THE UNIVERSITY OF HULL

A global perspective on mental health; the role of clinical psychology and the interaction between traditional healing and formal mental health systems

being a Thesis submitted in partial fulfilment
of the requirements for the degree of Doctor of Clinical Psychology
in the University of Hull

by

Josephine Church, BSc (Hons) Psychology

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Acknowledgements

I would firstly like to thank all the participants who contributed to this project. Their thoughtful contributions have greatly shaped my work and will hopefully go on to shape the work of others.

I would like to thank my supervisors. Peter for so kindly giving his time outside of his own projects to offer great encouragement and inspiration. Lesley for always offering insightful reflection, enthusiasm and the confidence to trust in the process of research.

I would like to thank all of my family and friends. My father for ensuring that I always remember the most important things in life. My mother for showing me how much is possible. My grandmother for teaching us all to be strong. Jack for his endless support and kindness. My brother, friends, housemate and fellow trainees for all of the necessary fun times along the way.
Overview

This portfolio has three parts.

Part One: A systematic literature review, in which the available research regarding the interaction of traditional healers and formal mental health professionals, from the perspective of both types of practitioners, is reviewed.

Part Two: A qualitative exploration of how clinical psychologists, trained in the United Kingdom, construct their work in countries classified as low to middle income. Taking the form of a social constructionist thematic analysis, informed by Foucauldian Discourse Analysis.

Part Three: Appendices for both part one and two. The appendices also include a reflective statement and epistemological statement.

Total word count (excluding references and appendices): 14 386
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Part One: Systematic literature review

This paper is written in the format ready for submission to the

*Journal of Cross-Cultural Psychology*

Please see Appendix A for the submission guidelines
A narrative synthesis of the interactive relationship between traditional healers and formal mental health professionals around the globe

Josephine Church*, Dr. Lesley Glover & Dr. Peter Oakes

Department of Psychological Health and Wellbeing,
University of Hull, Hull, United Kingdom

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*Corresponding author:
School of Health and Social Work
University of Hull
Hull
United Kingdom
HU6 7RX
Tel: +44 (0) 1482 464106
Fax: +44 (0) 1482 464093
J.Church@2014.hull.ac.uk
Abstract

Objectives: There is growing interest in, and arguments for, increased interaction between traditional healers and formal mental health professionals in mental health care around the globe. Literature on such interaction in physical health, as opposed to mental health, has found challenges to forming an interactive relationship. Learning from existing efforts of interaction is necessary to facilitate learning and good quality care for communities. However, there is little research and no reviews, to date, of such interaction in mental health care.

Method: Therefore, a systematic literature review was conducted. This paper presents a narrative synthesis of the available literature on the interaction between traditional healers and formal mental health professionals from the perspective of practitioners.

Results: Ten relevant studies were reviewed spanning Africa, Europe, North America and Asia. Studies organised their findings into barriers and facilitators to effective interaction. Barriers included; scepticism, fear and differences in valued ‘ways of knowing’. Facilitators included; learning, communication, mutuality & respect and organisational support.

Conclusion: This review provides consideration of the barriers and facilitators to effective interaction between traditional healers and formal mental health professionals. It also illuminates the need for interaction to be of equal worth to both practitioners, the significance of organisational and societal contexts and practitioners’ readiness for change. Studies were generally of high quality but overlooked the role of the researcher. Based on the review it is proposed that traditional healers should be involved at an organisational level and that ongoing conversations are necessary. Points of reflection for such conversations are suggested. Future research is necessary to focus on the meaning and expectations of interaction.
Introduction

There is growing interest in the interaction between traditional healers and formal mental health professionals. Traditional healing has been defined as the sum total of ‘knowledge, skills and practices based on the theories, beliefs and experiences indigenous to different cultures that are used to maintain health, as well as prevent, diagnose, improve or treat physical and mental illness’ (World Health Organization, 2000, p.1). A traditional healer (TH) can be defined as a person who heals or attempts to heal using religious, spiritual or energy-altering methods (Pouchly, 2012). More westernised medical or psychological approaches also attempt to reduce distress. Providers of this approach can be termed, ‘formal mental health professionals’ (FMHPs) (Patel, 2011). They encompass, amongst others, psychiatrists, psychologists and mental health nurses.

Some have argued for an increased interaction in mental health care between THs and FMHPs (Patel, 2011). One example is in the field of ‘global mental health’. Here the focus is on reducing a perceived ‘treatment gap’ (the difference between the number of people in need of mental health care and the number who receive it) in countries classified as ‘low to middle income’1 (LMIC) where the treatment gap is considered to be most pronounced (Lancet Global Mental Health Group., 2007). Within these countries there is often wide spread use of THs and a scarcity of resources for formal mental health services. This has led to THs being viewed, by some, as a valuable resource in ‘closing the gap’ (Patel, 2011). Within countries with more resourced formal mental health systems, there is a recognition that THs play an important role in reducing distress, especially within minority communities (Pouchly, 2012; Nortje, Oladeji, Gureje & Seedat., 2016). In South Africa, there is now a formal recognition of

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1 As classified by The World Bank based on gross national income per capita (The World Bank, 2017)
traditional healing and THs are involved in mainstream health care\(^2\). Overall, drawing upon all sources of support within a community seems beneficial for its wellbeing (Block & McKnight, 2010).

Interactions between THs and physical, as opposed to mental, health practitioners are more visible and widely researched. Freeman and Motsei (1992) outline three forms that such interactions can take. Firstly, ‘incorporation’ where THs are integrated into formal health care services. Secondly, ‘co-operation/collaboration’ where the two systems remain essentially autonomous and self-regulating, but consult and refer between one another. Lastly, ‘total integration’ with the evolution of a new system which blends and combines both approaches. In the case of HIV/AIDS, the interactive relationship between THs and formal health care professionals has been important (King, 2006). Wreford (2005) reviewed the literature within South Africa, noting the challenges of an interactive relationship and the significance of the wider context of colonial history. Wreford recommended that efforts need to focus on ‘true reciprocity’, where both partners feel equally valued, and noted the importance of research in learning lessons from existing interaction.

There has been less research into the interactive relationship in mental health, than in physical health. Gone (2010) explored differences between the approaches of FMHPs (privileging secular, rational and technical approaches) and THs (privileging sacred, mysterious and relational approaches) describing how both often have a poor understanding of the other. Such differences in approach could challenge effective joint working which can affect the quality of care communities receive (Doyle, 2008; Ndoro, 2014).

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\(^2\) Under apartheid government, THs were prohibited from practising as health practitioners following the 1974 Health Act. In 2003 the South African Traditional Health Practitioners Bill recognised THs as health practitioners. The Bill’s validity was initially challenged (Doctors for Life International, 2006) before being adopted in 2007 making way for the establishment of the Traditional Health Practitioners Council of South Africa and THs formal integration into the national health care system (Ramgoon et al., 2011).
It appears that interaction between THs and FMHPs is considered as a way forward in mental health care delivery around the globe. However, there are clearly inherent challenges with this as illustrated by the physical health literature. If interaction is going to work effectively for mental health care, then there needs to be a consideration of what can be learnt from existing efforts. This review looks at what is already known about the interactive relationship between THs and FMHPs within the current context of mental health care around the globe. This will offer an informative overview to all interested parties and shape reflection as mental health care delivery continues to develop.

Research question:
- What is known about the interaction between THs and FMHPs from the viewpoint of practitioners?

Method

Search strategy and screening process

A systematic search of five databases (Medline, Academic Search Premier, PsycINFO, CINAHL and Web of Science) was completed in February 2017. These databases encompass both broad and narrow topic areas and include research from a range of disciplines and countries. This allowed for a breadth and depth of searching.

Search terms were generated in order to specifically answer the research question. Terms were developed through scoping of abstracts and keywords used within the literature, policy papers, guideline papers and discussions with experts in the area. The search terms decided upon were:
- “Tradition* heal*” OR “faith heal*” OR “spirit* heal*” OR “religio* heal*” OR “Indigenous heal*”
The researcher took time deciding upon these terms and consulted experts in the field (individuals with experience of working in this way, as well as individuals who had studied or lectured in the area) to ensure that they were in keeping with the given definitions of THs and FMHPs. Limitations of grouping both will be addressed in the discussion. It is recognised that other FMHPs, such as occupational therapists or physiotherapists, contribute to some formal mental health services. However, this is not always the case in poorer resourced areas. These practitioners also do not often have a specific role in mental health care in these settings. The researcher considered adding such terms to the search strategy but found that they did not identify additional studies relevant to answering the review question.

Additional limiters were applied, to ensure the return of studies were:

- written in the English language (no funding for translation)
- published in the last ten years (2007 – 2017). Although traditional healing has been of significant importance throughout history, the year 2007 was chosen as it marks the release of ‘The Lancet Global Mental Health Series’ (Lancet Global Mental Health Group, 2007) which initiated a movement in global mental health that subsequently promoted interaction between THs and FMHPs. It is considered that this provides a new global context to consider the research within

- peer-reviewed

Initially titles and abstracts were searched to identify relevant articles related to the research question. Exclusion and inclusion criteria were implemented upon a review of the full text of the remaining articles. Studies were included if they met the following inclusion criteria:
- qualitative, quantitative or mixed methods
- participants included either THs and/or FMHPs (fitting with the given definitions)
- at least one aim of the study was identified as being concerned with the interaction between THs and FMHPs (fitting with the options of interaction outlined by Freemen & Motsei (1992))
- both studies that focused on interaction in an already existing context and those that set up interactions (e.g. through focus groups) were included as both were considered to be of interest to the research question
- studies of both trainee and qualified providers as again both were considered to be of interest to the research question

Studies were excluded if they;
- were discussion/review papers or personal reflections
- did not refer to the care provided as mental health (as opposed to physical health)
- focused upon opinions of practice or learning/integrating practice into individual work as opposed to the interaction between providers

Nine studies met the criteria. Through contact with experts in the field, the researcher was made aware of one further study; a qualitative action research project that was not published in a peer reviewed journal and therefore not captured in the initial search (Hills et al., 2013). This study was included as it was funded by a significant research funding body (The King’s Fund) and had an advisory group of experts from different healing traditions, mental health services and relevant organisations that met to review the project at research and dissemination stages. The researcher is not aware of any other research projects that may also have been included
for similar reasons or funded by the research funding body. See Figure 1 for an overview of the selection process.

Figure 1. Flowchart depicting the study selection process

Data Extraction

Key information from the included studies was extracted using a data extraction form (see Appendix B). Information about the setting, sample, method and findings were recorded for each study to give context.
**Quality Assessment**

A quality assessment tool was created to evaluate the quality of all included studies. The tool was an amalgamation of two published quality measures: Methodology Checklist for Qualitative Studies (NICE, 2012) and the Mixed Methods Appraisal Tool (MMAT) (Pluye et al., 2011) (see Appendix C). The checklist incorporated items to assess theoretical approach, design, validity, analysis and ethics for both qualitative and mixed method studies.

The overall quality score of each study was calculated (see Appendix D for individual ratings). This helped guide the researcher in considering the overall quality of the literature base as well as differences and similarities across studies. A random sample of four articles were chosen and blindly rated for quality by an independent researcher. There was some discrepancy over whether or not the lack of underpinning theory and epistemology meant that studies were clear in what they were seeking to do. This was discussed, discrepancies were resolved and it was decided that the lack of theory was understandable given the nature of the studies but was an area of interest for the overall body of literature. There was no discrepancies in other areas.

**Data Analysis**

Analysis of the extracted data was approached using narrative synthesis whereby data is summarised and explained through text. This allowed for the synthesis of findings from studies investigating different forms of interaction within a variety of settings. The narrative synthesis process was undertaken in line with guidance developed by Popay et al (2006).
Results

Characteristics of studies

Research approach

In total, 10 studies were included in the review (see Table 1 for an overview of included studies). Eight qualitative, one mixed methods whereby only the qualitative findings were relevant and reviewed (Shields et al., 2016), and one mixed methods whereby both quantitative and qualitative findings were relevant and reviewed (Musyimi, Mutiso, Nandoya & Ndebi., 2016). Across studies, participants were recruited via purposive and convenience sampling. Some studies included just THs (two studies), just FMHPs (two studies) or both (seven studies). Five studies also included other participants (such as service users, careers, policy makers and academics) but only the findings relating to the perspectives of THs or FMHPs were reviewed.

Data was collected via semi-structured interviews (two studies), focus groups (one study) or a mixture of both (four studies). Two studies used data from the Mental Health Poverty Project (MHaPP) which was a situation analysis, involving semi-structured interviews and focus groups, of mental health policy, legislation and services across four African countries. The mixed methods study collected data via focus groups and a questionnaire to evaluate dialogue formation. Hills et al (2013) drew upon anthropological methods, action research and intercultural dialogue - engaging THs and FMHPs from the UK in an action research project that facilitated intercultural dialogue. Moorhead, Gone and December (2015) adopted an equally novel approach by collecting data via a ‘roundtable discussion’ (borrowing from a common process in ceremonial protocol) that allowed for structured dialogue between FMHPs, researchers and THs. Approaches to data analysis included: thematic analysis (five studies), framework approach (three studies), constant comparative method (one study) and Hills et al (2013) analysis as described above.
Research context

Studies were published between 2010 and 2016. They were conducted in Ghana (2), India, Kenya, South Africa (4), New Zealand, USA/Canada and UK. Researchers were predominantly from universities; some studies had researchers who were all located in universities of the country which the research focused on (six studies) and others had researchers from both local and non-local universities (four studies) (for example, researchers from the USA in Ghana (Arias, Taylor, Ofori-Atta & Bradley., 2016). Studies also involved researchers from mental health foundations.

Studies conducted in India, Ghana and Kenya framed their research within the context of a lack of resources and a ‘treatment gap’ in mental health care. They discussed a need to better harness local resources (including that of THs). Meanwhile, studies conducted in South Africa addressed the formal recognition of THs in the health care system, the wide spread use of THs, the lack of FMHPs and the ‘cultural appropriateness’ of THs for indigenous populations. In the USA and UK, studies focused on the ‘cultural insensitivity’ of FMHPs’ approaches and the hidden nature of THs, historical injustices, trauma and violence toward communities from which THs practise.

All studies aimed to explore perspectives on interaction and effective working relationships. Some studies also aimed to explore what traditional healing is, what makes for an effective TH and the reasons underpinning their widespread appeal.

Quality assessment

All studies were subject to quality assessment. Aims and research questions were clear and a qualitative approach appeared appropriate for all. Researchers gave in-depth descriptions of the contexts in which they sourced their data and justified sampling and data collection methods. They referred to the limited pool of individuals
who could participate in their studies and the necessity of techniques that allowed for
the collection of detailed information. The data analysis procedures were often clear and
researchers referenced step-by-step guides to support their analysis. Analysis was often
completed by more than one researcher (eight studies) but participants were not
involved in feeding back on the findings. Findings and conclusions were clearly
presented and relevant.

One area that almost all studies appeared to overlook was reflexivity. On the
whole, researchers rarely considered how their personal values, assumptions and
interactions with participants may have influenced the research. This is an important
aspect of qualitative research which must be taken into consideration. Two studies
mentioned that the researcher may have had an influence on the findings due to not
being perceived as an independent and neutral party. However, they did not consider the
impact of this on findings or conclusions. The one study that did explicitly explore the
role of the researcher considered issues around race leading to an advisory group with a
strong representation from different communities.

Studies rarely linked their research to theory. Researchers did not report their
epistemological position (except for one study). This can play a significant role in
shaping methodology and findings (Willig, 2013). Researchers also rarely drew on
theories, for example of relationships, which may have assisted interpretation of
findings. This is understandable given the lack of research in the area, and exploratory
nature of the studies but is an interesting aspect of the overall body of literature.
<table>
<thead>
<tr>
<th>N</th>
<th>Authors &amp; Year</th>
<th>Aims</th>
<th>Country</th>
<th>Participants</th>
<th>Methodological Approach</th>
<th>Findings relevant to review</th>
<th>Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Ae-Ngibise, Cooper, Adiibokah, Akpalu, Lund, Doku, &amp; The MHAPP Research Consortium 2010</td>
<td>Explore the reasons underpinning the widespread appeal of THs and identify what barriers or enabling factors exist for forming partnership</td>
<td>Ghana</td>
<td>FMHPs, THs, Policy makers, service users, teachers, police officers, academics (n=122)</td>
<td>Qualitative Semi-structured interviews and focus groups Data analysis; Framework approach</td>
<td>Barriers to collaboration; human rights and safety concerns, scepticism of each other’s practice and TH solidarity Facilitators to interaction; mutual respect and bi-directional conversation</td>
<td>71</td>
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<tr>
<td>2</td>
<td>Arias, Taylor, Ofori-Atta &amp; Bradley 2016</td>
<td>Examine the beliefs and practices of prayer camp staff and the perspective of biomedical care providers, with the goal of characterizing interest in, and potential for, partnership</td>
<td>Ghana</td>
<td>Prayer camp staff (THs) (n = 14), FMHPs (n = 36) Purposive sampling</td>
<td>Qualitative Semi-structured interviews; individual and group Analysis; constant comparative method</td>
<td>Interest of both in collaborative working. Barriers to interaction; different beliefs on mental health and scepticism of each other’s practice</td>
<td>86</td>
</tr>
<tr>
<td></td>
<td>Research &amp; \citeyear{Campbell-Hall, Petersen, Bhana, Mjadu, Hosegood, Flisher &amp; MHAPP Research Consortium 2010}</td>
<td>South Africa</td>
<td></td>
<td>Qualitative</td>
<td>THs expressed a lack of felt appreciation from FMHPs, need for bi-directional learning and mutual respect</td>
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<td>Explore perceptions of service users and providers of current interactions between traditional and public sector healing and ways in which collaboration can be improved</td>
<td>FMHPs (9 interviews, 6 focus groups) NGO workers (1 interview) THs (2 interviews, 4 focus groups), service users (15 interviews)</td>
<td>Data collected from Mental Health and Poverty Project (MHaPP) Situational analysis</td>
<td>Individual and focus group interviews Data analysis; Framework approach</td>
<td>79</td>
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<td>4</td>
<td>Research &amp; \citeyear{Hills, Aram, Hinds, Warrington, Brissett, Stock 2013}</td>
<td>UK</td>
<td></td>
<td>Qualitative</td>
<td>FMHPs; enthusiasm, need for cultural sensitivity</td>
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<td>Explore what the role of traditional/faith-based healing practices originating from Africa are in the care of patients with mental health problems, what elements of these practices it would be useful for mental health care practitioners to be aware of, what guidance on biomedical knowledge would assist the work of healers, what is the potential for dialogue between providers</td>
<td>Interviews/focus groups; service users (n=30), THs (n=18), FMHPs (N=16), community services/organizations (n=10), policy makers (n=4). Action learning groups; FMHPs (n=2), THs (n=3), community organizer, service users/carers (n=3) Purposive sampling</td>
<td>Action research project. Combination of approaches; anthropological research, action research &amp; intercultural dialogue Exploring narratives through interviews and focus groups. 5 action learning groups (dialogue formation between THs and FMHPs)</td>
<td>THs; mistrust, practice as ‘hidden’, services ignoring culture, scepticism Action learning groups; traditional healing as ‘hidden’, differences in beliefs underpinning practice, ‘how do I work’, building trust, issues of authority, challenge &amp; competition</td>
<td>100</td>
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<tr>
<td>Study</td>
<td>Authors</td>
<td>Country</td>
<td>Study Focus</td>
<td>Sample Size</td>
<td>Methodology</td>
<td>Analysis</td>
<td>Key Findings</td>
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<td>5</td>
<td>Janse van Rensburg, Poggenpoel, Szabo &amp; Myburgh</td>
<td>South Africa</td>
<td>Capture the views and experiences of South African psychiatrists on the referral and collaboration of psychiatrists and spiritual advisors/workers</td>
<td>Psychiatrists (n=13)</td>
<td>Purposive sampling</td>
<td>Qualitative</td>
<td>Facilitating appropriate referral and intervention (concerns of integrating a TH into formal mental health system), information sharing and mutual awareness between disciplines (need for parallel process alongside each other, communication/dialogue at all levels)</td>
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<tr>
<td>6</td>
<td>Moorehead, Gone &amp; December</td>
<td>USA</td>
<td>Explore what is traditional healing, who is an effective TH and what are the possibilities of collaboration</td>
<td>THs, clinically trained service providers, cross-cultural mental health researchers (total n=18)</td>
<td>Purposive sampling</td>
<td>Qualitative</td>
<td>Need of cultural programming to achieve collaboration, observance of mutuality &amp; respect, importance of clear and honest communication, cultural differences as unique challenges to be collaboratively overcome through communication</td>
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<td></td>
<td>Authors</td>
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<td>Country</td>
<td>Participants</td>
<td>Methods</td>
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<td>7</td>
<td>Musyimi, Mutiso, Nandoya &amp; Ndetei, 2016</td>
<td>Identify barriers and solutions for dialogue formation between informal (faith and THs) and FMHPs in relation to enhancing collaboration in community-based mental health care</td>
<td>Kenya</td>
<td>THs, faith healers and clinicians</td>
<td>Mixed methods</td>
<td>Mistrust, lack of respect, interest in collaboration increased following dialogue formation</td>
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<td>Purposive sampling</td>
<td>Qualitative - 8 focus groups (n= 8-10 per group)</td>
<td>Evaluation of dialogue formation; 100% joined to improve the lives of patients. Their expectations; add new knowledge (23%), interact with other providers (43%), improve their work with respect to patient care (47%). 96% satisfactorily met expectations</td>
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<td>Quantitative – Questionnaire evaluating dialogue formation (n=30)</td>
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<td>Thematic analysis of focus groups. Qualitative and quantitative analysis of evaluative questionnaire</td>
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<td>8</td>
<td>Ramgoon, Dalasile, Paruk &amp; Patel, 2011</td>
<td>Explore trainee and registered psychologists perceptions of indigenous healing, their personal and professional experiences with THs and the formal recognition of THs in the mental health care system</td>
<td>South Africa</td>
<td>Trainee (n= 10) and registered (n= 8) psychologists</td>
<td>Qualitative</td>
<td>Themes; belief &amp; effectiveness (belief in treatment linked to efficacy), culture-sensitive services (enhanced by presence of THs), scepticism (held more by trainees), relevance of experience</td>
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<td>Purposive sampling</td>
<td>Semi-structured interviews and focus groups</td>
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<td>Thematic analysis</td>
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<td>9</td>
<td>Sorsdahl, Stein &amp; Flisher</td>
<td>Gain an understanding of THs common beliefs about referring to FMHPs, advantages and barriers</td>
<td>South Africa</td>
<td>THs (n=24)</td>
<td>Qualitative</td>
<td>Themes; views on collaboration with FMHPs (desire to but feel this is not occurring), advantages/disadvantages of referring to FMHPs (advantages of western medicine and technology. Scepticism of practice), feel undervalued and not respected</td>
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<td>Convenience sampling</td>
<td>3 focus groups</td>
<td>Analysis; framework approach</td>
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<tr>
<td>10</td>
<td>Shields, Chauhan, Bakre, Hamlai, Lynch &amp; Bunders</td>
<td>Explore the origins, use, and outcomes of a collaborative program between faith-based and allopathic mental health practitioners in The Dava Dua Program; how collaboration was established, what barriers and enablers to collaboration exist, who uses the program, service user and provider experiences</td>
<td>India</td>
<td>Faith based healers (n=3), allopathic mental health practitioners (provide medication and talking therapies) (n=3), service users (n=3) and carers (n=7)</td>
<td>Mixed methods (only qualitative used in review)</td>
<td>Theme; collaboration. Sub themes; Barriers to initial collaboration (apprehension due to perceived differences), building trust and rapport (developing a shared goal), training and sensitization activities, learning and openness, redefining the roles of allopathic mental health practitioners within the collaboration (cross-referral), bolstering roles</td>
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<td>Convenience sampling</td>
<td>Qualitative – semi-structured interviews</td>
<td>Thematic analysis</td>
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The findings

Studies tended to report ‘barriers’ and ‘facilitators’ to effective interaction between THs and FMHPs. Commonly, interactions took the collaborative approach introduced (Freeman & Motsei, 1992). Despite the differing contexts and locations of the studies, the findings were strikingly similar allowing for the grouping of barriers (scepticism, fear, different valued ‘ways of knowing’) and facilitators (learning, communication, mutuality and respect, organisational support). Discrepancies found between studies are incorporated in the discussion of each of these groupings below.

Barriers

Scepticism

Scepticism, held by THs and/or FMHPs toward each other’s practice, was found in all studies. FMHPs reported concerns around the human rights, safety and efficiency of THs’ practice (Arias et al., 2016). Ae-Ngibise et al (2013) found that FMHPs held concerns around ‘abuses’, ‘maltreatment’, ‘neglect’, ‘exploitation’ and discomfort with a lack of ‘scientific evidence’ (Ramgoon, Dalasile, Paruk & Patel., 2011; Janse Van Rensburg, Poggenpoel, Szabo & Myburgh., 2014).

Some concerns were considered ‘justified’ (Ramgoon et al., 2011) and researchers drew upon historical tragedies at traditional healing centres (Sheilds et al., 2016). Some concerns were considered unjustified and a result of a wider context. Ae-Ngibise et al (2010) noted that the discourses (spoken and written communication) of THs’ practices were frequently situated within colonial rhetoric which unjustly undermined traditional healing and framed it as harmful. Moorehead et al (2015) also reflected on ‘savagery’ versus ‘civilisation’ discourses that emerged during the colonialism of America.
THs were also doubtful of the ‘healing’ power of FMHPs. They considered FMHPs’ practice to be more ‘symptom management’ (Arias et al., 2016; Ae-Ngibise et al., 2010) with an over reliance on medication and sectioning (Hills et al., 2013; Arias et al., 2016). Some THs (especially those working with minority populations of a country) held concerns regarding the ‘potential racism’ of services that FMHPs worked within (Hills et al., 2013). THs were sceptical of the lack of ‘time’, ‘care’ and ‘affection’ provided by FMHPs (Sorsdahl et al., 2010).

“… Without the medicine for two weeks, you will fall back into your sickness… that is why you are being controlled. It is the medicine which is controlling you. Here, there is no medicine, just spiritual healing. If you are healed, you are healed forever.”

Church elder – Ghana (Arias et al., 2016)

Within the UK (Hills et al., 2013), THs were sceptical of other THs. This appeared to be linked to the ‘hidden’ nature of such practices within Western society. THs were away from the monitoring of larger communities where a knowledge of unauthentic healers is more widely shared.

Where there was scepticism of each others’ practice, a barrier to interaction formed. This appeared to relate to concerns regarding inadequate levels of care. FMHPs felt that interaction would ‘condone’ or ‘encourage’ practices they perceived as unsafe (Ae-Ngibise et al., 2010). Similarly, THs felt that service users would not be given the ‘hope they needed to go on’ due to the practices of FMHPs (Sorsdahl et al., 2010).

Fear

The title ‘fear’ was chosen to reflect the terminology of included studies. Fear of interaction was reported most prominently to be held by THs. THs were reported to be
fearful of their methods being ‘exploited’ by FMHPs (Campbell-Hall et al., 2010). If their methods were exploited, there was a fear that they would lose their livelihoods (Shields et al., 2016). It appeared that many THs had built systems of support and solidarity between one another that they did not want to risk losing (Ae-Ngibise et al., 2010).

“We cannot give away our secrets because they will take them and use them but they will never give us theirs.” TH – South Africa (Sorsdahl et al., 2010)

To a lesser extent, FMHPs were wary of the effect THs could have on their professional and societal status. It appeared that FMHPs also felt a fear to their remuneration. It was apparent from the studies that FMHPs were concerned that service users may lose confidence in them if they interacted with THs (Musyimi et al., 2016).

These fears created a barrier to interaction – especially for THs. In Shields et al (2016) study concerning a collaborative program in India, it was noted that THs held many of the fears outlined above. A FMHP described how he had approached ‘40 to 50’ THs and needed ‘police support’ before he was able to initiate a conversation around collaboration.

*Differences in valued ‘ways of knowing’*

FMHPs and THs had different approaches and ways of conceptualising wellbeing. This was framed as different ‘ways of knowing’ (Moorhead et al., 2015). There was a recognition in the studies reviewed that FMHPs’ way of knowing was given more value in interactions than that of THs. The value placed by FMHPs on scientific knowledge, an area of scepticism, was considered an example of this (Moorehead et al., 2015). Hills et al (2013) noted that THs are drawing on long standing
traditions but that these are not given as much recognition because of the value placed on scientific evidence. In the Ramgoon et al (2011) study, trainee clinical psychologists found it more difficult to include the views of THs in their representations of mental health than registered psychologists did. Authors related this to professional training programs being so in favour of scientific knowledge.

The position of THs' 'way of knowing' as inferior created a barrier to interaction as THs often felt undervalued. THs reported feeling as though they did not receive the amount of respect that their contribution to the health of communities warranted (Sorsdahl et al., 2010; Musyimi et al., 2016). In the two studies where THs were more unsure of interacting with FMHPs, they were notably ‘angry’ about this (Campbell-Hall et al., 2010; Sorsdahl et al., 2010).

“They take us as people who do not know anything about people’s illnesses…” TH – South Africa (Cambell-Hall et al., 2010)

**Facilitators**

**Learning**

In consideration of overcoming the above barriers, a large focus was placed upon the facilitative nature of learning. This is not surprising and many studies negotiated what form learning should take. In some studies the predominant focus was on the training of THs (Sorsdahl et al., 2010). For example, ‘extensive sensitisation and training’ around ‘symptoms of mental illness, referral strategies, and referral processes’ (Shields et al., 2016). There was also a consideration that FMHPs needed training in taking a ‘holistic’ (Shields et al., 2016) or ‘meaning centred’ (Campbell-Hall et al., 2010) approach to care.
Learning through experience was also important. As discussed earlier, those who had graduated from psychology training were more positive about interaction (Ramgoon et al., 2011). It was considered that the positive experiences of psychologists, post training, facilitated their tendency to interact. In keeping with this, other studies found that the potential for interaction surfaced in individuals’ accounts of positive experiences (Ae-Ngibise et al., 2010).

Ramgoon et al (2011) drew upon Moscovici’s (1984) Social Representations Theory to explain why learning through experience was an important facilitator. They considered how different groups (e.g. THs and FMHPs) have different social representations (beliefs, values, ideas and practices shared between the group). When challenged (e.g. by efforts at interaction) individuals tend to initially identify more closely with their own group with whom they share social representations and reject the out-group. Over time, and with experience, individuals are considered to gradually incorporate the new social representation into their own.

“I had the perception that people only get cured by medicine but once I started here I realised it was not only the medicine working but it was the faith and support of others which was making it work” FMHP – India (Shields et al., 2016)

Communication

All studies found that communication was the starting point for learning. This communication needed to be ongoing and honest in order to overcome fears and create a ‘much better chance of getting a decent working relationship’ (Janse van Rensburg., 2014). The importance of communication is reflected in the number of studies facilitating it in their research. Three studies created ‘dialogue formation groups’ (Musyimi et al., 2016; Hills et al., 2013; Moorehead et al., 2015). Hills et al (2013)
defined dialogue formation as the system of identifying ideas, sharing ideas through speech and exploring the emotional dynamics operating during this process.

On evaluation of dialogue formation between THs and FMHPs in Kenya, Musyimi et al (2016) found that dialogue formation met 96% of individuals’ expectations of gaining new knowledge, interacting with one another and improving care. Participants were enthusiastic to continue interacting as they found it gave new insights and motivated them to act differently. However, this information was collected using an adapted questionnaire where the form of adaptations were not made clear. Therefore, the context within which individuals gave these responses is unknown. Moorehead et al (2015) and Hills et al (2013) similarly reported that dialogue formation had a great deal of potential in transforming the relationships and relatedness between individuals and their systems of practice.

It was noted throughout such studies that dialogue formation provided an opportunity to negotiate the barriers outlined above. Moorehead et al (2015) reported that this required ‘pragmatic persistence’, ‘relational skills’ and a clear focus on mutuality and respect. Drawing upon the work of Martin Buber (1958), Hills et al (2013) proposed that one must trust the ‘emerging solutions’ of the process.

*Mutuality & Respect*

Many studies reported that learning and communication must be grounded in respect for one another and be ‘bi-directional’ in nature. Studies noted the significance of this based upon the disproportional value placed on FMHPs ‘ways of knowing’. Respect was mentioned in all included studies and commonly appeared alongside the words ‘mutual’ or ‘equal’. One individual stressed that there is always collaboration, interplay, or a mutual interface when two people come together but the most important question is whether the interaction occurs in an equitable fashion (Moorehead et al.,
There was a range of ideas around how to create mutuality and respect. As a practical example, this involved FMHPs and THs sitting together on the floor for client consultation to symbolise equality (Shields et al., 2016). In many studies, it grew from forming a shared goal (Arias et al, 2016). Shields et al (2016) stressed the importance of a shared, unified goal based on common values to consistently refer back to throughout the development of interaction. Where there was recognition of such a shared goal efforts at interaction were evident (Arias et al., 2016). It appeared to reduce competition and the feeling of being undervalued (Shields et al., 2016).

“You see, our sole mission is to see people who are sick get better. That is our sole thing, to see people who are sick, who are in trouble, and who have sickness, being better. If we are playing that part and the medical [staff] are also playing that part for the people to get better, why aren’t we happy? The result is a person is healed, we are all happy” Pastor – Ghana (Arias et al., 2016)

Organisational support

All of the above facilitators were desired at an organisational, as well as individual, level. For some this meant conversations between organisational bodies (Janse van Rensburg et al., 2014). For others, it meant THs and FMHPs proactively working together to build more culturally sensitive services. One FMHP in the USA gave the example of THs facilitating conversations around service development within their service (Moorehead et al., 2015). Cambell-Hall et al (2010) recommended the establishment of ‘multisectoral mental health advisory groups’ to plan and facilitate interactions, with THs being important contributors.
“I think it would be best if [communication] were to be done at an organisational level. I mean that doesn’t deter us from doing it at an individual level which we’ve had to do already”

Psychiatrist – South Africa (Janse van Rensburg et al., 2014)

Working at an organisational level facilitated learning and communication at an individual one. Hills et al (2013) found that there was a hierarchy within traditions with newer less experienced healers not having enough authority to talk on behalf of the tradition. This affected dialogue formation but improved following the involvement of a healer higher up in the organisation. Furthermore, FMHPs reported that they were less likely to be able to use the lessons they had learnt from dialogue formation without the support to do so at an organisational level (in this case, support from the UK National Health Service).

Discussion

The aim of the current review was to answer the question: what is known about the interaction between THs and FMHPs from the perspective of practitioners? Included studies spanned Africa, Europe, Asia and North America. This review found that studies organised their findings into perceived barriers and facilitators to effective interaction.

Barriers could be summarised as scepticism, fear and differences in valued ‘ways of knowing’ whereby FMHPs ideas and interests were favoured over THs, leaving THs feeling undervalued. Uncertainty (scepticism and fear) around interaction was apparent from the perspective of both THs and FMHPs. However, it seemed more prominent in THs. Social Exchange Theory (Emerson, 1976) proposes that to form a relationship, individuals must consider that the costs of doing so would not outweigh the rewards and for this to compare favourably to alternative options, such as acting alone. THs’ uncertainty and feelings of being undervalued could be linked to how worthwhile investing in the interactions (as they are currently proposed) would be for
them and how this compares to acting alone. For example, when one TH said, “we cannot give away our secrets because they will take them and use them but they will never give us theirs” (Sorsdahl et al., 2010) it could be taken to imply that the costs of interacting would outweigh what they would receive in return.

Studies identified facilitators that were used or should be used to overcome such barriers. These included learning through training, experience and ongoing conversation. Ramgoon et al (2011) drew upon Social Representation Theory (Moscovici, 1984) to propose that fear and scepticism would reduce with increased experience of and exposure to one another. There was an awareness that such learning and communication must be mutual and grounded in respect. Stemming again from a recognition that FMHPs’ ‘ways of knowing’ were favoured over THs. A close relation of Social Exchange Theory is Equity Theory (Adams, 1963) which proposes that individuals are concerned with fair distribution of cost and reward between relational partners. This seemed important to the participants of included studies, reflected in one FMHPs’ statement that the necessary question to ask in an interaction is whether it occurs in an equitable fashion (Morrehead et al., 2015). Forming a shared goal and having both THs and FMHPs involved in decision-making were suggested strategies for ensuring equitableness.

There was also a recognition that the wider context surrounding THs and FMHPs had an impact on such barriers and facilitators. In his Ecological Systems Theory, Bronfenbrenner (1979) identifies different environmental systems in which an individual interacts, for example: immediate surroundings (e.g. neighbourhood or co-workers), wider organisations (e.g. health services or churches), and attitudes of the surrounding society. Included studies drew upon the relevance of each. For example, societal attitudes were thought to have a significant impact on scepticism and the unequal nature of interaction. One study drew upon the ‘savagery’ versus ‘civilization’
discourses that emerged during the colonialism of America and implied that they still had relevance to how THs are viewed today (Moorehead et al., 2015). This resonated with similar findings in the physical health literature (Wreford, 2005) and criticisms that have been levelled at the global mental health movement as a whole (Mills et al., 2013). It has been argued that such histories contribute to a power imbalance whereby local (THs) understandings of wellbeing are marginalised by westernised (FMHPs) understandings (White et al., 2013). Elements of the wider context could also be facilitative, for example, through organisational support. The support of organisations (such as health services) assisted learning and communication at an individual level by giving individuals the authority to speak and allowing lessons to be put into practice (Hills et al., 2013).

It is interesting to consider the significance of the authors’ choices to focus on the facilitators and barriers of interaction. Using Prochaska and DiClemente’s (1986) stages of change model, it appears that authors have contemplated change and are at the stage of considering how best to prepare for action (action being the effective interaction of THs and FMHPs). For example, some studies created such action through the organisation of dialogue formation groups that brought THs and FMHPs together (e.g. Musyimi et al., 2016). This supports literature, which positively promotes the interaction between THs and FMHPs (Lancet Global Mental Health Group, 2007). However, this ‘preparation’ or ‘action’ stage seems disconnected with the uncertainty expressed by the participants of included studies. As previously discussed, participants often expressed a lot of fear and scepticism of one another and, despite reported enthusiasm, there was little evidence of interactions taking place. Where there was, this took the form of collaboration or referral as opposed to incorporation or total integration (Freeman & Motsei, 1992). Collaboration seemed to be a form of interaction that allowed for the most distance and autonomy. This is again, a possible indication of the
level of uncertainty around interacting. It could be proposed that participants (both THs and FMHPs) were often more at a stage of contemplation (aware but not committed to action), or in some cases pre-contemplation (no intent for action). For example, one study described FMHPs approaching THs ‘40 to 50’ times before they were able to initiate a conversation about interaction (Shields et al., 2016) indicating an initial pre-contemplation stage. This disconnection in stages of change between the researchers and participants highlights the significant role of the researcher and implications for future practice.

Before discussing such implications, it is necessary to consider the quality of included studies. The majority of studies appeared to overlook the role of the researcher. Studies rarely considered the personal values, assumptions or interactions between researcher and participant when drawing conclusions. From the limited amount of information provided it can be understood that researchers were predominantly from mental health trusts or universities and some were not local to the area. This creates a dynamic that is likely to have influenced how participants responded. For example, THs may have associated researchers with FMHPs and adapted their responses in a way that felt appropriate for this audience. It could also be proposed that the power imbalance emerging from colonial histories many have been relevant here. The values and assumptions of the researcher are likely to have influenced their overall approach to research. For example, researchers themselves may have been at the preparation and action stages of change because they were more affiliated with formal mental health systems, as opposed to traditional healing systems, where lower levels of uncertainty were reported. Such factors were rarely addressed and this should be taken into account in consideration of findings.

There were also limitations to the current review. As discussed, context is important. This study grouped all countries together and although findings were strikingly similar,
the reviewer is likely to have missed opportunities to link findings to the context of specific countries. There is also a grouping of THs and FMHPs, which overlooks the differences between traditions or religions of healers and professions of FMHPs. Furthermore, the role of the reviewer must be taken into consideration. The reviewer is a trainee clinical psychologist within a formal mental health system. Although great effort was made to reduce potential bias, their assumptions are likely to be more in line with those of FMHPs. This may have influenced the reviewer’s reading of studies and overall approach to the review. For example, the reviewer drew upon scientific theories in interpreting the studies. This approach is more in line with FMHPs’ assumptions or ‘ways of knowing’ and might not be as meaningful to THs (Moorhead et al., 2013).

Whilst keeping limitations in mind, implications for future practice can be proposed. The barriers and facilitators reported should be considered in future efforts to promote interaction. There needs to be a consideration about how to ensure costs and rewards of interaction are distributed fairly in any relationship that THs and FMHPs adopt. This is not just important at an individual practitioner level but also at an organisational level. THs need to be involved at an organisational level to ensure that their interests are taken into consideration when calls for increased interaction are made.

It appears that continuing conversation is important in understanding the developing culture of mental health delivery. It also seems important to note individuals’ stage of change within this. Stages of pre-contemplation and contemplation benefit from a focus on weighing up information (e.g. about one another’s approach), exploring the meaning of change (which is likely influenced by the wider context) and thinking about expectations (e.g. considering what would constitute a ‘good’ interaction) (Prochaska & DiClemente, 1986). Individuals and organisations should consider these as points of reflection in future discussions.
Efforts at interaction must be continually evaluated so as to facilitate learning. Future research could play an important role in this. Such research should continue to be qualitative and exploratory in nature to reflect the early stages of this way of working. It could focus on the areas of reflection outlined above by researching the meaning and expectations of interaction. Although this review focussed on the perspective of practitioners, it was clear that studies involved a whole range of perspectives (community organisers, policy makers, service users, carers, cross-cultural researchers). This would be important to maintain in future research as it speaks to the different levels of context influencing interaction (Bronfenbrenner, 1979). It is also important that THs are involved in the research process to ensure that what is known about interaction is equally contributed to by THs and FMHPs. THs could be involved in research advisory groups (Hills et al., 2013). Where this is difficult to implement, it would be important to feedback findings to participants, including THs, and report their perception of the conclusions drawn. Furthermore, this review aimed to demonstrate how different theories can be drawn upon to help support interpretation of the findings within this area of research.

In conclusion, this review adds to the knowledge of the interaction between THs and FMHPs by highlighting current barriers and facilitators to effective interaction. The literature is generally of good quality but overlooks the role of the researcher. The review has limitations in grouping countries and practitioners. There also needs to be a consideration of the reviewer’s position within formal mental health services. Nevertheless, the review suggests some important implications for future practice, such as the involvement of THs at an organisational level and points of reflection to be considered in future communication regarding interaction. Continued research of existing interactions is necessary to facilitate learning. It is proposed that this may also
focus upon the meaning and expectations of interaction. Suggestions are made as to how to ensure such research is of high quality.
References


Part Two: Empirical Paper

This paper is written in the format ready for submission to the Journal of Social Science & Medicine

Please see Appendix E for the submission guidelines
“Where do you draw the line?” A Social Constructionist Informed Thematic Analysis of UK Clinical Psychologists Working Globally

Josephine Church*, Dr Lesley Glover & Dr Peter Oakes

Department of Psychological Health and Wellbeing, University of Hull, Hull, UK

Word count (including tables, references. Excluding appendices): 7188

*Corresponding author:
The School of Health and Social Work
University of Hull
Hull
United Kingdom
HU6 7RX
Tel: +44 (0) 1482 464106
Fax: +44 (0) 1482 464093
J.Church@2014.hull.ac.uk
Abstract

Objective: The global mental health movement has been growing in momentum and support. However, it has also been met with criticism. Notwithstanding such debate, clinical psychologists from the United Kingdom have become increasingly involved; transferring their skills to countries classified as low to middle income (LMICs). There have been self-reports on the challenges of such work and a call for increased reflection on how to ensure ethical and effective practice. The way in which individuals talk about their world shapes how they see and behave in it. This study aimed to facilitate reflection by conducting a social constructionist thematic analysis, drawing upon ideas of Foucauldian Discourse Analysis, on how clinical psychologists construct their work in LMICs.

Method: Semi-structured interviews were conducted with seven clinical psychologists who had trained in the UK and worked for nine months or more in a LMIC.

Results: Two themes and four subthemes were identified. Participants constructed both their approach to work (theme 1) and who they were in relation to it (theme 2). They constructed approaches of professionalism and exchange. They constructed themselves as social activists and global citizens.

Conclusion: Participants appeared to be distancing themselves from discourses of dependency related to aid and the global mental health movement (as it currently exists). There was an underrunning significance of power, with participants very aware of power imbalance and the relevance of historical colonialism. This was a work of broad brush strokes that necessarily sacrificed some detail. Nevertheless, implications for future practice and research were drawn. A conversation involving individuals from different professions and experiences is necessary with the process of such documented in order to contribute to future directions of the global mental health movement.
Key words; global mental health, clinical psychology, low to middle income countries, mental health delivery, mental health care
Introduction

There is growing interest in mental health around the globe. In Western cultures (Europe and America), where the term ‘mental health’ developed, it refers to a scientific discipline, and a political and ideological movement interested in the promotion of human rights and quality of treatment (Bertolote, 2008). ‘Global mental health’ is a field of research, study and practice that places a priority on ‘improving mental ill health and achieving equity in mental health for all people worldwide’ (Patel & Prince, 2010). Pivotal in the development of this field was the publication of a series of high-profile papers in The Lancet (Lancet Global Mental Health Group, 2007). The authors proposed that there is a particularly large ‘treatment gap’ (the difference between the number of people perceived to be in need of mental health care and the number who receive it) across the globe but most prominently in countries classified as low and middle income (LMICs). Classification is based on the World Bank’s analysis of national gross income per person per year (The World Bank, 2017). This led to calls to ‘scale up’ services in these countries (Patel & Prince, 2010). The growth of educational programs, literature, study, and the increasing number of mental health trained professionals working in LMICs is evidence of subsequent efforts to bridge the ‘treatment gap’ (Collins et al., 2011; Movement for Global Mental Health, 2017). In support of these efforts, The World Health Organization (WHO) released a series of reports on the detection, management and treatment of ‘priority conditions’ such as ‘depression’ and ‘schizophrenia’ (The Mental Health Gap Action Programme (mhGAP) (WHO, 2008); mhGAP–Intervention Guide (WHO, 2010)). They have also launched campaigns, such as ‘Depression: let’s talk’, which are gaining publicity around the globe (WHO, 2017).

This approach has been met with some criticism. Especially from those who consider mental health as a social construct; a concept that has been created and
accepted by Western society (see Appendix F for a brief overview of the mental health system in the UK). They argue that this construct does not apply to all communities around the world where there are differing cultural beliefs. For example, some cultures understand the mind, body and environment as all in unison and not in isolation to the collective (both living and dead) (Summerfield, 2008; White, 2013). Some are concerned about an unhelpful marginalisation of local understandings and traditional practices (White, 2013). Efforts of ‘scaling up’ have been viewed through a political and economic lens with comparisons made to the underlying assumptions of British colonialism (Mills, 2014). There is a concern that communities are positioned as ‘in need of saving’ with an insufficient focus on reciprocity and acknowledgement of the imperfect system of care in high income countries (HICs) (Summerfield, 2008; White, 2013). This has led individuals to call for a ‘pull rather than push’ system whereby instead of HICs exporting ideas and interventions, LMICs ‘pull in’ what they are sure works for them (Kasujja, 2014).

Not withstanding this debate, clinical psychologists from the UK have become increasingly involved. A recent Clinical Psychology Forum Special Issue: Clinical Psychology in Low and Middle Economic Income Countries (Clinical Psychology Forum, 2014) published a diverse set of self-report contributions from UK National Health Service (NHS) trained clinical psychologists and trainees working globally. In his forward to the special issue, Yule (2014) commented that ‘altruism among clinical psychologists was alive and well’ and noted clear motivations from clinical psychologists and trainees to work globally. Following a trainee placement, Bosqui (2014) recommended that other trainees experience a placement overseas. However, contributors also drew upon the differing conceptualisations of mental health, a lack of clear role for psychology across the globe and the uncertainty this creates (Turpin, 2014). Brown (2014) commented that in light of these challenges, it is timely and
responsible for clinical psychologists to reflect on the ethical ways in which they can provide support in LMICs and contribute to the field of global mental health which has, to date, been predominantly led by psychiatry (Summerfield, 2012).

There is a need to consider the work of UK trained clinical psychologist working globally. This study is interested in how individuals construct (talk about) their work within countries classified as low and middle income (in line with the global mental health literature). It is considered that the way people talk about their world can shape how they experience and behave in it (Parker & Burman, 1993). The wider discourses drawn upon and the possible implications of this will be considered throughout analysis, drawing upon ideas of Foucauldian Discourse Analysis (FDA) (Willig, 2008). It is hoped that highlighting constructs, related discourses and implications will increase the reflexivity of individuals interested in this field thus contributing to effective and ethical practice (Kogan & Brown, 1998).

**Aims:**

- To explore how clinical psychologists, trained in the UK, construct their work in LMICs; identifying what is constructed, the discourses mobilised in these constructions and the related implications

- To foster further reflection on the global mental health movement

**Research question:**

- How do clinical psychologists, who have trained in the UK, construct their work in LMIC’s, what discourses do they draw upon and what may be the related implications?
Method

Design

Semi-structured interviews were completed to produce qualitative data. A thematic analysis, drawing upon ideas of Foucauldian Discourse Analysis (FDA), was completed. There is debate regarding the use of interviews, as opposed to naturally occurring speech, in obtaining data for such analysis (Taylor, 2001). However, it is considered that as long as care is taken to make the process as natural as possible and the data is read in the context of an interview process then the interaction between interviewer and participant is a meaningful one (Willig, 2008). Demographic information was collected in order to contextualise the analysis.

Measures

- Semi-structured interviews. Interviews began with general questions so to build rapport (Willig, 2008). These were initially open-ended and became more specific in follow up of participants’ responses (Harper, 2006) (see Appendix G for interview schedule)

- Demographic information. Information was collected on regions of work, time frames of work, time since training, ethnicity and recruitment (see Appendix H for recording form)

Recruitment

Participants were recruited via purposive and snowball sampling. Advertisement posters (see Appendix I) were emailed to potential participants identified via:

1. The Clinical Psychology Forum Special Issue

2. Individuals known to the researcher to have knowledge in the area
3. A post on the ‘Movement for Global Mental Health’ interest group
   (Movement for Global Mental Health, 2017)

4. Asking participants if they were aware of further potential participants
   (snowball sampling)

Participants were recruited if they fitted the inclusion and exclusion criteria (see Table 1).

Table 1. *Inclusion and exclusion criteria*

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<th>Criteria</th>
<th>Rationale</th>
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<tr>
<td><strong>Inclusion Criteria</strong></td>
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<tr>
<td>Qualified Clinical Psychologist</td>
<td>Qualified (as opposed to trainee) clinical psychologists as the stressors, impact of supervision, and placement length were considered as potential factors that would impact upon personal and professional practice (Cushway, 1992; O’Donovan, Halford &amp; Walters, 2011)</td>
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<tr>
<td>Trained on a UK NHS based training course</td>
<td>This builds upon the Clinical Psychology Forum Special Issue and also reduces the impact of within profession differences. All individuals will have been trained in accordance of the competencies established for professional training by the Health and Care Professionals Council (HCPC) and/or the Division of Clinical Psychology (DPS) of the British Psychological Society (BPS)</td>
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A combined experience of nine months or more working in LMIC since 2007 - 2007 was the publication date of The Lancet Global Mental Health Series. This allows for the analysis to be read in the current context and discourses of global mental health

- Any, or more than one, country classified as LMIC. Whilst the meaningfulness of the LMIC classification system has been debated (Fantom & Serajuddin, 2016) it is in line with that used within relevant literature

- A time frame of nine months is the minimum time frame advised by Medecins Sans Frontiers (MSF) for professionals working in LMIC’s on the basis that this is enough time for a professional to ‘adjust and engage with the work’ (MSF, 2017)

**Exclusion Criteria**

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<th>Lack of informed consent</th>
<th>Exclusion in absence of fully informed consent</th>
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**Participants**

Seven individuals participated in total. This sample was deemed to hold adequate ‘information power’ to develop new knowledge in reference to the research aims (Malterud, Siersma & Guassora, 2016). The researcher was aware of seven further potential participants. They were not recruited as they were either difficult to contact due to the nature of their work, one had worked for just under nine months in a LMIC or an adequate sample size had already been met.

A relatively small number of people work in this way. Therefore, to protect anonymity, demographic information is presented; as a whole, not on an individual basis, within time-frames, within geographical regions and not alongside direct quotes.
Some participants had worked in more than one LMIC region. See Table 2 for demographics.

Table 2. Demographic information

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<th>Criteria</th>
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<tr>
<td>Ethnicity</td>
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<tr>
<td></td>
<td>White Irish</td>
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<td></td>
<td>Six to ten years</td>
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<td></td>
<td>Eleven to fifteen years</td>
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<td>Over sixteen years</td>
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<td>Region of LMIC</td>
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<tr>
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<td>Time of work in LMIC</td>
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<td>One to three years</td>
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<td></td>
<td>Three years of more</td>
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<td>Individual with knowledge in the field</td>
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<td></td>
<td>Snow-ball sampling</td>
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</table>

Procedure

If following advertisement, individuals were interested in participating then they were emailed an information sheet (see Appendix J) and given an opportunity to ask questions. Those who agreed to participate were emailed a consent form (see Appendix K) to complete and return via email. A convenient date, time and location were agreed
upon for the interview. Two interviews were completed face-to-face, four with video Skype and one audio Skype. Skype allowed for geographical dispersion, necessary for the current study (Janghorban, Latifnejad & Taghipour, 2014). Fully informed consent was checked at the beginning of each interview. The researcher collected demographic information using the demographic recording form as a guide. This was followed by a semi-structured interview (interview length ranged from 1 hour 2 minutes to 1 hour 37 minutes). At the end of each interview, participants were reminded of the researcher’s contact details in case of any queries. Interviews were transcribed verbatim. Pauses, hesitation, laughter and noticeable changes in tone were included.

This was an ‘insider research project’ (Costley, Elliot & Gibbs, 2010) in the sense that the researcher was within the clinical psychology profession as a final year trainee. The researcher used supervision to help aid awareness of the impact this position may have on the process. A detailed reflective statement (see Appendix O) presents the researcher’s subjectivity as a resource (Parker, 1994) for consideration alongside the reading of the report.

**Ethical approval**

Ethical approval was obtained from The University of Hull Faculty of Health and Social Care Ethics Committee on 08 July 2016 (see Appendix L).

**Data analysis**

Data was analysed using thematic analysis. Thematic analysis is a flexible qualitative analytic method that can be applied across a range of theoretical and epistemological approaches (Braun & Clarke, 2006). The current study takes a social constructionist approach; it is concerned with examining the ways in which events, realities, meanings and experiences are the effects of a range of discourses operating within society (Braun & Clarke, 2006). To assist with the analysis of discourses in
operation, the researcher drew upon ideas from FDA (Timberlake, 2015). FDA is concerned with how discourse relates to wider societal and cultural contexts, considering where the speaker positions themselves and others within the discourse and the implications this may have (Willig, 2008).

The analysis was data-driven and guided by Braun and Clarke’s (2006) six phases; familiarising self with data (including transcription), generating initial codes, searching for themes, reviewing themes, defining & naming themes and producing the report. The researcher also drew upon Willig’s (2008) six stages of FDA; identifying the ways in which discursive objects are constructed, considering their relevance within wider discourses, examining the functions and gains generated through these constructions, examining the positions that speakers can take up and place others within, examining how this opens up or closes down opportunities for action/practice and considering what can be felt, thought or experienced from such positions. These stages are said to be a guide, particularly useful for researchers new to the approach, as there is no ‘set method’ for completing such an analysis (Willig, 2008). It is important to acknowledge that this is only meant to be one reading of the data and not a ‘true’ reading. A full statement of the epistemological stance taken is provided (see Appendix N). A worked example of the coding of transcripts, how this related to the generation of themes and the used of Willig’s guide is provided (see Appendix M).

**Results**

Two themes and four subthemes were generated, reviewed and defined (see Table 3). Participants tended to construct how they approached their work (theme 1) and who they were in relation to their work (theme 2). Two subthemes were identified in the participants’ approach to work; taking a professional approach (drawing upon the profession of clinical psychology) and discussing their work as being within an exchange system (both ‘giving’ and ‘taking’ from the countries and communities they
worked within). Two subthemes were also identified for participants’ self-identity in relation to work; self as a ‘social activist’ (with an awareness of the potential for others to be either oppressive or oppressed) and self as a ‘global citizen’ (with a sense of belonging to a worldwide community). Each will now be described in more detail. In order to assist the reader in understanding the wider concepts drawn upon – references of studies that explore them in greater detail will be offered alongside the analysis.

At the beginning of interviews participants tended to give an initial overview of what their day-to-day work entailed. This was noticeably constructed less throughout the entirety of interviews and was therefore not considered as an overarching theme. The descriptions given will be outlined below to contextualise the following analysis.

Table 3. Themes and subthemes

<table>
<thead>
<tr>
<th>Theme</th>
<th>Sub theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Approach to work</td>
<td>Professional</td>
</tr>
<tr>
<td></td>
<td>In exchange</td>
</tr>
<tr>
<td>(2) Self identity in relation to work</td>
<td>Social activist</td>
</tr>
<tr>
<td></td>
<td>Global citizen</td>
</tr>
</tbody>
</table>

**Overview of day-to-day work**

Participants described working with expats, repats and local populations across the age and ability range; often working with a whole family as opposed to one-to-one working. Some described only ever doing a “small amount of therapy” (P1) and working at a more organisational level. Many contributed to the development of services by: working closely with government on policy formation; offering supervision; informing strategies in post disaster and post conflict regions; working within Non-Governmental Organizations (NGOs) (training, monitoring and evaluating);
working with the United Nations. Over half of the participants had established their own private practices which required ‘clinical skills’ and ‘business development’; “I had to work out how to make it sustainable financially and how to market it so it became an actual business if you like” (P4). Participants had been involved in the development of, and/or teaching at, local universities. Many of these roles developed and changed with time; “There was no copy paste with how you do things” (P5).

**Approach to work**

**Professional**

Participants often constructed their work as that of a professional. Although this may not seem surprising, the significance of taking such an approach was not taken for granted in this context. They drew upon wider discourses of the clinical psychology profession situated within that of psychiatry. This resonated with the wider multi-disciplinary institution of the UK mental health care system. Individuals drew upon categories of the Diagnostic Statistical Manual (American Psychiatric Association, 1994), therapeutic models, professional competencies (such as “formulation” and “supervision”) and guidelines of ethical practice (drawing upon the regulatory discourses of the profession). Professional discourse positions individuals away from ‘layman’ and toward a more ‘knowledgeable’ position within which one is an ‘expert’ of something (Kong, 2014).

This affected the way in which individuals practised. For those participants who drew upon diagnosis and therapeutic models, it opened up the opportunity of adapting models used within Western countries, such as the UK, where these professional discourses are most prominent:

P7: We started seeing people with if you would like the pure anxiety, depression, trauma, you know erm relationship issues,
all kinds of things using CBT. We brought over trainers, we brought over CBT trainers from the UK.

I: How did you find the CBT worked?

P7: Amazing..

The use of the word “amazing” implies that this construction provided individuals with a sense of confidence in their work. Similarly, drawing upon regulatory discourses provided a sense of confidence and played the function of justifying work as ‘safe’ and ‘credible’. The need for confidence and justification seemed to stem from the lack of such regulatory systems within the countries they were working in and a sense that they were ‘isolated’ within this:

P2: You are trying to do work in a country where there is no standards, no regulations, no policy, no procedures. Erm that makes it difficult to practise. You don’t have this guideline saying ‘you should work like this and have supervision like this therefore you are doing it right’. You have to have a lot… er I mean I follow the guidelines that are issued by the HCPC and the BPS as a way of creating that sense of comfort. But in a regulatory manner, they don’t mean anything here. I maintain them so that my clients have that protection, I have that comfort and so that the people that I work with are also developing their standards

However, participants were also aware of a relationship between a ‘knowledgeable’ or ‘expert’ position and ‘power’. This position created a sense of discomfort and a dilemma in how best to approach their work. For example, P5 discussed how she found herself drawing upon the wider profession which positioned
her as an ‘expert’ whilst also feeling a sense of discomfort around this position which is evident in her use of laughter:

P5: You know NGOs.. anybody could call themselves a psychologist! It’s hard to try and be like I don’t want to be an expert [laughs]. However, [laughs] I’ve got a doctorate and I’m not having all this nonsense [laughs]. You kind of hear yourself going God I’ve just said I don’t want to be an expert and here I am being all assertive. It’s really hard

In exchange

Participants also constructed their approach to working in LMICs as being part of an exchange system. Participants described themselves as not just ‘giving’ to the countries and communities they were working within but also ‘taking’. On many occasions, they stated ‘taking’ more than they ‘gave’. When asked about the needs their work was meeting, participants often responded, “What for [country] or for myself?” (P2). Furthermore, participants regularly constructed their motivations for working globally as a form of personal gain. For example, in P3 response to her motivations the use of the word ‘I’ can be seen to indicate her position of ‘taking’ from the experience whilst distancing herself from only ‘giving’ to others, ‘the world’ or a certain ‘cause’:

I: What do you think motivated you to work in this way?

P3: I decided that if I was going to take some time out I may as well go for the most different so I knew I was going not because I wanted to save the world but because I wanted to try something very different. And so I was really explicit about that, I had no sense that I could.. erm I had no cause that I was trying to further just that I wanted to try something different
This appeared to be offering participants an alternative positioning to that of an ‘expert’. Within this approach the people they worked with were positioned as embodying ‘knowledge’ and therefore ‘power’. It also seemed to be a ‘counter-discourse’ to that of ‘dependency’. It appeared important to participants to position themselves away from the discourse of ‘dependency’ which they related to the approach of aid and development workers whom they described “saturating” the countries they were working within. Some participants drew upon the work of Toomey (2011) who discusses criticism levelled at the position of ‘rescuer’ or ‘provider’ in development work and relates this to the disempowerment of others. He also describes a different approach, that of an ‘ally’, whereby the emphasis is on friendship and equal exchange. This negotiation of approach could be seen in participants’ constructions:

I: It sounds like there were lots of positives to your work and bringing communities together. Were there any challenges?

P6: Oh yeah. I think… it’s really difficult erm.. in countries that have had a lot of support from foreign NGOs. You know they become really quite dependent on those structures and the kind of power imbalances that come to play and kind of the roles that people fall into. We were really concerned because we didn't want communities to feel victimised or be victimised because that’s almost against the idea of healing. If you are.. you know.. you’re helpless, you need help from these people. That’s a kind of a dance that’s been going on in [country] for a long time. So to actually go into communities and actually say like “well we actually don’t know, you guys know”. We, I, can learn so much from these communities who have been through so much.
The global mental health movement was often constructed in a similar way to that of aid and development work whereby the flow of knowledge and practice was considered unidirectional. It was noticeable that participants respected the work of those in the field but felt a sense of discomfort around identifying that approach with their own:

P3: One of the things that bugs me is when you see [prominent figure in global mental health arena] talk about, I know he’s done a lot of great stuff, but when he says we need to train up more psychologists and psychiatrists. You do not need more psychiatrists. You do not need more clinical psychologists or counsellors. What you need is to look at what the country already has as its natural healing systems and then you work with that. You strengthen them

As with the professional approach, the exchange approach also created a sense of dilemma for participants. They discussed periods of feeling unsure about their own ability to help or be of ‘use’ in the countries they were working in. It is considered that in order to position themselves within an exchange, participants were on occasion disempowering themselves. P7 has been working globally for the majority of her career and discussed the challenges that come with this way of working, in particular the feelings that arise when positioned within a wider discourse of exchange:

P7: you are going to learn much more from the people that you go to, indeed more then you may even give. It is important to always hold a very much student stance of ‘I’m learning here’. But not to hold it so much that you feel that you have got nothing to give. So it’s a dialectic
Self-identity in relation to work

Social activist

Participants constructed themselves as activists (although this was not a term used by all participants, the meaning seemed to fit with their descriptions). They drew upon what can be called a ‘social activism discourse’ where the wider world is made up of powerful people, who (intentionally or unintentionally) oppress others, and those who are oppressed (Hore, 2014). P1 discussed writing a research paper with the local staff groups. It can be seen that she positions herself as empowering and others as not having their voices heard or as oppressive (leading individuals in a direction that may not be beneficial for them):

P1: So yeah I guess the idea of writing a research paper was to get their voices heard about how they adapt psychological therapies out there but also to empower them with that so they felt that what they were saying was valuable because it was being put up for publication and they were helping write it as well. So I think that was quite a nice piece of work … just again, trying to empower them and not to be led by the western psychological therapies as the only way you should work and follow whatever the western people say

As well as empowering individuals, participants described engaging at different levels of the established political/professional system in order to reduce oppressive practice. For example, engaging in governmental decisions, involving themselves with the United Nations, challenging university training programs and releasing publications that were “critical of the status quo” (P5).

The potential for others to be oppressive seemed embedded within an awareness of the colonial histories of the countries within which they were working. Participants
were particularly aware of the interconnection of colonialism and the development of oppressive institutions – often drawing upon the existence of orphanages to illustrate this. It has previously been identified that drawing upon a social activist discourse can make individuals conscious of the potential for themselves to be engaging in oppressive action (Hore, 2014). There seemed to be a risk of their practice oppressing others and a sense that their position was so powerful that they could oppress others without intention. It was noticeable that throughout the interviews, participants were negotiating constant dilemmas over whether their practice was empowering or oppressive. This often led them to ask, “Where do you draw the line?” P2 discusses empowering elements of not having a developed mental health support system. In this example, communities are empowered to take on the ‘role’ of care. Her use of the terms ‘backwards’ and ‘forwards’ implies that there is opportunity for ‘good’ or ‘bad’ practice (relating to the idea of oppression or empowerment) that must be negotiated:

P2: Here it’s so backwards in many ways its almost sort of forward [laughs]. Yea so where we haven’t got round to those systems and processes because the government is so poor; they don’t have the finances, they don’t have the funding to be able to provide the support. The community has had to take a role in this and they don’t even think about it.. It’s just provided and so that’s yea ironically the big benefit

I: It’s interesting isn’t it

P2: Yeah [laughs] so that whole idea that we’re so backwards that we’re forwards. And that’s a risk that we run, undoing that. You know. Because that’s what’s happened with orphanages with colonization because the idea of an orphanage did not exist and that was something that was imported erm… and again
that’s a tricky issue as we all know that they are detrimental to children. There’s that risk... that that we’re trying to move forward but actually we’re going backward

**Global citizen**

Participants also constructed themselves as a ‘global citizen’. Again, this was not the terminology used by all but it was considered that the description fitted all individuals in some way. Global citizenship is understood as a sense of belonging to an emerging world community where individuals do not abandon other identities, such as allegiances to countries, but have an added layer of belonging to a worldwide community with an identity that transcends geographical or political borders and a respect for diversity (Israel, 2012).

Participants often drew upon a wider family tradition of being part of a global citizenship and a sense that they had “always been aware of the world” (P6). They did not discount identities related to the UK but they drew upon these as a shaping who they were within this greater global identity. Over half of participants discussed a relation to Ireland and in particular the conflicts within Ireland – noting that what they had learnt from that had assisted their work elsewhere. Participants positioned themselves as ‘more similar than different’ to the people they were working with and discussed diversities that transcended borders (urban/rural divide, gender, sexuality) often noting that their work felt “foreign but not all so foreign” (P7). This can be seen within P3 response to what motivated her. The level of hesitation and fillers (such as ‘erm’) can be taken to indicate that the emerging nature of this identity (Israel, 2012) and how it counters current world-wide rhetoric against ‘cross-border mobility’ (Brown, 2013) created a feeling of uncertainty:

P3: I had a sense that I. I. I. had an interest in adjustment which I’ve had all my career, an interest in trauma, I had worked
in a country of conflict erm and erm I was very curious about erm culture because culture is a very big thing in Northern Ireland you know. I have an English accent you know so being in Northern Ireland with an English accent at the time when the troubles were bad was you know.. yea that was quite shaping.

I: What do you think made you want that change and that difference?

P3: My nature I would say and it would probably be my family. Erm and I come from a family where there has been a lot er you know most people like it's hard to think of anyone who hasn’t worked for a number of years abroad [confidential information removed] you know they’re scattered all over the place

I: Ingrained

P3: I think we’re probably nomads

Constructing identity in this way, appeared to open up the opportunity for participants to work globally. They considered their training as preparation for this, stating; “We are training for the world, not for a particular trust” (P7). On occasion it appeared to justify a sense of confidence about working globally, which as can be seen from above, is sometimes difficult to maintain:

P4: The other thing I think is to have confidence in your skills. At the end of the day, you and a woman from Afghanistan share much more than you differ. You both want respect, you want peace, you want some freedom, you'd like autonomy and you have a lot of gifts to share. Both of you. The culture wrapped around you gives you permission and sets limitations and it’s you know acknowledging that, talking that, dialoguing it
Discussion

This study explored how UK trained clinical psychologists constructed their work in LMICs. Participants’ constructions were grouped into two overarching themes; how they approached their work and who they were in relation to it.

In approach to work, participants took either a professional or exchange approach. Where the professional approach was taken, they drew upon wider discourses of UK MDT mental health care that allowed for the adaptation of UK practices and a sense of comfort or confidence where there may otherwise have been isolation. With the exchange approach, participants were positioned as both ‘givers’ and ‘takers’ in an effort to equalise power dynamics and distance themselves from a discourse of ‘dependency’ which they related to that of aid work and the global mental health movement.

With regards to identity, participants constructed themselves as social activists and global citizens. They were very aware of the potential for oppressive action and the historical significance of colonialism. In the global citizen position, they constructed themselves as more similar to others than different with a view that training should be for the world, not for a particular trust.

This study’s aims were inspired by the self-reports of psychologists in the Clinical Psychology Forum Special Issue (Clinical Psychology Forum, 2014). Similar themes emerged in the sense of unclear roles and much uncertainty (Turpin, 2014). The existence of dilemmas is consistent across themes; discomfort around occupying an ‘expert’ position, the feeling of having nothing to ‘give’, negotiating the line between empowerment and oppression and feeling uncomfortable with a global identity within a current world-wide rhetoric countering cross-border movement (Brown, 2013). This supports Brown’s (2014) call for a reflection on this way of working being timely and
responsible. This seems important before psychologists position themselves as ‘altruistic’ (Yule, 2014) or involve trainees in placements in LMICs (Bosqui, 2014).

This study also aimed to foster further reflection on the global mental health movement. Support and respect for the movement could be seen in the participants’ efforts to transfer skills. This was particularly so in the case of a professional approach, drawing upon western diagnostic categories and interventions, similar to the efforts seen within the WHO intervention guides and campaigns that promote the use of CBT or talking therapy alongside medication (WHO, 2010; WHO, 2017). However, it appeared that the majority of participants were not comfortable with identifying wholly with such an approach. Justification for a need of such work came in the form of global citizenship and the potential for both parties to learn from one another as opposed to a desire to ‘scale up’ services (Lancet Global Mental Health Group, 2007).

The significance of power was an unavoidable thread throughout the study. This is perhaps why an analytic approach drawing upon the work of Michal Foucault was so relevant. Foucault was interested in how power works; arguing that ‘power is everywhere’ diffused and embodied in discourse, knowledge and regimes of truth (Foucault, 1984). He discussed the power of knowledge through professionalism and the necessity of learning from history (Foucault, 1984). Participants expressed concerns regarding the taken-for-granted power of professionalism and an awareness, emerging through a knowledge of colonial history, of the possibility of oppressive action. Foucault wrote about the power of professionalism within the introduction of mental health care in western society. He argued that individuals were constructed as ‘different’, as opposed to ‘mad’, before its introduction. He debated whether communities benefited from such a shift (Foucault, 1984). Conversations around power have not yet played a significant role in the development of global mental health.
Although Foucault’s work has been widely debated (Gane, 2013), it never the less provides a useful starting point for such conversations.

This is a work of broad brush strokes which has necessarily sacrificed a certain amount of depth and detail. Grouping countries classified as low and middle income allowed the study to speak to the relevant field of literature but it also missed the detail of each country’s political and economic context (both current and historical) which has been given great significance by both the participants in the current study and related literature (Mills, 2014). Including UK trained clinical psychologists allowed the researcher to draw upon the Clinical Psychology Forum Special Issue (Clinical Psychology Forum, 2014) and some homogeneity in training but missed the informative insights of others. This choice will have been influenced by the researcher’s position as a UK trainee clinical psychologist. Participants were aware of the ‘qualified to trainee’ dynamic and it was noticeable that on occasion they took the position of educator. This created a narrowed context of interaction in that participants used terminology that is taken for granted within the profession and reduced the necessity to explain this (for example, “formulation”). Within such a position, participants may also have moulded their talk into what they felt a trainee, interested in this field, should be aware of.

Whilst keeping limitations of the study in mind, implications for individual and organisational practice can be drawn. Individuals have been working in this way for a while, across the globe, and plan to continue doing so. Furthermore, this is not an individual endeavour; participants are drawing upon the profession of clinical psychology. This should move discussion away from whether this is ethical or effective and toward reflection and action on how to make it so. Reflection should be encouraged at an individual and organisational level. This should in no way replace what is built within countries but support individuals in accessing the ‘pull’ of countries as opposed to ‘push’ upon them (Kasujja, 2014). The researcher has become aware of pockets of
support systems that are not connected. An arena for discussion of such issues would be an effective way to facilitate reflection and counter isolation.

This topic clearly also spans issues wider than that of just clinical psychologists working globally. It strikes a remarkable resemblance to clinical psychology within the UK – a shift away from one-to-one work, working at an organisational and leadership level, an increasingly globalised service user population, negotiations of power imbalance and an awareness of an increasingly privatised ‘business nature’ to healthcare. The importance of ‘pull rather than push’ also resonates with an increasing focus on ‘experts by experience’ (Care Quality Commission, 2017); individuals who are experts in the systems within such countries must be involved. Furthermore, this is relevant beyond the profession of clinical psychology. Psychiatry has been playing a large role in global mental health and this study has found a relevance of discussions around aid and development work (Toomey, 2011).

Further research should look into integrating all of these varying perspectives. This should encourage reciprocity in learning not just between HICs and LMICs but between individuals of differing training and experience. A focus group approach would be appropriate for this and build on some of the limitations of the current study. Using such an approach would increase the context of interaction, access communications used in everyday interaction, and permit the possibility of hearing multiple/collective voices (Liamputtong, 2011). Approaches that draw upon the practices of different cultures and traditions are recommended when including individuals from multiple backgrounds.

In conclusion, participants constructed their approach and self-identity in relation to their work in countries classified as low to middle income. They constructed approaches of professionalism and exchange, distancing themselves from discourses of dependency related to aid work and the global mental health movement (as it currently exists). They constructed themselves as social activists and global citizens. There was an
underrunning significance of the role of power that highlighted the need for a
consideration of power within the global mental health movement. This was a work of
broad brush strokes necessarily sacrificing detail, such as the context of individual
countries. Nevertheless, implications for future practice and research can be identified.
This way of working is growing, and will continue to do so. It is timely to reflect, at
both an individual and organisational level, on how to negotiate the issues raised to
ensure effective and ethical practice. This should take the form of a joined up
discussion involving a range of professions and experiences. Research of such an event
is necessary to facilitate learning and contribute to the development of global mental
health.
References


Clinical Psychology Forum. (2014). Special Issue: Clinical Psychology in Low and Middle Economic Income Countries. Clinical Psychology Forum, 258


Clinical Psychology Forum Special Issue


Part Three: Appendices
Appendix A: Submission guidelines for Journal of Cross-Cultural Psychology

Journal of Cross-Cultural Psychology (JCCP) publishes material in three categories: (1) regular, unsolicited manuscripts, (2) brief reports, and (3) special issues. Summary details of each category are as follows:

1. Regular, Unsolicited Manuscripts. This is JCCP’s main emphasis. See Aims and Scope* for a detailed description of appropriate manuscripts.

Manuscripts should be submitted electronically to http://mc.manuscriptcentral.com/jccp. Authors will be required to set up an online account on the SageTrack system powered by ScholarOne. Manuscripts will be sent out anonymously for editorial evaluation. Obtaining permission for any quoted or reprinted material that requires permission is the responsibility of the author. Submission of a manuscript implies commitment to publish in the journal. Authors submitting manuscripts to the journal should not simultaneously submit them to another journal, nor should manuscripts have been published elsewhere in substantially similar form or with substantially similar content. Authors in doubt about what constitutes prior publication should consult the Editor.

Manuscript length should normally be 15 to 35 double-spaced, typewritten pages. Longer papers will be considered and published if they meet the above criteria. Manuscripts should be prepared according to the most recent edition of the American Psychological Association Publication Manual. Manuscripts are reviewed by the Editorial Advisory Board. Allow up to 3 months for a publication decision and up to 1 year for publication.

2. Brief Reports. Accepted Brief Reports should be no more than 10 double-spaced manuscript pages long, including title page, references and any tables.

3. Special Issues. An important part of JCCP’s publication policy is the periodic publication of special issues or special sections of regular issues. Current needs, emerging trends, and readership interest guide the publication of material in this category. Ideas or suggestions for special issues or special sections should be discussed with Walter J. Lonner (Walter.Lonner@wwu.edu), Founding and Special Issues Editor, or other members of the Editorial Advisory Board, especially current Editor, Deborah L. Best (best@wfu.edu).

English language editing services

Authors seeking assistance with English language editing, translation, or figure and manuscript formatting to fit the journal’s specifications should consider using the services offered by SAGE Language Services. Visit SAGE Language Services on our Journal Author Gateway for further information. Here is the link:

http://languageservices.sagepub.com/en/

*Aims and scope for review papers; Integrative reviews that synthesize empirical studies and innovative reformulations of cross-cultural theory will also be considered. These reviews are expected to reformulate or offer a novel perspective to an existing cross-cultural theory or research area.
**Appendix B: Data extraction form**

<table>
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<th>Author(s)</th>
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<tr>
<td>Year of publication</td>
</tr>
<tr>
<td>Country</td>
</tr>
<tr>
<td>Aim(s)</td>
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</table>

**Setting**

| Geographical area (and reported context) |
| Care setting (and reported context) |
| Timing of data collection |
| Rationale/reason for area, setting and timing |

**Sample**

| Inclusion/Exclusion criteria |
| Selection approach (and reasons why) |
| Size |
| Reported Characteristics (e.g. Age / Gender / Ethnicity / Religion / Role (Profession) / Experience) |

**Method**

| Data collection |
| Data analysis |
| Reported characteristics and role of researcher (any potential bias?) |

**Findings**

| Results (e.g. themes / sub themes) |
| Conclusions |
| Opinions / Implications |
| Ethics (what ethical issues were addressed?) |
### Appendix C: Quality assessment tool

**Theoretical Approach**

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<th>1.1 Is a qualitative approach appropriate?</th>
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<td>• Does the research question seek to understand processes or structures, or illuminate subjective experiences or meanings?</td>
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<tr>
<td>• Could a quantitative approach better have addressed the research question?</td>
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<table>
<thead>
<tr>
<th>1.2 Is the study clear in what it seeks to do?</th>
<th>Clear (1)</th>
<th>Comments:</th>
</tr>
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<tr>
<td>For example:</td>
<td>Unclear (0)</td>
<td>Mixed (0)</td>
</tr>
<tr>
<td>• Is the purpose of the study discussed – aims/objectives/research question(s)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Is there adequate/appropriate reference to the literature?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Are underpinning values/assumptions/theory discussed?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Design**

<table>
<thead>
<tr>
<th>2.1 How defensible/rigorous is the research design/methodology?</th>
<th>Defensible (1)</th>
<th>Comments:</th>
</tr>
</thead>
<tbody>
<tr>
<td>For example:</td>
<td>Not defensible (0)</td>
<td>Not sure (0)</td>
</tr>
<tr>
<td>• Is the design appropriate to the research question?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Is a rationale given for using a qualitative approach?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Are there clear accounts of the rationale/justification for the sampling, data collection and data analysis techniques used?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Is the selection of cases/sampling strategy theoretically justified?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2.2 How well was the data collection carried out?</th>
<th>Appropriate (1)</th>
<th>Comments:</th>
</tr>
</thead>
<tbody>
<tr>
<td>For example:</td>
<td>Inappropriate (0)</td>
<td>Not sure (0)</td>
</tr>
<tr>
<td>• Are the data collection methods clearly described?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Were the appropriate data collected to address the research question?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Was the data collection and record keeping</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
systematic?

<table>
<thead>
<tr>
<th>Mixed methods only</th>
<th>Appropriate (1) Inappropriate (0) Not sure (0) Comments:</th>
</tr>
</thead>
</table>

2.3 Is the mixed methods research design relevant to address the qualitative and quantitative research questions (or objectives), or the qualitative and quantitative aspects of the mixed methods question (or objective)?
For example:
The rationale for integrating qualitative and quantitative methods to answer the research question is explained.

Validity

<table>
<thead>
<tr>
<th>3.1 Is the role of the researcher clearly described?</th>
<th>Clear (1) Unclear (0) Not described (0) Comments:</th>
</tr>
</thead>
</table>
For example:
• Has the relationship between the researcher and the participants been adequately considered?
• Does the paper describe how the research was explained and presented to the participants?

<table>
<thead>
<tr>
<th>3.2 Is the context clearly described?</th>
<th>Clear (1) Unclear (0) Not sure (0) Comments:</th>
</tr>
</thead>
</table>
For example:
• Are the characteristics of the participants and settings clearly defined?
• Were observations made in a sufficient variety of circumstances?
• Was context bias considered?

<table>
<thead>
<tr>
<th>3.3 Were the methods reliable?</th>
<th>Reliable (1) Unreliable (0) Not sure (0) Comments:</th>
</tr>
</thead>
</table>
For example:
• Do the methods investigate what they claim to?

Analysis

<table>
<thead>
<tr>
<th>4.1 Is the data analysis sufficiently rigorous?</th>
<th>Rigorous (1) Not rigorous (0) Not sure/not reported (0) Comments:</th>
</tr>
</thead>
</table>
For example:
• Is the procedure explicit – is it clear how the data were analysed to arrive at the results?
• How systematic is the analysis – is the procedure
<table>
<thead>
<tr>
<th>Section</th>
<th>Question</th>
<th>Rating</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1</td>
<td>Are the data ‘rich’?</td>
<td>Rich (1)</td>
<td>Comments:</td>
</tr>
<tr>
<td></td>
<td>For example:</td>
<td>Poor (0)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• How well are the contexts of the data described?</td>
<td>Not sure/not reported (0)</td>
<td></td>
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<tr>
<td></td>
<td>• Has the diversity of perspective and content been explored?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.2</td>
<td>Is the analysis reliable?</td>
<td>Reliable (1)</td>
<td>Comments:</td>
</tr>
<tr>
<td></td>
<td>For example:</td>
<td>Unreliable (0)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Did more than one researcher theme and code transcripts/data?</td>
<td>Not sure/not reported (0)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• If so, how were differences resolved?</td>
<td></td>
<td></td>
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<td></td>
<td>• Did participants feedback on the transcripts/data? (if possible and relevant)</td>
<td></td>
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<tr>
<td></td>
<td>• Were negative/discrepant results addressed or ignored?</td>
<td></td>
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</tr>
<tr>
<td>4.3</td>
<td>Are the findings convincing?</td>
<td>Convincing (1)</td>
<td>Comments:</td>
</tr>
<tr>
<td></td>
<td>For example:</td>
<td>Not convincing (0)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Are the findings clearly presented?</td>
<td>Not sure (0)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Are the findings internally coherent?</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>• Are extracts from the original data included?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Are the data appropriately referenced?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Is the reporting clear and coherent?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.4</td>
<td>Are the conclusions adequate?</td>
<td>Relevant (1)</td>
<td>Comments:</td>
</tr>
<tr>
<td></td>
<td>For example:</td>
<td>Irrelevant (0)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• How clear are the links between data, interpretation and conclusions?</td>
<td>Partially relevant (0)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Are the conclusions plausible and coherent?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Have alternative explanations been explored and</td>
<td></td>
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</table>
discounted?
• Does this study enhance understanding of the research subject?
• Are the implications of the research clearly defined?
• Is there adequate discussion of any limitations encountered?

<table>
<thead>
<tr>
<th>Mixed methods only</th>
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</thead>
<tbody>
<tr>
<td><strong>4.7 Is the integration of qualitative and quantitative data (or results) relevant to address the research question (objective)?</strong></td>
</tr>
<tr>
<td>For example: There is evidence that data gathered by both research methods was brought together to form a complete picture, and answer the research question; authors explain when integration occurred (during the data collection-analysis or/and during the interpretation of qualitative and quantitative results); they explain how integration occurred and who participated in this integration.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Relevant (1)</th>
<th>Irrelevant (0)</th>
<th>Partly relevant (0)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Comments:</th>
</tr>
</thead>
</table>

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<tr>
<th>Mixed methods only</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>4.8. Is appropriate consideration given to the limitations associated with this integration, e.g., the divergence of qualitative and quantitative data (or results)?</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Appropriate (1)</th>
<th>Inappropriate (0)</th>
<th>Not sure (0)</th>
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</thead>
</table>

<table>
<thead>
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<th>Comments:</th>
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</thead>
</table>

<table>
<thead>
<tr>
<th>Ethics</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>5.1 How clear and coherent is the reporting of ethical considerations?</strong></td>
</tr>
<tr>
<td>For example:</td>
</tr>
<tr>
<td>• Have ethical issues been taken into consideration?</td>
</tr>
<tr>
<td>• Are ethical issues discussed adequately – do they address consent and anonymity?</td>
</tr>
<tr>
<td>• Have the consequences of the research been</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Clear (1)</th>
<th>Unclear (0)</th>
<th>Not sure (0)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Comments:</th>
</tr>
</thead>
</table>
considered; for example, raising expectations, changing behaviour?

• Was the study approved by an ethics committee?
## Appendix D: Quality assessment scores of included studies

<table>
<thead>
<tr>
<th>N</th>
<th>Approach</th>
<th>Design</th>
<th>Validity</th>
<th>Analysis</th>
<th>Ethics</th>
<th>Total (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>-</td>
<td>0</td>
</tr>
<tr>
<td>2</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>-</td>
<td>0</td>
</tr>
<tr>
<td>3</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>-</td>
<td>0</td>
</tr>
<tr>
<td>4</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>-</td>
<td>1</td>
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<tr>
<td>5</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>-</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Lack</td>
<td>of</td>
<td>theory</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| 6 | 1 | 0 | 1 | 1 | - | 0 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | - | - | 1 | 86 |
|   | Lack | of | theory |   |   |   | Role | of | researcher | not | considered |   |   |   |   |   |   |

| 7 | 1 | 0 | 1 | 1 | 1 | 0 | 0 | 1 | 1 | 1 | 1 | 1 | 1 | 0 | 1 | 1 | 1 | 76 |
|   | Lack | of | theory |   |   |   | Role | of | researcher | not | considered | Limited | information | on setting |   | No | limitations | discussed |   |

| 8 | 1 | 1 | 1 | 1 | - | 0 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | - | - | 1 | 93 |
|   |   |   |   |   |   |   | Role | of | researcher | not | considered |   |   |   |   |   |   |

| 9 | 1 | 1 | 1 | 1 | - | 0 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | - | - | 1 | 93 |
|   |   |   |   |   |   |   | Role | of | researcher | not | considered |   |   |   |   |   |   |

| 10 | 1 | 0 | 1 | 1 | - | 0 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | - | - | 1 | 86 |
|    | Lack | of | theory |   |   |   | Role | of | researcher |   |   |   |   |   |   |   |   |   |
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2) Peer-reviewed short communications of findings on topical issues or published articles of between 2000 and 4000 words.

3) Submitted or invited commentaries and responses debating, and published alongside, selected articles (please select the article type ‘Discussion’ when submitting a Commentary).

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• Full postal address

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• All figures (include relevant captions)
• All tables (including titles, description, footnotes)
• Ensure all figure and table citations in the text match the files provided
• Indicate clearly if color should be used for any figures in print
**Graphical Abstracts / Highlights files** (where applicable)
**Supplemental files** (where applicable)

Further considerations
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• All references mentioned in the Reference List are cited in the text, and vice versa
• Manuscript does not exceed the word limit
• All identifying information has been removed from the manuscript, including the file name itself
• Permission has been obtained for use of copyrighted material from other sources (including the Internet)
• Relevant declarations of interest have been made
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Essential cover page information
The Cover Page should only include the following information:

• **Title.** Concise and informative. Titles are often used in information-retrieval systems. Avoid abbreviations and formulae where possible and make clear the article’s aim and health relevance.

• **Author names and affiliations in the correct order.** Where the family name may be ambiguous (e.g., a double name), please indicate this clearly. Present the authors’ affiliation addresses (where the actual work was done) below the names. Indicate all affiliations with a lower-case superscript letter immediately after the author’s name and in front of the appropriate address. Provide the full postal address of each affiliation, including the country name and, if available, the e-mail address of each author.

• **Corresponding author.** Clearly indicate who will handle correspondence at all stages of refereeing and publication, also post-publication. **Ensure that telephone and fax numbers (with country and area code) are provided in addition to the e-mail address and the complete postal address.** Contact details must be kept up to date by the corresponding author.

• **Present/permanent address.** If an author has moved since the work described in the
article was done, or was visiting at the time, a 'Present address' (or 'Permanent address') may be indicated as a footnote to that author's name. The address at which the author actually did the work must be retained as the main, affiliation address. Superscript Arabic numerals are used for such footnotes.

Text
In the main body of the submitted manuscript this order should be followed: abstract, main text, references, appendix, figure captions, tables and figures. Author details, keywords and acknowledgements are entered separately during the online submission process, as is the abstract, though this is to be included in the manuscript as well. During submission authors are asked to provide a word count; this is to include ALL text, including that in tables, figures, references etc.

Title
Please consider the title very carefully, as these are often used in information-retrieval systems. Please use a concise and informative title (avoiding abbreviations where possible). Make sure that the health or healthcare focus is clear.

Abstract
An abstract of up to 300 words must be included in the submitted manuscript. An abstract is often presented separately from the article, so it must be able to stand alone. It should state briefly and clearly the purpose and setting of the research, the principal findings and major conclusions, and the paper's contribution to knowledge. For empirical papers the country/countries/locations of the study should be clearly stated, as should the methods and nature of the sample, the dates, and a summary of the findings/conclusion. Please note that excessive statistical details should be avoided, abbreviations/acronyms used only if essential or firmly established, and that the abstract should not be structured into subsections. Any references cited in the abstract must be given in full at the end of the abstract.

Research highlights
Research highlights are a short collection of 3 to 5 bullet points that convey an article's unique contribution to knowledge and are placed online with the final article. We allow 85 characters per bullet point including spaces. They should be supplied as a separate file in the online submission system (further instructions will be provided there). You should pay very close attention to the formulation of the Research Highlights for your article. Make sure that they are clear, concise and capture the reader's attention. If your research highlights do not meet these criteria we may need to return your article to you leading to a delay in the review process.

Keywords
Up to 8 keywords are entered separately into the online editorial system during submission, and should accurately reflect the content of the article. Again abbreviations/acronyms should be used only if essential or firmly established. For empirical papers the country/countries/locations of the research should be included. The keywords will be used for indexing purposes.

Methods
Authors of empirical papers are expected to provide full details of the research methods used, including study location(s), sampling procedures, the date(s) when data were collected, research instruments, and techniques of data analysis. Specific guidance on the reporting of qualitative studies are provided here.

Systematic reviews and meta-analyses must be reported according to PRISMA guidelines.
Footnotes
There should be no footnotes or endnotes in the manuscript.

Artwork

Electronic artwork

General points
• Make sure you use uniform lettering and sizing of your original artwork.
• Preferred fonts: Arial (or Helvetica), Times New Roman (or Times), Symbol, Courier.
• Number the illustrations according to their sequence in the text.
• Use a logical naming convention for your artwork files.
• Indicate per figure if it is a single, 1.5 or 2-column fitting image.
• For Word submissions only, you may still provide figures and their captions, and tables within a single file at the revision stage.
• Please note that individual figure files larger than 10 MB must be provided in separate source files.

A detailed guide on electronic artwork is available.

You are urged to visit this site; some excerpts from the detailed information are given here.

Formats
Regardless of the application used, when your electronic artwork is finalized, please 'save as' or convert the images to one of the following formats (note the resolution requirements for line drawings, halftones, and line/halftone combinations given below):
• EPS (or PDF): Vector drawings. Embed the font or save the text as 'graphics'.
• TIFF (or JPG): Color or grayscale photographs (halftones): always use a minimum of 300 dpi.
• TIFF (or JPG): Bitmapped line drawings: use a minimum of 1000 dpi.
• TIFF (or JPG): Combinations bitmapped line/halftone (color or grayscale): a minimum of 500 dpi is required.

Please do not:
• Supply files that are optimized for screen use (e.g., GIF, BMP, PICT, WPG); the resolution is too low.
• Supply files that are too low in resolution.
• Submit graphics that are disproportionately large for the content.

Color artwork

Please make sure that artwork files are in an acceptable format (TIFF (or JPEG), EPS (or PDF), or MS Office files) and with the correct resolution. If, together with your accepted article, you submit usable color figures then Elsevier will ensure, at no additional charge, that these figures will appear in color online (e.g., ScienceDirect and other sites) regardless of whether or not these illustrations are reproduced in color in the printed version. For color reproduction in print, you will receive information regarding the costs from Elsevier after receipt of your accepted article. Please indicate your preference for color: in print or online only. Further information on the preparation of electronic artwork.

Figure captions
Ensure that each illustration has a caption. A caption should comprise a brief title (not on the figure itself) and a description of the illustration. Keep text in the illustrations themselves to a minimum but explain all symbols and abbreviations used.

Tables

Please submit tables as editable text and not as images. Tables can be placed either next to the relevant text in the article, or on separate page(s) at the end. Number tables consecutively in accordance with their appearance in the text and place any table notes below the table body. Be sparing in the use of tables and ensure that the data presented in them do not duplicate results described elsewhere in the article. Please avoid using vertical rules and shading in table cells.
References

Citation in text
Please ensure that every reference cited in the text is also present in the reference list (and vice versa). Any references cited in the abstract must be given in full at the end of the abstract. Unpublished results and personal communications are not recommended in the reference list, but may be mentioned in the text. If these references are included in the reference list they should follow the standard reference style of the journal (see below) and should include a substitution of the publication date with either "Unpublished results" or "Personal communication" Citation of a reference as "in press" implies that the item has been accepted for publication.

Web references
As a minimum, the full URL should be given and the date when the reference was last accessed. Any further information, if known (DOI, author names, dates, reference to a source publication, etc.), should also be given. Web references can be listed separately (e.g., after the reference list) under a different heading if desired, or can be included in the reference list.

Data references
This journal encourages you to cite underlying or relevant datasets in your manuscript by citing them in your text and including a data reference in your Reference List. Data references should include the following elements: author name(s), dataset title, data repository, version (where available), year, and global persistent identifier. Add [dataset] immediately before the reference so we can properly identify it as a data reference. The [dataset] identifier will not appear in your published article.

References in special issue articles, commentaries and responses to commentaries
Please ensure that the words 'this issue' are added to any references in the reference list (and any citations in the text) to other articles which are referred to in the same issue.

Reference management software
Most Elsevier journals have their reference template available in many of the most popular reference management software products. These include all products that support Citation Style Language styles, such as Mendeley and Zotero, as well as EndNote. Using the word processor plug-ins from these products, authors only need to select the appropriate journal template when preparing their article, after which citations and bibliographies will be automatically formatted in the journal's style. If no template is yet available for this journal, please follow the format of the sample references and citations as shown in this Guide.

The current Social Science & Medicine EndNote file can be directly accessed by clicking here.

Users of Mendeley Desktop can easily install the reference style for this journal by clicking the following link:
http://open.mendeley.com/use-citation-style/social-science-and-medicine

When preparing your manuscript, you will then be able to select this style using the Mendeley plug-ins for Microsoft Word or LibreOffice.

Reference formatting
There are no strict requirements on reference formatting at submission. References can be in any style or format as long as the style is consistent. Where applicable, author(s) name(s), journal title/book title, chapter title/article title, year of publication, volume number/book chapter and the pagination must be present. Use of DOI is highly encouraged. The reference style used by the journal will be applied to the accepted article by Elsevier at the proof stage. Note that missing data will be highlighted at proof stage for the author to correct. If you do wish to format the references yourself they should be arranged according to the following examples:
Reference style

Text: All citations in the text should refer to:
1. **Single author:** the author’s name (without initials, unless there is ambiguity) and the year of publication;
2. **Two authors:** both authors’ names and the year of publication;
3. **Three or more authors:** first author's name followed by 'et al.' and the year of publication.

Citations may be made directly (or parenthetically). Groups of references should be listed first alphabetically, then chronologically.

Examples: 'as demonstrated (Allan, 2000a, 2000b, 1999; Allan and Jones, 1999). Kramer et al. (2010) have recently shown ....'

**List:** References should be arranged first alphabetically and then further sorted chronologically if necessary. More than one reference from the same author(s) in the same year must be identified by the letters 'a', 'b', 'c', etc., placed after the year of publication.

**Examples:**
Reference to a journal publication:

Reference to a book:

Reference to a chapter in an edited book:

Reference to a website:

Reference to a dataset:
Appendix F: Overview of constructs of mental health care in the UK

In the UK there’s an interest in ‘de-stigmatizing’ distress related to mental health and increasing resources to ‘treat’ this distress with slogans such as ‘no health without mental health’ prominent in the media and political arenas (Department of Health, 2011). Mental health care has taken on a multi-disciplinary team (MDT) approach with the profession of psychiatry traditionally taking a lead. Although varying and developing, a psychiatric approach can be predominantly understood as diagnosis, prognosis, etiology and treatment within a medical model that focuses upon the biological nature of distress (Rogers & Pilgrim, 2014). The discourse (written or spoken communication) of the Diagnostic and Statistical Manual of Mental Disorders (DSM) (American Psychiatric Association, 1994), an authoritative text within psychiatry, has been found to construct distress as a ‘pattern or syndrome that occurs within an individual' (Crowe, 2000). This is taken to imply that distress is a consequence of ‘faulty individual functioning’ and dichotomizes ‘normality’ and ‘abnormality’ with ‘normality’ grounded in behaviors of productivity, unity, moderation and rationality (Crowe, 2000).

Within MDTs, research has highlighted a ubiquitousness of medical discourse with a divide between ‘service user’ and ‘professional’ (Georgaca, 2014). A predominant profession, thought to have grown out of psychiatry, is that of clinical psychology (Rogers & Pilgrim, 2014). A more psychological approach can be understood as assessment, collaborative formulation, intervention and evaluation. There is a focus upon psychometric testing, behavioral observation, self-monitoring and interviewing that is informed by psychosocial theory. Interventions have traditionally been based around individual therapies with more systemic models, focusing on an individual’s context and relationships, becoming increasingly popular (The British Psychological Society, 2014).
References:


Appendix G: Interview schedule

1. Tell me about your work in [name of LMIC(s)].
   Follow up topics; what type of work did/do you do, what needs do you think this work addresses, what was the process and outcome of your work, what are your opinions on why this process/outcome came about, what were the pros and cons of your work?

2. What were your motivations for working in [name of LMIC(s)]?
   Follow up topics; how did you come to working in this way, what do you think influenced you?

3. What were your expectations of working in [name of LMIC(s)]?
   Follow up topics; what were your predetermined expectations based upon?

4. How did the experience meet or deviate from your expectations?
   Follow up topics; were there any unforeseen challenges or positives of the experience? Did your clinical training help you to prepare for your work in [LMIC(s)]?

5. What do you think the role of clinical psychology is in [name of LMIC(s)]?
   Follow up topics; how do you think this relates to the wider role of clinical psychology within global mental health?
Appendix H: Demographic recording form

Participant number ……..

In which region was the LMIC that you worked in for nine months or more? How long did you work there (1 – 9 months, 9 – 12 months, 1 – 3 years, 3 years+)?

Which other regions have you worked in? How long did you work in each region (1 – 3 months, 3 – 9 months, 9 – 12 months, 1 – 3 years, 3 years+)?

How long has it been since you completed your training in the UK? (circle)

Less that 1 year

1 – 5 years

5 – 10 years

10 – 15 years

15 years +

What ethnicity would you class yourself as?

How were you recruited for the current study?
Appendix I: Advertisement

- Are you a Qualified Clinical Psychologist?
- Did you complete your clinical training in the UK?
- Have you worked for nine months or more in a Low to Middle Income Country* since 2007?
- Would you feel comfortable discussing your work in a one-to-one interview?

If the answer is yes to all of these questions then you may be able take part in a research project that aims to understand more about the role of Clinical Psychologists in Low to Middle Income Countries.

This project is interested in how Clinical Psychologists, trained in the UK, talk about their work in Low to Middle Income Countries and how this relates to wider societal and cultural contexts.

You would be required to participate in a one-to-one interview with the researcher for approximately one hour and no more than two hours. The interview will be arranged for a time and place that is convenient – if you are currently working overseas then a Skype interview can be arranged. There are no right or wrong answers. Your data will be kept anonymously and your identity will be protected in the write up of this project.

For more information or if you are interested in taking part please contact
Josie Church:
J.Church@hull.2014.ac.uk

Department of Psychological Health and Wellbeing
Faculty of Health and Social Care

*Low to Middle Income Country as classified by The World Bank based on gross national income per capita. Please visit www.worldbank.org to view a list of countries classified as low and middle income.
Appendix J: Participant information sheet

Participant Information Sheet

UK Trained Clinical Psychologists’ Accounts of their Work in Low to Middle Income Countries

We would like to invite you to take part in our research study which is looking at the experience of clinical psychologists working in countries classified as low and middle income by The World Bank. Before you decide if you would like to participate we would like to offer you the opportunity to understand why this research is being done and what it will involve for you. Therefore, we have provided this information sheet and are more than happy to answer any questions you may have. You are also welcome to discuss participation with others before you decide if you would like to take part.

What is the purpose of the study?

We currently understand very little about the work of clinical psychologists in low to middle income countries. We are interested in the way in which you understand and talk about your role, motivations and expectations in relation to your work in low to middle income countries. We are not concerned with right or wrong answers or making judgments about your work overseas, but are curious to explore the role of clinical psychology and how it may fit with wider cultural and societal contexts.

Why have I been invited?

This information is given to qualified clinical psychologists who have worked in any low to middle income country for a period of nine months or more since 2007. We are aiming to recruit five to eight clinical psychologists who will all be interviewed independently.

Do I have to take part?

No, participation is completely voluntary. If you decide to take part you will be asked to sign a consent form to indicate your consent. You are free to withdraw from the study up to the point of analysis and write-up. You will not be asked to give a reason for this.

What will happen if I decide to take part?

If you are interested in taking part in this study then please contact the lead researcher (Josie Church, trainee clinical psychologist). The researcher will arrange an interview time that is convenient for you. It is understood that you may be working overseas at the time you wish to participate in an interview and therefore it is possible that interviews will be held over Skype. You will be asked for some descriptive information about yourself, for example the LMIC you have worked in. This will take no longer than ten minutes. You will then be involved in a discussion with the researcher about your work overseas. This will last around one hour and no more than two hours. The conversation will be recorded.
What are the possible disadvantages and risks of taking part?

Participating in the study will require your time and it is understood that this may be inconvenient for you. Furthermore, talking about your work may be distressing for you if you had difficult or upsetting experiences. It is asked that you make a considered judgment as to whether or not you feel able to discuss these experiences. If you do decide to take part and become distressed by the conversation, then the researcher will offer you a break or give you the option of finishing the interview. The researcher will also help you to consider the different options of support that are open to you.

What are the possible benefits of taking part?

We cannot promise that you will have any direct benefits from taking part in the study. However, it is hoped that the information you give will help us to understand more about this currently understudied area of working. It is hoped that this will help to shape future practice and inform training courses that are increasingly offering placements overseas. It is also hoped that the research will contribute the voice of clinical psychology to the wider literature on mental health care in low to middle income countries.

What will happen if I decide I no longer wish to take part?

You are free to withdraw from the study up to the point of the interview being transcribed and analysed. You would not need to give a reason for this decision.

What if there is a problem?

If you have any concerns about the study, then you are more than welcome to contact the researcher or their supervisors who will do their best to answer your questions. The contact details for all are provided at the end of this information sheet. If you feel that you would like to make a complaint, you may wish to contact Julie Jomeen – the Associate Dean for research at the Faculty of Health and Social Care at The University of Hull.

Will my taking part in this study be kept confidential?

Yes, all the personal information that you provide will be kept strictly confidential. Any information that could be used to identify you will not be used in the write-up. It is understood that there are a relatively small number of clinical psychologists working in this way and so extra care will be taken to protect your anonymity. For example, descriptive statistics will not be reported alongside direct quotes and your region of work will be reported as opposed to the country (e.g. ‘East Africa’ as opposed to ‘Uganda’). If you decide to participate then you will be given a code to protect your anonymity. After the research is completed all the audio recordings will be destroyed. The only time that information cannot be kept confidential is if you disclose something that suggests that you or someone else is at risk of serious harm. If this happens during the interview the researcher will need to contact appropriate authorities to ensure that you and other people are safe. The researcher will try to discuss this with you.

What will happen to the results of the study?
If you desire, the results of the study can be communicated to you after completion. The results will then be written-up for a thesis and submitted for publication in an academic journal. Some direct quotes from your interview may be used in the write-up but as mentioned previously, your anonymity will be protected. Your personal details and any identifiable data will not be included in the write-up.

Who is organising and funding the research?

This research is being undertaken as part of a doctoral research project in clinical psychology. The research is funded and regulated through The University of Hull. Some relevant sections of data collected during the study which are relevant to taking part in this research may be looked at by responsible individuals from The University of Hull or from regulatory authorities to ensure that appropriate guidance was followed by the researcher.

Who has reviewed the study?

The study is reviewed by an independent organization; a Research Ethics Committee. The committee protects the interest of people who participate in research and has given this study favourable opinion.

If you have any further questions, comments or queries, please don’t hesitate to contact the lead researcher (Josie Church). Thank you for taking the time to read this information and for considering participating.

Yours Sincerely,

Josie Church
Trainee Clinical Psychologist

Supervised by,

Dr Lesley Glover
Senior Lecturer
Faculty of Health and Social Care
The University of Hull

Dr Peter Oakes
Consultant Clinical Psychologist
Contact details and Further Information

Josie Church
The Department of Clinical Psychology
Hertford Building
The University of Hull
Cottingham Road
Hull
HU6 7RX
E-mail: J.Church@2014.hull.ac.uk

Peter Oakes
The Department of Clinical Psychology
Hertford Building
The University of Hull
Cottingham Road
Hull
HU6 7RX
E-mail: P.M.Oakes@hull.ac.uk

Dr Lesley Glover
The Department of Clinical Psychology
Hertford Building
The University of Hull
Cottingham Road
Hull
HU6 7RX
Email: L.F.Glover@hull.ac.uk

If you are interested in taking part in the study, please leave your contact details on the space provided below and return to the researcher. You will be able to ask the researcher any questions that you may have and if you consent to participating in the study and then an interview arrangement, which is convenient for you, will be arranged.

Name:

Telephone Number:

Mobile Phone Number:

Email Address:

Would you prefer to be contacted at a certain time of day or by any particular method?

Do you have any further comments?

Date:

Thank you very much for your interest!
Appendix K: Participant consent form

CONSENT FORM

UK Trained Clinical Psychologist’s Accounts of their Work in Low to Middle Income Countries

Name of Researcher: Josie Church

Please initial boxes

1. I confirm that I have read and understand the information sheet dated 24/7/16 (Version 1.1) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw without giving any reason up to the point of data analysis and write-up.

3. I confirm that direct quotes from the interview may be used in future publications and I understand that they will be anonymised.

4. I understand that relevant sections of the data collected during the study may be looked at by responsible individuals at The University of Hull or regulatory authorities, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my data.

5. I agree to take part in the interview and understand that my interview will be audio taped.

6. I would like to receive information on the outcome of the study

Name of participant Date Signature

Name of person taking consent Date Signature

When completed: 1 for participant; 1 for research file

Appendix L: Ethical approval documentation
Removed for hard binding
Appendix M: Example of data analysis

An example of transcription for participant 1, initial coding and the relation of codes to subthemes

<table>
<thead>
<tr>
<th>Transcript</th>
<th>Coding</th>
<th>Relation to subtheme</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Participant 1 (P1)</strong>: When you’re coming to a mental health unit the problem is very much in you, you’re very stigmatised. If you’ve been in the mental health unit then you will never get a job essentially if people find out about it and erm .1 they’re really horrible places to be. They’re probably more traumatising than not so I suppose there is always that dilemma that I was feeding into this system that perhaps I didn’t agree with and I didn’t really know if it was the best way to be working and perhaps if the traditional healers had been able to develop themselves then perhaps,</td>
<td>Aware that identifying with mental health care can be damaging for individuals</td>
<td>Social activist</td>
</tr>
<tr>
<td></td>
<td>Individuals can be oppressed by others</td>
<td></td>
</tr>
<tr>
<td></td>
<td>“Traumatising” – language of the profession</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Self could be oppressive</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dilemmas and uncertainty</td>
<td></td>
</tr>
</tbody>
</table>
don’t know, they’d have made a better model then we’d have (laughs). So I suppose there was always the dilemma that I’m sort of feeding into this problem and I suppose I disagreed with, I have difficulties with, the idea of aid anyway and since going across there I had quite a lot of dilemmas about you know the fact that I was there means the government isn’t essentially employing another clinical psychologist. I’m working in the government system for free but what does that say, the government needs to be doing this not me. So am I feeding into the problem that way

**Interviewer (I):** Hmm yea. I was also thinking about what maybe motivated you to work in [Country] – what do you think led you to that point?

Taking lessons from systems within communities (traditional healing)

Distancing self from position of ‘aid’ worker

Issues of creating dependency

“am I feeding into” – it’s not intentional but could be ‘accidently’ practicing in a oppressive way

Doing it for self (taking from it

Exchange

Exchange

Exchange

Social activist

Exchange
**P1:** On the surface of it at the time, I just thought I need to get out of [UK city] (laughs) and I need to go traveling then. I come from a family where there’s been lots of traveling. So it’s always been in my head that the world is there.

**I:** Sort of family tradition.

Yea exactly exactly. My Gran was out doing that sort of the work with the red cross all those years ago so I just love hearing her stories about it. I love looking at all the artefacts that she came back with but my yea they always sort of had friends they always did it kind of quite a nice way I think. Although back then it would have been quite colonial style but actually my gran always used to talk about the friends they made while they were there and who were more locals.

<table>
<thead>
<tr>
<th><strong>Awareness of the world</strong></th>
<th><strong>Travel within the family</strong></th>
<th><strong>Global citizen</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>‘friends’ – a friendship (give and take) is related to a ‘nice’ way of doing it</td>
<td>‘Not nice’ would be linked to a ‘colonial style’ – colonial histories</td>
<td>Exchange</td>
</tr>
<tr>
<td>It could be done in a ‘not nice’ way</td>
<td></td>
<td>Social activist</td>
</tr>
</tbody>
</table>
An example of the use of Willig (2008) six stages in guiding analysis for the subtheme of professional

<table>
<thead>
<tr>
<th>Six stages</th>
<th>Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Discursive construction</strong></td>
<td>Professional approach</td>
</tr>
<tr>
<td><strong>2. Wider discourse</strong></td>
<td>Professionalism</td>
</tr>
<tr>
<td></td>
<td>Clinical Psychology (within UK mental health care)</td>
</tr>
<tr>
<td><strong>3. Action orientation</strong></td>
<td>Justification of work as safe and credible when there is a lack of regulation, guidelines and a certain level of isolation</td>
</tr>
<tr>
<td>What is gained from such a construction?</td>
<td></td>
</tr>
<tr>
<td><strong>4. Positioning</strong></td>
<td>Self as ‘knowledgeable’ and ‘expert’</td>
</tr>
<tr>
<td>What subject positions are offered?</td>
<td></td>
</tr>
<tr>
<td><strong>5. Practice</strong></td>
<td>Adaptation of models individual is knowledgeable in from (UK) clinical psychology</td>
</tr>
<tr>
<td>How does it open up/close down opportunities for action?</td>
<td>Introduction of ideas that are new to the communities individuals are working in</td>
</tr>
<tr>
<td><strong>6. Subjectivity</strong></td>
<td>A sense of confidence in own ideas and practice. Also, a discomfort with an identified level of power that comes with a ‘knowledgeable’ position</td>
</tr>
<tr>
<td>What <em>might</em> be thought, felt, experienced from here?</td>
<td></td>
</tr>
</tbody>
</table>
Appendix N: Epistemological statement

“Epistemology” is concerned with ‘how we know what we know’ (Crotty, 1998) or the nature of the relationship between the ‘knower’ (participant) or ‘would be knower’ (researcher) and ‘what can be known’ (Ponterotto, 2005). This is related to “ontology” which refers to ‘what reality is’ (Lincoln & Guba, 1985). A researcher’s approach will always be based on these underlying assumptions of what reality is, what it is possible for one to know about reality, and how one can get to know it. The aim of this statement is to make transparent the epistemological assumptions or position underpinning the empirical research element of this thesis. It will consider the nature of a social constructionist approach, the use of a social constructionist thematic analysis informed by ideas of Foucauldian discourse Analysis (FDA), the critical realist stance taken and the role of the researcher within this.

A positivist epistemological stance, usually adopted by quantitative methodology, was rejected. Research taking this stance holds the world as external and objective with a true reality to be found through controlled research (Willig, 2013). In the case of this research, it would propose that there is a ‘true’ version of working globally that could be approximated in this sample of psychologists. It is considered that work is unique to each individual, is likely to vastly differ across individuals and be influenced by factors not easily observable or measurable. Therefore, a positivist approach seemed unhelpful.

Instead, a qualitative methodology and social constructionist epistemology was considered most appropriate. The ontological assumption underlying this epistemology is that there is no ‘true’ reality to be found and that knowledge is constructed within the social world (Ormston, Spencer, Barnard & Snape, 2013). Within such an approach, a researcher can focus on the way in which people talk about their world and experiences. The researcher is not concerned with knowledge about ‘how things really are’, or
necessarily how they are experienced, but rather the *process* through which ‘knowledge’ is constructed in the first place (Willig, 2008). Due to the importance of language in construction, researchers who adopt a social constructionist epistemology tend to be interested in the study of discourse.

The researcher utilised a social constructionist thematic analysis. Thematic analysis was considered an ideal method as it is not linked to any epistemological position and can draw on a social constructionist framework and set of Foucauldian informed principles (Braun & Clarke, 2006; Timberlake, 2015). Michel Foucault was a historian and philosopher whose work influenced the development of FDA. FDA aims to map the discursive worlds that people inhabit. Unlike other versions of discourse analysis, such as discursive psychology, FDA looks at a ‘macro level’ and asks questions about what people may do, how people may feel and relationships to wider institutions given the discursive worlds they inhabit. This informed how I analysed the themes; looking at the wider discourses drawn upon, considering how these position the individual and what may be felt or done from this position. This was considered of most interest to the current field of research, taking it one step further than the description of experiences given in the clinical psychology forum special issue.

Within this approach there has been ongoing debate between relativists and critical realists (Willig, 2008). Relativists argue that everything is discursively constructed. Whereas, critical realists acknowledge that one’s knowledge of the world is mediated by, and therefore also constructed through, language while maintaining that there are underlying structures and mechanisms that generate phenomena, versions of which one then constructs through language. This research takes the latter, critical realist, approach whereby constructions are seen to be grounded in social and material structures such as institutions and their practices (for example; institutions of clinical psychology or psychiatry and the practice of diagnosis).
Such a positioning creates a significant role of the researcher. Within a social constructionist approach the role of the researcher can be compared to that of an architect; the researcher looks at phenomenon of interest with a view to how it has been constructed (Willig, 2008). If knowledge is constructed through discourse, including scientific knowledge, then research papers are themselves constructed. The researcher has an active role in the collection, analysis and write up and can therefore only *author*, rather than discover, knowledge. As discussed in the paper, the researcher creates one reading of the data and not a ‘true’ reading.

**References**


Appendix O: Reflective statement

Within this statement, I aim to reflect on the research process. I have been guided by Gibbs’ (1988) reflective cycle. I have analysed and evaluated the actions I took and the feelings I held. I have used the model to think about what I could have done differently and what lessons I will take forward into future research projects.

My motivation

This research was completed in keeping with my belief that a lot can be learnt from the different ways in which individuals view the world. Because of this, I have long held an interest and awareness of working within cultures different to my own. I assumed that I would always have an interest in working globally, independent of my career path.

On beginning my training in clinical psychology, I questioned the propensity for cultural adaptation as opposed to drawing upon traditions existing within cultures. Due to my interests and experiences prior to the course, I was aware of UK mental health professionals working globally and the developing global mental health literature. I was surprised by the lack of conversation around this in clinical psychology and became aware of an opinion that, ‘we already have enough to worry about in the NHS’. I wanted to understand more about this way of working and be a catalyst to discussion and reflection within the field of mental health, both in the UK and globally.

I spent some time finding supervisors who could support me with this project. My endeavours led me to find both a departmental and field supervisor who were interested in my research ideas. We worked together on developing the project involving a range of other individuals interested in the field of global mental health.

Data collection

After developing the project, data collection began. All of the potential participants contacted were very willing to contribute to the study. Involving a wide
range of interested individuals from the beginning of the project enhanced data collection and the overall progress of the project. I also found the use of Skype both a necessary and successful aspect of data collection, one that I would recommend to similar projects. Ensuring that all areas of the interview schedule were met whilst allowing for exploration of participants’ responses, within the time-frame, was challenging as participants often had much to contribute.

Some ethical issues arose in terms of data collection and reporting the demographics of my participant sample. There was a concern that participants were often isolated and without regulatory bodies in their work. Although no issues arose during the interviews, consideration was needed as to the organisations that could be contacted if ethical issues did arise. Furthermore, relatively few psychologists work in this way and participants were aware of, and commented on, the work of other participants who they were unaware of being involved. Extra care was needed to protect anonymity.

Data analysis

After collecting all the data, I moved on to analysis. I found this stage quite difficult and overwhelming, at times. This was made more manageable by using a structured methodology to note patterns in the data and a stepped guide for the consideration of discourse. I also gained support from an individual with experience in a similar form of analysis. However, there is no ‘right way’ to analyse discourse and existing studies all take varying approaches. It was therefore necessary to use the guidelines and existing literature but also to trust my own judgement and interpretations. This balance was not always easy to achieve and I often found myself asking ‘Am I doing it right?’ and searching for the ‘perfect’ template or ‘how to’ guide. Supervision was vital in addressing this and helping me build trust in the process of analysis.
A driving force was my interest in the area but I was also aware that this came with values and opinions that could significantly shape analysis. I found that the themes developed in my empirical paper often mirrored my own process throughout the project. For example, I had concerns over my position as a western mental health professional researching this area. I often drew upon ideas of global citizenship or exchange to negotiate this. I was also aware of how relevant the findings seemed to working in UK mental health services and wondered if this was influenced by my positioning. Again, supervision was important in enabling me to reflect on my assumptions and opinions to ensure that they were within my awareness. Supervisors were involved in free association of ideas after independent reading of the data and I held an epistemological stance that recognised the active role of the researcher. Allowing for subjectivity to be seen not as a ‘problematic bias’ but a ‘resource to be minded’ (Parker, 1994).

**Dissemination**

Following analysis and write up, a decision was made regarding journals. The Journal of Cross-Cultural Psychology was chosen for the systematic literature review as it is interested in the relation between culture and working from an interdisciplinary standpoint. The Journal of Social Science and Medicine was chosen for the empirical paper as it encourages material that is of general interest to an international readership. It is also interested in clinical practice and organisation of health care. Sharing the write up with contributors to the study will play an important role in dissemination as many are linked to different areas of the field. Since completing the interviews, participants have been in contact to ask for help in setting up an arena whereby individuals working globally can meet and discuss the kinds of issues raised within this impact.

**Final reflections**

My assumptions of working globally and my work within the NHS have been greatly shaped by the different views that contributed to this project. I have become
aware of the inherent power of professionalism, the constructed nature of mental health, its inescapable position within a wider political and economic context and the value of existing community resources. I have reflected on the opinion that, ‘We already have enough to worry about in the NHS.’ I have wondered if in fact looking and learning from outside the NHS would help address some of those concerns.

With regard to research, especially within my SLR, I went through a period of questioning the legitimacy of scientific knowledge. I learnt the importance of taking flexible, integrative and novel approaches. I also learnt about the usefulness of drawing upon research outside of clinical psychology, such as that of anthropology. In doing so, I noticed how some of the approaches within these fields vary from those I am used to within psychology. This made them difficult to understand and I reflected on the importance of ensuring that my research was accessible to a wide audience. I will take all of these lessons forward with me into future research projects.

References
