagnosis	25. Family history should be considered when making a diagnosis of BD			
				◎ ◀ 45. Clients with a diagnosis of BD commonly appear in the media	26. BD is difficult for clinicians to recognise	20. BD is difficult to distinguish from other mental health difficulties	23. A screening questionnaire should be used to assist in the diagnosis of BD	50. BD should be considered using a 'continuum' approach				
					38. Receiving a diagnosis of BD leads to increased positive emotions for clients	5. Clinicians underestimate the impact of being told about a diagnosis of BD on clients	◉ ▶ 13. Clients should be told their diagnosis by a doctor or nurse					
						33. A diagnosis of BD allows access to treatment						
						24. Diagnosing BD is difficult because it is often comorbid with other mental health difficulties						

Legend

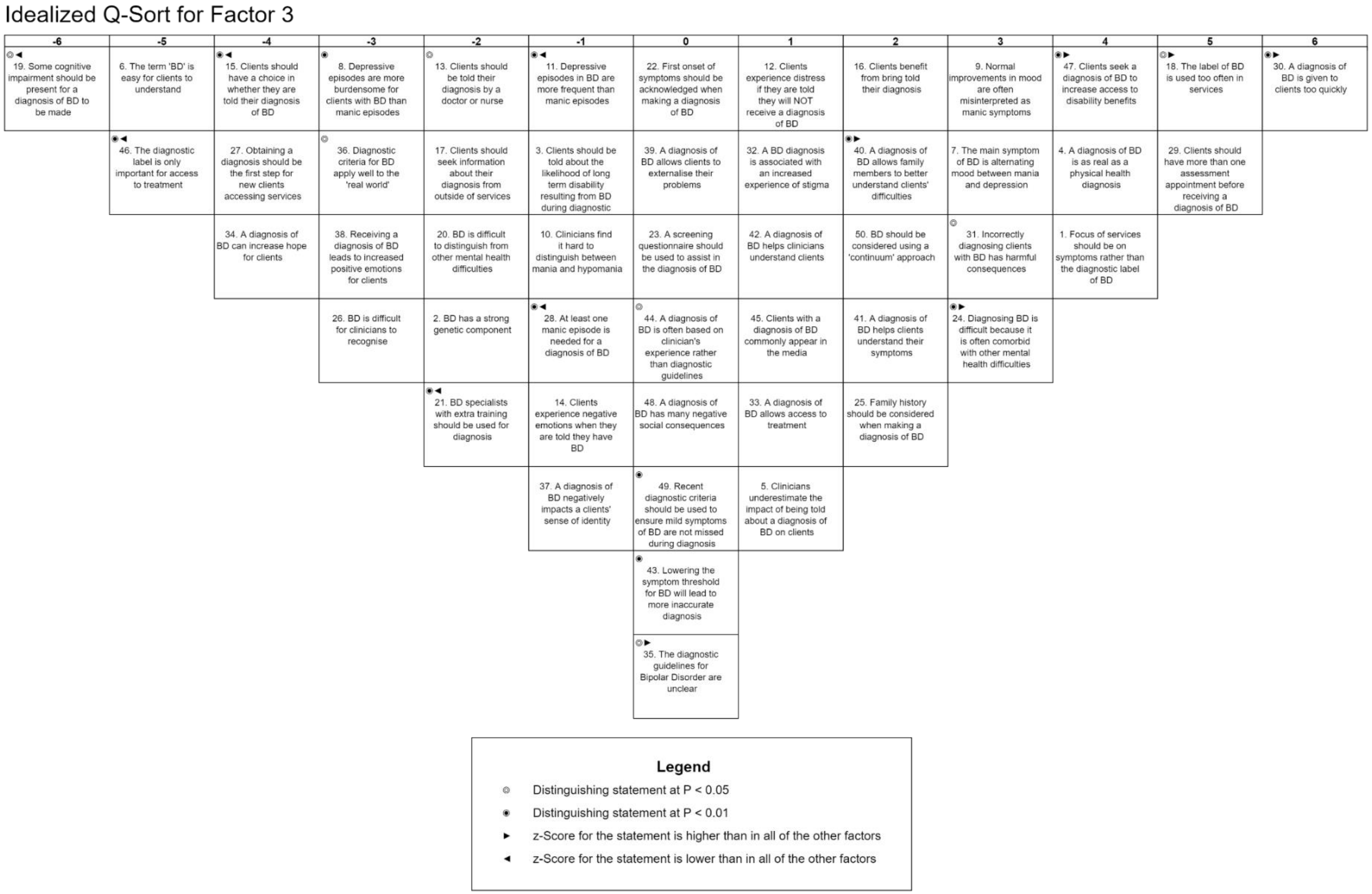
◎ Distinguishing statement at $P < 0.05$

◉ Distinguishing statement at $P < 0.01$

▶ z-Score for the statement is higher than in all of the other factors

◀ z-Score for the statement is lower than in all of the other factors

Appendix 15: Idealised Q-sorts Factor 3



Idealized Q-Sort for Factor 3

-6	-5	-4	-3	-2	-1	0	1	2	3	4	5	6
◎◄ 19. Some cognitive impairment should be present for a diagnosis of BD to be made	6. The term 'BD' is easy for clients to understand	◉◄ 15. Clients should have a choice in whether they are told their diagnosis of BD	◉ 8. Depressive episodes are more burdensome for clients with BD than manic episodes	◎ 13. Clients should be told their diagnosis by a doctor or nurse	◉◄ 11. Depressive episodes in BD are more frequent than manic episodes	22. First onset of symptoms should be acknowledged when making a diagnosis of BD	12. Clients experience distress if they are told they will NOT receive a diagnosis of BD	16. Clients benefit from bring told their diagnosis	9. Normal improvements in mood are often misinterpreted as manic symptoms	◉► 47. Clients seek a diagnosis of BD to increase access to disability benefits	◎► 18. The label of BD is used too often in services	◉► 30. A diagnosis of BD is given to clients too quickly
	◉◄ 46. The diagnostic label is only important for access to treatment	27. Obtaining a diagnosis should be the first step for new clients accessing services	◎ 36. Diagnostic criteria for BD apply well to the 'real world'	17. Clients should seek information about their diagnosis from outside of services	3. Clients should be told about the likelihood of long term disability resulting from BD during diagnostic	39. A diagnosis of BD allows clients to externalise their problems	32. A BD diagnosis is associated with an increased experience of stigma	◉► 40. A diagnosis of BD allows family members to better understand clients' difficulties	7. The main symptom of BD is alternating mood between mania and depression	4. A diagnosis of BD is as real as a physical health diagnosis	29. Clients should have more than one assessment appointment before receiving a diagnosis of BD	
		34. A diagnosis of BD can increase hope for clients	38. Receiving a diagnosis of BD leads to increased positive emotions for clients	20. BD is difficult to distinguish from other mental health difficulties	10. Clinicians find it hard to distinguish between mania and hypomania	23. A screening questionnaire should be used to assist in the diagnosis of BD	42. A diagnosis of BD helps clinicians understand clients	50. BD should be considered using a 'continuum' approach	◎ 31. Incorrectly diagnosing clients with BD has harmful consequences	1. Focus of services should be on symptoms rather than the diagnostic label of BD		
			26. BD is difficult for clinicians to recognise	2. BD has a strong genetic component	◉◄ 28. At least one manic episode is needed for a diagnosis of BD	◎ 44. A diagnosis of BD is often based on clinician's experience rather than diagnostic guidelines	45. Clients with a diagnosis of BD commonly appear in the media	41. A diagnosis of BD helps clients understand their symptoms	◉► 24. Diagnosing BD is difficult because it is often comorbid with other mental health difficulties			
				◉◄ 21. BD specialists with extra training should be used for diagnosis	14. Clients experience negative emotions when they are told they have BD	48. A diagnosis of BD has many negative social consequences	33. A diagnosis of BD allows access to treatment	25. Family history should be considered when making a diagnosis of BD				
					37. A diagnosis of BD negatively impacts a clients' sense of identity	◉ 49. Recent diagnostic criteria should be used to ensure mild symptoms of BD are not missed during diagnosis	5. Clinicians underestimate the impact of being told about a diagnosis of BD on clients					
						◉ 43. Lowering the symptom threshold for BD will lead to more inaccurate diagnosis						
						◎► 35. The diagnostic guidelines for Bipolar Disorder are unclear						

Legend

◎ Distinguishing statement at P < 0.05

◉ Distinguishing statement at P < 0.01

► z-Score for the statement is higher than in all of the other factors

◄ z-Score for the statement is lower than in all of the other factors

Appendix 16: Journal submission guidelines

Journal of Mental Health Training, Education and Practice

Issues for workforce development

Manuscript requirements

Please prepare your manuscript before submission, using the following guidelines:

Format	Article files should be provided in Microsoft Word format. LaTex files can be used if an accompanying PDF document is provided. PDF as a sole file type is not accepted, a PDF must be accompanied by the source file. Acceptable figure file types are listed further below.
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Paper Three: Executive Summary

‘Mental Health Clinicians’ Perceptions of the diagnosis of Bipolar Disorder: A Summary.’

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Words: 2619

Contents

Mental Health Clinicians Perceptions of the diagnosis of Bipolar Disorder: A Q-study

INTRODUCTION

Individuals with a diagnosis of Bipolar Disorder, a mental health difficulty characterised by extreme changes in mood between two polarised mood states, are regularly supported by mental health community teams. There has been a marked increase in the number of people being given a diagnosis of Bipolar Disorder in recent years (1) and the research evidence on the use of the diagnostic label in mental health services is contradictory. To support service users with this diagnosis in the best way, services need to provide consistent, high quality care and approach the difficulties from a unified position (2). Without this, interventions may be less effective and service users are more likely to experience negative emotions (3, 4). This research will therefore explore different mental health clinicians' perceptions of the diagnostic label 'Bipolar Disorder' to identify whether there are any similarities or differences.

Diagnosis in mental health

Diagnosis is widely used in mental health services to design their structure, referral and intervention processes. It is also how mental health services receive funding for their work (5). Despite this, there is a lot of disagreement between clinicians about whether diagnosis should be used to understand mental health difficulties. Clinicians taking a medicalised view of mental health may believe that difficulties arise from mechanisms in the brain not working correctly (6), and suggest that medication should be the dominant form of treatment (7). They are also likely to support the use of diagnostic criteria to ensure service users access the right care. This perspective also gives service users a name for their experience, something that can help them understand and accept what they have been through (8).

Some disagree with this viewpoint, suggesting that it medicalises ordinary responses to traumatic life events (9), leads to increased stigma (10) and does not recognise the influence of childhood experiences and relationships on an individual's difficulties (11). Instead, these clinicians may suggest a psychological standpoint should be taken towards mental health difficulties. They acknowledge the impact that early life experience can have on an individual's ability to recognise and manage emotions (12), and suggest that service users should be supported to develop a better understanding of factors that have led to the difficulties through the creation of a formulation (13), a way of understanding difficulties by exploring likely causes, early influences and current maintaining factors (14). The aim of this is to empower service users to identify and make changes to enable recovery.

Service users struggle to agree on whether diagnostic labels should be used in mental health services. Previous research shows that some service users see diagnosis as instilling feelings of hope (15), relief (16) and validation (17). However, other service users believed that diagnosis led to feelings of fear (18), anger (16) and distress (19). Service users felt more positive about being given a diagnosis if they were offered choice in whether they were told the diagnosis (18) and if it ensured access to treatment (20, 21). Service users further suggested that when they are told their diagnosis, it should be well planned, contain accurate information and give them hope for the future (22, 23).

What is Bipolar Disorder?

Bipolar Disorder is the name given to the mental health difficulty which is characterised by extreme, alternating mood states between depression and elation – a period of abnormally elevated or irritable mood and unusually high and persistent energy levels (24). These difficulties are thought to have a negative impact on the ability to do day to day tasks and overall quality of life (25), as well as decreasing life expectancy (26).

The diagnosis is made using diagnostic criteria set out in approved guidelines and clinicians can use the criteria as a checklist for symptoms (24). The exact reason for the increase in people receiving this diagnosis is not clear – it could be due to increased media coverage, changes in how the diagnosis is given or new guidance on the symptoms that may indicate this diagnosis (10).

Bipolar Disorder in services

The research on the use of the diagnosis in services is sharply divided. Some research suggests that many individuals who fit the criteria for Bipolar Disorder are being missed by services (27) and that it takes too long for a service user to be given this diagnosis (28). This delay in diagnosis can postpone access to intervention (29), meaning individuals remain in inpatient services for longer (30), and are associated with increased risk of suicide (31). On the other hand, an equally significant amount of research suggests that the diagnostic label is being used too often (10, 29, 32). Being given a mental health diagnosis incorrectly can lead service users to experience stigma and social labelling (10) and the prescription of inappropriate medication (33).

As noted earlier, clinicians can hold different views regarding diagnosis in mental health and how it is used, and this is particularly prominent for the diagnosis of Bipolar Disorder. Service users' attitudes towards their diagnosis can also affect how they engage with services and view their recovery. Research demonstrates that service users' with a diagnosis of Bipolar Disorder are best supported when clinicians work together towards a shared goal and use a similar approach (2,4). Maintaining a consistent approach for service users' across all clinicians they see is challenging, as clinicians have varied experiences, goals for recovery and different perspectives view of the foundation of mental health difficulties.

When clinicians are not unified, it can impact on how services are delivered (2) and make it difficult for clinicians to offer consistent, high quality care. Inconsistency in approaches can leave service users feeling confused and hamper intervention (3, 4). Therefore, the aim of this research is to explore clinicians' perspectives of the diagnosis of Bipolar Disorder to identify whether there are any significant differences. This information can then be used to make recommendations for future clinical practice.

METHOD

Q-methodology was the research method chosen for this study. The aim of this method is to understand a topic by gathering a collection of viewpoints from different people and comparing them to identify similarities and differences. By doing this, it ensures that every individual perspective collected is considered equally. Q-method results in a small number of themes that represent views across all the perspectives collected.

Participants

Participants were recruited via poster advertisements, posts on National Health Service (NHS) internal internet pages and talks at team meetings. Participants consisted of 19 clinicians who worked in an NHS mental health community team in the Midlands, United Kingdom. The sample was made up of 6 males and 13 females and included clinicians from multiple roles including community psychiatric nurses, clinical psychologists, occupational therapists and healthcare support workers. Participants were recruited from secondary care community mental health teams, psychiatric liaison and primary care services.

Procedure

Ethical approval was obtained prior to starting the research.

Q-methodology has two distinct stages of collecting data. The first is the creation of a set of statements representing a broad variety of viewpoints. The second stage asks participants to rank each of these statements on a scale from ‘most agree’ to ‘most disagree.’

- Stage 1:
  For the collection of statements, information was taken from interviews with clinicians, the research literature, the media and internet-based service user forums on Bipolar Disorder. The researcher ensured that statements represented a variety of different points of view. The final collection consisted of 50 statements such as, “A diagnosis of Bipolar Disorder is as real as a physical health diagnosis,” “The label of Bipolar Disorder is used too often in services”, and “A diagnosis of Bipolar Disorder helps clinicians understand clients.” Each individual statement was printed on a small card to create a set of flashcards.

- Stage 2:
  Each participant was asked to rate the statements using a triangle shaped grid (Figure 1) from ‘most agree’ to ‘most disagree.’ Participants were asked to place one card in each box based on their own opinion until the grid was complete and all the statements had been included. They were unable to place more than one card in each box, leave any cards out, or place any statements outside of the grid. Once completed, the researcher noted where each participant had placed the cards and entered this information into Q-methodology analysis computer software.

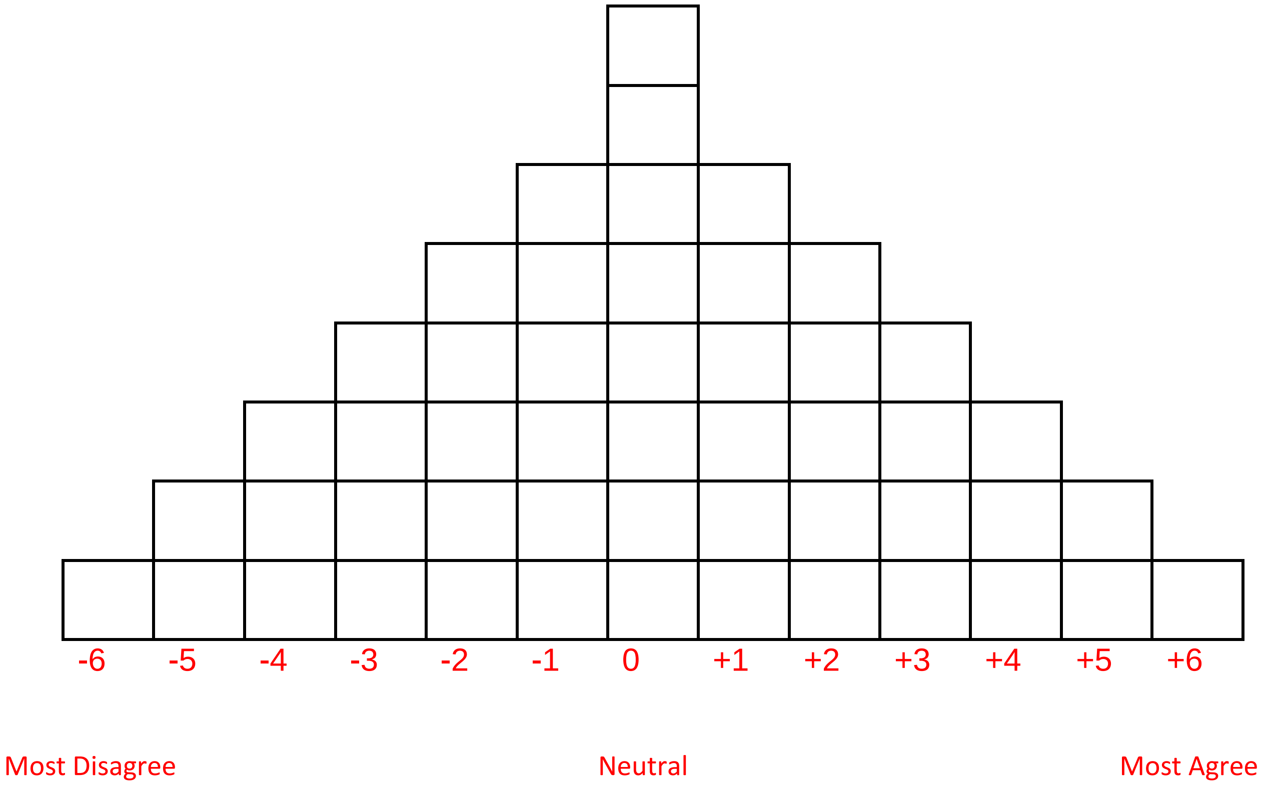

Figure 1: Blank Q-grid

KEY FINDINGS

Three important viewpoints were identified across all the completed grids. Most participants' completed grids fitted with one of these viewpoints. There was agreement across all viewpoints that assessment of service users' difficulties should be done over more than one appointment, and that difficulties should be described using symptoms rather than the diagnostic label of 'Bipolar Disorder.'

Viewpoint 1: 'Seeing the person and their experience'

This viewpoint focuses on the importance of service users' life stories in their experience of symptoms associated with Bipolar Disorder, and felt it was important for services to use a person-centred approach to diagnosis. Things that were important for this viewpoint include:

- Taking time to hear about a service user’s life experience and how this influences their current difficulties.
- Supporting service users to make sense of their own experience and empowering them to identify and make changes to their lives.
- Being mindful of the possible negative consequences of a diagnosis of Bipolar Disorder and the potential for service users to experience negative emotions following diagnosis.
- Questioning the accuracy and relevance of diagnostic criteria
- The term ‘Bipolar Disorder’ did not make things easier for service users, their families or clinicians to understand their experience.
- The diagnostic label of Bipolar Disorder was thought to be used too often in services and that individuals were given the label too quickly.
- Services being based on individual service user need rather than their diagnosis, and that diagnosis should not be the first step for new service users.

This viewpoint appears to demonstrate a psychological view of diagnosis in mental health by highlighting the importance of a tailored approach to diagnosis and aiming to prevent the over-use of the diagnostic label of Bipolar Disorder.

Viewpoint 2: ‘Promoting Quality through Standardised Processes’

This viewpoint values the diagnostic criteria set out in guidelines and believes that they help services follow standardised, evidence based processes for diagnosis. Things that were important for this viewpoint include:

- Using up-to-date diagnostic guidelines for Bipolar Disorder, which they felt were clear, applicable and easy to understand.
- Mental health difficulties should be seen in a similar way to physical health difficulties.
- Using specialist members of staff with extra training for the diagnosis of Bipolar Disorder.

- Exploration of genetic factors and family history during the assessment for Bipolar Disorder.
- A diagnosis of Bipolar Disorder increases hope for service users and helps them to understand their experiences.
- Disagreement that the diagnostic label was given too quickly or too often in services.

This second viewpoint links closely with a medical view of diagnosis in mental health that can be used to ensure consistent care and improve the reliability of mental health assessments. Taking this approach may prevent diagnoses being missed or delayed, and may help clinicians to manage high caseloads.

Viewpoint 3: ‘Understanding the function of diagnostic labels’

This viewpoint focused on the use of a diagnostic label for service users. Like the first viewpoint, it sees an individual’s experience as important but focuses more on the benefits for service users once they have been given a diagnosis of Bipolar Disorder. Things that were important for this viewpoint include:

- Service users benefit from being told their diagnosis as it helps them to understand their experience and it should be routine for service users to be given this information after accessing services.
- The diagnostic label helps clinicians to recognise and distinguish Bipolar Disorder from other mental health difficulties.
- The diagnostic label is important for more than just access to treatment and can be helpful for things outside of services such as access to financial support.
- The diagnostic label of Bipolar Disorder was used too often in mental health services.

This third viewpoint argues that diagnostic labels can have a useful function, both for those developing services and accessing support. Previous research exploring service users’ views of mental health diagnosis suggests that it is experienced more positively if it allows for access to services and support (17). Viewpoint 3 appears to support this previous research in that it suggests the diagnostic label should be used for positive consequences, but also acknowledges that it can also be used too often in services.

CONCLUSIONS

The results show that three distinct and separate perspectives of diagnosis in Bipolar Disorder were held by clinicians, with the first two viewpoints appearing to demonstrate somewhat opposite views. Results also showed that clinicians did not agree on whether the diagnostic label was over-or-under-used in mental health services; findings that further support previous research. There was agreement, however, that assessments should be completed over more than one session, and the language services use to communicate about difficulties associated with Bipolar Disorder should not focus on the diagnostic label alone. Despite the differences seen in the results, all clinicians aimed to assist with recovery and each viewpoint represents an important aspect of service users' contact with mental health teams.

RECOMMENDATIONS

When multiple clinicians involved in an individuals' care take different perspectives and have different priorities, it is likely to impact on the way the service user is assessed and the support that is offered to them.

- It is recommended that services work towards a combination of these three perspectives, noting the important factors of each and being guided by service user need. By finding common ground between these perspectives, it will prevent clinicians working in isolation and may improve multidisciplinary working.
- It is also recommended that service users receive a thorough assessment and that time is taken to collect relevant information of the service user's difficulties.

- It may also be beneficial for services to describe difficulties through symptoms rather than using the diagnostic label of Bipolar Disorder.
- As diagnosis in mental health continues to be a complex topic, it would warrant future research that includes the viewpoints of participants from a greater number of roles and with greater consideration of participants' history of working with service users who have been given a diagnosis of Bipolar Disorder.

RESEARCH LIMITATIONS

Despite attempts to reduce limitations, there are some aspects that need consideration. The results can only represent the participants' viewpoints at the time they completed the grid, meaning the conclusions may be different if the research was done at a different time or with different clinicians. Furthermore, the results lacked the view of Psychiatry, the clinicians who provide service users with a diagnosis and often hold ultimate responsibility for their care. Without this view, the results lack a highly influential perspective. Finally, despite the researcher's best attempts to remain neutral, she was responsible for the development and interpretation of the research. In order to prevent the interpretation of results being biased by the researcher's own viewpoints, she sorted the cards into the grid based on her own opinion prior to looking at the results. This helped the researcher be aware of her own perception and ensure that the conclusions drawn were not solely representing her own viewpoint.

DISSEMINATION

This executive summary can be shared with all clinicians working in mental health community teams supporting service users' with difficulties associated with Bipolar Disorder, and will be shared with the NHS Trust from which participants' were recruited. This summary aims to increase awareness of the different perceptions of the diagnosis of Bipolar Disorder and how this could potentially impact care provision, to encourage clinicians to be mindful of their own viewpoint and search for ways of more integrative working with colleagues.

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